



April 8, 2011

Committee on Economic, Social, and Cultural Rights

Office of the United Nations High Commissioner for Human Rights
Palais des Nations

CH-1211 Geneva 10, Switzerland

Re: Supplementary information on reproductive rights in Peru, scheduled for review by the pre-sessional working group during the 46th session of the Committee on Economic, Social, and Cultural Rights on May 23-27, 2011

Distinguished Committee Members:

This letter is intended to supplement the periodic report submitted by Peru, which is scheduled for review by the Committee on Economic, Social and Cultural Rights (the Committee) during its 46th session. The Center for Reproductive Rights (the Center), an independent, non-governmental, international legal organization, the Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos – PROMSEX, Católicas por el Derecho a Decidir - Perú, Centro de Investigación y Promoción Popular – CENDIPP, Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer – CLADEM Perú, Estudio para la Defensa de los Derechos de la Mujer – DEMUS, Instituto de Estudios en Salud, Sexualidad y Desarrollo Humano – IESSDEH, Lesbianas Independientes Feministas Socialistas – LIFS, Mesa de Vigilancia de los Derechos Sexuales y Reproductivos, Movimiento Manuela Ramos and Planned Parenthood Federation of America hope to further the work of the Committee by providing independent information concerning the rights protected in the International Convention on Economic, Social and Cultural Rights (ICESCR).¹ In this letter, we will address Peru’s failure to comply with its obligations under the Covenant particularly regarding the exercise of the right to comprehensive healthcare without discrimination.

As reproductive health and rights are fundamental to women’s health and equality, it is imperative that States Parties demonstrate a serious commitment to ensuring such rights, which receive broad protection under the ICESCR. Article 12(1) of the Covenant recognizes “the right of everyone to the enjoyment of the highest attainable standard of

physical and mental health.”² In interpreting this right in General Comment No. 14, the Committee has explicitly defined the right to health to “include the right to control one’s health and body, including sexual and reproductive freedoms,”³ and further confirmed that “[t]he realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.”⁴ The Committee has asserted that States Parties are required to take “measures to improve child and maternal health, sexual and reproductive health services, including access to family planning . . . emergency obstetric services and access to information, as well as to resources necessary to act on that information.”⁵

Articles 2(2) and 3 of the ICESCR guarantee the right to non-discrimination, specifically as to “sex, social origin or other status.”⁶ To that end, the Committee has characterized the duty to prevent discrimination in access to healthcare as a “core obligation” of the state.⁷ Despite these protections and the Committee’s interpretive guidance, the reproductive health of women in Peru, particularly their rights to safe pregnancy and child birth, access to legal abortion and comprehensive contraceptive methods, and the right to access reproductive healthcare services without discrimination because of sex, age or status, are being neglected and violated.

The obligation to protect, respect, and guarantee the right to health without discrimination as recognized by the ICESCR lies at the core of reproductive rights, which, thereby, includes the right to access reproductive healthcare services and information without discrimination. Such rights are firmly grounded in various international treaties to which Peru is a party⁸ and are fundamental to the exercise of women’s rights to life, health, dignity, equality, and self-determination. Indeed, the rights delineated in these instruments are integrated into the national law,⁹ and the “[r]ules concerning the rights and freedoms recognized by [the Peruvian] Constitution are construed in accordance with the Universal Declaration of Human Rights and international treaties and agreements on those rights, which have been ratified by Peru.”¹⁰ Moreover, the Peruvian Constitutional Court has determined that “international human rights treaties of which the Peruvian State is a party make up the legal order.”¹¹

And yet, inequality pervades all spheres of life in Peru. Peru is identified as a middle-income country, but over half of the population lives in poverty. Almost a quarter lives in extreme poverty.¹² Peru’s indigenous population is disproportionately represented in rural areas, especially among the rural poor. Further disparity is evident between the country’s rural and urban poor with 50,3% of Peru’s rural poor living in extreme poverty, while only 9.7% of the urban population does.¹³ This inequality is manifest in the country’s health system, which ranked 119/191 in 2000 by the World Health Organization (WHO) for equitable health systems, and 184/191 in fairness of financial distribution.¹⁴

I. The Right to Access Reproductive Healthcare without discrimination (Article 2, 3, and 12 of the ICESCR)

A. Introduction

There exist extensive structural problems in the protection of the right to access reproductive healthcare services without discrimination in Peru. Maternal mortality due to lack of obstetric care is an example. There is a direct relationship between the legal status of abortion services and maternal mortality in the country. Abortion is legal in Peru when the life or health of the women is threatened, yet despite its legality on these grounds, structural failures result in the denial of access to the procedure. There is no regulation of standard of care or recourse to access abortion when necessary. Additionally, Peru's restrictive interpretation of the law criminalizes abortion even in cases of rape and for serious physical or mental defects (characterized in the Penal Code as eugenic abortion)—perpetuating a discriminatory gender paradigm.

Peruvian law proscribes free distribution of emergency contraception in the public healthcare system, which generates inequalities in the access to this essential medicine,¹⁵ especially in cases of rape. Similarly, there is insufficient availability of regular contraception in the public healthcare system.

Not only does the HIV-positive population suffer severe discrimination in access to healthcare treatment specifically for HIV/AIDS, but it also experiences discrimination in access to reproductive healthcare. This discrimination extends to all people of diverse sexual orientation.

The aforementioned obstacles in access to reproductive healthcare, which all result in rights violations, are exacerbated in the case of adolescents. Adolescents face additional legal obstacles in the exercise of their sexual and reproductive rights in Peru; all sexual relationships with—and between—minors aged 14 to 18 are criminalized regardless of consent.¹⁶ Moreover, the General Health Law states that no minor may receive surgical or medical treatment without the consent of a legal guardian. Such provisions have dramatic implications on access to reproductive healthcare for adolescents.

The following sections will address each of the violations to the right to health without discrimination as enshrined in Articles 2, 3, and 12 of the ICESCR in the order presented above.

B. Discrimination of women in the exercise of the right to health

Article 12(2)a of the Covenant recognizes the right to maternal and child health and this Committee¹⁷ interprets this right to involve reproductive health, which includes “the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning...as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.”¹⁸

Articles 2(2) and 3 of ICESCR guarantee all persons “the equal right of men and women to the enjoyment of all economic, social and cultural rights”¹⁹ without discrimination, specifically as to “sex...social origin...or other status.”²⁰ This Committee affirms sex “as among the prohibited grounds of discrimination”²¹ and warns that particular vigilance must be exercised –“emphasized”²²—to avoid non-discrimination in the context of “the right to health, equality of access to health care and health services.”²³

This Committee has clarified that States Parties to ICESCR have a positive obligation to ensure child and maternal health, and sexual and reproductive health, including access to family planning, to emergency obstetric care, and to information.²⁴ It recognizes the inextricable link between women’s rights to non-discrimination and to health, including reproductive healthcare: “The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.”²⁵

Obstetric care, abortion services, and emergency contraception comprise healthcare services that only women need. The denial of quality, timely, and appropriate healthcare services that only women need constitutes discrimination and is a violation of Peru’s international obligations under ICESCR. Non-discrimination is an essential factor in the fulfillment of access to the right to health, among others, which States Parties must take measures to fulfill.

This Committee has characterized the duty to prevent discrimination in the exercise of the right to health and access to healthcare as a “core obligation”²⁶ of States Parties; “States have a special obligation...to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health.”²⁷ General Comment No. 14 reaffirms States’ obligations to fulfill “the rights of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups,”²⁸ including women.

1. Maternal Mortality in Peru -overview

According to 2009 statistics presented by Peru’s Ministry of Health (MINSA), Peru has the second highest maternal mortality rate in South America after Bolivia. In the year 2000, Peru’s maternal mortality rate was 185 for every 100,000 live births.²⁹ According to the WHO in 2010, 240 women die for every 100,000 live births; the regional average is 99.³⁰ This high rate of maternal deaths not only exposes the inequality and social exclusion suffered by Peruvian women; it also reveals weaknesses in the national institutional framework. In 2009, the MINSA reported that “the causes of (maternal) mortality in the last five years are the same as those for the year 2007: hemorrhages (40.5%), hypertension as a result of pregnancy (19%), abortion (6%) and infections (6%); most of the deaths occur while giving birth (preclampsia) and post birth (uterine lethargy).”³¹ These are defined as direct causes of maternal death, but there are many indirect causes; maternal deaths from direct causes are almost always preventable. The MINSA has reported that 71% of maternal deaths stem from direct causes and 29% of indirect causes.³² Indirect causes of maternal

death are linked to lack of access to legal abortion services in Peru.

According to the National Population and Family Health Survey (ENDES) 2000, the principal determinants of maternal mortality are concentrated in women less than 18 years old and women older than 35 who have more than three children and more than two years between pregnancies.³³ Moreover, between 1999 and 2001, “50% of the poorer population bore 85% of maternal deaths registered in the country.”³⁴ According to the Department of Epidemiology, which registers maternal deaths occurring in the public health system, most deaths occur in the poorer regions of the country, such as Cajamarca and Puno.

While the National Institute of Statistics and Information (INEI) collected information regarding maternal mortality rates in 2000 and 2009, neither of these surveys include such basic statistical information as economic level or education of the women; these factors contribute to maternal mortality. Additionally, official data on maternal mortality has been severely questioned during the last years. In 2002, the Peruvian government announced a reduction of maternal mortality to 164 x 100.000 live births, but this figure was rescinded after its veracity was questioned.³⁵

As part of its commitment to reducing maternal mortality, which, adhering to the Millennium Development Goals obligate Peru to reduce the maternal mortality ratio to 66 x 100.000 live births by 2015, the MINSA has developed the Multisectorial Strategic Plan for the Reduction of Maternal Mortality. But this plan does not obligate the regional governments, and it does not have sufficient funding to formulate or implement a sustainable advocacy plan.

The right to non-discrimination in the context of maternal healthcare requires States to guarantee access to quality healthcare to the most vulnerable populations, including ethnic minorities and those living in rural and low-income areas. The Covenant requires State Parties to ensure that the right to health may be exercised “without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”³⁶

When States fail to ensure that quality specific healthcare services, such as obstetric, contraceptive, gynecological, and antenatal care, are available to all women, they violate women’s rights to health³⁷ and to non-discrimination as an obligation of immediate application.³⁸ Thus, Peru has the obligation to provide accessible, available, and quality reproductive healthcare services; these enable women to exercise their right to the highest attainable standard of health as defined in Article 12. Moreover, the CEDAW Committee, concerning Peru, has noted “with concern that illegal abortion remains one of the leading causes of the high maternal mortality rate and that the State party’s restrictive interpretation of therapeutic abortion, which is legal, may further lead women to seek unsafe and illegal abortions.” Importantly, it has expressed concern “that the recommendations of the Human Rights Committee in *KL v Peru* (CCPR/C/85/D/1153/2003 (2005)) were not adhered to by the State party.”³⁹

Peru's dire reproductive health landscape exposes four structural problems in the country's public health system regarding maternal mortality: i) There is a lack of understanding of the conditions under which pregnancy-related deaths occur; ii) Maternal mortality, particularly due to denial of quality and timely obstetric care, has a harsher impact on the poorer population; iii) There is inequitable attention given to adolescent women, especially those victims of sexual violence; and iv) The criminalization of abortion leads women to seek unsafe abortions that can cause severe complications such as hemorrhaging, which comprises 41% of all maternal deaths in Peru.

The criminalization of abortion is directly related to the high rates of maternal mortality. A 2009 report from Amnesty International shows that the leading causes of maternal mortality in Peru are hemorrhages (40.5%), preeclampsia (18.9%), abortion (6.1%), and infections (6.1%); 26.5% of deaths had other causes.⁴⁰

2. Discrimination in women's access to reproductive healthcare services: Abortion

Unsafe abortion is one of the five main causes of pregnancy-related death in Peru,⁴¹ where one in seven women who undergo abortions is hospitalized for associated complications.⁴² Revealingly, a higher percentage of poor women who undergo an abortion are at risk of complications than women who are not poor.⁴³ Lack of clarity around the right and access to abortion services frequently leads women to seek clandestine, illegal, and unsafe abortions. According to a 2006 report, approximately 371,420 unsafe abortions are performed in Peru every year.⁴⁴ The MINSA reported that 40,794 incomplete abortions were treated in public health facilities that year, but there is reportedly a 10% rate of omission of cases reported due to under- or inaccurate reporting in Peru⁴⁵ such that, in reality, more women are hospitalized and are unnecessarily endangered.

Though abortion is generally criminalized, therapeutic abortion to save the life and protect the health of the pregnant woman has been permitted since Peru's 1924 Penal Code. In the current Penal Code, from 1991, "[a]bortion practiced by a physician with the consent of the pregnant woman...is not punishable when it is the only means to save the life of the woman or to avoid serious and permanent damage to her health."⁴⁶

Lack of access to legal abortion services contributes to Peru's high maternal mortality ratio. On various occasions, this Committee has linked illegal and unsafe abortions to high rates of maternal mortality.⁴⁷ Peru's systematic refusal to comply with the law authorizing therapeutic abortion when a woman's life or health is in danger, and its restrictive interpretation of the law, contravenes women's fundamental rights under the Peruvian Constitution, as well as to the rights promoted and upheld by this Committee and international law. Despite implicit and explicit protections under international law, the reproductive health and rights of women in Peru, and in turn their equality as full citizens of the state, and their enjoyment of living life with dignity, are being jeopardized and violated by lack of access to legal therapeutic abortion. Denial of legal abortion services often compounds the vulnerability of already marginalized groups, including adolescents. Two cases before UN treaty monitoring bodies reveal the systematic situation in Peru and the

particular need for the adoption of a protocol of attention for the cases where abortion is legal.

K.L.⁴⁸ was 17 years old and pregnant with a wanted pregnancy in 2001 when her fetus was diagnosed with anencephaly, a fatal abnormality. Not only did K.L. become severely depressed, but she also suffered nausea and other physical symptoms. Encouraged by her doctors who considered her pregnancy a “life-threatening risk,” and because she “suffered severe psychological consequences exacerbated by her status as a minor,”⁴⁹ K.L. sought a therapeutic abortion, but was denied one by Peruvian health officials. She was forced to carry her pregnancy to term, giving birth to a baby who died several days later. This case was submitted before the United Nations Human Rights Committee (UNHRC) in 2002, and in 2005, the Committee issued a decision recognizing K.L.’s forced pregnancy as constituting cruel, inhuman and degrading treatment and a violation of Articles 2, 7, 17, and 24 of the ICCPR.

The UNHRC also recommended that Peru implement measures and provide remedies to prevent such cases from happening in the future,⁵⁰ but the government has not complied with the recommendations to adopt clear legal guidelines for the provision of legal abortion⁵¹ and such cases continue to occur.

In Peru it has been estimated that around 945 new borne per year suffer from severe malformations incompatible with life. Comparative studies point that between 3% and 5% of all births present some kind of defect when born and that 5% of those comprise malformations incompatible with life. In Peru there are 630.000 births per year.⁵²

In the case of L.C. v. Peru,⁵³ submitted before the CEDAW Committee, a 13-year-old girl was denied a therapeutic abortion, despite it being necessary to save her from quadriplegia. L.C., who lives in an impoverished region near Lima, was repeatedly raped and became pregnant. Desperate, L.C. attempted suicide by jumping off of a two-story building. She was discovered and taken to the hospital where doctors concluded she needed an emergency intervention to realign her spine. Despite this consensus, and despite Peru’s abortion law, doctors refused to operate on L.C. once they realized she was pregnant. L.C. and her mother petitioned the hospital authorities repeatedly, but to no avail. L.C. eventually suffered a miscarriage and received the corrective spinal surgery four months later. But it was too late and the procedure had little effect: L.C. is quadriplegic. Her condition has affected her family.

As of today the MINSA has not issued guidelines of attention for cases of legal abortion, although it has proposed such project in several occasions.⁵⁴

Failing to guarantee legal access to therapeutic abortion directly endangers the health and lives of women who need it – sometimes even sacrificing their lives and health – and it also “den[ies] women their dignity and right to self-determination.”⁵⁵ Under the ICCPR, States Parties are obligated to safeguard its people from preventable, and arbitrary, loss of life,⁵⁶ and to increase life expectancy.⁵⁷ Consequently, Peru is responsible for ensuring access to

therapeutic abortion in order to protect women's rights to health, dignity, and self-determination, as well as to sexual equality, and to guarantee freedom from discrimination, as is pursuant to the principles established in the ICESCR.

This Committee understands the obligation to non-discrimination in a healthcare setting to apply both in fact and law to the most vulnerable sectors. In General Comment No. 14, the Committee explains this as the respect for medical ethics, considerations of gender, confidentiality, and the satisfaction of best standard of health.⁵⁸ For this reason, each treaty monitoring body has explicitly established the importance of guaranteeing women's rights to health, including reproductive health, and to implicitly keep in mind the particular needs imposed by biological difference.⁵⁹ This Committee recommends a gender perspective in all of programs related to health through recognition of the biological and socio-cultural factors that are determinants of women's health.⁶⁰ The UNHRC has established that women's lack of access to reproductive health services violates women's rights to equality and life, recognizing that the lack of available services and information on family planning, including abortion, compromises women's capacity for equal participation in all social and economic aspects of public life, and increases unwanted pregnancies, illegal and unsafe abortions, and maternal mortality.⁶¹

Peru's failure to adequately inform women and girls of their legal right to therapeutic abortion and provide them with legal recourse when this right is denied places a profound burden on the public health system. Further, the Committee against Torture recognizes laws that proscribe abortion even to preserve the life of the pregnant woman as being in violation of ethical standards of the medical profession.⁶²

By not instructing medical personnel of their protection under the law, or their professional and ethical obligation to provide this service to women and girls who need them,⁶³ Peru frustrates the ethical standards of its medical personnel. The government must implement protocols for clinical practitioners with regards to the provision of therapeutic abortion to obviate ethical violations, and protect the lives, health, and dignity of women.

On the other hand, although the MINSA has regulated medical attention for obstetric emergencies including post-abortion complications such as septic abortion,⁶⁴ there are still regulations that force health operators to denounce patients seeking post-abortion care.⁶⁵ While not all health operators comply with these provisions, women are inhibited from seeking such care in fear of being prosecuted.

Article 120 of the Peruvian Penal Code establishes a criminal sanction for cases of abortion when the woman has been raped. The same article stipulates a lower sanction for cases of abortion when the pregnancy is a result of rape outside of marriage, while it does not contemplate such attenuation when the rape happens within the marriage.

It is of great concern that abortion is criminalized for cases of sexual violence. This is particularly relevant as 12% of Peruvian women have at least once been forced to a sexual relationship.⁶⁶ One study found that almost half of Peruvian women in Cusco (46.6%) and

almost a quarter of women in Lima (22.5%) have suffered sexual violence at the hands of their partner, when the most frequent form of such violence is forced sexual intercourse accounting to 37.6% women in Cusco and 16.4% in Lima.⁶⁷ Other studies have found that 5% of such women bear an unwanted pregnancy, which amounts to 35,000 unwanted pregnancies as a product of sexual violence.⁶⁸

The UNHRC has recognized the link between the guarantee of equality of rights between men and women and the denial of access to abortions in cases of rape or where women are compelled to undergo “life-threatening clandestine” abortions,⁶⁹ which Peru effectively does. Furthermore, implicitly allowing medical providers to decide women’s access to a legal and essential medical treatment, according to their own whim, as in the case of L.C., implicates women’s autonomy and health. It also encourages the stigmatization of abortion, both belying and perpetuating gender discrimination in Peruvian society within the context of reproductive health. This Committee has observed that denial of access to reproductive healthcare services specific to women implicates the basic tenet of non-discrimination. Denying access to abortion services, particularly in the cases of rape, deprives women of their ability to fully enjoy the most fundamental of rights.

Article 120 of the Penal Code also criminalizes eugenic abortions, which are defined by said article as to be in cases of serious physical or mental defects as determined by a physician. Such legislation should also be revised.

In October 2009, the Special Revision Commission for the Penal Code⁷⁰ approved a draft of a new Penal Code that decriminalized abortion in cases of rape, non-consented artificial insemination or egg transference, and fetal abnormality, as diagnosed by a physician. This revision has been pending for more than two years. Moreover, there is uncertainty as to if such a proposal will pass when considered.

The lack of access to safe and legal abortion severely compromises the right to health of women and children in Peru, violating it as enshrined in the ICSECR and its duty to take positive measures to guarantee such right.

3. Discrimination of women in the access to reproductive healthcare: Contraception

Access to contraception for women in Peru is both unequal and inequitable. The Office of the Ombudsman has reported two critical problems:⁷¹ First, there is a constant shortage of modern contraceptives, including pills, injections and emergency contraception; second, though family planning services are free, the Office reports a constant of undue and illicit charges.⁷² ENDES statistics from 2000, 2004, and 2009 reflect a progressive increase of traditional methods of contraception, due to the lack of availability of modern contraceptives, in the urban area 74,5% uses some type of method: 53% uses modern methods and 21,3% uses traditional methods; in the rural area 70% uses some type of contraceptive: 42,3% uses modern methods and 27,8% uses traditional methods.⁷³

ENDES surveys of 2000 and 2009 reveal and increase in use of modern contraceptives through the private system, albeit at a cost. The MINSA and ESSALUD are directly responsible for the provision of contraceptives, as 68% of contraceptive users use the public system. Their failure to provide contraceptives directly affects the exercise of the right to reproductive health of poor woman, since the option to access contraceptives is directly linked to women’s economic capacity. The information in the following chart reveals the wide discrepancy between the desired rate of fertility among women in Peru and the actual fertility rate. This gap responds, in part, to the lack of access to contraceptives throughout the country, as stated above.

2000		2004		2009	
Wanted Fertility	Observed Fertility	Wanted Fertility	Observed Fertility	Wanted Fertility	Observed Fertility
1.80%	3.25%	1.85%	2.90%	1.90%	2.95%

Evolution of the fertility rate

Source: INEI (ENDES), own elaboration

In 2009, Peru’s Constitutional Court issued a decision declaring the unconstitutionality of the free distribution of emergency contraception, citing right to life violations. This decision impeded the development of “Píldora del día después,” a program designed to provide public health facilities with emergency contraception for its free distribution. It also ordered the laboratories that produced the medicine to include a warning stating that such medicine could inhibit the egg’s fertilization, citing uncertainty around the anti-implantatory effects of the pill.⁷⁴

In a previous Constitutional Court decision from 2006, however, the Court determined that the pill has contraceptive effects. The 2009 decision failed to address the change of the government opinion in those 3 years and disregards all the expert medical opinions submitted by the Pan-American Health Organization, the Peruvian Health College, and the Peruvian Health Academy that supported the 2006 conclusions.

In 2010, the MINSA issued Resolution No. 167-2010/MINSA based on a communication from the Pan-American Health Organization, a 2010 report by the General Direction of Medicines, Supplies and Drugs (DIGEMID), and a letter from the National Institute of Health, in which it was confirmed that levonostrengel, the emergency contraceptive pill, had a contraceptive use, is not abortive, and does not have secondary effects. Nevertheless, a petition was filed arguing the non-compliance of the constitutional prohibition of the free distribution of emergency contraception imposed by the MINSA, and the Court granted such petition. Subsequently, the Ministry issued Resolution No. 652-2010/MINSA by which the free distribution was prohibited.

This prohibition of emergency contraceptives within the public healthcare system majorly implicates women’s right to reproductive healthcare, predominantly poor women, as it is the primary supplier of these methods as well. 29,682 emergency contraception kits were distributed in 2007, 24,198 in 2008, and 27,731 between January and September of 2009.⁷⁵

This prohibition has particularly harsh consequences for women who become pregnant as a consequence of sexual violence. The MINSA official guidelines concerning violence against women⁷⁶ state the obligation to offer and administer emergency contraception to women victims of sexual violence.

General Comment No. 14 of this Committee asserts that the prohibition of discrimination in the services of sexual and reproductive rights is an obligation of immediate application.⁷⁷ In the same General Comment it also stated that the States, in compliance with their duty to respect the right to health, have the legal obligation to abstain from “deny[ing] or limit[ing] the equal access of all persons (...) to preventive health services (...) and impose discriminatory practices as a state policy; (...) moreover, the obligations of respect include the state obligation to abstain to prohibit or impede preventive care. Moreover, states must abstain to limit the access to contraceptives or other means to maintain sexual health, censor, hide or intentionally distort information regarding health, including sexual education and information (...).”⁷⁸

The policies adopted by the Peruvian State banning the free distribution of emergency contraception violate the right to the highest attainable standard of health and imposes an unequal regime that is regressive in relation to the policies once adopted by the State.

C. Discrimination in the access to reproductive healthcare because of status: HIV

According to the MINSA, there were 25,748 people living with AIDS and 40,181 cases HIV in Peru in January 2010.⁷⁹ Due to the gravity of this issue, the Office of the Ombudsman issued a report⁸⁰ regarding the prevalence and causes of HIV/AIDS in Peru, as reported by UNAIDS. The prevalence rate of adult men in Peru is 0,5%; it is 0,3% for women. 97% of people living with HIV/AIDS contracted the disease through sexual relations, 2% by vertical transmission, and 1% through blood transfusion.⁸¹

Although the prevalence rate is less than 1% for the general population of Peru,⁸² it is greater among men who have sex with other men (MSM), at 5%. Other populations at high risk are sex workers and those who are incarcerated.⁸³

Over the years, the number of women that have contracted HIV has increased considerably. According to the MINSA, the rate of men/women was 12/1 in 1990, while in the last 9 years it has been – and remains - 3/1.⁸⁴ This is partially explained by that fact that a sector of the MSM population is bisexual, leaving women vulnerable to the disease

By age group, younger populations are more vulnerable to HIV/AIDS. Indeed, 41% of cases occur among people aged 25-34 years.⁸⁵ The highest prevalence rates are found in Peru’s cities.⁸⁶

State healthcare expenditure for HIV/AIDS increased between 2007 and 2009, -or from 5% to 8% respectively –an increase of 18,665.841soles.⁸⁷ Medical treatment of HIV/AIDS constituted 42% of the State’s total expenditure, while prevention represented 32%. 13.4% was invested in research. Meanwhile, the principal source of funds for HIV/AIDS treatment and prevention was international; it comprised 48.9% of the total expenditure. The public sector represented 41.8%.⁸⁸

Reinforcing ICESCR’s provisions regarding the right to health without discrimination, the ICCPR establishes States’ obligation to guarantee equality in the enjoyment of rights without discrimination against men and women.⁸⁹ The UNHRC has expanded on this right, recognizing that there are a series of historical, cultural, and religious tradition and practices⁹⁰ that obstruct “the equal enjoyment of rights” “both in the public and the private sector” and has asked states to take the necessary measures to eliminate or modify them⁹¹ so they cannot be used as a pretext to justify discrimination against women in the enjoyment of their rights. In Peru in particular, the UNHRC has recognized the “the prevalence, throughout... society, of socio-cultural patterns of behavior that perpetuated prejudices and discrimination against women.”⁹²

Though Peru has increased its overall commitment to combat HIV/AIDS, albeit incrementally, the Peruvian government fails to protect those living with HIV/AIDS from rights transgressions, or from obstacles to appropriate healthcare. This compounds their already vulnerable state. As Constitutional Court decisions evidence, people living with HIV/AIDS are often unconstitutionally denied access to comprehensive healthcare outright.⁹³ There is an extreme dearth of anti-retroviral drugs in the public health system for the treatment of those with HIV/AIDS.⁹⁴ Additionally, HIV-positive women are not given the proper and essential care during labor to protect the transmission of the disease to their child, even though international law recognizes the right of HIV-positive pregnant women to caesarian section.⁹⁵

The lack of integration and implementation of HIV/AIDS prevention strategies into the public health system, as well as its loosely-monitored protocols, further undermines the government’s commitment to combat HIV/AIDS. By not strengthening oversight regarding the protocol of blood transfusions, Peru leaves its entire population vulnerable to HIV/AIDS⁹⁶--as does the extreme shortage of condoms available to populations at great risk of contracting the disease.⁹⁷

D. Discrimination in the access of healthcare services because of sexual orientation

Discrimination of the non-hetero-normative population in Peru is deeply entrenched in Peruvian society⁹⁸ and the lack of a properly implemented and monitored legal framework to protect these populations exacerbates their vulnerability to rights violations.

Peru’s new Constitutional Procedural Code, approved in 2004, recognized sexual orientation as a cause of discrimination from which one deserves constitutional protection.⁹⁹ Indeed, the Constitutional Court issued four decisions in 2004, which address discrimination for

sexual orientation and gender identity, respectively.¹⁰⁰ Additionally, Peru's National Human Rights Plan, explicitly includes a reference to sexual orientation in the fourth strategic guidelines establishing the implementation of affirmative policies in favor of the rights of people with increased vulnerability; the eighth strategic objective emphasizes the need "to guarantee the rights of people with HIV/AIDS as well as of people with different sexual orientation."¹⁰¹ Not one of these initiatives has been implemented, however.¹⁰²

Though legislation addressing sexual and reproductive sexual diversity in Peru has focused solely on HIV/AIDS,¹⁰³ Principle 17 of the Yogyakarta Principles affirms that all persons have the right to enjoy the highest level of physical and mental health without discrimination as to sexual orientation and gender identity and that sexual and reproductive health is an essential aspect of this right.¹⁰⁴

There are other health needs of this population that are not addressed by the State. For example, lesbian women are concerned about exposure to cervical cancer and breast cancer. For fear of prejudice from health professionals, they often do not make gynecological visits.¹⁰⁵ Moreover it is of grave concern the cases of domestic violence which include sexual violence, which is used to correct sexual orientation or to punish women for such choices. Such cases reveal the need for services directed to address mental health for the LGBT population which suffer from severe depression and anxiety evidenced in alcoholism and tabaquism as a direct consequence of a generalized homophobic environment.¹⁰⁶

Regarding the trans population, it has been highlighted that the category of men having sex with men makes invisible their exposure to HIV/AIDS and undermines possibility for focused health attention.

The medical attention necessary to transform the body to coincide with sexual identity is another demand of this group: In absence of formal services, transgender people resort to illegal substances and hormones without prescription, which often cause grave damage to their health. These procedures also require a mental healthcare policy because there is a high prevalence of drug and alcohol use due to trans-phobic violence and its effects on psychological health.¹⁰⁷

The non-hetero-sexual and transgender population faces discrimination not only in treatment by health personnel, but also in the lack of identification and prioritization of their health needs.¹⁰⁸ Not one of the protocols for sanitary health in Peru incorporates a sexual diversity perspective that addresses the health reality of this population.

One example exemplifies the Peruvian government's resistance to integrating a sexual diversity perspective into state health campaigns. In 2009, the MINSa and some grass roots organizations designed "Peru, diverse country" that aimed to combat, with resources from the Global Fund to fight HIV/AIDS, the stigma and discrimination of the gay, lesbian, bisexual, and transgender population,¹⁰⁹ but the MINSa ultimately decided to withdraw its logo from the campaign without explanation.¹¹⁰

E. Discrimination in access to reproductive healthcare because of age: adolescents

As mentioned above, adolescents are a particularly vulnerable segment of Peru's population. In 2009, there were 5,685,294 adolescents¹¹¹ and fifty-seven percent of all births occur to women under the age of 20.¹¹² 13% of adolescents are mothers or have been pregnant at least once. Nearly 36% did not want children at the time they became pregnant.¹¹³

According to ENDES the beginning of sexual intercourse before 18 years old in Peru increased from 38,2% in 2000, to 39,2% in 2009. Also, adolescent fertility on women between 15 and 19 years old has increased from the year 2000 to 2009. In 2000 13% of women had been pregnant at least once, 10,7% were already mothers and 2,3% were pregnant for the first time. However, in 2009 13,7% had been pregnant, 11,1% were already mothers and 2,7% were pregnant for the first time. Unplanned pregnancies went from 41.8% in 2000 to 56.2% in 2009.¹¹⁴

On the other hand, the use of contraceptives has decreased, while registered cases of STD's have increased. In 2000, the use of any contraceptive method and modern contraceptive methods was of 71.7%; registered cases of STDs was 0,3%. Later, in 2009, the use of any contraceptive method decreased to 58,3%, and modern methods to 40,9%. Accordingly, registered STDs in the same year increased to 0,9%.¹¹⁵

There are many risks inherent to adolescent pregnancy, including additional obstacles in accessing reproductive healthcare services, and it is physically and mentally more straining. The UNHRC has linked high rates of maternal mortality of adolescents with adolescent pregnancy.¹¹⁶ The WHO has classified adolescent pregnancy as a high-risk pregnancy.¹¹⁷ Moreover, the Committee on the Rights of the Child has stated that pregnancy after rape can be a "significant health risk"¹¹⁸ and has instructed states parties to "provide ... adolescent [victims of sexual abuse] with *all* the necessary services."¹¹⁹ In consequence, it has repeatedly urged State parties to permit abortion in cases of rape and incest.¹²⁰

Generally, Peru has failed in its obligations to protect the reproductive health of adolescents. Government officials in both the K.L. and L.C. cases were aware they were handling an adolescent pregnancy and its attending risks, one of which was a result from rape, but offered no particular protections.

While the number of pregnancies has decreased generally in Peru, the pregnancy rate for adolescents has increased recently.¹²¹ Pregnancy complication and abortion comprise one of the five major causes of death among women 15 to 19 years old. Adolescent pregnancy implicates the rights to life and health of adolescents, and also impedes the right to education and to non-discrimination in all spheres of life.¹²²

Exacerbating the situation of adolescent reproductive health in the country, in 2006, Peru enacted a law modifying the statutory rape law in the Penal Code.¹²³ According to this law, all sexual relations for adolescents aged 14 to 18 are considered a crime without distinction as to consent.¹²⁴ This law has had a negative impact on adolescents' access to sexual and reproductive health services¹²⁵ and the stigma around sexual activity. Medical practitioners

are unclear of the treatment that they should give to adolescents seeking reproductive healthcare, even jeopardizing pre-natal checkups, public institutional deliveries as the pregnancy is the evidence of the crime.

A 2009 report highlights different indicators of the negative impact of the law, recommending its withdrawal from the legal system as it recognizes that it “limits the decision making capacity of the physicians who are confused as to the attitude they should have towards this situation against the national law” and their obligation to “guarantee the sexual and reproductive rights of the population, especially adolescents.”¹²⁶ Moreover, such law intersects with the legal obligation to denounce patients in cases of crimes.¹²⁷

The Supreme Court of Peru has differentiated between the cases of consented and non-consented sexual intercourse issuing two Agreements¹²⁸ that delineate the criteria to determine the exemption of criminal responsibility before all national judicial bodies for adolescents between the ages of 14 to 18 years of age. Nevertheless, these agreements are binding only in the judicial branch, and not to for the Public Ministry or the police, both who prosecute the crimes. There have also been some attempts to present drafts of legislation in Congress that would eliminate Article 173 from the Penal Code. Nevertheless, the government has been inconsistent as it has also presented a draft that does not eliminate such provisions.¹²⁹

Access for adolescents to sexual orientation, and reproductive healthcare services is subject to the consent of their guardians, as stated in Article 4 of the General Health Law of Peru. Such legislation constitutes a clear legal barrier that discriminates against adolescents in exercising their right to health.¹³⁰

The rights to health, and its constituent rights, and to information are inseparable.¹³¹ Although men are susceptible to sexual and reproductive health risks, women and adolescents are especially at risk.¹³² The CEDAW Committee has noted, “adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health”¹³³ and that the implementation of the right to information and education is “central to the health and well-being of women.”¹³⁴ That Committee further asserts that an approach should be implemented in which women’s health services take into account their different needs; that all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health, are removed; that States allocate resources for programs directed at adolescents for the prevention of STDs; and that specific health education to adolescents address issues of gender equality, violence, prevention of STDs, and reproductive and sexual health rights, among other principles.¹³⁵

Children and adolescents have the right to the enjoyment of the highest attainable standard of health and access to facilities,¹³⁶ and services. Peru has an obligation to protect and ensure the rights of adolescents to access reproductive healthcare services without discrimination under the ICCPR, the ICESCR, and the Convention on the Rights of the Child, among other international treaties.

This Committee cites the Convention on the Rights of the Child when exploring the healthcare context for children and adolescents. It states, “the principle of non-discrimination requires that girls, as well as boys, have access to...safe environments, and physical as well as mental health services.”¹³⁷ And State Parties should “ensure[] the opportunity [for adolescents] to participate in decisions affecting their health...The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”¹³⁸

The situation presented in this report demonstrates a lack of compliance with Peru’s obligations under the ICSECR, particularly regarding the right to health without discrimination. Taking into account the information provided, as well as Peru’s periodic report, we hope this Committee will consider asking the government the following questions.

II. Questions for the State

1. What have been the advances in the registration of maternal mortality and morbidity and the analyses of its causes and consequences, especially for the registration of cases of adolescents and rural areas?
2. What is the State doing to improve the attention of obstetric emergencies in the first levels of attention? What particular steps is the State taking to guarantee access of quality and timely obstetric care for the poor and rural population?
3. What is the government doing to extend its Maternal Mortality Multisectorial plan so that it is binding for the local governments and that includes the prevention and control of STIs, HIV/AIDS?
4. Why has the State not complied with the recommendations issued by the UNHRC in the case of *K.L. v, Peru* to adopt measures of non-repetition to secure women’s exercise of their right to be free from cruel, inhumane and degrading treatment in cases of abortion where the health of the woman is in danger? What is Peru’s government doing to adopt a protocol of attention for the cases of legal abortion that will include clear mechanisms to access the procedure respecting the broad interpretation of its scope in relation to the protection of women’s physical and mental health?
5. What is Peru doing to decriminalize abortion for the cases of rape and for cases of eugenic abortion as determined by article 120 of the Penal Code?

6. What is Peru doing to improve the situation regarding the perpetual shortage of supply of modern contraceptives in the public health system reported by the Office of the Ombudsman?
7. What measures is the State taking to guarantee the broadest options of modern contraceptives for women in the public health sector? Why is Peru disregarding official technical information regarding the non-abortive effects of emergency contraception to ban its free distribution? What steps is Peru taking to assure the supply of emergency contraception to victims of rape?
8. What steps has the State taken to adopt a monitoring system with indicators for the treatment of HIV positive people in its public health system?
9. What is the current supply and demand of antiretroviral treatment for HIV positive people and what is the government doing to improve such supply?
10. What is the government doing to increase the supply in the public health sector of condoms as well as the inclusion of the provision of the female condom?
11. What actions has the State taken to sensitize medical personnel in the attention to LGBT population?
12. What action has the State taken or is planning to take to adopt sanitary protocols for the specific needs in sexual and reproductive health of the LGBT population?
13. What is the State doing to extend the Judicial Agreement that exempts responsibility for the cases of sexual relations with adolescents between ages 14 to 18 where there has been consent?
14. What steps is the State taking to minimize the effects of article 173/3 of the Penal Code for the exercise of the right to comprehensive reproductive health care of adolescents?
15. What is Peru doing to prioritize the adoption as law of the law reform pending in Congress that decriminalized sexual relations with adolescents between ages 14 to 18?
16. What is Peru doing to ensure that adolescents get appropriate reproductive healthcare services without the need of the intervention of third parties?
17. What measures is the State taking to increase and ensure access to adequate information on sexual and reproductive rights, particularly on access to

contraception and abortion services, especially for adolescents and the rural population?

We appreciate this Committee's longstanding commitment to reproductive rights and to the eradication of discrimination in the access to reproductive healthcare. Please do not hesitate to contact the undersigned should you have any further questions regarding reproductive health situation in Peru.

Sincerely,



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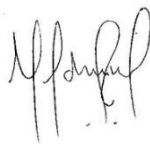
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¹ International Covenant on Economic, Social and Cultural Rights (ICESCR), *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N.GAOR, Supp. No. 16 at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976), *available at* <http://www2.ohchr.org/english/law/cescr.htm>.

² *Id.* art. 12(1).

³ Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The right to the highest attainable standard of health*, para. 8, U.N. Doc. E/C.12/2000/4 (2000), *available at* [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En) [hereinafter CESCR, *General Comment No. 14*].

⁴ *Id.* para. 21.

⁵ *Id.* para. 14.

⁶ ICESCR, *supra* note 1, arts. 2(2) and 3.

⁷ CESCR, *General Comment No. 14, supra* note 3, para. 19.

⁸ Apart from the ICESCR, Peru has ratified the International Covenant on Civil and Political Rights (ICCPR), *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180 (XXXIV), U.N. GAOR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (*entered into force* Sept. 3, 1981); the Convention on the Rights of the Child (CRC), *adopted* Nov. 20, 1989, G.A. Res. 44/25 (XLIV), Annex, U.N. GAOR, Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990); and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), *adopted* Dec. 10, 1984, G.A. Res. 39/46 (XXXIX), Annex, U.N. GAOR, Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984) (*entered into force* June 26, 1987), among others. Further, this Committee has also established in its General Comment No. 9 that domestic legislation should be interpreted in accordance with a State's international obligations: "Thus, when a domestic decision maker is faced with a choice between an interpretation of the law that would place the State in breach of the Covenant and one that would enable the State to comply with the Covenant, international law requires the choice of the latter." CESCR, *General Comment No. 9: The domestic application of the Covenant*, para. 15, U.N. Doc. E/C.12/1998/24. As such, Peru is obliged to uphold women's reproductive rights as they are enshrined in international treaties to which it is a party, and to take measures to fulfill the recommendations and interpretations of these rights as set forth by the United Nations treaty monitoring bodies.

⁹ CONSTITUCIÓN POLÍTICA DE PERÚ (1993) [hereinafter CONST. PERÚ], Art. 55.

¹⁰ *Id.* Fourth final and transitional disposition.

¹¹ Tribunal Constitucional de Perú [Constitutional Court of Peru], Sentencia [Decision] No. 0025-2005-PI/TC, nos. 25-34, *available at* <http://www.tc.gob.pe/jurisprudencia/2006/00025-2005-AI%2000026-2005-AI.html> (unofficial translation); Tribunal Constitucional de Perú [Constitutional Court of Peru], Sentencia [Decision] No. 0217-2002-HC/TC, no. 2.

¹² AMNESTY INTERNATIONAL (AI), FATAL FLAWS: BARRIERS TO MATERNAL HEALTH IN PERU 14 (2009), *available at* <http://www.amnesty.org/en/library/asset/AMR46/008/2009/en/442a4678-9f6d-4f91-9045-3c47198144d7/amr460082009eng.pdf> [hereinafter AI, FATAL FLAWS].

¹³ *Id.*

¹⁴ *Id.*

¹⁵ World Health Organization (WHO), MODEL LIST OF ESSENTIAL MEDICINES (16th ed., updated) (Mar. 2009), *available at* http://www.who.int/medicines/publications/essentialmedicines/Updated_sixteenth_adult_list_en.pdf.

¹⁶ PERU, PENAL CODE (1991), Art.173.

¹⁷ ICESCR, *supra* note 1, art. 12(2)a. (“[T]he steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.”).

¹⁸ CESCR, *General Comment No. 14*, *supra* note 3.

¹⁹ ICESCR, *supra* note 1, arts. 2(2) and 3.

²⁰ *Id.* art. 2(2).

²¹ CESCR, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights* (art. 2, para. 2), U.N. Doc. E/C.12/GC/20 (2009), *available at* <http://www1.umn.edu/humanrts/gencomm/escgencom20.html>.

²² CESCR, *General Comment No. 14*, *supra* note 3.

²³ *Id.*

²⁴ *Id.* para. 14. (States Parties must take “measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”).

²⁵ *Id.*

²⁶ *Id.* para. 19.

²⁷ *Id.*

²⁸ *Id.*

²⁹ MINISTERIO DE SALUD DE PERÚ [MINISTRY OF HEALTH OF PERU] (MINSa), DIRECCIÓN GENERAL DE SALUD DE LAS PERSONAS [PEOPLES’ GENERAL HEALTH], ESTRATEGIA SANITARIA NACIONAL DE SALUD SEXUAL Y REPRODUCTIVA [NATIONAL SANITARY STRATEGY FOR SEXUAL AND REPRODUCTIVE HEALTH], PLAN ESTRATÉGICO NACIONAL PARA LA REDUCCIÓN DE LA MORTALIDAD MATERNA Y PERINATAL 2009-2015 [NATIONAL STRATEGIC PLAN FOR THE REDUCTION OF MATERNAL AND PERINATAL MORTALITY: 2009-2015] 23 (2009), *available at* http://www.minsa.gob.pe/servicios/serums/2009/normas/1_penrmm.pdf [hereinafter MINSa, NATIONAL STRATEGIC PLAN FOR THE REDUCTION OF MATERNAL AND PERINATAL MORTALITY].

³⁰ WHO, WORLD HEALTH STATISTICS 2010, *available at* http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf.

³¹ MINSa, NATIONAL STRATEGIC PLAN FOR THE REDUCTION OF MATERNAL AND PERINATAL MORTALITY, *supra* note 2, at 27.

³² *Id.* at 23.

³³ MINSA, INFORMACIÓN DE MORTALIDAD [INFORMATION ON MORTALITY] (2004), *available at* http://www.minsa.gob.pe/ogei/estadistica/Archivos/SalaSituacional/04_Mortalidad.pdf.

³⁴ *Id.*

³⁵ *Id.*

³⁶ ICESCR, *supra* note 1, art. 2(2).

³⁷ *See generally*, CESCR, *General Comment No. 14*, *supra* note 3, paras. 12, 21.

³⁸ *See generally*, CESCR, *General Comment No. 16: The equal right of men and women to the enjoyment of all Economic, Social and Cultural Rights*, U.N. Doc. E/C.12/2005/4 (2005), *available at* [http://www.unhcr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/7c6dc1dee6268e32c125708f0050dbf6/\\$FILE/G0543539.pdf](http://www.unhcr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/7c6dc1dee6268e32c125708f0050dbf6/$FILE/G0543539.pdf).

³⁹ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Peru*, para 24, U.N. Doc. CEDAW C/PER/CO/6 (2007).

⁴⁰ AI, FATAL FLAWS, *supra* note 12, at 14.

⁴¹ *Id.*

⁴² *Id.*

⁴³ DELICIA FERRANDO, EL ABORTO CLANDESTINO EN PERÚ [CLANDESTINE ABORTION IN PERU] 20 (2006), *available at* http://www.observamujerpuno.org.pe/files/lecturas/Derecho%20de%20las%20Mujeres/aborto_clandestino_en_peru.pdf [hereinafter CLANDESTINE ABORTION IN PERU]. (44% of poor, rural, women who undergo an abortion are at risk of complications and 27% of urban poor are at risk; 24% of rural, non-poor, women are at risk and only 5% of urban women who are not poor run this risk.)

⁴⁴ *Id.*

⁴⁵ AI, FATAL FLAWS, *supra* note 12, at 14.

⁴⁶ PERU, PENAL CODE (1991), Art. 119.

⁴⁷ *See, e.g.*, CESCR, *Concluding Observations: Benin*, U.N. Doc. CESCR E/C.12/1/Add.78 (2002); *Brazil*, U.N. Doc. CESCR E/C.12/1/Add.87 (2003); *Cameroon*, U.N. Doc. CESCR E/C.12/1/Add.40 (1999); *Mauritius*, U.N. Doc. E/C.12/1994/8 (1994); *Mexico*, U.N. Doc. E/C.12/1/Add.41 (1999); U.N. Doc. E/C.12/MEX/CO/4 (2006); *Nepal*, U.N. Doc. E/C.12/1/Add.66 (2001); *Panama*, U.N. Doc. E/C.12/1/Add.64 (2001); *Paraguay*, U.N. Doc. E/C.12/PRY/CO/3 (2008); *Poland*, U.N. Doc. E/C.12/1/Add.26 (1998); *Russian Federation*, U.N. Doc. E/C.12/1/Add.94 (2003); *Senegal*, U.N. Doc. E/C.12/1/Add.62 (2001).

⁴⁸ United Nations Human Rights Committee (UNHRC), *K.L. v. Peru*, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005), *available at* <http://www1.umn.edu/humanrts/undocs/1153-2003.html>.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ HUMAN RIGHTS WATCH, WORLD REPORT 282 (2010), *available at* <http://www.hrw.org/world-report-2010>.

⁵² CENTRO DE PROMOCIÓN Y DEFENSA DE LOS DERECHOS SEXUALES Y REPRODUCTIVOS [CENTER FOR THE PROMOTION AND DEFENSE OF SEXUAL AND REPRODUCTIVE RIGHTS] (PROMSEX), APUNTES PARA LA ACCIÓN: EL DERECHO DE LAS MUJERES A UN ABORTO LEGAL [NOTES FOR ACTION: WOMEN'S RIGHT TO LEGAL ABORTION] 49 (Susana Chavez Alvarado ed.) (2007) [hereinafter PROMSEX, NOTES FOR ACTION].

⁵³ Center for Reproductive Rights & PROMSEX, Petition on behalf of L.C. against Peru before the CEDAW Committee (2009). *SEE* <http://reproductiverights.org/en/case/lc-v-peru-un-committee-on-the-elimination-of-discrimination-against-women>.

⁵⁴ The call for the National Protocol of Attention in cases of therapeutic abortion has had great presence in mass media. *See, e.g., Ministro Ugarte: "Próximamente será divulgado protocolo sobre el aborto*

terapéutico” [Minister Ugarte: “Protocol on Therapeutic Abortion will soon be published”], ANDINA, Sept. 30, 2010,

<http://www.andina.com.pe/Ingles/Noticia.aspx?id=jXRtUhw5Gy4=>; *Aborto terapéutico en dos o tres meses* [Therapeutic abortion in two or three months], PERÚ21, May. 28, 2010, <http://peru21.pe/noticia/486496/peru-aplicarian-aborto-terapeutico>; *Piden aprobar protocolo de aborto legal* [Request for approval of a legal abortion protocol], PERÚ21, May 29, 2010, <http://peru21.pe/impres/noticia/piden-aprobar-protocolo-aborto-legal/2010-05-29/276174>; Vanessa Herrera, *Piden al Ministro Ugarte honrar su palabra* [Minister Ugarte is asked to keep his word], LA REPÚBLICA, Sept. 8, 2010,

<http://www.larepublica.pe/archive/all/larepublica/20100908/23/node/288041/todos/13>; *Abortos terapéuticos no cuentan con protocolos* [There are no protocols for therapeutic abortions], PERÚ21, Feb.16, 2011, <http://peru21.pe/impres/noticia/abortos-terapeuticos-no-cuentan-protocolos/2011-02-16/297203>.

⁵⁵ The Special Rapporteur on Violence against Women, *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44, Integration of the Human Rights of Women and the Gender Perspective, Addendum: Policies and practices that impact women’s reproductive rights and contribute, to cause or constitute violence against women*, paras. 48, 59, U.N. Doc. E/CN.4/1999/68/ Add.4 (Jan. 21, 1999), available at <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/4cad275a8b5509ed8025673800503f9d?>.

⁵⁶ UNHRC, *General Comment No 6: The right to life (art. 6)*, 16th Sess., 1982, in *Compilation of General Comments and General Recommendations Adopted by the Human Rights Treaty Bodies*, U.N Doc. HRI/GEN/1/Rev.1, at 6 (1994), available at <http://www1.umn.edu/humanrts/gencomm/hrcom6.htm>.

⁵⁷ *Id.*

⁵⁸ CESC, *General Comment No. 14*, *supra* note 3, para. 12(b)(i), (c).

⁵⁹ CEDAW Committee, *General Recommendation No. 24: Women and Health*, para. 12(a), U.N. Doc. A/54/38, at 5 (1999), available at [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/77bae3190a903f8d80256785005599ff?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/77bae3190a903f8d80256785005599ff?Opendocument) [hereinafter, CEDAW Committee, *General Recommendation No. 24*].

⁶⁰ CESC, *General Comment No. 14*, *supra* note 3, para. 20.

⁶¹ UNHRC, *Concluding Observations: Georgia*, para. 12, U.N. Doc. CCPR A/52/40 (1997); *Mongolia*, para. 8(b), U.N. Doc. CCPR A/55/40 (2000); *Peru*, para. 21, U.N. Doc. CCPR A/51/40 (1996); *Peru*, para. 20, U.N. Doc. CCPR A/56/40 (2001).

⁶² Committee against Torture, *Concluding Observations: Nicaragua*, CAT/C/NIC/C0/1 (2009).

⁶³ International norms like WMA and FIGO emphasize the essential duty of providers to act in the best interest of their patients. See WORLD MEDICAL ASSOCIATION, *WMA INTERNATIONAL CODE OF ETHICS* (1949), available at <http://www.wma.net/en/30publications/10policies/c8/index.html>; FIGO Committee, *Resolution on Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights, Resolution on “Women’s Sexual and Reproductive Rights – A Social Responsibility for Obstetricians-Gynaecologists”*: *For approval by the FIGO General in Santiago Chile in November 2003*, available at https://www.figo.org/projects/ethical_responsibility.

⁶⁴ MINS, Resolución Ministerial No. 295-2006-MINS del 26 de julio de 2006, que aprueba la Guía Práctica Clínica para la atención de emergencias obstétricas según nivel de capacidad resolutoria [Ministry Resolution No. 295-2006, July 26, 2006, approving the Clinical Practice Guidelines for obstetric emergency care according to capacity level].

⁶⁵ Such a mandate is established in the following laws: Ley 26842, Ley General de Salud [Law 26842, General Health Law], art. 30 (The doctor who provides medical care, where there is evidence of criminal abortion, is required to bring the matter to the attention of the competent authority.); Decreto Legislativo [Legislative Decree] 957, Nuevo Código Procesal Penal [New Procedural Penal Code], art. 326 (Right and

obligation to report: 1. Any person has the right to denounce the criminal acts before the appropriate authority, provided that the exercise of the penal action to pursue is public. 2. However, the following should submit a complaint: a) Those required to do so by express mandate of the law. In particular, health professionals who are aware of the crimes in the course of their work, and educators aware of crimes that have taken place at educational center (schools)).

⁶⁶ INSTITUTO NACIONAL DE ESTADÍSTICA E INFORMÁTICA [NATIONAL INSTITUTE OF STATISTICS AND INFORMATION] (INEI), ENCUESTA DEMOGRÁFICA Y DE SALUD FAMILIAR (ENDES CONTINUA 2009) INFORME PRINCIPAL [DEMOGRAPHIC AND FAMILY HEALTH SURVEY (ENDES CONTINUOUS 2009) MAIN REPORT] 270-271 (2010), *available at* <http://desa.inei.gob.pe/endes/>.

⁶⁷ ANA GUÉZMES ET AL., FLORA TRISTÁN ET AL., VIOLENCIA SEXUAL Y FÍSICA CONTRA LAS MUEJRES EN EL PERÚ [PHYSICAL AND SEXUAL VIOLENCE AGAINST WOMEN IN PERU], ESTUDIO MULTICÉNTRICO SOBRE LA VIOLENCIA DE PAREJA Y LA SALUD DE LAS MUJERES [MULTICENTRIC STUDY ON INTIMATE PARTNER VIOLENCE AND WOMEN'S HEALTH] (2002).

⁶⁸ PROMSEX, NOTES FOR ACTION, *supra* note 52, at 53-54.

⁶⁹ UNHRC, *General Comment No. 28*, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000) [hereinafter UNHRC, *General Comment No. 28*].

⁷⁰ On Mar. 26, 2008, the Special Revision Commission for the Penal Code was formed by three congressmen and commissioner representatives from the offices of the Judiciary, the Attorney General, the Ombudsman, the Ministry of Justice, the Lima Bar Association, and universities of the republic, which have law schools with seniority of no less than ten years. See <http://www2.congreso.gob.pe/sirc/apoycomisiones/comisionespecial.nsf/www2.congreso.gob.pe/sirc/apoycomisiones/comisionespecial.nsf/especiales/E7005061D19E98B002574B7007FECC2?OpenDocument>.

⁷¹ The Ombudsman has three reports regarding the supervision and provision of family planning services: el Informe Defensorial No. 90 [Ombudsman Report No. 90] (2005), el Informe Defensorial No. 111 [Ombudsman Report No. 111] (2007), and el Informe de la Defensoría del Pueblo [Ombudsman Report], Adjuntía para los Derechos de la Mujer [Committee for Women's Rights], Segundo Reporte sobre el cumplimiento de la Ley de Igualdad de Oportunidades entre Mujeres y Hombres [Second Report on the Fulfilment of the Law of Equality of Opportunities between Men and Women], Informe de Adjuntía No. 001-2009-DP/ADDM [Committee report NO. 001-2009-DP/ADDM] (2009), *available at* <http://www.defensoria.gob.pe/inform-varios.php> [hereinafter Ombudsman Report No. 001-2009].

⁷² Ombudsman Report No. 001-2009, *supra* note 71, at 166-192.

⁷³ *Id.*

⁷⁴ Tribunal Constitucional de Perú [Constitutional Court of Peru], Sentencia [Decision] No. 02005-2009-PA/TC, *available at* <http://www.tc.gob.pe/jurisprudencia/2009/02005-2009-AA.html>.

⁷⁵ ESTUDIO PARA LA DEFENSA DE LOS DERECHOS DE LA MUJER (DEMUS), INFORME REGIONAL DE DERECHOS HUMANOS Y JUSTICIA DE GÉNERO [REGIONAL REPORT ON HUMAN RIGHTS AND GENDER JUSTICE] 164 (2010) (forthcoming).

⁷⁶ The protocol for attending to violence against women is included in the National Guidelines for Comprehensive Assistance of Sexual and Reproductive Health, approved by MINSA, Ministry Resolution No. 668-2004./MINSA

⁷⁷ CESCR, *General Comment No. 14*, *supra* note 3, para. 43. (“In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations: (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom

from hunger to everyone; (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”).

⁷⁸ *Id.* para. 34.

⁷⁹ VÍA LIBRE, INFORME DEL CUMPLIMIENTO DE LAS METAS DE LAS UNGASS-SIDA EN SALUD SEXUAL Y REPRODUCTIVA DE MUJERES Y POBLACIONES TRANS [REPORT ON THE FULFILLMENT OF THE UNGASS-AIDS GOALS ON SEXUAL AND REPRODUCTIVE HEALTH OF WOMEN AND THE TRANS COMMUNITY] 18-19 (2010).

⁸⁰ Defensoría del Pueblo [Office of the Ombudsman], Informe Defensorial No. 143 [Ombudsman Report No. 143], Fortaleciendo la respuesta frente a la epidemia del VIH/Sida: Supervisión de los servicios de prevención, atención y tratamiento del VIH/SIDA [Strengthening the response to the Epidemic of HIV/AIDS: Supervision of prevention Services, attention and treatment of HIV/AIDS] [hereinafter Ombudsman Report No. 143].

⁸¹ *Id.* at 12.

⁸² Joint United Nations Programme on HIV/AIDS (UNAIDS), Peru, <http://www.unaids.org/en/Regionscountries/Countries/Peru/>.

⁸³ See Ombudsman Report No. 143 *supra* note 80, at 30. (According to government studies, the prevalence of HIV in the MSM population is 13.9%. Yet the risk of contracting HIV/AIDS is not uniformly distributed throughout this population. For example, among gays, bisexuals, transvestites, and the transgendered, the latter groups encounter a higher prevalence of the disease.).

⁸⁴ *Id.*; MINSa, INFORME NACIONAL SOBRE LOS PROGRESOS REALIZADOS EN LA APLICACIÓN DEL UNGASS: PERIODO ENERO 2008-DICIEMBRE 2009 [NATIONAL REPORT ON THE PROGRESS MADE IN THE APPLICATION OF UNGASS: JANUARY 2008 – DECEMBER 2009] 12 (2010), available at <http://www.redsidaperu.org.pe/Storage/Documentos/Archivo/149-8909b73abd1a37d.pdf> [hereinafter MINSa, INFORME NACIONAL SOBRE LOS PROGRESOS REALIZADOS EN LA APLICACIÓN DEL UNGASS] (Information contained in both sources derives from MINSa, Department of Epidemiology.).

⁸⁵ Ombudsman Report No. 143 *supra* note 80, at 34.

⁸⁶ *Id.* at 31-32.

⁸⁷ MINSa, INFORME NACIONAL SOBRE LOS PROGRESOS REALIZADOS EN LA APLICACIÓN DEL UNGASS, *supra* note 84.

⁸⁸ *Id.*

⁸⁹ ICCPR, *supra* note 8, art. 3.

⁹⁰ UNHRC, *General Comment No. 28*, *supra* note 69, para. 5.

⁹¹ *Id.* para. 4.

⁹² CEDAW Committee, *Report of the Committee on the Elimination of Discrimination against Women*, para 317, Supplement No. 38, U.N. Doc. A/53/38/Rev.1 (1998), available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N98/256/59/PDF/N9825659.pdf?OpenElement>.

⁹³ Tribunal Constitucional del Perú [Constitutional Court of Peru], Sentencia (Decision) No. 2945-2003-AA/TC. (In April 2004, the Constitutional Court upheld the appeal for protection filed in 2002 by a woman with HIV/AIDS, who requested that the MINSa give her comprehensive care, including treatment and periodic examinations); Tribunal Constitucional del Perú [Constitutional Court of Peru], Sentencia [Decision] No. 2016-2004-AA/TC (In October 2004, the Court ruled in the same way on a similar writ of protection of fundamental rights.).

⁹⁴ *ESSALUD incumple con dar antiretrovirales* [ESSalud fails to give antiretrovirals], DIARIO LA REPÚBLICA, Jul. 10, 2010, http://www.diariolaprimeraperu.com/online/actualidad/essalud-incumple-con-dar-antiretrovirales_63997.html; *Infectados con VIH denuncian desabastecimiento de medicamentos* [People living with HIV report shortage in the supply of medicines], DIARIO LA REPÚBLICA, May 28, 2010, <http://www.larepublica.pe/28-05-2010/infectados-con-vih-denuncian-desabastecimiento-de-medicamentos>. (Several people living with HIV / AIDS reported that after repeated interruptions of antiretroviral treatments (ARV's) in the Hospital Edgardo Rebagliati ESSALUD, they developed resistance to them and that, despite this fact, the drugs used as "rescue therapy" are not considered in the National Drug Request. As a reaction, social mobilization actions took place and the media was informed about the ongoing problem of shortages in ESSALUD. By social pressure and legal action from civil society, including affected people, the state agency bought treatments for 18 patients with drug resistant conditions, a monthly cost of approximately \$2,000 and \$3,000 dollars each. These complaints led to reorganization in the drug supply chain in ESSALUD.)

⁹⁵ *Denuncian vulneración de derechos de gestantes con VIH* [Report of Rights Violation of Pregnant Women with HIV], LA MULA, <http://lamula.pe/2010/10/12/denuncian-vulneracion-de-derechos-de-gestantes-con-vih/1433>. (In Piura, northern region of Peru, the Association for Life made aware to the relevant authorities several cases of HIV-infected pregnant women whose deliveries take place naturally when they should be scheduled by cesarean. Health Technical Standard No. 054-2008 MINSA/DGSP-V.01, Technical Standard for prophylaxis of mother-child transmission of HIV and congenital syphilis, states that the form of delivery of mothers with HIV should be elective caesarean. The last of the four cases that the Association knew about, happened on October 4, 2010 when a pregnant woman who was admitted at the Hospital of Sullana the previous night, had to give birth naturally in the morning of that day. According to a confidential document, despite being prepared to be operated by cesarean, the doctor responsible argued that he could not perform the operation due to lack of surgical equipment and disposable clothing.)

⁹⁶ *Mazzetti: No hay más infectados con VIH* [Mazzetti: there are no more infected with HIV], LA REPÚBLICA, Nov. 27, 2004, <http://www.larepublica.pe/node/104267>. (On August 15, 2004 Mrs. Carmen Guevara gave birth to her third child, Christopher, in the National Maternal-Perinatal Institute. A few hours after birth, the child received donated blood contaminated with HIV, as well as seven other infants and an adult woman. Following a court ruling, on December 4, 2009 the Ministry of Health acknowledged its responsibility for the spread and gave a check of 800,000 soles to Carmen Guevara in response to a court order.); *Perdón y dinero para Judith* [Apology and Money for Judith], LA REPÚBLICA, Sept. 16, 2007, www.larepublica.pe/archive/all/larepublica/20070916/pasadas/13/35771. (A second case happened in April 2007 when Mrs. Judith Rivera Díaz entered the operating room of the National Hospital Daniel Alcides Carrión because of a tumor in the uterus. During the surgical procedure she received a transfusion of 3 units of blood and six months later she was diagnosed as infected with HIV. According to the official response from the Ministry of Health she was infected despite all the screening and tests were fulfilled according to the respective standards and protocols. Through Resolution N ° 012-2007-SA published on September 28, 2007 an extrajudicial settlement of 300 thousand soles was authorized in favor of the complainant as payment for damages.)

⁹⁷ *Denuncian falta de condones para prevenir sida en Perú* [Report of lack of condoms to prevent AIDS in Peru], RPP, July 26, 2010, [www.rpp.com.pe/2010-07-26-denuncian-falta-de-condones-para-prevenir-sida-en-peru-noticia\)282875.html](http://www.rpp.com.pe/2010-07-26-denuncian-falta-de-condones-para-prevenir-sida-en-peru-noticia)282875.html). (A total of 76 organizations of lesbians, transvestites, gays, bisexuals (LGBT) and sex workers in the country complained, in a letter to the Ministry of Health, that the distribution of condoms in government health facilities has been declining since April 2010; that they have run out in many facilities, and that this situation has become especially critical in the poorest regions.)

⁹⁸ A survey by the newspaper El Comercio on homophobia developed by Ipsos Apoyo in 2009 indicates that 80% of respondents replied that tolerates homosexuals and more than 60% said they agreed that homosexuality is a different, but valid, sexual orientation. However, 61% considered it dangerous for children to have a homosexual teacher and 51% said they would not share a room with a homosexual. 76% disapprove of marriage between men and 77% disapprove of marriage between women, according to the

survey. 81% disapprove of the adoption of children by these couples. *El 80% de la población dice tolerar a los homosexuales* [80% of the population tolerates homosexuals], EL COMERICIO, Aug. 29, 2009, <http://elcomercio.pe/impresa/notas/80-poblacion-dice-tolerar-homosexuales/20090823/331872>.

⁹⁹ Ley No. 28237 [Law No. 28237], Código Procesal Constitucional [Constitutional Procedural Code], art. 37, available at <http://spij.minjus.gob.pe/CLP/contenidos.dll?f=templates&fn=default-codproconstitucional.htm&vid=Ciclope:CLPdemo>.

¹⁰⁰ Tribunal Constitucional del Perú [Constitutional Court of Peru], Sentencia [Decision] No. 0023-2003-AI/TC, available at <http://www.tc.gob.pe/jurisprudencia/2004/00023-2003-AI.html> (In the first decision, the Court declared article 269 of the Military Justice Code unconstitutional, which prohibits homosexual relations.); Tribunal Constitucional del Perú [Constitutional Court of Peru], Nov. 24, 2004, Sentencia [Decision] No. 2868-2004-AA/TC, available at <http://www.tc.gob.pe/jurisprudencia/2005/02868-2004-AA.html> (In the second, the Court ordered the reintegration into the National Police of Peru of a person who had been discharged for marrying a transsexual) Tribunal Constitucional del Perú [Constitutional Court of Peru], Sentencia [Decision] No. 2273-2005-PHC/TC, available at <http://www.tc.gob.pe/jurisprudencia/2006/02273-2005-HC.html> (In the third decision, a change of name was ordered in the national document of identity of a transexual person, recognizing the right to be individualized as conforming to the distinctive features that are derived from the development and behavior personal.).

¹⁰¹ MARIO RÍOS, ANÁLISIS DE LA RESPUESTA NORMATIVA PARA LA PREVENCIÓN Y ATENCIÓN DE LA POBLACIÓN VULNERABLE (HSH, TRANS Y TS) FRENTE A LAS ITS Y EL VIH [ANALYSIS OF THE LEGAL RESPONSE FOR THE PREVENTION AND ASSISTANCE OF VULNERABLE POPULATION (HOMOSEXUALS, TRANS AND SEX WORKERS) TOWARDS THE SEXUALLY TRANSMITTED DISEASES AND HIV] (2009), available at http://www.prosa.org.pe/perupaisdiverso/images_camp/materiales/estudios/analisis_%20respuesta_normativa.pdf.

¹⁰² MARTÍN JAIME BALLERO, PROMSEX, INFORME ANUAL SOBRE DERECHOS HUMANOS DE PERSONAS TRANS, LESBIANAS, GAYS Y BISEXUALES EN EL PERÚ 2009 [ANNUAL REPORT ON HUMAN RIGHTS OF TRANS, LESBIANS, GAYS AND BISEXUALS IN PERU 2009] 11 (2009), available at <http://www.promsex.org/docs/Publicaciones/informeddhhhtlgb2009promsexredtlgb.pdf> [hereinafter PROMSEX, ANNUAL REPORT ON HUMAN RIGHTS OF TRANS, LESBIANS, GAYS AND BISEXUALS IN PERU 2009].

¹⁰³ See Mario Ríos Barrientos & MINSA ET AL., ANÁLISIS DE LA RESPUESTA NORMATIVA PARA LA PREVENCIÓN Y ATENCIÓN DE LA POBLACIÓN VULNERABLE (HSH, TRANS Y TS) FRENTE A LAS ITS Y EL VIH [ANALYSIS OF THE LEGAL RESPONSE FOR THE PREVENTION AND ASSISTANCE OF VULNERABLE POPULATION (HOMOSEXUALS, TRANS AND SEX WORKERS) TOWARDS THE SEXUALLY TRANSMITTED DISEASES AND HIV] (2009), available at http://www.prosa.org.pe/perupaisdiverso/images_camp/materiales/estudios/analisis_%20respuesta_normativa.pdf.

¹⁰⁴ The Yogyakarta Principles, The Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity, available at: http://www.yogyakartaprinciples.org/principles_sp.htm.

¹⁰⁵ XIMENA SALAZAR ET AL., LINEAMIENTOS PARA EL TRABAJO MULTISECTORIAL EN POBLACIÓN TRANS, DERECHOS HUMANOS, TRABAJO SEXUAL Y VIH/SIDA [GUIDELINES FOR MULTISECTORIAL WORK ON TRANS POPULATION, HUMAN RIGHTS, SEX WORK AND HIV/AIDS] 13-15 (2009), available at <http://www.unfpa.org.pe/publicaciones/publicacionesperu/IESSDEH-Lineamientos-Trabajo-Multisectorial.pdf> [hereinafter GUIDELINES FOR MULTISECTORIAL WORK ON TRANS POPULATION]; INTERNATIONAL LESBIAN AND GAY ASSOCIATION (ILGA), LA SALUD DE LAS LESBIANAS Y MUJERES BISEXUALES: CUESTIONES LOCALES, PREOCUPACIONES COMUNES. LUCHANDO [HEALTH OF LESBIANS, AND BISEXUAL WOMEN: LOCAL ISSUES, COMMON CONCERNS. STRUGGLING] (2007), available at http://america-latina-caribe.ilga.org/ilga/publicaciones/publicaciones_en_espanol/otras_publicaciones/la_salud_de_las_lesbianas_y_mujeres_bisexuales [hereinafter ILGA, HEALTH OF LESBIANS, AND BISEXUAL WOMEN].

¹⁰⁶ ILGA, HEALTH OF LESBIANS, AND BISEXUAL WOMEN, *supra* note 105.

¹⁰⁷ GUIDELINES FOR MULISECTORIAL WORK ON TRANS POPULATION, *supra* note 105, at 13-15.

¹⁰⁸ *Id.*; ILGA, HEALTH OF LESBIANS, AND BISEXUAL WOMEN, *supra* note 105.

¹⁰⁹ Perú, Un País Diverso [Peru, a diverse country], http://www.minsa.gob.pe/portada/especiales/2009/pais_diverso/archivo/vih_peru_pais_diverso.pdf.

¹¹⁰ PROMSEX, ANNUAL REPORT ON HUMAN RIGHTS OF TRANS, LESBIANS, GAYS AND BISEXUALS IN PERU 2009, *supra* note 102, at 37-38.

¹¹¹ MINSA, *Servicios Diferenciados para la Atención Integral de Salud del Adolescente [Differentiated Services for Integral Health Assistance of the Adolescent]* (2009), available at http://www.minsa.gob.pe/portada/ciudadanos/serv_diferenciados/Del_1_20_SD.pdf.

¹¹² http://www.prb.org/Datafinder/Geography/Summary.aspx?region=111®ion_type=2.

¹¹³ INEI (ENDES 2000 & 2009).

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ UNHRC, *Concluding Observations: Senegal*, U.N. Doc. CCPR/C/79/Add.82 (1997).

¹¹⁷ WHO, DEPARTMENT OF REPRODUCTIVE HEALTH AND RESEARCH ET AL., UNHRC, REPRODUCTIVE HEALTH IN REFUGEE SITUATIONS: AN INTERAGENCY FIELD MANUAL, GENEVA, Chap., p. 9, 93 (1999).

¹¹⁸ In General Comment 4, this Committee expressed its concern that adolescent victims of sexual abuse are “exposed to significant health risks, including...unwanted pregnancies, unsafe abortions...and psychological distress.” Committee on the Rights of the Child, *General Comment No.4: Adolescent health and development in the context of the Convention on the Rights of the Child*, para. 37, U.N. Doc. CRC/GC/2003/4 (2003), available at <http://daccess-ods.un.org/access.nsf/Get?Open&DS=CRC/GC/2003/4&Lang=E>.

¹¹⁹ *Id.* para. 22.

¹²⁰ See, e.g., Committee on the Rights of the Child, *Concluding Observations: Chile*, para. 56, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Guatemala*, para. 40, U.N. Doc. CRC/C/15/Add.154 (2001).

¹²¹ Between the census of 2003 and census of 2007 there was a recorded increase of 16.8% in teenage pregnancy in the country. In the Loreto region, part of the forest zone, indicators show that 26% of adolescents are already mothers. In the mountain zone this percentage is 15%, while on the coast it is 8.5%.

¹²² Only 58.3% of adolescent mothers study for one year of high school, while adolescents who are not mothers are 5.5% more likely to finish high school. Adolescent mothers make up 22.4% of the economically active population, while adolescents who are not mothers constitute 13.9%. Adolescent mothers who work mostly are household employees (34.2%), though 32.4% work in agriculture, fishing, and mining; 19.1% are at home workers without compensation.

¹²³ Law No. 28704, modified Article 137 of the PERU, PENAL CODE (1991).

¹²⁴ This reform is contradictory to other legal norms. For example, the Peruvian Civil Code recognizes the capacity of adolescents from 14 years of age for acts related to sexuality and reproduction: They can recognize their children, claim the costs of pregnancy and childbirth, and sue and participate in the processes of judicial recognition of extramarital affairs, holding and food from their children, and can get married at the age of 16 (Articles 46, 241 and 244, respectively). Likewise, on Oct. 15, 2010, Law No. 29600, was enacted. Recognizing the reality of pregnancy among adolescents, this law establishes the State’s obligation to adapt educational services by promoting school reintegration after pregnancy. In short, other Peruvian laws recognizes the reality of the beginning of consensual sexual relations during adolescence, but the current wording of Article 173 of the Criminal Code comes into open conflict with them.

¹²⁵ See also, JENNIFER NAGLE & SUSANA CHAVEZ, PROMSEX, DE LA PROTECCIÓN A LA AMENAZA [FROM PROTECTION TO THREAT]: CONSECUCENCIA DE UNA LEY QUE IGNORA LOS DERECHOS SEXUALES Y DERECHOS

REPRODUCTIVOS DE LAS Y LOS ADOLESCENTES [THE CONSEQUENCE OF A LAW THAT IGNORES SEXUAL AND REPRODUCTIVE RIGHTS OF ADOLESCENTS], EL CASO DE LA MODIFICATORIA DEL CÓDIGO PENAL, LEY N° 28704 [THE CASE OF THE MODIFICATION OF THE CRIMINAL CODE, LAW No. 28704] (2007); MARÍA CONSUELO BARLETTA, CARE, MARCO NORMATIVO DE LA PROTECCIÓN DE DERECHOS DE LOS NIÑOS, NIÑAS Y ADOLESCENTES EN SITUACIÓN DE VULNERABILIDAD [LEGAL FRAMEWORK FOR THE PROTECTION OF CHILDREN'S AND ADOLESCENTS' RIGHTS IN SITUATIONS OF VULNERABILITY] (2008); RED SIDA PERÚ [AIDS NETWORK PERU], ANÁLISIS DEL MARCO NORMATIVO PARA EL ACCESO DE LOS/LAS ADOLESCENTES A LOS SERVICIOS DE SALUD SEXUAL Y REPRODUCTIVA CON ÉNFASIS EN VIH/ SIDA [ANALYSIS OF THE LEGAL FRAMEWORK FOR ADOLESCENTS' ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE WITH AN HIV/AIDS FOCUS] 10-11, 27 (2009); MINISTRY OF HEALTH AND UNITED NATIONS POPULATION FUND (UNDP), BALANCE POLÍTICO NORMATIVO SOBRE EL ACCESO DE LAS Y LOS ADOLESCENTES A LOS SERVICIOS DE SALUD SEXUAL Y REPRODUCTIVA Y PREVENCIÓN DEL VIH-SIDA [POLITICAL-LEGAL BALANCE OF ADOLESCENTS' ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE SERVICES AND HIV/AIDS PREVENTION] (2009); MINSA & UNDP, LOS ESTABLECIMIENTOS DE SALUD COMO ESCENARIOS DE LA VIDA Y LA SALUD SEXUAL DE LAS Y LOS ADOLESCENTES [HEALTH FACILITIES AS SCENARIO OF LIFE AND SEXUAL HEALTH OF ADOLESCENTS]: AGRÉGAME A TUS CONTACTOS, HAZTE FAN Y APOYA LA CAUSA PARA SUPERAR LAS BARRERAS QUE NOS DISTANCIAN [ADD ME TO YOUR CONTACT LIST, BECOME A FAN AND SUPPORT THE CAUSE TO OVERCOME THE BARRIERS THAT SEPARATE US] (2010).

¹²⁶ MINSA, DOCUMENTO TÉCNICO [TECHNICAL DOCUMENT], ANÁLISIS DE SITUACIÓN DE SALUD DE LAS Y LOS ADOLESCENTES [ANALYSIS OF THE HEALTH SITUATION OF ADOLESCENTS]: UBICÁNDOLOS Y UBICÁNDONOS [LOCATING THEM AND LOCATING US], *available at* <ftp://ftp2.minsa.gob.pe/normaslegales/2009/RM636-2009.pdf>.

¹²⁷ General Health Law, *supra* note 65, art. 30, states that doctors are required to report cases of patients who seek treatment due to criminal acts of violence. Similarly, Art 326 (2)(a) of the New Criminal Procedure Code compels health personnel to report cases of teenage pregnancy. For example, in response to the aforementioned rules, the Judicial District of Lima's Public Ministry issued Resolution No. 257-2007-DSDJL-MP-FN of Jan. 24, 2007, which adopted Directive No. 001-2007 - DSDJL-MP-FN and affirmed the obligation of those responsible for private and public healthcare facilities to notify the District Attorney within 72 hours of the admission of children and adolescents under eighteen years old who are pregnant.

¹²⁸ Corte Suprema del Perú [Supreme Court of Peru], Nov. 16, 2007, Acuerdo Plenario [Plenary Agreement] No. 7-2007/CJ-116; Corte Suprema del Perú [Supreme Court of Peru], July 18, 2008, Acuerdo Plenario [Plenary Agreement] No. 4-2008/CJ-116.

¹²⁹ Bill of law, No. 4686/2010-PE, presented before Congress on Mar. 2, 2011, *available at* <http://www2.congreso.gob.pe/Sicr/TraDocEstProc/CLProLey2006.nsf> (Peru).

¹³⁰ PERU, CIVIL CODE, Art 44 (Incapacidad relativa. Son relativamente incapaces: 1.- Los mayores de dieciséis y menores de dieciocho años de edad ... Peru, General Health Law, Art. 4 (Ninguna persona puede ser sometida a tratamiento médico o quirúrgico, sin su consentimiento previo o el de la persona llamada legalmente a darlo, si correspondiere o estuviere impedida de hacerlo... En caso que los representantes legales de los absolutamente incapaces o de los relativamente incapaces, a que se refieren los numerales 1 al 3 del Artículo 44 del Código Civil, negaren su consentimiento para el tratamiento médico o quirúrgico de las personas a su cargo, el médico tratante o el establecimiento de salud, en su caso, debe comunicarlo a la autoridad judicial competente para dejar expeditas las acciones a que hubiere lugar en salvaguarda de la vida y la salud de los mismos.).

¹³¹ ICESCR, *supra* note 1, art. 12; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, "Protocol of San Salvador," *adopted at* San Salvador, El Salvador, Nov. 17, 1988, art. 10, O.A.S.T.S. No. 69, *reprinted in* Basic Documents Pertaining to Human Rights in the Inter-American System, O.A.S. Off. Rec. OEA/Ser.L.V/11.82 doc. 6 rev.1, at 67 (1992) (*entered into force* Nov. 16, 1999) [hereinafter Protocol of San Salvador].

¹³² Paul Hunt, *Report of the Special Rapporteur on the Rights of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: The Rights to Sexual and Reproductive Health*, para. 32-40, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004).

¹³³ CEDAW, *General Recommendation No. 24*, *supra* note 59, para. 18.

¹³⁴ *Id.* paras. 29-31.

¹³⁵ *Id.*

¹³⁶ CESCR, *General Comment 14*, *supra* note 3, para. 22.

¹³⁷ *Id.*

¹³⁸ *Id.* para. 23.