CENTER FOR REPRODUCTIVE RIGHTS

July 31, 2002

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary information on Peru
Scheduled for review by CEDAW on August 15, 2002

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by Peru, which is scheduled to be reviewed by the CEDAW Committee during its Exceptional Session in August 2002. The Center for Reproductive Law and Policy (CRLP), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This letter highlights several areas of concern related to the status of women's reproductive health and rights in Peru. Specifically, it focuses on discriminatory or inadequate laws and policies related to Peruvian women's reproductive rights.

Because reproductive rights are fundamental to women's health and equality, states parties' commitment to ensuring them should receive serious attention. Further, reproductive health and rights are explicitly protected in CEDAW. Article 12 requires states parties to "take all appropriate measures to eliminate discrimination against women in the field of health care," and specifies that governments should ensure access to "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[1] Article 10(h) requires that women have "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[2]

The Committee's General Recommendation on Women and Health considers it the responsibility of states parties to "[e]nsure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health," and to "[p]rioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance."[3]

We wish to bring to the Committee's attention the following issues of concern, which directly affect the reproductive health and lives of women in Peru:

1. Women's Participation in Political and Public Life (Article 7(b) of CEDAW)

Article 7(b) of CEDAW requires governments to ensure women's right to equal participation in "the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government." The CEDAW Committee, in its General Recommendation on Women and Health, calls upon states to "[p]lace a gender perspective at the centre of all policies and programmes affecting women's health and . . . involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women. . . ."[4]

A. Ministry for the Promotion of Women and Human Development

In 1996, Peru created the Ministry for the Promotion of Women and Human Development (PROMUDEH) in compliance with agreements reached at the Fourth World Conference on Women (Beijing Conference, 1995) to create mechanisms at the highest level to assure the advancement of women.[5] The Toledo government had been discussing a plan to eliminate PROMUDEH on the pretext of technical and economic efficiency.[6] Women's organizations protested, in the hope that PROMUDEH, as a governing body, would continue to ensure the advancement of women and guarantee the integration of a gender perspective in all state policies.[7] In response to these protests, the government has reversed its position and a new law on the powers of the Executive Branch maintains PROMUDEH and renames it "Ministry of Women and Social Development." This ministry is expected to continue to promote policies aimed at gender equity and equal opportunities for women.[8]

B. Ministry of Health

The near loss of PROMUDEH was not an isolated case. There are reports that a similar plan is being considered within the Ministry of Health regarding the Women and Development Program.[9] The future of the Women and Development Program[10] and the possibility of discontinuing the program are being discussed internally. Such a decision would reflect a rejection of a gender-sensitive approach to health policy development and would potentially undercut the effectiveness of future programs that directly concern women, especially those related to reproductive health.[11]

C. National Agreement

On the other hand, a promising development has been achieved through a process referred to as "National Agreement," in which the principal political parties and members of civil society agree on binding policies, which must be respected by members of the government. Among these is Policy Number 11 on the Promotion of Equality of Opportunities without Discrimination. In this policy, the state agrees to combat all forms of discrimination and promote equality of opportunities; strengthen the participation of women as social and

political entities who interact and work with the government and civil society; strengthen institutional mechanisms at the highest level of the government charged with directing policies and programs aimed at gender equality; give equal access to women to resources for income-generating activities and employment; develop systems ensuring the protection of children, adolescents, the elderly, homemakers, persons lacking support, persons with disabilities, and others facing discrimination or exclusion; and promote and protect the rights of members of ethnic communities facing discrimination by creating programs for social development that favor those groups. Policy Number 13 on health calls for the promotion of safe pregnancy and family planning services, with guarantees of choice in selecting methods and without coercion.[12]

2. Right to Health Care, Including Reproductive Health Care and Family Planning (Articles 12, 14(2)(b) and (c), and 10(h) of CEDAW)

As noted above, Article 12 of CEDAW requires states parties to ensure that all women have access to services related to pregnancy, confinement, and the postnatal period and have adequate nutrition during pregnancy and lactation. Article 10(h) requires that women have "access to … information and advice on family planning." Article 14 (2)(b) and (c) directs states parties to ensure that women in rural areas have access to adequate health care, including information, counseling, and family planning services, and that they benefit directly from social security programs. In its General Recommendation on Women and Health, the CEDAW Committee affirms that access to health care, including reproductive health care, is a basic right afforded to women under CEDAW.[13]

A. Access to Health Care

In Peru, many sectors of the population have difficulty accessing public health care services. The primary reasons for this are the geographical distribution of services and the low income levels of many families. There have been a number of studies documenting the disadvantages facing rural sectors in accessing health care.[14] Women face particular barriers to accessing health care services; women's incomes continue to be lower than those of men,[15] and single-parent homes are generally headed by women.[16] It is therefore not surprising that low-income women who live in rural areas face the greatest difficulties in accessing health care.[17]

The deprivations are even greater in the area of reproductive health. Although official figures from 1997 show some advances in health coverage,[18] they also reveal an enormous disparity between services offered and the needs of the population. For example, that year, only 8.8% of health care services at the national level had the capacity to provide basic obstetric care and only 6.4% of primary health care facilities offered the complete range of reproductive health services.[19] The government must urgently develop its capacity to meet the health care needs of all those living within its jurisdiction.

B. Maternal Mortality

Peru has an elevated maternal mortality ratio, with estimates ranging between 185 and 280 per 100,000 live births. Approximately 1,400 to 1,500 women die each year from pregnancy-related causes.[20] The situation is worse for adolescents[21] and women living in rural areas, where women are two times more likely to die from pregnancy-related causes than women in urban areas.[22]

Although Peru's law prioritizes maternal and child health care among the services that are to be provided free of charge, fees have not been eliminated. Instead, a sliding scale fee system has been created by the government, which takes into account the type of service and the patient's membership in a vulnerable group. Because eligibility for reduced fees is determined arbitrarily, however, the system has become a mechanism for discrimination.[23] Moreover, Peru's recently designed integral health system has not corrected this situation, making no provision for offering maternal/infant health care free of charge.[24]

C. Breast and Uterine Cancer

Programs to prevent breast and uterine cancer are still in the early stages; the major obstacles are lack of information and economic resources.[25] A large majority of Peruvian women do not undergo examinations to detect these diseases. In 1998, barely 12.3% of women underwent breast exams and only 22.7% had a pap smear. [26]

D. Unmet Need for Family Planning

Meeting women's family planning needs, which has been a stated government objective in recent years, has yet to be realized in Peru. A significant number of women have more children than they want.[27] Although the new administration has announced that by the end of 2002 the Ministry of Health will increase basic health insurance coverage for beneficiaries,[28] this insurance does not cover the contraceptive needs of women of reproductive age.[29] Reproductive health organizations are troubled by a gradual diminution of sexual and reproductive health care services offered in MINSA facilities. The Draft Sectorial Policy 2002-2012 reflects this shift in service priorities, raising only the subject of maternal mortality, without mentioning access to methods of family planning, even for the most low-income sectors of the country. [30]

E. Emergency Contraception

In July 2001, the government approved the use of emergency contraception (EC) pills in public health care facilities.[31] Instructions for their use were detailed over two years ago in the Family Planning Manual approved by RM No. 0738-92-SA/DM. However, EC has not been incorporated into the range of contraceptive methods offered by the Ministry of Health.

F. Quality of Care and Violations of the Human Rights of Women Health Care Users

Quality of care is an essential factor in ensuring access to reproductive health care services because it can either attract or repel those who use the health care system. This subject is still in need of attention in Peru. In some places, the provider/patient relationship has been inequitable and discriminatory, especially for low-income patients.[32] Although some of the rights of health care users are outlined in the General Law on Health, women are generally not aware of these rights. In fact, ignorance of these rights exists not only among the patients, but also among providers.

G. Abortion

In 1998, the CEDAW Committee examined Peru's Third and Fourth Periodic Report and noted the link between clandestine abortion and maternal mortality.[33] It further recognized that the criminalization of abortion did not prevent abortions but rather made them unsafe and dangerous for women. It recommended that the Peruvian government revise the legislation on abortion and protect women's access to basic and complete health care, including the right to safe abortion and emergency medical care for post-abortion complications.[34] However, Peru has ignored this recommendation.

In reality, there are a large number of abortions performed under unsafe conditions throughout the country. Although the clandestine nature of these abortions makes it difficult to estimate their exact number, it is estimated that 30% of all pregnancies annually end in abortion. On average, 5 out of 100 Peruvian women between the ages of 15 and 49 have an abortion each year. In 1997, that number came to 324,000 abortions.[35] Unsafe abortions account for 22% of maternal deaths.[36] There is a large demand for treatment of abortion complications in the public health care system,[37] leading many organizations to worry about the quality of post-abortion care.[38]

The requirement that health providers inform authorities of cases of induced abortion, ignoring their duty of confidentiality, discourages women from using health services when an interruption of pregnancy results in complications.[39] This law not only violates the right to privacy, but also the right to physical integrity. Women fearing punishment and the demeaning treatment to which they are often subjected in public health facilities—intimidating interrogations and other practices arising from the idea that women who have abortions should be punished[40]—do not get timely care for incomplete abortions.[41]

H. Conscientious Objection

Conscience clauses, which permit health care providers to refuse to offer services they deem objectionable, are a matter of concern at the national and global levels. A proposed law that "guarantees the absolute professional freedom of health professionals to exercise the right to conscientious objection" has been presented to the Peruvian Congress.[42] It represents a threat to women's exercise of their sexual and reproductive rights by imposing a potential barrier to such services as therapeutic abortion and the distribution of EC.

I. Sterilization

Peru's Minister of Health issued an apology in July 2002 for the forced sterilization of indigenous women during the presidency of Alberto Fujimori.[43] The apology follows the release of a government report confirming the violations and recommending that sterilization be banned as a method of family planning.[44] While the government's apology for these abuses is a welcome development, the proposed response – the banning of even consensual sterilization – threatens to further limit family planning options in a country where women already have difficulty meeting their contraceptive needs. Safe, freely chosen and non-coercive sterilization should remain an option for Peruvian women.

The government should continue to pursue institutional reforms to prevent the recurrence of these abuses,[45] and, to that end, work with the National Ombudsman and members of civil society.[46] It should also seek accountability for perpetrators of these coercive sterilizations. There have already been a number of criminal investigations and prosecutions related to these charges. However, a recent report from the National Ombudsman states that only five perpetrators have been successfully prosecuted to date.[47] Finally, the government should take action to compensate victims of coercive sterilizations.

J. HIV/AIDS and Sexually Transmissible Infections

Although HIV/AIDS is a relatively new phenomenon in Peru, the disease is rapidly spreading. The most common cause of transmission is sexual activity (95.7%).[48] It is estimated that there are 75,000 people living with HIV/AIDS, although officially registered cases only amount to 22,696.[49] The ratio of men to women infected is rapidly closing; it has gone from 11 men to 1 woman to 2.7 men to 1 woman.[50] The average age at infection is decreasing, so that now the majority of new cases appear in the 15- to 25-year old group, which may mean that people are being infected during childhood and/or adolescence, given the long incubation period of the disease.[51] This indicates that the educational efforts aimed at preventing adolescents from engaging in unsafe sex have not accomplished their objective.

3. Violence against Women (Article 5 of CEDAW)

CEDAW requires state intervention to prevent gender-based violence. Article 5 calls upon states to "modify the social and cultural patterns of conduct of men and women" in order to eliminate practices based on the idea of women's inferiority. In addition, violence against women within marriage and the family is condemned by Article 16(c), which guarantees women and men the same "rights and responsibilities during marriage. . . ."

The CEDAW Committee, in its General Recommendation 19 on Violence against Women, recognizes that gender-based violence denies women enjoyment of their rights and freedoms on a basis of equality with men.[52] The Committee defines "gender-based violence" as "violence that is directed against a woman because she is a woman or that affects women disproportionately."[53] It includes acts that inflict sexual harm or suffering.[54] The Committee

emphasizes that CEDAW is concerned not only with acts of gender-based violence perpetrated by governments, but also those acts committed by private parties. Governments have a duty to act with due diligence to prevent such acts among all individuals living within their jurisdictions.[55]

A. Sexual Violence

Recent laws have reconceptualized sexual violence to positive effect. Today it is considered a public health issue that the state has a duty to eradicate. However, the system for recording sex crimes is extremely deficient, despite the high incidence of these crimes recorded by social science data.[56] Official statistics show that in 1998 there were 4,677 rapes nationally,[57] while various studies estimate much higher figures. A 1995 study found 25,000 rapes in that year[58] and a 1997 study found that in Metropolitan Lima alone, there were 19,332 rapes.[59] An efficient recording system is an important aspect of understanding the dimensions of this problem and its absence reveals a lack of commitment to addressing it.

B. Domestic Violence

An efficient recording system is lacking not only for sex crimes but also for domestic violence cases. There is no unified system and cases are recorded in the agencies where they are brought, such as ombudsmen's offices, police stations, and health centers. In the rural and Andean regions of Peru there have been no studies to record the magnitude or particularities of the problem of domestic violence. The first national effort measuring the incidence of domestic violence in Peruvian society was the 2000 Demographic and Health Survey.[60] This survey found that 41% of women had been physically attacked by a husband or partner at least once; of those women, 83% responded that the violence was repeated occasionally and for 16%, it was repeated frequently.

In spite of the recent undeniable advances in legislation on domestic violence in Peru, obstacles to its practical application persist. For example, during investigations, law enforcement officials continue to resist adopting cautionary and protective measures, and when they do adopt them, these measures are not timely and do not achieve their objective, which is to prevent future violence. Neither have measures for follow-up on protective measures or prison sentences been instituted. The fact that the law defines domestic violence as a "reconcilable offense" contributes to greater impunity.[61] Moreover, the authorities often refuse to get involved in what they call private problems.[62]

Additionally, Peru has not complied with obligations under its own legislation to create policies to eradicate domestic violence. For example, the subject of violence has not been included in educational programs—an omission that permits the perpetuation of patterns of sexist behavior and attitudes conducive to domestic violence.[63]

C. Sexual Harassment

Sexual harassment as a manifestation of gender violence receives little attention in government policies.[64] In the workplace, victims encounter widespread acceptance of the

practice. The difficulty of proving "employer fault" has ensured that few or no cases are brought to the attention of labor authorities and practically none have been favorably resolved in accordance with the procedures set out by the law. Authorities who are called upon to suppress sexual harassment in schools have not done so. Municipal, parish, community and school ombudsmen register harassment cases involving female students and teachers, but generally no actions are taken, or the aggressor is simply moved to another school without an examination of the facts or the imposition of an administrative or legal punishment. [65]

We hope the Committee will consider addressing the following questions to the Peruvian government:

1. What is being done to address the barriers that women face in accessing full and affordable reproductive health and family planning services, in particular the practice of charging fees for maternal health care? What steps are being taken to address the consistently high level of maternal mortality in Peru, particularly among rural women?

2. How is the Peruvian government holding health care service providers accountable for physical and psychological violence and discrimination against women in the health care setting? What measures are being taken to address quality of care as a component of access to health services? Has an effort been made to disseminate the rights of health care service clients or enact a law on female patients' rights?

3. What has been done to follow up on the Committee's recommendations concerning the revision of legislation penalizing abortion, even in the case of rape? Is there an effort to revise the law that violates patients' rights by obliging health care providers to inform law enforcement officials about cases of induced abortion?

4. What measures has the government taken to guarantee women's right to access services and information for the prevention and treatment of HIV/AIDS and to prevent and punish discrimination against women living with HIV/AIDS? Is the government taking steps to address the key determinants in women's increased vulnerability to HIV/AIDS such as unequal power relations to men and social subordination?

5. What efforts are being made to enforce the state's policies and address issues of impunity with respect to sexual and domestic violence against women? In particular, are there currently any mechanisms in place to accurately record cases of sexual and domestic violence and to follow up on protective measures and sentences against perpetrators?

6. What is being done to address issues of sexual harassment in the work and school environments, in particular, are there any administrative regulations in place? Has there been a move forward on the draft legislation concerning sexual harassment in the workplace and in education?

There remains a significant gap between CEDAW's guarantees and the reality of women's reproductive health and lives. We appreciate the active interest that the CEDAW Committee has taken in women's reproductive health and rights and the strong concluding observations and recommendations the Committee has issued to governments in the past, stressing the need to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Peruvian government's compliance with the provisions of CEDAW. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,

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Endnotes

[1] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec.18, 1979, G.A. Res. 34/180, U.N.GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
[2] *Id.*
[3] Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation 24*, *Women and Health*, art. 12 para. 31(b), (c), U.N. Doc.A/54/38/Rev.1 (1999) [hereinafter *General Recommendation 24, Women and Health*].
[4] *Id*. at para. 31(a).
[5] *See* Legislative Decree 866, 29.10.96. Under the Fujimori government (1990-2000) there were reports of corruption through social support programs by this ministry. For this reason, the ministry underwent an intense reorganization process during Dr. Paniagua's administration (Nov. 2000-July 2001), which concluded with proposals for the possible restructuring of the office.
[6] *See PROMUDEH cambiará de nombre en julio* [*PROMUDEH Will Change its Name in July*], LA REPÚBLICA, May 2, 2002, *available at* http://www3.larepublica.com.pe/2002/MAYO/pdf2/ (last visited June 12, 2002), *citing* Carlos Bruce, Ministry of the Presidency and the General Secretary of the Government Party.
[7] *See Por la vigencia del PROMUDEH* [*In Defense of PROMUDEH*], EL COMERCIO, May 12, 2002, at A13. The statement was sponsored by civil society organizations.
[8] *See* Law No. 27779, *Organic Law Modifying the Organization and Functions of the Ministries*, July 11, 2002, *available at* http://www.congreso.gob.pe/out_of_domain.asp?URL=http%3A//200.37.159.7/pley/pley.htm (last visited July 31, 2002).
[9] *See* MINISTRY OF HEALTH, JUDICIAL ADVICE REPORT (Jan. 15, 2002); MINISTRY OF HEALTH, ADVISING REPORT FROM THE VICE MINISTERIAL OFFICE (Mar. 26, 2002). According to the new authorities "health is a holistic vision of the human being and family whose doctrine is contrary to the dichotomization or fragmentation of gender." Additionally, it has been disclosed that Ministry of Health authorities oppose the use of gender language in official documents, such as the National Plan of Action for Childhood and Adolescence, in spite of the fact that the terminology is used in international treaties signed by Peru.
[10] The Women and Development Program was created in 1990 and approved program objectives in 1995. The objectives focused on gender as the basis for activities related to the health of women with the purpose of contributing to the elimination of all forms of discrimination against women that adversely affect their health and family. *See* MOVIMIENTO MANUELA RAMOS, DERECHOS DE LAS MUJERES Y EQUIDAD DE GÉNERO: ESTADO ACTUAL DE SU CUMPLIMIENTO POR EL ESTADO PERUANO [WOMEN'S RIGHTS AND GENDER EQUALITY: ACTUAL COMPLIANCE IN PERU] 42 (2001) [hereinafter MOVIMIENTO MANUELA RAMOS, WOMEN'S RIGHTS AND GENDER EQUALITY].
[11] *See id.*
[12] *See* Government of Peru, *National Agreement, Social Equality and Social Justice, avaiable at* http://www.acuerdonacional.gob.pe/tematicos/equidad/textos.htm (last visited July 31, 2002).
[13] *General Recommendation 24, Women and Health*, *supra* note 3, para. 1.
[14] *See* JOSE CARLOS VERA LA TORRE, NATIONAL INSTITUTE OF STATISTICS AND INFORMATION (INEI), GASTOS DE LOS HOGARES EN SALUD [HOUSEHOLD HEALTH EXPENSES] (1999) [hereinafter NATIONAL HOUSEHOLD SURVEY]. According to the National Household Survey 98 II (NH 98 II), those with the least access to health services are people that live in rural areas (52% of the rural population versus 70% of the urban population). Regarding the economic variable, data suggests that one of the principal reasons people do not seek health care is lack of money. According to the National Household Survey 98 IV (NH 98 IV), this was the reason given by the highest percentage of respondents (36.6%). NH 98 II showed that in the zones with the highest level of poverty—like the north and south Sierras and in the east—the number of people who could not access health services when in ill health was greater than 40%. *Id*.
[15] According to the national average, a female worker receives less than half of what a male worker earns: a gap of 55.4%, with the most extreme difference in rural areas (87% gap in the rural sierra, 68.8% in the rural jungle and 64.8% on the rural coast). *See* Rosa Flores Medina, *La mujer y la brecha salarial* [*Women and the Wage Gap*], *in* POBREZA Y ECONOMÍA SOCIAL: ANÁLISIS DE UNA ENCUESTA ENNIV—1997 [POVERTY AND SOCIAL ECONOMICS: ANALYSIS OF ENNIV—1997 SURVEY] 233 (Richard Webb and Moisés Ventocilla eds., 1999).
[16] Of all female-headed households, 27.2% are living in a situation of poverty, while for male-headed households the percentage is only half that, at 13.5%. *See* INEI & MINISTRY FOR THE PROMOTION OF WOMEN AND HUMAN

DEVELOPMENT (PROMUDEH), GÉNERO EQUIDAD Y DISPARIDADES: UNA REVISIÓN EN LA ANTESALA DEL NUEVO MILENIO [GENDER EQUITY AND DISPARITIES: A REVIEW ON THE VERGE OF THE NEW MILLENNIUM] 136 (1999).

[17] Although rural women have the highest probability of becoming sick (37.8% versus 34.7% of rural men, 30% of urban women and 25.8% of the male urban population) they constitute one of the sectors that use institutional health services the least: 21.4% versus 38.8% of the female urban population and 37.8% of the male urban population. *See* Margarita Petrera, *La demanda por servicios de salud de la mujer rural en el Perú* [*Rural Women's Need for Health Services in Peru*], *in* POBREZA Y ECONOMÍA SOCIAL: ANÁLISIS DE UNA ENCUESTA ENNIV—1997 [POVERTY AND SOCIAL ECONOMICS: ANALYSIS OF ENNIV—1997 SURVEY] 198, 199, 205 (Richard Webb and Moisés Ventocilla eds., 1999); WORLD HEALTH ORGANIZATION (WHO), UNITED NATIONS CHILDREN'S FUND (UNICEF) & UNITED NATIONS POPULATION FUND (UNFPA), MATERNAL MORTALITY IN 1995: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA 45 (2001) [hereinafter MATERNAL MORTALITY IN 1995].

[18] The Maternal-Perinatal Program of the Ministry of Health indicates that between 1990 and 1996 the number of users increased considerably; prenatal monitoring increased 2.7 times, delivery 2.3 times and puerperium almost quintupled. *See* INEI, ESTADO DE LA POBLACIÓN PERUANA: 1997—SALUD REPRODUCTIVA [STATE OF THE PERUVIAN POPULATION: 1997—REPRODUCTIVE HEALTH] 28 (1997).

[19] *See* INEI, ENCUESTA DEMOGRÁFICA Y DE SALUD FAMILIAR 2000 [DEMOGRAPHIC AND FAMILY HEALTH SURVEY 2000] (2001) [hereinafter INEI, DEMOGRAPHIC AND FAMILY HEALTH SURVEY 2000]. The actual rate of coverage for at least one prenatal visit was 85% in 2000, while in 1996 it was 67% and in 1992, 64%. However, there are significant differences between rural and urban areas, so that in 2000, professional prenatal care reached 89% in urban areas; in rural areas it reached less than half of that at 45%. Regarding delivery, qualitative differences exist depending on socioeconomic condition and place of residence. So, while more than three quarters of women had their basic needs satisfied (79.6%) in health centers, the situation of women in extreme poverty is exactly the inverse: almost three quarters of births (72.6%) took place at home. *See id*.

[20] *See id*.; MATERNAL MORTALITY IN 1995, *supra* note 17, at 45. In some areas with a high percentage of rural, poor and extremely poor populations, the probability quintuples, so that while the national average is one death every five hours due to pregnancy-related causes, in these areas it becomes one death every hour. The zones referred to are in the districts of Huancavelica, Puno, Cusco, Apurímac, and Ucayali. *See* Nazario Carrasco Izquierdo, *Embarazo precoz y violencia* [*Teenage Pregnancy and Violence*], *in* LA VIOLENCIA COTIDIANA: VISIÓN DEL ESTADO Y LA SOCIEDAD CIVIL [DAILY VIOLENCE: VISION OF THE STATE AND CIVIL SOCIETY] 90 (1998).

[21] In terms of age, the mortality rate for adolescent mothers between the ages of 15 and 19 is 22.2 per 100,000 women, almost double the rate of the 30 to 34-year-olds which is 12.3 per 100,000 women. *See id. citing* INEI, DEMOGRAPHIC AND FAMILY HEALTH SURVEY 2000 at 123.

[22] *See* INEI, ENCUESTA DEMOGRÁFICA Y DE SALUD FAMILIAR 1996 [DEMOGRAPHIC AND FAMILY HEALTH SURVEY 1996] 131 (1997) [hereinafter INEI, DEMOGRAPHIC AND FAMILY HEALTH SURVEY 1996].

[23] Health care institutions, for whom fees for services are a primary source of income, select and attend to clients capable of paying, to the detriment of those who cannot. In addition, reproductive health care in many cases implies costs for care, drugs and examinations that are paid for exclusively by clients. The case of childbirth care is illustrative of this point. The fee for this service is fixed by each health facility. It covers expenses for complications, medications and test analyses, which are assumed by the patient sometimes, including a deposit as a guarantee. In the interior of the country, in a village in the jungle where the majority of inhabitants live in extreme poverty, the high cost of services lead most women to give birth at home. *See* COMITÉ DE AMÉRICA LATINA Y EL CARIBE PARA LA DEFENSA DE LOS DERECHOS DE LA MUJER (CLADEM) & THE CENTER FOR REPRODUCTIVE LAW AND POLICY (CRLP), SILENCE AND COMPLICITY: VIOLENCE AGAINST WOMEN IN PERUVIAN PUBLIC HEALTH FACILITIES 82-83 (1999) [hereinafter CLADEM & CRLP, SILENCE AND COMPLICITY].

[24] *See* D.S. No 003-2002-SA, *Legal Norms,* EL PERUANO, 223616, May 25, 2002 [hereinafter D.S. No 003-2002-SA].

[25] Among women in the sierra, 45.3% cited ignorance as the reason for not having breast exams and 41.5% gave this reason for not having a pap smear. In the greater metropolitan area of Lima, the main reason given was lack of necessity or disinterest. Among women who had their basic needs satisfied, 14.6% had breast exams and 25.3% pap smears, while among the poorest women only 6.9% had the former and 15.5% the latter. *See* ELSA ALCANTARA DE SAMANIEGO, INEI, SALUD REPRODUCTIVA, POBREZA Y CONDICIONES DE VIDA EN EL PERÚ [REPRODUCTIVE HEALTH, POVERTY AND CONDITIONS OF LIFE IN PERU] 5-6 (1999).

[26] *See* NATIONAL HOUSEHOLD SURVEY, *supra* note 14, at 4.

[27] Official figures show that in 1996, 12% of women in relationships had unmet family planning needs: 9% wanted to limit the size of their family and 3% to space the birth of children. *See* INEI, DEMOGRAPHIC AND FAMILY HEALTH SURVEY 1996, *supra* note 22, at 107.

[28] Coverage is projected to reach 7.5 million Peruvians at the lowest economic levels, of whom 6.4 million will be children and adolescents, 420 thousand pregnant women and 680 thousand adults. *See Atención de salud en distritos pobres se ampliará a 7.5 millones de personas* [*Health Care Services Will be Increased to Cover 7.5 Million People in Poor Districts*], EL PERUANO, Sept. 28, 2001, at 6.
[29] *See* D.S. No 003-2002-SA, *supra* note 24. This is inferable from D.S. No 003-2002-SA, which establishes the services offered by the Integral Health Insurance in which the maternal/infant component is the sole reference to care for pregnant women and makes an express exclusion for "persons in contact with health care in circumstances related to reproduction."
[30] *See* MINISTRY OF HEALTH, SECTORIAL POLICY PROPOSALS FOR THE PERIOD 2002-2012 AND FUNDAMENTAL PRINCIPLES FOR THE SECTORIAL STRATEGIC PLAN FOR FIVE-YEAR PERIOD AUGUST 2001-JULY 2006, *available at* http://www.minsa.gob.pe (last visited June 14, 2002). This is of particular importance, moreover, considering that 80% of women who use contraceptives receive them from some public sector entity. *See* INEI, DEMOGRAPHIC AND FAMILY HEALTH SURVEY 2000, *supra* note 19, at 69, Table 5.10.
[31] *See* R.M. No 399-2001.SA/DM, *Legal Norms*, EL PERUANO, July 17, 2001.
[32] *See* GRUPO IMPULSOR NACIONAL (GIN), MUJERES Y CIUDADANÍA EN EL PERÚ: AVANCES Y BARRERAS [WOMEN AND CITIZENSHIP IN PERU: ADVANCES AND BARRIERS] 50 (1998). This has been documented in particularly serious cases. Research between 1996 and 1997 established, through documentation of cases and testimony, the existence of several forms of violence against clients of the public health facilities, particularly in marginalized urban and rural zones. These included sexual violence and violence against pregnant women, women giving birth and patients suspected of incomplete abortion. *See* CLADEM & CRLP, SILENCE AND COMPLICITY, *supra* note 23, at 56.
[33] *See* CEDAW Committee, *Concluding Observations of the Committee for the Elimination of Discrimination against Women: Peru*, paras. 292-346, U.N. Doc. A/53/38/Rev.1 (1998). The Human Rights Committee made a similar recommendation on examining the periodic Third Report of Peru (1996), in which it recognized the relationship between clandestine abortion and maternal morbidity/mortality and the fact that the criminalization of abortion could constitute cruel, inhuman and degrading treatment in direct violation of article 7 of PDCP. It further recommended the revision of legislation that penalizes abortion, even in cases of rape. *See* Human Rights Committee, *Concluding Observations of the Human Rights Committee: Peru*, para. 15, U.N. Doc. CCPR/C/79/Add.72 (1996).
[34] *See id.*
[35] *See* INEI, ESTADO DE LA POBLACIÓN [STATE OF THE POPULATION] 33-34 (1997).
[36] *See* MINISTRY OF HEALTH, PROGRAMA DE SALUD REPRODUCTIVA Y PLANIFICACIÓN FAMILIAR 1996-2000 [REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAM 1996-2000] 17 (2000).
[37] The Maternal Perinatal Program of the Ministry of Health revealed that in 1997, 15% of obstetric/gynecological admissions were due to abortion complications. *See* INEI, INDICADORES SELECCIONADOS PARA EL SEGUIMIENTO DE LOS EJES ESTRATÉGICOS DE LOS ACUERDOS DE LA CONFERENCIA INTERNACIONAL SOBRE POBLACIÓN Y DESARROLLO [SELECTED INDICATORS FOR FOLLOW-UP STRATEGIES OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT ACCORDS] 91 (2000).
[38] According to information from a group of independent institutions that work in the area of health, the Ministry of Health is attempting to return to the use of dilation and curettage, ignoring advances in health care for women with incomplete abortion, including manual vacuum aspiration which has less traumatic effects and is used in 48 hospitals in Peru, and which permits thousands of women safer health care. *See* Letter to the Minister of Health (May 17, 2002) (on file with CRLP).
[39] *See* Peru, General Health Law 26842 of 1997.
[40] *See* CLADEM & CRLP, SILENCE AND COMPLICITY, *supra* note 23, at 56, 59.
[41] In cases of suspected abortion, some health care providers believe that it is their role to punish women and, considering these women criminals, subject them to threatening interrogations and cruel treatment. *See* CLADEM & CRLP, SILENCE AND COMPLICITY, *supra* note 23, at 56. It is important to note the low crime figures for abortion-related practices which demonstrate the inefficiency and ineffectiveness of punitive laws. In reality, instead of preventing women from turning to abortion, these laws have a tragic consequence: thousands of women who decide to interrupt their pregnancy must do so under unsafe conditions and at risk of their lives. In 1998, the National Police registered 772 abortion cases at the national level, which constitutes only 3.1% of all crimes against life, body and health. *See* INEI, PERÚ: COMPENDIO DE ESTADÍSTICAS SOCIODEMOGRÁFICAS 1998-1999 [PERU: COMPENDIUM OF SOCIODEMOGRAPHIC STATISTICS 1998-1999] 512 (1999) [hereinafter INEI, SOCIODEMOGRAPHIC STATISTICS 1998-1999].
[42] *See* Ministry of Health, Bill 0116 (2001), *available at* http://www.congreso.gob.pe/out_of_domain.asp?URL=http%3A//200.37.159.7/pley/pley.htm (last visited June 14,

2002). The bill was presented by Congressman Dr. Luis Solari, ex-minister of health for the current government and leader of the most conservative factions on sexual and reproductive rights in Peru. Conscientious objection is recognized as a right that permits health professionals to refuse to perform any procedure or legal medical act that goes against their beliefs or principles, and is currently included in the General Health Law. Extending this right without restrictions could jeopardize the rights of health facility users, especially of the most vulnerable populations.

[43] Owain Johnson, *Peru Apologizes for Sterilizing Indians*, UNITED PRESS INTERNATIONAL, July 25, 2002.

[44] Investigatory Sub-Commission on Persons and Institutions Involved in Voluntary Surgical Sterilization, Peruvian Congress, *Informe final sobre la aplicación de la AQV en los años 1990-2000* [Final Report on the use of Voluntary Surgical Contraception from 1990-2000], p. 110. (June 2002).

[45] In 2001, two commissions were created within the Ministry of Health and the Congress of the Republic, respectively. In the first two years of the program (1996-1997), as a result of the Ministry of Health's aggressive family planning campaign, there was a surprising increase in female sterilization. Investigations by the media and women's groups alerted the national and international community to numerous cases of unauthorized sterilization; systematic, house-by-house campaigns promoting sterilization in marginalized urban and rural areas; coercion and undermining of free and informed consent; and the pervasive establishment of sterilization quotas by health authorities which personnel and health facilities were pressured and rewarded for fulfilling. On consideration of these facts, the National Ombudsman's office issued a report on the problem and proposed a set of measures and recommendations for the health sector. These proposed measures addressed laws that regulate family planning services in general and also the provision of surgical sterilization. *See* Ombudsman's Resolution no. 03-DP-2000, Jan. 28, 2000, *available at* http://www.ombudsman.gob.pe/informes/aqvii/dp003-2000.pdf (last visited June 14, 2002) [hereinafter Ombudsman's Resolution no. 03-DP-2000]; CLADEM, NADA PERSONAL: REPORTE DE DERECHOS HUMANOS SOBRE LA APLICACIÓN DE LA ANTICONCEPCIÓN QUIRÚRGICA EN EL PERÚ: 1996-1998 [NOTHING PERSONAL: HUMAN RIGHTS REPORT ON THE USE OF SURGICAL STERILIZATION IN PERU: 1996-1998] 151 (1999) [hereinafter CLADEM, HUMAN RIGHTS REPORT ON THE USE OF SURGICAL STERILIZATION IN PERU].

[46] In July 1998, at the Nineteenth Session of the CEDAW Monitoring Committee, the official Peruvian delegation distributed a document titled "El Programa Peruano de Salud Reproductiva" ["The Pervuvian Reproductive Health Program"], that outlined the corrective measures to PNSRPF, among others, which stated that "providers will not have goals for tubal ligations, vasectomies or any other family planning method…" *See id. citing* CLADEM, HUMAN RIGHTS REPORT ON THE USE OF SURGICAL STERILIZATION IN PERU at 141. However, in 1998 and 1999 cases were reported in which women did not have sufficient access to information before surgical sterilization, waiting periods were not respected, consent was given under pressure, or the post-operative evaluation system was deficient. *See id. citing* Ombudsman Resolution no. 03-DP-2000, paras. 4, 6.

[47] *See Declaraciones de defensora adjunta para los Derechos de la Mujer* [*Declarations by the Deputy Ombudsman for Women's Rights*], EL COMERCIO, Sept. 28, 2001, at A15.

[48] *See* MOVIMIENTO MANUELA RAMOS, WOMEN'S RIGHTS AND GENDER EQUALITY, *supra* note 10, at 56.

[49] *See id.*

[50] *See id.*

[51] *See id.*

[52] CEDAW Committee, *General Recommendation 19*, *Violence against Women,* para 1. U.N. Doc. No. A/47/38 (1992), *available at* http://www.un.org/womenwatch/daw/cedaw/recomm.htm (last visited June 14, 2002).

[53] *Id.* para. 6.

[54] *See id.*

[55] *See id.* para. 9.

[56] According to official statistics, 44.1% of crimes against liberty are crimes of rape, the third most frequent crime, after assault and drug dealing. *See* INEI, SOCIODEMOGRAPHIC STATISTICS 1998-1999, *supra* note 41, at 514.

[57] *See id*.

[58] *See* PERMANENT COMMISSION ON THE RIGHTS OF WOMEN AND CHILDREN, MINISTRY OF JUSTICE OF PERU, INFORME NACIONAL DE LA MUJER: CUARTA CONFERENCIA MUNDIAL SOBRE LA MUJER [NATIONAL REPORT ON WOMEN: FOURTH WORLD CONFERENCE ON WOMEN] 106 (1995).

[59] *See* ESTUDIO PARA LA DEFENSA DE LOS DERECHOS DE LA MUJER (DEMUS), QUÉ ESTAMOS PENSANDO LOS LIMEÑ OS SOBRE LAS AGRESIONES SEXUALES? APROXIMACIÓN A LAS CONCEPCIONES Y EXPERIENCIAS DE LOS POBLADORES DE LIMA METROPOLITANA EN DOS PERIODOS: 1997 Y 1999 [WHAT DO THE PEOPLE OF LIMA THINK ABOUT SEXUAL VIOLENCE? PERCEPTIONS AND EXPERIENCES OF METROPOLITAN LIMA IN TWO TIME PERIODS: 1997 AND 1999] (2000) (on file with CRLP).

[60] *See* INEI, DEMOGRAPHIC AND FAMILY HEALTH SURVEY 2000, *supra* note 19.

[61] The law states that conciliation is an obligatory step of the process and the judge and the district attorney promote

and in many cases impose this resolution to the conflict to preserve the family unit. It has been found—especially in the interior of the country—that the police assume this power when in fact it is reserved to judges. *See id*.

[62] Testimony collected from work with women organized from the poorest rural areas. *See* MOVIMIENTO MANUELA RAMOS, NADIE SABE LO QUE PASA DENTRO DE MI CASA, YO NO MÁS CONOZCO MI PENA... [NO ONE KNOWS WHAT HAPPENS IN MY HOUSE, I NO LONGER FEEL THE PAIN…] 9 (1997).

[63] Actions the State should develop as policies to eradicate domestic violence. *See* Protection from Domestic Violence Law, art. 3, 1993.

[64] The bill attempting to address this subject in the labor and educational sectors has remained in the Congress of the Republic for more than five years. This fact reveals the scant interest the subject has for legislators.

[65] *See* GIN & Mujeres por la Igualdad Real [Women for Equality], *Balance del Grado de Cumplimiento de la Plataforma de Acción Mundial en el Perú [Evaluation of the Implementation of the Global Platform of Action in Peru*] 48.