



"PROGRAMA UNIVERSITARIO DE
ESTUDIOS DE GENERO" - U.N.A.M.

F 27.34 / W872W

WOMEN'S SEXUAL AND REPRODUCTIVE RIGHTS IN PERU:

A Shadow Report

Latin American and Caribbean Committee for the Defense of
Women's Rights (CLADEM)

The Center for Reproductive Law and Policy (CRLP)

DEMUS, Estudio para la Defensa de los Derechos de la Mujer

June 1998

Compiled for the Nineteenth Session of the Committee on the Elimination of
All Forms of Discrimination Against Women

4347

3600

Salud 19/10
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Perú

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Introduction

The recognition and exercise of sexual and reproductive rights — in addition to the right to health, which includes reproductive health — are especially critical matters for women. States parties to the Convention on the Elimination of All Forms of Discrimination Against Women (Convention) must examine the extent to which women are able to effectively exercise these rights. This report analyzes rights that have been of concern to the Committee along with other issues critical to women's reproductive life, as addressed in the international consensus documents adopted at recent conferences in Vienna (1993), Cairo (1994), Copenhagen (1995), and Beijing (1995).

In Peru, discriminatory legal norms, policies, and practices persist that decisively affect women's lives, exposing them to grave risks, dangers, and disadvantages. In addition, cultural prejudices restrict women's right to make decisions regarding their sexuality and reproductive capacity. Moreover, various forms of violence against women in both public and private spheres also constitute violations of their human rights and negatively impact their sexual and reproductive health. Discrimination and violence in public health services is a particularly severe form of discrimination because it involves women victimized due to their economic situations, their age, and their racial or ethnic condition, among other circumstances. These women are exposed to unacceptable abuses with very limited possibilities of obtaining justice. Such situations will be described in this document.

The purpose of this shadow report is to present independent information to the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) which, during its next session, will examine the Fourth Periodic Report of Peru.

The Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), based in Lima, the Center for Reproductive Law and Policy (CRLP), based in New York, and DEMUS, Estudio para la Defensa de los Derechos de la Mujer, also of Lima, are non-governmental organizations which, in recent years, have been systematically collecting information concerning the issue of sexual and reproductive rights along with the right to health, including reproductive health, in Peru.

This report is organized in two parts. The first provides statistical and contextual information and the second sets forth information relevant to women's sexual and reproductive rights in Peru according to the pertinent provisions of the Convention. Each topic analyzed in the second part is divided into two sections. The shaded section describes existing laws and policies. The unshaded section concentrates on how these laws are implemented and carried out. The information in the first part was principally obtained from the chapter on Peru in the report *Women of the World: Laws and Policies Affecting Their*

Reproductive Lives — Latin America and the Caribbean. That report is one of a series of regional reports being compiled by CRLP in collaboration with national-level NGOs in each country. DEMUS and CRLP authored the report's chapter on Peru.

The present report is the collaborative product of Giulia Tamayo and Raquel Cuentas (CLADEM), Katherine Hall Martinez, Gaby Oré Aguilar, and Alison-Maria Bartolone (CRLP) and Roxana Vásquez (DEMUS).

Lima, June 1998

Principal Areas of Concern

1. Peru has the second highest rate of maternal mortality in South America and one of the highest rates in the world. This rate is a strong indicator of a state's commitment to women's human rights and the elimination of all forms of discrimination against women. (See Section II D.)

2. The State has been applying a system of fees and charges for care related to pregnancy and childbirth, violating its own national regulations as well as the Women's Convention itself, both of which provide that such services should be free. The application of these charges excludes an important number of women who are poor, young, and in vulnerable situations from care essential to their reproductive health and fosters abusive and arbitrary treatment from health care providers.¹ (See Section II D and E.)

3. In public health care services for women, episodes of physical and psychological violence, exposure to grave risks to life, body, and health, including unnecessary suffering, coercive, humiliating, and discriminatory treatment continue to occur with alarming frequency. The Peruvian State has not developed effective and timely means to ensure the right to present grievances or to obtain justice in these cases involving abuses committed against women in public health services. When such cases are reported, health authorities' response has been one of institutional cover-up, while the judiciary fails to respect guarantees for the due process of law. Corruption and discriminatory criteria in the courts and the pressure on victims to abandon their allegations contribute to impunity. Nonetheless, the efforts of the Defensoría del Pueblo (National Ombudsman's Office) in defending the rights of users of public health services is an important exception to the above trends. (See Section II A and E.)

4. In implementing the present Program of Reproductive Health and Family Planning 1996-2000 there have been practices instituted that are contrary to women's informed consent, and that compromise their health and their very lives, affecting disproportionately the poorest and, among these, women from rural areas. The State has emphasized female sterilization over other forms of contraception, holding so-called "contraception fairs" or "festivals" whose sole purpose was to obtain female clients for sterilization without any guarantees ensuring free and informed consent or quality service. In addition, the government has failed to ensure the dissemination of complete and accurate information about a wide range of contraception methods. Finally, it has established mandatory quotas for health establishments and providers that have resulted in forced sterilizations and other practices against women's lives and health. (See Section II A, D and E.)

5. The present Program of Reproductive Health and Family Planning is being implemented with little transparency, with no mechanisms that would open it to citizen control, and without the legal machinery necessary for the protection and guarantee of the rights of precisely that segment of the population targeted by such programs: poor women and adolescents. (See Section II D.)
6. The Peruvian State has ignored recommendations from CEDAW² and the Human Rights Committee (1996)³ on the necessity of revising its restrictive policies and laws regarding abortion. On the contrary, in 1997 it passed more restrictive regulations for health providers, requiring them to report women who arrive at hospitals with complications due to abortions.⁴ Neither has the Peruvian State developed mechanisms for the prevention of abortion nor for post-abortion care. The long-standing criminalization of abortion has not reduced its incidence; maternal mortality figures attributable to abortion continue to rise daily. (See Section II D.)
7. The development of patients' rights in Peru has been precarious at best. What is particularly notable is the lack of judicial rulings in regard to informed consent. Existing laws do not guarantee the decision-making process nor users' rights to receive adequate, quality, and complete information in order to make informed decisions about their sexuality and reproduction. (See Section II D and E.)
8. Rape of adult women is still considered a private legal action, which is to say, investigation and prosecution of this crime are only carried out at the request of the injured party. The State thus abdicates its responsibility to initiate actions against those accused of this crime. (See Section II A.)
9. The public health system has cut back on its expenditures on human resources and infrastructure. As a result, the population's ability to access health establishments and receive treatment from qualified health professionals have been reduced as has the quality of the services. In 1998, public spending on health was below that for 1995 and the per capita investment on health has not yet risen to 1985-87 levels. (See Section II D.)
10. There are no effective and timely mechanisms to protect working women's rights in the event of pregnancy. Dismissal of women for pregnancy along with the suppression of labor rights and social security benefits are common and tolerated practices. (See Section II C.)

I. Statistical and Contextual Information

Sexual and Reproductive Health

- In 1996 Peru had a total population of 23,947,000 inhabitants; 50.3% were women of whom 6,259,000 were in their childbearing years.⁵
- In 1996 the annual rate of population growth was 1.8%.⁶ The previous measure (in 1992) was 2.0%.⁷
- In 1996 the rate of maternal mortality was estimated at 265 per 100,000 live births.⁸ The primary factors resulting in this high rate are the marginalization of the rural population and teenage pregnancies.⁹
- Adolescent pregnancies make up 15% of maternal mortalities. Twenty percent of abortion fatalities are adolescents.¹⁰
- The infant mortality rate has been estimated at 43 for every 1,000 live births.¹¹
- Life expectancy at birth is 67.9 years.¹²
- The total fertility rate is 3.5 children per woman. This figure drops to 2.8 children per woman in urban zones but rises considerably in rural areas to 5.6 children per woman.¹³

Economic and Social Situation

- The GNP grew by 6.4% and 12.7% for the years 1993 and 1994, respectively. Nevertheless, formal employment dropped 2% in 1993 and 0.5% in 1994.¹⁴ While Peru spent 1.2% of its GNP in 1991 on health, including social security, in 1995 it spent only 0.8%.¹⁵
- Forty-eight percent of the population lives in poverty and 18% lives in extreme poverty. More than 12 million Peruvians now evidence some indicator of poverty.¹⁶
- Of the total population, 66.7% lives in urban areas and 33.3% lives in rural areas.¹⁷
- Three out of every four illiterate persons are women. In urban areas one out of every 10 women is illiterate while more than four out of 10 are illiterate in rural districts.¹⁸

- Displacement due to internal armed conflict affects predominately women and children; 78% of displaced heads of households are women.¹⁹
- Violence against women is a grave social problem for the country. Statistical data are hard to obtain due to the fact that many of these crimes go unreported by the victims. Nevertheless, according to reports from Lima's Delegación Policial de Mujeres (Women's Police Precinct) in 1996 there were 6,244 charges of sexual violence brought while in 1995 the number was 4,181.²⁰
- Despite the fact that many women do not report sexual violence, rape and other forms of sexual aggression occupy third place among the most frequently committed crimes in the country.²¹ According to statistical data, in 1995 the National Police Force registered 8,531 "crimes against personal liberty" on a nation-wide level, of which 48.6% were rapes.²²

II. Women's Sexual and Reproductive Rights in Peru: Information Provided Pursuant to the Relevant Provisions of the Women's Convention

A. Article 5: *Various Forms of Violence Against Women*

The current Constitution of Peru recognizes the individual's right to life, to autonomy, to moral, psychological, and physical integrity, to his or her personal development and well being,²³ as well as to personal freedom and security;²⁴ no one is under obligation to do anything not prescribed by law or restricted from doing anything that is not prohibited by law.²⁵ The Constitution also establishes the right of persons not to be victims of moral, psychological, or physical violence, nor to be subject to torture or inhuman or degrading treatment.²⁶ In 1996 the Peruvian government ratified the Interamerican Convention on the Prevention, Punishment and Eradication of Violence Against Women.

1. Sexual Violence

Laws and Policies

Rape is a crime under Articles 170 and 178 of the Penal Code.²⁷ Rape is considered to be the sexual intercourse or any analogous act carried out with violence or grave threat to the victim.²⁸ In all cases of rape, if the acts committed cause the victim's death and the aggressor could have prevented this, or if he acted with cruelty, the penalty is between 20 and 25 years imprisonment.²⁹ If the acts cause the victim serious injury, the sentence is between 10 and 20 years.³⁰ Rape that involves the taking advantage of a situation of dependence, authority, or guardianship, or when the victim is a patient of a hospital, asylum, or other similar establishment or is under arrest, in detention, or in jail, the crime is considered an aggravated felony and is punished with from five to eight years of prison along with a suspension of the rapist's professional license for between two and four years. Those who are convicted and sentenced to prison for these crimes must undergo psychological treatment to facilitate social rehabilitation.³¹

Until April of 1997 the rapist and his partners, if any, were exempted from all punishment if one of them married the victim.³² A 1997 amendment eliminated this provision from the statute in cases of rape but left it in force in the case of those found guilty of seducing an adolescent.³³ Thus, he who, through deception and without violence, has sexual relations with an adolescent girl between the ages of 14 and 18 years old may be exempted from punishment if he marries the victim with her consent.³⁴ The 1997 amendment also failed to modify the classification of the rape of an adult woman as a private action. Thus, the Peruvian State does not automatically prosecute such crimes against women, unless the victim insists on pressing charges.

The Penal Code punishes other acts of indecency "contrary to modesty" carried out through violence or under threat of serious harm and without intent to commit a sexual act, with up to three years' imprisonment.³⁵ Sexual harassment is treated by labor legislation as an act of hostility by the employer, comparable to dismissal without cause.³⁶ The worker who is deemed to have been harassed

may choose exclusively between either taking action to end the harassment or terminating her employment contract. In the latter case she is entitled to demand her compensation for arbitrary dismissal as established by law, independently of the fine to be imposed on the employer.³⁷ Legislation that seeks to prevent and punish sexual harassment in the workplace is currently under consideration by Congress.³⁸

Reality

Rape of adult women tends to go unpunished. Once women decide to press charges for rape they come up against judicial malfeasance at both the investigatory and prosecutorial stages involving this crime. Traditional prejudices based on gender stereotyping by the agents of the criminal justice system often compromise women's right to obtain justice regarding conduct that affects personal integrity and autonomy in the sexual sphere. In 1997, Congress rejected CLADEM-Peru's legislative proposal for a Law on Sexual Violence that would have included modifications to correct these problems, as identified by the Committee on Human Rights (1996).

A 1995 study of judicial proceedings in rape cases carried out by DEMUS in the police stations of the province of Lima showed that in 44.4% of the cases where charges were pressed, the police did not visit the scene of the crime,³⁹ and in only 10% of the remaining 55.6% did they do so the same day;⁴⁰ in 88.9% of the cases the police attempted to gather evidence,⁴¹ but arrests occurred in only 38.9% of the cases where the perpetrator was identified,⁴² and in only 55.6% of the cases did the police take a statement from the alleged aggressor.⁴³ The Office of the Public Prosecutor took no part in 83.3% of these cases;⁴⁴ in 50% of them the police asked for a physical examination⁴⁵ and in only 62% of these cases were the results sent to the police by the relevant agency, the Institute of Forensic Medicine.⁴⁶

Rape victims' rights are not adequately guaranteed. During trials, these women are forced to undergo unreasonable and prejudicial cross-examinations as well as discriminatory treatment by the courts. The victim's sexual conduct continues to be examined since the criterion of a woman's "honor" persists in practice as relevant in determining guilt or innocence. According to the aforementioned study, 45.5% of the victims of sexual assault were cross-examined about their sexual history.⁴⁷ Men sentenced for rape often go free without providing any civil reparations to the victim and without submitting to court-ordered rules of conduct. Since the rape of adult women continues to be considered a "private action," these victims are often exposed to pressure and threats from the perpetrators.

As of this writing not one case of sexual harassment has been decided in favor of the victim under the procedures prescribed under current law.

2. Domestic Violence

Laws and Policies

In 1993 the Law Against Domestic Violence was enacted, setting out the state's policy in regard to this type of violence.⁴⁸ The Ministry for the Advancement of Women and Human Development (PROMUDEH) is the governmental agency responsible for coordinating policy action on this issue.⁴⁹ The law defines domestic violence as any act or omission that causes physical or psychological harm or abuse including any serious threat or act of coercion, involving spouses, cohabitants, ascendants,

descendants, other relatives or other persons living in the same household.⁵⁰ The Law's objectives are: to strengthen the teaching of ethical values and respect for personal dignity; to establish effective legal processes for the victims of family violence; to reinforce existing law enforcement personnel with specialized staff; to promote the establishment of temporary shelters for victims of violence and to create institutions for the treatment of aggressors; and to train public and judicial functionaries.⁵¹

In regard to the legal process itself, the law specifies that the National Police are to receive complaints about domestic violence and carry out preliminary investigations.⁵² The provincial family prosecutor also receives direct complaints, verbally or in writing, from victims, their relatives, or from any person where the protection of a minor is at stake; he or she thus acts upon this direct knowledge of the alleged occurrences.⁵³ The police report is sent to the justice of the peace or to the provincial criminal prosecutor and to the family prosecutor⁵⁴ who may order immediate protective measures for the victim.⁵⁵

Reality

In 1996 domestic violence rose 50.53% over the previous year.⁵⁶ Between 1990 and 1996 charges were pressed in 32,030 cases of abuse of women which translates to an average of 4,576 yearly or 381 cases per month.⁵⁷ Of these reports, 64% cite marital problems as the reason for the violence.⁵⁸

Despite legislative advances, the practical application of the law presents serious problems. There persists a tendency by the police and the judiciary to downplay incidents of domestic violence; cases that progress satisfactorily through the courts and those where protection is granted are the exception. One of the deficiencies in the domestic violence law is that it offers no effective and timely recourse in terms of protection and justice to rural women. Moreover, although since 1991 the Penal Code has provided a measure of non-explicit protection to protect women from sexual abuse within marriage, in fact, law enforcement officials are reluctant to prosecute aggressors for the crime of rape if a conjugal link exists; this attitude extends to cases of common-law or cohabitating relationships.

The Peruvian State has not committed funds from the national budget to provide the services and facilities needed to ensure protection for victims of domestic violence, despite having pledged itself to do so by law.

3. Violence Against Women in Public Health Services:

- **Sexual Violence;**
- **Violence Against Pregnant Women and those in Labor;**
- **Violence Against Women who Arrive at Health Establishments with Indications of Incomplete Abortion;**
- **Forced Sterilizations**

Laws and Policies

In contrast to the legislative development in the arena of domestic violence, there has been no governmental effort to eradicate violence against women in other crucial spaces such as educational and public health establishments, where unequal power relationships — between clients and private

practitioners or public functionaries — are dominant. No express legal provisions regarding the diverse forms of violence women suffer in obtaining health services exist, so they must resort to general provisions contained in the Constitution, the Penal and Civil Codes, the General Health Law, and the National Population Law for protection.

In general, the Penal Code classifies assault and harm to life, body, and health as felonies or misdemeanors depending on the gravity of the harm. The Penal Code provides that a medical doctor or other health professional who, through some form of negligence, causes minor injury to a patient shall be sentenced to a maximum of one year imprisonment or a fine of between 60 and 120 days' wages.⁵⁹ If the injury to the patient is serious, the penalty is between one and two years of prison and a fine of between 60 and 120 days' wages.⁶⁰ If the patient dies because of failure to comply with the professional standards applicable to a doctor, nurse, technician, or health auxiliary, the penalty is between two and six years imprisonment and professional disqualification.⁶¹

Adequate legal standards protecting mental well-being and thus punishing psychological violence do not exist, which leaves people virtually unprotected from this type of aggression. Exposure to unnecessary suffering at the hands of public health employees is not expressly punished either in the penal nor administrative areas. Chapter IV of the Penal Code only encompasses the crimes of "exposure to danger or abandonment of persons in danger."⁶² Even if the act of "coercion" were deemed to fall within "crimes against freedom,"⁶³ it is unlikely that the courts would classify as such practices compromising women's autonomy that are committed in public or private spheres.

Under Peruvian law there exist other generic legal measures available to persons affected by acts of violence in health establishments: civil actions for damages due to negligence by a doctor or other health professional or due to abuse of authority by a public functionary. However, pursuit of such measures lacks judicial development and thus the victims' ability to secure favorable rulings and fair and effective reparations is far from certain.

The 1997 General Health Law establishes that violations of its provisions are punishable with warnings, fines, or closings — temporary or indefinite — of the offending health establishment.⁶⁴ It also provides that the health establishment is jointly liable for injury or damage to patients caused by the negligence of its doctors, nurses, technicians, or assistants employed by the establishment.⁶⁵ If the establishment has not provided its staff with adequate means for treating patients, then it is exclusively responsible for any injury or damage caused.⁶⁶ Even though the General Health Law is presently in force, no regulations have been issued nor do any legal procedures exist for demanding compliance with its terms.

In respect to the prohibition on forced sterilization, the National Population Law was the first law to expressly prohibit intent to coerce or unduly influence persons regarding family planning.⁶⁷ The recent General Health Law regulates implementation of this program.⁶⁸ It provides that in the specific case of sterilization and other permanent methods of contraception, the patient's prior written consent must be given.⁶⁹

Reality

During 1996 and 1997 CLADEM and CRLP studied the incidence of violence against women in the public health establishments of Peru through case documentation and direct testimonies, and examined the State's response to these incidents.⁷⁰ The forms of violence identified were: sexual

violence, including rape; violence against pregnant women and women in labor; and violence against women who arrive with indications of incomplete abortion.

In more than 60 testimonies gathered in five Peruvian cities, women describe health care providers' various forms of mistreatment, criminal acts, humiliations, indifference, and negligence within public health establishments. These cases demonstrate physical and verbal aggression, sexual violence, procedures practiced on patients' bodies without informing them or obtaining their consent, abandonment, and exposure to unnecessary harm and suffering. In cases where induced abortion is suspected, there have also been intimidating interrogations, inhuman treatment, and other practices that can be classified as torture, as these acts are linked to the provider's view that a woman who makes this kind of decision should be punished.

The statements of women in labor consistently mention health care personnel's aggressive replies to being asked for assistance by the patient or admonishments for "not helping" the doctor during their deliveries, being humiliated over the number of children they have borne, and receiving verbal harassment intended to punish them for being sexually active, as well as instances of abandonment, refusals to provide treatment, and admission delays due to inability to pay.

Cases of "retaining" the users and their newborn babies for failure to settle the hospital bill have also been documented. Only recently, on May 28, 1998, did the National Ombudsman's Office intervene promptly and effectively at the Lima Maternity Hospital in the case of the "retention" of a patient, presented by CLADEM.

Legal actions brought against health care personnel and establishments are riddled with complicity and institutional cover-up. The possibilities of proving the allegations are reduced because the patient's word is automatically devalued and health care professionals are perceived as possessing unquestionable authority and prestige. Of the cases documented in the aforementioned study where charges were pressed, the responsible parties were not punished nor were reparations obtained at either the administrative or judicial levels.

Regarding forced sterilization and sterilizations undertaken without informed consent, there is abundant evidence of unauthorized sterilizations, systematic and house-by-house pressure in impoverished urban and rural localities, coercion, and the provision of treatment under conditions that constrain free and informed choice. There also exists overwhelming proof regarding the existence of sterilization quotas fixed by health authorities who pressure or induce health care providers and establishments to fulfill them. The existence of these quotas has fostered human rights violations that have affected particularly and disproportionately the poorest women as well as those who live in rural areas.

In January of 1998 the National Ombudsman's Office published a report⁷¹ taking a stand on this issue and presenting a series of measures and recommendations to the health sector. In March, the *Manual of Regulations and Procedures for Voluntary Surgical Contraception* was amended. Some modifications to the Program of Reproductive Health and Family Planning also have been announced. However, to date, no corrective amendments to higher order legal norms have been initiated.

B. Article 10 (h): *Access to Educational Information to Ensure Family Health and Welfare, including Family Planning Information and Counseling*

• Sexual Education

Laws and Policies

At the beginning of 1996 the government announced that material on family planning and sex education would gradually be included in high school curricula.⁷² It also announced that it would train 15,000 teachers on these subject matters and would print one million texts that would include these topics along with methodological guides for teachers.⁷³ To this end, the Ministry of Education has prepared and presented the *Guides for Family and Sex Education for Teachers and Parents* as part of the National Sex Education Program for the years 1995-2001.⁷⁴ The general plan for teacher training proposes to educate children and young people in the following: basic aspects of family life and sexual development, moral values, self-esteem, gender roles, and gender equality. In high school courses, special emphasis is placed on sexual responsibility, and the need to delay the commencement of sexual activity, as well as the prevention of sexually transmissible infections (STIs), AIDS, and unplanned pregnancies.⁷⁵ Within the framework of the Program for Schoolchildren and Adolescents' Health, *Comprehensive Health Promotion: Instruction for Parents* was recently published with the aim of achieving parents' participation in the educational responsibilities that they share with the state.⁷⁶

The Program on Reproductive Health and Family Planning 1996-2000 has a goal that modern, safe, and effective contraceptive prevalence reach no less than 60% of adolescent girls living in unions.⁷⁷ The Children and Adolescents' Code⁷⁸ provides that it is the state's responsibility to guarantee and society's responsibility to aid in the creation of adequate conditions for attending to teenage mothers during pregnancy, childbirth, and the post-natal period, by offering them special attention and facilitating breast-feeding time and the introduction of day care centers.⁷⁹ In addition, the state ensures that adolescents' basic education shall include sexual guidance and family planning.⁸⁰ This program considers the risk of adolescent reproduction to be one of the primary public health problems⁸¹ and proposes to develop strategies to reduce the following indexes: the frequency of teenage pregnancies; maternal mortality rates; the frequency and consequences of induced abortions; frequency of STIs, including HIV/AIDS; and the increase in all forms of physical and sexual violence.⁸²

Reality

Adolescents make up 22.5% of Peru's population⁸³ with the under-15 age group comprising 38% of all inhabitants;⁸⁴ nevertheless, the cited sexual education policies have not efficiently addressed critical reproductive health and sexual issues. In Peru, 9% of women between the ages of 15 and 19 are already mothers while another 2% are pregnant for the first time; one out of every five teenage mothers has had between two and four pregnancies before the age of 20.⁸⁵ Twenty per cent of childbirths at the Ministry of Health hospitals correspond to adolescent mothers.⁸⁶ In urban areas teenage pregnancies are generally undesired and occur in couples who are not living together.⁸⁷ Many

teenage pregnancies end in illegal abortions; adolescent pregnancies are responsible for about 15% of the total maternal mortality rate.⁸⁸

Twenty-nine percent of teenage women between the ages of 15 and 19 living in unions use some form of contraception but only 11% use modern methods. The traditional method of periodic abstinence (the rhythm or calendar method) is most frequently used by adolescents.⁸⁹

C. Article 11 (2): *Maternity Benefits and Protection from Pregnancy-related Discrimination*

Laws and Policies

Peru is a party to international instruments adopted by the International Labor Organization (ILO) for the protection of women's work, equality of treatment in the workplace, and protection of maternity.⁹⁰ The Constitution establishes respect for equality and non-discrimination in employment⁹¹ and special protection for working mothers. It also provides protection against discrimination in employment due to pregnancy.⁹² The Law for the Promotion of Employment⁹³ states that a dismissal on grounds of pregnancy within 90 days before or after birth is null and void.⁹⁴ If such a dismissal takes place, the employee must be reinstated.⁹⁵

The 1997 Law on Modernizing Social Security⁹⁶ regulates health care for female employees. Female workers and the wives or domestic partners of male workers who are affiliated with the social security system are entitled to medical services, including prenatal health care.⁹⁷ Housewives and mothers can become affiliated with health care and pension insurance systems if they wish to.⁹⁸ Minor children of employees affiliated with the social security system have the right to benefits from conception.⁹⁹

Pregnant workers have the right to 45 days of prenatal and 45 days of post-childbirth leave.¹⁰⁰ They may also claim a maternity subsidy for 90 days, provided they do not engage in any other paid employment.¹⁰¹ A breast-feeding subsidy used to be paid to breast-feeding workers or to the mother or person responsible for the child of an insured worker.¹⁰² In 1997, this benefit was restricted to women workers.¹⁰³ Women in certain jobs are entitled to breast-feeding leave so that they can take an hour each day to feed their child with natural milk during the child's first year. This leave is only available now to public and private sector female teachers¹⁰⁴ and to women working in public administration.¹⁰⁵

Reality

There are no timely nor effective mechanisms that implement the rights established for wage-earning mothers. In addition, the flexibility of the labor market throughout the 1990's has resulted in the imposition of short-term job contracts. Women are primarily found working in the informal sector or in unpaid domestic labor. These sectors are not protected by labor laws. Thus, women with paid jobs are concentrated in the sectors of commerce and domestic work. Women employed as small retailers, peddlers, and domestic personnel make up 50.6% of employed urban women while the men employed in these activities comprise just 16.3%.¹⁰⁶ Women's position in these sectors of the labor market is extremely precarious. Workdays last between 12 and 14 hours; there are no social security nor maternity benefits. Sixty-seven point one percent of employed urban women are not enrolled in

any health care plan; 80.7% of employed urban women are not affiliated with any kind of pension system (nor are 69% of employed urban men).¹⁰⁷

In Peru there is no labor legislation that encourages the sharing of family responsibilities by men and women in low-income homes. Thus, the extension of the workday for working mothers means that adolescent — or even much younger — daughters must take up adult responsibilities to the detriment of their education and leisure time. Girl children and adolescents from extremely poor households in the rural Amazon and Andean regions become domestic workers under conditions of servitude, running grave risks of sexual, physical, and psychological violence. The Peruvian State has taken absolutely no measures to address this issue.

D. Article 12 (1 and 2): *Discrimination against Women in Health Care, including Sexual and Reproductive Health Care*

Laws and Policies

The current Constitution of 1993 includes the right to health among the social and economic rights enumerated¹⁰⁸ and recognizes the right of families and individuals to make decisions in the sphere of reproduction. This same Constitution also requires that the Peruvian State defend the interests of consumers and users of public services, especially in regard to the protection of the population's health and security.¹⁰⁹

The General Health Law declares that "the State's responsibility for providing public health care may not be renounced," reiterating that it must provide medical attention "in accordance with the principles of equity." The same law recognizes the right of persons who use these services to receive accurate, timely, and complete information regarding the health services to be provided, the economic conditions under which they will be provided, and all other terms and conditions of such services.¹¹⁰ Everyone has the right to receive information without having to explain why he or she is requesting it.¹¹¹ Moreover, the law recognizes the right to demand that health care services attain levels of quality commensurate with professional standards and practices.¹¹² It also establishes a person's right to receive emergency medical care in any health establishment "when it is needed and life or health are at risk."¹¹³

Denying or delaying treatment, abandonment of patients, negligence, or recklessness by a doctor or other health professional may also provide a basis for a court action for "exposure to danger or abandonment of persons in danger."¹¹⁴

The following are among the goals of the Program of Reproductive Health and Family Planning 1996-2000: to reach a prenatal care coverage rate of 75% of probable pregnancies (the current rate is 67%);¹¹⁵ to ensure that at least 75% of births are attended by health care professionals (the current rate is 56%);¹¹⁶ and to improve the screening of STIs to reach 60% of women of reproductive age, adolescents, and infants who are at risk. Another key objective of this program is "to increase coverage, quality and sensitivity of maternal and prenatal care, giving priority to care and timely referrals in cases which present complications."¹¹⁷

Reality

In 1992 more than 60% of pregnant women living in rural areas did not receive any prenatal care whatsoever.¹¹⁸ Only 63.9% of all pregnant women in Peru were seen by a doctor, obstetrician, or nurse during their pregnancies. Forty-three percent of pregnant women were under medical supervision and 21% under that of a nurse or obstetrician.¹¹⁹

Although there had been improvements by 1996, 53% of women living in rural areas still did not receive any prenatal care at all.¹²⁰ During this same year, prenatal care reached 67% of all births.¹²¹ At those health establishments without doctors or obstetricians, nursing personnel assumed responsibility for maternal health.¹²² During 1996, 32% of pregnant women were under the care of a physician while 35% were seen by obstetricians and nurses.¹²³ Forty-six percent of births occurred in a health care facility.¹²⁴ However, in rural areas only 15.4% of births took place in a health care facility.¹²⁵

At the national level, fifty-six percent of childbirths were attended by health care professionals, 32% by doctors and 24% by obstetricians or nurses. The remaining births were attended by traditional midwives (24%) or a family member (19%).¹²⁶ Thus, in rural areas only 22% of all births were attended by a health professional.¹²⁷

During the past five years, more than half (52%) of all births presented complications: prolonged labor or excessive bleeding (35% in each case) and, to a lesser degree, vaginal infections (12%) and convulsions (7%).¹²⁸

1. Costs of Pregnancy, Childbirth, and Post-Partum Care

Laws and Policies

In 1981 the Ministry of Health created a fee system that is scaled according to the type of service and the economic situation of certain vulnerable sectors within the population, especially rural and low-income urban groups.¹²⁹ This ministerial decree provides that basic service, medications, and diagnostic tests,¹³⁰ including care during pregnancy, childbirth, and the postnatal period, are free.¹³¹ It also established that treatment and medication in hospitals that offer specialized treatment¹³² would be free of charge for qualifying low-income individuals.¹³³ In 1985, the Population Law provided that the health care needs of the population should be provided "with a tendency towards being offered free of charge" and endorsing the view that "comprehensive maternal/infant health care" is a priority among free health services.¹³⁴

Without revoking this decree, the Ministry of Health's establishments began to charge fees to those who are able to pay for so-called "clinical services." The revenue generated by such clinical services was intended to partially pay for health care costs for indigent patients.¹³⁵

The 1997 General Health Law does not expressly or implicitly revoke the 1981 standard establishing free health care,¹³⁶ but does state that health establishments and medical service personnel are obliged to inform patients and their families about what the economic conditions to obtain care are, along with all other terms and conditions of service.¹³⁷ The law does not establish any criteria for determining said economic conditions.

Reality

Evaluating the repercussions of charging fees in its hospitals since 1990, the Ministry of Health declared in 1995 that the partial financing of these health institutions through fees had not brought about qualitative changes in health care services, and that it was probable that the new fees had had a negative impact on the poor and indigent population that traditionally relies on public establishments.¹³⁸ The demand on hospitals by the most destitute decreased between 1991 and 1994 from 30.1% to 28%, while the lowest-income middle classes¹³⁹ increased their demand from 34.8% to 45%.¹⁴⁰ The Ministry of Health stated that in certain cases hospitals were as much as 65% self-financing.¹⁴¹ Such income comes from, among other things, fees charged to women for pregnancy and childbirth care.

The fees for pregnancy, childbirth and postnatal care are determined by each health establishment. These fees are not available to the public and the CLADEM and CRLP report¹⁴² found that there were considerable differences in the fee schedules from one health establishment to another. Frequently, 50% of the total fee is demanded from women as a condition to their being admitted.¹⁴³ Poor women who seek discounts or exemptions are subject to the arbitrary decisions of hospital social workers or personnel at the health care centers or health posts. A considerable number of cases have come to light in which women suffered verbal aggression, refusals of treatment, delays (thus exposing them to unnecessary suffering), or illegal detention in the hospitals for lack of economic resources.¹⁴⁴

2. Family Planning

Laws and Policies

The National Population Law guarantees the right of all human beings to freely determine the number of their children, to comprehensive health, and to the free development of their personality.¹⁴⁵ It also establishes that it is the state's responsibility to promote family planning programs by providing services at all health establishments.¹⁴⁶ These programs must respect the fundamental rights of the individual,¹⁴⁷ and any form of coercion or manipulation in regard to family planning is expressly prohibited.¹⁴⁸

In 1995 the field of reproductive health and family planning in Peru underwent significant changes. The National Population Law was modified to include sterilization as one of the methods of family planning to be provided in government programs.¹⁴⁹ That same year a regulation was also published that established that "the widest range of contraception methods" would be available completely free of charge at public health establishments.¹⁵⁰

In 1996 the Program of Reproductive Health and Family Planning 1996-2000 (PRHFP) proposed to provide services for the promotion, protection, treatment, and rehabilitation¹⁵¹ of reproductive health and in particular "to administer to women's reproductive health during their different life stages."¹⁵² The program recognizes reproductive health as a human and fundamentally social right.¹⁵³ Family planning is considered a priority in reproductive health, whose aim is to assure men and women the capacity and freedom to decide on the number of their offspring.¹⁵⁴ Among its priority problem areas, the PRHFP identifies the high levels of unsatisfied demands for contraception and the increase of high-risk reproductive behavior among adolescents.¹⁵⁵ Among the program's goals is: to reach a total contraceptive prevalence rate of no less than 50% of women of childbearing age,

including 70% of women in stable relationships and 60% of all adolescent girls in relationships.¹⁵⁶ To reach these goals, the Ministry of Health began a process designed to "democratize reproductive health and family planning information and assure universal access to these services."¹⁵⁷

Family planning services are available at all public health establishments. In 1995, the Ministry of Health published a regulation that requires all public sector health establishments to consider family planning a priority and to reinforce their actions in this regard through family planning education.¹⁵⁸ The PRHFP emphasizes the provision of free services along with the provision of contraceptives, including surgical sterilization.¹⁵⁹ However, free medical services in cases of complications resulting from surgical sterilization are not expressly included.¹⁶⁰

Reality

The latest Demographic Health Survey (1996) shows that 12% of women living in a union have unmet needs for family planning: 9% desire to limit the size of their families and 3% wish to space their children's births.¹⁶¹ With respect to the incidence of unwanted pregnancy, one third (35%) of all births in the last 5 years were not desired, which is to say, over one million children.¹⁶² Thus, the country's total fertility rate would be an average of 2.2 children per women if all unwanted births could be prevented.¹⁶³

The state gives precedence to some contraceptive measures over others and does not provide adequate access to all the existing methods of family planning.¹⁶⁴ Female sterilization takes precedence over male sterilization and constituted the second most used contraception method in Peru in 1996.¹⁶⁵ At present, the percentages of sterilizations of women who live in a stable union are 11.3% in urban areas and 5.4% in rural areas.¹⁶⁶ In 1990 the Ministry of Health recorded 2,593 tubal ligations and 0 vasectomies in its health establishments while in 1995 it recorded 32,883 tubal ligations and 1,424 vasectomies. This means that for every man who underwent a vasectomy, 23 women had tubal ligations.¹⁶⁷

In the period between January and August of 1996, the Ministry of Health carried out 35,558 surgical sterilizations of which 3,376 were vasectomies.¹⁶⁸ According to ENDES-96, the average age of women sterilized is 32. In rural areas, surgical sterilizations of women less than 25 years old have been reported.¹⁶⁹

3. Abortion

Laws and Policies

The Peruvian Constitution provides that human life begins at conception and that the "conceived" is subject to the law insofar as this is in its favor.¹⁷⁰ Consequently, abortion is illegal and is considered a crime against life, body, and health,¹⁷¹ except for therapeutic abortion which may be performed to save the woman's life or to prevent serious and permanent damage to her health.¹⁷² The Penal Code punishes a woman who causes her own abortion or who permits another to perform an abortion on her¹⁷³ as well as the person who performs an abortion with the pregnant woman's consent or who performs it on a woman without her consent.¹⁷⁴ Any person who causes an abortion through violence is also punished even though there was no intention to cause the abortion.¹⁷⁵ The Population Law prohibits abortion as a family planning method.¹⁷⁶ It also establishes the state's obligation to

adopt appropriate methods, coordinated by the Ministry of Health, to help women avoid abortions.¹⁷⁷ What is more, it establishes the State's commitment to offer medical treatment and psychological support to women who have suffered an abortion.¹⁷⁸ In 1996 the PRHFP established that its immediate plan to reduce maternal mortality¹⁷⁹ must confront the problem of reducing deaths due to complications from illegally induced abortions which, in turn, are caused by unwanted pregnancies.¹⁸⁰

Contrary to all previous laws and policies, the General Health Law of 1997 requires doctors to inform the director of their health establishments about cases where indications of induced abortion are present and the director, in turn, is under obligation to report the suspected abortion to the competent law-enforcement authorities.¹⁸¹ The law mandates that when the police or authorities from the Office of the Public Prosecutor require information about abortion cases, the doctor must provide it,¹⁸² in which case he or she is excused from his pledge of patient confidentiality.¹⁸³

Reality

The illegal status of abortion is one of the most significant contributing factors to maternal mortality in Peru. Clandestine abortion constitutes the second highest cause of maternal deaths in the country (22%).¹⁸⁴ There were approximately 271,150 abortions carried out in 1989.¹⁸⁵ Thus, four out of every 10 pregnancies ended in induced abortion. These figures place Peru among the countries with the highest incidence of induced abortions in Latin America.¹⁸⁶ It was estimated in 1994 that 30% of available hospital beds in obstetrical and gynecological wards were used for women with complications due to induced abortion.¹⁸⁷

The principal cause of induced abortion in Peru is unplanned pregnancy.¹⁸⁸ The total potential demand for abortion services would be approximately 350,000 women a year. It is calculated that of every 100 induced abortions, 47 cause complications, 20 of which result in hospitalization.¹⁸⁹ At present, 30% of available beds in obstetrical and gynecological hospital wards are still occupied by patients with post-abortion complications, a figure that stands with all its attendant financial and social costs.¹⁹⁰

Legal restrictions on abortion impede many women from seeking medical attention in cases of complications for clandestine abortion due to their fear of prosecution or to the cruel, inhuman, and degrading treatment many health establishments mete out to women who seek treatment for incomplete abortion.¹⁹¹ The incompatibility between state-declared political objectives for the reduction of maternal mortality on the one hand, and the criminalization of abortion on the other, must be resolved, or women suspected of having undergone an induced abortion will continue to be exposed to abuse in health facilities.

E. Article 14 (2) (b), (c) and (h): *Discrimination Against Rural Women: Access to Adequate Health Care, including Family Planning*

Laws and Policies

Under existing policy, the Executive Branch is responsible for designing and carrying out the national health policy in a pluralistic and decentralized manner in order to facilitate equal access for all

to health services.¹⁹² The state administers the provision of medical services under principles of equity.¹⁹³

The PRHFP identified the following as the most vulnerable sectors of the population: the poorest women and newborn infants, adolescents, and women who live in rural areas or who belong to certain ethnic or cultural groups.¹⁹⁴ This program also proposed decentralizing reproductive health and family planning services through the coordinated participation of NGOs in addition to the public and private sectors.¹⁹⁵

Reality

According to the Demographic and Health Survey, rural women are twice as likely to die from childbirth complications as their urban counterparts.¹⁹⁶ Professional prenatal care in rural areas has reached 47% in comparison with 88% in urban centers.¹⁹⁷ While 73% of births in 1996 in the cities occurred at a health care establishment, in the countryside only 15% occurred at a health care center.¹⁹⁸ While 93% of births in metropolitan Lima were attended by a health care professional, in rural areas the corresponding figure was only 22%, which is to say, 4 times less than in metropolitan Lima.¹⁹⁹ In rural areas, less than 51% of women living in relationships use some method of contraception.²⁰⁰ The unsatisfied need for family planning is also greater in rural zones (20%) than in urban ones (9%).

Health care establishments in these localities have low capacities for addressing obstetrical complications and emergencies. In 1994 only 32.6% of the rural population had some kind of medical insurance. Of the remaining 73.8%, one-quarter had no access to any kind of health service and dealt with their problems by means of alternative medicines (medicinal herbs, etc.).²⁰¹ The quality of services is deficient and it is the women from out-lying rural areas who are the most affected.²⁰² Ethnocentrism is a very important factor contributing to the mistreatment of Andean and rural women by health personnel.

For a large sector of rural women in Peru, discrimination and gender violence acquire specific and/or more severe expressions due to unfavorable economic circumstances, racial prejudice, ethnicity and other factors. In addition to finding themselves exposed to unacceptable deficiencies and abuses, their possibilities of obtaining justice are extremely limited. Rural women — and particularly those in the most remote locations — are mostly indigenous; many are monolingual (Quechua speaking), illiterate, and with very low levels of schooling.

The PRHFP, despite using language professing equity and declaring its intention of “democratizing” access to reproductive health and family planning services, has failed in practice to respect the free and informed choice of the poorest women and of those living in rural areas. An investigation²⁰³ undertaken by CLADEM documents actual cases of systematic sterilization achieved by applying intense pressure on rural women. The report reveals a state endeavor to modify by compulsion the reproductive behavior of the indigenous and rural population. Health care providers violated the rights of these women, pressuring them to accept immediate surgical sterilization. When they resisted, the providers pressured their husbands into “authorizing” the intervention, thus forcing the women to submit to surgical contraception.²⁰⁴

Despite the fact that a considerable number of rural women presented health conditions that contraindicated tubal ligation (tuberculosis, anemia, malnutrition, obesity, chronic pelvic infections, etc.), they were not warned of the risks nor possible complications. Neither were the conditions of their lives, the demands of their domestic work nor their subordinate position in the family structure taken into account, causing grave consequences for these women's health.²⁰⁵ It must be added that in rural health facilities, operations were often carried out by unqualified personnel while the surgeries themselves took place in inadequate and unsanitary surroundings.²⁰⁶

F. Article 16: Inequality in Relationships and the Right to Make Decisions on Issues Related to Sexuality and Reproduction

Laws and Policies

In reference to autonomy in decisions regarding contraception, the National Population Law recognized both individuals' and couples' right to decide on the number of and interval between their offspring.²⁰⁷ The 1993 Constitution endorsed the right of families and individuals to make such decisions and affirmed responsible maternity and paternity as matters to be encouraged by national population policies.

The PRHFP considers a woman's social and economic situation as determinative of the status of her reproductive health.²⁰⁸ Within this program's framework, the Ministry of Health has identified women's situation of inequality among the priority problems affecting each individual woman's reproductive health, something that impacts on her decisions regarding health and reproduction.²⁰⁹ The population groups most affected by this situation are, again, the poorest women, adolescents, those living in rural areas, and those belonging to certain ethnic or cultural traditions.²¹⁰

The General Health Law, passed in July of 1997 and in force since January of 1998, clearly entrusts these decisions to individuals without the necessity of a spouse's or partner's authorization.

Reality

According to data from the latest national demographic survey (in 1996), there are differences in the prevalence of contraception methods according to whether women live in a union or not. Ninety-one percent of single but sexually active women have used some type of contraception method, a level that is five percentage points higher than that seen among women living in a union.²¹¹ This may reflect the woman's lack of negotiating capacity within the couple regarding sexuality and reproduction.

Surgical sterilization is four times greater among women living in a union than among single women who are sexually active.²¹² Condom use is eight times greater among single but sexually active women than among women living in unions.²¹³ In certain socio-cultural and economic sectors, men's resistance to their partner's use of modern contraceptives, along with the unmet need to access alternative methods of family planning among women living in unions, accounts for the high prevalence of sterilization as a contraceptive method among them.

CLADEM gathered testimonies from sterilized women — both those who had been forced and those who had given their consent — and found that women in a union frequently mentioned the need to hide the surgery from their spouses so as to avoid acts of violence or abandonment.²¹⁴ These women had to live in situations that posed risks to their life and health. Most had no post-operative rest period and they had to perform heavy labor, go on long walks, etc. Many of these women suffered domestic violence and actual abandonment, especially when their work capacity was diminished due to complications from the sterilization. Lack of family support for post-operative recovery was an evident problem found by the study.

Implementing the PRHFP failed to take into account the systematic and pervasive character of gender discrimination, and measures were not developed to ensure against violence in health care facilities or other forms of violence that result in the alienation of the most marginalized women from reproductive health and family planning services.

ENDNOTES

1. Supreme Decree No. 019-81/SA declared this service to be free of charge as of 1982. This has not been rescinded. At present, users pay fees which contribute to financing the services at public health establishments under the heading of "self-generated income."
2. Concluding comments of the Committee on the Report of Peru (CEDAW/C/1995/WP.10/Add.1, February 1 - 3, 1995, Fourteenth Session), paragraph 15.
3. Concluding Observations of the Human Rights Committee: Peru 18/11/96 (CCRP/C.79/Add.72 [Original in Spanish], 58th Session, November of 1996), ¶ 22.
4. According to Articles 25 and 30 of the recently effected Ley General de Salud (General Health Law), medical confidentiality is excepted in cases of illegal abortion, constraining doctors to notify the police or the Office of the Public Prosecutor of those cases "where indications of criminal abortion exist."
5. *Encuesta Demográfica y de Salud Familiar 1996 (Survey of Demographics and Family Health*, hereafter known as *ENDES 1996*), INEI, Lima, 1996, p. XXXIII.
6. Ibid.
7. *Encuesta Demográfica y de Salud Familiar 1992 (Survey of Demographics and Family Health 1991-92*, hereafter known as *ENDES 1992*), INEI, Lima, 1992, p. 9.
8. *ENDES 1996*, p. XXXIII.
9. "Proyecto de Presupuesto del Sector Salud 1988 (Proposal for 1988 Health Sector Budget)," Ministry of Health (MINSA), Lima, 1997, p. 3.
10. Ibid.
11. *ENDES 1996*; ibid.
12. Ibid.
13. Ibid., p. 44.
14. *Programa de Salud Reproductiva y Planificación Familiar 1996-2000 (Program of Reproductive Health and Family Planning)*, p. 10.
15. *Control Ciudadano (Social Watch)*, N° 1, 1997, Montevideo, Instituto del Tercer Mundo, p. 224.
16. Data from the *Encuesta Nacional de Niveles de Vida ENNIV 1994 (National Survey on Living Levels 1994)*, cited in "Proyecto del Presupuesto 1998 del Sector Salud (Project for 1998 Health Budget Sector)," MINSA, Lima, 1997, p. 2.
17. *ENDES 1996*, p. 13.
18. PROMPERU, *Mujer peruana. La apuesta del futuro. (Woman of Peru: Betting on the Future)*. Lima, 1995.
19. Ibid.
20. MOVIMIENTO MANUELA RAMOS. *Situación Actual de la Mujer. Cuántas Somos y Cómo Estamos (Women's Present Situation: How Many We Are and How We Are)*. Lima, 1997, p. 12.
21. Ibid., p. 13.

22. CUANTO, S.A., *Perú en números 1996. Anuario Estadístico (Peru in Numbers, 1996. Statistical Abstract)*, Lima, 1996, p. 405.
23. Article 2, Section I of the Constitution of Peru.
24. Ibid., Art. 2, Section 24.
25. Ibid., Art. 2, Section 24, ¶ a.
26. Ibid., Art. 2, Section 24, ¶ h.
27. Código Penal (Penal Code), Book II, Title IV, Chapter IX, modified by Laws N° 26923 of Feb. 14, 1994 and N° 26357 of Sep. 28, 1994.
28. Ibid., Art. 170.
29. Ibid., Art. 177.
30. Ibid.
31. Ibid., Art. 178-A.
32. Ibid., Art. 178, modified by Law N° 26770.
33. Law N° 26770 (Apr. 7, 1997), Art. 2, complement of Art. 175 of the Penal Code.
34. Ibid.
35. Penal Code, Art. 176.
36. Ley de Fomento del Empleo (Law for the Encouragement of Work), Art. 63, ¶ g.
37. Decreto Supremo (Supreme Decree) N° 05-95-TR, Art. 68.
38. Proyecto de Ley (Bill) N° 2842/96-CR, introduced by the Congressional Commission on Women to the Commission on Labor, July 10, 1997.
39. DEMUS, *Agresiones sexuales contra Mujeres: ¿Responsabilidades compartidas? (Sexual Violence Against Women: A Shared Responsibility?)*. Lima, 1997, graph 4, p. 36.
40. Ibid.
41. Ibid., graph 5, p. 37.
42. Ibid., graph 6, p. 37.
43. Ibid., graph 7, p. 38.
44. Ibid., graph 8, p. 38.
45. Ibid., graph 9, p. 39.
46. Ibid., graph 10, p. 39.
47. Ibid., graph 40, p. 54.
48. Law No. 26260, December 25th, 1993.
49. Law for the Organization and Function of the Ministry for the Advancement of Women and Human Development, Legislative Decree 866, Oct. 25, 1996, Art. 4. See the section on women's bureaus.
50. Law No. 26260, Art. 2, modified by Law No. 26768, of Mar. 11, 1997. Note that the amendment does not expressly include ex-spouses or ex-domestic partners as was established by Law No. 26260. This error has not been corrected. It also does not include those persons who reside in the home through a work relationship, such as domestic workers.
51. Ibid., Art. 3, modified by Law No. 26768, sole article.
52. Ibid., Art. 5.
53. Ibid., Art. 7.
54. Ibid., Art. 5.
55. Ibid., Art. 7.
56. CUANTO, S.A., op. cit., p. 405.
57. MOVIMIENTO MANUELA RAMOS. *La Paz Empieza por Casa (Peace Begins at Home)*, mimeo., Lima, 1997.
58. Ibid.
59. Penal Code proclaimed by Legislative Decree No. 635, Apr. 3, 1991, Art. 124.
60. Ibid.
61. Ibid., Art. 111.
62. Ibid., Articles 125 and 128.
63. Ibid., Art. 151.
64. General Health Law, Art. 134.

65. Ibid., Art. 48.
66. Ibid.
67. National Population Law, Art. 28.
68. General Health Law, Art. 6.
69. Ibid.
70. CLADEM/CRLP, *Silence and Complicity: Violence Against Women in the Public Health Services in Peru*, at press.
71. National Ombudsman, *Report on the Application of Voluntary Surgical Contraception: Cases Investigated by the National Ombudsman*. Lima, January, 1998.
72. "¿La educación sexual en la escuela? (Sex Education in the Schools?)," in *Atajos*, trimestral bulletin of the Women's Documentation Center (CENDOC), year 1, No. 1, Sep. 1996, p. 3.
73. Ibid.
74. Ibid.
75. Ibid. The preparation of these teaching guides created a debate between the State and the Catholic Church in regard to sex education. The Peruvian Bishop's Commission has already published, in March of 1996, a different guide for parents and teachers called "Formación y Orientación para el Amor y la Sexualidad (Formation and Orientation for Love and Sexuality)."
76. Minister of Health. Marino Costa Bauer's speech before the Congressional Commission on Women, October 15, 1996, p. 44.
77. MINISTERIO DE SALUD (MINISTRY OF HEALTH), Directorate of Persons, *Directorate of Social Programs; Program of Reproductive Health and Family Planning 1996-2000* (henceforth PRHFP), approved by Ministerial Resolution No. 071-96-SA/DM, Feb. 6, 1996.
78. Código del Niño y el Adolescente, approved by Legislative Decree No. 26102, Dec. 23, 1992, Art. I, Preliminary Title.
79. Ibid., Art. 2.
80. Ibid., Art. 15, ¶ f.
81. PRHFP, p. 24.
82. Ibid.
83. Ibid., p. 13.
84. ENDES 1996, p. 15.
85. PRHFP, p. 14.
86. Ibid.
87. Ibid.
88. Ibid.
89. Ibid.
90. The ILO conventions signed by Peru are: [Convenio N° 4 (Night Work), Convenio N° 41 (Night Work), Convenio N° 45 (Underground Work), Convenio N° 100 (Equality of Remuneration), Convenio N° 111 (Discrimination en Employment and Occupation), and Convenio N° 156 (Workers with Family Responsibilities).
91. Article 26 of the Constitution of Peru.
92. Ibid., ¶ 1.
93. Single Ordered Text of the Ley de Fomento del Empleo, approved by Supreme Decree No. 05-95-TR, Aug. 18, 1995.
94. Ibid., Art. 62, ¶ e.
95. Ibid., Articles 63 and 67. Under Peruvian labor legislation, dismissals categorized as "null" call for the reinstatement of the worker in his/her former job.
96. Law No. 26790, proclaimed on May 14, 1997, and published on June 17 of the same year.
97. Ibid., Art. 3.
98. Law No. 24705, Articles 1 and 4; Law No. 26790, Art. 3.
99. Law No. 26790, Art. 3.
100. Law No. 26644, Art. 1.
101. Law No. 26790, Art. 12, ¶ b.
102. Law Decree N° 22482, Art. 30, modified by Law N° 25143, of Dec. 20, 1989, rescinded by Law N° 26790.
103. Law N° 26790, Art. 12, para. b, b.1 and b.3.
104. Supreme Decree N° 19-90-ED, Art. 65, para. a.

105. Supreme Decree N° 005-90-PCM, Art. 108.
106. Richard Webb and Graciela Fernández Baca, *Perú en números 1997. Anuario Estadístico (Peru in Numbers, 1996. Statistical Abstract)*, CUANTO, S.A., Lima, 1997, p. 538.
107. Ibid., p. 547.
108. Articles 7 and 9 of the Constitution of Peru.
109. Ibid., Art. 65.
110. Ibid., Art. 2.
111. Ibid., Art. 5.
112. Ibid., Art. 2.
113. Ibid., Art. 3.
114. Penal Code, Chapter IV, Articles 124 and 125.
115. ENDES 1996, p. 134.
116. Ibid., p. 141.
117. PRHFP, p. 34.
118. ENDES 1992, p. 95.
119. Ibid.
120. ENDES 1996, p. 134.
121. Ibid.
122. Ibid.
123. Ibid.
124. "Project for 1988 Health Sector Budget," Ministry of Health, September 1997, p. 3.
125. ENDES 1996, p. 140.
126. Ibid., p. 141.
127. Ibid.
128. Ibid., p. 134.
129. Supreme Decree No. 019-81-SA, Aug. 6, 1981.
130. Ibid., Art. 1, ¶ a.
131. Ibid., ¶ d. In 1985, the National Population Law, Art. 34 confirmed that these services were free.
132. Categorizing hospitals is regulated by the Ministry of Health in its General Hospital Regulations for the Health Sector, Art. 8.
133. Supreme Decree No. 019-81-SA, Art. 1, ¶ c.
134. Ibid., Art. 22.
135. Ministerial Resolution 071-90-SA/DM, February of 1990.
136. The Fourth Complementary Order of the General Health Law expressly revokes the following statutes: Decree Law N° 17505 (Sanitary Code), Decree Law No. 19609 on emergency medical treatment, Law N° 2348 (from 1916), the 1888 Law on the practice of medicine and pharmacy, Decree Law No. 25596 and the Third Complementary Order of Decree Law N° 25988. At the same time, it also revokes implicitly all the legal norms that are contrary to it. Given that Supreme Decree 019-81-SA is not contrary to General Health Law provisions, nor do the General Health Law provisions replace the content of Supreme Decree 019-81-SA, the latter is still in force.
137. General Health Law, Art. 40.
138. Ibid. See also MINISTRY OF HEALTH. *Lineamientos de política de salud 1995-2000. Un sector salud con equidad y calidad, (Alignments of Health Policies 1995-2000: A Health Sector with Equity and Quality)*. Lima, 1995, p. 19.
139. Ibid.
140. Ibid.
141. Ibid., p. 18.
142. *Silence and Complicity, op. cit.*
143. Ibid.
144. Ibid.
145. National Population Law, Preliminary Title, Art. IV.
146. Ibid.

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147. Ibid., Art. 24.
 148. Ibid., Art. 28.
 149. Prior to the amending law (No. 26530, Sep. 9 1995), Art. IV of the Population Law expressly prohibited sterilization and abortion as contraception methods. At present only abortion is excluded as such.
 150. Ministerial Resolution No. 572-95-SA/DM.
 151. PRHFP, p. 19-23.
 152. Ibid., p. 3.
 153. Ibid., p. 5.
 154. Ibid.
 155. Ibid., pp. 24-25.
 156. Ibid.
 157. Ibid., pp. 28 and 30.
 158. Ministerial Resolution No. 572-95-SA/DM, Aug. 17, 1995, Art. 2.
 159. PRHFP, op. cit., pp. 20 and 28.
 160. ENDES 1996.
 161. Ibid.
 162. Ibid.
 163. See Section IIA on *Violence Against Women*.
 164. ENDES 1996, p. 72.
 165. Ibid., p. 66.
 166. CLADEM, *Reporte de Derechos Humanos sobre Anticoncepción Quirúrgica en el Perú. Avance de investigación (Human Rights Report on Surgical Sterilization in Peru)* investigation preview, at press.
 167. Data from the MINSA Office of Statistics and Information, Directorate of Social Programs, Directorate of Family Planning, Nov. 26, 1996 (mimeo. in CRLP archives).
 168. Ibid.
 169. CLADEM, *Reporte de Derechos Humanos sobre Anticoncepción Quirúrgica en el Perú. Avance de investigación (Human Rights Report on Surgical Sterilization in Peru)* investigation preview, at press.
 170. Article 2, ¶ 2 of the Constitution of Peru. Other laws that reaffirm the rights of the "conceived" are: Civil Code of Peru (Art. 1), Population Law (Art. VI of Preliminary Title), and Legal Decree N° 26102 (Children's and Adolescents' Code, Art. I of the Preliminary Title).
 171. Penal Code, Articles 114 and 120.
 172. Ibid., Art. 119.
 173. Ibid., Art. 114.
 174. Ibid., Articles 115 and 116.
 175. Ibid., Art. 118.
 176. Population Law, op. cit., Art. VI of the Preliminary Title, modified by Law N° 26530.
 177. Ibid., Art. 29.
 178. Ibid.
 179. PRHFP, p. 46.
 180. Ibid.
 181. General Health Law, Art. 43.
 182. Ibid., Art. 25, ¶¶g and 30.
 183. Ibid.
 184. PRHFP, p. 17.
 185. The Alan Guttmacher Institute, *Aborto Clandestino: una realidad latinoamericana (Clandestine Abortion: A Latin American Reality)*, New York, 1994, p. 20.
 186. In 1990 the rate of abortions in Peru was around 5.19 for every 100 women between the ages of 15 and 49, a higher figure than that of Brazil (in 1991), Colombia (in 1989), Chile (in 1990), Mexico (in 1990), and the Dominican Republic (in 1992).
 187. The Alan Guttmacher Institute, op. cit., p. 20.
 188. Ibid.

189. Ibid.
190. Manarelli, M. E., *Diagnóstico de la Salud Reproductiva de la Mujer en el Perú (Diagnosis of Women's Reproductive Health in Peru)*, Centro de la Mujer Peruana "Flora Tristán," Lima, 1997, pp. 117-118.
191. *Silencio y Complicidad*, op. cit.
192. Article 9 of the Constitution of Peru.
193. National Population Law, Art. VI of the Preliminary Title.
194. PRHFP.
195. Ibid.
196. ENDES 1996, p. 131.
197. Ibid., p. 134.
198. Ibid., p. 139.
199. Ibid., p. 141.
200. Ibid., p. 65.
201. *Lineamientos de política de salud 1995-2000. Un sector salud con equidad y calidad, (Alignments of Health Policies 1995-2000: A Health Sector with Equity and Quality)*, Lima, 1995, p. 24.
202. Manarelli, op. cit., p. 68.
203. CLADEM, *Reporte de Derechos Humanos sobre Anticoncepción Quirúrgica en el Perú. Avance de investigación (Human Rights Report on Surgical Sterilization in Peru)* investigation preview, at press.
204. Ibid.
205. Ibid.
206. Ibid.
207. National Population Law, Art. IV.
208. PRHFP, p. 18.
209. Ibid.
210. Ibid.
211. ENDES 1996, p. 60.
212. Ibid., p. 61.
213. Ibid.
214. CLADEM, *Reporte de Derechos Humanos sobre Anticoncepción Quirúrgica en el Perú. Avance de investigación (Human Rights Report on Surgical Sterilization in Peru)* investigation preview, at press.