CENTER *for* REPRODUCTIVE RIGHTS

Lima, Bogotá, June 21st, 2021

Secretariat of the Committee against Torture
Office of the United Nations High Commissioner for Human Rights
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Re: Independent information for Peru's Periodic Review scheduled for the 72nd Session of the Committee against Torture

Distinguished Members of the Committee against Torture:

The Center for the Promotion and Protection of Sexual and Reproductive Rights ("**PROMSEX**"),[1] and the Center for Reproductive Rights ("the **CRR**"),[2] in the framework of the elaboration of the list of issues prior to reporting for the Peruvian State, which will be considered during the 72nd session, present this communication to contribute to the work of the Committee against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the "**Committee**") by providing information regarding the Peruvian State's failures to guarantee the rights of women, adolescents, and girls, protected by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the "**Convention**").

This report is divided into six parts and addresses: (i) the Peruvian State's restrictive interpretation of its abortion law; (ii) the lack of access to sexual and reproductive information, education, and services; (iii) the inadequate protection of maternal health, particularly the high incidence of forced pregnancies and maternal mortality; (iv) the systemic problems of gender-based violence, including sexual violence and obstetric violence; (v) the impact of COVID-19 on the rights of women and girls; and (vi) questions that PROMSEX and the CRR respectfully suggest the Committee ask the Peruvian State.

I. Peru's Restrictive Interpretation of its Abortion Law

A. Peru interprets its abortion law narrowly and there are few circumstances in which legal therapeutic abortion is available.

Pursuant to Article 119 of the Peruvian Penal Code, therapeutic abortion is only legal to save the life of a pregnant person or prevent serious and permanent damage to their health—all other forms of abortion are criminalized.[3] Pregnant people who do not meet this exception are forced to either carry their pregnancies to term, face the threat of degrading and stigmatizing criminal penalties, or risk an illegal, unsafe abortion. While the text of Article 119 allows for legal abortion when the health of a pregnant person is in danger,[4] healthcare providers interpret "health" so narrowly that it only applies in practice when the pregnant person's life is in grave danger.[5] **Most healthcare providers also do not consider non-physical health impacts, <u>including the severe psychological, social, and mental health impacts of denying an abortion to pregnant</u>**

people who are victims of sexual violence, to be applicable to their analysis, thereby forcing these individuals into unwanted pregnancy and motherhood[6].

Although Peru's National Technical Guide attempted to standardize access to therapeutic abortion,[7] it also interprets therapeutic abortion restrictively and creates further barriers to access. In particular, it establishes an arbitrary gestational limit of 22 weeks for therapeutic abortion.[8] This limit is not contained in the Penal Code and practically curtails access to this health service, forcing a pregnant person to continue with an unwanted high-risk pregnancy, *even if it poses serious risks to her health or life and would otherwise meet the exception for legal abortion.* The National Technical Guide also does not consider serious non-physical health impacts, such as the impact to mental or social health, sufficient to warrant a therapeutic abortion—even for victims of rape.

Other practical barriers to accessing therapeutic abortion also persist. Practitioners generally lack clarity about the legality of therapeutic abortion and the applicability of the health/life exception, further restricting access to medically necessary, legal abortions. This is compounded by a lack of public information about legal abortion[9] and the use of conscientious objection by healthcare providers to avoid informing pregnant people about their right to a therapeutic abortion when they may be eligible for one, leaving women unaware of their reproductive rights and unable to access an essential health service.[10]

In fact, access to therapeutic abortion is very limited in Peru. Even though between July 2014 and 2016, 917 women were able to access a therapeutic abortion[11], in the absence of public information regarding requests for, and provision of, abortion care, the actual number of abortion request which were denied is unknown in their entirety. Two recent cases exemplify the lack of access to therapeutic abortion and complete disregard of non-physical health impacts, particularly for girls and adolescents. In each case, a 13-year-old rape victim was not informed of the risks of pregnancy or her right to a therapeutic abortion by medical practitioners and, in one of the cases, the girl died due to complications from giving birth.[12]

B. Peru criminalizes women who receive an abortion and abortion providers, further restricting access.

Peru imposes broad criminal penalties when a woman does not meet the sole exception for legal abortion. Any woman who self-induces an abortion or receives a medical abortion that does not meet this exception, may be sentenced to up to two years in prison.[13] Peru also criminalizes abortion in cases of extramarital rape and fetal malformations incompatible with extrauterine life.[14] In these two circumstances, the criminal penalty is three months in prison.[15]

Although women are not often sentenced to jail time in either scenario, and the imposed sanction is often largely "symbolic," forcing women to endure criminal prosecution, investigation, and the possibility of conviction results in mental suffering and degrading social stigmatization.[16] In addition, Article 120 of the Penal Code establishes that the reduced three-month sentence in cases of extramarital rape will only be applied if the victim has filed a complaint with the police, creating additional burdens for rape victims.[17]

In the last decade, 571 women were prosecuted for self-induced abortion.[18] Between 2015 and 2018, prosecutors filed 961 claims for illegal abortion and prosecuted 321 before judicial

courts.[19] **The threat of criminal prosecution and social stigmatization creates further barriers to access to legal abortion, and encourages women to resort to clandestine abortions that involve serious risks to their life and health**.[20] Further, as mentioned above, the reduced sanction in cases of rape only applies to extramarital rape,[21] which not only seems to subject married women to greater criminal penalties, but also reinforces the presumption that husbands cannot rape their wives.

Additionally, the medical and non-medical assistance available to women who are considering an abortion is extremely limited. A layperson who helps a woman obtain an illegal abortion can be sentenced to up to four years in prison.[22] Healthcare providers, including doctors, pharmaceutical providers, and obstetricians who help a woman obtain an illegal abortion may also be sentenced to up to four years in prison and may lose their professional licenses.[23] The penalties for healthcare providers make access to therapeutic abortion even more difficult even in those cases where is legal under Peruvian law, as medical professionals are less willing to provide a therapeutic abortion or care for women who have undergone an abortion out of fear their decision may be challenged and they could face criminal penalties and the loss of their medical licenses.

Not only are healthcare providers threatened with criminal penalties for assisting women with a therapeutic abortion, they are also obligated, pursuant to Article 30 of the General Health Law, to report women with indications of a "criminal abortion" to the authorities.[24] This reporting requirement constitutes **a breach of medical professional confidentiality**—an unethical medical practice—**which also constitutes mistreatment in accessing reproductive healthcare services that can cause enormous and long-lasting physical and emotional suffering amounting to torture or cruel, inhuman, or degrading treatment towards women.**[25] Even though the Peruvian Penal Code punishes under Article 165 the violation of professional secrecy, including medical confidentiality,[26] Article 30 of the General Health Law, compounded with Article 407 of the Penal Code which also criminalizes authorities who do not report a crime when the have a duty to do so,[27] effectively deputizes healthcare providers as prosecutors of Peru's restrictive abortion laws and the "crime" of illegal abortion. Indeed, given the lack of knowledge about the legal framework for therapeutic abortion, as mentioned above, medical professionals essentially report almost every obstetric emergency to the authorities.

Thus, this reporting requirement, in violation and contradiction to the duty to preserve professional secrecy, serves as a legal tool that discourages pregnant people from accessing abortion services or reproductive care for any obstetric complication, and prevents medical personnel from assisting women, girls, adolescents and all pregnant people for fear of being apprehended[28] and facing criminal and administrative sanctions. As a result, pregnant people, including girls, adolescents, and victims of sexual violence, are faced with the decision of whether to subject themselves to potential criminal penalties and health risks from an illegal abortion or the prospect of forced pregnancy and motherhood, all of which disproportionately impacts the most marginalized and poor.[29]

C. Peru's restrictive abortion laws force women to seek abortions outside of the medical setting or continue their pregnancy, at great risk to their health and life.

Unsafe abortions and associated complications account for a quarter of maternal deaths in Peru.[30] Due to the lack of access to safe and legal abortions, it is estimated that 350,000 illegal clandestine abortions are performed per year in predominantly unsanitary and dangerous conditions by less-skilled practitioners.[31] Each year, nearly 65,000 girls and women are hospitalized due to complications from such abortions, and 800 die from such complications.[32]

Official data does not fully capture this dire situation. In the last decade, 424,570 women were treated in Peruvian public hospitals due to the medical consequences of either self-induced abortion or spontaneous abortion (miscarriage).[33] Further, according to the Ministry of Health, from 2014 to 2016, 86 women, six of whom were girls or adolescents, died from abortions not attended to in a timely manner.[34] This situation is alarming and directly evidences the harsh consequences of the criminalization of abortion, the associated stigma, and healthcare providers' own fear of criminal prosecution.[35]

While both the lack of access to abortion, which forces women to undergo illegal abortions, and healthcare providers' failure to properly care for women following such procedures, result in preventable deaths, the inaccessibility of legal abortion also leads to higher incidences of teen and adolescent pregnancies that are carried to term. Indeed, early pregnancy is a significant issue in Peru. It is estimated that 13 out of every 100 adolescents between 15 and 19 years old are mothers or pregnant for the first time.[36] Between 2015 and 2018, 29 girls under the age of 10 and a total of 6,240 girls between the ages of 11 and 14 became mothers prematurely.[37] In 2019 alone, there were 1,303 births to mothers under the age of 14.[38] Furthermore, as discussed in Section III.A, *infra*, the trend has dramatically increase during the pandemic: **between January 2020 and May 2021, 65,166 girls and adolescents under the age of 19 gave birth,[39] 1,506 of whom were under 14, and 28 of whom were younger than 10.[40]**

Early pregnancy is a significant risk factor for adolescent health, as abortion is among the five leading causes of death among women aged 15 to 19, and there is an increased suicide rate for pregnant adolescents.[41] By adopting a restrictive interpretation of the exception for legal abortion, and threatening criminal consequences for violations, Peru leaves pregnant people with only two options—forced pregnancy or unsafe abortions—effectively amounting to no meaningful choice in their reproductive determination.

The Committee has previously called on Peru to review its legislation and expand the grounds for legal abortion to include cases of rape, incest, and severe fetal impairment,[42] yet Peru continues to impose criminal penalties in each of these circumstances. **Peru's failure to provide access to therapeutic abortion, including through its strict interpretation of the sole exception provided by law, its continued imposition of criminal penalties in most circumstances, and its failure to remove other practical barriers impeding access to abortion is discriminatory, results in preventable deaths and forced pregnancies causing women, girls, adolescents and pregnant people substantial suffering amounting to torture and cruel, inhuman, or degrading treatment in violation of Articles 2 and 16 of the Convention**.[43]

Further, Peru also is violating Articles 2 and 16 of the Convention through its failure to protect medical confidentiality and ensure adequate medical care for pregnant individuals who undergo an abortion, resulting in physical and emotional suffering constituting torture and cruel, inhuman, or degrading treatment. Finally, Peru's failure to adequately educate medical personnel on the availability of therapeutic abortion, and thereby prevent the suffering of pregnant people in need of this essential and life-saving health service, is a violation of Article 10 of the Convention.

II. Barriers to Access and Utilization of Sexual and Reproductive Health Services and Information

A. Social and economic structural barriers restrict access to information and services for women and girls.

While women and girls in Peru are entitled to reproductive health services and education by law, several barriers restrict access in practice. The government is required to provide contraception—including condoms, emergency contraceptive pills, subdermal implants, IUDs, and birth control shots—for free.[44] Despite this, access to contraception (particularly the emergency contraceptive pill) is limited. As of 2017, an estimated 53.9% of women of reproductive age in Peru used some form of contraception.[45] However, only 21.3% used modern methods (i.e., contraceptive pills, birth control injections, implants, or IUDs).[46] An additional 12.2% used condoms, while 12.4% used traditional methods (i.e., rhythm, withdrawal).[47] A 2016 study by the *Instituto Nacional de Estadística e Informática* found that while 74.6% of women of reproductive age who are married or cohabitating with their partner used some method of birth control, only 52% used modern birth control methods, while 24% relied on traditional methods.[48] Further, in urban areas, 17.1% had no access to any type of contraceptive; in rural areas, that number rose to 24.5%.[49]

While the government contributes significant funds to the procurement of contraceptives, insufficient resources are directed towards distribution, storage, and training of healthcare personnel.[50] As a result, in addition to issues with distribution and storage, healthcare workers often do not adequately inform women, adolescents and girls about the full range of family planning methods available at no cost, and instead recommend contraceptive methods that are more practical for the healthcare worker to administer, like birth control shots.[51] Further, in some cases, even adequately trained healthcare personnel allow their own religious beliefs to prevail upon the health of their female patients and do not adequately inform them of their rights.[52]

B. Access is particularly limited in rural, campesino[53] and indigenous communities.

In rural areas many women do not have access to sexual and reproductive health services and information. In the Amazon region of Loreto, 41% of women indicated that health facilities are sometimes closed when they arrive, 58% indicated that health facilities often lack essential material and medicines, and 31% preferred to speak to a community health agent rather than their local health professional.[54] Of the adolescent mothers surveyed, only 10% had heard of any adolescent health services or family planning services.[55] Furthermore, only 63% of women in Loreto reported using any method of contraception, with only 43% using modern methods of contraception.[56] Specifically regarding care during pregnancy and delivery, the study reports that

16.5% of women in this region did not receive prenatal care and 28.5% of women did not give birth in a health establishment[57]. The low statistics on hospital deliveries is not *per se* a negative indicator, but rather evidences both, the use of home birthing as a traditional and common practice for many rural, indigenous and campesino communities in Peru,[58] as well as the fact that many of these women have reported that their needs, demands, and traditions are not respected by the health personnel and that the face threats, violence, and insults.[59] In this sense, even where local health services are offered, rural, indigenous and campesino women do not have access to adequate and appropriate sexual and reproductive information and care.

In fact, the distrust and fear of indigenous and campesino communities of government-sanctioned sexual and reproductive health services has a historical context. Throughout the 1990s, Peru's government conducted a forced sterilization campaign targeting indigenous, campesino and Quechua-speaking women, masquerading as a family planning program for impoverished communities.[60] Efforts to overcome such distrust are hampered, not only because to this date victims of forced sterilizations have yet to access justice and reparations[61] and some political sectors refuse to recognize the thousands of forced sterilizations that occurred in the country during the armed conflict,[62] but also because of the lack of access to comprehensive sexual and reproductive health information and education for women in these communities.

Indeed, many indigenous and campesino women and girls do not receive any form of sexuality education[63] and even when sexual and reproductive information, education, and services on reproductive rights are available and women are able to access them, **these are not provided with an inter-cultural approach**. Not only is there a complete disregard for traditional knowledge, customs, and practices[64], such as vertical and home birthing under the belief that "western" methods are superior, but as well, there is a significant language barrier as the education, information and services are often offered only in Spanish. Specifically, the indigenous custom of vertical birth is often disregarded in hospitals or health clinics,[65] as exemplified by the case of *Eulogia and her son Sergio vs. Peru*, discussed in Section IV.B, *infra*.

Different human rights bodies have raised alarms regarding this context. For example, in 2014, the Committee for the Elimination of Discrimination Against Women expressed its concern about "the linguistic, cultural and economic barriers faced by indigenous women and women living in poverty in gaining access to health services [...], in addition to the discrimination against and degrading treatment of such women by medical personnel,"[66] and recommended that Peru "strengthen its gender-sensitive and intercultural approach in the provision of health services, including by adequately developing the capacity of health personnel."[67]

C. The emergency contraceptive pill.

Only 18.7% of providers of integral care for adolescents provide access to the emergency contraceptive pill.[68] In addition, despite being legally required to do so, healthcare institutions often refuse to grant access to emergency kits, which contain the emergency contraceptive pill, to victims of sexual violence.[69] Even if healthcare institutions seek out supplies of the emergency contraceptive pill the country has historically experienced shortages. For example, in 2017, the emergency contraceptive pill was distributed in only 15 out of 25 departments in Peru.[70]

Much of this situation is due to the legal uncertainty surrounding the emergency contraceptive pill. The emergency contraceptive pill was incorporated into family planning services in 2001, but uptake was slow due to resistance from anti-abortion religious groups and turnover in the government, which resulted in a greater presence of officials opposed to contraception.[71] In 2009, the Peruvian Constitutional Court ruled that the Ministry of Health was no longer allowed to distribute the emergency contraceptive pill for free because it had not clearly demonstrated that the pill was not abortive.[72] Although a precautionary measure allowing access to the emergency contraceptive pill was granted in 2016, and the 2009 decision was overturned by a first-level judge in 2019,[73] the emergency contraceptive pill ban still lives in institutional memory, creating a knowledge gap regarding the pill's legality. In addition, in 2020 anti-abortion organizations appealed the 2019 decision overturning the ban, and a second-instance court declared the decision null.[74] **This decision is currently on appeal to the Constitutional Tribunal,[75] and event tough the 2016 precautionary measure remains in place, the ongoing legal uncertainty creates confusion and contributes to lack of access to this essential health service.**[76]

In addition, a 2014 study found that a quarter of the emergency contraceptive pills sold in Peru did not work.[77] Eight percent of the pills in the study lacked the active ingredient necessary to prevent pregnancy, while another 20% did not release the active ingredient quickly enough, leading to lower rates of effectiveness.[78] A legacy of distrust followed in the wake of this revelation.

D. Cultural stigma plays a significant role in reducing access to and utilization of sexual and reproductive health information, education, and services

The oft-challenged and historically-in-flux legality of the emergency contraceptive pill has also contributed to cultural stigma surrounding its use as well as other forms of contraception. This is further compounded by religious barriers to sex education. Studies have shown that only 8% of teachers in Peru teach comprehensive sex education, and only 21% of children in the nation receive information on reproductive rights in school.[79] While private schools in Peru are required to comply with the government's national curriculum, they can still choose which pedagogy and books they want to use, and as a result many private schools choose books that promote abstinence as a method of contraception.[80] Government-led campaigns to educate the public about reproductive rights and services must compete with disinformation campaigns from religious and anti-abortion groups recommending "natural" contraceptive methods and claiming that other contraceptive methods, like the emergency contraceptive pill, are abortive.[81]

As discussed further in Section III below, lack of access to integral comprehensive reproductive health services and education has led to higher rates of unplanned pregnancy and adolescent pregnancy in Peru,[82] which directly contributes to Peru's high maternal mortality rate.

Peru's failure to ensure that women, girls, and adolescents have access to sexual and reproductive health services and information directly contributes to the severe issues and violations of the Convention discussed in Sections I, III, and IV, *infra*, and also **constitutes a failure to take effective measures to prevent torture or cruel, inhuman, or degrading treatment in violation of Articles 2 and 16 of the Convention, and the Committee's elaboration of these obligations in General Comment No. 2**. Moreover, Peru's failure to ensure

medical professionals are well-equipped to provide adequate, effective, and non-discriminatory reproductive and sexual health information and services to indigenous, campesino and rural women, and the harms that result from such inadequate efforts, are a violation of Article 10 of the Convention.

III. The Consequences of the Lack of access to sexual and reproductive healthcare and information: high incidence of forced pregnancies and maternal mortality

The high incidence of adolescent and forced pregnancies and the high rate of maternal mortality in Peru, which disproportionately affect rural, indigenous, and low-income women, are direct consequences of the lack of access to sexual and reproductive healthcare and information, including maternal health resources, and the restrictive interpretation of abortion laws. Undoubtedly, this poses serious consequences for the physical health of pregnant people. Equally important however is the lasting impact to the social, emotional, and psychological health of pregnant people, which is often neglected in considerations of access to sexual healthcare services and represents a serious violation of their human rights. These health impacts, physical and otherwise, are even more serious for victims of sexual violence.

A. Forced pregnancy in adolescents and girls and the devastating impact for their lives, health, and wellbeing

Almost 20% of girls in Peru are pregnant by the age of 19.[83] This number is even higher for girls from marginalized and/or low-income populations, reaching 32% in some rural areas and in the Amazon region of Loreto.[84] The main causes of pregnancy in girls below the age of 19 include rape and sexual exploitation, lack of access to contraception, and lack of understanding of reproductive processes.[85] For example, 34% of adolescents who reported suffering sexual violence and rape became pregnant as a result[86] and 14% were between 10-14 years old.[87] In 2019, there were 1,432 births to mothers under 15,[88] despite the fact that all sexual relations with a girl under 14 constitute rape under Peruvian law. The barriers to accessing safe, legal abortion, and the limited provision of sexual and reproductive health information, education,[89] and services, including specifically the emergency contraceptive pill (*supra* II.C), means that Peru is effectively forcing pregnancy and motherhood adolescents and girls, exacerbating the impacts for those who were victims of sexual violence or rape.

There are undeniable physical health consequences of adolescent pregnancy (discussed further in Section III.B below). However, the lack of care for, mistreatment of, and obstetric violence committed against women and particularly girls, many of whom are survivors of sexual violence, is less documented. **Girls who are victims of sexual violence are often denied specialized sexual and reproductive health services, or their access to such services is delayed as "punishment" for being victims of sexual violence**.[90] Further, they are generally subjected to continued victimization, including **emotional and verbal abuse** by medical staff.[91] Suicide is disproportionately associated with adolescent pregnancy, particularly in settings where reproductive choice is limited.[92]

Equally, forced pregnancy has a critical impact on the social health of adolescents. Adolescent pregnancy is met with social stigma in most cases, leading to reputational damage to young girls who may be shunned and abandoned by their families and communities.[93] This stigma

is used to justify reinforcing stereotypes of female behaviors of inferiority and subordination and thereby perpetuates gender-based violence. Furthermore, adolescent pregnancy impairs girls' ability to continue their education or find stable employment, exposing them to high levels of life-time poverty and abusive relationships.[94] This is an affront to the right to a life with dignity, as recently developed by the Human Rights Committee's General Comment No. 36, which requires States to ensure that girls can fulfill their life plans, such as continuing their education, pursuing a rewarding professional life, and being able to socially engage in their communities,[95] and **the compounding effects of these negative impacts amounts to cruel, inhuman, or degrading treatment**.

B. Maternal mortality

Promoting maternal health throughout pregnancy, childbirth, and postnatal care is crucial to protecting and supporting women's health. Although reported statistics on maternal health are relatively positive in certain areas of Peru,[96] these statistics are not representative of more vulnerable groups of women, such as rural, indigenous and campesino women, who experience substantially worse maternal health outcomes than the rest of the population and are less likely to benefit from healthcare services.[97] As discussed in Section II.A, *supra*, a large percentage of women in the Amazon region of Loreto report irregular closures of health facilities, a lack of essential material, medicines and trained personnel,[98] and long wait times, all of which combine to make it practically difficult to access these services.[99] Even where healthcare facilities and reproductive services are available, women experience active violence and neglect. This results in high rates of maternal mortality.

In 2017, Peru had a maternal mortality rate of 88 deaths per 100,000 live births,[100] one of the highest in Latin America[101] and significantly higher than Organization for Economic Cooperation and Development nations.[102] The maternal mortality rate for adolescents below the age of 19 is even higher at 14.9%.[103] Adolescent girls face a risk of dying in childbirth four times higher than adult women due to a higher risk of hemorrhage, hypertension, preeclampsia, preterm labor, and several other neonatal conditions, in addition to an augmented risk of suicide as a result of the mental and social trauma of adolescent pregnancy.[104] Furthermore, in the Sierra and Selva regions, the maternal death rate is four times that of the coastal regions[105] and it is estimated that in rural areas, obstetric hemorrhage is responsible for more than 50% of maternal mortalities,[106] which evidences that the lack of access to sexual and reproductive healthcare information and services has disproportionate consequences for rural women and girls.

In addition, as discussed in Section I.C, *supra*, extremely limited access to abortion leads many women, including adolescents, to undergo unsafe abortions, which account directly or indirectly for a quarter of maternal deaths each year.[107] Delays and failures in seeking medical treatment for complications arising from illegal abortion due to fear of criminal punishment further increase the rates of maternal mortality directly linked to unsafe abortion and, by extension, Peru's restrictive abortion laws.

Peru's failure to protect women, particularly adolescents and girls, from forced pregnancies and motherhood, the accompanying severe mental health effects, including an increased risk of suicide, and the devastating impacts on social and emotional health that affect their well-being and ability to carry out their life plan, **constitutes torture and cruel, inhuman,**

or degrading treatment in violation of Articles 2 and 16 of the Convention. Further, Peru's failure to take measures to address maternal mortality subjects women, adolescents, and girls to suffering and preventable deaths, contributing to these violations.

IV. Systemic Gender-Based Violence

Peru "is one of the countries in the region most affected by gender-based violence."[108] Official rates of gender-based violence are difficult to ascertain due to the underreporting of cases which in itself is a consequence, among other things, of the impunity and revictimization survivors experience within the judicial system and the fear, shame, stigma, and stereotypes associated with gender-based violence.[109] As of 2017 it was estimated that 31% of women aged 15-49 experienced physical or sexual violence from their current intimate partner.[110] **Between 2014 and 2020, reported cases of violence against women at the Emergency Center for Women almost doubled, rising from 43,810 to 97,926 cases**.[111] This, even despite the fact that the Emergency Centers for Women were forced to discontinue their services between April and June of 2020 due to the COVID-19 pandemic, leaving vulnerable women without access to support and resources.[112] **Further, only as of April 2021, there have already been 45,670 reported cases of violence against women**.[113]

According to official government statistics, 149 women were victims of femicide in 2018, and between January and July 2019, 99 women were victims of femicide.[114] In 2015, Peru passed a law providing for comprehensive measures to prevent and punish violence against women,[115] but femicides have not decreased since then.[116] In general, the laws addressing gender-based violence are not enforced or implemented effectively,[117] and the prevalence of of sexual and obstetric violence specifically are alarming in Peru.

A. Sexual Violence

The rates of violence against women and, particularly, sexual violence in Peru, are staggeringly high and have continued to rise over time. In 2019, 155,092 cases of violence against women, including sexual violence, were treated at the Emergency Centers for Women[118]—an increase of over 40,000 cases from the prior year.[119] **Of these, there were 18,044 cases of sexual violence and 55,565 of the victims were younger than 18**.[120] Nationwide, according to the Ministry of the Interior of Peru, between 2017 and May, 2019, 18,138 acts of rape were reported, of which 93.2% of the victims were women, 60.6% of whom were younger than 18 .[121] Sexual violence is also disproportionately prevalent in rural areas, as demonstrated by the fact that, between 2017 and 2018, 49% of the cases of rape treated at Emergency Centers for Women involved women from rural areas, and the victims of 47.6% of these cases were girls and adolescents between 13 and 14 years old.[122] While the rates of sexual violence against women in Peru have been troubling for many years, as discussed further in Section V below, the COVID-19 pandemic has only served to exacerbate sexual violence against women.

In addition to the concerning rates of sexual violence against women, **the justice system in Peru fails to protect women and girls who are victims of sexual violence or provide them with adequate reparations for the harms they experience**. Societal and cultural norms and stigma perpetuate impunity and tolerance for perpetrators of sexual violence, and the justice system is influenced by gender-based norms and stereotypes. For example, in November 2020, a

judge ruled against a 20-year old woman's rape allegations because she was wearing "suggestive red underwear" that signaled she "wanted intimacy."[123] **Rulings like this not only constitute re-victimization and cause great pain and suffering for survivors of sexual violence, they also demonstrate that judges continue to employ harmful gender-based stereotypes to mitigate sentences in sexual abuse cases, perpetuating cycles of impunity and normalizing sexual violence. This situation represents a violation of women and girls' rights to life, integrity, health, and access to justice, among others.**

B. Obstetric violence and the intersectional and structural discrimination suffered by indigenous, campesino and rural women.

The 2016-2021 *National Plan Against Gender Violence* established that obstetric violence "includes all acts of violence by health personnel in relation to the reproductive processes…" including dehumanizing treatment, abuse of medication and the pathologization of natural processes, which negatively impacts the quality of life of women.[124] The National Plan sought to change sociocultural patterns that exacerbate gender-based violence (including obstetric violence) through specific strategic actions, including developing a national communication strategy, building the capacity of local leaders, and implementing guidelines for preventing gender violence in state institutions and at all levels of government.[125] **Yet Peru has failed to take any action to address incidents of obstetric violence, as evidenced by the absence of a public policy or budget to address it**.[126] While the Ministry of Health has several policies that regulate the care of victims of violence, none of them specifically address obstetric violence.[127] Further, the budget allocated to the Ombudsman's Office for issues related to gender-based violence in general was dramatically reduced in 2020—impeding its ability to advocate against gender-based violence and develop a decentralized process for monitoring the progress of the National Plan.[128]

The Special Rapporteur on Violence against Women has identified discriminatory laws and practices as one of the root causes of obstetric violence, which are often further aggravated by the intersecting forms of discrimination experienced by women.[129] According to reports from the Ombudsman's Office, **pregnant women from rural areas, and those with few economic resources, particularly campesino and Quechua-speaking women, receive cruel and degrading treatment at public health centers where they "are shouted at, they are not guided, even during childbirth."**[130] As a result, many women do not feel they will receive quality care at public health centers, and experience feelings of distrust and shame.[131] Similarly, *Physicians for Human Rights* found evidence that health providers consider indigenous customs "backward" or "ignorant"[132] and impose *de facto* fines to obtain birth certificates on women when they give birth at home.[133]

Various organizations have expressed concerns regarding obstetric violence, considering it a form of "instrumentalization of women in the birthing process" [134] and a form of discrimination.[135] The Special Rapporteur on Violence against Women stated that mistreatment and violence against women in reproductive health services and during childbirth "occur in the wider context of structural inequality, discrimination and patriarchy."[136] **Indigenous, campesino and rural Peruvian women experience structural violence and intersectional discrimination based on their gender, ethnicity, and economic status in accessing reproductive health services, especially during childbirth, including verbal aggression, mistreatment, the**

imposition of institutionalized and horizontal childbirth, and ignorance of their language and customs.

The case of *Eulogia and her son Sergio vs. Peru*, currently pending before the Inter-American Commission on Human Rights, clearly exemplifies the structural violence, intersectional discrimination, and obstetric violence experienced by these groups of women, which amounts to torture and cruel, inhuman, or degrading treatment. Like many indigenous, campesino and rural women, in 2003, during her sixth pregnancy, Eulogia, a campesino woman descendant from the original Quechua people of Peru, did not have access to adequate prenatal care, healthcare, or information due to the inaccessibility -physically and culturally- of these health services in her community. [137] On August 10, 2003, she went into labor.[138] Instead of respecting her customs and traditions and her decision to have a homebirth (as she had done for her other five children), Eulogia was forced to go to a public health center under the threat of both a monetary fine and the withholding of the birth certificate of her child. Once there, instead of receiving the obstetric care she needed in accordance, which included having a vertical birth, Eulogia was not only not provided with assistance in her language – even though she is a Quechua-speaking woman- but was in fact abandoned without care notwithstanding she was in evident pain and was going into labor.[139] When her delivery was imminent, Eulogia was violently and physically forced to give birth in a horizontal position (against her ancestral customs) and as a result her son Sergio was hit in the head at the moment of birth.[140]

After this violent birthing, Eulogia not only was denied information regarding the state of Sergio's health, she was also forced to shower with cold water against her will and against her cosmovision that considers cold water to be a wound to a body that has just given birth.[141] As a result of the injury Sergio suffered at birth, he acquired multiple disabilities (deaf, blind, impaired mobility, among others) and ultimately died at the age of 12 as a result of the State's failure to provide the care that he required due to his condition.[142] This case speaks to, and clearly reveals, **a system of institutionalized gender-based violence that perpetuates discriminatory stereotypes against indigenous, rural, Quechua-speaking, campesino and poor women**. Additionally, Eulogia's treatment during and after birth demonstrates the commission of acts of violence, discrimination, and **obstetric violence amounting to torture** due to the serious violations of her right to integrity, aggravated by her condition as a pregnant, poor, campesino, rural, Quechua-speaking woman. The severe and serious impacts of the violence Eulogia suffered before, during, and after giving birth were prolonged and intensified during Sergio's life and constitute serious human rights violations.[143]

Peru's failure to implement effective measures to prevent gender-based violence, sexual violence, and obstetric violence at the hands of medical officials, as demonstrated by the *Eulogia* case, **constitute violations of Articles 2 and 16 of the Convention and specifically contravene the Committee's emphasis on the protection of marginalized individuals and women from torture and cruel, inhuman, or degrading treatment in General Comment No. 2**.[144] Further, the failure of Peru's government and judicial system to provide adequate redress for victims of sexual and obstetric violence, including through the systematic failure to prosecute the perpetrators of sexual and obstetric violence, is a clear violation of Article 14 of the Convention and a de facto violation of Article 4 of the Convention.

V. The Impact of the COVID-19 Pandemic in Peru

Despite implementing strict measures to control the spread of COVID-19, including restricting non-emergency primary health services, Peru has one of the highest infection rates both in Latin America and globally[145] and, after revising its official COVID-19 death toll upwards to over 180,000 deaths (more than double the prior figure), in early June, 2021, Peru has the highest mortality rate per capita in the world.[146] Beyond proving ineffective at preventing the spread of the virus, **the restrictions have had a severe and disproportionate impact on the health and welfare of women and girls**. According to estimates by the United Nations Population Fund, the impact of COVID-19 could represent a setback of one third of the progress in the prevention of gender-based violence, the promotion of maternal health, and access to family planning in Peru.[147]

A. The rise in gender-based and sexual violence during the lockdown period, particularly against girls and adolescents.

As discussed in Section IV.A, *supra*, before the COVID-19 pandemic, Peru had alarmingly high rates of gender-based and sexual violence, particularly with respect to sexual violence against girls and adolescents. Lockdowns and school closures have meant that women and girls are kept at home with abusive family members, posing a serious threat to their wellbeing. UN Women has described this dangerous increase in domestic violence as a "shadow pandemic."[148] Between the beginning of lockdown and July 2020, Peru's nation hotline for victims of domestic and sexual violence received 104,000 calls, more than double the number received during the same period in 2019.[149] **Of these, 17,000 calls were about sexual violence against children**,[150] and the Ministry for Women and Vulnerable Populations reported nearly 1,000 victims of rape, of which 703 were girls and adolescents.[151]

Indeed, the situation is particularly dangerous for adolescents and girls, who are at a higher risk of being victims of rape by relatives at home[152] and who, as a result and given the lack of access to sexual and reproductive health services, may also experience **forced pregnancies**, which pose the serious health risks discussed in Section III.B, *supra*. **Between January 2020 and May 2021, 65,166 girls and adolescents under the age of 19 gave birth.**[153] As discussed in Section I.C, *supra*, this includes 1,506 girls under 14, and 28 girls younger than 10.[154] Each of these pregnancies and births was the result of rape under Peruvian law, which considers the legal age of consent to be 14 years old.[155] Further, as victims of sexual violence during the COVID-19 pandemic are trapped at home, access to justice and protection has become even more complex and restricted.

B. The discontinued provision of sexual and reproductive health services.

Use of reproductive health and family planning services in Peru has decreased 50% since the start of the pandemic due to closures of services, redistribution of healthcare staff, and decreased access to services due to potential patients' vulnerabilities to infection and anxiety about infection.[156] Despite their importance, reproductive health services have not been considered essential and have not been made a priority during the pandemic. Due to the reduced use of reproductive health services, an increase of up to 100,000 unplanned births is expected in 2020-2021.[157]

In addition, many in Peru rely on the use of short-term contraceptives[158] as a primary form of birth control.[159] As a result of this reliance on short-term methods, Peru has been particularly vulnerable to supply and other access disruptions caused by COVID-19. **It is estimated that 119,000 women in Peru interrupted the use of modern contraceptive methods in 2020**.[160] The suspension of non-essential services and the diversion of staff to pandemic response has also reduced the number of available consultation appointments which, in conjunction with the general reluctance to visit healthcare facilities and restrictions on mobility caused by the pandemic, further limits access to contraceptives.[161] In addition, economic turmoil caused by the pandemic has led to general reductions in household incomes, making it more difficult to afford contraception,[162] resulting in more than 62,000 women who had previously been purchasing modern short-term contraceptives discontinuing their use.[163]

The COVID-19 pandemic has also had a **negative impact on the provision of emergency kits, which contain emergency contraception and other medical services and care that is essential for survivors of sexual violence**.[164] In addition to the issues discussed in Section II.C *supra*, some hospitals have not received additional kits since the pandemic began.[165] In fact, Ministry of Health records show that despite 786 reports of sexual violence during quarantine, only 250 emergency kits were distributed.[166]

C. Further lack of access to sexual and reproductive health services and information and increase in maternal mortality.

Sexual and reproductive health has not been discussed during the almost daily public messages of the President and his ministers and there is little information available on the topic in the context of COVID-19.[167] In the case of family planning services, the lack of information places women at further risk of an unwanted or unplanned pregnancy. While private information sources remain available, the lack of public information disproportionately affects the most vulnerable women—those who live in rural areas or are otherwise unable to access private information or contraceptive services due to economic, social, educational, or other factors.

As a result of the pandemic, specific barriers to access to adequate maternal healthcare in Peru have also grown, including the prohibition in public hospitals of the entry of midwives, partners, and other family members during childbirth and postpartum (due to risk of virus transmission), leaving pregnant people in a state of isolation during and after they give birth.[168] There have also been incidents where women in labor have been turned away from hospitals that have reached capacity[169] and where the circumstances have forced them to give birth with only the assistance of the fire department.[170] Given that there is no other option for pregnant people to obtain access to sexual and reproductive health services other than going to public hospitals, pregnant people have also been exposed to a higher risk of COVID-19 infection at public hospitals that are overwhelmed with COVID-19 patients.[171]

Although since April 2020 Peru's Ministry of Health issued a Health Directive *see infra* Section IV.D) guaranteeing access to antenatal, perinatal, and postpartum care during COVID-19,[172] maternal deaths increased by 33% in Peru in 2020.[173] These deaths -**which are preventable** – have occurred as a result of the lack of timely, and suspension, of maternal healthcare services due to the pandemic,[174] even despite the issuance of such Health Directive. The main causes of maternal death in 2020 were pre-eclampsia and eclampsia, both conditions associated with a lack

of prenatal care.[175] With intensive care units for pregnant people occupied by COVID-19 patients, a lack of timely diagnoses and lack of access to emergency obstetric care led to a rise in childbirth complications.[176] Media reports confirmed that at times gynecological-obstetric care could not be provided due to lack of space and personnel.[177] COVID-19 has also been responsible for alarming rates of maternal mortality in Peru, as it has the fourth highest number of maternal deaths caused by COVID-19 in the region.[178]

As 60% of maternal deaths in Peru occur in the 42 days following delivery of the baby, access to care during this time is critical[179], which was aggravated by the fact that until the end of 2020 across the country obstetric outpatient services remained restricted.[180] This situation further impacts disproportionately the most vulnerable. In Peru, only those who are employed officially by a company or organization have the right to access antenatal and postnatal health care[181] and only a small percentage of the population, mainly based in urban areas – specifically Lima-, have been able to work from home during the pandemic and benefit from security and healthcare.[182] Informal workers can have access to certain health care services through the *Seguro Integral de Salud* (SIS), which can cover for prenatal health controls. However, the SIS does not cover other social security benefits – such as paid maternity leave-[183] and the inherent deficiencies of this public system have only worsened during the pandemic. Further, the pandemic has also increased rates of informal jobs and workers,[184] exacerbating as such the disparities in access to maternal and reproductive care. **As a result, evidence is showing that five years of progress in maternal mortality have been reversed during the pandemic**.[185]

D. Enhanced constraints on access to abortion.

Access to therapeutic abortion in Peru, already extremely limited for the reasons set forth in Part I, *supra*, has become even more restricted during the pandemic. While Peru technically allows for a legal abortion when the health or life of a woman is in serious danger, the *Health Directive to guarantee the health of pregnant women and the continuity of family planning care in the face of COVID-19 infection* ("Health Directive")[186] further limits the exception to only those circumstances where "the life of the pregnant woman infected with COVID-19 is at risk."[187] This entirely leaves out pregnant people who are not infected with COVID-19, regardless of whether their life or health is at risk, in contravention of the National Technical Guide and the Penal Code, and it also circumscribes access to abortion to cases when a woman's "life" is at risk, excluding any impacts to her health.

The COVID-19 pandemic has also restricted access to proper care for women who experience complications because of "illegal" abortions. The lack of public transportation (necessary for many women to reach hospitals and other medical care), the restrictions on movement, and other issues related to the pandemic have made it more difficult for women to travel to health centers and purchase necessary supplies.[188] Further, across the globe, disruptions in supply chains, resource shortages, and lockdown rules have made access to safe clinic-based abortion care more difficult.[189] Specifically, lockdown rules have made access to Misoprostol—which, in certain circumstances, could be purchased in pharmacies without a prescription by women seeking to self-administer an abortion—more difficult.[190] The difficulties in accessing Misoprostol can lead or be connected to, as some studies show, an increase of unsafe abortion performed with household items or other unsafe means.[191]

Finally, lockdown and social isolation have increased the domestic burden women carry, such that they are more likely to spend additional time caring for elderly or sick relatives and children whose schools are closed,[192] diminishing their opportunities to access abortion healthcare services.[193] Many young women living with their parents and families, and women who are quarantined with partners who oppose abortion, find themselves pressured not to go through with an abortion.[194]

Peru's failure to protect women and girls from the disproportionate detrimental impact of COVID-19 with respect to gender-based violence, sexual and reproductive health services and information, maternal healthcare, and access to abortion exacerbates its violations of Articles 2, 10, 14, and 16 of the Convention and its obligations under General Comment No. 2, discussed in Sections I-IV, *supra*, and amounts to further violations of those same Articles and obligations. **Further, it is a violation of the spirit of the Convention, which considers the protections against torture and cruel, inhuman, or degrading treatment absolute and non-derogable, and emphasizes that *no exceptional circumstances whatsoever* can justify allowing these acts to occur**.[195]

VI. Questions

Based on the information presented here, CRR and PROMSEX respectfully request this Committee to take into consideration the above and, in the framework of the elaboration of the list of issues prior to reporting, ask the Peruvian State the following questions:

A. Access to therapeutic abortion

- What measures are being taken by the State to eliminate barriers to access to therapeutic abortion related to the restrictive interpretation of the health/life exception under the current legal framework?

- Why has the Peruvian State not decriminalized abortion in cases of rape and malformations incompatible with extrauterine life, in compliance with the *LC v. Peru* case?

- Why has the Peruvian State not guaranteed the access to therapeutic abortion for girls under 14 years of age, considering the higher risk that the pregnancy poses to her physical health and the fact that, under the Peruvian Criminal Code, all sexual relations with minors under that age are considered rape and, therefore, mental, and social health are at risk?

- How many women, girls and adolescents have been prosecuted for the crime of abortion and what penalties were imposed? How many medical professionals have been criminally charged for performing an abortion under Articles 115 and 117 of the Criminal Code? How many medical professionals have reported an abortion, and in how many instances have any been charged for doing so in breach of Article 30 of the General Health Law?

- What measures have been adopted to guarantee due process for girls and adolescents prosecuted for the crime of abortion, which entails guaranteeing impartiality in the justice system?

B. Access to sexual and reproductive health services, education, and information

- What steps are being taken to reform laws and policies so that women and girls can access reproductive health services and information, including information on:

  (i) actions to ensure access to sexual and reproductive health information and education that is comprehensive, non-discriminatory, evidence-based, scientifically accurate, up-to-date and age appropriate;

  (ii) actions to guarantee comprehensive reproductive health care services that are of quality, accessible to all, and non-discriminatory, which include provision and explanation of family planning methods, emergency contraception, access to abortion, all under the principles of confidentiality, informed consent, progressive capacity of girls and adolescents, best interests of the child, and non-discrimination;

  (iii) actions to combat misinformation, taboos, fears and stigma regarding sexual and reproductive health, including information, goods and services; and

  (iv) specific actions to ensure effective, timely, non-discriminatory, and adequate access to sexual and reproductive health care services and information specifically for rural and indigenous women.

C. Prevention of forced pregnancies and maternal mortalities

- What regulatory and budgetary policies are being adopted to reduce the rate of forced pregnancies, particularly regarding pregnancies resulting from rape and pregnancies in girls and adolescents?

- What regulatory and budgetary policies are being adopted to ensure that sexual violence survivors, with special regard to girls and adolescents, have access to comprehensive sexual and reproductive health services without discrimination and re-victimization by health sector officials, including access to emergency kits, the emergency contraceptive pill, and access to abortion services?

- What preventive measures are being adopted to address maternal mortality and morbidity, particularly with respect to girls and adolescents?

D. Prevention of systemic gender-based violence

- What regulatory and budgetary policies are being adopted to prevent sexual violence, especially against girls and adolescents at home and in the school setting, and to combat impunity, ensuring the implementation of a gender-based approach in cases of sexual violence, and to provide substantive redress for victims?

- What regulatory and budgetary policies is the State adopting to ensure that indigenous and rural women have access to health services without fear of obstetric violence by health sector officials?

- Notably, what steps are being taken to ensure access to culturally appropriate obstetric care for indigenous and rural women, free from violence and discrimination, provided in their language, and that respects their traditions, customs, and beliefs?

- What strategies or mechanisms are being used to ensure the implementation of the National Plan Against Gender Violence 2016-2021 vis-à-vis the prevention of obstetric violence?

- What steps is the State taking to guarantee that health sector officials are investigated and, if appropriate, sanctioned for having committed humiliating and degrading acts amounting to torture, cruel, inhuman, and degrading treatment against pregnant women before, during, and after childbirth, with a particular emphasis on indigenous, rural, and rural women?

E. Protection for women and girls in the context of the COVID-19 pandemic

- What measures is Peru taking to ensure access to timely, non-discriminatory, and adequate sex and reproductive health care services, education, and information for women and girls during the Covid-19 pandemic, considering in particular indigenous girls and women and those living in rural or low socio-economic contexts?

- Especially, what measures is Peru taking to ensure the provision of free contraceptive methods, as well as the supply of the emergency kit for victims of sexual violence, that includes the emergency contraceptive pill and access to therapeutic abortion in cases of forced or unwanted pregnancies?

- What measures is Peru taking to guarantee during the COVID-19 pandemic adequate care for pregnant women, particularly indigenous and rural women, during their prenatal checkups and adequate delivery care with quality standards, including the right to terminate a pregnancy for health reasons?

- What normative and budgetary measures has the State adopted for the prevention of and protection from, especially for children and adolescents, sexual violence suffered in homes and other places of confinement during the COVID-19 pandemic?

Cordially,

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Program Director

Center for the Promotion and Protection of Sexual and Reproductive Rights (**PROMSEX**)

Catalina Martínez

Regional Director for Latin America and the Caribbean

Center for Reproductive Rights (**CRR**)

[1] **PROMSEX** is a feminist non-governmental organization that contributes to the integrity and dignity of people's access to sexual and reproductive health and to people deciding on their sexuality and reproduction with autonomy, dignity, justice, and equality.
[2] **CRR** is a global non-governmental legal advocacy organization that works for the protection and respect of the sexual and reproductive rights of girls and women around the world and seeks to promote reproductive freedom and autonomy as a fundamental right that all governments are legally obligated to protect, respect and guarantee.
[3] CODIGO PENAL [C. PEN.] [PENAL CODE] art. 119 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.
[4] CODIGO PENAL [C. PEN.] [PENAL CODE] art. 119 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.
[5] *See My Rights, and My Right to Know: Lack of Access to Therapeutic Abortion in Peru*, HUMAN RIGHTS WATCH (July 8, 2008) https://www.hrw.org/report/2008/07/08/my-rights-and-my-right-know/lack-access-therapeutic-abortion-peru (explaining that the Penal Code "doesn't specify what is meant by the term 'health.' It only looks at the imminence of death or [potentially fatal] problems of physical health without considering mental health repercussions.").
[6] *See*, Human Rights Committee., *Views, K.L. v. Peru*, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005) (available at: https://reproductiverights.org/wp-content/uploads/2020/12/KL-HRC-final-decision.pdf), whereby the Committee noted that even though medical authorities were aware that the pregnancy of an anencephalic fetus, exposed the author – a minor- to a life-threatening risk. Notwithstanding, the author was denied access to an abortion, para 6.2. *See*, CEDAW Committee, *Views, L.C. v Peru*, U.N. Doc CEDAW/C/50/D/22/2009. Available at https://www2.ohchr.org/english/law/docs/CEDAW-C-50-D-22-2009_en.pdf whereby the Committee found that the medical authorities refused to perform and urgent and necessary spinal surgery because L.C was pregnant – to prevent "potential harm to the foetus", notwithstanding the evident physical and mental health risks for the author – who had been a victim of rape, had attempted suicide, and was facing a possibility of physical immobility or permeant disability if not surgery was performed, paras… *See also*, the case of El Golf Clinic, where a woman was denied access to an abortion notwithstanding the mental health impacts. La Ley, *Indecopi: clínicas deben tramitar pedido de aborto terapéutico si se acredita daño a la salud mental de la gestante*, July 11, 2017. Available at: https://laley.pe/art/4066/indecopi-clinicas-deben-tramitar-pedido-de-aborto-terapeutico-si-se-acredita-dano-a-la-salud-mental-de-la-gestante

[7] *See* Ministry of Health (MINSA), *Guía Técnica Nacional para la Estandarización del Procedimiento de la Atención Integral de la Gestante en la Interrupción Voluntaria por Indicación Terapéutica del embarazo menor de 22 semanas con consentimiento informado en el marco de lo dispuesto en el artículo 119 del Código Penal*, approved by Resolution No. 486-2014/MINSA (June 27, 2014), http://bvs.minsa.gob.pe/local/MINSA/3795.pdf.
[8] *Id.*
[9] Luis Távara Orozco et al., *Barriers to Access to Safe Abortion in the Full Extent of the Law in Peru*, 62 REVISTA PERUANA DE GINECOLOGÍA Y OBSTETRICIA, no. 2 (2008), https://www.redalyc.org/jatsRepo/3234/323446799003/html/index.html#redalyc_323446799003_ref29.
[10] Luis Távara Orozco, *Simposio: Bioética y Atención de la Salud Sexual y Reproductiva: Objeción de Conciencia*, 63 REVISTA PERUANA DE GINECOLOGÍA Y OBSTETRICIA, no. 4 (2017), http://www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S2304-51322017000400010.
[11] Response from the Ministry of Health to the request for access to public information: Exp.16-051635-001; Response from the Ministry of Health, to the request for public information: Number of women who have undergone voluntary termination of pregnancy for therapeutic indication by months according to departments from July 2014 to 2016.
[12] The first case involves the 13-year-old girl N.G.R.H who went on January 30 and March 7, 2019 to the Edgardo Rebagliati National Hospital presenting complications in her pregnancy. The doctors did not inform her about the risks of the pregnancy and the possibility of accessing the evaluation of a Medical Board that, by therapeutic indication, would recommend the termination of the pregnancy. According to the Ombudsman's Office, the facts show that N.G.R.H.'s mother did not feel satisfied with the care received by her daughter and went to the Lima Maternity Hospital to request a second technical opinion. The Ombudsman's Office intervened due to the violation of the right to health of N.G.R.H. Paola Mendieta Medina, *El drama de la niña N.G.R.H.: Tantas veces ultrajada*,

DIARIO CORREO (Mar. 31, 2019), https://diariocorreo.pe/edicion/lima/el-drama-de-la-nina-ngrh-tantas-veces-ultrajada-878936/. The second case is about the 13-year-old girl M.F.A.M., who died after giving birth on February 26, 2019 at the Hospital San Juan de Dios de Pisco, in Ica. Neither she, nor her family were given adequate counseling about the risks of pregnancy and her right to a therapeutic abortion. She underwent a cesarean section at nine months of pregnancy when her health condition became complicated. Leonor Perez-Durand, *Una niña muere por parir "su bendición"*, LA MULA (Mar. 7, 2019), https://teleoleo.lamula.pe/2019/03/07/una-nina-muere-por-parir-su-bendicion/leoperezdurand/.

[13] CODIGO PENAL [C. PEN.] [PENAL CODE] art. 114 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.

[14] *Id.* at arts. 114, 120.

[15] *Id.* at art. 120.

[16] Juan Carlos Díaz Colchado & Beatriz Ramírez Huaroto, *El aborto y los derechos fundamentales: Análisis de la constitucionalidad de la prohibición penal de la interrupción del embarazo en supuestos de violación sexual y de malformaciones fetales incompatibles con la vida extrauterina*, CENTRO DE PROMOCIÓN Y DEFENSA DE LOS DERECHOS SEXUALES Y REPRODUCTIVAS (PROMSEX), May 2013, at 44, https://promsex.org/wp-content/uploads/2013/10/elAbortoylosDerechosFundamentales.pdf.

[17] CODIGO PENAL [C. PEN.] [PENAL CODE] art. 120 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.

[18] Elizabeth Salazar Vega, *Abortar en Perú: cuando víctima y familiares son llevados a cárcel*, OJO PUBLICO (Oct. 22, 2019), https://ojo-publico.com/1411/abortar-en-peru-victima-y-familiares-son-llevados-carcel.

[19] *Id.*

[20] Juan Carlos Díaz Colchado & Beatriz Ramírez Huaroto, *El aborto y los derechos fundamentales: Análisis de la constitucionalidad de la prohibición penal de la interrupción del embarazo en supuestos de violación sexual y de malformaciones fetales incompatibles con la vida extrauterina*, CENTRO DE PROMOCIÓN Y DEFENSA DE LOS DERECHOS SEXUALES Y REPRODUCTIVAS (PROMSEX), May 2013, at 72, https://promsex.org/wp-content/uploads/2013/10/elAbortoylosDerechosFundamentales.pdf.

[21] CODIGO PENAL [C. PEN.] [PENAL CODE] arts. 114, 120 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.

[22] *Id.* at arts. 114, 115, 120.

[23] *Id.* at arts. 115, 117.

[24] LEY GENERAL DE SALUD [GENERAL HEALTH LAW], Ley No. 26842, art. 30 (Peru), which establishes that "[t]he physician who provides medical attention to a person injured by a knife wound, gunshot wound, traffic accident or other type of violence that constitutes a crime prosecutable ex officio or when there are indications of criminal abortion, is obliged to report the incident to the competent authority". Available at: http://www.essalud.gob.pe/transparencia/pdf/publicacion/ley26842.pdf.

[25] General Assembly, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, U.N. Doc. A/HRC/22/53 at 10-12 (Feb. 1, 2013), https://undocs.org/A/HRC/22/53.

[26] CODIGO PENAL [C. PEN.] [PENAL CODE] art. 165 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.

[27] CODIGO PENAL [C. PEN.] [PENAL CODE] art. 407 (Peru), http://spij.minjus.gob.pe/content/publicaciones_oficiales/img/CODIGOPENAL.pdf.

[28] Sara Gomez, O'Neill Inst. for Nat'l and Global Health L. & IPAS, *Delatando a las mujeres: el deber de cada prestador/a de servicios de denunciar*, LATIN AMERICAN CONSORTIUM AGAINST UNSAFE ABORTION (CLACAI), 2016, at 15. Available at: https://clacaidigital.info/bitstream/handle/123456789/790/CRIPPCS16.pdf?sequence=5&isAllowed=y.

[29] For instance, a study performed by PROMSEX, revelad that the majority of women who had abortions were in the lowest socio-economic levels (C, D and E). PROMSEX, Abortion in numbers: Survey of Women in Peru This was a survey conducted by the Public Opinion Institute (IOP-PUCP) commissioned by the Center for the Promotion and Defense of Sexual and Reproductive Rights (PROMSEX), 2019. Avaialble at: https://promsex.org/wp-content/uploads/2019/02/EncuestaAbortoDiptico.pdf

[30] Sarah A. Huff, *Abortion Crisis in Peru: Finding a Woman's Right to Obtain Safe and Legal Abortions in the Convention on the Elimination of All Forms of Discrimination Against Women*, 30 B.C. INT'L & COMP. L. REV. 237 (2007), http://lawdigitalcommons.bc.edu/iclr/vol30/iss1/14.

[31] *Id.*

[32] Sarah A. Huff, *Abortion Crisis in Peru: Finding a Woman's Right to Obtain Safe and Legal Abortions in the Convention on the Elimination of All Forms of Discrimination Against Women*, 30 B.C. INT'L & COMP. L. REV. 237,

240 (2007), http://lawdigitalcommons.bc.edu/iclr/vol30/iss1/14; Alyssa Rayman-Read, *The Sound of Silence*, AM. PROSPECT, Sept. 24, 2001, at A21. *See also* Office of the Deputy Director, *Health Situation in the Americas: Basic Indicators*, PAN AM. HEALTH ORG., 2005. Available at: http://www.paho.org/English/DD/AIS/BI-brochure-2005 (estimating the maternal mortality rate in Peru at 185 deaths per 100,000 births and in the United States at 8.9 deaths per 100,000 births).

[33] Elizabeth Salazar Vega, *Abortar en Perú: cuando víctima y familiares son llevados a cárcel*, OJO PUBLICO (Oct. 22, 2019), https://ojo-publico.com/1411/abortar-en-peru-victima-y-familiares-son-llevados-carcel.

[34] Response from the Ministry of Health to the request for public information: PROMSEX No. 151-2016: File No. 16-051635-00; Letter dated May 17, 2019 addressed to the Special Rapporteur on Violence Against Women, Its Causes and Consequences, PROMSEX (May 17, 2019), https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/PROMSEX.pdf.

[35] Healthcare providers are hesitant to provide timely care for women presenting with complications from an illegal abortion even though the *Clinical Practice Guidelines for Obstetric Emergency Care* considers such complications an obstetric emergency that can lead to maternal mortality, which should not be punished as the crime of providing or assisting with the provision of an illegal abortion. *See* Ministry of Health (MINSA), *Guía Técnica: Guías de Práctica Clínica para la Atención de Emergencias Obstétricas Según Nivel de Capacidad Resolutiva*, 2007. Available at: http://bvs.minsa.gob.pe/local/IMP/852_IMP198.pdf.

[36] Equipo de Seguimiento Concertado a las Políticas de Salud Sub Grupo "Prevención del Embarazo en Adolescentes", *Embarazo en Adolescentes Peruanas Aumentó*: *Un Problema de Salud Pública, de Derechos y Oportunidades para las Mujeres y de Desarrollo para el País*, ALERTA N° 1-2018-SC/MCLCP. June 12, 2018. Available at: https://www.mesadeconcertacion.org.pe/sites/default/files/archivos/2018/documentos/06/alerta_embarazo_en_adolescentes_aumento_junio_2018.pdf

[37] CNV, *Caracteristicas De La Madre*, Sistema de Registro del Certificado de Nacido Vivo en Linea, June 2021, https://webapp.minsa.gob.pe/dwcnv/dwmadrenew.aspx.

[38] *Id.*

[39] CNV, *Caracteristicas De La Madre*, Sistema de Registro del Certificado de Nacido Vivo en Linea, June 2021, https://webapp.minsa.gob.pe/dwcnv/dwmadrenew.aspx.

[40] *Id.*

[41] National Institute of Statistics and Informatics (INEI), *Peru: Situación Social de las Madres Adolescentes*, *2007*, Mar. 2010. Available at: http://repositorio.minedu.gob.pe/bitstream/handle/20.500.12799/869/504.%20Per%c3%ba%20Situaci%c3%b3n%20social%20de%20las%20madres%20adolescentes%2c%202007.pdf?sequence=1&isAllowed=y.

[42] Committee Against Torture, *Concluding observations on the seventh periodic report of Peru*, U.N. Doc. CAT/C/PER/CO/7 at ¶41 (December 18, 2018), https://undocs.org/en/CAT/C/PER/CO/7.

[43] *See* General Assembly, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, U.N. Doc. A/HRC/22/53 at ¶¶ 49-50 (Feb. 1, 2013) (available at: https://undocs.org/A/HRC/22/53) ("The Committee against Torture has repeatedly expressed concerns about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment."); *see also* Int'l Covenant on Civ. and Pol. Rts., *Views, K.L. v. Peru*, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005) (available at: https://reproductiverights.org/wp-content/uploads/2020/12/KL-HRC-final-decision.pdf) (finding the denial of a therapeutic abortion a violation of the individual's right to be free from ill-treatment).

[44] Hiperderecho, *Country case-study: sexual and reproductive rights in Peru*, PRIVACY INTERNATIONAL (May 15, 2020), https://privacyinternational.org/long-read/3791/country-case-study-sexual-and-reproductive-rights-peru. *See also* LEY DE POLÍTICA NACIONAL DE POBLACIÓN [NAT'L POP. POL'Y LAW], Ley Nº 26530 (Peru).

[45] U.N. Dep't of Econ. & Soc. Affairs, *Contraceptive Use by Method 2019*, UNITED NATIONS, 2019, https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Jan/un_2019_contraceptiveusebymethod_databooklet.pdf.

[46] *Id.*

[47] *Id.*

[48] Myriam Escalante, *El 24% de mujeres en el Perú no accede a métodos anticonceptivos*, OJO PUBLICO (Mar. 19, 2018), https://ojo-publico.com/642/el-24-de-mujeres-en-el-peru-no-accede-metodos-anticonceptivos.

[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] *Id.*

[53] For the purposes of this communication, the term campesino is being used in relation to the Peruvian context and refers to the "peasant community" (*comunidad campesina*) of Peru, which includes the Aymara, Quechua and Uro indigenous communities of the Andean region. *See*, General Assembly, Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya. *The situation of indigenous peoples' rights in Peru with regard to the extractive industries*. July 3, 2014, U.N. Doc. A/HRC/27/52/Add.3, para 4. Indeed, it is particularly worth mentioning that in Peru, as part of the Agrarian Reform that took place in the 1970s, "*the indigenous population was divided in two, adopting the term campesino for the indigenous farmers of the Andes and the term nativo for the indigenous peoples of the Amazon. As a result, most Quechua and Aymara-speaking populations favor the use of the term peasant communities and reject the label "indigenous communities"*. *See*, World Bank. *Latinoamérica Indígena en el Siglo XXI Primera década Latinoamérica Indígena en el Siglo XXI Primera década*. Banco Internacional de Reconstrucción y Fomento/Banco Mundial: Washington. 2015, p. 19, n24. Avaible at: https://documents1.worldbank.org/curated/en/541651467999959129/pdf/Latinoam%C3%A9rica-ind%C3%ADgena-en-el-siglo-XXI-primera-d%C3%A9cada.pdf.

[54] Christopher M. Westgard et al., *Health service utilization, perspectives, and health-seeking behavior for maternal and child health services in the Amazon of Peru, a mixed-methods study*, 18 INT'L J. OF EQUITY IN HEALTH 155 (2019), https://doi.org/10.1186/s12939-019-1056-5.

[55] *Id.*

[56] *Id.*

[57] Christopher M. Westgard et al., *Health service utilization, perspectives, and health-seeking behavior for maternal and child health services in the Amazon of Peru, a mixed-methods study*, 18 INT'L J. OF EQUITY IN HEALTH 155 (2019), https://doi.org/10.1186/s12939-019-1056-5.

[58] *See*, Defensoría del Pueblo del Perú. La defensa del derecho de los pueblos indígenas amazónicos a una salud intercultural. Serie Informes Defensoriales – Informe N°169, pág. 53. Available at: https://www.defensoria.gob.pe/wp-content/uploads/2018/05/Informe-Defensorial-N-169.pdf; and Estrada, L. *Voces de Mujeres quechuas y aymaras de Puno. Género y Salud Reproductiva. Manuela Ramos y USAID*. 2003, p. 37 y 38. Citando a: Hammer, Patricia J. Sistematización de autodiagnósticos y estudios complementarios realizados por ReproSalud en las zonas quechua y aymara de Puno. *Informe realizado por encargo del Movimiento Manuela Ramos-ReproSalud. Inédito*. 2001. Available at: https://pdf.usaid.gov/pdf_docs/pnadb090.pdf

[59] *Id.*

[60] Ñusta Carranza Ko, *Peru's government forcibly sterilized Indigenous women from 1996 to 2001, the women say. Why?*, WASHINGTON POST (Feb. 19, 2021), https://www.washingtonpost.com/politics/2021/02/19/perus-government-forcibly-sterilized-indigenous-women-1996-2001-why/. *See* María Mamérita Mestanza Chávez, Informe No. 71/03, COMISIÓN INTERAMERICANA DE DERECHOS HUMANOS, Oct. 10, 2003, https://www.cidh.oas.org/women/peru.12191sp.htm (discussing an example of a campesino woman who was harassed and coerced into undergoing sterilization, where doctors performed the procedure without conducting a prior medical examination, and subsequently ignored her husband's reports of her quickly worsening condition in the following days, eventually resulting in her death).

[61] *See*, France 21, "Perú: empieza el juicio contra Fujimori por esterilizaciones forzadas", March 2, 2021. Available at: https://www.france24.com/es/am%C3%A9rica-latina/20210301-peru-juicio-fujimori-esterilizaciones-forzadas-ddhh; La Republica, "Esterilizaciones, 25 años después", May 12, 2021. Available at: https://larepublica.pe/opinion/2021/05/12/esterilizaciones-25-anos-despues-editorial/; DEMUS, *Deuda histórica. Esterilizaciones forzadas y derecho a reparaciones integrals*, March 20, 2021. Available at: http://www.demus.org.pe/noticias/deuda-historica-esterilizaciones-forzadas-y-derecho-a-reparaciones-integrales/

[62] *See*, DW, "Perú: Keiko Fujimori niega las esterilizaciones forzadas", May 15, 2021. Available at: https://www.dw.com/es/per%C3%BA-keiko-fujimori-niega-las-esterilizaciones-forzadas/a-57538771; Canal N, Tweet, "Keiko Fujimori sobre caso esterilizaciones forzada", May 14, 2021. Available at: https://twitter.com/canalN_/status/1393328076273168389?s=20;

[63] Bryan Boggiano, *Indigenous Women's Rights in Peru*, THE BORGEN PROJECT (Oct. 17, 2020) https://borgenproject.org/womens-rights-in-peru/.

[64] Physicians for Human Rights, *Fatal Delays. Maternal mortality in Peru: a human rights approach to safe motherhood*, 2007, at 11. Available at: http://bvs.minsa.gob.pe/local/minsa/929_GRAL1101-1.pdf.

[65] Carlos Gomez, *Giving birth upright, with mate – Peru clinics open arms to indigenous women*, UNFPA (Sep. 29, 2016), https://www.unfpa.org/news/giving-birth-upright-mat%C3%A9-%E2%80%93-peru-clinics-open-arms-indigenous-women.

[66] Committee on the Elimination of Discrimination against Women (CEDAW), *Concluding observations on the combined seventh and eighth periodic reports of Peru*, U.N. Doc. CEDAW/C/PER/CO/7-8 (July 24, 2014), at ¶ 33.

Available at: https://www.icj.org/wp-content/uploads/2014/10/Concluding-Observations-CEDAW-Peru-2014-eng.pdf.
[67] *Id.* at ¶ 34.
[68] Ombudsman's Office, *Resultados de la supervisión defensorial a los servicios de salud diferenciados para la atención integral a adolescentes*, Informe No. 0011-2018-DP/ANA (2018). Available at: https://www.defensoria.gob.pe/wp-content/uploads/2018/07/Informe-de-Adjuntia-011-2018-DP-ANA.pdf.
[69] Jésica León, *Aún hay trabas en entrega de la píldora del día siguiente*, LA REPÚBLICA (Oct. 28, 2019), https://larepublica.pe/sociedad/2019/10/28/anticonceptivos-aun-hay-trabas-en-entrega-de-la-pildora-del-dia-siguiente-violencia-sexual/.
[70] Press Release No. 243/18, IACHR, *IACHR completes working visit to Peru*, ORG. OF AM. STATES (Nov. 16, 2018), https://www.oas.org/en/iachr/media_center/PReleases/2018/243.asp.
[71] Cristina Puig Borràs & Brenda I Álvarez Álvarez, *The history of universal access to emergency contraception in Peru: a case of politics deepening inequalities*, 26 REPROD. HEALTH MATTERS, no. 54, Nov. 2018, at 47-50. Available at: https://www.tandfonline.com/doi/full/10.1080/09688080.2018.1542913.
[72] *Peru Reinstates Free Distribution of Emergency Contraception After WHO Asserts that EC Does Not Cause Abortion*, INT'L WOMEN'S HEALTH COALITION (Apr. 22, 2010), https://iwhc.org/2010/04/peru-reinstates-free-distribution-of-emergency-contraception-after-who-asserts-that-ec-does-not-cause-abortion/.
[73] Rossina Guerrero, *La última ruta para la distribución gratuita de la anticoncepción oral de emergencia*, PROMSEX (Mar. 3, 2021), https://promsex.org/la-ultima-ruta-para-la-distribucion-gratuita-de-la-anticonceptivo-oral-de-emergencia/.
[74] Cinthya Qquelcca & Ángel Pineda, *Pleno del Tribunal Constitucional debe decidir sentencia definitiva sobre la Anticoncepción Oral de Emergencia (AOE*), PROMSEX (Apr. 28, 2021), https://promsex.org/pleno-del-tribunal-constitucional-debe-decidir-sentencia-definitiva-sobre-la-anticoncepcion-oral-de-emergencia-aoe-2.
[75] *Id.*
[76] Rossina Guerrero, *La última ruta para la distribución gratuita de la anticoncepción oral de emergencia*, PROMSEX (Mar. 3, 2021), https://promsex.org/la-ultima-ruta-para-la-distribucion-gratuita-de-la-anticonceptivo-oral-de-emergencia/.
[77] Gail Sullivan, *more than one-quarter of morning-after pills in Peru don't work*, WASHINGTON POST (Apr. 21, 2014), https://www.washingtonpost.com/news/morning-mix/wp/2014/04/21/morning-after-disaster-more-than-a-quarter-of-contraceptive-pills-in-peru-dont-work/.
[78] *Id.*
[79] Hiperderecho, *Country case-study: sexual and reproductive rights in Peru*, PRIVACY INTERNATIONAL (May 15, 2020), https://privacyinternational.org/long-read/3791/country-case-study-sexual-and-reproductive-rights-peru.
[80] *Id.*
[81] *Id.*
[82] *See My Rights, and My Right to Know: Lack of Access to Therapeutic Abortion in Peru*, HUMAN RIGHTS WATCH (July 8, 2008), https://www.hrw.org/report/2008/07/08/my-rights-and-my-right-know/lack-access-therapeutic-abortion-peru.
[83] Marta Favara et al., *Understanding teenage fertility in Peru: An analysis using longitudinal data* (2020), https://doi.org/10.1111/rode.12648. In comparison the age specific fertility rate (ASFR) for 15-19 years was 65 per 1000 in 2015 in Latin American and the Caribbean. Sarah Neal et al., *Trends in adolescent first births in five countries in Latin America and the Caribbean: disaggregated data from demographic and health surveys*, REPROD HEALTH 15, 146 (2018), https://doi.org/10.1186/s12978-018-0578-4.
[84] Vanessa Rojas & Francis Bravo, *Young Lives and Child Frontiers: Experiences of cohabitation, marriage and parenting in Peruvian adolescents and youth*, YOUNG LIVES, July 2020. Available at: https://www.younglives.org.uk/sites/www.younglives.org.uk/files/YL-CountryReport-Peru-Jul20-Proof04.pdf; Marta Favara et al., *Understanding Teenage Fertility, Cohabitation, and Marriage: The Case of Peru*, IZA Discussion Paper No. 10270, IZA INST. OF LABOR ECON., Oct. 2016 (based on a study conducted by Young Lives). Available at: https://www.iza.org/publications/dp/10270/understanding-teenage-fertility-cohabitation-and-marriage-the-case-of-peru. 71% of these pregnancies are unwanted. *Id.*
[85] Save the Children, *Every Last Child Country Spotlight: Peru* (2016), https://resourcecentre.savethechildren.net/node/10045/pdf/peru_spotlight.pdf.
[86] Cristina Puig Borràs & Brenda I Álvarez Álvarez, *The history of universal access to emergency contraception in Peru: a case of politics deepening inequalities*, 26 REPROD. HEALTH MATTERS, no. 54, Nov. 2018, at 47-50, https://www.tandfonline.com/doi/full/10.1080/09688080.2018.1542913. However this number is likely to be much higher, considering that sexual violence is likely to go unreported and the general culture of impunity in the case of

sexual and gender-based violence. Often police and other authority figures do not believe the girls, trivialize their concerns or choose not to take their complaints seriously.

[87] *Id.*

[88] Mariela Jara, *Shedding Light on Forced Child Pregnancy and Motherhood in Latin America*, IPS NEWS (Jan. 14, 2019), http://www.ipsnews.net/2019/01/shedding-light-forced-child-pregnancy-motherhood-latin-america/ (based on CLADEM 2019 data). *See also* Juan Pablo Casapia, *Teen moms in Peru pinpoint need for sexuality education, health services*, UNFPA (Feb. 19, 2018), https://www.unfpa.org/news/teen-moms-peru-pinpoint-need-sexuality-education-health-services?utm_source=27+February+2018&utm_campaign=2%2F2%2F2017&utm_medium=email (emphasizing the gravity of adolescent pregnancy in Peru); Mariela Jara, *Shedding Light on Forced Child Pregnancy and Motherhood in Latin America*, IPS NEWS (Jan. 14, 2019), http://www.ipsnews.net/2019/01/shedding-light-forced-child-pregnancy-motherhood-latin-america/ (based on CLADEM 2019 data). Generally, it should be noted that global and regional data on pregnancies in girls younger than 15 years is limited. Instead, broader Latin American and Caribbean (LAC) statistics provide helpful contextualization; 2% of women of reproductive age in LAC reported having their first delivery before the age of 15; LAC is noted as the only region in the world with an upward trend in births among girls younger than 15 years. Source: *Adolescent Pregnancy in Latin America and the Caribbean*, WHO / Pan American Health Organisation Technical Brief (August 2020). Available at: https://lac.unfpa.org/sites/default/files/pub-pdf/final_dec_10_approved_policy_brief_design_ch_adolescent.pdf.

[89] The impact of poor or limited access to education is particularly notable, the highest percentages of pregnant adolescents were girls with only primary education (34%). Save the Children, *Every Last Child Country Spotlight: Peru* (2016), https://resourcecentre.savethechildren.net/node/10045/pdf/peru_spotlight.pdf. The surveys conducted between 2008-2016 and reported in *Accelerating progress toward the reduction of adolescent pregnancy in LAC* (2017) by Pan American Health Organisation, UNFPA and UNICEF in relation to Bolivia, Colombia, Dominican Republic, Guyana, Haiti, Honduras, and Peru emphasize that adolescent girls with no education or only primary education were up to 4 times more likely to be pregnant relative to girls with secondary or higher education. Access at: https://iris.paho.org/bitstream/handle/10665.2/34493/9789275119761-eng.pdf?sequence=1&isAllowed=y.

[90] Susana Chávez Alvarado & Elisa Juárez Chávez, *Historias para no olvidar: La violência como factor associado a la muerte materna de adolescentes. Un estudio cualitativo 2012-2014*, CENTRO DE PROMOCIÓN Y DEFENSA DE LOS DERECHOS SEXUALES Y REPRODUCTIVAS (PROMSEX), 2015, at 63. Available at: https://promsex.org/wp-content/uploads/2015/10/HistoriasParaNoOlvidarSChavez.pdf. Among the results of this research: of the adolescents who died, four were 15 years old or younger and six were between 16 and 18 years old at the time of death; regarding the causes of death, in three of the cases their deaths were associated with abortion and two were due to indirect causes, reporting one suicide and one died during the puerperium; regarding birth control, only four of them had some type of control; two of the deaths occurred in the first trimester, one in the second, three in the third and two died during the puerperium.

[91] Ximena Casas et al., O'Neill Inst. for Nat'l and Global Health L. & Ibis Reprod. Health, *Stolen lives: A multi-country study on the health effects of forced motherhood on girls 9-14 years old*, PLANNED PARENTHOOD GLOBAL, 2015, at 55-56. Available at: https://www.plannedparenthoodaction.org/uploads/filer_public/db/6d/db6d56cb-e854-44bb-9ab7-15bb7fc147c5/ppfa-stolen-lives-english.pdf.

[92] Save the Children, *Every Last Child Country Spotlight: Peru* (2016), https://resourcecentre.savethechildren.net/node/10045/pdf/peru_spotlight.pdf. *L.C. v Peru*, a case concerning a 13-year old girl who attempted to commit suicide when she became pregnant as a result of sexual abuse by a 34 year old man, provides a direct example of this. As a result of this case, the Committee on the Elimination of Discrimination Against Women recommended that Peru provide reparations of specific compensation for L.C. and that Peru review its legislation restricting therapeutic abortion and criminalizing abortion where pregnancy results from rape or sexual abuse. Available at https://www2.ohchr.org/english/law/docs/CEDAW-C-50-D-22-2009_en.pdf. Peru still has yet to modify its legislation restricting therapeutic abortion and criminalizing abortion where pregnancy results from rape or sexual abuse.

[93] *See* National Institute of Statistics and Informatics (INEI), *Peru: Situación Social de las Madres Adolescentes, 2007*, at 13, Mar. 2010. Available at: http://repositorio.minedu.gob.pe/bitstream/handle/20.500.12799/869/504.%20Per%c3%ba%20Situaci%c3%b3n%20social%20de%20las%20madres%20adolescentes%2c%202007.pdf?sequence=1&isAllowed=y.

[94] Ximena Casas, *They Are Girls, Not Mothers: The Violence of Forcing Motherhood on Young Girls in Latin America. Health and human rights*, 21 HEALTH AND HUM. RTS. J., no. 2, Dec. 2019, 157-167, 159. Available at: https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2019/12/Casas.pdf.

[95] *Id.* at 163-64. *ee also* Hum. Rts. Comm., *General Comment No. 36: Article 6 (Right to Life)*, U.N. Doc.

CCPR/C/GC/36 (2018) (describing the role of dignity in the protection of the right to life).
[96] Latest UNICEF data for Peru, available at *Country Profiles: Peru*, UNICEF (last accessed Apr. 25, 2021), https://data.unicef.org/country/per/.
[97] Nancy Armenta-Paulino et al., *Overview of equity in maternal health care coverage by ethnicity*, 30 EUR. J. OF PUB. HEALTH Supp. 5, (Sep. 30, 2020), https://doi.org/10.1093/eurpub/ckaa165.830.
[98] Brianna Vargas et al., *An exploration of patient-provider dynamics and childbirth experiences in rural and urban Peru: a qualitative study,* 21 BMC PREGNANCY AND CHILDBIRTH 135 (2021, https://doi.org/10.1186/s12884-021-03586-y).
[99] Christopher M. Westgard et al., *Health service utilization, perspectives, and health-seeking behavior for maternal and child health services in the Amazon of Peru, a mixed-methods study*, 18 INT'L J. OF EQUITY IN HEALTH 155, 160, 163 (2019), https://doi.org/10.1186/s12939-019-1056-5
[100] World Health Org., *Figure 3.20, Health at a Glance: Latin America and the Caribbean 2020, Maternal Mortality*, OECD ILIBRARY (2019), https://www.oecd-ilibrary.org/sites/a9304593-en/index.html?itemId=/content/component/a9304593-en#figure-d1e17916. By comparison, official data from the Ministry of Health places the maternal mortality rate as of December 2019 at a lower figure of 56.1 per 100,000 live births, but excludes death due to suicide in this figure. To contextualize this, the same data estimated the maternal mortality rate at 60.7 per 100,000 live births in 2016, reducing significantly to 57.9 when not accounting for suicide. It is also worth noting that this official data does not disaggregate deaths caused by complications of unsafe abortions, or indeed appear to account for such deaths at all. Ministry of Health (MINSA), *Boletin Epidemiologico Del Peru*, at 1335, December 2019. Available at: https://www.dge.gob.pe/portal/docs/vigilancia/boletines/2019/52.pdf.
[101] World Health Org., *Figure 3.20, Health at a Glance: Latin America and the Caribbean 2020, Maternal Mortality*, OECD ILIBRARY (2019), https://www.oecd-ilibrary.org/sites/a9304593-en/index.html?itemId=/content/component/a9304593-en#figure-d1e17916. *See also Health in the Americas+. Summary: Regional Outlook and Country Profiles*, Scien. & Tech. Publ'n No. 642, PAN AMERICAN HEALTH ORG., 2017, https://iris.paho.org/handle/10665.2/34321.
[102] By comparison, the maternal mortality rate of the United States is 17.4 deaths per 100,000 live births, 6.5 for the United Kingdom and 3.2 for Germany. Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries,* COMMONWEALTH FUND (Nov. 2020), https://doi.org/10.26099/411v-9255.
[103] Ministry of Health (MINSA), *Número de muertes maternas anual y hasta la SE 21, 2000-2020*, 2020. Available at: https://www.dge.gob.pe/portal/docs/vigilancia/sala/2020/SE21/mmaterna.pdf.
[104] Ximena Casas et al., O'Neill Inst. for Nat'l and Global Health L. & Ibis Reprod. Health, *Stolen lives: A multi-country study on the health effects of forced motherhood on girls 9-14 years old*, PLANNED PARENTHOOD GLOBAL, 2015. Available at: https://www.plannedparenthoodaction.org/uploads/filer_public/db/6d/db6d56cb-e854-44bb-9ab7-15bb7fc147c5/ppfa-stolen-lives-english.pdf. Also see, *Adolescent Pregnancy in Latin America and the Caribbean*, WHO / Pan American Health Organisation Technical Brief (August 2020). Available at: https://lac.unfpa.org/sites/default/files/pub-pdf/final_dec_10_approved_policy_brief_design_ch_adolescent.pdf.
[105] Susana Chávez Alvarado & Elisa Juárez Chávez, *Historias para no olvidar: La violência como factor associado a la muerte materna de adolescentes. Un estudio cualitativo 2012-2014*, CENTRO DE PROMOCIÓN Y DEFENSA DE LOS DERECHOS SEXUALES Y REPRODUCTIVAS (PROMSEX), 2015. Available at: https://promsex.org/wp-content/uploads/2015/10/HistoriasParaNoOlvidarSChavez.pdf. Ministry of Health (MINSA), *Muerte materna en el Perú 2001-2011*, 2013. Available at: http://bvs.minsa.gob.pe/local/MINSA/2896.pdf.
[106] Ministry of Health (MINSA), *Muerte materna en el Perú 2001-2011*, 2013. Available at: http://bvs.minsa.gob.pe/local/MINSA/2896.pdf.
[107] Sarah A. Huff, *Abortion Crisis in Peru: Finding a Woman's Right to Obtain Safe and Legal Abortions in the Convention on the Elimination of All Forms of Discrimination Against Women,* 30 B.C. Int'l & Comp. L. Rev. 237, 237, 240 (2007), http://lawdigitalcommons.bc.edu/iclr/vol30/iss1/14.
[108] *Annotated Index of Relevant Conditions In Peru,* Sanctuary for Families, 2016, https://sanctuaryforfamilies.org/wp-content/uploads/2020/12/Annotated-Country-Conditions-Index.docx.
[109] Ambassador Krishna R. Urs, *Mobilizing against gender-based violence*, U.S. EMBASSY IN PERU (Dec. 16, 2019), https://pe.usembassy.gov/mobilizing-against-gender-based-violence/.
[110] Sarah Bott et al., *Intimate partner violence in the Americas: a systematic review and reanalysis of national prevalence estimates*, 43 REVISTA PANAM. SALUD PUBLICA 26 (Mar. 20, 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6425989/.
[111] Ministry of Women and Vulnerable Populations (MIMP), *Estadísticas del MIMP*, GOB.PE,

https://www.mimp.gob.pe/omep/estadisticas-violencia.php. (comparison between statistics of cases of violence against women documented by the CEM in 2014 (43,810) in relation to 2020 (97,926).
[112] *Id.*
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