



My Rights, and My Right to Know

Lack of Access to Therapeutic Abortion in Peru

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I. Summary and Key Recommendations

In Peru interrupting a pregnancy is legal in order to save the life of the woman or to avoid serious and permanent damage to her health. Other forms of procuring or performing an abortion are criminal offenses that can result in prison terms and fines for pregnant women and girls, and for their healthcare providers.

In practice there are significant barriers to accessing lawful abortions. Legal “therapeutic” abortion—abortion needed to save the life of the woman or avoid damage to her health—is a vital public health service, and denial of this service jeopardizes a broad range of fundamental human rights of women and girls. This report examines the obstacles to accessing therapeutic abortion in Peru’s public health system.

Women and girls confronting crisis pregnancies that could kill them or permanently harm their health have an urgent need to be able to access safe, dignified, affordable abortions. Human Rights Watch documented just the opposite in Peru. Women, adolescent girls, health providers, and government officials all described a situation where women and adolescent girls who were clearly eligible for legal abortions were refused or unable to access the service, with terrible consequences to their mental and physical health.

There is no reliable national data on the number of therapeutic abortions performed in Peru. There are no national-level guidelines on eligibility or administrative procedures for healthcare practitioners to respond to girls and women in need of a therapeutic abortion. It is impossible to ascertain accurately how many therapeutic abortions are actually being performed, and even the Ministry of Health recognizes that its own estimates are not reliable. Given the obstacles to accurately defining, accessing, and registering therapeutic abortions described in this report, it is likely that the performance of therapeutic abortions is both underestimated and underutilized.

The government has done little to ensure that therapeutic abortions are available when needed, and has actively obstructed some initiatives intended to improve access. Major obstacles to accessing therapeutic abortion in Peru include: (1) vague and restrictive laws and policies on therapeutic abortion, including ambiguity as to whether harm to mental health is considered a ground for a legal abortion; (2) the absence of a national protocol on eligibility and administrative procedures for therapeutic abortion; (3) ad hoc approval and referral procedures for legal abortions, and lack of accountability for failure to approve legal abortions; (4) healthcare providers' fear of prosecution or malpractice lawsuits; (5) the cost of abortion procedures and coverage for therapeutic abortion under the social insurance system; and (6) low levels of awareness among women and healthcare providers about exceptions to the criminalization of abortion.

For many women and girls, the decision to undergo a therapeutic abortion is not an easy one to make, even with the expert counsel and advice of physicians. When policy makers and medical authorities make this decision for women and girls even more difficult, and complicate access to legal abortion services and information about them, the number of abortions is not reduced. Abortion care simply goes underground. For those with enough money and information, clandestine abortions may be performed in relatively safe circumstances in private clinics or even at home with studied pharmaceutical methods. For the many poor women and girls in Peru, the abortions are often induced by unqualified, unregulated practitioners or even by themselves through home remedies. Practices of clandestine abortion vary and some can carry grave risks, contributing to Peru's high maternal mortality and morbidity rates.

Peru has an obligation under international human rights standards to ensure that access to therapeutic abortion in the public health system is a reality. The drastic restrictions on abortion generally in Peru, and the failure to ensure access to even abortions authorized by law, can lead to violations of the fundamental human rights of women including the rights to health, life, non-discrimination, physical integrity, and freedom from cruel, inhuman, or degrading treatment. International human rights authorities, including the United Nations Human Rights Committee, the UN special rapporteur on the right to health, and the UN Committee on the Elimination of

Discrimination against Women have repeatedly and forcefully called on Peru to eliminate barriers to therapeutic abortion and to ensure compliance with their human rights obligations.

Ensuring access to therapeutic abortion in Peru is possible with political will. Yet Peru continues to neglect this issue, putting the lives of women and girls in jeopardy. Evidence-based technical protocols for the management of legal pregnancy termination are being shuffled within the Peruvian bureaucracy with little accountability or respect for time limits, while public hospitals continue to operate in the void; some lucky women will be assisted, but many others in medical need will not.

Peru should act immediately to remedy this situation. It should:

- As a first and crucial step, adopt a clear medical protocol approved at the national level to standardize administrative procedures and ensure access to quality therapeutic abortion services. The protocol should guarantee that the decision making process is timely; that the pregnant woman has the right to be heard in person and have her views considered; and that the grounds for decision making are stipulated.

Absent a national-level protocol, it is firmly within the mandate of the regional and central ministries of health to approve hospital protocols and issue respective guidelines on standard medical procedures, to clarify any legal or medical ambiguity, and ensure the highest quality of care in the public healthcare sector.

Peru should also:

- Rescind the law that requires healthcare providers to report cases of suspected induced abortions to the police;
- Strengthen data collection and analysis at the regional and national levels;
- Inform women, health practitioners, and the general public of the legal standards for abortions authorized by law.;
- Ensure that social insurance schemes cover costs associated with therapeutic abortion;

- Monitor and investigate instances in which healthcare providers refuse to provide therapeutic abortions to eligible women and girls, and discipline them appropriately; and
- Consider working toward abortion law reform to ensure that all women are able to decide freely on matters relating to reproduction.

While it is not the subject of this report, Human Rights Watch also believes that ongoing public debate in Peru about the broader issue of women's right to abortion is crucial to ensuring women's human rights. Authoritative interpretations of international human rights law support the right of all women to decide independently in matters related to abortion, without interference from the state or others. Only through legal reform that does not criminalize access to health care, including abortion, can women make free and informed decisions about the best ways to protect their health and well-being and decide if and when to have children and found a family.

II. Methodology

This report is based on field research conducted in Lima, Peru, in June, July, and December 2007 by two Human Rights Watch researchers.

Human Rights Watch conducted individual interviews and group discussions with 77 key individuals about access to reproductive health services, primarily therapeutic abortion, in the public health sector in the capital city. The interviews were conducted in Spanish and, in most cases, at the subject's workplace. Those interviewed included: 10 women who have experienced an abortion or crisis pregnancy;¹ 26 healthcare providers, including public hospital directors and employees, private practitioners, and heads of professional medical societies; more than 20 civil society advocates, mostly leaders in the women's rights movement; 12 government officials from the Ministry of Health, the National Ombudsman Office for Human Rights, the Ministry of Women and Social Development, and the Presidential Council of Ministers; and three officials within the United Nations system. Interviews with representatives of international donor organizations, such as the Spanish Agency for International Cooperation and the United States Agency for International Development, and several others were conducted by telephone.

The interviews were completely voluntary with participants' verbal informed consent obtained prior to the interview. Except for several highly publicized cases, the names of all women and some of the other interviewees for this report have been disguised with initials in the interest of the privacy and security of the individuals concerned. There was no compensation awarded for the interviews, but for some of the women interviewed, reimbursement for transportation to and from the interview was provided.

Lima has a population of more than 7.8 million in a country of 28.7 million inhabitants (that is, the capital accounts for 27 percent of the national population). Peru is in the process of decentralizing its health sector. In the meantime, tertiary-

¹ In two cases, the mothers were interviewed about their daughters' abortions, rather than the daughters, due to the daughters' hospitalization and migration, respectively.

and higher-level public healthcare services in the country are still mostly centralized in Lima due to inadequate distribution of resources, long distances, and difficult terrain throughout the country. The largest number of specialized healthcare services—public and private—is offered in Lima. Therefore, the services represented here cannot be generalized, but may, in fact, represent a best-case scenario for the urban areas of the country as a whole.

Human Rights Watch investigated what happens to women in the public healthcare sector, as the state is obligated to provide services for the poorest and most vulnerable. A limitation of the research was the difficulty in identifying women who had sought or procured a therapeutic abortion in the public health system, in part, because there were so few. The lack of accurate medical records, misclassification of diagnoses, confusion about what constitutes a legal or therapeutic abortion, furtiveness, and stigma surrounding the procedure compounded the difficult search.

III. Background

Maternal mortality and morbidity in Peru

Peru is a developing country with the second highest maternal mortality ratio in Latin America after Bolivia. Peru receives assistance from foreign governments and donor agencies but does not designate enough of its resources to women's health, including combating maternal mortality and morbidity.² According to the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), there are 410 maternal deaths per 100,000 live births in Peru every year,³ although these figures are higher than official government estimates.

Peru's restrictive abortion laws and policies, which criminalize abortion generally and provide only vague guidance on when an abortion may be procured lawfully, also contribute to maternal death and disability. Approximately 16 percent of maternal deaths in Peru are attributable to unsafe abortions,⁴ but accurate estimations are difficult because the unsafe abortions are clandestine. Many of the deaths and injuries from unsafe abortion are avoidable given that abortion, when legal, accessible, and practiced by trained providers with proper equipment and under sanitary conditions, is a very safe medical procedure, and generally far safer than childbirth.⁵

² One overarching problem is the amount of health spending in Peru, a figure that has decreased proportionately as a percentage of GDP in recent years at the same time that overall GDP increased, indicating that cuts in health spending were not due to a lack of available resources. According to an extensive report on maternal mortality by Physicians for Human Rights, "by objective measures, Peru is not currently devoting the maximum extent of available resources to realize the right to health, or to address maternal health concerns in particular. As compared with other countries with comparable GDP per capita, Peru's health system faces a dramatic shortage of funding." Physicians for Human Rights (PHR), *Deadly Delays: Maternal Mortality in Peru: A Rights-Based Approach to Safe Motherhood* (PHR: Cambridge, MA, 2007), p. 9.

³ United Nations Children's Fund (UNICEF), "At a Glance: Peru," undated, http://www.unicef.org/infobycountry/peru_statistics.html#24 (accessed June 25, 2007).

⁴ Luis Távara et al., "Current state of maternal mortality in Peru" ("Estado actual de la mortalidad maternal en Perú"), *Gynecology and Obstetrics (Peru)*, vol. 45, no. 1 (1999), pp. 38-42.

⁵ Up to the sixteenth week of pregnancy, abortion is 10 times safer than childbearing, and the risk of death from abortion remains lower than the risk of death from childbirth throughout most of the second trimester. Rachel N. Pine, "Achieving Public Health Objectives through Family Planning Services," *Reproductive Health Matters*, no. 2 (November 1993), p. 79.

Abortion prevalence and conditions warranting therapeutic abortion

Based on a study conducted by Flora Tristan and Pathfinder International, the estimated number of all abortions performed annually in Peru is 352,000, or one abortion for each live birth.⁶ The estimate suggests that each year five percent of Peruvian women of reproductive age are likely to undergo an abortion. In Lima that number approximates to 100,000 abortions annually.⁷ It is unclear how many of those might have been eligible for a legal therapeutic abortion instead.

Despite the many barriers to accessing legal therapeutic abortions in Peru's public health system and the dearth of reliable records, the numbers of such procedures appear to have been rising. At the request of Human Rights Watch, the Ministry of Health sent a file of national statistics on therapeutic abortions performed in public hospitals for the last five years available. Just for the greater Lima metropolitan area, the estimated number of therapeutic abortions has seemingly shown a dramatically rising trend—26 in 2002, 41 in 2003, 24 in 2004, 215 in 2005, and 699 in 2006.⁸ For one hospital alone, the number of abortions listed as “medical abortions” rose from three in 2002 to 137 in 2005 to 687 in 2006.⁹ But rather than a drastic growth in the number of abortions performed, these statistics illustrate the erratic tallying and classification of legal abortions performed in the public sector. The tally includes a number of lawful medical procedures that are emergency obstetric services.¹⁰ Furthermore, these figures are still below the estimated level of necessary interventions.

There are no reliable data collection procedures in Peru on the number of severe or fatal complications during pregnancy for the pregnant woman or the fetus. Based on

⁶ Delicia Ferrando, *Clandestine Abortion in Peru: Facts and Figures 2002* (Lima: Centro de la Mujer Peruana Flora Tristan and Pathfinder International, April 2002), p. 26.

⁷ *Ibid.*, p. 27.

⁸ Email communication from Marco Polo Bardales Espinoza, General Office of Statistics and Information (Oficina General de Estadísticas e Información), Ministry of Health, to Human Rights Watch, October 16, 2007.

⁹ Email communication from Marco Polo Bardales Espinoza to Human Rights Watch, April 4, 2008.

¹⁰ Human Rights Watch telephone interview with Marco Polo Bardales Espinoza, Ministry of Health, Lima, March 2008. Further investigation revealed that the Ministry of Health uses a list of eight categories to classify abortions, all of which are medically necessary interventions upon arrival at the hospital and therefore should be non-punishable. The categories are ectopic pregnancy, hydatidiform mole (molar pregnancy), other abnormal products of conception, spontaneous abortion, medical abortion (meaning “medically necessary”), other abortion, non-specified abortion, failed abortion attempt, and post-abortion complications. However, there is no glossary of terms that explains to the medical doctors the differences in these mostly administrative terms.

studies of the prevalence of severe and often fatal congenital malformations in different countries and the wide range of medical conditions that could threaten the life or health of the pregnant woman, there are likely hundreds of cases in addition to those officially recorded where women and girls would be eligible to consider a therapeutic abortion but did not receive one.¹¹ For example, one calculation estimates that every year in Peru there are 945 births of fatally malformed babies.¹² Anencephalic births are but one example: according to its own statistics, the Ministry of Health reports at least 80 women with anencephalic pregnancies every year who do not receive a therapeutic abortion.¹³

Anencephaly is fetal malformation incompatible with life, in which the brain and spinal cord fail to develop in utero. When the outcome is not a stillbirth, death usually occurs within hours or days after birth.¹⁴ Carrying an anencephalic fetus can be a great source of mental anguish and pose physical risks for the pregnant woman.¹⁵

As with anencephaly, there are dozens of medical conditions that could warrant a therapeutic abortion to save the life of the mother and preserve her health and well-being. To that end, a group of reproductive health specialists from nine medical associations in Peru developed a clinical profile to establish criteria for consideration of legal pregnancy interruption. Their list, neither exhaustive nor prescriptive, includes over 30 pathologies that could lead a pregnant woman to

¹¹ Luis Távara Orozco, Sheilah Verena Jacay Murguía, and María Jennie Dador Tozzini, *Notes for action: Women's right to legal abortion. Fulfillment of the right to therapeutic abortion and the foundation for broadening legal exceptions to abortion in cases of rape or fatal congenital malformations (Apuntes para la acción: El derecho de las mujeres a un aborto legal. Cumplimiento del aborto terapéutico y fundamentación para la ampliación de las causales de aborto por violación y por malformaciones congénitas incompatibles con la vida)*, (Lima: Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX), September 2007), p. 49.

¹² Luis Távara Orozco, *Why fatal congenital malformations and rape justify a legal abortion (Porqué las malformaciones congénitas letales y la violación justifican un aborto legal)* (Lima: Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX), 2008), pp. 8-9.

¹³ "Therapeutic abortion authorized at national level" ("El aborto terapéutico autorizado a nivel nacional"), *RPP Noticias*, March 8, 2007, http://www.rpp.com.pe/portada/nacional/68474_1.php (accessed July 10, 2007).

¹⁴ Jerrold B. Leikin, MD and Martin S. Lipsky, MD (eds.), *American Medical Association Complete Medical Encyclopedia* (New York: Random House Reference, 2003), p. 160.

¹⁵ Polyhydramnios, postural hypotension, hypertension, premature membrane rupture, breech birth or other forms of dystocia, and amniotic embolisms are some of the physical consequences that an anencephalic pregnancy can have on maternal health. Equally important are the potential consequences on the emotional health of the pregnant woman, including anxiety, severe depression, and post-traumatic stress disorder (PTSD). For PTSD, one-third of women may recover within one year, while another third still experience symptoms 10 years after having received the diagnosis. See Távara Orozco, *Why fatal congenital malformations and rape justify a legal abortion*, p. 11.

consider a therapeutic abortion.¹⁶ Dr. Luis Távara is an internationally recognized obstetrician and gynecologist, former president of the Peruvian Society of Obstetrics and Gynecology (Sociedad Peruana de Obstetricia y Ginecología, SPOG), and the former president of the sexual and reproductive health committee that organized the workshop. He published a document that focuses solely on why anencephaly should justify a therapeutic abortion for the pregnant woman on both physical *and* mental health grounds,¹⁷ arguing that abortions in such cases should be considered lawful due to the serious and permanent harm such a pregnancy can cause to a woman's mental and physical health.

Most of the physical health justifications for therapeutic abortion have been assiduously outlined by the Professional Society of Obstetricians and Gynecologists in Peru, and approved by the larger Medical College of Peru.¹⁸ In addition, the Medical College of Peru has endorsed legal access to abortion for pregnancy as the result of reported rape and sexual violence, and for severe or fatal fetal malformations, recognizing that both can have physical and mental health repercussions.¹⁹

International assistance

Although the onus of change, responsibility, and accountability is on the state of Peru, international donors have also had a role in supporting Peru's public health system and a variety of reproductive health programs, including culturally sensitive

¹⁶ The list includes: chronic kidney failure, systemic lupus erythematosus (an auto-immune disorder), chronic arterial hypertension with organ damage, congestive heart failure, chronic liver failure, gastrointestinal cancer requiring radiation or chemotherapy, respiratory failure, advanced diabetes mellitus, malignancies of the central nervous system, treatment-adverse epilepsy, invasive cervical cancer and other gynecological cancers, unresolved ectopic pregnancy, precedents of postpartum psychosis or suicide risk, rape and sexual violence for increased risk of subsequent pathologies, and multi-drug-resistant tuberculosis. PROMSEX, "Therapeutic abortion in Peru: It is legal and saves lives" ("El aborto terapéutico en el Perú: es legal y salva vidas"), PROMSEX pamphlet series, 2008. Furthermore, the same group recommended that fetal malformations (like anencephaly) must be included explicitly in article 119 of the criminal code (see footnote 34), but did not draft specific guidelines on the topic at that time. Sociedad Peruana de Obstetricia y Ginecología, Comité de Derechos Sexuales y Reproductivos, "Medical Associations' Workshop to identify the clinical profile for therapeutic abortion" ("Taller de Sociedades Médicas para identificar el perfil clínico para el aborto terapéutico"), December 2005.

¹⁷ Távara Orozco, *Why anencephaly should justify a therapeutic abortion*, p. 6.

¹⁸ Colegio Médico del Perú, Consejo Nacional, Comisión de Alto Nivel de Salud Reproductiva, "First Workshop on Sexual and Reproductive Rights, Lima, Peru, 21 and 22 March 2007" (I Taller Nacional sobre Derechos Sexuales y Reproductivos), May 2007, pp. 16-17, 19-20.

¹⁹ Ibid.

birthing practices and emergency obstetric care. But access to therapeutic abortion is not included among them at present.

Since the 1970s the United States Agency for International Development (USAID) has been one of the largest bilateral donors of foreign aid to the Peruvian government, especially for maternal and other reproductive healthcare services, through both government services and nongovernmental organizations (NGOs).²⁰ But for the past eight years it has also operated under the Mexico City Policy (also known as the Global Gag Rule), reinstated on the first day of the George W. Bush administration. This policy prohibits foreign NGOs receiving family planning assistance funds from USAID from providing or promoting abortion as a family planning method, among other restrictions. This prohibition has been interpreted by USAID to deny funding to organizations that provide legal voluntary abortion services, lobby for abortion law reform, and offer referrals to safe abortion services, even when these activities are funded from other sources.²¹ While the policy clearly makes some exceptions for abortions, such as in the case of rape, incest, or when the life of the pregnant woman would be endangered, under a strict interpretation of the policy, no funds could be designated for information about or provision of therapeutic abortions to preserve the health of the mother or for fetal abnormalities incompatible with life.

In spite of available financial resources, none of the other major or traditional international donors, including the United Nations Population Fund and the Spanish

²⁰ United States Agency for International Development, USAID/Peru: Country Strategic Plan for Peru, FY 2002 to FY 2006, <http://peru.usaid.gov/docmtos/ApprovedPeruStrategicPlanFY2002-06.pdf> (accessed August 2, 2007).

²¹ Memorandum from Francis A. Donovan, Bureau for Management, Office of Acquisition and Assistance, Office of the Director within USAID, to all contracting officers and negotiators, regarding Voluntary Population Activities—Restoration of the Mexico City Policy, February 15, 2001, http://www.usaid.gov/business/business_opportunities/cib/pdf/cib0103.pdf (accessed March 12, 2008). Excerpts of the memorandum on the restoration of the Mexico City Policy follow: “Abortion is a method of family planning when it is for the purpose of spacing births. That includes, but is not limited to, abortions performed for the physical or mental health of the mother but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term or abortions performed following rape or incest (since abortion under these circumstances is not a family planning act)....To actively promote abortion means for an organization to commit resources, financial or other, in a substantial or continuing effort to increase the availability or use of abortion as a family planning method. This includes, but is not limited to.... [p]roviding advice that abortion is an available option in the event other methods of family planning are not used or are not successful or encouraging women to consider abortion (passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning counselor reasonably believes that the ethics of the medical profession in the country requires a response regarding where it may be obtained safely).... Excluded from the definition of active promotion of abortion as a method of family planning are referrals for abortion as a result of rape, incest or if the life of the mother would be endangered if the fetus were carried to term. Also excluded from this definition is the treatment of injuries or illnesses caused by legal or illegal abortions, for example, post-abortion care.” (pp. 7, 9).

Agency for International Cooperation (Agencia Española de Cooperación Internacional), is currently supporting direct efforts to ensure access to therapeutic abortion in the public healthcare sector. However, the United Kingdom's Department for International Development gave a grant of £3 million to the International Planned Parenthood Federation (IPPF) in 2006 to kick-start the Global Safe Abortion Programme for work exclusively with its affiliates, like the Peruvian Institute for Responsible Parenthood (Instituto Peruano de Paternidad Responsable, INPPARES) in Peru. Those affiliates-- one per country in about 180 countries worldwide-- are mandated to work toward stopping unsafe abortions and ensuring that internationally agreed targets to reduce the number of maternal deaths in the world's poorest countries are achieved by 2015.²²

As a part of that global program, IPPF established a separate pool of money known the Safe Abortion Fund in 2006 with additional funding from the governments of Denmark, Norway, Sweden, Switzerland, and the UK, for groups such as Marie Stopes International, Manuela Ramos in Peru, and others, which have seen a decline in their family planning and reproductive health services partly as a result of loss of US funding. The Safe Abortion Fund is established to “increase access to comprehensive safe abortion services, with particular regard for the needs of marginalized and vulnerable women.”²³

The long history of international donor involvement in sustaining healthcare services in Peru shows prior commitment to this issue that could be rekindled with proper political will and support.

²² “UK Government announces support to help combat threat to women's health in developing world,” UK Department for International Development press release, February 6, 2006, <http://www.dfid.gov.uk/news/files/pressreleases/reproductive-health060206.asp> (accessed March 12, 2008).

²³ International Planned Parenthood Federation, <http://www.ippf.org/en/What-we-do/Abortion/Safe+Abortion+Action+Fund+awards+111m+to+reduce+unsafe+abortion.htm> (accessed March 31, 2008).

IV. Illustrative Cases of Lack of Access and Its Consequences

In spite of ongoing contacts with various hospitals and nongovernmental health organizations, Human Rights Watch was not able to secure interviews with many women who should have been eligible for therapeutic abortions and were denied services. Key factors behind this were difficulties in identifying such women, reluctance to speak about intimate matters, and a lack of awareness that their rights had been violated. In Peru it is rare for cases of the denial of therapeutic abortion to be exposed in public. Those that are brought to light illustrate just how difficult access to legal, therapeutic abortions can be, how the many obstacles can combine to defeat access, and how serious the consequences can be. The three case studies below illustrate both the barriers and the consequences.

Case of M.L.²⁴

M.L., a 31-year-old married woman with one son, told Human Rights Watch that she had hoped for a daughter when she got pregnant in 2004. But an ultrasound at 30 weeks of gestation revealed that her pregnancy was not normal; despite a lack of apparent symptoms. M.L. was hospitalized and was told that the fetus was malformed, but was not given details. After a week in the public maternity hospital, medical staff members informed M.L. that the fetus had no brain and no bladder and was not going to live: it would die at birth if not in utero.

M.L. asked for a therapeutic abortion, but was refused. She told Human Rights Watch, “They didn’t want to induce me because they told me that the law did not permit it, that it couldn’t be done.”²⁵ M.L. took them at their word and was ignorant of the possibility of convening a review by a medical committee of her case.

M.L. began looking for alternative ways to procure a therapeutic abortion. She found clandestine abortion providers, but her husband did not want M.L. to risk her life with an unsanitary and unsafe procedure. Moreover, in a private clinic she consulted, the operation would have cost 2,000 soles (about US\$700), a price too high for M.L.

²⁴ Human Rights Watch interview with M.L., La Paz Apart Hotel, Lima, July 7, 2007.

²⁵ Ibid.

She returned to the hospital two months later (at about 38 weeks of gestation), where an amniocentesis test was performed and M.L. started to have contractions. Hospital staff gave M.L. an intravenous drip, which, according to M.L., was intended to prevent early labor. She said she overheard hospital staff discussing how to prevent early labor.

Shortly after that, M.L. returned to her parents' village. She described herself as depressed and despondent; she said she cried continuously and did not eat.

When her pregnancy was full-term, there was no fetal movement. She was admitted to the hospital in great pain: "I was screaming with the pain. I thought I was going to die. I shouted out that I couldn't take it any more.... It wasn't fair that they made me wait so long when they knew that they were going to operate on me.... Then they had to make a vertical cut [for a Cesarean section] due to the emergency."²⁶ The hospital told M.L. that the fetus was a girl, but refused to allow M.L. to see the body. To this day, she explained to Human Rights Watch that she has nightmares about what actually happened to the body.

M.L. said she continued to feel severely depressed and struggles to afford treatment for her depression. She never learned the cause of the malformation and fears that something is genetically wrong with her or her husband, even as they long for another child. She said, "I wouldn't want this to happen to any other woman; it's something horrible that happened to me.... I dropped down to 40 kilos (about 88 pounds). People don't know how much one suffers [in this situation]; they don't want to know the truth about that kind of suffering."²⁷

Case of K.L.

The case of K.L. is one of the rare high-profile therapeutic abortion cases in Peru, and the information that follows is from publicly available sources (Human Rights Watch did not interview K.L.).²⁸ In 2001 when K.L. was 17 years old, she learned at 14 weeks of pregnancy from doctors at a public hospital that the fetus she was carrying was

²⁶ Ibid.

²⁷ Ibid.

²⁸ Pardiss Kebriaei, "UN Human Rights Committee Decision in K.L. v. Peru," *INTERIGHTS Bulletin*, vol. 15, no. 3, 2006, pp. 151-2.

anencephalic (which, as described in the chapter above, is an anomaly incompatible with life for the fetus and a condition that jeopardizes the pregnant woman's health). The attending physician recommended interrupting the pregnancy. K.L. struggled with the news and discussed her situation with her family.

Knowing that continuing the pregnancy could endanger her physical and mental health, and feeling emotionally unable to continue the pregnancy knowing that the fetus would not survive, K.L. (via her mother, as she was still a legal minor) petitioned the Loayza Hospital in Lima for a therapeutic abortion and had all of the necessary tests carried out. Two weeks after she was counseled to end her pregnancy, K.L. returned to the hospital only to find out she needed the approval of the director. A week later, the hospital director denied her request based on his view that the pregnancy itself did not pose a serious threat to her health. K.L. had no choice but to carry the pregnancy full-term against her will. During this time she suffered from malnutrition and severe depression. When she finally gave birth three weeks after her due date—lateness is a common occurrence in anencephalic pregnancies—hospital employees forced her to breastfeed for four days until the baby died. K.L. was later diagnosed with severe depression requiring psychiatric treatment.²⁹

Two Peruvian organizations, DEMUS and the Latin American and Caribbean Committee for the Defense of Women's Rights (Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer, CLADEM), together with the US-based Center for Reproductive Rights, presented K.L.'s case to the United Nations Human Rights Committee (HRC) in 2002. The HRC found in favor of K.L. As described in Chapter VI, below, the HRC ruled that Peru must compensate her and undertake policy reforms to ensure that similar rights violations do not recur.

Case of L.C.

Human Rights Watch interviewed the mother of L.C., a girl from a poor area in Lima, who was raped repeatedly when she was 14 years old over the course of several months by a man 20 years her senior. She became pregnant and told no one.

²⁹ DEMUS et al., "The right to a therapeutic abortion protocol" ("El Derecho a un protocolo para aborto terapéutico"), Lima, 2007.

According to an interview with her mother, L.C. grew desperate and depressed, and then attempted suicide; she threw herself off the roof of her family's living quarters. Her mother first learned of her daughter's rape and pregnancy in the hospital emergency room. "The girl cried and after she told me that there was a man who drives a motorcycle who abused her."³⁰ L.C. survived, but fractured several cervical vertebrae in the fall and became quadriplegic. Her pregnancy continued.

In the public hospital the girl's mother told Human Rights Watch that she requested a therapeutic abortion for her daughter so that the doctors could operate on her spinal column and improve her chances of future mobility. According to the mother's testimony, "the doctor said they can't because it's criminalized."³¹ But L.C.'s mother understood that the final decision could be made by an ad hoc medical committee if the patient could provide the appropriate documentation to the hospital director. According to L.C.'s mother, after several meetings and unexplained delays, the medical advisory committee finally refused the petition for L.C.'s legal abortion on the grounds that the pregnancy no longer posed a threat to her physical health: "Just like that, even though my daughter is the way she is, they said, 'We can't, señora. That is a criminal offense.'"³² Later L.C. miscarried while in the hospital, her mother told Human Rights Watch. But by that time, the planned operation on her spine would have had little or no effect on restoring her range of physical activity.³³

³⁰ Human Rights Watch interview with mother of L.C., Lima, June 26, 2007.

³¹ *Ibid.*

³² *Ibid.*

³³ Human Rights Watch interview with Dr. Julio Aguilar, Lima, June 14, 2007; "Pregnant at 13" ("Embarazada a los 13"), *Caretas Ilustración Peruana*, edition 1982, June 28, 2007.

<http://www.caretas.com.pe/Main.asp?T=3082&id=12&idE=730&idSTo=363&idA=26938> (accessed July 10, 2007).

V. Obstacles to Therapeutic Abortion

There are many obstacles to accessing therapeutic abortion in the public health sector in Peru, but they are not insurmountable. Some of those barriers are administrative and legal, including the absence of standard definitions, protocols, and medical guidelines; unpredictable approval procedures; lack of accountability; vague and restrictive laws that pit the provider's professional obligations against misguided legal reporting requirements; and lack of social security (public health insurance) coverage for the procedure. Other barriers are attitudinal, based on fear of reprisals and confusion about the legal exceptions to abortions. Most of these obstacles can be attributed to the government's failure to adequately inform women and girls of their right to therapeutic abortion, and the failure to inform medical personnel of their protection under the law and their professional obligation to provide these services to women and girls who need them.

Vague and restrictive laws and definitions

While abortion is generally criminalized in Peru, the Peruvian penal code of 1924 established that therapeutic abortion to save the life and protect the health of a pregnant woman would not be criminalized. In subsequent reforms the penal code has always allowed an exception to protect the interests of the woman. Article 119 of the present penal code, from 1991, states, "Abortion practiced by a physician with the consent of the pregnant woman or her legal representative, if applicable, is not punishable when it is the only means to save the life of the woman or to avoid serious and permanent damage to her health."³⁴ In 1989 a draft penal code was proposed to further decriminalize abortion in cases of sexual violence, non-consented artificial insemination, and fetal abnormalities incompatible with life (also referred to as eugenic abortion). The draft was approved by the Peruvian Congress, but was never promulgated by the executive office. Therefore, the revised

³⁴ Peruvian Penal Code, Legislative Decree no. 635, published April 3, 1991, ratified April 8, 1991 (Código Penal de Perú, Decreto Legislativo No. 635, Promulgado 03.04.91, Publicado 08.04.91), <http://www.cajpe.org.pe/rij/bases/legisla/peru/pecodpen.htm> (accessed November 14, 2007), art. 119.

(Original text "No es punible el aborto practicado por un médico con el consentimiento de la mujer embarazada o de su representante legal, si lo tuviere, cuando es el único medio para salvar la vida de la gestante o para evitar en su salud un mal grave y permanente.")

code with the expanded exemptions never went into effect, nor did subsequent discussions on this topic ever yield concrete penal code reform for those additional exceptions.³⁵

The current penal code imposes sanctions, in theory, for women who procure an abortion and those who provide the services.³⁶ For the pregnant woman the maximum penalty is two years in prison or 104 days of community service. For the doctor, midwife, pharmacist, or other healthcare professional who performs an abortion with the woman's consent, the maximum penalty is four years in prison. In aggravating circumstances, the practitioners can lose their licenses and any other military or police rankings or honorary titles or distinctions.³⁷

³⁵ *Ibid.*, art. 120, para. 2.

³⁶ *Ibid.*, arts. 114 and 120. Article 114: "Self-induced abortion: The woman who causes her abortion, or consents to letting someone else practice it, will be punished with detention of no longer than two years or with community service from 52 to 104 days." (Original text: Artículo 114. "Autoaborto: La mujer que causa su aborto, o consiente que otro le practique, será reprimida con pena privativa de libertad no mayor de dos años o con prestación de servicio comunitario de cincuenta y dos a ciento cuatro jornadas.")

³⁷ *Ibid.*, arts. 115-117, 36.4 and 36.8 "Article 115.- Consented abortion: He who causes abortion with the consent of the pregnant woman, will be punished with imprisonment not less than one nor greater than four years. If the woman dies and the abortion provider could have prevented it, the punishment shall be no less than two nor greater than five years.

Article 116.- Abortion without consent: He who causes a woman to abort without her consent shall be imprisoned for no less than three nor greater than five years. If the woman dies and the abortion provider could have prevented it, the punishment will be no less than five nor greater than 10 years.

Article 117.- Increased penalties according to the status of the perpetrator: The physician, obstetrician, pharmacist, or other health professional that misuses his science or art to cause an abortion will be punished according to articles 115 and 116 and restricted from practicing according to article 36, clauses 4 and 8."

"Article 36: Disqualification—Effects: Disqualification will produce, according to the sentence: Clause 4. Inability to exercise personally or through a third party one's profession, business, art or industry, which should be specified in the sentence; [or] Clause 8. Stripping of military or police credentials, honorary titles or other distinctions that correspond to the rank, profession or trade that would have enabled the abortion provider to commit the crime." (Original text in Spanish: "Artículo 115.- Aborto consentido: El que causa el aborto con el consentimiento de la gestante, será reprimido con pena privativa de libertad no menor de uno ni mayor de cuatro años. Si sobreviene la muerte de la mujer y el agente pudo prever este resultado, la pena será no menor de dos ni mayor de cinco años.

Artículo 116.- Aborto sin consentimiento: El que hace abortar a una mujer sin su consentimiento, será reprimido con pena privativa de libertad no menor de tres ni mayor de cinco años. Si sobreviene la muerte de la mujer y el agente pudo prever este resultado, la pena será no menor de cinco ni mayor de diez años.

Artículo 117.- Agravación de la pena por la calidad del sujeto: El médico, obstetra, farmacéutico, o cualquier profesional sanitario, que abusa de su ciencia o arte para causar el aborto, será reprimido con la pena de los artículos 115^o y 116^o e inhabilitación conforme al artículo 36^o, incisos 4 y 8."

"Artículo 36.- Inhabilitación-Efectos: La inhabilitación producirá, según disponga la sentencia: 4. Incapacidad para ejercer por cuenta propia o por intermedio de tercero profesión, comercio, arte o industria, que deben especificarse en la sentencia; [o] 8. Privación de grados militares o policiales, títulos honoríficos u otras distinciones que correspondan al cargo, profesión u oficio del que se hubiese servido el agente para cometer el delito.")

Abortions performed without the woman's consent carry stiffer penalties: five years if the woman survives, 10 years if she dies. Death also means the practitioner will lose his or her professional license.³⁸

The penalties are reduced if the abortion is performed for "sentimental or eugenic" reasons, explained as reported rape outside of marriage, reported artificial insemination outside of marriage, or grave physical or mental defects with a medical diagnosis. In these cases, imprisonment is prescribed for no more than three months, although the penal code does not stipulate if for the woman, the abortion provider, or both.³⁹

Although article 119 clearly provides exceptions to criminalization of abortion for the woman's life and health, the law does not clarify (nor does any official regulation or protocol) exactly what circumstances entitle women to therapeutic abortion.

A key unanswered question is to what degree damage to mental health is contemplated as a ground for non-criminalized abortion under Peru's penal code. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."⁴⁰ But in those rare cases where some form of legal abortion has been practiced in Peru, the medical grounds cited referred to the threats to a woman's physical health only. Dr. Luis Távara explains 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

³⁸ Ibid., arts. 114-118.

³⁹ Ibid., art. 120: "Abortion will be punished with detention of no longer than three months: 1) when the pregnancy is the product of rape outside of marriage or artificial insemination without consent that also occurred outside of matrimony, as long as the facts have at least been reported to or investigated by the police; 2) when it is probable that the fetus has congenital malformations with serious physical or mental manifestations, as long as there is a medical diagnosis." (Original text: Artículo 120. "Aborto sentimental y eugenésico. El aborto será reprimido con pena privativa de libertad no mayor de tres meses: 1. Cuando el embarazo sea consecuencia de violación sexual fuera de matrimonio o inseminación artificial no consentida y ocurrida fuera de matrimonio, siempre que los hechos hubieren sido denunciados o investigados, cuando menos policialmente; o 2. Cuando es probable que el ser en formación conlleve al nacimiento graves taras físicas o psíquicas, siempre que exista diagnóstico médico.")

⁴⁰ World Health Organization (WHO), Preamble to the Constitution of the WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948, <http://www.who.int/suggestions/faq/en/> (accessed November 10, 2007).

repercussions.”⁴¹ According to Dr. Wilifredo Vázquez of San Bartolomé Hospital, “there is no consensus on the emotional aspect [legal exceptions for mental health]... A woman who gives birth to an anencephalic baby will suffer emotional damage.... We hope we always act within medical discretion.”⁴²

Article 30 of the Peruvian General Health Law (number 26842) is very clear in requiring healthcare providers to report women who are suspected of inducing an unauthorized abortion to the police. The law establishes that: “the physician who gives medical attention to a person wounded by a knife, bullet, or traffic accident, or due to any type of violence that is punishable by law, or when there are indicators of criminal abortion, is obligated to report that information to the appropriate authorities.” Such an obligation requires physicians to violate women’s basic rights to health and privacy.⁴³ The Medical College of Peru (Colegio Médico de Perú) issued a statement calling for the immediate repeal of article 30 in a national workshop held in Lima in March 2007.⁴⁴

Absence of protocols on therapeutic abortion

The state is doing nothing to ensure that healthcare providers give women access to legal abortions. A major impediment to complying with existing law is the lack of a national protocol on therapeutic abortions or any regulation to clarify the law, despite Peru’s obligations under human rights law to ensure such clarity exists.⁴⁵

⁴¹ Human Rights Watch interview with Dr. Luis Távara, Lima, June 16, 2007.

⁴² Human Rights Watch interview with Dr. Edgardo Wilifredo Vázquez Perez, Lima, June 8, 2007.

⁴³ It also seems incompatible with the provider-patient professional oath of secrecy provided for in article 199 of the Peruvian criminal code, which states, “1) He who reveals the secrets of others, gained through professional or work relations, will be punished with a prison sentence of one to three years and a fine of six to 12 months [of salary]. 2) The professional who, by not fulfilling his obligation of secrecy and reserve, divulges the secrets of another person, shall be punished with a prison sentence of one to four years, a fine from 12 to 24 months [of salary], and a revocation of his professional license for a period of two to six years.” (Original text of Article 199: “1. El que revelare secretos ajenos, de los que tenga conocimiento por razón de su oficio o sus relaciones laborales, será castigado con la pena de prisión de uno a tres años y multa de seis a doce meses. 2. El profesional que, con incumplimiento de su obligación de sigilo o reserva, divulgue los secretos de otra persona, será castigado con la pena de prisión de uno a cuatro años, multa de doce a veinticuatro meses e inhabilitación especial para dicha profesión por tiempo de dos a seis años.”)

⁴⁴ National Council of the Medical College of Peru, First Workshop on Sexual and Reproductive Rights, Lima, March 21 and 22, 2007, May 2007 (Colegio Médico de Perú, Consejo Nacional, 1 Taller Nacional sobre Derechos Sexuales y Reproductivos, Lima, 21 y 22 de marzo de 2007, impreso en mayo de 2007).

⁴⁵ Kebriaei, “UN Human Rights Committee Decision in K.L. v. Peru,” pp. 151-2. By way of similar international precedent, the European Court of Human Rights in *Tysiác v Poland* also spelt out that states have an obligation to ensure clarity in the law relating to access to legal abortions, to the pregnant woman’s legal position, and that there must be an effective and timely procedure in place to determine whether the conditions for obtaining a lawful abortion are met in an individual case so that the pregnant woman is protected from prolonged uncertainty, and any unnecessary distress and anguish. *Tysiác v Poland*,

The UN Human Rights Committee (HRC) in the decision of K.L. v. Peru ordered Peru to “adopt measures to avoid committing similar violations in the future.”

Nongovernmental organizations and medical societies have called on the Ministry of Health to issue a national-level protocol on therapeutic abortion, as one of the most efficient ways to avoid such violations and to regulate and standardize this medical care. But progress has been very slow. Below we describe the evolution of the discussions on therapeutic abortion protocols at the national, regional, and local institutional levels.

National-level protocols

The Peruvian Ministry of Health (Ministerio de Salud, MINSA), under the guidance of then-Minister of Health Dr. Pilar Mazetti, started to discuss the development of a national therapeutic abortion protocol in January 2006. That year civil society organizations, human rights officials, conservative legislators, medical societies, high-level government employees in various ministries, intersectoral working groups, reproductive rights networks, and journalists battled publicly and privately on the theme of therapeutic abortion and the need for a protocol.

In May 2006 a group of civil society organizations sent letters to the National Human Rights Ombudsman Office, congressional representatives of various parties, MINSA, and the then-President of Peru Alejandro Toledo, expressing their profound concern about the lack of implementation of the recommendations in the case of K.L. v. Peru regarding therapeutic abortion. In response to one of those letters, the deputy ombudsperson for women’s rights wrote to the vice-minister of health, emphasizing the lack of implementation and all of the corresponding commitments the state had with respect to these types of services. The vice-minister of health, Jose Gilmer Calderón Ybérico, then charged the Ministry’s working group (*estrategia sanitaria*) on sexual and reproductive health with developing a protocol for national dissemination. The working group did so, then convened a meeting with a group of

Judgment of March 20, 2007, paras. 116-124. Poland has similar restrictive laws on abortion but allows therapeutic abortion. In this case, a pregnant woman was unable to obtain an abortion, despite being eligible for one, and consequently, as a result of the pregnancy sustained serious damage to her eyes placing her at risk of blindness. The failure of the Polish government to provide an effective mechanism ensuring the pregnant woman could obtain a therapeutic abortion was found to be a violation of her right to physical integrity and private life protected under the European Convention on Human Rights.

outside experts, revised the protocol, and returned it to the vice-minister of health in a matter of months.

In 2007, after a series of queries about the protocol's status and with the clamor from civil society organizations ongoing, the minister of health notified concerned legislators on June 1 that the "technical guide project," as it was known, had been channeled to the Presidential Council of Ministers (la Presidencia de Consejo de Ministros, PCM) for review by a multisectoral committee.⁴⁶ Later that month Dr. Daniel Robles, a medical doctor and legislator for the ruling party, convened a public meeting for discussion on therapeutic abortion in the Congress in response to the persistent and urgent petition for public participation. Two days before the event, Dr. Robles canceled the meeting. Nearly a year later, it had not been rescheduled in spite of the ongoing attention to and importance of developing a protocol with input from civil society.

Human Rights Watch learned that the PCM returned the national protocol to MINSA in December 2007 with the observation that the protocol is unconstitutional. The PCM did not convene a multisectoral committee. The general legal counsel from the Ministry of Justice advised against convening a multisectoral committee for deliberation based on the observation that the contents of the protocol "contravene the constitutional and legal normative framework by affecting the fundamental right to life of the conceived [fetus]."⁴⁷

At the time of writing, no national protocol on therapeutic abortion has been adopted.⁴⁸ The protocol is again in limbo at MINSA.

⁴⁶ The PCM is a group of presidential cabinet advisors and committees, led by the chief of staff, which coordinates and manages follow up with multisectoral policies and programs for the executive branch of government. Though not a standard administrative procedure, the PCM can solicit official documents for review at will and is not obliged to publicly disclose the status of the investigation.

⁴⁷ "Formation of the Multisectoral Commission to evaluate the Technical Guide Project proposed by the Ministry of Health" ("Conformación de Comisión Multisectorial para evaluar el Proyecto de Guía Técnica por el Ministerio de Salud"), communiqué from the Ministry of Justice, General Office of Legal Assistance, reference H.E. No. 258-2007-JUS/VM, June 27, 2007 (stamped "received" December 11, 2007); Human Rights Watch telephone interviews with Dr. Milagros Nuñez, PCM, Lima, March 17 and 18, 2008.

⁴⁸ PROMSEX, *A right denied, a responsibility evaded: The behavior of the Peruvian State on therapeutic abortion (Un derecho negado, una responsabilidad eludida: Comportamiento del Estado Peruano frente al aborto terapéutico)*, (Lima: PROMSEX, August 2007), pp. 33-34.

In the absence of national guidance, a few hospitals and one regional government established protocols or technical guides on therapeutic abortions themselves, but in the process have faced great pressures and setbacks.

Hospital-level protocols

As part of the original vice-ministerial review and input for the draft national protocol, the National Materno-Perinatal Institute (Instituto Nacional Materno Perinatal, INMP), the oldest maternity hospital in Lima, was consulted for its expert opinion and comments. After months of uncertainty, waiting for a national protocol to be released, the INMP took matters into its own hands. In February 2007 Dr. Enrique Guevara, INMP director, issued a directive for the “integral management of therapeutic interruption for gestations of less than 22 weeks (therapeutic abortion).”⁴⁹ INMP (known locally as the “Maternity of Lima”) sent a copy to the Ministry of Health for its records. On April 19, 2007, Calderón Ybérico of MINSA overrode the INMP’s directive and declared it null and void, for failure to adhere to proper administrative procedures.⁵⁰ Shortly after that, the Ministry of Health removed Dr. Guevara from his leadership position for “exceeding his authority.”⁵¹ Dr. Esteban Chiotti, then the director of the General Directorate for People’s Health within the Ministry of Health, told Human Rights Watch that the hospital’s protocol “had flaws... and didn’t adhere to the established norms.... A [hospital] directive cannot regulate a medical act.”⁵²

Elsewhere in the country, three hospitals still retain their individual protocols: the San Bartolomé Maternal-Child National Teaching Hospital in Lima (protocol issued in 2005),⁵³ the Hospital Belén in Trujillo (protocol issued in 2006),⁵⁴ and the Hipólito Unanue National Hospital (protocol issued in 2007) of Lima.⁵⁵

⁴⁹ National Materno-Perinatal Institute (Instituto Nacional Materno-Perinatal), Resolución Directoral No. 031-DG-INMP-07, Lima, February 7, 2007.

⁵⁰ Ministry of Health, Republic of Peru (Ministerio de Salud, República del Perú), Vice-Ministerial Resolution (Resolución Vice Ministerial), No. 336, Lima, April 19, 2007.

⁵¹ Human Rights Watch interview with Dr. Esteban Chiotti, Ministry of Health, Lima, July 5, 2007.

⁵² Ibid.

⁵³ Hospital Nacional Docente Madre Niño San Bartolomé, “Protocol for Case Management of Legal Pregnancy Termination” (“Protocolo de Manejo de Casos para la Interrupción Legal del Embarazo”), Centro de la Mujer Peruana Flora Tristan, Lima, May 2005.

⁵⁴ Departamento de Ginecoobstetricia del Hospital Belén de Trujillo, “Protocol for Case Management of Legal Pregnancy Termination” (“Protocolo de Manejo de Casos para la Interrupción Legal de Embarazo”), PROMSEX, Lima, February 2006.

⁵⁵ Hospital Nacional Hipólito Unanue, Departamento de Ginecología y Obstetricia, “Guide for Case Management of Legal Pregnancy Interruption” (“Guía para el Manejo de Casos de Interrupción Legal del Embarazo”), Lima, December 2007.

These evidence-based hospital protocols, framed within the scope of existing laws, responded to an immediate need and were formulated with assistance from the Peruvian Society of Obstetrics and Gynecology, and in one case, with the technical support of the Sexual and Reproductive Rights Committee of the Latin American Federation of Obstetric and Gynecological Societies (Federación Latinoamericana de Sociedades de Obstetricia y Ginecología, FLASOG).⁵⁶ Unfortunately, rather than supporting their implementation overtly or using them as a basis for a more inclusive national protocol, the Ministry of Health has remained silent about these existing protocols.

Regional-level protocols

At the regional level, only the health ministry of Arequipa has acted to regulate therapeutic abortion, citing 24 clinical conditions that are grounds for legal pregnancy interruption. The regional government published a protocol in December 2007 and in February 2008, publicly announced that the protocol would go into effect immediately for all public and private hospitals in the region. The counterattack was immediate and well-publicized in the newspapers and periodicals. Under direct pressure from the Archbishop of Arequipa,⁵⁷ the highest regional authority of the Roman Catholic Church, the regional president suspended the protocol, stating that regional officials had not followed the appropriate constituent consensus process or sought the endorsement of the Ministry of Health or the Pan American Health Organization.⁵⁸

Dr. Mercedes Neves, a public health specialist and 16-year employee of the Ministry of Health of Arequipa, noted that the unprecedented action is clearly “political maneuvering on behalf of the regional government” as a result of “a very aggressive campaign by the Archbishop” and goes “against their professional competence ... [and] against decentralization.”⁵⁹ The national Ministry of Health has not publicly

⁵⁶ Other reproductive health NGOs like the Population Council, Ibis Reproductive Health, and PROMSEX also provided technical assistance and held workshops for physicians to help formulate the standards. The Peruvian Society of Obstetrics and Gynecology, Sexual and Reproductive Rights Committee (Sociedad Peruana de Obstetricia y Ginecología (SPOG), Comité de Derechos Sexuales y Reproductivos), “Medical Societies’ Workshop to identify the clinical profile for therapeutic abortion” (“Taller de Sociedades Médicas para identificar el perfil clínico para el aborto terapéutico”), Lima, August 13, 2005.

⁵⁷ Enrique Chávez, “Holy Anger in the White City” (“Ira Santa en la Ciudad Blanca”), *Caretas*, February 21, 2008, pp. 48-51.

⁵⁸ Human Rights Watch telephone interview with Dr. Mercedes Neves, Arequipa, Peru, March 17, 2008.

⁵⁹ *Ibid.*

announced its position on the regional protocol. At the time of writing, the regional health ministry of Arequipa is still waiting for MINSA's pronouncement on the regional protocol. According to Dr. Neves, for the Catholic church hierarchy, "the protocol's suspension is a triumph ... and is a major setback for us."⁶⁰

The Bar Association (Colegio de Abogados) in Arequipa issued a statement to clarify the legal exceptions to the criminalization of abortion, claiming that the protocol is valid as stands.⁶¹ According to the president of the bar association, Hugo Salas, who spoke to Human Rights Watch, "the religious campaign [led by the Archbishop of Arequipa] is confusing therapeutic abortion with generalized abortion ... [which] goes against the legal code."⁶² He explained that this is the first time the Church has intervened in medical matters and opponents of the protocol are "confusing faith with medical and judicial matters.... The president of the regional government has dealt us a major blow in order to avoid confrontation with the Church.... [In response] we are preparing a lawsuit so that the protocol remains in force" in order to protect and defend the health and lives of women in the region.⁶³

Ad hoc approval and referral procedures / lack of accountability

There is neither administrative nor legal clarity on how women can obtain approval for therapeutic abortion in the public health system. Regardless of ambiguity, the principles of medical ethics dictate that healthcare professionals should act in accordance with the maximum benefits for the health and life of the person under their care, while always respecting the patient's informed consent.

A staff obstetrician at the Maternity Hospital of Lima described the arbitrariness of individual physician decision making: "it depends on each shift, on what each doctor decides."⁶⁴ Dr. Miguel Gutierrez, the former president of the Peruvian Society of Obstetrics and Gynecology and a practicing gynecologist, said, "We are only beginning to learn how to streamline the procedure [for therapeutic abortion].... We

⁶⁰ Ibid.

⁶¹ Pronouncement by the Arequipa Bar Association (Pronunciamiento del Ilustre Colegio de Abogados de Arequipa), Arequipa, March 2008. Email communication from Hugo Salas, president, to Human Rights Watch, April 7, 2008.

⁶² Human Rights Watch telephone interview with Hugo Salas, president of the Arequipa Bar Association, March 19, 2008.

⁶³ Ibid.

⁶⁴ Human Rights Watch interview with Dr. Enrique Guevara, private office, Lima, July 9, 2007.

can't really talk about a routine system." A director at a public hospital where approximately 120,000 obstetric procedures take place each year acknowledged that "there have been very few cases [of therapeutic abortion]... They are subject to the logic of each service provider."⁶⁵ Dr. Daniel Robles López, a trained physician and congressional legislator from the province of La Libertad said, "There are a lot of medical [conditions] that justify a therapeutic abortion ... Why do we have to make the mother suffer when the fetus is not going to live?... But there should be some form of regulation surrounding this."⁶⁶

Ad hoc committees convened by hospital staff to approve therapeutic abortion have the final say. They work with no guidelines or concrete timelines, and by accounts from those interviewed by Human Rights Watch, approve relatively few abortions.⁶⁷ Human Rights Watch was not able to obtain any written documentation on the formation or procedures of ad hoc medical committees for therapeutic abortion. As the name implies, the committees are convened spontaneously with the available physicians on call at the time of the procedure. According to Dr. Wilifredo Vázquez, director of the San Bartolomé National Mother-Child Teaching Hospital, the committee normally follows the decision that the attending physician has already made, and therefore serves as legal safeguard for the decision.⁶⁸ Human Rights Watch was also told that it was only in exceptional circumstances that a committee is convened to debate a controversial case, which may require multiple meetings.⁶⁹

There are also problems with referrals from physicians in other specialties. For example, several cancer specialists described how important it may be for women with cancer to interrupt pregnancies, but sometimes referrals from specialists to obstetricians and gynecologists for therapeutic abortion are delayed or not made at all. One cancer specialist explained that "in general, we don't talk about pregnancy [with our female patients, but] ... it wouldn't be advisable for a woman with breast cancer to get pregnant [because of hormone fluctuations].... For women with aggressive cervical cancer, they often have to interrupt their pregnancy because the

⁶⁵ Human Rights Watch interview with Dr. Miguel Gutierrez, La Paz Apart Hotel, Lima, June 8, 2007.

⁶⁶ Human Rights Watch interview with Dr. Daniel Robles Lopez, Congressional office, Lima, July 5, 2007.

⁶⁷ Human Rights Watch interviews with various medical doctors and hospital administrators, Lima, June and July 2007.

⁶⁸ Human Rights Watch interview with Dr. Edgardo Wilifredo Vázquez Perez, June 8, 2007.

⁶⁹ Human Rights Watch interview with Dr. Julio Aguilar, Hospital Daniel A. Carrion, Callao, Lima, June 14, 2007.

radiation treatments will affect the pregnancy.”⁷⁰ A gynecological oncologist at the same National Cancer Institute said that if a pregnant woman needs radiation treatments or chemotherapy, the attending physicians would first determine fetal viability. If the fetus were close to viability, the medical staff would withhold the woman’s treatment until she could have a Cesarean section delivery and begin treatment afterwards. Dr. Oscar Barriga recalls very few cases where they have referred women for therapeutic abortions. He said that some doctors in other hospitals “stalled and didn’t perform the procedure on time, so the fetus kept growing,” a situation that created more health problems for the patient and further delayed her treatment.⁷¹

In part due to the lack of standardized approaches to physician or committee approvals for therapeutic abortion, there is little, if any, accountability for healthcare providers who unjustly deny women therapeutic abortions. Human Rights Watch was not able to obtain any information about disciplinary actions against providers who failed to provide such abortions.

Fear of prosecution or malpractice lawsuits

An important obstacle to physicians’ performing therapeutic abortions in public hospitals is the risk of facing lawsuits, either medical malpractice suits or criminal prosecution. The lack of explicit policies and procedural guidelines can leave healthcare providers uncertain, unprotected, and less apt to apply the necessary medical exemptions to the penal code. The “chilling effect” the legal situation has on doctors when deciding whether the requirements of legal abortion are met in an individual case makes it all the more important that “provisions regulating the availability of lawful abortion should be formulated in such a way as to alleviate this effect.”⁷² Successful medical malpractice suits are practically non-existent in Peru, but one hospital director interviewed feels they may be on the rise.⁷³ In addition,

⁷⁰ Human Rights Watch interview with Dr. Felix Bautista, director of health promotion, National Cancer Institute (Instituto Nacional de Neoplasias), Lima, June 21, 2007.

⁷¹ Human Rights Watch interview with Dr. Oscar Barriga, National Cancer Institute (Instituto Nacional de Neoplasias), Lima, June 21, 2007.

⁷² *Tysiác v Poland*, para. 116.

⁷³ Human Rights Watch interview with Dr. Edgardo Wilifredo Vázquez Perez, June 8, 2007.

public hospitals do not provide malpractice insurance for their medical staff; each doctor is responsible for his or her own insurance and fees in the event of a lawsuit.⁷⁴

According to information provided by the Lima Superior Court, there have been 108 arraignments involving 125 men and 111 women in the period between 2000 and 2007, 27 of which were for self-induced abortion, 20 for abortion without consent, and 10 for “eugenic” abortion.⁷⁵ However, there is no information provided to identify the case numbers, exact years, charges, ages, circumstances, or outcomes of these cases.⁷⁶ From this data alone it is impossible to determine how many of the total people arraigned were healthcare providers, how many were formally charged, or how many were obliged to serve prison time or perform community service.

There are no official statistics from the Ministry of Justice that indicate how many physicians and how many women have actually been sanctioned with community service or imprisoned for committing or submitting to an abortion. Anecdotally, too, according to many of the health officials and civil society representatives that we interviewed, there are few known cases of actual criminal prosecutions against medical care providers, and prosecutions of women seem to be rare. Nonetheless, physicians report risk of prosecution as a major deterrent to providing legal abortions.⁷⁷

Cost of abortion procedures and lack of social insurance coverage

There are no official cost data on therapeutic abortion procedures, whether costs to the institution or to the patient. But in theory therapeutic abortion, like any other medically necessary and time-sensitive surgery to save a life or protect health from lasting and permanent damage, should be made accessible to women regardless of

⁷⁴ Ibid.

⁷⁵ Thanks to a petition from the Study for Women’s Defense and Rights (Estudio para la Defensa de los Derechos de la Mujer, DEMUS) under the Transparency and Access to Public Information Law, Human Rights Watch obtained a consolidated chart of women and men processed for the “crime of abortion” from 2000 to 2007 in 43 precincts in greater Lima.

⁷⁶ Lima Superior Court, Table of Men and Women Arraigned for the Crime of Abortion between 2000 and 2007 (Corte Superior de Lima, Consolidado de Hombres y Mujeres Procesados por Delito de Aborto en el Periodo 2000 a 2007). Email communication from Jeannette Llaja of DEMUS to Human Rights Watch, October 4, 2007.

⁷⁷ Susana Chiarotti, “Judicial and Legal Strategies for the Defense of Health and Sexual and Reproductive Rights” (“Las Estrategias Jurídico Legales para la Defensa de la Salud y los Derechos Sexuales y Reproductivos”), unpublished manuscript, 1999, p. 8.

ability to pay.⁷⁸ Costs could create barriers to access care when women are expected to pay for such services.

Payment for medical services happens in four ways in Peru: through an employment-based health insurance system called Seguro Social de Salud, or EsSalud; through private insurance plans; through military health insurance; or through subsidized public health services managed and largely paid for by MINSA.⁷⁹

The absence of a national protocol means that government-dependent insurance schemes do not cover therapeutic abortions explicitly, nor do the private insurance plans that a small fraction of the Peruvian population can afford.⁸⁰

Women seeking therapeutic abortions in the public health system pay for some aspects of the service. Human Rights Watch interviewed several women, medical practitioners, and researchers in Lima who confirmed reports that patients are often required to pay for emergency transportation to the hospital, and medicines and hospital supplies required before, during, and after the operation. Interviewees also reported that patients are required to reimburse the hospital for various expenses, and knew of patients not being released from the hospital until payment was made.⁸¹ (Although this is not the focus of our report, Human Rights Watch is concerned about these serious allegations that could represent the violation of the human rights principle of no imprisonment for debt.⁸²)

⁷⁸ Human Rights Watch interview with Raquel Cuentas, employee of the government health sector, Lima, June 15, 2007.

⁷⁹ Stephanie Rousseau, "The Politics of Reproductive Health in Peru: Gender and Social Policy in the Global South," *Social Politics: International Studies in Gender, State & Society*, vol. 14, no. 1, Spring 2007, p. 99-100; Human Rights Watch Interview with Raquel Cuentas, June 15, 2007.

⁸⁰ Rousseau, "The Politics of Reproductive Health in Peru," p. 99.

⁸¹ Human Rights Watch interviews with various individuals, Lima, June and July 2007.

⁸² For more information on and an analysis of the detention of indigent patients in healthcare facilities, see Human Rights Watch, *A High Price to Pay: Detention of Poor Patients in Burundian Hospitals*, vol. 18, no. 8(A), September 2006. An excerpt from the summary follows: "International human rights law provides that everyone has the right to liberty and security of person. Arbitrary detention of any kind is a violation of article 9 of the ... ICCPR.... The detention of anyone for non-payment of a debt specifically violates ICCPR article 11, which states: "No one shall be imprisoned merely on the ground of inability to fulfill a contractual obligation."... Article 12 of the ... ICESCR ... requires states to progressively realize the right to the highest attainable standard of health. The detention of hospital patients who cannot pay their bills has important implications for health care ... [as h]ospital detention discourages indigent people from seeking health care in the first place, subjects patients to having their treatment curtailed or ended when it is apparent to doctors and hospital staff that the patient cannot pay, and incarcerates recovering patients in conditions that may exacerbate their health problems." (http://hrw.org/reports/2006/burundi0906/3.htm#_Toc144258844)

Women who can afford to, may pay out-of-pocket for a therapeutic abortion performed by a private physician. Many physicians work in both the public and private sector, for financial reasons: the public sector provides stability, a government pension, and a sense of social service, but the private sector provides a greater income on average for physicians. Abortions in private clinics in Lima vary greatly, but cost at least 300 soles (US\$107) and often more, and are thus out of reach for many poorer women.

Low levels of awareness about exceptions to the criminalization of abortion

Public knowledge is very low about legal exceptions to criminalized abortion, and the government has done virtually nothing to raise public awareness.⁸³ Many women and girls, as well as healthcare providers, are unaware of the fact that abortions in some circumstances are legal. With so little information available, potentially eligible candidates are uncertain about what they are entitled to and where to go. It is likely that the general legal prohibition on abortion means they also fear incarceration.

Dr. Luz Monge Talavera, former deputy ombudsman for women’s rights, laments that most women are not aware of their rights and that the government does little to disseminate the information: “They think that if the state does not provide services, it is normal. That’s not a reason to complain because they’re not expecting it.”⁸⁴

Medical doctors and other professional healthcare workers seem to be unaware of exceptions for non-punishable abortion, or feel unprotected from the legal ambiguity and possible negative repercussions within the public healthcare system.⁸⁵

Numerous interviewees revealed this sentiment to Human Rights Watch throughout the course of this investigation.⁸⁶

⁸³ Human Rights Watch interviews with various key stakeholders, Lima, June and July 2007; and PROMSEX, “Special Edition: Legal Abortion in Peru” (“Edición Especial: Aborto Legal en el Perú”), *Sumando Voces*, 2007, p. 4.

⁸⁴ Human Rights Watch interview Dr. Luz Monge Talavera, Office of the Deputy Ombudsperson for Women’s Rights, Lima, July 2, 2007.

⁸⁵ Human Rights Watch interviews with key stakeholders, Lima, June and July 2007.

⁸⁶ *Ibid.*

VI. International Law Standards and Response of International Human Rights Officials and Experts

Although this report addresses the issue of therapeutic abortion specifically, authoritative interpretations of international human rights law support the right of all women to decide independently on matters related to sexuality and reproduction, including the issue of abortion. International human rights law is consistent with a woman's right to choose if and when to have children and if and when to interrupt her pregnancy, and supports the provision of timely and accessible healthcare services within evidence-based guidelines and safe and sanitary conditions. The criminalization of abortion, on the other hand, is a clear violation, *inter alia*, of a woman's right to privacy and non-discrimination.

Peru's highly restrictive abortion law and its poor record on making legal abortions accessible has resulted in repeated, forceful critiques by national and international human rights bodies and experts. Some of the strongest critiques have come from the Human Rights Committee (HRC), the body which monitors compliance with the International Covenant on Civil and Political Rights (ICCPR), the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee), and the UN special rapporteur on the right to the highest attainable standard of health (special rapporteur).

In October 2005 the HRC decided in favor of K.L. as an individual complainant under the Optional Protocol to the ICCPR. The Committee found the government of Peru in breach of its international obligations and in violation of its domestic laws for denying access to therapeutic abortion for a pregnant adolescent. The Committee ordered the state to "furnish the author [K.L.] with an effective remedy, including compensation" and to "take steps to ensure that similar violations do not occur in the future."⁸⁷ This decision is the HRC's first on the theme of abortion for an individual complaint.⁸⁸ The Committee found violations of the following rights

⁸⁷ UN Human Rights Committee, *K.L. v. Peru*, Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003(2005), paras. 8-9.

⁸⁸ *Ibid.*; and Pardiss Kebriaei, "UN Human Rights Committee Decision in *K.L. v. Peru*," pp. 151-152.

guaranteed by the ICCPR: respect for and guarantee of rights (article 2); freedom from torture and cruel, inhuman or degrading treatment (article 7); privacy (article 17); and special measures of protection for minors (article 24).⁸⁹

The CEDAW Committee, in evaluating Peru's compliance with the Convention on the Elimination of All Forms of Discrimination against Women, has noted that "illegal abortion remains one of the leading causes of the high maternal mortality rate and that the State party's restrictive interpretation of therapeutic abortion... may further lead women to seek unsafe and illegal abortions." The Committee urged "the State party to review its restrictive interpretation of therapeutic abortion, which is legal, ... 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."⁹⁰

Over the past several years the special rapporteur has made multiple visits and appeals to the government of Peru on the issue of access to therapeutic abortion. In an urgent appeal in July 2006, the special rapporteur admonished Peru for failing to comply with the HRC ruling in *K.L. v. Peru*, and expressed concern for the "continuing uncertainty surrounding the precise circumstances in which women are legally entitled to access therapeutic abortion ... exposing some to potentially serious physical and mental health risks, if their pregnancy was carried to term."⁹¹ The special rapporteur also signaled that such legal and procedural uncertainty was "contributing to a rise in unsafe and clandestine abortions, and consequently an increased likelihood of maternal mortality" in a country still plagued with relatively high rates. In a subsequent report in February 2007, the special rapporteur regretted that, to date, he had received no reply from the Peruvian government.⁹²

International standards on the link between access to abortion and women's exercise of their human rights have undergone significant development over the past 15 years. This development has manifested itself in over 130 concluding comments

⁸⁹ UN Human Rights Committee, *K.L. v. Peru*, para. 6.6.

⁹⁰ UN Committee on the Elimination of Discrimination against Women, *Concluding Comments: Peru*, UN Doc CEDAW/C/PER/CO/6 (2007), paras. 24-25.

⁹¹ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Paul Hunt, A/HRC/4/28/Add.1, February 23, 2007, paras. 36-37.

⁹² *Ibid.*

from UN treaty monitoring bodies, in which these international human rights experts have expressed their opinion on abortion restrictions in over 90 countries.⁹³ This jurisprudence furthers an understanding that firmly established human rights are jeopardized by restrictive or punitive abortion laws and practices.

There have also been significant developments in regional human rights systems relevant to women's right to decide on matters relating to abortion.⁹⁴ For example, the African regional human rights system now has a binding protocol that stipulates a state's obligation to take all appropriate measures to "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."⁹⁵ The Protocol on the Rights of Women in Africa "affirms reproductive choice and autonomy as a key human right and ... represents the first time that an international human rights instrument has explicitly articulated a woman's right to abortion when pregnancy results from sexual assault, rape or incest; when continuation of the pregnancy endangers the life or health of the woman; and in cases of grave fetal defects that are incompatible with life."⁹⁶ The significance and potential impact of this protocol go well beyond Africa, including Latin America.

⁹³ Janet Walsh and Marianne Møllmann, "Human Rights and Access to Abortion," *Revista Iberoamericana de Derechos Humanos*, no. 3 (publication pending); and Center for Reproductive Rights, *Bringing Rights to Bear: Abortion and Human Rights* (New York: Center for Reproductive Rights) (publication pending), pp. 1-28 of draft manuscript.

⁹⁴ Inter-American Commission on Human Rights, "Friendly Settlement, Paulina del Carmen Ramírez Jacinto, Mexico," Report no. 21-07, Petition 161-02, March 9, 2007, <http://www.cidh.org/annualrep/2007eng/mexico161.02eng.htm>, accessed June 10, 2008. In a case brought before the Inter-American Commission on Human Rights on behalf of "Paulina" —a girl who was raped at the age of 13 and then denied a legal abortion by justice and health authorities in her home state of Baja California, Mexico—the IACHR approved the friendly settlement that had been signed by both parties on March 8, 2006, and committed to monitoring its implementation. In that settlement, the Mexican government admitted its wrongdoing, agreed to compensate Paulina and her son, and agreed to issue a decree regulating guidelines for access to abortion for women who have been raped. This decision marks the first time that a Latin American government has acknowledged that denying access to a legal abortion is a violation of human rights. (See "Mexico Admits Responsibility for Denying Child Rape Victim's Rights: Landmark Settlement Reached in Case of 13-year-old Mexican Rape Victim Denied Abortion," Center for Reproductive Rights, CRR press release, March 8, 2006, http://www.reproductiverights.org/pr_06_0308MexicoPaulina.html (accessed June 10, 2008). See also Grupo de Información sobre Reproducción Elegida (GIRE), *Themes for Debate 6: Paulina, Justice the International Way (Temas para el Debate 6: Paulina, Justicia por la Vía Internacional)*, (Mexico City: GIRE, 2008).

⁹⁵ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, September 13, 2000, CAB/LEG/66.6, entered into force November 25, 2005, art. 14.

⁹⁶ Center for Reproductive Rights, "The Protocol on the Rights of Women in Africa: An Instrument in Advancing Sexual and Reproductive Rights," Briefing Paper, February 2006, p. 1, http://www.reproductiverights.org/pdf/pub_bp_africa.pdf, accessed June 17, 2008.

Right to life

The right to life, a fundamental right in many human rights treaties,⁹⁷ is in jeopardy when women and girls are denied access to safe, legal abortions. In Latin America and the Caribbean, over four million abortions are performed each year, and the regional maternal mortality rate is 190 out of 100,000 live births.⁹⁸ Of those deaths, 5,000 women are estimated to die from unsafe abortions every year.⁹⁹ In Peru, where maternal death rates are among the highest in the region, unsafe abortions cause approximately 16 percent of all maternal deaths.¹⁰⁰ Criminalizing abortion does not reduce its incidence. In fact, abortion rates are often highest where the laws are most restricted,¹⁰¹ and women can be obliged to seek clandestine abortions from unlicensed, unregulated practitioners, often under conditions that are medically unsafe and therefore life-threatening.¹⁰²

UN treaty bodies have often expressed concern that restrictive abortion laws may violate the right to life. For example, the HRC has often noted with concern the relationship between restrictive abortion laws, clandestine abortions, and threats to women's lives.¹⁰³ In 2000, in its general comment on equality of rights between men and women, the HRC called upon states to inform the committee of "any measures

⁹⁷ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by Peru, August 11, 1977; and Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990, ratified by Peru on April 28, 1978.

⁹⁸ WHO, *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA* (Geneva: WHO, 2004), http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf (accessed March 13, 2008).

⁹⁹ Yolanda Palma, Elsa Lince, and Ricardo Raya, "Unsafe abortion in Latin America and the Caribbean: priorities for research and action," in Ina K. Warriner and Iqbal H. Shah, eds., *Preventing Unsafe Abortion and its Consequences: Priorities or Research and Action* (New York: Guttmacher Institute, 2006), p. 188.

¹⁰⁰ Luis Távara et al., "Current state of maternal mortality in Peru," pp. 38-42.

¹⁰¹ Heather D. Boonstra et al., *Abortion in Women's Lives*, (New York: Guttmacher Institute, 2006), p. 10.

¹⁰² Marge Berer, "Global Perspectives: National Laws and Unsafe Abortion: The Parameters of Change," *Reproductive Health Matters*, vol. 12, no. 24 supplement (2004), pp. 1-8.

¹⁰³ See, for example, the HRC's concluding observations on Honduras, UN Doc. CC PR/C/HND/CO/1 (2006), para. 8; Madagascar, UN Doc. CCPR/C/MDG/CO/3 (2007), para. 14; Chile, UN Doc. CCPR/C/CHL/CO/5 (2007), para. 8; Zambia, UN Doc. CCPR/C/ZMB/CO/3 (2007), para. 18; Kenya, UN Doc. CCPR/CO/83/KEN (2005), para. 14; Mauritius, UN Doc. CCPR/CO/83/MUS (2005), para. 9; Bolivia, UN Doc. CCPR/C/79/Add.74 (1997), para. 22; Cameroon, UN Doc. CCPR/C/79/Add.116 (1999), para. 13; Chile, UN Doc. CCPR/C/79/Add.104 (1999), para. 15; Colombia, UN Doc. CCPR/CO/80/COL (2004), para. 13; Costa Rica, UN Doc. CCPR/C/79/Add.107 (1999), para. 11; Ecuador, UN Doc. CCPR/C/79/Add.92 (1998), para. 11; Guatemala, UN Doc. CCPR/CO/72/GTM (2001), para. 19; Mali, UN Doc. CCPR/CO/77/MLI (2003), para. 14; Morocco, UN Doc. CCPR/CO/82/MAR (2004), para. 29; Peru, UN Doc. CCPR/CO/70/PER (2000), para. 20; Poland, UN Doc. CCPR/C/79/Add.110 (1999), para. 11; Poland, UN Doc. CCPR/CO/82/POL (2004), para. 8; Senegal, UN Doc. CCPR/C/79/Add.82 (1997), para. 12; Sri Lanka, UN Doc. CCPR/CO/79/LKA (2003), para. 12; and Venezuela, UN Doc. CCPR/CO/71/VEN, (2001), para. 19.

taken by the state to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions.”¹⁰⁴

Right to health

International law also guarantees women the right to the highest attainable standard of physical and mental health.¹⁰⁵ Unsafe abortions are a grave threat to women’s health: between 10 and 50 percent of women who undergo unsafe abortions require post-abortion medical attention for complications such as incomplete abortion, infection, uterine perforation, pelvic inflammatory disease, hemorrhage, or other injury to internal organs. These may result in death, permanent injury, or infertility. Denial of access to safe, legal abortion can also result in mental health harm, including depression.

The right to health requires four interrelated features: availability of services in sufficient quantity; accessibility of services and information, within physical and economic reach of everyone without discrimination; acceptability of services with respect to culture, gender, and life-cycle; and scientifically appropriate services of adequate quality.¹⁰⁶ Prof. Rebecca J. Cook points out that in addition to constituting poor public health policy, “laws and policies that unreasonably restrict safe abortion services would not comply with this performance standard.... [It] may be a human rights violation to jeopardize health care.”¹⁰⁷

UN treaty bodies have commented on the impact of unsafe abortions and restrictive abortion laws on health. For example, citing concerns about possible violations of the right to health, the UN Committee on Economic, Social and Cultural Rights, has recommended that states legalize abortion in some circumstances, such as when

¹⁰⁴ Human Rights Committee, General Comment 28, Equality of rights between men and women (Article 3), U.N. Doc. CCPR/C/21/Rev/1/Add/10 (2000), para. 10.

¹⁰⁵ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, ratified by Peru on April 28, 1978, art. 12.1.

¹⁰⁶ UN Committee on Economic, Social and Cultural Rights, “Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights,” General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), para. 12..

¹⁰⁷ Rebecca J. Cook, “Abortion, human rights and the International Conference on Population and Development (ICPD),” in Warriner and Shah, eds., *Preventing Unsafe Abortion and its Consequences*, p. 15.

the pregnancy is the result of rape or incest, and when the life of the pregnant women is endangered.¹⁰⁸

International law also has specific standards for the right to health as applied to adolescents. In its 2003 General Comment on adolescent health and development, the Committee on the Rights of the Child noted the physical and mental health risks related to early pregnancy, and urged governments to provide adequate services, including abortion services where they are not against the law. It also urged states to take measures to reduce maternal morbidity and mortality in adolescent girls, including those caused by unsafe abortion practices.¹⁰⁹ In *K.L. v. Peru* the HRC found that Peru had violated the right to special measures of protection for minors (article 24 of ICCPR) and should have provided K.L. with the “medical and psychological support necessary in the specific circumstances of her case” given her special vulnerability “as a minor girl.”¹¹⁰ The HRC recognized the need for special access and services to protect the vulnerable rights and well-being of adolescents, especially with respect to reproductive health. In previous recommendations the HRC has called upon states to guarantee safe, timely, and affordable access to abortion for adolescents with unwanted pregnancies when the law allows.¹¹¹

Right to non-discrimination

The right to non-discrimination is also a fundamental right in every major human rights treaty. Denying women access to therapeutic abortion in order to terminate dangerous pregnancies amounts to a discriminatory denial of health care that only women need. Women are consequently exposed to health risks not experienced by men.

In its General Recommendation on women and health, the UN Committee on the Elimination of Discrimination against Women suggests that the denial of medical

¹⁰⁸ CESCR, concluding observations on Nepal, UN Doc. E/C.12/1/Add.66 (2001), para. 55; Malta, UN Doc. E/C.12/1/Add.101 (2004), para. 41; Monaco, UN Doc. E/C.12/MCO/CO/1 (2006), para. 23; Mexico UN Doc. E/C.12/CO/MEX/4 (2006), paras. 25 and 44; Chile, UN Doc. E/C.12/1/Add.105 (2004), para. 25; and Kuwait, UN Doc. E/C.12/1/Add.98 (2004), para. 43.

¹⁰⁹ UN Committee on Rights of the Child, General Comment No. 4, “Adolescent health and development in the context of the convention on the rights of the child,” UN Doc. CRC/GC/2003/4 (2003), para. 31.

¹¹⁰ UN Human Rights Committee, *K.L. v. Peru*, para. 6.3.

¹¹¹ Kebraie, “UN Human Rights Committee Decision in *K.L. v. Peru*,” pp. 151-152.

procedures only women need is a form of discrimination against women. It explains that “barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo these procedures.”¹¹² Moreover, in several concluding observations on country reports from the Latin American region, the HRC has established a clear link between women’s equality and the availability of reproductive health services, including abortion.¹¹³ In the case of Argentina, the HRC noted, “The Committee is concerned that the criminalization of abortion deters medical professionals from providing this procedure without judicial order, even when they are permitted to do so by law, inter alia when there are clear health risks for the mother or when pregnancy results from rape of mentally disabled women. The Committee also expresses concern over discriminatory aspects of the laws and policies in force, which result in disproportionate resort to illegal, unsafe abortions by poor and rural women.”¹¹⁴

Right to privacy; the right to decide on the number and spacing of children

Moreover, international human rights law protects the right to noninterference with one’s privacy and family,¹¹⁵ as well as the right of women to decide on the number and spacing of their children.¹¹⁶ These rights can only be fully implemented where women have the right to make decisions about when or if to carry a pregnancy to term without interference from the state. The HRC noted in the case of *K.L. v. Peru* that by denying K.L. access to a therapeutic abortion, Peru “interfered arbitrarily in her private life” and violated article 17 of the ICCPR.¹¹⁷

¹¹² UN Committee on the Elimination of Discrimination against Women, General Recommendation 24, Women and Health, (Twentieth session, 1999), U.N. Doc. A/54/38 at 5 (1999), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003), para. 14.

¹¹³ See UN Human Rights Committee, Concluding Observations on Argentina, UN Doc. CCPR/CO.70/ARG (2000), para. 14; Colombia, UN Doc. CCPR/C/79/Add.76 (1997), para. 24; Ecuador, UN Doc. CPR/C/79/Add.92 (1998), para. 11; Paraguay, UN Doc. CCPR/C/PRY/CO/2 (2006), para. 10; and Guatemala, UN Doc. CCPR/CO/72/GTM (2001), para. 19.

¹¹⁴ UN Human Rights Committee, Concluding observations on Argentina, UN Doc. CCPR/CO.70/ARG (2000), para. 14.

¹¹⁵ ICPPR, art. 17.

¹¹⁶ CEDAW, art. 16(1)(e). This article reads, “States Parties shall ... ensure, on a basis of equality of men and women ... (e) the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education, and means to enable them to exercise these rights.”

¹¹⁷ UN Human Rights Committee, Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003 (2005).

Right to information

The right to information, certainly as it relates to the right to health, includes both the negative obligation for a state to refrain from interference with the provision of information by private parties and a positive responsibility to provide complete and accurate information necessary for the protection and promotion of reproductive health and rights, including information about abortion.¹¹⁸ Human rights law further recognizes the right to non-discrimination in access to information and health services, as in all other services.¹¹⁹ Women stand to suffer disproportionately when information concerning safe and legal abortion is withheld.

Freedom from cruel, inhuman, or degrading treatment

The right to be free from cruel, inhuman, or degrading treatment is protected by international customary law as well as by several international and regional human rights treaties.¹²⁰ The HRC, in concluding observations on Peru, expressed concern that under Peru's laws, abortion gave rise to penalty even if the woman was pregnant as a result of rape. It found that the penal code restrictions on abortion subjected women to inhuman treatment incompatible with article 7 of the ICCPR.¹²¹ In its 2005 decision on the K.L. v. Peru case, the HRC noted that “the right set out in article 7 of the Covenant relates not only to physical pain but also to mental suffering.” The Committee found that K.L.'s depression and emotional distress “could have been foreseen” and “not enabling her to benefit from a therapeutic abortion was ... the cause of the suffering she experienced.”¹²² In this case, the HRC considered “the facts before it reveal a violation of article 7 of the Covenant.”¹²³

¹¹⁸ Article 19, *The Right to Know: Human Rights and Access to Reproductive Health Information* (Philadelphia: University of Pennsylvania Press, 1995), pp. 39 and 61-72.

¹¹⁹ ICCPR, art. 19(2); UN Committee on Economic, Social and Cultural Rights, General Comment 14, “The Right to the Highest Attainable Standard of Health,” paras. 12(b) and 18.

¹²⁰ ICCPR, art. 7; American Convention on Human Rights (“Pact of San José, Costa Rica”), adopted November 22, 1969, O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123, entered into force July 18, 1978, reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 25 (1992), art. 5.

¹²¹ UN Human Rights Committee, Concluding Observations on Peru, UN Doc. CCPR/C/79/Add.72 (1996), para. 15; UN Human Rights Committee, Concluding Observations on Peru, UN Doc. CCPR/CO/70/PER (2000), para. 20.

¹²² UN Human Rights Committee, K.L. v. Peru, para. 6.3.

¹²³ UN Human Rights Committee, Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003 (2005), para. 6.3. The Committee also found violations of articles 2, 17, and 24, and decided that it was not necessary to make a finding on article 6.

Purported conflict of rights

Although the right to life clearly protects the interests of pregnant women, opponents of abortion rights also argue that the “right to life” of a fetus should predominate. There is debate as to when “legal personhood” commences and when the right to life should apply, with many arguing that it should only apply as a legal concept after birth.

The American Convention on Human Rights is the only international human rights instrument that contemplates that the right to life can apply from the moment of conception, though not in absolute terms.¹²⁴ The American Declaration on the Rights and Duties of Man, the predecessor instrument to the ACHR, does not mention conception, guaranteeing instead that “every human being has the right to life, liberty, and the security of his person.”¹²⁵

In 1981 the body that monitors the implementation of the human rights provisions in the American regional system, the Inter-American Commission on Human Rights, was asked to establish whether the right to life provisions in these documents are compatible with a woman’s right to access safe and legal abortions. The commission concluded that they are.

The question reached the commission through a petition brought against the United States government by individuals related to a group called Catholics for Christian Political Action when a medical doctor was acquitted of manslaughter after performing an abortion in 1973 in the “Baby Boy” case.¹²⁶ The petitioners asked the commission to declare the United States in violation of the right to life under the American Declaration on the Rights and Duties of Man, using the American

¹²⁴ American Convention on Human Rights, art. 4.

¹²⁵ American Declaration on the Rights and Duties of Man, O.A.S. Res. XXX, adopted by the Ninth International Conference of American States (1948), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/11.82 doc. 6 rev. 1 at 17 (1992), art. 1.

¹²⁶ Inter-American Commission of Human Rights, White and Potter (“Baby Boy Case”), Resolution N23/81, Case 2141 (United States), Inter-Am. C.H.R. 25/OEA/ser. L./V./II.54, doc. 9 rev. 1 (1981), http://www.wcl.american.edu/pub/humright/digest/Inter-American/english/annual/1980_81/res2381.html (accessed March 13, 2008).

Convention on Human Rights as an interpretative tool.¹²⁷ In the deliberation on the Baby Boy case, the Commission went to great pains to examine the provisions on the right to life in both the declaration and the convention, looking to the preparatory work for both documents to clarify the intended object and purpose of the wording of the provisions.¹²⁸ In the case of the declaration, the commission explained,

[I]t is important to note that the conferees in Bogotá in 1948 rejected language which would have extended that right to the unborn ... [and] ... adopted a simple statement on the right to life, without reference to the unborn, and linked it to the liberty and security of the person. Thus it would appear incorrect to read the Declaration as incorporating the notion that the right to life exists from the moment of conception. The conferees faced this question and chose not to adopt language which would clearly have stated that principle.¹²⁹

With regard to the convention, the commission found that the wording of the right to life in article 4 was very deliberate and that the convention's founders specifically intended the "in general" clause to allow for non-restrictive domestic abortion legislation. As the commission phrased it, "[I]t was recognized in the drafting session in San José that this phrase left open the possibility that states parties to a future Convention could include in their domestic legislation 'the most diverse cases of abortion,'"¹³⁰ allowing for legal abortion under this article. The commission went on to correct the petitioners in their selective reading of the ACHR:

[I]t is clear that the petitioners' interpretation of the definition given by the American Convention on the right of life is incorrect. The addition of the phrase "in general, from the moment of conception" does not mean

¹²⁷ The American Convention on Human Rights was not directly applicable, since the United States had not ratified this convention. However, as a member of the Organization of American States, the United States is bound by the American Declaration on the Rights and Duties of Man.

¹²⁸ The 1969 Vienna Convention on the Law of Treaties, which guides public international treaty law, establishes as a general rule of interpretation of international treaties that "a treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose," and notes that the preparatory works of a treaty can be used as a supplementary means of interpretation. Vienna Convention on the Law of Treaties, arts. 31 and 32.

¹²⁹ Inter-American Commission of Human Rights, Baby Boy Case, para. 14 (a).

¹³⁰ *Ibid.*, para. 14(c).

that the drafters of the Convention intended to modify the concept of the right to life that prevailed in Bogotá, when they approved the American Declaration. The legal implications of the clause “in general, from the moment of conception” are substantially different from the shorter clause “from the moment of conception” as appears repeatedly in the petitioners’ briefs.¹³¹

The commission also cited several countries, including the United States and Brazil, for having clarified during the negotiations that, notwithstanding any language contained in article 4(1) of the convention, they retained the right to “preserv[e their] discretion with respect to the content of legislation in the light of their own social development, experience and similar factors.”¹³²

¹³¹ *Ibid.*, para. 30.

¹³² *Ibid.*, para. 14(c).

VIII. Recommendations

To the Ministry of Health

- Issue a national-level protocol on therapeutic abortion. The protocol should cover:
 - eligibility criteria, including for harm to mental health;
 - the right of the pregnant woman to be heard and to have her views considered;
 - techniques and medical procedures to use;
 - standardized data collection requirements;
 - confidentiality protections;
 - referral procedures;
 - timelines and lines of authority for making decisions on therapeutic abortions; and
 - accountability mechanisms for redress of grievances.
- Do not block the efforts of regional health ministries to disseminate evidence-based protocols on therapeutic abortion, including the Arequipa regional protocol.
- Formulate and incorporate clear-cut guidelines for legal abortion on mental health grounds, including the mental health risks to women carrying fetuses with congenital malformations or disorders incompatible with life, and in the case of pregnancy as a result of rape or incest.
- Ensure through information in the form of a technical guide for a variety of medical specialists (including oncologists, cardiologists, and internists) that physicians counsel women about the availability of therapeutic abortion for pathologies that could worsen in the course of pregnancy or could affect the pregnancy adversely.
- Ensure that women and communities have access to evidence-based information tailored to varying levels of literacy to prevent pregnancies that could endanger their health or life.

- Guarantee special attention to and access for adolescents in fulfilling their sexual and reproductive healthcare needs, including therapeutic abortion.
- Implement the UN Human Rights Committee judgment in the case of K.L. v. Peru, recognizing adolescent girls as an especially vulnerable population that must receive safe, timely, free, non-stigmatizing, accessible, and appropriate services.

To regional health ministries and departments

- Investigate whether any out-of-pocket expenses are associated with access to therapeutic abortion in public healthcare facilities. Ensure, with other ministries, that social and private insurance schemes provide coverage for therapeutic abortions and do not act as barriers for women to access healthcare services
- Monitor compliance and investigate instances where physicians or medical administrators have refused to provide therapeutic abortion services to eligible women and girls. Appropriately discipline healthcare providers who impede access to therapeutic abortions.
- Wage public information campaigns to inform women, health service practitioners, and the general public of the legal standards for non-punishable abortions and the public's right to access services that are accessible, affordable, available, and of adequate quality. The Ministry of Health should spearhead this effort but also work with the Ministry of Education, Ministry of Justice, and other relevant ministries as appropriate to target specific audiences with appropriate messaging in Spanish and indigenous languages and to monitor the campaigns' effect on actual service delivery.
- Ensure the ongoing participation of civil society actors, especially women's rights and health organizations and professional medical associations, in the design, implementation, and monitoring of programs and systems to ensure access to therapeutic abortion and other vital components of sexual and reproductive health.

To the Ministry of Justice

- Issue a statement clarifying the existing penal code and its provision for therapeutic abortions. Disseminate the statement to members of the police force, prosecutors, the Executive Office, legislators, Ministry of Health administrative officials and their healthcare service employees, all regional government offices, and relevant medical associations.
- Devise and implement a public information strategy with other public ministries as appropriate to ensure that the status of legal access and entitlement to abortion is known to the general population, to dispel and remedy widely held misconceptions.

To the National Human Rights Ombudsman Office (Defensoría del Pueblo)

- Investigate outstanding complaints about denial of access to therapeutic abortion.

To the Peruvian Congress

- Repeal immediately the clause of article 30 of the General Health Law that obliges medical practitioners to report to the police women who are suspected of having induced an abortion. Repeal the penal code provisions that criminalize abortion and impose penalties on women and girls who procure abortions.
- Appropriate adequate funds for public information awareness campaigns on the availability of safe and legal abortion services.
- Earmark funds for therapeutic abortion training and service delivery, including: training of all public hospital personnel and employees of possible referral centers; implementation of the best evidence-based termination, infection prevention, and pain management procedures; and provision of psychological counseling and social support services for women who undergo therapeutic abortions.

To the Medical College of Peru

- Continue to disseminate the recommendations on therapeutic abortion from the Peruvian Society of Obstetrics and Gynecology (Sociedad Peruana de Obstetricia y Ginecología, SPOG) and the Medical College of Peru to all levels of healthcare services in different disciplines throughout the country to inform physicians and other healthcare providers of their ethical and legal responsibilities. Reiterate that performing medical duties comes first, even in the absence of a national protocol.
- Promote the recommendations on therapeutic abortion from SPOG and the Medical College of Peru as part of the medical school curriculum.
- Introduce therapeutic abortion as part of the training and accreditation process for medical and midwifery school graduates, via the Peruvian Association of Medical Schools and the National Association of Midwifery Schools, respectively.
- Instruct members of the Medical College of Peru on the ethical and legal violations and the possibility of malpractice liability for those healthcare providers who refuse to attend women in need of therapeutic abortion.
- Clarify to local, regional, and national healthcare institutions the principle of conscientious objection, and the fact that it applies to individuals and not institutions.
- Develop and disseminate general pregnancy prevention recommendations, tailored for different specialties, for counseling women with pathologies that could worsen in the course of pregnancy or could affect the pregnancy adversely about the risks that pregnancy poses to their health and lives. Expand those guidelines to include counseling on pregnancy termination for pregnant patients whose pathologies or the treatment required to cure them could endanger the life and health of the fetus.
- Encourage scientific societies, the technical branches of the Medical College of Peru, to provide guidance for affiliated members on pregnancy prevention for women whose health or lives could be endangered. Utilize a woman-centered, risk reduction approach as part of the preventive care strategies.

- Pressure the Ministry of Health at the national and regional levels to implement fully the clinical guides on therapeutic abortion.

To the US Agency for International Development

- Clarify to the Peruvian Ministry of Health that the Mexico City Policy does not impact situations where the woman's life is in danger, nor does it affect the provision of post-abortion care. As US policies change, provide funds, technical assistance, and the necessary inputs to assist the Ministry of Health in improving access to safe and legal abortion.

To Other Bilateral Donors

- Follow the lead of the United Kingdom's Department for International Development in funding and actively supporting the Safe Abortion Action Fund, managed by the International Planned Parenthood Federation, with designated funds for improving access to therapeutic abortion in Peru.
- Provide funding and support for raising awareness about therapeutic abortion among diverse audiences in Peru. Also provide funding and support for reproductive health programs including abortion prevention, access to legal abortion, and integral post-abortion care.

To the International Federation of Gynecology and Obstetrics

- Support the Latin American and Peruvian affiliates (the Latin American Federation of Obstetric and Gynecological Societies (Federación Latinoamericana de Sociedades de Obstetricia y Ginecología, FLASOG) and Peruvian Society of Obstetrics and Gynecology (Sociedad Peruana de Obstetricia y Ginecología, SPOG), respectively) in developing and promoting ethical guidelines on the provision of humane therapeutic abortion care, including explicit condemnation of doctors and ad hoc medical committees who refuse to perform or approve therapeutic abortions.
- Encourage obstetricians and gynecologists to work with specialists in other fields of medicine to counsel women on pregnancy prevention, and to provide

timely referrals for legal pregnancy interruption when the woman's life or health is endangered.

To the Inter-American Commission on Human Rights

- Research obstacles to access therapeutic abortions in the region, including Peru. Issue a report on the findings and disseminate it widely among policymakers, legislators, and other key stakeholders.

To the United Nations Population Fund and other organizations within the UN System, and the Pan American Health Organization

- Work towards adopting policies to advocate for the global decriminalization of abortion as a means of protecting women's human rights and as an evidence-based means to reduce the rate of maternal disability and mortality associated with unsafe abortion, consistent with the UN Millennium Development Goals and the commitment to international human rights.
- Work with governments to prevent unwanted pregnancies and reduce the need for abortions, to ensure that health systems have the capacity to deal effectively with the complications of unsafe abortion, and to ensure access to quality abortion services where they are legal.
- Support the finalization and dissemination of a national evidence-based protocol(s) on the management of therapeutic abortion.
- Participate in monitoring and interagency reporting on maternal health and universal access to reproductive health services, including access to therapeutic abortion, in Peru.
- Raise public awareness in Peru and on a global scale that mental health and wellness is a fundamental component of the right to health, including sexual, reproductive, and maternal health.
- Provide increased technical assistance to the Peruvian Ministry of Health in registering and analyzing adequately the number of therapeutic abortions performed at each public sector hospital.

- Sensitize and educate policymakers, communities, and individuals about the role of therapeutic abortion in saving women’s lives.
- Generate and update an analysis of regional trends in and data on access to therapeutic abortion for policymakers and other key stakeholders.

To the UN Human Rights Council

- Recognize the serious adverse impact that the criminalization of abortion and denial of therapeutic abortion has on women in Peru, particularly with endangerment to their lives and physical, mental, and social health.
- Ask the incoming special rapporteur on the right to the highest attainable standard of health to follow up on the previous rapporteurs’ findings in Peru as a matter of urgency.
- Urge Peru’s compliance with the Human Rights Committee recommendations on therapeutic abortion in the Universal Periodic Review and at other opportunities.

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