

Women's Rights in Peru: A Shadow Report

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WOMEN'S RIGHTS IN PERU: A SHADOW REPORT

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Introduction

The purpose of this report is to provide the members of the Human Rights Committee information gathered by non-governmental organizations (NGOs) on the Peruvian government's laws, policies, and practices relating to those rights upheld in the International Covenant on Civil and Political Rights (ICCPR) that are of particular importance to women. Our intent is to give Committee members information that will enable them to review and assess the government of Peru's official report on this topic.

The specific reference to women's rights is made in the interest of reviewing women's enjoyment of a fundamental human right: the right to equality. According to the ICCPR, the Peruvian government must guarantee equal enjoyment of all rights. It also must provide equal and effective protection against all forms of discrimination, including gender discrimination. This means that the government must recognize and attend to the specific needs of the female population, a group that faces a number of forms of gender discrimination.

The report will attempt to give an account of the situation of women in Peru. It will also address the regulations, policies, and practices that affect women, with special emphasis on women who live in rural areas and who are disproportionately at risk of having their rights abused.

We have focused our attention on reproductive rights and on all rights that create the conditions for their fulfillment. These include the right to health care services; the right to physical, mental, and moral integrity and to non-violence; the right to equality between spouses; the right to sexuality education; the right to property and inheritance; and the right to equal access to the labor market. These rights are guaranteed by several provisions of the ICCPR, particularly the right to equality (Articles 2, 3, 24); to life (Article 6); to physical integrity (Article 7); to privacy (Article 17); to freedom of expression (Article 19); to protection of the family by the State (Article 23); and to non-discrimination (Article 26).

The report covers five key issues: 1) access to reproductive health and family planning services, including safe and legal abortion; 2) violence against women; 3) family relations, including equality of spouses in marriage; 4) the right to education; and 5) economic and social rights. Each aspect is dealt with in two separate sections. The first, shaded section outlines the government's laws and public policies related to the issues in question. The second section provides information on the implementation and enforcement of these laws and policies.

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Principal Areas of Concern

1. Peru has the second highest maternal mortality rate of any nation in South America, which in turn has one of the highest such rates of any region globally. This rate has been constant for the last decade, indicating the Peruvian government's lack of commitment to the human rights of women, particularly the right to health; it also represents a serious violation of the right to life.

2. The system of charging fees for prenatal and postnatal care makes reproductive health services inaccessible to a considerable number of women. Those most affected are women who are in a precarious position due to poverty and social exclusion. This practice therefore compromises the right to life and to non-discrimination.

3. Female users of health care services are subject to physical and psychological violence. Their lives are put at risk, and they are exposed to coercive and humiliating treatment on the part of health care providers. The government's response to this conduct, involving violations of the rights to life, to physical integrity, to be free of violence, to be free from torture, and to non-discrimination, has been one of institutional cover-up. Those rare cases that have been brought to the legal system have been undermined by the neglect and indifference of the courts. Discrimination based on socio-economic status, ethnic origin, and gender, as well as corruption, serve as shields for the perpetrators of these violations. This creates an environment where such violations go unpunished and, therefore, persist.

4. In implementing the Program on Reproductive Health and Family Planning, female sterilization has been emphasized as a method of family planning. The use of this method often involves practices that violate the right to informed consent and the prohibition against cruel and degrading treatment. The Program particularly affects the poorest women in urban and rural areas, many of whom are the victims of forced sterilization. Such practices conflict with the rights to life, to physical integrity and non-violence, to information, and to non-discrimination based on gender, economic position, and cultural status.

5. The Peruvian government has not revised its restrictive policies and laws concerning abortion, despite the Human Rights Committee's recommendations,¹ and despite the well-known fact that criminalization gives rise to clandestine, unsafe practices that endanger the lives and physical integrity of women who interrupt their pregnancies. This situation compromises the right to life and the right to physical integrity. In an outright violation of the right to privacy, the government has gone further by issuing regulations forcing health care providers to report women who are hospitalized due to abortion-related complications.

6. Peruvian legislation shows the precarious status of female patients' rights. There have been no laws to develop the content of these rights, merely generic regulations that are not widely disseminated by the State. More specific administrative regulations that are mandatory for care providers are generally unknown to patients. This prevents the enjoyment of the right to information.

7. The State continues to downplay sexual and domestic violence against women. While there has been progress in gaining recognition of these issues as a matter of public concern, the perception that these types of violence occur only as isolated incidents impedes the adoption of sustained measures to prevent violence and to protect victims. Domestic violence is underestimated for another reason as well: regulations establish that an attempt must be made at reconciliation of the parties. Furthermore, with regard to both sexual and domestic violence, those in a position to administer justice use various mechanisms to stay accusations or to keep from imposing effective sanctions. This undermines the rights to physical and emotional integrity, to non-discrimination, and to be free from violence.

8. The State does not concern itself with matters of sexual harassment in the work and school environments. It is not seen as a crime, and there are not even administrative regulations that provide measures for its prevention and sanction. This omission constitutes failure on the part of the government to preserve the rights to physical and emotional integrity, to non-discrimination, and to be free from violence.

Observations on the Peruvian Government's Periodic Report

The Peruvian government's report limits itself to outlining the legal provisions that formally recognize and guarantee the rights established by the ICCPR. It does not include information on the population's enjoyment of these rights.

We also must consider, as the Human Rights Committee has pointed out,² that the State's responsibility to protect the equal rights of men and women involves the elimination of all obstacles to the effective enjoyment of rights under equal conditions. Purely legislative provisions do not suffice. Furthermore, after examining Peru's previous official report, the Committee requested information from Peru on the progress made to achieve women's full enjoyment of the rights established by the ICCPR, particularly with regard to issues such as sexual violence, abortion, and labor rights. The Peruvian government has failed to meet the Committee's request.

A. Access to Reproductive Health and Family Planning Services, Including Safe and Legal Abortion (Articles 3, 6, 23, and 26 of the ICCPR)

The ICCPR's guarantee of the right to life in Article 6 requires governments to take "positive measures" aimed at preserving life.³ Such measures should respond to the needs of both women and men, in keeping with Articles 3 and 26, which guarantee the right to equal enjoyment of the rights in the Covenant and equality before the law. Because reproductive health care is an essential condition for women's survival, these provisions collectively give rise to a governmental duty to ensure the full range of reproductive health services, including the means of preventing unwanted pregnancy.

The Human Rights Committee (hereinafter "the Committee") has recognized in its General Comment 19(39) the right to "procreate and live together," which by inference includes the right to reproductive health care and to all safe and appropriate forms of contraception.⁴ Accordingly, the Committee has found possible violations of the Covenant where women have difficulty accessing contraceptive methods to prevent unwanted pregnancies.⁵

The Committee has further acknowledged that States' duties to protect and ensure the right to life include a duty to protect women who terminate their pregnancies.⁶ It has called upon States to take measures "to ensure that women do not risk life because of restrictive legal provisions on abortion," i.e. being forced to seek abortions under clandestine, unsafe conditions.⁷ In this regard, the Committee has recommended liberalization of laws that criminalize abortion.⁸

1. Access to Reproductive Health and Family Planning Services

Laws and Policies

The Political Constitution of 1993 establishes the right to protection of health.⁹ It requires the State to defend the interests of those who use public health services, and particularly to watch over the health and safety of the population.¹⁰ With regard to family planning, the Constitution recognizes the right of families and individuals to decide on reproductive matters.¹¹

The General Law on Health¹² indicates that the State has the responsibility to provide public health services in accordance with principles of fairness. The Law also recognizes a series of rights that protect those who use these services,¹³ including the right to know the costs of services.¹⁴ With regard to family planning services, it states that individuals have the right to select freely the contraceptive method of their choice¹⁵ and to receive adequate information on these methods, their risks, counter-indications,

precautions and warnings, as well as on the physical, physiological, or psychological side effects that their use or application may incur.¹⁶

The National Population Policy Act¹⁷ establishes the State's obligation to attend to the population's health needs, with a preference for free services.¹⁸ It also confirms that overall maternal and infant health care is a priority among free services.¹⁹ It recognizes the right to overall health and the right to decide freely the number of one's children,²⁰ while indicating the State's duty to promote family planning programs with corresponding services in all health sector institutions.²¹ The Ministry of Health later issued a Ministerial Order²² to force these institutions to strengthen and give priority to their initiatives in this area;²³ the Order specifically provides for supplying the full range of contraceptive methods free of charge.²⁴

In 1995, the Program on Reproductive Health and Family Planning 1996-2000 was created to implement the reproductive health policy.²⁵ The program recognizes reproductive health as a fundamental human and social right, and considers family planning to be a priority.²⁶ Its principal objectives include "increasing timely access to reproductive health and family planning services [and] improving the coverage, quality and humaneness of institutional care."²⁷ Consistent with this, it confirms the cost-free status of contraceptive services and methods, including surgery and sterilization.²⁸

A 1990 Ministerial Order provides for Ministry of Health institutions to offer a paid "clinical" care option, to be applied to persons with economic means. The proceeds from this option are partially used to defray the costs of care for indigent patients.²⁹

In 1998, the National Population Plan 1998-2002 was created to act as the main instrument for implementing the population policy.³⁰ The Plan's goals include expanding health care coverage to 100% of the urban population and 80% of the rural population; lowering the maternal mortality rate by 50%; increasing contraceptive use among males so that they account for no less than 10% of overall prevalence; and increasing access to perinatal, childbirth and post-partum care provided by qualified personnel to 75% of pregnant women.³¹

In 1999, the Ministry of Health's Family Planning Program introduced a measure to integrate all aspects of reproductive health.³² Among other things, the program aims to ensure the professional competence of those who provide treatment as part of family planning services, guarantee that service facilities are well equipped,³³ and to promote reproductive health education sessions in geographically remote areas. The Program also contains a series of provisions aimed at guaranteeing free and informed choice of contraceptive methods, without any type of coercion, deception, or incentive; decent treatment of female patients; and Program accountability in cases of medical complications or fatalities attributable to family planning services.

Also in 1999, the National Plan for Gynecological Cancer Prevention was adopted.³⁴ Its objectives include promoting effective, efficient, and quality alternatives to control cancer in the medium term. The Plan is also aimed at cutting the rate of female mortality due to uterine and breast cancer through preventive and promotional measures among female adolescents and women from the ages of 15 to 24, as well as through detection, diagnosis, and treatment for low-income women between the ages of 30 and 49.³⁵

Reality

Access to Health Services

In Peru, large segments of the population have difficulty accessing formal health care services.

There are a number of reasons for this lack of access, but the primary factors are geographical location and low family income levels. Data show that the rural population is at a serious disadvantage in accessing health care due to its relative isolation. In the 1998 National Household Census, those with the least chance of accessing health services when they need them are those who live in rural areas (52% as opposed to 70% access for the urban population).³⁶ Even among those for whom geographical remoteness poses no barrier to access, it can be inferred from the data that one of the main reasons for not seeking health care services is lack of financial resources. In the 1998 National Household Census, poverty was cited by 36.6% of those surveyed as a factor in their lack of access to health services, making it the most prevalent response.³⁷

There is evidence that the variables of remoteness and poverty have a greater impact on women. This is explained by the fact that women tend to have lower incomes than men,³⁸ and that the single-parent households with the lowest incomes are those headed by women.³⁹ Gender, then, is itself a factor in lack of access to services. It is therefore not surprising that access to health services is most difficult for women with low incomes who live in rural areas.⁴⁰ The heightened impact on women is even more apparent with respect to reproductive health services, for which women have greater demand due to their physical characteristics.

Maternal Mortality

Peru has the second-highest maternal mortality rate of all South American countries (265 for every one hundred thousand live births), which means that approximately 1,800 women die of pregnancy-related causes annually. This rate has not gone down in recent years, despite the Peruvian government's commitment to cutting the rate in half by the year 2000. The situation is worse in the countryside, where women are twice as likely to die of pregnancy-related causes as are women in urban areas.⁴¹

Preventive Reproductive Health Services

Breast cancer and uterine cancer prevention techniques are still very new. The vast majority of Peruvian women do not undergo examinations to detect these illnesses. In 1998, barely 12.3% of women had breast exams, and only 22.7% had Pap smears.⁴² Among the stated reasons for not using these important preventive reproductive health measures, the most worrisome was given by women in the Sierra region, who said they were not familiar with them.⁴³ Differences in income levels are also significant in this part of the country. Those who underwent the exams were mostly women whose basic economic needs were met; however, the proportion dropped by almost half for women living in extreme poverty.⁴⁴

Maternal and Infant Care

It is the State's responsibility to eliminate the barriers to obtaining prenatal care. In 1996, professional prenatal care was provided to 81% of pregnant women in urban areas, whereas only 47% of pregnant women in rural areas received it.⁴⁵ Furthermore, there are qualitative differences in childbirth care according to socio-economic status and place of residence. While nearly 80% of the women whose basic economic needs were met managed to receive care in health institutions, the reverse was true for women living in extreme poverty: almost three quarters (72.6%) gave birth at home.⁴⁶ If this situation is examined according to the geographical location of women about to deliver, it is clear that there is a similar discrepancy between rural and urban women: only 15% of births in rural areas took place in health care institutions, compared to 73% in urban areas.⁴⁷ With regard to the type of care received during delivery, less than a quarter of the women who gave birth in the countryside had professional care (22%) — four times less than in metropolitan Lima (93%).⁴⁸

Official figures for 1997 do show some increased coverage in terms of the still limited provision of reproductive health services,⁴⁹ but they also show the enormous gap that persists between supply of services and the needs of the population. Two telling examples are revealed in data for the same year: only 8.8% of health services nationwide had the capacity to provide basic obstetrical care, and only 6.4% of primary health care services directly offered a full range of reproductive health services.⁵⁰

Similarly, despite the legal mandate to make free maternal and infant care a priority, patients continue to be charged compulsory fees. The government's tiered cost system, based on the type of service and the situation of certain vulnerable sectors of the population, has become a tool of discrimination rather than a levelling mechanism. Since fee-payment proceeds are considered income for the health care institutions, they have a de facto institutional imperative to select and treat women who can pay, to the detriment of those who are unable to pay. In many cases, patients are fully responsible for the costs of services, medications and testing.⁵¹

Unmet Demand for Family Planning

The goal of meeting the population's family planning needs, a fundamental government objective in recent years, has not been fully achieved. A significant number of Peruvian women have more children than they would like.⁵² Between 1991 and 1996 alone, approximately one million unwanted children were born in Peru.⁵³

Quality of Care and the Violation of Female Patients' Human Rights

The quality of care is an essential component in access to reproductive health services, since it can either attract women or discourage them from using the health care system. Quality of care in Peru is still a significant issue. Particularly in marginal urban and rural areas, the relationship between care providers and patients—especially poor female patients—tends to be discriminatory and sometimes violent.⁵⁴ Serious cases of such discrimination have been documented, for example, in an inquiry carried out between 1996 and 1997 that established through case documentation and testimonies that various forms of violence are committed against female patients in public health care centers. In more than 60 testimonies gathered in five Peruvian cities, women complained of bodily interventions without any kind of information or consent; abandonment and exposure to unnecessary harm and suffering; aggressive responses from health care staff when asked for assistance; humiliation because of the number of their children; verbal violence criticizing women patients about their sexual behavior; refusal or postponement of admission to the institution for economic reasons; and “detainment” of women patients and newborns for unpaid hospital debts.⁵⁵

While some of the rights of health care service users are set out in the General Law on Health, they are not disseminated to the population. Various studies have determined that patients and even health care providers themselves are unaware of these rights. It is clear that if patients were more informed of their rights, they would have wider access to health care services.

2. Abortion

Laws and Policies

Abortion is illegal in Peru. It is considered a crime against life, the body, and health, with the exception of therapeutic abortion to save the pregnant woman's life or to protect her from serious and permanent harm.⁵⁶ The National Population Policy Act not only prohibits abortion as a family planning method,⁵⁷ it also establishes the State's obligation to adopt appropriate measures to help women

avoid abortion, as well as to provide medical care and psychological support to women who have had abortions.⁵⁸

The General Law on Health states that it is the responsibility of the State to watch over, protect, and attend to the health problems of mothers and children.⁵⁹ The State should fulfill this responsibility by either fully or partially subsidizing health care for low-income sectors of the population.⁶⁰ Consistent with this duty, the Ministry of Health established maternal and infant insurance in 1999. The plan covers all insured women during pregnancy and up to 42 days after delivery, as well as insured children from the time they are born to the time they turn four.⁶¹ The benefits of this insurance for pregnant women include treatment for all pregnancy-related complications, including hemorrhaging during the first trimester due to abortion or abortion-related complications.⁶²

For its part, the Program on Reproductive Health and Family Planning takes the position that efforts to reduce the maternal mortality rate should include a focus on fatalities caused by complications of illegal abortions due to unwanted pregnancies.⁶³ Despite this, the General Law on Health requires doctors to inform their institution's director of cases that show signs of induced abortion. The director is in turn obligated to report these cases to the appropriate authorities.⁶⁴ The law further states that, when the police and Public Prosecutor request information on abortion cases, the doctor must provide it, thus depriving these patients of confidentiality.⁶⁵

Since 1997, the Ministry of Health, with financing and technical support from international agencies, has been carrying out a post-abortion care program. Initiatives with a year-2001 deadline are: assessing the treatment of incomplete abortions in some national health institutions; training health care personnel to provide humane treatment using modern techniques; monitoring activities; and promoting and defending rights.⁶⁶

Reality

In 1996, upon examination of the Peruvian government's Third Periodic Report, the Human Rights Committee pointed out the relationship between clandestine abortion and maternal morbidity and mortality. The Committee also recognized that the criminalization of abortion could constitute cruel, inhuman and degrading treatment, in outright violation of Article 7 of the ICCPR. It therefore recommended that the legislation penalizing voluntary interruption of pregnancy, even in the case of rape, be revised. The Peruvian government has ignored this recommendation.⁶⁷

Peru has a high rate of abortions carried out under unsafe conditions. While the clandestine nature of such procedures makes it difficult to estimate the prevalence of dangerous abortions, it is estimated that each year 30% of all pregnancies end in abortion. On average, five out of every one hundred Peruvian women between the ages of 15 and 49 have abortions annually. Based on these figures, it is estimated that there were 324,000 abortions in 1997,⁶⁸ directly causing 22% of maternal deaths. Despite the illegality of abortion, treatment for abortion-related complications is relatively common in the public health care system.⁷⁰

The law that forces health care providers to inform law enforcement authorities about cases that show signs of induced abortion exempts them from professional secrecy. This discourages women from seeking health care services when they experience complications from interrupting a pregnancy. Not only does this regulation contravene the right to privacy set out in Article 17 of the ICCPR, by interfering in one of the most difficult decisions women must make about their private lives, it also undermines the right to physical integrity protected by Article 7 of the ICCPR. Women do not obtain proper treatment for complications related to abortions⁷¹ because they fear both legal penalties and the cruel treatment they may have to face in health care facilities, where they are subjected to intimidating interroga-

tions and other practices aimed at punishing them for interrupting their pregnancies.⁷²

While the clandestine nature of abortion is the principal reason for women's lack of access to safe procedures, it is not the only one. Economic factors and the woman's place of residence also play an important role. Facilities where treatment for complete or incomplete abortion can be obtained safely, in terms of health and possible legal sanctions, are only accessible to women with economic means. It follows that, of the women who undergo clandestine abortions, the poorest and/or those who live in rural areas are the principal victims of complications. In fact, 69% of poor rural women who undergo abortions have complications, as do 44% of women living in poor urban areas.⁷³ On average, fewer than half of the women nationwide who suffer these complications are treated in a health care institution.⁷⁴ It is therefore not surprising that abortion is a significant cause of morbidity and mortality among low-income Peruvian women.

It also should be noted that the low prosecution rate for illegal abortion practices only demonstrates the ineffectiveness of punitive legislation. In practice, rather than preventing women from having abortions, the regulations have a tragic effect: the thousands of women who decide to interrupt their pregnancies are forced to do so under dangerous conditions, at an enormous risk to their lives.⁷⁵

3 Sterilization

Laws and Policies

The National Population Act was amended in 1995 to provide for sterilization as one of the family planning methods under government programs.⁷⁶ The General Law on Health states that use of this method requires written consent on the part of the patient.⁷⁷

Voluntary Surgical Contraception (VSC) has been the object of a specific regulation from the Ministry of Health under the Family Planning Program.⁷⁸ In the case of female VSC, institutions must be certified to guarantee the safety and quality of interventions. For male VSC, health care premises need not have an operating room, making specific certification unnecessary. The regulation establishes local committees responsible for the certification process, who in turn are supervised and regulated by a central certifying committee.⁷⁹

The National Program for Reproductive Health and Family Planning 1996-2000 establishes specific provisions for VSC-related treatment. These provisions are aimed at reducing surgical risk and obtaining informed consent from women patients.⁸⁰

Reality

In recent years, the National Program on Reproductive Health and Family Planning 1996-2000 was implicated in a national scandal arising from accusations of forced sterilization of women from the most vulnerable social sectors. During the first two years of the program (1996-1997), there was a surprising increase in the number of female sterilizations throughout the country, due to the Ministry of Health's aggressive family-planning campaign.⁸¹ However, the preference for this method was not due in all cases to the voluntary consent of the women involved. Investigations carried out by the media and by women's groups revealed to the national and international community several cases of unauthorized sterilization. There were also reports of systematic, door-to-door pressure tactics in marginalized urban and rural areas, coercion and, perhaps most disturbing, sterilization quotas established by health care authorities that involved pressuring and providing incentives to the staff of health care institutions to meet these quotas.⁸² In light of these facts, the Ombudsman's Office generated a report, taking a stand on the issue and proposing a set of measures and recommendations for the health care sector.⁸³

As this situation gradually came to light, the administrative authority of the health care sector was forced to take corrective measures, recognizing and incorporating some of the suggestions proffered by the Ombudsman's Office and by NGOs.⁸⁴ These measures were integrated into the set of regulations that govern family planning services in general and surgical contraception in particular.⁸⁵ But these provisions have not been widely disseminated among those most affected, making it difficult for them to demand that their rights be protected.⁸⁶

Problems with the application of VSC therefore persist despite corrective measures. In 1998 and 1999, cases arose of women undergoing VSC without having had sufficient access to information before the operation. Furthermore, the waiting period was not always respected, consent forms for the operation were sometimes signed under pressure, and the postoperative assessment system was at times deficient. Examples exist of consent forms and family planning information material written exclusively in Spanish, making them inaccessible to women who speak Quechua.⁸⁷ Furthermore, the judiciary has failed to investigate many of the deaths thought to be caused by surgical sterilization procedures.⁸⁸

4 HIV/AIDS and other Sexually Transmissible Infections (STIs)

Laws and Policies

In 1996 a law laying the foundations for the National Plan to Fight AIDS was promulgated.⁸⁹ The Plan's objectives include: a) coordinating and facilitating the implementation of national strategies to control HIV/AIDS and other STIs; b) promoting national and foreign technical and financial cooperation aimed at preventing and controlling these diseases and assisting their victims; and c) proposing legislative changes to facilitate the adequate development of the struggle against HIV/AIDS and other STIs.⁹⁰ According to this law, diagnostic tests for these diseases are voluntary and accompanied by counseling.⁹¹ Test results and information on the certain or probable causes of infection are confidential and can only be requested by the Public Prosecutor or the judiciary.⁹² The law also protects people with HIV/AIDS as long as they are able to carry out their duties. The law prohibits employment discrimination, including termination, against people with HIV/AIDS.⁹³

That same year also saw the approval of a policy called "Doctrine, Regulations and Procedures to Control STIs and AIDS in Peru." The document aims to standardize all health care-institution operating principles and criteria for the prevention and control of HIV/AIDS within government institutions.⁹⁴ The application of these standards is mandatory in all health care facilities.⁹⁵

Reality

While HIV/AIDS is a fairly new phenomenon in Peru, it is spreading rapidly. According to official figures, there were 933 reported AIDS cases in 1990; 3,500 by 1995, and 8,354 by January 1999.⁹⁶ As of January 1999, there were 7,977 officially registered HIV-positive individuals,⁹⁷ but estimates put the actual figures much higher. It is expected that, by the year 2000, there will be 100,000 people infected with HIV in Peru.⁹⁸

AIDS is a very real danger for the adolescent population. According to the Ministry of Health's Program to Control Sexually Transmissible Diseases and AIDS (PROCETSS), 40% of the almost 6,000 cases reported as of September 1997 (the actual figure was by then estimated at above 8,000)⁹⁹ involved people in the 20-to-29 age group. Given the disease's long latency period, it is highly possible that this group was infected during adolescence.¹⁰⁰ This suggests that education efforts to prevent unsafe sexuality among adolescents are falling short of the mark.

Women's risk of contracting this deadly disease is also growing on a yearly basis. In 1990, for every 15 men with AIDS, there was one woman with the disease. By 1998, that gap had closed, with a ratio of

one woman with the disease for every five infected men.¹⁰¹ Women in rural areas are at the greatest risk of infection. The proportion of women who are unaware of the disease is higher in rural areas than in urban areas. Those who do know about the disease are for the most part poorly informed and therefore are not taking preventive measures.¹⁰²

B. Violence Against Women (Articles 3, 6, and 7 of the ICCPR)

Article 7 of the ICCPR states that no one shall be subjected to torture, inhuman or degrading treatment, or punishment. Article 6 ensures the individual's right to life. Both of these rights are potentially violated when women are subjected to rape and domestic violence. Article 3, which provides for the equal enjoyment by both sexes of the Covenant's rights, is violated if women are not protected from violence by law and the government's diligent enforcement of such law.

The Committee has urged States to promulgate laws providing effective protection against rape, sex abuse, and violence against women.¹⁰³ It has also said that making rape a privately prosecutable crime (so that survivors, rather than the state, must file an action), and subjecting abortion to criminal penalties even in the case of rape, are incompatible with Articles 3, 6, and 7 of the Covenant.¹⁰⁴ In the same vein, the Committee holds a negative view of legal provisions that exempt a rapist from punishment if he marries his victim,¹⁰⁵ and has criticized States that do not consider rape in marriage an offense.¹⁰⁶ It has further expressed concern over high incidence of sexual harassment in the workplace¹⁰⁷ and commented that such acts of discrimination should "be established as punishable crimes."¹⁰⁸

The Committee has acknowledged that certain groups are particularly vulnerable to violence and has emphasized the importance of full participation of States Parties in the disclosure of information concerning violence and sexual abuse against female detainees and prisoners.¹⁰⁹

1. Rape

Laws and Policies

The crime of rape is defined in the 1991 Penal Code as a "sexual or analogous act" perpetrated with violence or serious threat to the victim.¹¹⁰ Prison sentences are quite severe, and have even been increased in subsequent laws, particularly in cases where the victim is a minor. If the sexual or analogous act is committed against boys or girls under the age of seven, the sentence is life imprisonment.¹¹¹ In 1998, the Children and Adolescents' Code was modified to establish that boys and girls have the right to be respected by their teachers. This respect includes the non-perpetration of sexual harassment, abuse, or violence.¹¹²

In 1999, a law was passed to establish the rights of victims of sexual violence, particularly victims under the age of 14. The principal legal mechanisms include: the Ministry for the Promotion of Women and Human Development (PROMUDEH), which must promote public and private programs to prevent, protect, and treat cases of sexual violence against boys and girls and adolescents; mandatory attorney involvement in all police and legal proceedings; and mandatory and free provision of comprehensive, professional legal assistance to boys, girls, and adolescents.¹¹³

In 1997, legislation was adopted to eliminate the Penal Code provision allowing a suspended sentence for the rapist and co-perpetrators if one of them married the victim.

In 1999, an act to amend the Penal Code was adopted that permits the public exercise of penal action for crimes against sexual liberty, which previously could only be addressed in private proceedings.¹¹⁴ The amendment also establishes special procedures to investigate such crimes, whereby

the identity of the victim must be kept confidential, consent must be obtained for the forensic examination, and the victim's physical and emotional state must be considered when the evidence is presented in court.¹¹⁵

Reality

Legal regulations issued over the last few years have had the positive effect of re-conceptualizing sexual violence. It is now considered an issue of public concern, giving the State a direct, leading role in its elimination. However, this formally stated aim is contradicted by the absence of specific policies in this area.

It should be noted that sexual offenses are seriously under-recorded, despite the fact that they make up a significant proportion of actual crimes.¹¹⁶ Official statistics show that there were 4,677 rapes nationwide in 1998,¹¹⁷ although a number of studies have produced much higher estimates. A study conducted in 1995 revealed that 25,000 rapes took place that year.¹¹⁸ Another study from 1997 indicated that, for metropolitan Lima alone, as many as 19,332 rapes may have occurred the previous year.¹¹⁹ Given the fact that timely and accurate records are important in assessing the true nature of the problem of sexual violence, the absence of such records indicates a lack of real intention on the part of the government to confront the situation effectively.

The fact that it is difficult to press charges, and the virtual impunity of perpetrators in most cases, particularly when the victims are adult women, are further signs that the State is not serious in the enforcement of its own stated policies. There is sufficient evidence to support the conclusion that negligence on the part of law enforcement officials when investigating and prosecuting crimes,¹²⁰ as well as the gender stereotypes that permeate the process for administering justice, are determining factors in this impunity.¹²¹ Investigations have shown that, at the center of the justice system, there seems to be very little priority given to sexual assault offenses against women. The sentences sought for such offenses are often light, below the legal minimum, or even symbolic, resulting in the perpetrators' immediate release.¹²² Many final rulings exclude or restrict the rights of women who press charges, leading to acquittals, suspended guilty sentences, tolling of the statutes of limitations, and even the dismissal of complaints.¹²³

There are also regulations that reinforce discriminatory behavior on the part of the legal system's agents, such as openly sexist police procedures when investigating this type of offense. For example, a victim must undergo an investigation of the extent of her resistance to her aggressor, whether she screamed, and the type of relationship she had with the aggressor before the offense, among other things.¹²⁴

The lack of policies and programs to prevent this sort of discrimination, and to get full compensation for the victims, combined with the fact that penal sanctions have been the State's only response to the problem, suggests that the State not only diminishes the significance of crimes of sexual violence, but also tolerates their perpetuation.

2. Domestic Violence

Laws and Policies

The Protection from Domestic Violence Act (PDVA) was promulgated in 1993. It establishes the policy of the State and of society with regard to domestic violence.¹²⁵ The PDVA defines domestic violence as "any act or omission that causes physical or psychological harm, abuse without obvious injury, including serious and/or repetitive threats and coercion, as well as sexual violence" among spouses, for-

mer spouses, common-law spouses, former common-law spouses, parents and descendants, relatives, people inhabiting the same home or who have children together.¹²⁶ With regard to the legal process, the legislation allows for the police to receive complaints and carry out preliminary investigations.¹²⁷ A government attorney must act *ex officio* when directly apprised of the facts, and also receives direct complaints, in writing or orally, from the victims or family members, or from any other person when it is a question of protecting minors.¹²⁸ Judges or attorneys may order the following precautionary measures: removing the aggressor from the home, issuing a restraining order, temporary suspension of visitation rights, inventory of the aggressor's assets, and other measures to guarantee the victim's physical, mental and moral integrity.¹²⁹

In 1997, a law was passed to modify the Penal Code, rendering the existence of a matrimonial relationship, common-law relationship or other family ties between the aggressor and the victim an aggravating factor for the offenses of serious bodily harm and bodily harm.¹³⁰

In 1998, an amendment to the PDVA established that medical certificates issued by the Forensic Medicine Institute, as well as certificates issued by other State medical institutions,¹³¹ may be used as evidence of the victim's state of physical and mental health in family violence court proceedings.

Institutional measures over the last few years have included the creation of women's police stations and specialized sections in district police headquarters at the national level. Similarly, in 1999 PRO-MUDEH started a pilot project to deal with family violence, aimed at providing the Lima population with various services to ensure fast and timely processing of domestic violence court proceedings.¹³²

Reality

As with sexual violence, Peru has no efficient mechanism in place to record cases of domestic violence. The system is not unified, and cases are handled according to where they are initiated (particular ombudsman's offices, police stations or health care institutions). Furthermore, there have been no studies of the extent and characteristics of this type of violence in the rural and Andean regions of Peru, which makes it difficult to know exactly how widespread the problem is.¹³³

The few available statistics are on metropolitan Lima, and, to a certain extent, these data permit an estimate of the prevalence of family violence throughout the country. In a survey undertaken in April 1999, over 80% of respondents stated that, in the previous year, they had heard of situations involving violence against women in a family setting near them.¹³⁴ Another study, also in 1999, revealed that 35% of women suffer psychological abuse from their partners.¹³⁵

Despite the undeniable progress in domestic violence legislation in Peru over the last few years, there have been serious problems with its application. Police and legal bodies tend to downplay the seriousness of incidents of domestic violence. Cases are very rarely processed appropriately by the legal system. In this respect, the views and attitudes of those who operate the legal system constitute a very serious obstacle to women exercising their rights when they have been abused by their partners.¹³⁶

One obstacle to the effective application of the law is legal authorities' unwillingness during investigations to issue the protective measures they have at their disposal. When such measures are issued, it is often too late to avoid further violence. There are no mechanisms to follow up on protective measures and sentences; and the belief that domestic violence is a reconcilable situation rather than a violent offense helps further generate impunity for the perpetrators.¹³⁷ In fact, the authorities often prefer not to get involved, on the pretext that domestic violence is a private problem.¹³⁸

Moreover, the Peruvian State has failed to fulfill its obligations under the PDVA to implement poli-

cies to eradicate family violence, such as the introduction of the subject of violence as part of the school curriculum. This means that sexist patterns of behavior toward violence continue unchecked. The government has also failed to create shelters for battered women as stipulated in the PDVA.¹³⁹

3 Sexual Harrassment

Laws and Policies

Sexual harassment is regulated by labor law provisions¹⁴⁰ as a hostile act on the part of the employer comparable to dismissal,¹⁴¹ but not as an offense. Labor law also considers acts against moral standards, and acts that constitute dishonest attitudes affecting workers' dignity, to be acts of hostility. According to this law, the worker who feels that he or she has been harassed in this way may choose to act unilaterally to end the hostility or to terminate the work contract. In that case he or she would request compensation for arbitrary firing, independently from the fine levied on the employer.¹⁴² The time frame for initiating legal proceedings for acts of harassment is within 30 calendar days from the occurrence of the act.¹⁴³

There is currently a draft bill that deals with sexual harassment in places of work and study, construing harassment as a labor misdemeanor and applying the corresponding sanctions. The draft bill provides for an administrative procedure within the workplace, which must be carried out before a lawsuit can be filed.¹⁴⁴

Reality

Sexual harassment is one of the manifestations of violence that government policies deal with least. Despite its serious impact on the physical and moral health of female victims, not to mention its effect on their productivity at work, very little has been done to eliminate this problem.

With regard to sexual harassment in the workplace, the first major obstacle faced by the victim is the regulatory framework. The difficulty of proving "fault on the part of the employer" means that almost no cases have been brought before the labor administration authorities, and virtually none have been resolved satisfactorily according to the procedure established by law.

Meanwhile, the authorities charged with enforcing the legislation governing sexual harassment in the school environment do not appear to carry out their duties. Municipal, parish, community, and school ombudsman's offices record cases of sexual harassment perpetrated by teachers against adolescents in school. Generally, however, no action is taken against the aggressor, or the teacher/perpetrator simply is transferred to another school without applying administrative or legal sanctions—or even an investigation into the incident.¹⁴⁵

The draft legislation dealing with sexual harassment in the workplace and in education has been languishing in the Congress of the Republic for two years, revealing the lack of interest in this issue on the part of the country's legislators.

C. Family Relations, Including Equality of Spouses in Marriage (Articles 23, 24, and 26 of the ICCPR)

Article 23 of the ICCPR declares the family to be the "natural and fundamental" unit of society and proclaims that the family is entitled to protection by the State. This provision also guarantees the right to marry and affirms the duty of States to ensure equality of rights and responsibilities of both par-

ties to marriage.

The Committee has elaborated upon the ICCPR's provisions on marriage and family life. While the Covenant does not endorse any particular age of marriage, the Committee has noted that the age chosen by a State "should be such as to enable each of the intending spouses to give his or her consent in a form and under conditions prescribed by law."¹⁴⁶ The Committee has further recommended that States parties introduce a uniform minimum age for marriage of males and females to comply with the requirements of article 23 of the Covenant.¹⁴⁷ It has expressed serious concern over legal provisions that discriminate against women in marriage¹⁴⁸ including differences in legal age for marriage of women and men. The Committee has clearly stated that such provisions are incompatible with articles 3, 23, 24 and 26 of the Covenant.¹⁴⁹

The Committee has made firm statements regarding divorce and the rights of women. It has criticized laws in some States that instruct judges in divorce cases to take into account the education, habits, and conduct of both spouses, since these considerations may lead to discrimination against women.¹⁵⁰ It has also asserted that "any discriminatory treatment in regard to the grounds and procedures for divorce, child custody, maintenance or alimony or the loss of recovery of parental authority must be prohibited."¹⁵¹ Furthermore, the Committee has expressed concern over the denial of access to divorce, which may leave married women permanently subject to discriminatory property laws. The Committee views such circumstances as a potential violation of article 23.¹⁵²

Laws and Policies

The 1993 Constitution guarantees protection of the family and indicates that the community and the State must promote marriage, recognizing it as a natural institution and one of the foundations of society.¹⁵³ According to the Civil Code,¹⁵⁴ spouses have equal rights, duties and authority within the home.¹⁵⁵

Marriage of minors

The Civil Code establishes 18 as the minimum age for entering into a marriage without requiring any type of authorization.¹⁵⁶ As a general rule, minors under the age of 16 are completely without legal capacity and may not enter into a marriage unless a judge issues a dispensation for serious reasons. A recent law¹⁵⁷ has set a minimum age of 16 for both men and women to enter into marriage with such a dispensation. The law furthermore stipulates that minors over the age of 14 acquire legal capacity upon the birth of a child, but only for certain legal actions, such as recognizing their children, suing for pregnancy and childbirth costs, and bringing charges or participating in lawsuits for child custody and alimony. Furthermore, when minors under the age of 14 have children, they may legally recognize their children as soon as they turn 14.¹⁵⁸

Common-law marriages

The Political Constitution of 1993 defines and guarantees common-law marriage by providing that a stable couple made up of a man and a woman, for whom there is no impediment to marriage, gives rise to community of property, subject to the same partnership of profits established by marriage.¹⁵⁹ The Civil Code adds that such a relationship must strive toward similar ends and fulfill similar duties to marriage, and sets the required minimum duration of two consecutive years.¹⁶⁰

Divorce and custody

After a divorce, custody of and parental authority over any children are granted to the spouse who obtained the separation for a specific cause, unless the family-court judge decides that, for the children's well-being, some or all children should be put in the care of the other spouse, or of a third person.¹⁶¹ If both spouses are responsible for the separation, male children over the age of seven go to their father, and girls under the age of majority, as well as boys under the age of seven go to their mother, although the judge may order a different arrangement.¹⁶²

Reality

According to official statistics, the average age at marriage for women is 21 compared to 25 for men.¹⁶³ Assuming that marriage increases the risk of pregnancy and gives rise to domestic responsibilities, it may follow that, by marrying younger, women's opportunities for individual development are curtailed in comparison with men. Rural women are at even more of a disadvantage: they wed at approximately 19 years of age, compared to 22 years of age in urban areas. Studies show that women nationwide are marrying at a progressively younger age.¹⁶⁴

In Peru, a significant proportion of households are run solely by women, without the presence of a spouse.¹⁶⁵ The situation of these single mothers is quite difficult. Figures show that they are far more vulnerable to poverty than their married counterparts, mostly because they must carry the full burden of raising the family without any kind of support. Single-parent households led by women are those most affected by poverty.¹⁶⁶

D. The Right to Education (Articles 2, 3, 19, 24, and 26 of the ICCPR)

Education is necessary for the exercise of all other rights, including the right to make informed decisions about reproductive health and one's reproductive capacity. Articles 2, 3, and 26 guarantee equal enjoyment of rights and equality under the law, which imply that men and women should have equal access to education, including sexual education. Article 19 provides for freedom of expression and opinions. It is an integral part of an individual's ability to exercise this right. Because education provides the knowledge one needs to form opinions and beliefs, Article 24 guarantees children special protection. Education is a crucial source of protection, for it prepares girls to participate on an equal footing with their male counterparts in the public and private spheres. In the reproductive context, education allows young women to protect themselves against unwanted pregnancies and sexually transmissible infections.

The Committee has encouraged measures, including affirmative action, to remedy discrimination, "as identified in articles 2 and 26," in such areas as education.¹⁶⁷ It has suggested "education and information campaigns" as means that can be used to prevent and eliminate persisting discriminatory attitudes and prejudices against women."¹⁶⁸ Further indicating its focus on education, the Committee has suggested that steps be taken to publish educational material in the most-used vernacular languages in States where there are multiple dialects.¹⁶⁹

Laws and Policies

The 1993 Constitution establishes the State's duty to ensure that no one is prevented from receiving an adequate education due to their economic situation or to mental or physical limitations. Education is free in public institutions. In public universities, the State guarantees the right to education of students with satisfactory performance who do not have the economic means to cover educational costs.¹⁷⁰

Sexuality Education

In early 1996, the government announced that sexuality education would be introduced gradually into the secondary-school curriculum. For this purpose, the Ministry of Education issued the Guide to Family and Sexuality Education for Teachers and Parents as part of its 1995-2001 Program.¹⁷¹

The General Teacher Training Plan's objectives include educating boys, girls and adolescents on the following topics: basic aspects of family life and sexual development, values, self-esteem, and gender-equal roles. In secondary education, the curriculum emphasizes responsible sexuality, the need to postpone the beginning of sexual activity, and the prevention of STIs, AIDS and unplanned pregnancies.

In 1998, The Ministry of Education presented the National Sexuality Education Program, with the overall objective of "contributing to pupils' comprehensive education so that, freely and according to their socio-cultural situation, they may make healthy and responsible decisions for their personal well-being and that of their family and society, in the context of learned values, gender equality, citizenship and democracy."¹⁷² Among its specific objectives, the Program confirms the government's interest with regard to incorporating sexuality education content into preschool, primary, secondary, and teacher-training curricula.¹⁷³

Reality

Lack of access to education is one of the major barriers to the exercise of rights, and it is a problem that affects the majority of the population in Peru. Even though indicators related to basic education coverage and school attendance records have improved in recent years,¹⁷⁴ other problems persist. For example, in just over half of Peruvian households, family members aged 15 and up have had less than 7 years of schooling. Barely one seventh of these households will provide a family environment that will encourage boys, girls, and adolescents to reach their full intellectual potential.¹⁷⁵ The situation is far more critical in rural areas: low and very low levels of education affect 89.3% of households.¹⁷⁶ The living conditions of the population lacking education are likely to be much more difficult as education is a significant factor in decreasing the likelihood of poverty.¹⁷⁷

Within this larger context, women are at an even greater disadvantage. The primary indicator of this disadvantage is the female illiteracy rate. While illiteracy dropped somewhat in the 1990s, this decrease has not been equal for men and women. Men experienced a greater decrease in illiteracy, with a drop of 50%, with women's illiteracy dropping by less than 40%.¹⁷⁸ Women still make up the majority of illiterate persons, and the rate is particularly high among women who live in rural areas.¹⁷⁹ Overall the ratio of illiterate women to illiterate men has increased. In 1961, there were two illiterate women for every illiterate man. Today, 40 years later, that ratio stands at three to one.¹⁸⁰

Men continue to attain higher levels of education than women, a gap indicative of women's unfavorable situation.¹⁸¹ The most marked inequalities in women's educational attainment are expressed regionally and ethnically: women who belong to the indigenous groups of the mountains and to the ethnic groups of the forest areas tend to attain the lowest educational levels.¹⁸²

With regard to sexuality education, although more topics related to sexuality have been introduced into the school curriculum, teacher's stereotypes and old-fashioned attitudes have not yet been overcome. The information given in the classroom is of an anatomical and physiological nature, without going into aspects such as sexuality, self-esteem and individual rights.¹⁸³

E. Women's Economic and Social Rights (Articles 3 and 26 of the ICCPR)

Reproductive health and rights cannot be fully evaluated without investigating women's economic and social standing in the societies in which they live. Not only does women's socioeconomic status reflect societal attitudes that affect reproductive rights, it also often has a direct impact on women's ability to exercise their reproductive rights. For example, laws affecting a woman's economic status can contribute to the promotion or hindrance of her access to reproductive health care and her ability to make voluntary, informed decisions about such care.

The Committee has recognized that economic and social rights, such as the right to work, intersect with other rights found in the Covenant, which have an important impact on women's reproductive lives. The Committee has affirmed that inequality of access to the labor market is a violation of the Covenant and has made strong recommendations that States parties eliminate *de jure* as well as *de facto* discrimination against women in this domain.¹⁸⁴ The Committee has also expressed serious concern over discriminatory practices in employment, particularly the requirement that women prove that they are not pregnant or that they have been sterilized.¹⁸⁵

In further recommendations regarding economic and social rights, the Committee has voiced its concern over "the application of customary laws in matters of personal status . . . and inheritance rights which reinforce attitudes concerning the role and status of women."¹⁸⁶

1. Right to Property and Inheritance

Laws and Policies

The 1993 Constitution stipulates equality before the law,¹⁸⁷ which includes equal opportunities to enter into lawful contracts and to exercise the right to property and inheritance, among other rights.¹⁸⁸

The State guarantees property as an inviolable right. The Civil Code indicates that men and women have equal capacity to enjoy and exercise their civil rights.¹⁸⁹ There are no legal restrictions to women's right to own property.

With regard to the right to inherit, according to a provision of the Civil Code, a married man and woman must have the consent of the other spouse in order to refuse an inheritance or bequest, or to refrain from accepting a gift.¹⁹⁰

Reality

Although regulations guarantee the right to property and inheritance on the part of all individuals regardless of gender, there are imperfect legal mechanisms that, in conjunction with certain practices and customs, prevent women from exercising these rights.¹⁹¹

Social customs and the vestiges of previous laws, in certain cases, have the effect of preventing women from fully exercising their patrimony rights within marriage. In fact, despite the legal requirement of joint administration of common assets,¹⁹² it is most common for the man to be the administrator as well as the one who has use of these assets. The woman's consent is only needed as a formality. This situation is even more marked in households where the woman does not have an income.¹⁹³

Current legislation is even more disadvantageous to women in common-law marriages in this respect. If they are unable to certify in writing that the relationship has lasted two years or more¹⁹⁴ (which is extremely difficult to do) then the regulation with regard to partnership of profits can not be

applied. Meanwhile, the man administers his partner's assets and can even make use of them without her consent, because such consent is not required outside of formal, legal marriages.¹⁹⁵

The situation is far more restrictive in rural areas when it comes to women's formal access to property. According to the 1994 farming census, 20.3% of farming units were managed directly by women; of these, only 7.5% had title deeds. However, of the farming units managed by men, 28.1% had title deeds.¹⁹⁶

Low-income families on the outskirts of urban areas have similar problems. When an attempt is made to formalize informal property, often women are required to present different documentation than men are. While men usually do not need any kind of certification in order to declare their civil status, women must present a marriage certificate. In certain business or real estate transactions, only the civil status declared in the husband's identification papers is considered. The wife may thereby lose her share of the profits and even her own assets if the husband declares himself single. In the case of unmarried domestic partners, the problems facing women are even worse. While registry offices allow people who live together to jointly register real estate, this is only possible in cases of common-law relationships where there is no impediment to marriage. However, in situations where the man has more than one relationship or is already married, in practice, the title is made out to the man. There is still no legislation addressing this issue.¹⁹⁷

2. Labor Laws

Laws and Policies

The Constitution establishes respect for equality and non-discrimination in employment,¹⁹⁸ as well as special protection for working mothers.¹⁹⁹ There is protection against on-the-job discrimination due to pregnancy and a dismissal will be invalid if it takes place at any time during the gestation period or within 90 days of childbirth. Furthermore, the burden of proof no longer falls to the pregnant woman. It is the employer who must certify that there is just cause to fire her.²⁰⁰

Legislation passed in 1997 stated that job offers may not contain requirements that are discriminatory in any way or that cancel or alter equal opportunity or treatment.²⁰¹

The Social Security Modernization Act, passed in 1997, also regulates health care for women workers.²⁰² These workers, and the wives and unmarried domestic partners of insured male workers, are entitled to ESSALUD health benefits.²⁰³ This organization provides coverage for insured workers and their rightful claimants²⁰⁴ by granting prevention, recovery, rehabilitation, economic assistance, and social assistance allowances under the Public Health Insurance Plan.²⁰⁵

Stay-at-home wives and mothers may be included in health care and pension plans as affiliated members.²⁰⁶

With regard to women workers' rights, a previous regulation dictating protective measures for them was repealed in 1995.²⁰⁷ Some rights, such as prenatal and postnatal leave for 45 days each,²⁰⁸ and the right to nurse, have subsequently been reestablished.²⁰⁹ The right to have a nursery at work has not been reinstated.

Similarly, women workers are entitled to maternity payments for 90 days, on the condition that they do not perform any kind of paid work during that period;²¹⁰ however, the issue has not been fully regulated. The nursing allowance is now only granted to the women workers themselves²¹¹ (formerly, this benefit was also granted to the mother or person taking care of the child of an insured worker).

With regard to pensions, the retirement age for both men and women is 65, and both men and women must contribute 20 years before receiving a pension.²¹²

Reality

Women currently represent a higher proportion of the nation's economically active population than do men,²¹³ but they tend to work in low-productivity, low-skill jobs.²¹⁴ Furthermore, unemployment continues to have a greater impact on women.²¹⁵

Women still receive significantly lower wages than men. As of 1997, women's average income was 74.2% of the average income for men. This gender disparity in income is found in almost all work activities, particularly at the management level, where women earn, on average, almost one third of what men earn.²¹⁶ Some studies show that higher educational attainment does not level the playing field, as disparities persist even with the same number of years of schooling.²¹⁷

Regulations that uphold equality among men and women are not implemented so as to allow the exercise of these rights. For example, pregnancy continues to be a hidden cause for dismissal in a number of workplaces, and job advertisements in the newspaper are still rife with hidden discrimination against women in the form of requirements that women cannot fulfill.

Finally, it must be noted that the draft bill on shared family responsibilities, which seeks to distribute evenly the duties and rights of working fathers and mothers to make their work situation more equal, has been before the Congress of the Republic for a number of years without undergoing definitive debate.²¹⁸

¹ Final observations of the 58th session of the Human Rights Committee: Peru, UN Doc. CCPR/C/79/Add.72, November 18, 1996, ¶ 15.

² United Nations Human Rights Committee, Equal Rights for Men and Women: General Observation no. 28, UN Doc. CCPR/C/21/Rev.1/Add.10, March 29, 2000, ¶ 3.

³ Human Rights Committee, The Right to Life (article 6), General Comment 6, para. 5, July 30, 1982.

⁴ United Nations Center for Human Rights, Manual on Human Rights Reporting 120, U.N. Doc. HR/PUB/91/1 (1991) [hereinafter Manual on Human Rights Reporting] at 113.

⁵ *Id.* ¶ 239.

⁶ *Concluding Observations of the Human Rights Committee: Chile*, ¶ 15, 79th Sess., U.N. Doc. CCPR/C/79/Add.104 (1999) [hereinafter U.N. Doc. CCPR/C/79/Add.104].

⁷ *Report of the Human Rights Committee*, ¶ 167, 52nd Session, U.N. Doc. A/52/40 [hereinafter U.N. Doc. A/52/40].

⁸ U.N. Doc. CCPR/C/79/Add.104 ¶ 15.

⁹ Political Constitution of Peru, entry into force Dec. 31, 1993 [hereinafter Peru Const.] art. 7.

¹⁰ *Id.*, art. 65.

¹¹ *Id.*, art. 6.

¹² Law No. 26482, General Law on Health (July 20, 1997) [hereinafter General Law on Health].

¹³ Such as the right to demand health care services that meet the accepted levels of quality for professional procedures and practices (art. 2), to receive emergency medical-surgical treatment in any health care institution when one's life or health is in danger (art. 3), to request information regarding health without having to explain the reason for this request (art. 5), to be given accurate, timely and complete information on the characteristics of health services, on the economic conditions for providing treatment and on all of the terms and conditions of the ser-

vice (art. 40). *Id.*

¹⁴ *Id.*, art. 40.

¹⁵ *Id.*, art. 6.

¹⁶ *Id.*

¹⁷ National Population Policy Law, Order in Council No. 346 (July 6, 1985) [hereinafter Population Law].

¹⁸ *Id.*, art. 22.

¹⁹ *Id.*, art. 34. Cost-free status had already been established in Article 1 of E.D. No. 019-81-SA (Aug. 6, 1981).

²⁰ *Id.*, art. IV, Prelim. Title.

²¹ *Id.*, art. 24.

²² Ministerial Order No. 572-95-SA/DM (Aug. 19, 1995).

²³ *Id.*, art. 1. Priority was to be given via services to disseminate information and knowledge of the subject.

²⁴ *Id.*, art. 2.

²⁵ Programa de Salud Reproductiva y Planificación Familiar 1996-2000 [Program on Reproductive Health and Family Planning 1996-2000] approved by Ministerial Order No. 071-96-SA/DM (Feb. 6, 1996).

²⁶ *Id.*, at 5.

²⁷ *Id.*, at 26.

²⁸ *Id.*, at 28.

²⁹ Ministerial Order 071-90-DM (Feb. 23, 1990), intro. These regulations pertain to treatment in Ministry of Health institution clinics. According to this regulation, the "clinical" fees are set according to the institution's cost analysis, and 50% of the proceeds generated are considered to belong to the hospital, while the other 50% are considered to be the fees of the professional or professionals who generate the proceeds.

³⁰ Executive Decree No. 011-98-PROMUDEH (Sept. 29, 1998).

³¹ Ministerial Order No. 009-99-PCM (Jan. 26, 1999). This ministerial order created a national coordinating body, the National Commission to Coordinate the National Population Plan 1998-2000 (COORDIPLAN), to implement this plan. The Commission is multisectoral and consists of the Ministry for the Promotion of Women and Human Development (PROMUDEH), the Ministry of Health, the Ministry of Education, the Ministry of the Presidency, the Peruvian Institute for Social Security, the National Institute of Statistics and Information Sciences, and the National Environment Council.

³² Ministerial Order No. 465-SA/DM, Family Planning Regulations, (Sept. 22, 1999) [hereinafter Family Planning Regulations].

³³ They must have a waiting room and an examination area that provides privacy from being seen or heard, etc.

³⁴ Ministerial Resolution No. 103-00-SA/DM, National Plan for Gynecological Cancer Prevention: Cervical Canal and Breast 1998-2000 (Feb. 26, 1999).

³⁵ *Id.*, at 4.

³⁶ Vera La Torre, José Carlos, *GASTOS DE LOS HOGARES EN SALUD [HOUSEHOLD SPENDING ON HEALTH CARE]*, Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science], Off print, 1999.

³⁷ The ENH 98 II showed that, in areas where the poverty rate is highest such as the northern and southern mountains and the eastern part of the country over 40% of persons did not seek treatment when they were ill. *Id.* There are even more alarming figures. According to the National Standard of Living Measurement Survey (1997), almost 70% of the national population with the lowest per capita spending levels did not seek treatment when they were ill; compared to the group with the highest spending levels, of which only 37.3% failed to seek treatment. *POBREZA Y ECONOMÍA SOCIAL. ANÁLISIS DE UNA ENCUESTA ENNIV-1997 [POVERTY AND SOCIAL ECONOMICS. ANALYSIS OF A SURVEY ENNIV-1997]*, United Nations Children's Fund (UNICEF)/United States Agency for International Development (USAID), Richard Webb and Moisés Ventocilla (ED), 1999 [hereinafter *POVERTY AND SOCIAL ECONOMICS*], at 320.

³⁸ On national average, working women earn less than half of what male workers earn (gap of 55.4%), with the most marked difference in rural areas (the gap is 87% in rural mountain areas, 68.8% in rural forest areas and 64.8% in rural coastal areas). Rosa Flores Medina, "La mujer y la brecha salarial" [Women and the Wage Gap], *POBREZA Y ECONOMÍA SOCIAL. ANÁLISIS DE UNA ENCUESTA ENNIV-1997 [POVERTY AND SOCIAL*

ECONOMICS. ANALYSIS OF A SURVEY ENNIV-1997, United Nations Children's Fund (UNICEF)/United States Agency for International Development (USAID), Richard Webb and Moisés Ventocilla (Editors), at 233.

³⁹ Of all of the households run exclusively by women, 27.2% live in poverty, whereas the percentage is almost half that (13.5%) for households run exclusively by men. Instituto Nacional de Estadística e Informática - Ministerio de Promoción de la Mujer y Desarrollo Humano, *GÉNERO: EQUIDAD Y DISPARIDADES. UNA REVISIÓN EN LA ANTESALA DEL NUEVO MILENIO* [Gender: Equity and Disparity. An Overview on the Verge of the New Millennium], Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science]/ PROMUDEH, 1999 [hereinafter Gender: Equity and Disparity] at 136.

⁴⁰ Although rural women are most likely to get sick at a rate of 37.8% compared to 34.7% for rural men, 30% for urban women and 25.8% for urban men, they constitute one of the sectors that uses institutional health services the least: 21.4% compared to 38.8% of the female urban population and 37.8% of the male urban population. Margarita Petrera, "La demanda por servicios de salud de la mujer rural en el Perú" [The Demand for Health Services on the Part of Rural Women in Peru], *POBREZA Y ECONOMÍA SOCIAL. ANÁLISIS DE UNA ENCUESTA ENNIV-1997* [POVERTY AND SOCIAL ECONOMICS. ANALYSIS OF A SURVEY ENNIV-1997], United Nations Children's Fund (UNICEF)/United States Agency for International Development (USAID), Richard Webb y Moisés Ventocilla (Editors), at 198, 199, 205.

⁴¹ *ENCUESTA DEMOGRÁFICA Y DE SALUD FAMILIAR 1996* [Demographic and Family Health Survey], Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science], 1997, [hereinafter Family Health Survey] at 131. In some areas with a high proportion of poor and extremely poor rural populations, the probability rises fivefold. In other words, if the national average is one woman dying of childbearing-related causes every five hours, in these areas, a woman dies every hour. The areas in question correspond to the departments of Huancavelica, Puno, Cusco, Apurímac, Ucayali. Nazario Carrasco Izquierdo, "Embarazo precoz y violencia" [Early Pregnancy and Violence], in Congreso de la República, *LA VIOLENCIA COTIDIANA. VISIÓN DEL ESTADO Y LA SOCIEDAD CIVIL* [Congress of the Republic, Daily Violence. View of the State and Civil Society], Congreso de la República - Comisión Especial que Investiga las Causas y Consecuencias de la Violencia Cotidiana en el País [Special Congressional Commission to Investigate the Causes and Consequences of Daily Violence in the Country], 1998, at 90.

⁴² Figures taken from the National Survey of Households 1998 II. Elsa Alcántara de Samaniego, "SALUD REPRODUCTIVA, POBREZA Y CONDICIONES DE VIDA EN EL PERÚ" [REPRODUCTIVE HEALTH, POVERTY AND LIVING CONDITIONS IN PERU], Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science], 1999, Off print, [hereinafter Alcántara de Samaniego] at 4.

⁴³ This was declared by 45.3% of the women who did not have breast exams, and 41.5% of those who did not have Pap smears. In Metropolitan Lima, however, the main reason given was lack of need or interest. *Id.*, at 5.

⁴⁴ Among women whose basic needs were covered, 14.6% had a breast exam, and 25.3% had a Papanicolaou test, whereas only 6.9% of the poorest women had the first test, and 15.5% the second. *Id.*, at 6.

⁴⁵ *FAMILY HEALTH SURVEY*, *supra* note 35 at 134.

⁴⁶ Elsa Alcántara de Samaniego, *supra* note 36, at 6.

⁴⁷ *FAMILY HEALTH SURVEY*, *supra* note 35 at 139.

⁴⁸ *Id.*, at 141.

⁴⁹ The Ministry of Health's Maternal-Perinatal Program indicates that between 1990 and 1996, the number of patients increased considerably: there was 2.7 times more prenatal monitoring, 2.3 times more childbirth care, and post-partum care increased almost fivefold. *ESTADO DE LA POBLACIÓN PERUANA: 1997. SALUD REPRODUCTIVA* [STATE OF THE PERUVIAN POPULATION: 1997. REPRODUCTIVE HEALTH], Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science]- United Nations Population Fund (UNFPA), 1997 [hereinafter *STATE OF THE PERUVIAN POPULATION*] at 28.

⁵⁰ *INDICADORES SELECCIONADOS PARA EL SEGUIMIENTO DE LOS EJES ESTRATÉGICOS DE LOS ACUERDOS DE LA CONFERENCIA INTERNACIONAL SOBRE POBLACIÓN Y DESARROLLO* [INDICATORS SELECTED TO TRACK THE CENTRAL

STRATEGIES OF INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT AGREEMENTS] [hereinafter INDICATORS] at 88 (unpublished document, on file with CRLP).

⁵¹ The case of childbirth care is fairly illustrative. The cost of this service is set by each health institution according to its own criteria. Around 1997, normal childbirth care in Lima's hospitals could cost 250.00 new soles (100.00 USD at the time) or 90.00 new soles (35.00 USD), whereas care for cesarean childbirth could cost 450.00 new soles (180.00 USD) or 380.00 new soles (150.00 USD). The cost of complications, medications and tests are paid by the patient, who must even occasionally leave a deposit. In the country's interior, in forest villages where the majority of inhabitants live in extreme poverty, most women prefer to give birth in their homes because they are unable to pay the cost of services. *SILENCIO Y COMPLICIDAD, VIOLENCIA CONTRA LAS MUJERES EN LOS SERVICIOS PÚBLICOS DE SALUD EN EL PERÚ [SILENCE AND COMPLICITY, VIOLENCE AGAINST WOMEN IN PERU'S PUBLIC HEALTH CARE FACILITIES]*, Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM) – Center for Reproductive Law and Policy (CRLP), 1999 [hereinafter *SILENCE AND COMPLICITY*], at 82-83.

⁵² Official figures show that in 1996, 12% of women in relationships had unmet family planning needs: 9% to limit the size of the family, and 3% for spacing the children's births. *Id.*, at 107.

⁵³ The million children correspond to 35% of the births that took place during that period. If all unwanted pregnancies could be prevented, the country's fertility rate would be 2.2 children per woman, not 3.5 as it is currently. *Id.*, at 113-114.

⁵⁴ *MUJERES Y CIUDADANÍA EN EL PERÚ. AVANCES Y BARRERAS [Women and Citizenship in Peru. Progress and Obstacles]*, Grupo Impulsor Nacional (GIN) [National Impulsor Group], 1998, at 50.

⁵⁵ *SILENCE AND COMPLICITY*, *supra* note 45, at 56. According to this study, lawsuits against health care staff and institutions have discouraging results because complicity and institutional cover-ups limit their effectiveness. There is less chance of proving one's case because the word of female patients is often devalued when matched against the statements of health professionals, who are perceived as authoritative figures with unquestionable prestige. Of the cases examined in the study, the accusations that were brought did not result in sanctions for the perpetrators or compensation for the victims, at the administrative or legal level. *Id.*, at 68-71.

⁵⁶ Penal Code, Legislative Decree No. 635 (Apr. 3, 1991) [hereinafter Penal Code], arts. 114 and 120.

⁵⁷ National Population Policy Law, *supra* note 6, art. VI, Prelim. Title.

⁵⁸ *Id.*, art. 29.

⁵⁹ General Law on Health, *supra* note 6, art. V, Prelim. Title.

⁶⁰ *Id.*, art. VIII, Prelim. Title.

⁶¹ Ministerial Order No. 448-99-SA/DM (Sept. 15, 1999). It also establishes progressive coverage, with insurance for a set number of Peruvian provinces every year from 1999 to 2002.

⁶² Seguro materno infantil [Maternal and Infant Insurance], ministry of Health, Information folder, February 2000.

⁶³ *Program on Reproductive Health*, *supra* note 19 at 46.

⁶⁴ General Law on Health, *supra* note 6, arts. 30 and 43.

⁶⁵ *Id.*, art. 30.

⁶⁶ Programa para la atención integral del aborto incompleto y planificación familiar postaborto [Program for Comprehensive Treatment of Incomplete Abortion and Post-Abortion Family Planning], Pathfinder International, at 3-4 (Unpublished document, on file with CRLP).

⁶⁷ Concluding observations of the 58th session of the Human Rights Committee: Peru, UN Doc. CCPR/C/79/Add.72, November 18, 1996, ¶ 15.

⁶⁸ *State of the Population: 1997*, *supra* note 43, at 33-34.

⁶⁹ *Program on Reproductive Health*, *supra* note 19, at 17.

⁷⁰ The Ministry of Health's Maternal Perinatal Program indicates that in 1997, 15% of obstetrical admissions were due to abortion-related complications. *Supra* note 44, at 91.

⁷¹ In cases of suspected abortion, some health care providers express the intention of punishing women, and subject them to threatening interrogations and even inhuman treatment on the assumption that they are criminals. *Id.*, at 56.

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⁷² *SILENCE AND COMPLICITY*, *supra* note 45, at 56 and 59.

⁷³ *Id.*, at 34.

⁷⁴ Out of 100% of women who induce an abortion, 47% suffer complications and only 20% are hospitalized and receive treatment. *Id.*, at 35.

⁷⁵ In 1998, the National Police recorded 772 abortion offences at the national level, accounting for only 3.1% of all crimes against life, body and health. *PERÚ: COMPENDIO DE ESTADÍSTICAS SOCIODEMOGRÁFICAS 1998-1999 [PERU: COMPENDIUM OF SOCIO-DEMOGRAPHIC STATISTICS 1998-1999]*, Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science], 1999, at 512.

⁷⁶ Before, the National Population Law expressly prohibited sterilization and abortion as contraceptive methods. Now only abortion is prohibited.

⁷⁷ General Law on Health, *supra* note 6, art. 6.

⁷⁸ Family Planning Regulations, *supra* note 26.

⁷⁹ *Id.*, at 27-29. Institutions are evaluated *in situ* and must comply with physical and equipment infrastructure requirements (environment, surgical equipment and instruments and supplies), as well as with administrative aspects (standards and management systems). The certification remains in effect for two years.

⁸⁰ Family Planning Regulations, *supra* note 26, at 43-45. These regulations establish the obligation to carry out a complete clinical evaluation, to give the patient no less than 72 hours to think about the procedure, to obtain written consent, and to provide clear information to the patient on the risks, benefits and permanent nature of this birth-control method. The regulations also state that it is obligatory to provide at least two orientation and counseling sessions, one general and one specific, in which the VSC request form must be read and analyzed thoroughly, with subsequent verification that all of its points have been properly understood. At any time, even minutes before the operation, the patient may desist from going through with the procedure.

⁸¹ In 1996 there were 81,762 tubal ligations; in 1997 the figure rose to 109,689, then dropped in subsequent years, with 25,995 tubal ligations in 1998 and 26,788 such interventions in 1999. Figures from the Ministry of Health, Ombudsman's Resolution No. 03-DP-2000 (Jan. 28, 2000), Third Antecedent.

⁸² *NADA PERSONAL. REPORTE DE DERECHOS HUMANOS SOBRE LA APLICACIÓN DE LA ANTICONCEPCIÓN QUIRÚRGICA EN EL PERÚ 1996-1998 [NOTHING PERSONAL. HUMAN RIGHTS REPORT ON THE APPLICATION OF SURGICAL CONTRACEPTION IN PERU]*, Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), 1999, at 151. The report deals with events that occurred during the initial years of the Ministry of Health's Program on Reproductive Health and Family Planning, and presents several cases of forced sterilization carried out in violation of the right to informed consent.

⁸³ Ombudsman's Resolution No. 01-98 (Jan. 26, 1998). The proposals included amending the Standards and Procedures Manual for Voluntary Surgical Contraception in order to clearly establish the requirement of a minimum of two separate counseling sessions before the operation, fixing a reasonable time period between the date on which the consent form is signed and the date of the operation, among others.

⁸⁴ In July 1998, at the Nineteenth Session of CEDAW's Monitoring Committee, Peru's official delegation distributed a document titled "Peru's Reproductive Health Program", which indicated the corrective measures incorporated into the NPRHFP, including the measure establishing that "there will be no quotas for care providers in relation to tubal ligations or vasectomies, or in relation to any other method of family planning..." *Id.*, at 141.

⁸⁵ These are the Family Planning Regulations approved by Ministerial Order No. 465-SA/DM (Sept. 22, 1999).

⁸⁶ The official newspaper *El Peruano* only published the legal disposition approving the Family Planning regulation, which has only ministerial authority and not the status of law. It did not publish the text of the regulations.

⁸⁷ Ombudsman's Resolution No. 03-DP-2000 (Jan. 28, 2000), 4th and 6th 'whereas' clauses.

⁸⁸ *Id.*

⁸⁹ Law No. 26626 (June 20, 1996).

⁹⁰ *Id.*, art. 2.

⁹¹ *Id.*, art. 4.

⁹² *Id.*, art. 5.

⁹³ *Id.*, art. 6.

⁹⁴ Ministerial Order No. 235-96-SA/DM (April 11, 1996).

⁹⁵ *Id.*, art. 1.

⁹⁶ Richard Webb and Graciela Fernández Baca, *PERÚ EN NÚMEROS 1999 [PERU IN NUMBERS 1999]*, Cuánto S.A., 1999 [hereinafter Webb and Baca], at 374.

⁹⁷ *Id.*

⁹⁸ *FAMILY HEALTH SURVEY*, *supra* note 35 at 185.

⁹⁹ Rogelio Fernández Castilla, "Salud reproductiva y sexualidad desde la perspectiva de la Conferencia de Población y Desarrollo de El Cairo" [Reproductive Health and Sexuality from the Perspective of the Cairo Population and Development Conference], *Revista de la Academia Peruana de Salud [Peruvian Health Academy Journal]*, Year V, No. 1, 1999, at 90.

¹⁰⁰ *PLAN NACIONAL PARA LA ATENCIÓN INTEGRAL DE LA SALUD DEL ESCOLAR Y ADOLESCENTE 1997-2001. SUBPROGRAMA DE SALUD DEL ESCOLAR Y ADOLESCENTE [NATIONAL PLAN FOR OVERALL SCHOOL CHILD AND ADOLESCENT HEALTH CARE 1997-2001, SUB-PROGRAM OF SCHOOL CHILD AND ADOLESCENT HEALTH]*, Ministry of Health, 1998, at 17. The Plan was approved by Ministerial Order No. 175-98-SA/DM (May 13, 1998).

¹⁰¹ Webb and Baca, *supra* note 90 at 374.

¹⁰² Only 40.7% of rural women know about the existence of AIDS. Whereas 35% of women at the national level are badly informed on how to prevent AIDS, the percentage almost doubles in rural areas, where it is 68.9 *FAMILY HEALTH SURVEY*, *supra* note 35 at 87 and 190.

¹⁰³ U.N. Doc. A/52/40, ¶ 167.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* ¶ 431.

¹⁰⁶ *Id.*

¹⁰⁷ U.N. Doc CCPR/C/79/Add.104 ¶ 18.

¹⁰⁸ *Id.* ¶ 249.

¹⁰⁹ *Concluding Observations of the Human Rights Committee: Peru*, ¶ 13, 79th Sess., U.N. Doc. CCPR/C/79/Add.72 (1996) [hereinafter U.N. Doc. CCPR/C/79/Add.72].

¹¹⁰ Penal Code, art. 170.

¹¹¹ Legislative Decree No. 896 (May 24, 1998). If the victim is from seven to under 10 years of age, the sentence is 25 to 30 years, and if the victim is between 10 and 14, the sentence is 20 to 25 years. Life imprisonment is the sentence when the crime causes serious injury or the victim's death.

¹¹² Law No. 26941 (Apr. 16, 1998).

¹¹³ Law No. 27055 (Jan. 24, 1999). The cautionary statement must be given before the family prosecutor, not before the criminal judge. It is also prohibited for the boy, girl or adolescent to participate in any reconstruction of the event.

¹¹⁴ Law No. 27115 (May 17, 1999).

¹¹⁵ *Id.*

¹¹⁶ According to official statistics, 44.1 % of crimes against freedom are rape offenses, which are the third most frequent type of offense, after bodily harm and illegal drug trafficking. *PERÚ: COMPENDIO DE ESTADÍSTICAS SOCIODEMOGRÁFICAS 1998-1999 [PERU: COMPENDIUM OF SOCIO-DEMOGRAPHIC STATISTICS 1998-1999]*, Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science], 1999, at 514.

¹¹⁷ *Id.*

¹¹⁸ *INFORME NACIONAL DE LA MUJER - CUARTA CONFERENCIA MUNDIAL SOBRE LA MUJER [NATIONAL REPORT ON WOMEN - FOURTH WORLD CONFERENCE ON WOMEN]*, Comisión Permanente de los Derechos de la Mujer y del Niño – Ministerio de Justicia del Perú [Permanent Commission on the Rights of Women and girls – Ministry of Justice of Peru], 1995, at 106.

¹¹⁹ *QUÉ ESTAMOS PENSANDO LOS LIMEÑOS SOBRE LAS AGRESIONES SEXUALES? APROXIMACIÓN A LAS CONCEPCIONES Y EXPERIENCIAS DE LOS POBLADORES DE LIMA METROPOLITANA EN DOS PERIODOS: 1997 Y 1999 [WHAT DO THE PEOPLE OF LIMA THINK ABOUT SEXUAL ASSAULT? ATTEMPT TO GATHER THE THOUGHTS AND EXPERIENCES OF THE INHABITANTS OF METROPOLITAN LIMA OVER TWO PERIODS: 1997 AND 1999]*, Estudio Para la Defensa de los Derechos de la Mujer (DEMUS) [Study for the Defense of Women's Rights], 2000.

¹²⁰ Studies show that police work is not carried out properly when it comes to investigating these crimes: in 44.4% of cases, they do not go to the scene of the crime, in 88.9% they do not obtain evidence, and in 83.3% of cases, the Public Prosecutor is not involved. *AGRESIONES SEXUALES CONTRA MUJERES: ¿RESPONSABILIDADES COMPARTIDAS? [SEXUAL ASSAULT AGAINST WOMEN: SHARED RESPONSIBILITY?]*, Estudio Para la Defensa de los Derechos de la Mujer (DEMUS) [Study for the Defense of Women's Rights], 1997, at 36-39.

¹²¹ Victims have stated that, during the forensic medicine examination, doctors ask them upsetting questions, they do not let them go in accompanied, and there are more than two people present for the exam. It has also been shown that, when the case involves rape of a female student by high-school teachers, the latter are simply transferred to another school, and receive no administrative sanctions. *Id.*, at 116-117.

¹²² Abraham Siles Vallejos, *CON EL SOLO DICHO DE LA AGRAVIADA: ¿ES DISCRIMINATORIA LA JUSTICIA EN PROCESOS POR VIOLACIÓN SEXUAL DE MUJERES? [AGAINST THE VICTIM'S WORD: IS JUSTICE DISCRIMINATORY WHEN IT COMES TO RAPE CASES WITH WOMEN VICTIMS?]*, Estudio Para la Defensa de los Derechos de la Mujer (DEMUS) [Study for the Defense of Women's Rights], 1995, at 260.

¹²³ *Id.*, at 259.

¹²⁴ *LA VIOLENCIA SEXUAL: UN PROBLEMA DE SEGURIDAD CIUDADANA. LAS VOCES DE LAS VÍCTIMAS [SEXUAL VIOLENCE: A MATTER OF CITIZEN SAFETY. VICTIM'S VOICES]*, Ombudsman's Office, 2000, at 115.

¹²⁵ Law No. 26260 (Dec. 25, 1993), amended by Law No. 26768 (March 25, 1997), and subsequently re-issued as Executive Decree No. 006-97-JUS (June 27, 1997), then modified by Law No. 27306 (July 15, 2000).

¹²⁶ *Id.*, art. 2.

¹²⁷ *Id.*, art. 4.

¹²⁸ *Id.*, art. 9.

¹²⁹ *Id.*, arts. 10 and 23.

¹³⁰ Law No. 26788 (May 16, 1997).

¹³¹ Law No. 27016 (Dec. 20, 1998). The certificates are free in both types of institutions. Private medical centers that have signed an agreement with the Public Prosecutor and the Judiciary may also issue these certificates to be used as evidence.

¹³² Ministerial Order No. 216-99-PROMUDEH (July 6, 1999). To put the module into operation, PROMUDEH signed an agreement with the ministries of the Interior, of Health and of Justice, as well as with the Public Prosecutor.

¹³³ *BALANCE DEL GRADO DE CUMPLIMIENTO DE LA PLATAFORMA DE ACCION MUNDIAL EN EL PERU [TAKING STOCK OF THE FULFILLMENT OF THE WORLD PLATFORM OF ACTION IN PERU]*, Grupo Impulsor Nacional: Mujeres por la Igualdad Real (GIN) [National Impulse group: Women for Real Equality], 2000 [hereinafter *TAKING STOCK*], at 47.

¹³⁴ Eighty-two percent gave this answer. *ENCUESTA DE HOGARES SOBRE VIDA FAMILIAR EN LIMA METROPOLITANA. PRIMEROS RESULTADOS [HOUSEHOLD SURVEY OF FAMILY LIFE. PRELIMINARY RESULTS]*, Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science], 1999 [hereinafter *HOUSEHOLD SURVEY*], at 81.

¹³⁵ Epidemiological study of violent behaviors carried out by the Ministry of Health with *the Universidad Nacional Federico Villarreal* [Federico Villarreal National University]. The study was also carried out in Metropolitan Lima and El Callao. *TAKING STOCK*, *supra* note 120 at 48.

¹³⁶ Rural women in particular are seriously affected by problems with access to justice. They are not informed about the possibility of making a family-violence accusation before a justice of the peace. Nor do these judges have sufficient awareness or training to intervene adequately in domestic violence cases. *Id.*, at 47.

¹³⁷ Since the Law stipulates that an attempt at reconciliation is an obligatory step of the process, the judge and attorney promote and often impose conflict resolution, based on the need to preserve family unit. There are even signs, particularly in the interior of Peru, that police officers frequently take on this job reserved for judges. *Id.*

¹³⁸ Statements gathered during work with women who have formed organizations in the poorest rural areas. *NADIE SABE LO QUE PASA DENTRO DE MI CASA, YO NO MÁS CONOZCO MI PENA... [NOBODY KNOWS WHAT GOES ON AT MY HOUSE, I ALONE KNOW MY SADNESS...]*, Manuela Ramos, 1997, at 9.

- ¹³⁹ This represents action that the government must take as part of policies to eradicate family violence. Protection from Family Violence Law, art. 3.
- ¹⁴⁰ Executive Decree No. 003-97-TR, Official Transcript of the Work Productivity and Competitiveness Act.
- ¹⁴¹ *Id.*, art. 30.
- ¹⁴² *Id.*, art. 35.
- ¹⁴³ *Id.*, art. 36.
- ¹⁴⁴ Draft Bill No. 2842/96-CR. The draft bill has been the object of a number of consultations with Labor Law experts, the Ombudsman's Office, and the Ministry for Women and Human Development, among others.
- ¹⁴⁵ *TAKING STOCK*, *supra* note 120, at 48.
- ¹⁴⁶ Manual on Human Rights Reporting at 113.
- ¹⁴⁷ U.N. Doc CCPR/C/79/Add.104 ¶ 21.
- ¹⁴⁸ U.N. Doc CCPR/C/79/Add.104 ¶ 16.
- ¹⁴⁹ U.N. Doc CCPR/C/79/Add.72 ¶ 14.
- ¹⁵⁰ U.N. Doc A/52/40, ¶ 161.
- ¹⁵¹ Manual on Human Rights Reporting at 113.
- ¹⁵² U.N. Doc CCPR/C/79/Add.104 ¶ 17.
- ¹⁵³ Peru Const., art. 4.
- ¹⁵⁴ Civil Code, approved by Legislative Decree No. 295 (July 24, 1984) [hereinafter Civil Code].
- ¹⁵⁵ *Id.*, art. 234, ¶ 2.
- ¹⁵⁶ *Id.*, art. 42.
- ¹⁵⁷ Law No. 27201 (Nov. 14, 1999).
- ¹⁵⁸ *Id.*
- ¹⁵⁹ Peru Const., art 5.
- ¹⁶⁰ Civil Code, art. 326.
- ¹⁶¹ *Id.*, art. 340.
- ¹⁶² *Id.*, art. 420.
- ¹⁶³ *FAMILY HEALTH SURVEY*, *supra* note 35 at 89.
- ¹⁶⁴ In rural areas, older women (45-49 years of age) were married on average at 196 years of age, while younger women (25-29 years of age) were married at 191 years of age. *Id.*, at 91.
- ¹⁶⁵ According to the 1993 census, 23.3% of households are headed by women, and 95% of these women are sole providers. Instituto Nacional de Estadística e Informática (INEI) [national Institute of Statistics and information science]– Ministerio de Promoción de la Mujer y Desarrollo Humano [Ministry of Promotion of Women and Human Development], at 135-137.
- ¹⁶⁶ This appears in the National Household Survey IV Quarter 1998, according to which, of the total number of households led by women alone, 27.2% live in poverty, whereas only 13.5% of households led solely by men were affected by poverty. *Id.*
- ¹⁶⁷ *Report of the Human Rights Committee*, ¶ 158, 51st Sess., U.N. Doc. A/51/40 [hereinafter U.N. Doc.A/51/40].
- ¹⁶⁸ U.N. Doc. A/52/40, ¶ 300.
- ¹⁶⁹ U.N. Doc. A/51/40, ¶ 166.
- ¹⁷⁰ Peru Const., art. 17.
- ¹⁷¹ “La educación sexual en la escuela” [“Sexuality Education in School”], *ATAJOS*, Centro de Documentación de la Mujer (CENDOC) [Women's Documentation Center], year I, No. 1, Sept. 1996, at 3.
- ¹⁷² *GUÍA DE EDUCACIÓN FAMILIAR Y SEXUAL PARA FORMACIÓN MAGISTERIAL [TEACHER TRAINING GUIDE FOR FAMILY AND SEXUALITY EDUCATION]*, Ministry of Education, 1998, at 7, 8.
- ¹⁷³ *Id.*, at 8.
- ¹⁷⁴ The enrollment of minors in all three levels of education (preschool, primary and secondary) grew by over a million between 1990 and 1998. According to the 1981 census, 68.4% of children between the ages of five and nine attended school. This indicator rose to 79.3% in 1993, and by 1998, the national attendance rate for primary education was 91.1%. Instituto Nacional de Estadística e Informática (INEI) [national

Institute of Statistics and information science]– Ministerio de Promoción de la Mujer y Desarrollo Humano [Ministry of Promotion of Women and Human Development], at 95, 101, 102.

¹⁷⁵ The environment in 51.2% of households is that of a very low level of education; 13.3% have a low level of education (members of the household have an average of 6 to 10 years of schooling), 21.7% have medium education levels (10 to 13 years of schooling), and 13.8% have high levels of education. *Id.*, at 110.

¹⁷⁶ *Id.*, at 109-110.

¹⁷⁷ The probability of being poor for a head of household with no education would drop by 78.2% if he or she had a university education. Nelson Eduardo Shack Yalta, “La educación y la probabilidad de ser pobre en el Perú de hoy” [“Education and the Probability of Being Poor in Peru Today”], *POBREZA Y ECONOMÍA SOCIAL. ANÁLISIS DE UNA ENCUESTA ENNIV-1997 [POVERTY AND SOCIAL ECONOMICS. ANALYSIS OF A SURVEY ENNIV-1997]*, United Nations Children’s Fund (UNICEF)/United States Agency for International Development (USAID), Richard Webb and Moisés Ventocilla (ED), 1999, at 147.

¹⁷⁸ Between 1981 and 1998, men’s illiteracy rate dropped from 7.1% to 3.9%, while women’s went from 18.3% to 11.4%. Instituto Nacional de Estadística e Informática Informática (INEI) [national Institute of Statistics and information science]– Ministerio de Promoción de la Mujer y Desarrollo Humano [Ministry of Promotion of Women and Human Development], at 93.

¹⁷⁹ In 1993, the illiteracy rate was 12.8%. Of the total number of illiterate persons, 72.7% were women, two thirds of whom lived in rural areas.¹⁸⁰ In 1997, the illiteracy rate dropped to 8.9%, but women’s rate rose to 76%. Of this total number of women, 61.1% belonged to the rural population. *POVERTY AND SOCIAL ECONOMICS, supra* note 31, at 309.

¹⁸¹ In 1961, 25.6% of men and 51.6% of women were illiterate. In 1998, the rates were 3.9% and 11.4% respectively. Instituto Nacional de Estadística e Informática Informática (INEI) [national Institute of Statistics and information science]– Ministerio de Promoción de la Mujer y Desarrollo Humano [Ministry of Promotion of Women and Human Development], at 92.

¹⁸² Eight point seven percent of men and 13.7% of women have no education whatsoever. However, 10% of men get a university education, and 7.3% of women. *POVERTY AND SOCIAL ECONOMICS, supra* note 31, at 310, 313.

¹⁸³ *TAKING STOCK, supra* note 120 at 32.

¹⁸⁴ *Id.*, at 32.

¹⁸⁵ U.N. Doc. A/51/40, ¶318.

¹⁸⁶ U.N. Doc. A/51/40, ¶335.

¹⁸⁷ U.N. Doc. A/51/40, ¶ 195.

¹⁸⁸ Peru Const., art. 2, subsection 2.

¹⁸⁹ *Id.*, art. 2, subsection 16.

¹⁹⁰ Civil Code, art. 4.

¹⁹¹ *Id.*, art., 304.

¹⁹² Laureano Del Castillo, La propiedad y la herencia de las casadas y convivientes: prácticas discriminatorias y mecanismos legales imperfectos [Property and Inheritance for Wives and Concubines; Discriminatory Practices and Imperfect Legal Mechanisms], *Las derechos de la mujer. Tomo II comentarios jurídicos [Women’s Rights. Volume II Legal Commentaries]*, Estudio Para la Defensa de los Derechos de la Mujer (DEMUS) [Study for the Defense of Women’s Rights], 1998 [hereinafter Del Castillo], at 137.

¹⁹³ Civil Code, art. 313.

¹⁹⁴ Del Castillo, *supra* note 165, at 132-133.

¹⁹⁵ Civil Code, art. 326, ¶ 2.

¹⁹⁶ Del Castillo, *supra* note 165, at 133.

¹⁹⁷ *Id.*, at 134.

¹⁹⁸ *Id.*, p. 135.

¹⁹⁹ Peru Const., art. 26.

²⁰⁰ *Id.*, art. 23.

²⁰¹ Law No. 27185 (Oct. 19, 1999). This Law amends Article 29 of the Official Transcript of Legislative Decree No. 728, Work Productivity and Competitiveness Law.

²⁰² Law no. 26772 (Apr. 17, 1997). This Law has been regulated by Executive Decree No. 002-98-TR (Feb. 1, 1998). The employer who engages in this type of conduct is liable to a fine and the affected person may furthermore sue the employer in court for damages. Subsequently, Law No. 27270 (May 29, 2000), established that administrative sanction applied against the employer can include having the place of employment closed down. This regulation also specifies discrimination as an offense.

²⁰³ Law No. 26790, Social Security Modernization Law (May 17, 1997) [hereinafter Social Security Modernization Law].

²⁰⁴ Law No. 27056, Law Creating Public Health Insurance (Jan. 30, 1999).

²⁰⁵ Rightful claimants are the direct and legal beneficiaries of the insured person, as his or her wife, concubine or child, according to Executive Decree No. 009-97-SA, Rules of the Social Security Modernization Law with regard to Health Care.

²⁰⁶ Law 27056 and Executive Decree No. 002-99-TR (Apr. 27, 1999), art. 1.

²⁰⁷ Social Security Modernization Law, *supra* note 176, art.3.

²⁰⁸ Law No. 26513 (July 27, 1995), amending Legislative Decree No. 728, Job Promotion Law.

²⁰⁹ Law No. 26644 (June 27, 1996), art. 1.

²¹⁰ Law No. 27240, (Dec. 23, 1999). The law mandates that, following the postnatal period, working mothers are entitled to one hour of break time a day for nursing up until their baby is a minimum of six (6) months old.

²¹¹ Social Security Modernization Law, *supra* note 176, art. 12, subsection b.

²¹² *Id.*, art. 12, subsection b, ¶¶ b.1 and b.3.

²¹³ Law No. 26504 (July 18, 1995).

²¹⁴ In 1995, women represented 40.6%; 41.2% in 1996; 43.2% in 1997; and 44.3% in 1998. Instituto Nacional de Estadística e Informática Informática (INEI) [national Institute of Statistics and information science]- Ministerio de Promoción de la Mujer y Desarrollo Humano [Ministry of Promotion of Women and Human Development], at 125.

²¹⁵ More women than men participate in low-productivity sectors: 65% compared to 51.7% of men. The activities women carry out are sales (21%), housekeeping (14.3%) and informal jobs (14.3%). *Id.*, at 125-126.

²¹⁶ According to the Ministry of Labor and Social Promotion, the rate in 1998 was 6.4% for men and 9% for women. Webb and Baca, *supra* note 90 at 568.

²¹⁷ Women earn 7.1 times the amount established as the poverty line, whereas men earn 198 times that amount. *Id.*, at 127.

²¹⁸ According to the results of the National Household Census 1997, men with 12 years of education or more have an average income that is 8.6 times the poverty-line amount, whereas women with the same education only earn 5.1 times the poverty-line amount. Instituto Nacional de Estadística e Informática Informática (INEI) [national Institute of Statistics and information science]- Ministerio de Promoción de la Mujer y Desarrollo Humano [Ministry of Promotion of Women and Human Development], at 127-129.

²¹⁹ Draft Bill No. 4358/98-CR, dropped in December 1998. This draft bill has antecedents in a previous bill that was dropped in 1994.