

BOLIVIA

BRIEFING TO THE UN
COMMITTEE ON THE
ELIMINATION OF
DISCRIMINATION AGAINST
WOMEN

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EXECUTIVE SUMMARY

Amnesty International is presenting the following information to the Committee on the Elimination of Discrimination against Women (the Committee) in connection with the Committee's forthcoming consideration of the fifth and sixth periodic reports submitted by the Plurinational State of Bolivia under Article 18 of the Convention on the Elimination of All Forms of Discrimination against Women (the Convention).¹ The Committee's review of Bolivia's periodic reports in July 2015 provides an opportunity to assess the progress made by Bolivia in implementing the provisions of the Convention, both in law and in practice, since the previous review in 2008.

Amnesty International welcomes the measures taken by the Government of the Plurinational State of Bolivia to fulfil its obligations under the Convention. Bolivia has undoubtedly made significant progress at the legislative and constitutional level since the Committee's 2008 recommendations.² These advances are set out in detail in the report submitted by Bolivia to the Committee in 2014.

In certain areas, the progress made is clear. For example, women's participation in politics, and particularly the number of women in elected posts, has improved markedly thanks to the introduction of legislation guaranteeing gender parity and its effective enforcement in the last elections.³ There has also been an improvement in women's political participation in some areas of government; for example for the first time in Bolivian history, Indigenous women now hold positions of power.

Nevertheless, Amnesty International remains concerned about the implementation of legislation and public policies designed to fulfil the state's obligations under the Convention. There is no evidence to suggest that public policy concerning sexual rights and reproductive rights is being implemented appropriately. On the contrary, the information available suggests that there is a lack of adequate and targeted funding and that the government structures that should implement and coordinate all the measures approved remain weak and lack sufficient personnel with specialist training.⁴

¹ CEDAW/C/BOL/5-6, 17 December 2013, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fBOL%2fCO%2f4&Lang=en

² CEDAW/C/BOL/CO/4, 8 April 2008, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fBOL%2fCO%2f4&Lang=en

³ The March 2015 elections saw the proportion of women representatives in the departmental legislative assemblies rise to 44.5% (compared to 27% following the 2010 elections). Observatorio de Género, Coordinadora de la Mujer, available at [http://www.coordinadoradelamujer.org.bo/observatorio/boletin/boletin_alertas2.php?id=186&tip=2]

Similarly in the Plurinational Legislative Assembly (Asamblea Legislativa Plurinacional, ALP), 48% of seats will be held by women in the 2015-2020 parliament. For more information, see: <http://eju.tv/2014/12/mujeres-ocupan-el-48-de-los-espacios-en-la-nueva-asamblea-legislativa-de-bolivia/#sthash.fva6zXZA.dpuf>.

⁴ List of issues and questions in relation to the combined fifth and sixth periodic reports of the Plurinational State of Bolivia, para 5 on national machinery for the advancement of women.

For example, according to information gathered by Bolivian NGOs, in 2014 the Deputy Minister for Equal Opportunities, under whose mandate the Mechanism for the Advancement of Women falls, received 5.3% of the budget allocated to the Minister of Justice and Fundamental Rights.⁵ Reliable sources have assured Amnesty International that in 2014 the Gender Office had just five members of staff and was almost wholly dependent on international aid for its funding.⁶ The Unit for Depatriarchalization, which is part of the Deputy Ministry for Decolonization in the Culture Ministry, faces a similar situation. This body, created to develop and formulate depatriarchalization plans in state institutions and in society at large, is unique in Latin America. However, it does not appear to have the funds or structures needed to implement this ambitious project.

In addition, some important legislative measures needed in order to fulfil the state's obligations under the Convention have yet to be adopted, such as the Law on Sexual and Reproductive Rights.

The information presented by Amnesty International in this briefing is not exhaustive. A coalition of Bolivian civil society organizations has set out in detail a number shortcomings in implementation relating to various issues covered by the Convention. In this briefing, Amnesty International will restrict its comments to certain aspects of women's right to health and, in particular, to sexual rights and reproductive rights, the subjects of its recent body of research and campaign in several countries in the region.

Amnesty International delegates visited Bolivia in May 2013 and August 2014. They carried out interviews with NGOs, representatives of social movements, state officials, health workers and experts and officials in the field of international cooperation. These took place in La Paz, Sucre and Potosí. This report draws primarily on the information gathered in these interviews as well as other secondary sources.

THE RIGHT TO HEALTH AND SEXUAL AND REPRODUCTIVE RIGHTS

Current legislation relating to health is extensive and incorporates in large part a human rights perspective. However, Amnesty International was unable to find studies, evaluations or indicators of any kind that would allow it to assess whether this had translated into effective protection of women's right to health. This was particularly problematic for those sections of

⁵ Sociedad Civil Hacia Cairo+20 Report, Bolivia 2013, pp. 19-23. (Available only in Spanish)

⁶ The Office for the Prevention and Elimination of all Forms of Violence based on Gender and Age (Gender Office) forms part of the Office of the Deputy Minister for Equal Opportunities in the Ministry of Justice. The Ministry of Justice' mandate in relation to gender equality includes acting as the principle body responsible for coordinating, formulating and overseeing the effective implementation of Law N° 348, the Comprehensive Law to Guarantee Women a Life Free from Violence.

the population that have traditionally been disadvantaged in terms of access to health, such as Indigenous or Afrodescendent women and girls and *campesinas* (peasant farmers).

In its report to the Committee, Bolivia set out a detailed description of the legislation relating to health. Key components of this are the National Health Plan 2012-2020, which aims to end social exclusion in health; the Intercultural Family and Community Health (Salud Familiar Comunitario Intercultural, SAFCI) model, which is currently being applied; and various policies adopted in different parts of the health sector.⁷

The intercultural approach is without doubt one of the most notable aspects of policy in Bolivia. The official recognition of 36 Indigenous nations in the new Constitution and that a large percentage of the population self-identify with them testify to the importance of interculturalism in Bolivia. The SAFCI model integrates interculturalism as a focus for public health policy, setting out the principle of “formulation, complementarity and reciprocity based on acceptance, recognition of and mutual respect for our knowledge and practices in matters of health... in order to help achieve symmetry in power relations.”

However, Amnesty International could find no evidence of this important and ambitious agenda being implemented or bringing about the desired changes in the lives of Bolivian women and girls. Indeed, information came to light suggesting quite the opposite.

For example, a 2013 study of maternal mortality among Indigenous women shows that major barriers to access to health services persist. These include key obstacles linked to geography (health centres are often located far from women’s homes and women cannot afford to pay for transport), to language and culture, to discriminatory treatment, to a lack of care; and invasive medical practices. Such factors seriously affect the quality of health services.⁸

The study mentioned above notes that: “despite the creation of a Deputy Ministry of Traditional Medicine and Interculturalism and intense debates about decolonization policies, initiatives to facilitate access to health services for the diverse female population of Bolivia remain marginalized.”⁹

The confusion in society as a whole and among high-ranking state officials about the legality and availability of some fundamental sexual and reproductive health services – such as emergency contraception or safe abortions in those circumstances allowed for by law – illustrates the extent to which the authorities have failed to prioritize women’s access to health services.

For example, in 2014 representatives of the Catholic Church called on the state to stop the provision of emergency contraception. The then Minister of Health made public statements declaring that: “The Ministry of Health has taken no official position on the contraceptive pill. It is not mentioned in our health system (...)and we cannot comment on something

⁷ CEDAW/C/BOL/ 5-6, paras 311-326.

⁸ Manigeh Roosta coordinadora, *Salud materna en contextos de interculturalidad*, CIDES-UMSA, UNFPA, OMS-OPS editores, p. 16. (Available only in Spanish)

⁹ Manigeh Roosta coordinadora, *Salud materna en contextos de interculturalidad*, CIDES-UMSA, UNFPA, OMS-OPS editores, p. 16

which the Ministry has not included”.¹⁰

However, the emergency oral contraception (Anticoncepción Oral de Emergencia, AOE) and the emergency contraceptive pill (Píldora Anticonceptiva de Emergencia, PAE) are listed among the methods covered and provided by the Public Health and Security System, in the National Rules, Regulations, Protocols and Procedures on Contraception which have been in force since 2010. A Ministry of Health official told Amnesty International that the PAE had been distributed to those public health facilities “that wanted it” since 2004 but that they could not publicize its availability for fear of provoking a backlash from church hierarchy, which certain senior state officials either belonged or answered to.¹¹

This attitude clearly is not consistent with the obligation of the state to ensure access to sexual and reproductive health information and services as set out in the Committee’s General Recommendation 24. The Committee on Economic, Social and Cultural Rights (CESCR) has also said that the right to health extends “not only to timely and appropriate health care but also to the underlying determinants of health, such as (...) access to health-related education and information, including on sexual and reproductive health.”¹²

In December 2013, the Human Rights Committee had made a recommendation that Bolivia: “Ensures the effective implementation of current national health plans and programmes for educating people and raising their awareness about the importance of using contraceptives and about their sexual and reproductive health rights and ensure their implementation at the formal (schools and universities) and informal (mass media) levels.”¹³

According to a recent study, for most adolescents the main source of information and knowledge about contraception is their school, followed by workshops on the issue organized by municipal bodies. However, the information they get is superficial and tailored to their ability to pay attention.¹⁴ It is clear that there is a high and unmet demand for contraception among teenagers. More than half the teenagers in the study were in a relationship and were not planning to get pregnant and yet more than 80% were not using any form of contraception.¹⁵ The low level of use of modern contraceptives suggests that the situation

¹⁰ See also <http://eju.tv/2014/03/gobierno-boliviano-retrocede-y-descarta-entrega-gratuita-de-pildora-del-da-despus/#sthash.06etfYx9.dpuf> ; <http://eju.tv/2014/03/ministerio-de-salud-entreg-ms-de-1-000-pildoras-del-da-despus-en-tres-regiones-de-bolivia/>; http://www.la-razon.com/index.php?url=/sociedad/Iglesia-Catolica-gobierno-Bolivia-suspender_0_2012798767.html

¹¹ The official asked that his identity be withheld. Amnesty International interview, August 2014.

¹² See, CESCR General Comment No 14, para 11, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fc.12%2f2000%2f4&Lang=en.

¹³ Human Rights Committee, Concluding observations on the third periodic report of the Plurinational State of Bolivia, 6 December 2013 (CCPR/C/BOL/CO/3), para 9(c), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR/C/BOL/CO/3&Lang=En.

¹⁴ United Nations Population Fund (UNFPA) and the Comparative and International Education Society (CIES), *Estudio sobre causas, características y consecuencias del embarazo en la adolescencia en 14 municipios de Bolivia, Informe Ejecutivo*, La Paz, January 2015, p. 58. (Available only in Spanish)

¹⁵ UNFPA and CIES, *Estudio sobre causas, características y consecuencias del embarazo en la adolescencia en 14 municipios de Bolivia, Informe Ejecutivo*, La Paz, January 2015, p. 58.. The study found that contraceptives such as condoms were available in most health centres free of charge. However, only teenage girls had access to male condoms; their partners (who would actually use them) cannot get them from public health centres.

regarding teenage pregnancy may well not change in the coming years unless strategies to improve access to contraceptive information and supplies are strengthened.¹⁶

According to reliable sources, in 2014 the government received modern contraceptives to the value of 1.4 million bolivianos (approximately US\$2 million) from the United National Population Fund (UNFPA). However, as a result of administrative difficulties and ineffective organization and coordination between the authorities at the national, departmental and municipal levels many of these supplies were not being distributed to public hospitals throughout the country and many are reported to have expired before they could be used.

These are only some examples of the concerns that Amnesty International documented during its visit. They raise serious questions about state responsibility and accountability mechanisms on this issue and whether the right to health and sexual and reproductive rights have in reality been given priority on the government agenda.

The failure to make this a priority is all the more worrying given that sexism continues to permeate all levels of Bolivian society, including high-ranking officials. Health professionals interviewed by Amnesty International confirmed the prevalence of notions that “a woman’s role is to have children”; “the population of Bolivia is very small and therefore women, and especially Indigenous women, must keep on having children in order to increase the population”; and that “a woman is not a woman unless she has kids”.¹⁷ These ideas are deeply ingrained in society, so much so that health workers providing sexual and reproductive care told Amnesty International that in many cases women who asked them for modern contraceptive methods, including irreversible procedures, have requested that their husbands or partners not be told because they would not have allowed the women to have the contraception they wanted. Staff have even been asked to lie to men who came to the health centre to check what treatment “their women” had received.¹⁸

MATERNAL MORTALITY

(Para 18, List of issues and questions in relation to the combined fifth and sixth periodic reports of the Plurinational State of Bolivia)¹⁹

“Maternal deaths epitomize the continuing enormous levels of gender-based discrimination and lack of equity. They are one of Bolivia’s silent epidemics and constitute one of the forms of violence against women with the greatest repercussions”.²⁰

¹⁶ UNFPA and CIES, *Estudio sobre causas, características y consecuencias del embarazo en la adolescencia en 14 municipios de Bolivia, Informe Ejecutivo*, La Paz, January 2015. According to the report, although contraceptives are available to women, cultural barriers remain, such as the view that the right to contraception applies to adults only. The result is that teenagers feel afraid and embarrassed about asking for contraceptive services in public health centres. The use of other modern methods is limited because of misinformation about the potential side effects.

¹⁷ The officials asked that their identity be withheld. Amnesty International interview, August 2014.

¹⁸ The officials asked that their identity be withheld. Amnesty International interview, August 2014.

¹⁹ CEDAW/C/BOL/Q/5-6, 17 November 2014, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fBOL%2fQ%2f5-6&Lang=en

²⁰ Dr Michel Thieren, World Health Organization and Pan American Health Organization Representative, in Bolivia, quoted in Manigeh Roosta coordinadora, *Salud materna en contextos de interculturalidad*, CIDES-UMSA, UNFPA, OMS-OPS editores, 2013, p.13. (Available only in Spanish)

The pattern of maternal mortality in Bolivia provides a dramatic illustration of the systemic inequalities that are costing the lives of women and girls, and particularly those of women and girls living in poverty or who have a low level of educational attainment and/or belong to Indigenous communities. The measures needed to prevent the vast majority of deaths related to pregnancy and childbirth are well known²¹ and are readily available to women who have the necessary economic resources. They are: better access to family planning, better access to quality care during pregnancy and childbirth, and better access to safe abortion.²²

Despite various policies and initiatives designed to improve the situation, including the creation of the Bolivian National Committee for Safe Motherhood and Childbirth, according to the most recent official statistics available, Bolivia has one of the highest levels of maternal mortality in the region.²³ As the Committee has noted, there has been an increase in the number of women receiving prenatal care and in the number of childbirths where a doctor was present, although this is not uniform and discrepancies persist between urban and rural areas. Similarly, discrepancies exist regarding maternal mortality which remains considerably higher in rural areas. In addition, prenatal care still appears to focus more on the number rather than the quality of clinic appointments.²⁴

Quality care during pregnancy and childbirth is one of the clearest indicators of improved access to basic health services for women living in poverty. In Bolivia, however, this is a particularly controversial area for a number of reasons. On the one hand, for the past decade the policy of “safe motherhood” has had as one of its key indicators an increase of the number of births that take place in an “institutional setting”.²⁵ However, in Bolivia 37% of maternal deaths occur in health care facilities,²⁶ which is one of the reasons why women have a well-founded fear of giving birth such facilities.

On the other hand, safe motherhood policies also have an impact on the right of women, using the best information on the potential risks, to choose freely how and where they want to give birth. This is a particularly important issue in a multicultural society like Bolivia. Such policies measure success in terms of the cost of childbirth and in Bolivia medical care is free and the “Bono Juana Azurduy” even gives women grants for going to their prenatal appointments. However, women who do not go to health centres are criticized. According to a study carried out in various parts of the country among Indigenous communities, the policy is seen as a way of “correcting mistaken beliefs or ideas” (for example wanting to give birth at

²¹ Most of these deaths could have been avoided. <http://www.guttmacher.org/pubs/AddingItUp2014-summary-SP.html>

²² The three strategies to improve maternal health care are: increase access to family planning, increase access to quality care during pregnancy and childbirth and increase access to safe abortion services. <http://www.womendeliver.org/knowledge-center/facts-figures/maternal-health/>

²³ In the National Health Survey (Encuesta Nacional de Demografía y Salud, ENDSA) in 2003, the figure was 229 deaths for every 100,000 live births. Only Haiti had a higher rate of maternal mortality. The comparable figure for neighbouring countries is an average of 50 deaths for every 100,000 live births.

²⁴ UNFPA and CIES, *Estudio sobre causas, características y consecuencias del embarazo en la adolescencia en 14 municipios de Bolivia, Informe Ejecutivo*, La Paz, January 2015, p.59.

²⁵ This policy, which offers a number of incentives to encourage women to give birth in health centres, has expanded in recent years, owing to the fact that treatment is free of charge and the creation of the Bono Juana Azurduy which provides a grant to women who attend at least four prenatal check-ups.

²⁶ Memoria de la Mesa Nacional por una Maternidad y Nacimientos Seguros de Bolivia, 2012, © Socios para el Desarrollo/PROSALUD, p. 21. (Available only in Spanish)

home). As a result, the health system is reproducing some of the prevailing social inequalities.²⁷

Aymara women, for example, prefer to give birth at home with the “help” of their husband. In their worldview, women are the key players and those who are with them during childbirth are “helpers” rather than “carers”. They have great confidence in their intuition and their innate abilities during childbirth and they find it unsettling to delegate decisions to others, all the more so if their ideas about health care are not understood or respected. Health centres are seen as cold, desolate places both physically and emotionally. Having someone they know present, particularly their husband, is seen as crucial and the absence of such support is believed to result in problems, even fatal complications, during childbirth. The phrase “we give each other strength” is often repeated.²⁸

According to the World Health Organization/Pan American Health Organization (WHO/PAHO), the accounts and testimonies of Indigenous women highlight the fact that, over and above the medical and clinical aspects, reducing maternal mortality requires the social determinants of health and barriers to access to services linked to the right to health to be addressed.²⁹

It would appear that there is still much to do in this regard in Bolivia. It is difficult to assess Bolivia’s progress in terms of improving maternal health in recent years, given that there is no reliable data on the causes of maternal mortality in the country and no information on progress made since 2000.³⁰ In a welcome development, the Minister of Health has announced that the Ministry of Health will shortly publish the results of a study on maternal and infant mortality that started in November 2014.³¹ In the absence of this information, public policy will at best rely on intuition and strategies for preventing maternal deaths that have been successful elsewhere rather than on an analysis of the Bolivian context and the cause of maternal mortality in the country.

To date information about the multicultural approach to providing health care to Indigenous women is limited to a number of successful pilot projects by local and international NGOs. While these are valuable, they do not as yet appear to have been replicated at a national level. Clearly, the new SAFCI model provides an opportunity to make progress in this area. However, a strong political will is needed if this is to be implemented. In addition, in order to have real impact, effective mechanisms to ensure that Indigenous women are consulted will need to be put in place so that they can influence the development of policies and initiatives

²⁷ Manigeh Roosta coordinadora, *Salud materna en contextos de interculturalidad*, CIDES-UMSA, UNFPA, OMS-OPS editores, p. 99.

²⁸ Manigeh Roosta coordinadora, *Salud materna en contextos de interculturalidad*, CIDES-UMSA, UNFPA, OMS-OPS editores, p. 101.

²⁹ Dr Michel Thieren, World Health Organization and Pan American Health Organization Representative, in Bolivia, quoted in Manigeh Roosta coordinadora, *Salud materna en contextos de interculturalidad*, CIDES-UMSA, UNFPA, OMS-OPS editores, 2013, p.13.

³⁰ The maternal mortality ratio in 2000 was 235 for every 100,000 live births, based on a Post-Census Maternal Mortality study of 2002. A similar study was carried out at the end of 2014/beginning of 2015 to verify the results of the previous census. Experts involved in the study interviewed by Amnesty International in 2014 believed that it was possible the maternal mortality ratio may have remained the same or increased in the last 10 years (those interviewed asked that their names be withheld, Amnesty International interview, August 2014).

³¹ <http://www.paginasiete.bo/sociedad/2015/5/8/ministra-salud-rechaza-datos-save-children-55894.html>

to reduce maternal mortality from a multicultural perspective.

SAFE, LEGAL ABORTION

(Para 18, List of issues and questions in relation to the combined fifth and sixth periodic reports of the Plurinational State of Bolivia)³²

There is a close link between high rates of maternal mortality and the failure to ensure that all women, and in particular women living in rural areas and Indigenous women, have access to safe, legal abortion, including post-abortion care, without fear of prosecution. The Human Rights Committee has recently expressed concern about this issue.³³

Abortion is a criminal offence in Bolivia, with the exception of cases where the woman's health is in danger or the pregnancy is the result of rape. Nevertheless, even in cases where the law allows for abortion, it imposes a number of obstacles to access to abortion services. Among these is the requirement that prior judicial authorization be obtained, the practical effect of which is to render the exceptions meaningless.³⁴ As the Human Rights Committee has stated:

“The Committee wishes to express its concern about the fact that prior court authorization is needed in order for therapeutic abortions and abortions following rape, statutory rape or incest not to be punishable offences. It is also concerned by reports according to which only six legal abortions have been authorized by the courts in the State party.”³⁵

As a result, most of the abortions carried out in Bolivia are clandestine, exposing women to very real risks both in terms of the law and their health. Unsafe abortions also have a negative impact on the health system in Bolivia. It is estimated that some 60% of obstetric and gynaecological costs are spent on treating complications arising from unsafe abortions through Post-abortion care (PAC) provision.³⁶

Unsafe abortion is the third most frequent cause of maternal death in Bolivia, according to the latest available official figures (9.1%).³⁷ However, other studies suggest that more than a quarter of all maternal deaths in the country are the result of unsafe abortions.³⁸ Although

³² CEDAW/C/BOL/Q/5-6, 17 Novembre 2014, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fBOL%2fQ%2f5-6&Lang=en

³³ The Committee also expressed concern at “reports which indicate that a large percentage of maternal deaths are due to unsafe abortions and that an alarming number of criminal investigations of women suspected of having had illegal abortions are being conducted.” Human Rights Committee, Concluding observations on the third periodic report of the Plurinational State of Bolivia, 6 December 2013, (CCPR/C/BOL/CO/3), para. 9.

³⁴ This requirement for prior judicial authorization has been declared unconstitutional by the Plurinational Constitutional Court, as mentioned above.

³⁵ Human Rights Committee, Concluding observations on the third periodic report of the Plurinational State of Bolivia, 6 December 2013, CCPR/C/BOL/CO/3, para 9.

³⁶ Billings, D.L., et al., *Scaling-up a public health innovation: a comparative study of post-abortion care in Bolivia and Mexico*. Soc Sci Med, 2007. 64(11): p.2210-22, quoted in Marie Stopes International, *The Realities of Unsafe Abortion in Bolivia: Evidence from the Field*.

³⁷ Post-Census Study of Maternal Mortality, Ministry of Health and Sport, 2003, La Paz.

³⁸ Billings, D.L., et al., *Scaling-up a public health innovation: a comparative study of post-abortion care in Bolivia and Mexico*. Soc Sci Med, 2007. 64(11): p.2210-22, quoted in Marie Stopes International,

abortion is a criminal offence in Bolivia, the law makes provision for exceptions in cases of rape, incest or where the woman's life or health is at risk. Nevertheless, the legal and cultural-religious climate means that abortion remains a taboo subject. The high rate of unwanted pregnancies (74%)³⁹ results in an estimated 80,000 induced abortions each year. These are particularly prevalent in communities with a majority Indigenous population, those with low socio-economic indicators⁴⁰ and among teenagers. According to a recent UNFPA report, the number of teenage pregnancies that end in abortions is very high (27%), accounting for a third of all abortions, the highest percentage of any age group. The high incidence of abortion has implications for the health of teenagers and highlights the failure of the health services both in terms of prevention and diagnosis.⁴¹

In June 2013, the Committee against Torture had raised its concerns with Bolivia about the requirement that victims of rape obtain authorization from a judge in order to undergo an abortion. The Committee stated that it believed in many cases this could result in women resorting to clandestine abortions. It recommended that the state: "ensure that rape victims who voluntarily decide to interrupt their pregnancy have access to safe abortions. To this end, the State party should do away with any unnecessary obstacle in that regard". It urged Bolivia to: "evaluate what effects the current highly restrictive laws on abortion have on women's health."⁴²

In February 2014, the Plurinational Constitutional Court ruled that the requirement that women who have been raped obtain authorization from a judge in order to have an abortion was unconstitutional. However, it ruled that, instead, women should be required to produce the formal complaint of rape. On 29 January 2015, the Ministry of Health issued Ministerial Resolution No 0027 setting out the "Technical Procedures for the Implementation of the Constitutional Ruling on Health Services". According to the information received by Amnesty International, health personnel in the main public hospitals in Bolivia were consulted during the drafting of the Procedures and discussions with them are continuing with a view to prompt implementation.

If applied effectively, these Procedures would represent an important step forward in eliminating the barriers to safe abortion for rape victims and also help clarify the law regarding when abortion is not an offence. However, a concerted campaign of information and education will be needed to overcome the high levels of confusion and disinformation that currently exist among those working in the health service, the police, prosecutors, defence lawyers and other officials responsible for implementing the ruling and procedures, as well as among the public at large and some senior state officials. Anecdotal information received by Amnesty International suggests that despite the February Constitution Court ruling, many doctors are continuing to demand authorization from a judge and many

The Realities of Unsafe Abortion in Bolivia: Evidence from the Field.

³⁹ IPAS Bolivia, *Las Cifras Hablan: El aborto es un problema de salud pública*, 2011, quoting figures from the National Health and Demographic Survey 2008.

⁴⁰ J Friedman-Rudovsky, "Abortion under siege in Latin America", *Time Magazine*, 9 August 2007, cited in Marie Stopes International, *The Realities of Unsafe Abortion in Bolivia: Evidence from the Field*.

⁴¹ UNFPA and CIES, *Estudio sobre causas, características y consecuencias del embarazo en la adolescencia en 14 municipios de Bolivia, Informe Ejecutivo*, La Paz, January 2015, p.57

⁴² Committee against Torture, Concluding observations on the second periodic report of the Plurinational State of Bolivia as approved by the Committee at its fiftieth session (6–31 May 2013), 14 June 2013 (CAT/C/BOL/CO/2). The Human Rights Committee has made similar statements, as mentioned above.

prosecutors also believe that such authorization is necessary.

Access to safe, legal abortion in cases of rape must be a priority in a country where the level of gender-based violence constitutes an epidemic and in which, according to a recent study by UNFPA, most teenagers begin their sex lives with unwanted sexual activity.⁴³

Despite the Plurinational Constitutional Court ruling and the recent approval of the Technical Procedures, access to abortion remains restricted in Bolivia. A law to decriminalize abortion could definitively remove current barriers to abortion that are costing the lives of so many women and girls. Indeed, the Plurinational Constitutional Court ruling calls for a reform of the law.⁴⁴

Various UN treaty bodies have consistently called for an end to criminal sanctions for abortion.⁴⁵ The Human Rights Committee has also called on states to stop the prosecution of women for the offence of abortion, to release women imprisoned for undergoing clandestine abortions and to reform their abortion laws.⁴⁶ In 2013, the Human Right Committee expressed concern at the alarming number of criminal investigations being conducted into cases where women were suspected of having had illegal abortions.⁴⁷

In addition, the Human Rights Committee has noted the negative and disproportionate effect of these Procedures on women living in rural areas and Indigenous women.⁴⁸

THE LAW ON SEXUAL AND REPRODUCTIVE RIGHTS

(List of issues and questions in relation to the combined fifth and sixth periodic reports of the Plurinational State of Bolivia, para 17)⁴⁹

All the Bolivian civil society organizations with whom Amnesty International was able to speak agreed on the need for a comprehensive law on sexual and reproductive rights that brings together all Bolivia's international obligations and has broad public support. There

⁴³ UNFPA and CIES, *Estudio sobre causas, características y consecuencias del embarazo en la adolescencia en 14 municipios de Bolivia, Informe Ejecutivo*, La Paz, January 2015. See also http://www.la-razon.com/sociedad/UNFPA-violaciones-marcen-inicio-vida-sexual_0_2258174189.html

⁴⁴ Clause 5 of the ruling calls on the Plurinational Legislative Assembly to “institute laws that guarantee the exercise of the sexual and reproductive rights... and that contribute to resolving the problem of clandestine abortions”.

⁴⁵ See: Rights Committee, Concluding observations: El Salvador (CCPR/C/SLV/CO/6), para. 10; Human Rights Committee, Concluding observations: Costa Rica (CCPR/C/79/Add.107), para.11; Committee on the Rights of the Child, Concluding Observations: Nicaragua (CRC/C/NIC/CO/4), para. 59 (b); CEDAW, Concluding Observations: Andorra para. 32(a) (2013); Committee on Economic, Social and Cultural Rights, Concluding observations: Chile (E/C.12/1/Add.105), para. 53.

⁴⁶ See Rights Committee, Concluding observations: El Salvador (CCPR/C/SLV/CO/6), para. 10 and Rights Committee, Concluding observations: Republic of Moldavia (CCPR/C/MDA/CO/2), para. 17.

⁴⁷ Human Rights Committee, Concluding Observations: Bolivia (CCPR/C/BOL/CO/3), para. 9.

⁴⁸ CEDAW/C/BOL/Q/5-6, 17 November 2014, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolNo=CEDAW%2FC%2FBOL%2FQ%2F5-6&Lang=en, para 19.

⁴⁹ CEDAW/C/BOL/Q/5-6, 17 November 2014, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolNo=CEDAW%2FC%2FBOL%2FQ%2F5-6&Lang=en

have been various attempts at creating such a law supported by, for example, a number of Indigenous women's organizations that are part of the governing coalition. However, leadership in the Plurinational Legislative Assembly was lacking and the law was not approved. Several of those interviewed mentioned that there was pressure from certain religious groups which wielded a great deal of influence in the Assembly and were able to ensure that the law did not pass.

Clearly, this remains to be resolved in Bolivia and the passing of such a law would be a clear sign that the state is committed to dealing with this issue. The evidence suggests that not only is a law needed, but also that sufficient funds need to be allocated to establish, with the participation of civil society, clear mechanisms for implementation and evaluation. This is vital if the law is to have a real impact on the lives of women and girls.

CONCLUSIONS AND RECOMMENDATIONS

As the government itself has stated: "The Bolivian State has made significant progress in the area of legislation, starting with the enactment of the Political Constitution of 7 February 2009 in which women's rights are recognized in more than 30 articles. In the period 2009-2014, several laws were enacted that incorporate provisions to protect the rights of women, such as gender equity and equal opportunities, parity and alternation, non-discrimination, the right to a life free from violence, as well as de-patriarchalization, among others."⁵⁰ This has been reiterated in alternative reports compiled by Bolivian civil society groups.

Nevertheless, legislative advances, at least in the area of sexual and reproductive rights, remain incomplete and have not been accompanied by an effective and comprehensive strategy that addresses the fundamental causes of the inequalities set out in this report. These inequalities are intrinsically linked to power disparities that affect women when making decisions about their reproductive lives. The results are often serious harm to women's health which can be fatal.

There are undoubtedly a number of systemic, social factors that perpetuate the injustices manifested by the maternal mortality rates, for example, rural poverty and gender and ethnic inequalities. Maternal mortality may be the most startling example of these inequalities, but there are others. These systemic flaws also affect other sexual and reproductive rights, such as effective access to modern contraceptives, including emergency contraception, and access to safe, legal abortion.

The government has made significant efforts over the past decade to tackle discrimination and increase access to social rights for groups that have traditionally been disadvantaged. However, these have fallen short of ending preventable deaths related to pregnancy. There has been a lack of concerted political will to reverse many years of discrimination and violations of fundamental rights. Amnesty International therefore urges the Plurinational

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http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/BOL/INT_CEDAW_NGO_BOL_18421_E.pdf

State of Bolivia to implement the following recommendations in order to address this:

- Pass a Law on Sexual and Reproductive Rights as a matter of urgency and allocate sufficient funds, human resources and management structures to implement it effectively and ensure universal access to sexual health and reproductive health care to all without discrimination. Ensure that the specific needs of men and women; teenagers and young people; lesbian, gay, bisexual and transgender people; the elderly; and people with disabilities are taken into account. Pay particular attention to vulnerable populations, Indigenous people and people living in remote rural areas.
- Develop a comprehensive, effective, evidence-based strategy to reduce maternal mortality. The plan for its implementation should be informed by a robust multicultural focus which is arrived at through a process which actively involves Indigenous women in influencing the design of multicultural health strategies and evaluating them.
- Reform legislation to decriminalize abortion in all cases and to ensure effective access to safe, legal abortion at least in cases where women's lives or health are at risk; where foetal impairment prevents independent life outside the womb; and in cases where the pregnancy is the result of rape.
- Take urgent steps to ensure that health personnel do not violate patient confidentiality; do not report women who arrive at the health centre for treatment who they suspect of having an illegal abortion; and ensure that such women receive quality and sympathetic health care without delay.
- Ensure that in those cases where abortion is allowed by the current law, women who have unwanted pregnancies are informed of the availability of safe, quality abortion services. This should include the effective implementation of the "Technical Procedures for the Implementation of the Constitutional Ruling on Health Services" and be accompanied by information campaigns and training for medical staff, judicial officials and the public at large.
- Implement quality comprehensive sexual health and reproductive health programmes that are timely and geared to the needs of teenagers and young people. These should include accessible services that integrate a gender, human rights and intergenerational and intercultural perspectives. They should ensure access to safe, effective, modern methods of contraception and respect patient privacy and confidentiality so that teenagers and young people can exercise their sexual rights and reproductive rights; have responsible, pleasurable and healthy sex lives; avoid early and unwanted pregnancies, HIV transmission and other sexually transmitted infections; and take free, informed and responsible decisions about their sexual and reproductive lives and sexual orientation.
- Prioritize the prevention of teenage pregnancies and end unsafe abortions through comprehensive sexual education and timely, confidential access to information, counselling, health-care products and quality services, including emergency oral contraceptives without prescription and male and female condoms.
- Promote policies that help ensure that people can exercise their sexual rights and that cover the right to express their full sexual potential in safety, to take free, informed, autonomous and responsible decisions about their sexuality in relation to sexual orientation and gender identity free from coercion, discrimination and violence. Ensure the right to

information and access to the necessary means to safeguard sexual and reproductive health.

- Reaffirm the commitment and political will of the Plurinational State of Bolivia, at the highest level, to combat and eliminate all forms of discrimination and violence against women and girls and actively promote awareness of gender perspectives among officials in all three branches of government.

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