

June 13, 2014

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

**RE: Report for the 58th Session of the Committee on the Elimination of Discrimination against Women (June 30 to July 18, 2014) on the right to sexual and reproductive health in Peru**

Dear Sirs/Madams:

1. In the context of the 58th session of the Committee on the Elimination of Discrimination against Women (CEDAW Committee), [the Center for Reproductive Rights \(CRR\)](#), [Planned Parenthood Federation of America Global \(PPFA\)](#) and the [Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos \(PROMSEX\)](#) wish to complement the Committee's work by offering information on the Peruvian situation to the rights protected in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)<sup>1</sup>. The three organizations presenting this report are especially concerned over Peru's level of compliance with its international obligations under the CEDAW as concerning the enjoyment of reproductive rights, particularly access to emergency contraception, access to abortion, and limits to adolescents' enjoyment of these rights.

2. This report is divided into two parts. The first describes the legal framework to which Peru is bound. The second provides up-to-date information on three issues facing Peru: i) obstacles to access free emergency oral contraception, particularly in cases of rape; ii) limits on access to abortion; and iii) limits on access to sexual and reproductive health services (SRHS) for adolescents. These three issues are indications that the Peruvian State has been in violation of its CEDAW obligations regarding rights to substantive equality, health, sexual and reproductive rights (SRR), a life free from violence, the right to information, and the right to due process.

### **1. Legal Framework**

3. The CEDAW establishes the principle of non-discrimination (Art. 1) as one of its central obligations. Substantive equality derives from this obligation, according to which men and women must have equal access to "*human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.*"<sup>2</sup> Article 2 requires States to "*pursue by all appropriate means and without delay a policy of eliminating discrimination against women,*"<sup>3</sup> along with any specific actions that must be taken toward this end.

4. Regarding the right to health without discrimination, Article 12 stipulates that States shall adopt “*all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.*” Article 14 establishes that women should be able to access “*adequate health care facilities, including information, counselling and services in family planning.*” Article 16 establishes the right to choose the number of children to have and how frequently to have them, referring to reproductive freedom in connection with the right to health.

5. These articles include protections for reproductive rights (RR). RR are specifically recognized under Article 16 of the CEDAW and include the right to reproductive autonomy and allowing individuals to decide whether they wish to have children, how many, and the timing of the pregnancies without suffering discrimination or sanctions; in order to do so, these individuals must have access to information and scientific progress on health and family planning.<sup>4</sup> Protections of the right to life; health; autonomy; personal integrity; freedom from cruel, inhuman and degrading treatment; and to have a family, as well as the prohibition of arbitrary interference in private life, also contain protections for RR.<sup>5</sup>

6. The right to health without discrimination is linked to access to information. Article 10 of the CEDAW establishes that States must ensure “*access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.*” Specifically with regard to reproductive autonomy, Article 16 requires States to ensure “*access to the information, education and means to enable them to exercise these rights.*”

7. General Recommendation No. 24 of the CEDAW Committee establishes that States Parties have both positive and negative obligations with regard to the right to health. States are required to refrain from “*obstructing action taken by women in pursuit of their health goals*”<sup>6</sup> and to take “*action to prevent and impose sanctions for violations of rights by private persons and organizations.*”<sup>7</sup>

8. The right to health includes a life free from violence. According to General Recommendation No. 24, States shall promulgate and implement “*health-care protocols and hospital procedures to address violence against women*”<sup>8</sup> and shall ensure “*the provision of appropriate health services*”<sup>9</sup> for victims of gender violence, including victims of rape. This Committee has explained that States must train health professionals to be aware of “*the health consequences of gender-based violence,*”<sup>10</sup> and on how to handle those consequences.<sup>11</sup>

9. General Recommendation No. 19 of the CEDAW Committee also requires States to take measures to prevent and combat gender-based violence, including by providing rehabilitation and health services for victims.<sup>12</sup> It has also recommended that States “*prevent coercion in regard to fertility and reproduction*”<sup>13</sup> and ensure that women are not forced to turn to illegal abortions. In particular, the Committee has established that States should provide “*services for victims of family violence, rape, sex assault [, etc.]*”<sup>14</sup> and must ensure availability of adequate services for sexual assault victims for controlling their fertility and reproduction.<sup>15</sup>

10. Specifically, the CEDAW Committee has issued statements on the state of RR in Peru. In its 2007 Concluding Observations, the Committee expressed its “*concern about the inadequate recognition and protection of the reproductive health and rights of women,*”<sup>16</sup> in particular “*that the recommendations of the Human Rights Committee in KL v Peru (CCPR/C/85/D/1153/2003 (2005)) were not adhered to by the State party.*”<sup>17</sup> The Committee recommended that Peru “*step up the provision of **family planning information** and services to women and girls, including **emergency contraception**, and to promote **sex education widely, in particular in the regular education curriculum targeted at adolescent girls and boys**, with special attention to the prevention of teenage pregnancies. The Committee also urges the State party to provide women with access to **quality services for the management of complications arising from unsafe abortions** so as to reduce women’s maternal mortality rates. The Committee urges the State party to **review its restrictive interpretation of therapeutic abortion**, which is legal, to place greater emphasis on the prevention of teenage pregnancies and to consider reviewing the law relating to abortion for unwanted pregnancies with a view to **removing punitive provisions imposed on women who undergo abortion**...*”<sup>18</sup> (emphasis added).

11. Likewise, in the case of *L.C. v Peru*,<sup>19</sup> the Committee made the general recommendation that Peru should “*ii. (...) establish a **mechanism for effective access to therapeutic abortion** under conditions that protect women’s physical and mental health and prevent further occurrences in the future of violations similar to the ones in the present case Take measures to ensure that the relevant provisions of the Convention and the Committee’s general recommendation No. 24 with regard to reproductive rights are known and observed in all health-care facilities. Such measures should include education and training programmes to encourage health providers to change their attitudes and behaviour in relation to **adolescent women seeking reproductive health services and respond to specific health needs related to sexual violence. They should also include guidelines or protocols to ensure health services are available and accessible in public facilities. The State party should also review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse.***”<sup>20</sup> (emphasis added)

12. The right to due process is enshrined in Article 15, which establishes that “*1. States Parties shall accord to women equality with men before the law*” and “*2. (...) shall treat them equally in all stages of procedure in courts and tribunals.*” According to the Universal Declaration of Human Rights and the ICCPR, due process means that every individual subjected to a court proceeding has effective resources to defend against violations of fundamental rights and is not subject to arbitrary rulings depriving them of liberty. They shall be guaranteed adequate means for pleading freely; being heard without coercion; and gathering and presenting evidence that will allow them to defend themselves in order for cases to be judged impartially and with a presumption of innocence until proven otherwise.<sup>21</sup>

13. This report seeks to demonstrate that the Peruvian State’s policies and regulations regarding emergency oral contraception, access to abortion, and SRHS for adolescents violate Peru’s international obligations regarding the aforementioned rights, as well as the recommendations regarding reproductive rights made to Peru by the CEDAW Committee in its 2007 Concluding Observations and in the case of *L.C. v. Peru*. ***We ask the CEDAW Committee to recommend that Peru i) revise domestic legislation to allow free access to emergency oral contraceptives through***

*the public health system, ii) emphasize the obligation to guarantee access to legal therapeutic abortion that has been in place since 1924, through an integral interpretation of the right to health in its three dimensions (physical, mental and social), decriminalize abortion in cases of sexual assault, and strike down the legal provisions that require health professionals to report women for alleged crimes of abortion; iii) guarantee compliance with non-repetition measures established in the case of L.C. v. Peru; and iv) guarantee that adolescents have access to SRHS.*

## **2. Current status of reproductive rights in Peru: limits on access to emergency contraception, abortion, and sexual and reproductive health services for adolescents**

### ***2.1 The ban on distributing emergency contraception through the public health system in Peru violates women's rights to health and substantive equality, and their reproductive rights***

#### *1) Legal status of access to emergency contraception in Peru*

14. In 2006, Peru's Constitutional Court ordered the Health Ministry (MINSA for its name in Spanish) to distribute the emergency oral contraceptive pill (ECP) free of charge, emphasizing its contraceptive effects and guaranteeing women's reproductive rights.<sup>22</sup> However, the ECP's health registry information still includes a possible anti-implantation effect (preventing implantation of the fertilized egg), which has erroneously been understood to be an abortion. This led the Constitutional Court to change its jurisprudence regarding the ECP, and in response to a suit from a religious organization, it ruled in October 16, 2009<sup>23</sup> to ban free distribution of Levonorgestrel – one of the components of the ECP – through public health services, though it did not ban purchase of the drug at pharmacies. This places the ECP out of reach of poor women and those living in remote parts of the country where pharmacies are few or not well stocked. The ECP remained available to women with money to buy it with a prescription at a private pharmacy. Although technically there is a brand on the private market that produces the ECP and sells it for one sol (less than one US dollar),<sup>24</sup> most pharmacies sell POSTINOR, which costs between 7.90 sols (3 dollars) and 26 sols (10 dollars). The brand TIBEX is a second option selling for between 2.79 sols (1 dollar) and 16.50 sols (6 dollars).<sup>25</sup>

15. The 2009 judgment comes with the provision that it may be reversed should new scientific information demonstrate that the ECP does not cause abortion. In response, MINSA published Ministerial Resolution No. 167-2010/MINSA (March 9, 2010), ordering ECP distribution and indicating that the use of Levonorgestrel does not in itself cause abortion nor have any harmful side effects. However, in light of the fact that a motion was admitted arguing that this resolution violated the Constitutional Court's order, MINSA issued Ministerial Resolution No. 652-2010/MINSA (August 19, 2010), which again banned free ECP distribution. This new ban contravenes the judgment of the Inter-American Court of Human Rights in the case of *Artavia Murillo et al. v. Costa Rica*, in which the Court found that “‘conception’ in the sense of Article 4(1) occurs at the moment when the embryo becomes implanted in the uterus, which explains why, before this event, Article 4 of the Convention would not be applicable.”<sup>26</sup> Thus, even though the outdated health registry continues to indicate that the ECP has anti-implantation effects, the right to life prior to implantation is not protected, meaning that the public health system could again distribute freely the ECP.

2) *Facts on access to emergency contraception in Peru*

16. The ECP is a hormonal contraceptive that the World Health Organization (WHO) considers an essential medical supply. This method of contraception plays a crucial role in reproductive health services because it is the only one that can prevent a pregnancy after an unprotected sexual encounter, when regular contraception has been used incorrectly or failed, or in cases of rape. The ECP is especially necessary in Peru, where there is a high rate of incidents of sexual violence against women, as preventing a pregnancy resulting from rape can reduce the number of unsafe and clandestine abortions, in a legal context where terminating such pregnancies is a crime, and where the right to health is interpreted in a restrictive way, since the possibility of therapeutic abortion is not a possibility for rape victims whose mental health might be affected.

17. The Office of the Ombudsman has reported two serious problems within the national Family Planning Program: i) shortage of contraceptives, especially the ECP; and ii) wrongful billing for provision of family planning services.<sup>27</sup> These two structural problems add up to a violation of women's rights. MINSA and ESSALUD attend 60.6% of those seeking family planning services.<sup>28</sup> MINSA's ban on ECP distribution has hindered access for women who use these public services: According to MINSA, in 2007, 29,682 ECP kits were used; in 2008 it was 24,298, and in 2009, 35,324. Following the judgment of the Constitutional Court, these services began providing the Yuzpe Regimen: 4,631 times in 2010, 9,503 times in 2011, and 7,296 times in 2012.<sup>29</sup> Although the ban on the public health system distributing the ECP free of charge has reduced access, women's needs have persisted. This is a violation not only of reproductive rights but also of women's access to scientific progress.

18. Since the ECP is a contraceptive method used only by women, the ban on the health system distributing it free of charge is an obstacle that specifically affects the most vulnerable women who wish to prevent an unwanted pregnancy following the failure of a different method of contraception or when they have been rape victims. Considering this violation of women's right to care for and have control over their own bodies, this ban on the ECP is discriminatory and violates the right to substantive equality (Art. 1). As it was the Constitutional Court that issued this ban, Peru is in violation of its duty to take action to limit discrimination against women (Art. 2).

19. Since pregnancy increases the risks women face regarding their health and lives, the ECP is an essential medication that States must provide in order to ensure women's right to health and to live.<sup>30</sup> Limiting its distribution also constitutes a violation of the right to substantive equality and the right to equal access to health services, especially regarding family planning, as established in the CEDAW's Article 12 and in General Comment No. 24, as well as in paragraph 25 of the CEDAW Committee's General Comments to the State of Peru on the provision of emergency contraceptives. In fact, this Committee has expressed concern at States Parties' failure to provide adequate emergency contraceptives.<sup>31</sup>

20. The ban on ECPs is an indication of the Peruvian State's failure to fulfill its duty to guarantee women's reproductive autonomy pursuant to Article 16 of the CEDAW. Insofar as the ECP is a method that allows women to decide on the number of children they have and how often, banning

it limits women from making decisions regarding their own bodies, which is the essence of women's reproductive rights.

***2.1.1 Banning the public health system provision of emergency contraceptives is a violation of the State's obligation to provide special protection to rape victims in conjunction with the right to health***

21. Victims of sexual assault are the most affected by the ban on distribution of the ECP free of charge in Peru, since as a result of the 2009 judgment of the Constitutional Court, the ECP cannot be included in Sexual Assault Emergency Care Kits, even though protocols to respond to sexual assault include the ECP. The WHO has stated that “*if a woman seeks health care within a few hours and up to 5 days after the sexual assault, emergency contraception should be offered.*”<sup>32</sup> The ban has been set although the ECP is an important resource for victims of sexual violence, and despite the fact that a large number of girls and adolescents become pregnant as a result of rape in Peru.<sup>33</sup>

22. The majority of victims of sexual violence are women part of vulnerable groups, including girls and adolescents, women living in rural and jungle areas, and poor women. From 2000 to 2009, a study by PROMSEX found that victims under the age of 18 filed 78% of criminal complaints for rape (49,659).<sup>34</sup> This same study found that Peru has the highest rate of rape complaints in South America (22.4 for every 100,000 inhabitants),<sup>35</sup> for a total of 63,545 criminal complaints of violations of sexual freedom. It should also be noted that underreporting is common.<sup>36</sup> Comparative studies find that approximately 5% of rape victims become pregnant as a result, which in the case of Peru would be equivalent to 35,000 unwanted pregnancies annually due to sexual assault.<sup>37</sup> Approximately 12% of Peruvian women have been forced at least once in their lives to have nonconsensual sexual relations.<sup>38</sup>

23. According to the Ministry for Women and Vulnerable Populations, in 2010, the Women's Emergency Centers recorded a total of 1,333 cases of sexual violence against women between the ages of 10 and 14, as well as 1,191 cases of sexual violence against women between the ages of 15 and 19. As a result, 258 (34%) of women from both age groups became pregnant.<sup>39</sup> The severe violation of the sexual rights of Peruvian women is compounded by the ban on free access to the ECP and on abortion in cases of rape, which also violate their RR.<sup>40</sup>

24. The situation of sexual violence is especially serious in two areas in the country. In Huánuco, in Peru's central region, 5,602 cases of sexual violence against boys, girls, and adolescents were recorded between January and October 2009.<sup>41</sup> In Mazán, Loreto, in the Peruvian jungle, 97% of rapes went unreported. Teenage pregnancy is very common there. One explanation for this is the high rate of sexual violence in the region.<sup>42</sup>

25. Rape perpetrated by the partners of the victims is persistent. According to the 2013 Demographic and Family Health Survey (ENDES for its name in Spanish), 7.6% of women were forced by their partners to have sexual relations at least once.<sup>43</sup> This situation is especially serious in areas like la Sierra (9.9%) and the department of Apurímac (18.8%).<sup>44</sup> Likewise, 4.2% of women responded that in the last year, their husbands or partners had forced them to have unapproved sexual relations.<sup>45</sup>

26. While there are no official disaggregated statistics, information collected by civil society organizations indicates that many of these rapes result in unwanted pregnancies, which sometimes end in unsafe abortions. These are reflected in the country's high maternal mortality rates.<sup>46</sup> ECP usage could prevent abortions, reduce maternal mortality caused by abortion, and lower the rate of teenage pregnancy. It could also partially mitigate the effects that sexual abuse has on girls, adolescents, and women.

27. Peru is required to protect the health and dignity of victims of rape and sexual violence.<sup>47</sup> These obligations include allowing women and girls to prevent themselves from becoming pregnant after becoming victims of rape, as access to the ECP through the public health system would make possible. Likewise, health professionals should be sensitized and trained to provide the ECP to victims of rape, as pregnancies caused by rape can pose a serious danger to the physical and mental health of women and girls.<sup>48</sup> In addition, according to the Committee against Torture, unwanted pregnancies are considered a harmful act in themselves or an action that constantly exposes the victim to the rape she suffered.<sup>49</sup> As this Committee has already condemned the Peruvian State for failing to fulfill its international duties by not allowing termination of pregnancies in cases of rape,<sup>50</sup> in order to fulfill its obligations under CEDAW, the State could also guarantee women the ability to *prevent* pregnancy following rape using the ECP.

28. Refusing to provide ECPs violates the rights enshrined in the CEDAW regarding States Parties' obligation to guarantee women the ability to equally enjoy their rights as men. This includes the right to substantive equality (articles 1 and 2) insofar as women are the ones who can take the ECP and whose reproductive autonomy (Article 16) and health (Article 12) is affected if they do not have access to it, and they can become pregnant with an unwanted pregnancy suffering implications on their health and lives. When the ECP is used in cases of sexual assault, banning it also represents a violation of women's right to live, to a life free of violence, and to receive adequate care pursuant to General Recommendations No. 24 and 19 of the CEDAW Committee. Denying access to the ECP violates the recommendation found in paragraph 25 of the CEDAW Committee's General Observations to Peru (2007) on provision of emergency contraception to women and girls. *We respectfully request the CEDAW Committee to recommend the State to provide the ECP free of charge through the public health system, especially to those women, adolescent girls, and girls who have been victims of sexual violence.*

## **2.2 Limits on access to therapeutic abortion and abortion on the grounds of sexual assault, and violation of professional secrecy by physicians in alleged cases of abortion in Peru violate women's rights to health, reproductive rights, substantive equality, and due process**

29. The three fundamental problems facing women who wish to have an abortion in Peru are i) a failure to implement a 1924 provision of the Penal Code that decriminalizes therapeutic abortion. This has been aggravated by the lack of a protocol regulating therapeutic abortion that would facilitate the provision's implementation; ii) criminalization of abortion on the grounds of sexual assault, in consideration of the high rates of sexual violence in Peru, as well as the narrow interpretation of the right to health that does not include the risk to the mental health of victims of

rape within therapeutic abortion; and iii) the law that violates the constitutional duty to maintain professional secrecy by requiring physicians to report suspected abortions, thereby preventing women from seeking obstetric care even in cases of miscarriages, due to fear of being imprisoned. These three issues violate their right to health, reproductive rights, and substantive equality.

***2.2.1. Lack of implementation of the 1924 law allowing therapeutic abortion in Peru constitutes a violation of women's right to health, reproductive rights, and substantive equality***

30. Therapeutic abortion, which is defined in Article 119 of the Penal Code as the termination of a pregnancy in order to save the life of the pregnant mother or to prevent serious and permanent harm to her health,<sup>51</sup> has been legal in Peru since 1924.<sup>52</sup> In countries like Peru where therapeutic abortion is legal, the public health system has an obligation to provide this service, thereby eliminating unnecessary risks and barriers for women who need it.<sup>53</sup> However, this provision has not been systematically implemented, violating women's rights to health, RR, and substantive equality.

31. One element that would facilitate real and non-discriminatory access for all women requiring a legal abortion is the existence of protocols or guidelines for clinical practice. Throughout the world, medical practice includes standards for health professionals aimed at ensuring proper care for patients. In Peru, general sexual and reproductive health services are governed by specific national care guidelines.<sup>54</sup> The therapeutic abortion protocol is only a regulation, but the right to abortion has existed since 1924 and should be protected beyond that protocol.

32. One of the 2012-2017 National Gender Equality Plan's goals for reducing maternal mortality by 2017 is the approval of a protocol for therapeutic abortion.<sup>55</sup> However, the protocol has yet to be approved. The Office of the Ombudsman, a national human rights body, has also recommended in its first and second reports on compliance with the Equal Opportunities for Men and Women Act that MINSA approves the protocol for therapeutic abortion.<sup>56</sup> It has done the same in its annual reports from 2006 to 2009.<sup>57</sup>

33. The duties to apply the 1924 provision and implement a therapeutic abortion protocol also arise from Peru's international obligations. The following are two cases in which the Human Rights Committee and the CEDAW Committee have recommended promoting the right to therapeutic abortion, and along those lines adopting a protocol; Peru has not taken any action in this regard.

*1) Case of K.L. versus Peru*

34. In October 2005, the UN Human Rights Committee issued its final decision in the case of K.L. v. Peru. K.L. was an adolescent who became pregnant with an anencephalic fetus in 2001. Doctors at a public hospital in Lima did not terminate her pregnancy despite the recommendation of a gynecologist, who was part of the medical team there, and despite confirmation that the pregnancy presented a risk of serious and permanent harm to her physical and mental health. The Committee recommended Peru to take measures - including adoption of the therapeutic abortion protocol - to prevent repetition of similar cases.<sup>58</sup>

35. Although the civil society organizations representing K.L. have repeatedly filed petitions with officials from different ministries<sup>59</sup> and have brought writs for the protection of fundamental rights before Peruvian judges<sup>60</sup> to make the State comply with the general recommendations of the Human Rights Committee - specifically, to adopt a therapeutic abortion protocol - the State has not complied.

2) *Case of L.C. versus Peru*<sup>61</sup>

36. L.C. was 13 years old in 2007 when she was the victim of sexual violence and tried to commit suicide by throwing herself off the roof of her house. She was taken to a public hospital, where the doctors recommended surgery to prevent the injuries suffered in the fall from worsening. The surgery was not performed after she was found to be pregnant. Although a formal request was made to hospital directors for a therapeutic abortion, the procedure was denied. L.C. suffered a miscarriage, and it was only after this that her spinal operation was scheduled. The operation was performed almost three and a half months after it was recommended.

37. In its October 2011 report, the CEDAW Committee found that the Peruvian State had violated L.C.'s human rights and presented the State with recommendations for providing individual redress to L.C., as well as with the general recommendations described in the legal framework of this document. Since the CEDAW Committee's report, L.C.'s representatives have tried to start a constructive dialog with the Peruvian State to encourage implementation of the general and individual recommendations. Thus far, the Peruvian State has not provided individual redress to L.C., nor has it implemented general reparations.

3) *Other cases*

38. In addition to the cases of K.L. and L.C., two other cases exemplify the obstacles preventing access to therapeutic abortion, which has been legal since 1924. In 2010, the media revealed the case of a woman who needed treatment for cancer, yet her right to receive accurate information and terminate her pregnancy was not respected. Rather, she received chemotherapy during her pregnancy. This damaged her health and unnecessarily prolonged her pregnancy.<sup>62</sup> A case came to light in March of 2012 of a woman who was not properly cared for in a health center where she was initially evaluated.<sup>63</sup> Administrative proceedings put her life at risk and posed a serious and permanent risk to her health, and she therefore had to go to another public hospital for a therapeutic abortion.

39. According to information from the Mesa de Lucha contra la Pobreza, which processes data from MINSA, abortion is the third leading cause of maternal mortality in Peru (17.5%).<sup>64</sup> MINSA's General Epidemiology Directorate indicates that from January 2013 until the 15th week of this year, there have been 402 maternal deaths in Peru. It states that 30.8% (160) of them resulted from indirect causes - that is, illnesses that complicated the pregnancy or that worsened by the pregnancy and that could have been avoided if access to a therapeutic abortion had occurred.<sup>65</sup>

40. The Committee on Economic, Social and Cultural Rights, the Human Rights Committee,<sup>66</sup> the Committee against Torture,<sup>67</sup> and the States of the Universal Periodic Review Working Group<sup>68</sup>

have expressed concern at the high rate of abortion-related maternal deaths in Peru and have recommended approval of a national therapeutic abortion protocol.

4) *Status of the process for adopting a therapeutic abortion protocol*

41. Civil society organizations have taken legal action in their demands for information on the status of a therapeutic abortion protocol adoption by filing writs of protection of fundamental rights.<sup>69</sup> The Health Ministry is the body responsible for adopting the therapeutic abortion protocol. Toward doing so, it has drawn up a *Technical Guidance* and sought input on it from a number of government and non-government bodies. Despite a favorable response, the Ministry has yet to adopt it, as detailed hereinafter.

42. On March 25, 2013, the President of the Council of Ministers and the Minister of Women and Vulnerable Populations presented to the full Congress the Annual Report on progress toward compliance with Law 28983, the Equal Opportunities for Women and Men Act, reporting that MINSA had prepared a draft of the “*Technical guidance for comprehensive care in voluntary pregnancy termination for therapeutic reasons of a pregnancy of less than 22 weeks with informed consent*” and sending it to the Presidential Council of Ministers, MINJUS, MIMP, and the Office of the Ombudsman for their opinions. In May of 2013, the Ministry of Women and Vulnerable Populations, the Office of Ombudsman, and the Ministry of Justice and Human Rights<sup>70</sup> sent their opinion to MINSA, which stated that therapeutic abortion is fully constitutional and the State is constitutionally obliged to provide it.

43. On October 3, 2013, the Congress of the Republic called on the Health Ministry to resolve a series of issues surrounding its administration of the health care sector and she reported that the therapeutic abortion protocol “*has taken into account all the opinions from these sectors and is being assembled.*”<sup>71</sup> However in a letter dated January 24, 2014 (N° 203/2014-DGSP/MINSA) MINSA asked the obstetrics and gynecology professional organization (*Sociedad de Obstetricia y Ginecología*) and other medical organizations in Peru to issue technical opinions on the Technical Guidance. We view this situation as extremely serious because it will delay approval of the guide even further. The process has already taken more than 10 years, an unreasonable and disproportionate period of time for approving any MINSA regulation, especially one that has received favorable opinions on its viability from the Office of the Ombudsman, MINJUS, and the Ministry of Women and Vulnerable Populations (MIMP).

44. On March 14, 2014, the Ministry of Health informed the Plenary of the Congress of the Republic about the approval and implementation of the National Guidance to Therapeutic Abortion, noting that MINSA was “*making the final adjustments to the Guidance and that before the semester was over (June 2014) it would be approved and implemented throughout the country.*”<sup>72</sup> However, the Technical Guidance has not been approved yet.

45. The lack of implementation of a rule allowing therapeutic abortion and the obstacles for MINSA’s approval of the protocol violate women’s exercise of RR in the sense that abortion is one of the main causes of maternal mortality, and has a significant impact among adolescents. Limits on access to therapeutic abortion violate the right to substantive equality insofar as it is a service

that only women need. Limiting it means that women are not able to prevent a pregnancy in cases in which their lives or their physical, mental and social health is at risk. This is discriminatory and violates articles 1 and 2 of CEDAW. The violation of the right to health of these women evidences in the serious risks posed to their health and lives - including their life projects- by carrying these pregnancies to term. This is a violation of both Article 12 and CEDAW's General Comment No. 24. Reproductive autonomy (Article 16) and women's life projects are limited when they lose the ability to make decisions regarding their pregnancies and bodies, which violates their RR. ***We request the CEDAW Committee to reiterate to the Peruvian State its obligation to respect the right to therapeutic abortion that has been enshrined in the Penal Code since 1924, and also to recommend it to approve a protocol to facilitate access to therapeutic abortion.***

***2.2.2 The ban on legal abortion in cases of rape violates women's rights to health, sexual and reproductive rights, the right to substantive equality, and the right to live a life free from violence.***

46. Abortion in Peru is a crime in cases of rape, pursuant to articles 114 and 120 of the Penal Code.<sup>73</sup> The Human Rights Committee,<sup>74</sup> the Committee against Torture,<sup>75</sup> and the Committee on Economic, Social and Cultural Rights<sup>76</sup> have expressed concern at the criminalization of abortion in cases of rape in Peru. Likewise, in its report in the case of *L.C. versus Peru*, the CEDAW Committee recommended Peru to "review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse."<sup>77</sup> Despite the recommendations of the UN human rights treaty enforcement bodies, there has still been no legal initiative to decriminalize abortion in cases of rape.<sup>78</sup>

47. The absolute ban on abortion in cases of rape is very relevant, considering that sexual violence is part of daily life for Peruvian women (as noted in section 2.1.1) and that free access to the ECP is prohibited (see section 2.1 and 2.1.1). The ban on abortion in cases of rape violates women's right to substantive equality (Articles 1 and 2) for two reasons: First, as in the case of therapeutic abortion, women are the only ones who would benefit from this medical procedure. Banning it limits their access to health services in a discriminatory fashion. Second, girls, adolescent girls, and women represent the majority of victims of sexual violence in Peru. This is the result of gender stereotypes according to which women are sexual objects belonging to men and whose sexuality is broadly available. Placing limits on a health service that could, to a certain degree, reduce the resulting damage is discriminatory because it reinforces this stereotype, making women not only sexual objects, but also vehicles for reproduction, regardless of consent.<sup>79</sup>

48. The lack of a proper interpretation regarding the effects on health produced by pregnancies that result from rapes, limits women's right to health (Article 12 and General Comment No. 24) insofar as that first, the Peruvian State is hindering women's efforts to obtain their health objectives. Second, rape has a serious impact on the mental health of women, and a ban on abortion following rape does not take into account the right of Peruvian women to access therapeutic abortion when their health is in danger, including their mental health. Additionally, access to family planning is completely restricted, more so if one considers that the ECP is not even being provided in cases of rape. This ban also limits reproductive autonomy, forcing women to carry unwanted pregnancies to term because of the rape that caused them.

49. Finally, the ban on legal abortion in cases of rape limits women's right to live a life free from violence. As detailed in General Recommendation No. 24 and No. 19, States should establish health protocols that are appropriate for addressing violence against women. The ban on abortion in this case does not compensate for the damage, and puts women's health at risk. It even forces them to seek illegal abortions, violating the State's obligation to prevent coercion as regarding fertility and reproduction, pursuant to General Recommendation No. 19. For this reason, *we request the Committee to recommend that Peru to decriminalize abortion in cases of rape.*

***2.2.3 The Peruvian law requiring health professionals to violate professional secrecy by reporting women for the alleged crime of abortion violates their right to substantive equality, to health, reproductive rights, and to due process***

50. Article 30 of the General Health Law and Article 326 of the Procedural Criminal Code<sup>80</sup> require health care providers to report women for the alleged crime of abortion. This has meant that i) many women are reported, including women who have had miscarriages, and those who sought clandestine abortions and experienced complications; and ii) physicians take on the functions of a judge or prosecutor, functions that do not belong to them; this allows some to abuse their power and even prosecute cases of miscarriages.

51. In contrast to legal obligations, Articles 2, 38, and 138 of the Peruvian Political Constitution establish a duty to maintain professional secrecy that requires physicians to protect their patients' right to privacy.<sup>81</sup> These articles establish the Constitution's precedence over the legal provisions. In the case *De la Cruz Flores v. Peru*, the Inter-American Court of Human Rights found Peru responsible for having violated the legality principle by requiring doctors to report possible criminal conducts.<sup>82</sup> The Board of Physicians noted the inconsistency between the legal obligation and the Constitution, and had in fact presented Bill 3040/2008-CR on the subject, indicating that the medical community itself is asking that aforementioned Articles 30 and 326 be declared unconstitutional.

52. According to the Criminology Observatory of the Office of the Public Ministry, reports from the Prosecutor Support Information System and the Prosecutor Administration System indicate that 3271 criminal complaints over abortion were received nationally between 2009 and 2012.<sup>83</sup> The judicial branch reported that in 2012, there were 73 criminal complaints against women for self-practicing abortions and 32 convictions; 45 criminal complaints over consensual abortions and 44 convictions; 67 criminal complaints over nonconsensual abortions and 15 convictions; 23 criminal complaints against accomplices and five convictions; and 23 criminal complaints for unintentional abortion and eight convictions. In all, 231 criminal complaints over abortion of different kinds were filed, and 104 convictions were handed down for these crimes.<sup>84</sup>

53. Health care professionals reporting women for the crime of abortion, produce serious consequences for women's RR because: i) it violates the constitutional provisions establishing professional secrecy and respect for patient privacy, violating women's right to privacy and therefore their RR;<sup>85</sup> ii) it strengthens the gender stereotype that women's central function is reproductive, which violates women's right to substantive equality (Articles 1 and 2). This stigmatization leads the baseless persecution of many women who go to hospitals with obstetric

emergencies that have nothing to do with induced abortions,<sup>86</sup> violating women's right to presumption of innocence, and therefore due process (Article 15); iii) imprisoning women who have not committed a crime but who, as a result of an obstetric emergency, were prosecuted for having murdered their children is a due process violation (Article 15) given that no such crime took place. This also causes women who need emergency obstetric care to decline to seek it for fear of criminal prosecution, thus violating their right to receive good quality health services (Article 12 and General Recommendation No. 24). In light of the foregoing, *we request the CEDAW Committee to recommend Peru to revoke Articles 30 and 326, which require physicians to report patients for the alleged crime of abortion.*

### **2.3 Peru does not legally recognize that adolescents have sexual and reproductive rights, thereby violating their right to health, their sexual and reproductive rights, and their right to information**

54. Legal barriers currently prevent adolescents from accessing information and SRHS, resulting in an increase in teenage pregnancies, sexually transmitted diseases, adolescent maternal mortality, clandestine abortions, and suicide.

55. On December 12, 2012, the Constitutional Court issued judgment N° 00008-2012-PI/TC recognizing that adolescents between the ages of 14 and 18 have a right to sexual freedom. The State is therefore required to guarantee them their rights to information, health, and privacy in order for them to be able to exercise this right.<sup>87</sup> As a result, a bill is currently before the Congress of the Republic called the “New Code for Children and Adolescents” (Bill No. 495/2011-CR). The bill proposes a series of amendments, including the recognition of sexual and reproductive rights of adolescents between the ages of 14 and 18. However, the bill has passed through two congressional committees (Justice and Human Rights, and Women and Family) where versions approved with majority votes restrict adolescents’ access to SRHS, while also violating confidentiality, the right to privacy, and the right to information.

56. On May 30, 2012, the Justice and Human Rights Committee passed a version by majority vote<sup>88</sup> that modifies the bill and states that “*parents or guardians are primarily responsible for and in charge of providing sexual and reproductive information and education to the children and adolescents under their custody...*” Also, on June 17, 2013, the Women and Family Committee passed a version with a majority vote, indicating that parents or guardians are responsible for guiding adolescents’ sexual education, leaving the State in a secondary role as a parental assistant.

57. There is a barrier regarding the interpretation and enforcement of Article 4 of the General Health Act<sup>89</sup> that indicates that no one can be subjected to medical or surgical treatment without their prior consent, or the consent of the individual who is legally required to give it in cases of incompetence. Provisions of civil law establishing that adolescents are absolutely incompetent (Article 43 of the Civil Code) and that children between the ages of 16 and 18 are relatively incapability (Article 44 of the Civil Code) have been interpreted to mean that parents must accompany adolescents in order to have access to SRHS. Bill 2443/2012-CR is currently pending before the Health Committee of the Congress of the Republic. This bill would modify Article 4 of

the General Health Act to allow adolescents older than 14 to access sexual and reproductive health information and care without requiring parents or guardians to be present.

58. This interpretation of laws restricting adolescents' sexual and reproductive rights contradicts certain public policies currently in place, such as i) the National Plan of Action on Childhood and Adolescence 2012-2021, which calls for a **20%** reduction in the rate of teenage pregnancy; ii) the Multisectorial Plan for Teenage Pregnancy Prevention, which is the key to meeting the goals established in national and international law on reducing teenage pregnancy, and that do not establish an age range for access to SRHS, information, and access to contraceptive supplies; and iii) health sector rules on adolescent access to SRHS.<sup>90</sup>

59. The lack of information and sexual and reproductive health services for adolescents has a serious impact on their health and lives.<sup>91</sup> Out of students who have had sexual relations, 46.7% have their first sexual relations before the age of 14. Only **64% of school-age children who have sexual relations used some form of contraceptive in their last sexual encounter**, increasing the chance of pregnancy and sexually transmitted disease.<sup>92</sup>

60. Although there have been no significant changes in teenage pregnancy rates over the last 11 years, 13.9% of adolescents between the ages of 15 and 19 have been pregnant at some point - that is, 4,092 adolescents. Out of that total, 25.8% are already mothers and 3.5% are pregnant for the first time (97).<sup>93</sup> The number of adolescents between the ages of 15 and 19 who have had sexual relations went from 18.4% from 1991 to 1992, to 29.2% in 2012. The number of adolescents who became sexual active before the age of 15 went from 3.6% in 1991 to 1992, to 6% in 2012.<sup>94</sup> Although adolescents become sexually active early on, 45.8% of them do not use any method of contraceptive. The teenage pregnancy rate differs by place of residence: 32.2% of adolescents in Loreto have a child or are pregnant. In Arequipa, it is 5.2%.<sup>95</sup>

61. A total of 18.4% of adolescent girls who have a partner have family planning needs that are not being met. This is higher than the rate for other groups of adult women with a partner.<sup>96</sup> Sixty-eight point three percent of women under the age of 20 had unplanned pregnancies that they wanted to have later (57.9%) or did not want at all (8.4%).<sup>97</sup> A high percentage of adolescents have had and sexually transmitted disease (STD) or show symptoms of a possible STD, which contrasts with a high level of ignorance regarding said infections, since 46.6% do not know what STDs are. The largest portion of sexually active women interviewed who had STDs/discharge, sores, or blemishes were between the ages of 15 and 19 (12%).<sup>98</sup>

62. MINSA's General Epidemiology Directorate indicates a clear increase in abortions among adolescents: 18.2% (2005), 17.6% (2006), 20.06% (2007), and 20.18% (2008). In 2010, 7,000 adolescents were treated for incomplete abortions, 16% of the total of such treatments. Abortion is one of the main direct causes of maternal death in Peru, while among adolescent mothers it is the second most common cause.<sup>99</sup>

63. Adolescents' right to health (Article 12) is violated in that they do not have direct access to SRHS, representing a serious risk to health and life, as evidenced by high rates of teenage pregnancy, unsafe abortion, and maternal mortality, as well as alarming numbers of suicides. This

is the result of a lack of complete information regarding their sexuality and reproduction, which is compounded by limited access to contraception in general and the ECP in particular. This lack of access to information violates the right enshrined in articles 10 and 16 of the CEDAW, as well as the recommendation found in clause 25 of the 2007 Concluding Comments to Peru that specifically direct it to step up “*the provision of family planning information and services to women and girls, including emergency contraception, and to promote sex education widely, in particular in the regular education curriculum targeted at adolescent girls and boys, with special attention to the prevention of teenage pregnancies.*”<sup>100</sup> The lack of information and SRHS that limit the reproductive autonomy of adolescent girls and boys and provisions that limit their privacy because they do not have rights violate their SRR. ***We ask the CEDAW Committee to recommend Peru to recognize that adolescent boys and girls have sexual and reproductive rights, and to assist them by providing good information on the topic and a broad range of contraceptives.***

### 3. Questions and Recommendations

64. Considering the information presented in this report, we hope this Committee will consider requesting the State of Peru the following questions:

- What measures is it undertaking to ensure that all its health facilities provide victims of rape and sexual violence with access to emergency contraceptives?
- What measures is it undertaking to raise women’s awareness regarding their right to emergency contraceptives, particularly in cases of rape?
- Does the change in the Inter-American Court of Human Rights’ case law regarding the protection of the right to life affect the Constitutional Court’s decision on -to start with- distribution of the ECP free of charge through the public health system?
- What measures are being taken to guarantee the right to access therapeutic abortion?
- When will the therapeutic abortion protocol be adopted?
- What measures are being taken to guarantee the right to access abortion on the grounds of rape?
- What measures are being taken to reconcile legal and constitutional provisions on physicians’ duty to maintain professional secrecy?
- What measures are being taken to fulfill the National Plan of Action on Childhood and Adolescence 2012-2021 and the Multi-Sectorial Plan for the Prevention of Teenage Pregnancy with regard to increasing and guaranteeing access to adequate information and sexual and reproductive health services for adolescents, and reducing teenage pregnancy?
- What measures are being taken to guarantee adolescents their sexual and reproductive rights pursuant to the ruling of the Constitutional Court in its judgment in case file No. 00008-2012-PI/TC, and what measures are being taken to modify any legislation (such as the General Health Law, Article 4) that limit access to sexual and reproductive health services?

65. Based on the State of Peru’s violation of the rights to substantive equality (Articles 1 and 2), health (Article 12), information (Article 10 and 16), reproductive autonomy (Article 16) and the right to a life free from violence, which form part of reproductive rights and the right to due process (Article 15), contained in the CEDAW, general comments No. 19 and 24 of the CEDAW

Committee, as well as numeral 25 of its General Comments to Peru in 2007, we respectfully request that the CEDAW Committee make the following recommendations to Peru during its next session:

- i. Urge the Peruvian State to adopt all legislative or regulatory measures to allow it to provide emergency contraceptives free of charge through the public health system, especially to those women, adolescent girls, and girls who have been the victims of sexual violence.
- ii. Urge the Peruvian State to adopt all measures necessary to guarantee access to therapeutic abortion, including adoption of a national protocol that includes a broad interpretation of the right to health in its three dimensions (physical, mental, and social).
- iii. Reiterate to the State its duty under the CEDAW to amend its legislation to decriminalize abortion when pregnancy is the result of rape or non-consensual artificial insemination.
- iv. Urge the Peruvian State to amend its legislation so the Constitutional provisions protecting professional secrecy prevail, preventing health professionals from reporting women for the alleged crime of abortion.
- v. Urge the Peruvian State to address each of the problems arising as a consequence of adolescent boys' and girls' lack of rights with regard to the exercise of the sexual and reproductive rights (ex: high rates of teenage pregnancy and its relationship with sexual violence: limited access to contraceptives; sexually transmitted diseases; and adolescent maternal mortality, and its connection with clandestine abortion).
- vi. Recommend that Peru take all measures necessary to ensure its public policies on sexual education and access of adolescent boys and girls to sexual and reproductive health services are able to (or intended to) reduce pregnancy, sexually transmitted diseases, maternal mortality, clandestine abortions, and suicide in that population.

Respectfully,



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<sup>1</sup> Convention on the Elimination of All Forms of Discrimination against Women, adopted on Dec. 18, 1979, G.A. Res. 34/180, UN GAOR, 34<sup>th</sup> Sess., Supp. No. 46, U.N. Doc. A/34/46, 1249 U.N.T.S. 13 [hereinafter CEDAW].

<sup>2</sup> *Id.* Art. 1.

<sup>3</sup> *Id.* Art. 2.

<sup>4</sup> Plan of Action of the United Nations International Conference on Population and Development, UN Doc. A/CONF.171/13/Rev.1 (Sept. 5-13, 1994) [hereinafter CIPD].

<sup>5</sup> Center for Reproductive Rights, *Reproductive Rights are Human Rights* (2009) [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR\\_final.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR_final.pdf).

<sup>6</sup> Committee on the Elimination of Discrimination against Women, General Recommendation No. 24 (Article 12): *Women and Health*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 358, para. 14 and 15, U.N.Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, Gen. Recommendation No. 24]. [hereinafter CEDAW Committee, General Recommendation No. 24].

<sup>7</sup> *Idem*.

<sup>8</sup> *Id.* para. 15(b)).

<sup>9</sup> *Id.* para. 15(b)).

<sup>10</sup> *Id.* para. 15(b)).

<sup>11</sup> *Id.* para. 15(b)).

<sup>12</sup> Committee on the Elimination of Discrimination against Women, General Recommendation No. 19: *Violence against Women*, paras. 24, UN Doc. HRI/GEN/1/Rev. (1984) [hereinafter CEDAW Committee, General Recommendation No. 19].

<sup>13</sup> *Id.* para. 24 (m).

<sup>14</sup> *Idem*.

<sup>15</sup> *Id.* para. 24 (k and m).

<sup>16</sup> Committee on the Elimination of Discrimination against Women, *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Peru*, para. 24, U.N. Doc. CEDAW/C/PER/CO/6 (Jan. 15 to Feb. 2, 2007) [hereinafter CEDAW Committee, *Concluding Observations. Peru 2007*].

<sup>17</sup> *Idem*.

<sup>18</sup> *Id.* para. 25.

<sup>19</sup> *L.C. v. Peru*, Committee on the Elimination of Discrimination against Women. U.N. Doc. CEDAW/C/50/D/22/2009 (2011) [hereinafter *L.C. v Peru*].

<sup>20</sup> In its concluding observations to the Peruvian State, the CEDAW Committee also expressed concern that Peru had not implemented the recommendations of the Human Rights Committee in the case of K.L. and asked it to comply with them. (Committee on the Elimination of Discrimination against Women, *Concluding Observations: Peru*, para. 24-25, U.N. Doc. CEDAW/C/PER/CO/6 (2007)).

<sup>21</sup> Universal Declaration of Human Rights, *adopted on* Dec. 10, 1948, art. 8, 10 and 11, G.A. Res. 217A (III); International Covenant on Civil and Political Rights, *adopted on* Dec. 16, 1966, art. 9, 10 and 14, G.A. Res. 2200 A (XXI).

<sup>22</sup> Tribunal Constitucional [T.C.] [Constitutional Court], *Noviembre 13, 2006, Sentencia Expediente 7435-2006-PC/TC* (Perú).

<sup>23</sup> Tribunal Constitucional [T.C.] [Constitutional Court], *Octubre 16, 2009, Sentencia Expediente File 02005-2009-PA/TC* (Perú).

<sup>24</sup> MEDICATION OBSERVATORY, HEALTH MINISTRY OF PERU, *Levonorgestrel, available at* [http://observatorio.digemid.minsa.gob.pe/Precios/ProcesoL/Consulta/BusquedaGral.aspx?grupo=2402\\*3&total=1\\*1&con=0.75mg&ffs=3&ubigeo=15&cad=LEVONORGESTREL\\*0.75mg\\*Tableta\\*-\\*Capsula](http://observatorio.digemid.minsa.gob.pe/Precios/ProcesoL/Consulta/BusquedaGral.aspx?grupo=2402*3&total=1*1&con=0.75mg&ffs=3&ubigeo=15&cad=LEVONORGESTREL*0.75mg*Tableta*-*Capsula)

<sup>25</sup> *Id.*

<sup>26</sup> *Case of Artavia Murillo et al. ("In vitro fertilization") v. Costa Rica*, [hereinafter *Artavia Case*] Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-American Court (ser. C) No. 257, para. 264 (Nov. 28, 2012).

<sup>27</sup> MINSAs, *Servicios Diferenciados para la Atención Integral de Salud del Adolescente* [specialized services for comprehensive adolescent health care] (2009), *available at* [http://www.minsa.gob.pe/portada/ciudadanos/serv\\_diferenciados/Del\\_1\\_20\\_SD.pdf](http://www.minsa.gob.pe/portada/ciudadanos/serv_diferenciados/Del_1_20_SD.pdf).

<sup>28</sup> INSTITUTO NACIONAL DE ESTADÍSTICA E INFORMÁTICA (INEI) DE PERÚ, *ENCUESTA DEMOGRÁFICA Y DE SALUD FAMILIAR - ENDES CONTINUA 2010. INFORME PRINCIPAL*, 98 (Lima, INEI, 2011).

<sup>29</sup> Information provided by the National Personal Health Directorate of the Ministry of Health. Official Communication No. 1400-2013/MINSA.

<sup>30</sup> Emergency contraceptives have substantially less severe side effects, according to the Pan-American Health Organization. (PAHO, *Fact Sheet: Emergency Contraception in the Americas*).

<sup>31</sup> CEDAW Committee, *Concluding Observations: Mexico*, paras. 32-33, UN Doc. CEDAW/MEX/CO/6 (2006).

<sup>32</sup> World Health Organization, *Guidelines for Medico-Legal Care for Sexual Violence* (2003), *available at* <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>.

<sup>33</sup> In 2010, MINSAs reported 1,333 cases involving children between the ages of 10 and 14, and 1,191 cases of children between the ages of 15 and 19. Of these minors, 14% and 20% became pregnant, respectively. MINISTERIO DE SALUD, *VIOLENCIA CONTRA LAS MUJERES ADOLESCENTES*, (Lima, 2012).

<sup>34</sup> JARIS MUJICA, *VIOLACIONES SEXUALES EN PERÚ 2000 – 2009. UN INFORME SOBRE EL ESTADO DE LA SITUACIÓN 66* (Lima, Promsex, 2011) *taken from* MESA DE VIGILANCIA CIUDADANA EN DERECHOS SEXUALES Y REPRODUCTIVOS, *CONFERENCIA INTERNACIONAL SOBRE LA POBLACIÓN Y EL DESARROLLO CAIRO + 20: HACIA UNA LECTURA DE LA PLATAFORMA PARA LA ACCIÓN DE CAIRO 20 AÑOS EN PERÚ* (1994 – 2014) 16 (Lima, 2013).

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> Chávez Alvarado, Susana (ed.), *Apuntes para la acción: El derechos de las mujeres a un aborto legal*, Lima, Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos – PROMSEX (2007) at 53-54, <http://www.promsex.org/docs/Publicaciones/apuntesabortolegalsegedicion.pdf>.

<sup>38</sup> INSTITUTO NACIONAL DE ESTADÍSTICA E INFORMÁTICA (INEI) DE PERÚ, *Encuesta Demográfica y de Salud Familiar 2011* [demographic and family health survey], Lima, INEI (2012).

<sup>39</sup> Health Ministry and UNFPA. *Hoja de datos 3. Violence against women journalists* Lima: Health Ministry and UNFPA (2012). The connection between sexual violence and pregnancy is deepened by lack of access to contraceptive methods, as Peru's Constitutional Court has banned national distribution of the ECP free of charge since 2009.

<sup>40</sup> *Op. Cit.* Artavia Case, *supra* note xxvi, para. 264. “Moreover, it can be concluded from the words ‘in general’ that the protection of the right to life under this provision is not absolute, but rather gradual and incremental according to its development, since it is not an absolute and unconditional obligation, but entails understanding that exceptions to the general rule are admissible.”

<sup>41</sup> Mujica, Jaris; Zevallos, Nicolás; Vizcarra, Sofía, *Estudio de Estimación de impacto y prevalencia de la violación sexual de mujeres adolescentes en un distrito de la Amazonía peruana* [Study Estimating the Impact and Prevalence of Rape of Adolescent Women in one District in the Peruvian Amazon], Pontificia Universidad Católica del Perú, PROMSEX (2009).

<sup>42</sup> *Id.*

<sup>43</sup> INSTITUTO NACIONAL DE ESTADÍSTICA E INFORMÁTICA (INEI) DE PERÚ, *Encuesta Demográfica y de Salud Familiar* (Demographic and Family Health Survey) 2013, 328-357 (Lima, INEI, 2014) [Hereinafter INEI 2014].

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> The causes of maternal mortality are associated with a lack of access to legal abortion services in Peru. Rates are highest in rural and poor areas. (MESA DE LUCHA CONTRA LA POBREZA, PROGRAMA PRESUPUESTAL “SALUD MATERNA NEONATAL” (2013), REPORTE DE SEGUIMIENTO CONCERTADO: BALANCE DE EJECUCIÓN, 7 (2012) taken from MESA DE VIGILANCIA CIUDADANA EN DERECHOS SEXUALES Y REPRODUCTIVOS, CONFERENCIA INTERNACIONAL SOBRE LA POBLACIÓN Y EL DESARROLLO CAIRO + 20: HACIA UNA LECTURA DE LA PLATAFORMA PARA LA ACCIÓN DE CAIRO 20 AÑOS EN PERÚ (1994 – 2014) 24 (Lima, 2013)).

<sup>47</sup> If women have access to emergency contraceptives, they will likely not have to turn to abortion as often after falling victim to sexual violence. The State has similar obligations regarding adolescent and girl victims of rape and incest under the Convention on the Rights of the Child (Convention on the Rights of the Child, adopted on Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44<sup>a</sup> Sess., Sup. 49, en 166, arts. 19, 34, 37(a), 39, UN Doc. A/44/49 (1989)).

<sup>48</sup> *Op. Cit. supra* note 31.

<sup>49</sup> Committee against Torture, *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).

<sup>50</sup> See: CEDAW Committee, *Concluding observations: Colombia*, para. 393, U.N. Doc. A/54/38 (1999); *Jordan*, paras. 180 - 181, U.N. Doc. A/55/38 (2000); *Myanmar*, para. 129, U.N. Doc. A/55/38 (2000); *Nepal*, para. 147, U.N. Doc. A/54/38 (1999); *Panama*, para. 201, U.N. Doc. A/53/38/Rev.1 (1998); *Venezuela*, para. 236, U.N. Doc. A/52/38/Rev.1 (1997).

<sup>51</sup> CÓDIGO PENAL (Criminal Code) [C.P.] Art. 19.- Therapeutic abortion. “Abortion performed by a physician with the consent of the pregnant woman or her legal representative, should she have one, is not a crime if it is the only way to save the pregnant woman’s life or prevent serious and permanent harm to her health.” (Personal translation).

<sup>52</sup> Therapeutic abortion is necessary i) in a number of pregnancies that take place at the same time as other illnesses and worsen the woman’s health, putting her at risk, and ii) when illnesses emerge during a pregnancy that complicate it and put the woman’s life and physical and mental health at risk.

<sup>53</sup> See: World Health Organization, *Safe abortion: technical and policy guidance for health systems*, available at [http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf)

<sup>54</sup> Ministry of Health, *Guías Nacionales de Atención Integral de la Salud Sexual y Reproductiva* [National guidelines for comprehensive sexual and reproductive health care]. Lima: MINSA (2004).

<sup>55</sup> Plan Nacional de Igualdad de Género 2012-2017 [National Gender Equality Plan 2012 – 2017] (2012), [http://www.mimp.gob.pe/files/mimp/planes/planig\\_2012\\_2017.pdf](http://www.mimp.gob.pe/files/mimp/planes/planig_2012_2017.pdf).

<sup>56</sup> Office of the Ombudsman, Women’s Rights Unit, *Primer Reporte sobre el cumplimiento de la Ley de Igualdad de Oportunidades entre Mujeres y Hombres* [First report of compliance with the Equal Opportunities for Men and Women Act] Unit Report No. 001-2008-DP/ADDM. Lima: Office of the Ombudsman, at 21, 28, 39 (2008); Office of the Ombudsman, Women’s Rights Unit, *Segundo Reporte sobre el cumplimiento de la Ley de Igualdad de Oportunidades entre Mujeres y Hombres* [Second report of compliance with the Equal Opportunities for Men and Women Act] Unit Report No. 001-2009-DP/ADDM, Lima, Office of the Ombudsman (2009) at 98-100, <http://www.defensoria.gob.pe/informes-publicaciones.php>.

<sup>57</sup> Office of the Ombudsman, *Décimo Informe Anual de la Defensoría del Pueblo (enero-diciembre 2006)* [10th annual report of the Office of the Ombudsman, January-December 2006], at 176-177 (2006); Office of the Ombudsman, *Decimoprimer Informe Anual de la Defensoría del Pueblo (enero-diciembre 2007)* [11th annual report of the Office of the Ombudsman, January-December 2007], at 69-170 (2007); Office of the Ombudsman, *Decimosegundo Informe Anual de la Defensoría del Pueblo (enero-diciembre 2008)* [12th annual report of the Office of the Ombudsman, January-December 2008], at 143 and 156 (2008); Office of the Ombudsman, *Décimo tercer Informe Anual de la Defensoría del Pueblo (enero-diciembre 2009)* [13th annual report of the Office of the Ombudsman, January-December 2009] (2009) at 155, <http://www.defensoria.gob.pe/informes-publicaciones.php>.

<sup>58</sup> K.L. v. Peru, Human Rights Committee, 85 session, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

<sup>59</sup> The organizations Demus, CLADEM, and CRR have met regularly with MINSA, the Justice Ministry, the Foreign Affairs Ministry, and the Ministry of Women and Social Development to urge compliance with the recommendation to provide individual reparations to K.L., as well as with the general non-repetition measures. The Human Rights Committee has been informed of the response to the case, as has the public. Demus has also repeatedly asked MINSA to approve a protocol for therapeutic abortion, but received no response. It has also demanded that the Specialized Supranational Office of the Public Ombudsman of the Justice Ministry publish the Human Rights Committee's report (No. 1153/2003). The Office of the Comptroller has responded that the State's Legal Defense Council is weighing the request. (DEMUS, *Denegación de aborto terapéutico en caso de embarazo de feto anencefálico Caso K.L* [Denial of therapeutic abortion in case of pregnancy with anencephalic fetus: The case of K.L.] (2003) available at <http://www.demus.org.pe/caso5.php>)

<sup>60</sup> In March 2012, the "Judicial Branch admit(ted) KL's writ of constitutional protection against the Health Ministry and the Justice Ministry in respect for her right to international jurisdiction in order to comply with the United Nation's findings against the Peruvian State for having failed to provide legal abortion services" ( DEMUS, *Poder Judicial admite demanda de amparo de KL contra el Ministerio de Salud y el Ministerio de Justicia* [Judicial Branch admits KL's writ of constitutional protection against the Health Ministry and the Justice Ministry] (March 21, 2012) available at: <http://www.demus.org.pe/notihome/notihome01.php?noti=192>).

<sup>61</sup> *Op. Cit.* L.C. v. Peru, *supra* note xix.

<sup>62</sup> Toro, Claudia, *Me negaron aborto terapéutico*, LAREPUBLICA.PE (Oct. 9, 2010), available at <http://www.larepublica.pe/imprensa/me-negaron-aborto-terapeutico-2010-10-09>.

<sup>63</sup> Caretas, *Protocolo Que No Espera*, available at <http://www.caretas.com.pe/Main.asp?T=3082&S=&id=12&idE=1004&idSTo=0&idA=57425>.

<sup>64</sup> *Op. Cit. supra* note 46.

<sup>65</sup> Ministerio de Salud, Dirección General de Epidemiología, *Situación semana 52 de 2013 a semana 15 de 2014*, <http://www.dge.gob.pe/portal/docs/vigilancia/sala/2014/SE17/mmaterna.pdf> and [http://www.dge.gob.pe/portal/index.php?option=com\\_content&view=article&id=424](http://www.dge.gob.pe/portal/index.php?option=com_content&view=article&id=424).

<sup>66</sup> Human Rights Committee, *Concluding observations on the fifth periodic report of Peru*, U.N. Doc. CCPR/C/PER/CO/5 (2013).

<sup>67</sup> Committee against Torture, *List of Issues Prior to Sixth Periodic Report on Peru*, U.N. Doc. CAT/C/PER/Q/6 (2012).

<sup>68</sup> Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Peru*, U.N. Doc. A/HRC/22/15 (2012).

<sup>69</sup> On August 8, 2013, the Fifth Constitutional Court of Lima admitted a writ of constitutional protection on the grounds of the right to petition against MINSA for its having failed to respond to requests for information submitted in November 2007, July and October 2008, and January and May 2009 regarding approval of the therapeutic abortion protocol. In this ruling, the court ordered "the Health Ministry to respond in writing to the citizen request on approval of the therapeutic abortion protocol" (personal translation). (Demus, *MINSA ordered to respond regarding therapeutic abortion protocol must end its six years of silence, a step forward in the report in the case of KL* (August 13, 2013), available at <http://www.demus.org.pe/notihome/notihome01.php?noti=216>).

<sup>70</sup> Promsex, *Aborto terapéutico es legal en Perú e implementación de su protocolo obligatoria, indica MINJUS* (Feb. 6, 2014) available at <http://www.promsex.org/notas-de-prensa/item/2259-aborto-terapeutico-es-legal-en-el-peru-e-implementacion-de-su-protocolo-obligatoria-indica-minjus.html>.

<sup>71</sup> Congreso de la República del Perú, *Diario de Debates del Congreso de la República, Sesión N° 11 del 03 de octubre de 2013*, [http://www2.congreso.gob.pe/Sicr/DiarioDebates/Publicad.nsf/SesionesPleno/05256D6E0073DFE905257BFA00538649/\\$FILE/PLO-2013-11.pdf](http://www2.congreso.gob.pe/Sicr/DiarioDebates/Publicad.nsf/SesionesPleno/05256D6E0073DFE905257BFA00538649/$FILE/PLO-2013-11.pdf).

<sup>72</sup> Congreso de la República del Perú, *Diario de Debates del Congreso de la República, Sesión N° 3 del 14 de marzo del 2014*, [http://www2.congreso.gob.pe/Sicr/DiarioDebates/Publicad.nsf/SesionesPleno/05256D6E0073DFE905257C9C001E23CA/\\$FILE/SLO-2013-3.pdf](http://www2.congreso.gob.pe/Sicr/DiarioDebates/Publicad.nsf/SesionesPleno/05256D6E0073DFE905257C9C001E23CA/$FILE/SLO-2013-3.pdf).

<sup>73</sup> CÓDIGO PENAL (Criminal Code) [C.P.] Art. 114 "Self-Abortion: A woman who causes her own abortion or consents to such practice by a third party shall be punished with a prison term of no longer than two years or with community service equivalent to between 52 and 104 working days" (personal translation).

Art. 120- "Abortion of pregnancy resulting from rape and for reasons of eugenics. Abortion shall be punished with a prison term of no more than three months: 1. When the pregnancy is the result of rape outside of marriage or nonconsensual artificial insemination outside of marriage, as long as the facts have been reported or investigated, at the very least by the police; or 2. When it is likely that the fetus will have serious physical or mental defects at birth, as diagnosed by a physician".

<sup>74</sup> Human Rights Committee, *Concluding Observations: Peru*, U.N. Doc. CCPR/C/79/Add.72, para. 22 (1996). Human Rights Committee, *Concluding observations: Peru*, U.N. Doc. CCPR/CO/70/PER, para. 20, (2000).

<sup>75</sup> Committee Against Torture, *Conclusions and Recommendations: Peru*, U.N. Doc. CAT/C/PER/CO/4, para. 23 (2006).

<sup>76</sup> Committee on Economic, Social and Cultural Rights, *Concluding Observations: Peru*, U.N. Doc. E/C.12/PER/CO/2-4, para. 21 (2012).

<sup>77</sup> *Op. Cit.* L.C. v. Peru, *supra* note 19.

<sup>78</sup> In October of 2009, the last Special Committee for Revision of the Penal Code in the Draft Bill of the new Penal Code approved decriminalization of termination of pregnancy in cases of rape, nonconsensual artificial insemination or transfer of a fertilized egg, and fetal deformities, as long as a criminal complaint has been filed as regarding the facts; however, it was not brought for debate in the Congress of the Republic.

<sup>79</sup> *Op. Cit.* L.C. v. Perú, *supra* note 19, para. 300.

<sup>80</sup> L. 26842, Julio 9, 1997, DIARIO OFICIAL [D.O.] (Peru) Art. 30.- “When the physician providing medical attention notes signs of criminal abortion, the physician is required to call this fact to the attention of the competent authority” (personal translation). CÓDIGO DE PROCEDIMIENTO PENAL (Criminal Procedural Code) [C.P.P.] Art. 326- “Authority and obligation to report: 1. All individuals have the authority to report criminal acts to the corresponding authority, as long as the exercise of the criminal action to prosecute them is public. 2. However, the following are required to file a criminal complaint: a) Those who are required to do so by law. Health professionals are especially required to do so with regard to crimes they learn about while performing their duties, as are educators regarding the crimes that may take place in educational facilities. [...]” (personal translation).

<sup>81</sup> CONSTITUCIÓN POLÍTICA DE PERÚ [C.P.] Art. 2- “Everyone has the right... (18) to keep their political, philosophical, religious or other convictions confidential, as well as to maintain professional confidentiality” (personal translation).

<sup>82</sup> “...physicians have a right and an obligation to protect the confidentiality of the information to which, as physicians, they have access”. Case of *De la Cruz Flores v. Peru*. Merits, Reparations and Costs. Judgment, Inter-American Court (ser. C) No. 115, para. 101 (Nov. 18, 2004).

<sup>83</sup> The information provided by the Judicial Branch does not differentiate between women, physicians, and individuals who offer abortion services. (Criminality Observatory of the Office of the Public Inspector, *Chart No. 1. Crimes of abortion recorded by the Office of the Public Inspector according to prosecutorial district, geographical area, and year*, Lima (2013).

<sup>84</sup> General Secretariat of the Judicial Branch, *Official Communication N° 123-2013-SG-GG/PJ. Requests for access to public information on criminal complaints, records, and convictions for the crime of abortion during 2012*. Lima (2013).

<sup>85</sup> *Op. Cit.* Case of *De la Cruz Flores v. Peru*, *supra* note 82, para. 101.

<sup>86</sup> THE CENTER FOR REPRODUCTIVE RIGHTS AND THE AGRUPACIÓN CIUDADANA POR LA DESPENALIZACIÓN DEL ABORTO TERAPÉUTICO, ÉTICO Y EUGENÉSICO, REPORT, “EXCLUIDAS, PESEGUIDAS, ENCARCELADAS EL IMPACTO DE LA CRIMINALIZACIÓN ABSOLUTA DEL ABORTO EN EL SALVADOR” 61 (2013).

<sup>87</sup> “As regards the right to sexual freedom as part of the right to free development of personality, the Constitutional Court finds that (...) minors between the ages of 14 and 18 can also have that right.” (personal translation). Tribunal Constitucional [T.C.] [Constitutional Court], Diciembre 12, 2012, Sentencia Expediente 00008-2012-PI/TC (Perú) para. 22.

<sup>88</sup> The working committees of the Congress of the Republic issue majority, minority, and unanimous recommendations on bills. The majority recommendations must be signed by at least a majority of the members of Congress present at the time the matter under discussion is approved.

<sup>89</sup> *Op. Cit.* L. 26842, *supra* note 80.

<sup>90</sup> Res. del Ministerio de Salud de Perú (MINSa), N° 731-2003, *Directiva “Sistema de atención para el tratamiento antirretroviral en los niños infectados por el virus de la inmunodeficiencia humana”*; Res. del Ministerio de Salud de Perú (MINSa) N° 668-2004 *Guías Nacionales de atención integral de la Salud Sexual y Reproductiva*; Res. del Ministerio de Salud de Perú (MINSa) N° 107-2005, *Lineamientos de política de salud de los/las adolescentes*; Res. del Ministerio de Salud de Perú (MINSa) N° 536-2005, *Norma Técnica de Planificación Familiar*; Res. del Ministerio de Salud de Perú (MINSa) N° 583-2005, *Protocolos de Consejería para la atención integral del adolescente*; Res. del Ministerio de Salud de Perú (MINSa) N° 633-2005, *Norma Técnica para la Atención Integral de Salud de la Etapa de Vida Adolescente*; Res. del Ministerio de Salud de Perú (MINSa) N° 290-2006, *Manual de Orientación y Consejería en Salud Sexual y Reproductiva*; Res. del Ministerio de Salud de Perú (MINSa) N° 328-2006, *Documento Técnico “Centros de Desarrollo Juvenil, un Modelo de Atención Integral de salud para Adolescentes”*; Res. del Ministerio de Salud de Perú (MINSa) N° 353-2006, *Documento Técnico “Implementación de Redes Locales Multisectoriales de Desarrollo Juvenil”*; Res. del Ministerio de Salud de Perú (MINSa) N° 1077-2006, *Orientación para la atención integral de salud del adolescentes en el primer nivel de atención*; Res. del Ministerio de Salud de Perú (MINSa) N° 278-2008, *Documento Técnico “Adecuación cultural de la orientación/consejería en salud sexual y reproductiva”*; Res. del Ministerio de Salud de Perú (MINSa) N° 264-2009, *Documento Técnico “Consejería en ITS/VIH y SIDA”*; Res. del Ministerio de Salud de Perú (MINSa) N° 636-2009, *Análisis de Situación de Salud de las y los Adolescentes - Ubicándolos y Ubicándonos*.

<sup>91</sup> In the same sense, in 2012, the DESC Committee (48th Session, April 30 to May 2012) expressed concern over low rates of contraceptive use, rates of teenage pregnancy, and access to sexual and reproductive health services for adolescents. However, several years later, its recommendations still have not been implemented. (Committee on Economic, Social and Cultural Rights, *Concluding Observations: Perú*, U.N. Doc. E/C.12/PER/CO/2-4 (April 30 to May 2012)).

<sup>92</sup> Health Ministry, General Directorate for the Advancement of Health, *Results of Comprehensive School Survey - Peru 2010*, Lima (2011), at 47.

<sup>93</sup> *Op. Cit.* INEI 2014, *supra* note 43 at 121.

<sup>94</sup> *Id.* at 166.

<sup>95</sup> *Idem.*

<sup>96</sup> *Id.* at 186.

<sup>97</sup> *Id.* at 195.

<sup>98</sup> *Id.* at 332.

<sup>99</sup> La Mesa de Concertación de Lucha contra la Pobreza, which reports using data it has processed from MINSa’s National Sexual and Reproductive Health Strategy (2011), <http://www.unfpa.org.pe/publicaciones/publicacionesperu/UNFPA-AECID-Hoja-de-Datos-2.pdf>.

<sup>100</sup> *Id.* Para. 25.