



DEADLY DELAYS

Maternal Mortality in Peru

A Rights-Based Approach
to Safe Motherhood

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PHYSICIANS FOR HUMAN RIGHTS

Physicians for Human Rights (PHR) mobilizes health professionals to advance the health and dignity of all people through action that promotes respect for, protection of, and the fulfillment of human rights.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to healthcare caused by ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; exploitation of children in labor practices; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers, and poor health stemming from vast inequalities in societies. PHR has undertaken significant work on health systems and on healthcare workforce issues in particular.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

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CONTENTS

I. Acknowledgements	1
II. Map of Peru	3
III. Executive Summary	5
IV. Approach to Investigation and Methods	23
V. Context: Peru and the Peruvian Health Care System	25
Socio-Demographic Overview.....	25
Economic Overview	26
Gender Inequality.....	27
The Peruvian Health Care System.....	29
Maternal Mortality	32
Most Recent Health Sector Reform and Maternal Mortality	34
VI. Overview of Maternal Mortality as a Human Rights Issue	43
International Legal Framework; Focus on the Right to Health	43
International Obligations to Respect, Protect and Fulfill the Right to Health	44
Domestic Law.....	46
“Progressive realization” to the “maximum extent of available resources”; Defining “appropriate” means and measures in light of best available evidence.....	47
The Three Delays Model; Available, Accessible, Acceptable, and Quality Care.....	49
Availability	49
Accessibility	50
Acceptability.....	51
Quality	51
VII. Case Studies	55
A. Puno	55
“If only...”: Antonia	57
A Double Injustice: Melania	64
Placing Blame Where it Belongs: Pabla.....	69
The Not-So-Secret Killer: Carolina	75
B. Huancavelica	79
Death Strikes Twice: Evarista	79
A Precarious Success: Tomasa.....	86
Escaping Conflict to Face Tragedy and Injustice: Francisca	91
VIII. Applying a Rights-Based Approach to Address Maternal Mortality in Peru	103
Non-retrogression and Adequate Progress to the Maximum Extent of Available Resources.....	103
Non-discrimination and Equality.....	108
Meaningful Participation	113
Accountability; Access to Effective Remedies	117
International Assistance and Cooperation.....	119
IX. Conclusions	127
X. Recommendations	129
XI. Glossary of Terms and Acronyms	139

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But it is to the women who have experienced obstetric emergencies and the family members of women who died from obstetric emergencies that we are most deeply grateful, for sharing their tragic and painful experiences so that others may not have to endure the same fates.

II. MAP OF PERU



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III. EXECUTIVE SUMMARY

Patterns of maternal mortality in Peru dramatically illustrate systemic inequities that ravage the overall society, and in turn reflect systematic violations of human rights.¹ In the region of the world with the greatest income inequalities, Peru stands out for its social inequities and the concomitant disparities in health and social indicators among population groups, as well as for the paltry resources devoted to the health sector. Peru's persistently high maternal mortality ratio, which is the second highest in South America, provides a telling indicator not only of the social exclusion faced by rural, and especially indigenous, women in Peru but also—and crucially—of structural deficiencies and inequities in the health system.²

Physicians for Human Rights (PHR) conducted an investigation between January and June 2007 to analyze the systemic and social factors that perpetuate the injustice of maternal mortality in Peru. The interventions needed to treat obstetric emergencies—and therefore to prevent the great majority of deaths—are well-known and readily available to women with economic means and to most of those living in urban areas of Peru. Yet lack of available, accessible, acceptable and quality obstetric services leads to delays in the decision to seek care, in arriving at care and in receiving appropriate care, which, in turn, lead far too many women to die during pregnancy and childbirth in rural Peru. Maternal mortality thus provides a kind of social X-ray of Peruvian society, illuminating the interactions of rural poverty and gender inequality, which disproportionately affect indigenous women and those who are illiterate and otherwise marginalized, as well as the way in which the health system exacerbates those patterns of exclusion.

Approach to Investigation; Use of Case Studies

According to the World Health Organization (WHO), at least fifteen percent of pregnancies will result in serious obstetric complications.³ Not all of those women die, but in Peru each year over 1,200 do. Thousands of others come close to dying and are left with life-long debilitating complications. Behind each death and “near

miss”, there is a woman with a story. In this report, PHR puts faces to the numbers. In collaboration with CARE-Peru, PHR identified seven emblematic cases of women who died due to pregnancy-related complications (and one woman who survived an obstetric emergency, for purposes of juxtaposition) in Puno and Huancavelica, two of the regions with the highest maternal mortality ratios in Peru (361 and 302 per 100,000 live births in 2000, respectively).⁴ This report tells their stories and gives voice to their families.

In Puno, we encounter Antonia, who went into labor early on a rain-drenched Good Friday, and seemingly every possible factor that could have delayed care did; Melania, who was nervous about having her first child but trusted the midwife and waited in vain for her to show up at her house as promised; Pabla, who did everything she could to follow the health post's recommendation to deliver at the hospital, but was sent home and died in the room where her own mother had also died giving birth, and Carolina, who, desperate not to have another child with her abusive husband, chose to induce an abortion after her husband forbade her from using birth control. In Huancavelica, we encounter Evarista, the playful young woman who loved to watch videos in Quechua, who had married Alejandro to raise the children left motherless when his first wife died due to pregnancy-related complications; Tomasa, who watched her children's faces in terror and thought about her hopes for their future as she felt the blood seeping out of her, and Francisca, who dreamed of returning to Ayacucho, from where the family had fled during the civil conflict, only to die of neglect and poor care at the health center. We also get a glimpse of their families and the health professionals who were involved in each case—both the dedicated ones, from Dr. Taysaco in Huancavelica to the midwife, Hermelinda Abado Sucapuca, in Puno—and the callously indifferent and negligent ones.

The report also traces back the paths that led to these women's deaths (and in one case, the saving of a women's life) and analyzes the structural obstacles to reducing maternal mortality at the level of the household and community, the health center, the regional government, the national government, and ultimately

international actors, such as the World Bank and Inter-American Development Bank, which are playing a fundamental role in the restructuring of Peru's health sector through PARSaLud (*Proyecto de Apoyo a la Reforma del Sector Salud*). Thus, it is possible to understand that these deaths are not random biological events but the foreseeable result of systematic policy, programming and budgeting decisions, as well as social and cultural factors.

In each case, the factors leading to the deadly delays that cause the woman's death (as well as the factors that mitigated the delays in the case of the woman who survived) are analyzed explicitly in terms of Peru's human rights obligations relating to the right to health under international law, including the obligation to provide available, accessible, acceptable and quality emergency obstetric care (EmOC).

Although the seven cases are drawn from Puno and Huancavelica, many of the issues—those relating to the emotional and physical distance between the population and the health system, interactions between gender and ethnic discrimination in the exclusion of rural women, and structural deficiencies in the health system—confirm findings of other studies and illustrate challenges faced across Peru in realizing women's rights to safe motherhood.⁵ The case studies also permit a glimpse into the lives of individual women, the roles they played in their families and communities, and the impact of their deaths on their partners and children.

The reconstruction of each case included 1) multiple in-depth interviews with family and community members of women who died due to pregnancy-related complications, as well as with women who survived obstetric emergencies; 2) semi-structured interviews with health-care personnel at health posts, health centers and district hospitals and visits to the relevant wings and areas of those facilities to evaluate their resolution capacity in the event of obstetric emergencies; 3) review of relevant medical records, and in some cases, autopsy and other forensic medical reports and trial documents; 4) physical re-tracing of the path of events in each emergency, and 5) interviews with policymakers and key local informants in each department.

That information was supplemented with 32 key informant interviews in Lima and Washington, DC, and a focus group held in the peri-urban area of Carabayllo, outside of Lima. Analysis of Peruvian laws, budgetary allocations, the social insurance scheme, and loan documents relating to health sector restructuring complemented information obtained in the field.

Context: Peru and the Peruvian Health Care System

Peru's population was close to 28 million in 2005.⁶ Approximately 47% of Peru's population is indigenous.⁷ There are 5 million Quechua speakers in Peru, many of whom are concentrated in the *Sierra* region, along with Aymara speakers, who are concentrated in the *Altiplano* region, in particular.⁸ A number of other native communities, representing 55 ethno-linguistic groups, live in the *Selva* region of Peru.⁹ Indigenous populations are disproportionately represented in rural areas and especially among the rural poor.¹⁰

The Truth and Reconciliation Commission (TRC), which examined the brutal armed conflict with Shining Path (*Sendero Luminoso*) between 1980 and 2000, underscored in its 2003 report that it was these rural indigenous campesinos who had borne the brunt of the violence. Seventy-five percent of the nearly 70,000 victims in the armed conflict were indigenous, largely rural *campesinos* from the Quechua-speaking communities of Peru's poorest and most marginalized Andean departments, and Asháninkas from its jungle regions.¹¹ The TRC report called for a national reconciliation based on "full citizenship for all Peruvians" which is oriented toward overcoming the historical fragmentation and discrimination in Peruvian society.¹² Patterns of maternal mortality, which disproportionately affect the same populations of *campesinos*, reflect that historical fragmentation and discrimination.

Although Peru is a middle-income country, over half the population lives in poverty and almost a quarter—24%—lives in extreme poverty.¹³ By measuring poverty according to the percentage of the population living on less than USD\$1 per day, Peru's socioeconomic situation parallels that of countries such as Kenya, India and Senegal rather than its Latin American neighbors.¹⁴

Disparities in the distribution of poverty are noteworthy: over half of the rural population (50.3%) lives in extreme poverty, while only 9.7% of the urban population does.¹⁵ Peru's indigenous population is disproportionately represented among the poor and especially the extremely poor. The country's GINI coefficient—a measure of income inequality—was 54.6 when it was last calculated in 2002, ranking Peru as the 15thnd most inequitable of the 177 countries surveyed.¹⁶

Gender inequality pervades Peruvian society and interacts with poverty and ethnic discrimination. For example, in 2002, girls living in extreme poverty attended secondary school at a rate of 80% that of boys living in

extreme poverty.¹⁷ In the *Sierra*, these differences are even more stark. According to data from 2004, in the *Sierra*, 17.4% of girls and women over the age of 6 have no education whatsoever, while almost 40% had not finished primary school.¹⁸ The median number of years of education for women in the *Sierra* was 4.2, while among women in the poorest quintile it was 2.3.¹⁹

Peru's social spending is extremely low compared with its South American neighbors. In the year 2000, Peru allocated only 2.9% of its GDP to education and 1.4% to the health system, while Bolivia, South America's poorest nation, spent 6.3% of its GDP on education and 3.7% on health.²⁰ In fact, health spending in Peru has decreased proportionally in recent years, and only 0.9% of its GDP was allocated toward health programs in 2005, down from 1.4% in 2001.²¹

Furthermore, spending patterns in health reinforce rather than ameliorate underlying inequalities. In the WHO's *World Health Report* from 2000, Peru ranked 119 of 191 countries in terms of the equity of its health system's performance, ranked from most fair to least, and 184 out of 191 in terms of fairness of financial contributions—placing it closer in ranking to countries such as Somalia, Myanmar and Sierra Leone than to its regional neighbors.²²

These disparities are reflected in patterns of maternal mortality and the programmatic interventions necessary to reduce Peru's high maternal mortality. The government claims that the maternal mortality ratio (MMR) was 168 per 100,000 live births in 2005, down from the 185 the government claimed in 2000. However, the WHO, UNFPA, and UNICEF arrived at an estimate of 410. The government's own 2004 progress report on achieving the Millennium Development Goals (MDGs) acknowledges that the estimates are unreliable and probably reflect a serious under-counting of maternal deaths.²³

Nonetheless, disparities in MMRs can illustrate broad truths about inequity. While the MMR for Lima was 52 per 100,000 live births in 2000, the MMR for Huancavelica and Puno were 302 and 361 per 100,000 live births, respectively.²⁴

The leading causes of maternal mortality in Peru are the same obstetric complications responsible for the great majority of maternal deaths around the world. They are hemorrhage, 45.7 % (and in particular, postpartum hemorrhage); toxemia (pre-eclampsia/eclampsia), 26.5%; abortion-related complications, 7.3%, and infection, 6.6%. Indirect causes of death constitute 13.6% of maternal deaths and include malaria and tuberculosis.

Obstetric complications, including those stemming from incomplete abortions, require access to EmOC.²⁵ In Peru, there are deep inequities in relation to having access to the programmatic interventions necessary to prevent the majority of maternal deaths, which include access to EmOC, skilled birth attendance and referral networks.²⁶ For example, despite overall coverage that is comparable to some of its Latin American neighbors, the disparities between rich and poor in access to skilled birth attendance are greater in Peru than any other country in South America.²⁷

When looking at the data by department, it becomes clear that income is combined with other factors to create a cumulative disadvantage with respect to these interventions. Thus, the extremely low percentages of women attended by skilled professionals in Huancavelica (21%) and Puno (28%) relate not just to the high levels of poverty of the population but also to the high percentage of indigenous populations that live disproportionately in rural areas. Nationwide, in rural areas, 74% of women give birth in their homes, while 90% of women in indigenous communities do so.²⁸

The low level of government funding for health led to formal and informal user fees being imposed, which created significant barriers to care. In recent years, the centerpiece of the government's efforts to reduce economic barriers to care—including to EmOC—has been the comprehensive social insurance scheme, the *Seguro Integral de Salud*, or SIS. Although the SIS has been successful in expanding health care coverage for the poor, the program suffers from a number of problems, including failure to cover the costs of production overhead, inefficient management, failure to ensure that benefits go to the truly needy, and lack of overall funding.²⁹

In April of 2007, the government issued a supreme decree creating a new public insurance scheme meant to transform the SIS from a reimbursement plan into a true insurance scheme with co-payments and premiums. The new scheme includes exonerations for extremely indigent people, but it is unclear whether in practice this scheme will reduce economic barriers to care more or less effectively than the SIS has to date.

In addition to a lack of comprehensive plans of action, a primary reflection of funding shortages—left largely unaddressed by the SIS—is the complex and irrational labor regime for healthcare workers in Peru. Any given health establishment may have a number of workers subject to entirely different labor regimes with different remuneration, protections and benefits. Over the years,

the government attempted to increase coverage at low cost by providing short-term contracts with no benefits. This situation has produced both inequity and high turnover rates, especially in rural areas, which undermines the capacity of the health system to maintain the availability of trained professionals and, in turn, quality care.

In 1999, the World Bank and the Inter-American Development Bank (IDB) jointly developed loan packages designed to facilitate health sector reform in Peru.³⁰ The total amount of the original loan was approximately USD 87,000,000, with the Peruvian treasury contributing slightly over one-third of the funds. For the first three years of the program, the overly-broad objectives laid out by the government in conjunction with the Banks failed to produce any tangible outcomes.³¹

In 2004, the goal of the Program to Support Health Sector Reform (*Programa de Apoyo a la Reforma del Sector Salud, PARSalud*) was narrowed to focus in large measure on maternal and child health and the reduction of maternal mortality as a means of improving the overall health sector, and focused on eight regions with some of the worse maternal and child health indicators.³² Importantly, PARSalud I focused on evidence-based interventions, including emergency obstetric care and referral networks.

Currently, negotiations are in process to draft the second phase of PARSalud. The agreement for PARSalud II, which should be finalized in 2008, is slated to include more regions of the country than PARSalud I, and could amount to more than USD 100,000,000.³³

Overview of Maternal Mortality as a Human Rights Issue

The government of Peru has assumed obligations under both domestic and international law to address different factors that lead to persistently high levels of maternal mortality. Obligations to address maternal mortality derive from the rights enumerated in international treaties to which Peru is a party, some of which have also been implemented through Peru's constitution and domestic legislation.³⁴ Under Peruvian law, norms recognized in the Constitution, such as health, are to be interpreted in accordance with the Universal Declaration of Human Rights and the human rights treaties ratified by Peru.³⁵

Additionally, at the United Nations Millennium Summit in 2000, States—including Peru—adopted the Millennium Declaration. The Millennium Declaration and the Millennium Development Goals (MDGs), which are drawn from the Declaration, include a commitment

to reduce maternal mortality by 75% from 1990 levels by the year 2015 (MDG 5). The Millennium Project Task Force Report on Child and Women's Health explicitly recognizes the crucial importance of human rights in both understanding the underlying elements of MDG 5 and in achieving it.³⁶

Recognizing that no right can be realized in isolation from others, in this report PHR focuses primarily on the obligations of the Peruvian government to respect, protect and fulfill the right to health, so as to be able to clarify them with greater precision.³⁷

The reduction of maternal mortality is explicitly mentioned in both the 1999 General Recommendation by the Committee on the Elimination of Discrimination against Women (CEDAW) on "Women and Health," and in the 2000 General Comment by the ESC Rights Committee on "the Right to the Highest Attainable Standard of Health," which are considered authoritative interpretations of State parties' obligations.³⁸ In fact, the ESC Rights Committee and CEDAW both explicitly acknowledge that obstetric services must be provided and made accessible to women in fulfilling a State's obligations under those respective treaties.³⁹ Of course, obstetric services cannot be provided in isolation from women's other reproductive and sexual health needs, including contraception.

These authoritative interpretations of law reflect the fact that normative obligations relating to what constitute "appropriate services" or "appropriate means" to fulfill women's rights to health, should be construed in light of the best epidemiological evidence relating to the key interventions to reduce maternal mortality, including EmOC. In the context of maternal mortality, even greater guidance on the concrete implications of normative prescription is possible. Guidelines, jointly issued by the WHO, UNICEF and UNFPA, exist as to what signal functions constitute EmOC.⁴⁰

If empirical evidence from public health indicates that EmOC, skilled attendance and referral networks are the keys to preventing and reducing maternal mortality, human rights law requires that these aspects of care are to be made available, accessible, acceptable and of adequate quality for the entire population on the basis of non-discrimination.⁴¹

Maternal deaths overwhelmingly occur due to three delays relating to EmOC: the delay in the decision to seek care; the delay in arriving at care; and the delay in receiving appropriate care.⁴² These delays are closely linked to lack of available, accessible (economically and physically, with respect to information, and on a basis of non-discrimination), acceptable (culturally and ethically),

and quality health care. PHR found all three forms of deadly delays to be present in Peru.

Further, in Puno and Huancavelica, PHR found that the rural indigenous women who die and the families they leave behind are in effect often blamed for their own deaths because there is a delay in the decision to seek care, and that delay is ascribed to “cultural preferences” or “idiosyncrasies.” Upon closer examination, however, all of these deadly delays, including the delay in the decision to seek care, are related to systemic inequities in Peruvian society and in the Peruvian health care system. For example, delays in the decision to seek care are affected by the inequitable distribution of healthcare facilities, goods and services that makes EmOC both unavailable and physically inaccessible. PHR found that it can also be attributable to economic barriers to access for these impoverished families which persist in spite of the SIS, including the costs of transportation. PHR also documented how the lack of cultural sensitivity and acceptability of care at health facilities, including both language and respect for traditional birthing customs, provokes delays in the decision to seek care. Finally, when the population perceives that there is poor quality of care at facilities, PHR found that it also delays decisions to seek care.

Applying a Human Rights-Based Approach to Address Maternal Mortality in Peru

In addition to highlighting the centrality of available, accessible, acceptable and quality EmOC, human rights law sets out principles that can be used to evaluate Peru’s current efforts to address maternal mortality, as well as guide future policy-making and programming. These principles, taken together, can highlight concerns and inform actions taken by regional governments, the national government, and third-party actors such as the United States, the World Bank and IDB, which play a large role in the ability of women in Peru to realize their rights to safe motherhood. It is now widely agreed that human rights-based approaches include at least the following principles: non-retrogression and adequate progress; non-discrimination and equality; participation; accountability, and international assistance and cooperation.⁴³

Non-retrogression: Adequate Progress to the Maximum Available Extent of Resources

Although the right to health cannot be implemented overnight, governments have an obligation to demonstrate adequate progress in fulfilling all treaty rights

to which they have subscribed, including the right to health.⁴⁴ Furthermore, there is a strong presumption that retrogressive measures are impermissible under international law.⁴⁵ Furthermore, under international law, the Peruvian government does not have unlimited discretion in construing what constitutes the extent of its “maximum available resources” that can be devoted to the implementation of the right to health.⁴⁶

Nevertheless, despite being consistently touted as a political priority, there is no national concerted plan of action to reduce maternal mortality or to address systematic problems relating to healthcare workforce. Also, although PARSalud I employed some key indicators to classify facilities according to EmOC capacity, all of the appropriate process indicators have not been implemented to measure progress. Moreover, there has been retrogression with respect to the family planning program and the availability of contraception, the coverage by the SIS and changes relating to abortion.

First, as a result of reorganizing the National Family Planning Program in 2001, family planning and reproductive health lost priority and funding. The availability of modern methods of birth control within the public section decreased by an average of 10% between 2000-2005.⁴⁷ In turn, shortages translate into reduced access and usage. PHR’s findings relating to systematic shortages of family planning methods in health establishments in Puno and Huancavelica confirm those of national studies.

A second form of retrogression was evidenced in Article 30 of the General Health Law of 1997, which included a requirement that doctors are obligated to denounce indications of a criminal abortion to the “competent authority.”⁴⁸ This legislative provision created an additional barrier to accessible EmOC in Peru which had not existed previously.

A third form of retrogression can be observed in the coverage of the poorest populations under the SIS. Rather than extending coverage of the SIS, there was a reduction in coverage for those in the lowest income quartiles (35% to 28% for those in extreme poverty, and 28% to 20% for those in poverty) between 2003 and 2005.⁴⁹

Furthermore, by objective measures, Peru is not currently devoting the maximum extent of available resources to realize the right to health, or to address maternal health concerns in particular. As compared with other countries with comparable GDP per capita, Peru’s health system faces a dramatic shortage of funding. Peru spent USD 102.80 per capita on health care in the period 1995 – 2000,⁵⁰ considerably less than its South American neighbors of Brazil (\$267),

Venezuela (\$233), and Colombia (\$186).⁵¹ According to the Economic Commission for Latin America and the Caribbean (ECLAC), Peru spends amounts of no more than USD 180 on social spending—including health—per year whereas the regional average stands at USD 610 per capita per year.⁵²

Furthermore, Peru's per capita healthcare investment declined from 95 *nuevos soles* in 2001 to 78 *nuevos soles* in 2003, or from approximately 28 to 23 US dollars.⁵³ However, this decrease in healthcare spending was accompanied by positive GDP growth,⁵⁴ indicating that the availability of resources was not the source of such decreases. When considering the period between 2000 and 2004, although the health sector's annual budget increased in absolute terms, it still decreased in relative terms, despite government commitments to increase social spending as part of the National Agreement (*Acuerdo Nacional*) signed by former President Toledo in 2002.

Due to a legacy of tax amnesties and inadequate tax enforcement, Peru's tax revenues currently constitute only 13% of GDP, while the International Monetary Fund (IMF) recommends that they constitute at least 15%. Thus, the Peruvian government's failure to increase the extent of resources that it devotes to health, and maternal health in particular, reflects political choices and a lack of political will, rather than absolute resource constraints.

At the regional level, regulations regarding tax revenues from mining and other sources of revenue which could be channeled to health care are not so channeled because of a lack of clarity in regulations. For example, tax proceeds on mining and petroleum (*canon minero* and *canon petrolero*, respectively) are not currently interpreted to explicitly include spending on infrastructure that would improve healthcare referral systems.

Non-discrimination and Equality

Non-discrimination and equality are cross-cutting principles in human rights law. Persistently high maternal mortality levels in Peru reflect multiple levels of combined discrimination based on gender and race/ethnicity.

Ethnic Discrimination and Inequality: Individual, Institutional and Structural

PHR found evidence of widespread discriminatory attitudes among individual healthcare providers in Huancavelica and Puno, which mirror the findings of other studies.⁵⁵ Healthcare providers described indigenous customs as “backwards,” or “ignorant.” Coercive practices targeted at indigenous populations, documented by PHR, appear to be rooted in these discriminatory attitudes. For example, PHR found examples of outright coercion

targeted at indigenous populations to give birth in health establishments, such as the use of police and threats of incarceration in the Pampas health center in Huancavelica. Other practices, such as the imposition of *de facto* fines for obtaining birth certificates when deliveries occur at home, have a disproportionate impact on indigenous populations in practice.

Current efforts to promote cultural sensitivity are inadequate. For example, the brief training modules for health providers funded through PARSalud I in “interculturality” are radically insufficient in both their coverage and their content. Among other things, curricula in medical and other health professional schools need to incorporate concepts of interculturality and cultural competence.

At the institutional level, PHR found many health establishments that did not permit traditional vertical birthing positions (in contravention of Peruvian law) or other traditional practices.⁵⁶ Even when facilities had been recently remodeled, such as the Obstetric Center in the Regional Hospital in Puno, they had not been equipped to permit vertical delivery. Additionally, in the absence of systemic provision of interpreters, the lack of health personnel who speak the local language in the institution is a form of discrimination and constitutes a barrier to accessible and quality care.

In Peru, structural inequalities in resource allocation result in *de facto* discrimination against ethnic minorities. There are greater health-related resources available on a per capita basis to Peruvians in areas with low indigenous populations, as compared with areas such as Huancavelica, Ayacucho and Puno, with high indigenous populations.⁵⁷ This translates into fewer health facilities, doctors, and specialists per capita, which has the “effect of nullifying or impairing the equal enjoyment or exercise” of the right to health to many rural women.⁵⁸ This spending inequity results in measurably less availability and accessibility of care necessary to reduce maternal mortality, including skilled birth attendance.⁵⁹

This resource dichotomy is replicated within the departments themselves, with significantly more resources devoted to healthcare facilities in the more urbanized areas of these departments and fewer to rural areas, where the indigenous populations overwhelmingly reside.⁶⁰

Gender Inequalities and Discrimination

Gender inequality in Peru is inextricably linked with ethnic discrimination and rural poverty. PHR observed in Puno and Huancavelica that women continue to remain

disempowered as decision-makers in their own right to seek health care. Even in cases of emergency, PHR found that the men in the family make life-changing health decisions for their wives or other female relatives. All of the case studies included in this report reflect the ineluctable connections between the lack of agency women have in their private lives—relating to bodily integrity, choice of sexual relations and birth spacing, etc—and the lack of agency they have in the public sphere.

Government health and other social programs aimed at providing assistance to women and children in poverty, such as the JUNTOS program, tend to reinforce stereotyped roles of women as caregivers rather than fostering gender equity and treating women as rights-holders.

Gender discrimination is also reflected in laws and policies that have a detrimental impact upon women's health, including Peru's restrictive abortion law.⁶¹ Under Peruvian law, abortion is illegal except when necessary to preserve the life or health of the mother. Both the woman who undergoes the procedure and the health professionals who perform it are subject to sanctions in all cases other than therapeutic abortions.⁶² The narrow interpretation of such "therapeutic abortions" to exclude situations where the woman's mental health is at risk, was found to violate women's rights in a binding holding by the United Nations Human Rights Committee in *Karen Llantoy v Peru*, a case involving a teenager who was forced to carry an anencephalic fetus to term.

Meaningful Participation

A rights-based approach to addressing maternal mortality in Peru calls for the democratization of the entire health sector, with a transfer of planning and decision-making power to the individuals and communities the health system is supposed to serve, as well as the health professionals who work within the system.⁶³

Community Participation, especially in Indigenous Communities

The UN Special Rapporteur calls specifically for "the active and informed participation of indigenous people in the formulation, implementation and monitoring of health policies and programs."⁶⁴ In Peru, PHR found just the opposite to be true. The health system is perceived across many indigenous communities as a colonizing force that does not respect indigenous cultural traditions and preferences.

Although not particularly targeted at indigenous populations, the CLAS (*Centros Locales de Administración de Salud*) potentially provide a mechanism to facilitate community participation including control over healthcare priorities

at the local level, especially among indigenous communities. However, in the last eight years, the CLAS have been systematically under-funded, leaving few resources for community members to prioritize or allocate. Further, as CLAS doctors now work on contracts with the Ministry of Health (MINSA), they are increasingly less accountable to the community members who sit on the council, and rather, behave as any other MINSA employee would, as evidenced in the case of Melania from Puno.

Political Participation, Especially by Rural Women

Voting must be accompanied by other measures to increase the participation of rural women in political decisions affecting their well-being. However, without the ability to vote, these rural residents—and in particular women—are left invisible and uncouned when health policies and budget allocations are made. Numerous studies have found that many rural Peruvians, and in particular *campesina* women, do not possess the identity documents required to vote.⁶⁵ The Human Rights Ombuds Office (*Defensoría del Pueblo*) estimates that more than three million people do not have the identity documents that are necessary to vote⁶⁶, nor do they have access to certain social benefits and services, including through the social insurance scheme.⁶⁷

Obstacles to having appropriate identity documents include discrimination against children of unwed parents (*convivencias*)—common in the *Sierra* and other parts of rural Peru—and the imposition of *de facto* fines for seeking birth certificates for children born at home, a practice PHR documented in both Huancavelica and Puno.

Participation by NGOs and Civil Society Groups

Since the end of the Fujimori regime, Peru has seen a broad array of processes and institutions aimed at fostering participation. Some civil society organizations have grown to play important roles in monitoring policy-making. However, civil society institutions continue to have little actual power over policy or budgetary decisions.⁶⁸ The World Bank goes further, arguing that the lack of clarity in roles and the great energy invested in these activities could be producing "participation fatigue" or worse, that all efforts are focused on the design of budgets and plans with no attention paid to monitoring of implementation.⁶⁹

The World Bank itself, together with the IDB, was heavily criticized by numerous key informants for the lack of transparency and participation in PARSalud I. Susan Thollaug, Office Chief for the USAID Peru Country Office, stated that PARSalud had worked very little with other agencies, such as AID and UNFPA.⁷⁰ There was no

civil society participation in the evaluation of PARSalud I. As of April, 2007, no consultations had been held with UN agencies, user groups, or NGOs on the design of PARSalud II.⁷¹

Participation within the Health Sector

Peru's health sector is highly autocratic and vertical.⁷² PHR found that this autocracy is reproduced within the Regional Directorates of Health (DIRESAs) as well.

Health professionals who work in establishments have little control as to how funds are to be spent or what policies their establishments follow. PHR encountered numerous health professionals in Puno and Huancavelica who were deeply frustrated by decisions that had been made regarding the allocation of ambulances or funds to hospitals, without regard to their needs.

There are systemic policies that influence the ability of front-line health workers to have a voice in how decisions are made as well. For example, the MINSA still imposes quotas autocratically for institutional births and prenatal visits on front-line health workers in the name of promoting "productivity." In addition to the women in the population who bear the consequences of the perverse incentives created by such policies, it is the health professionals who are on short-term contracts without benefits who suffer most from such quotas. Health workers such as those PHR met at the Hanajquia health post in Puno are left with unlivable salaries if they fail to meet arbitrarily-set productivity quotas, into which they have had no say or input whatsoever.

Information

In order for people to participate in and evaluate programs and policies to reduce maternal mortality, it will be necessary for them to have access to adequate information, including budget numbers and health statistics—making it apparent that the right to health is interdependent on the right to information.⁷³ Information regarding health at the individual, institutional or systemic level is not widely accessible in Peru, especially to those for whom Spanish is not their first language.

Accountability

Accessible and effective accountability mechanisms are crucial to a rights-based approach to health, including women's rights to safe motherhood.⁷⁴ Accountability includes important dimensions of financial and political accountability. It is also closely linked to effective remedies.⁷⁵

The existing mechanisms for redress are largely focused on individual errors, rather than institutional and systemic factors, and are therefore inadequate to provide true accountability in the context of maternal mortality, where underlying causes tend to be systemic in nature. A malpractice or negligence case only rises to the level of a human rights violation when there is some institutional or systemic failure to provide accountability. Sometimes, an overemphasis on individual fault can in fact detract attention from problematic policies and programs. Additionally, although some existing mechanisms could prove important to protecting safe motherhood rights, their use suffers from many of the same obstacles to access as health care does. Additionally, there is a lack of familiarity of these mechanisms on the part of lawyers and judges.

Under Peruvian law, there are essentially three avenues or mechanisms for the enforceability of health rights, including those relating to maternal health: administrative, judicial, and through the Defensoría del Pueblo.

A soon-to-be published study on regional systems for the protections of the rights of health system users found that administrative procedures are not an effective means of resolving health rights violations.⁷⁶ This deficiency was illustrated in the cases of Francisca in Pampas, Huancavelica and Pabla in Ramis, Puno. Francisca received little, if any, attention from the doctor on duty at the time of her emergency. The subsequent investigation, however, cleared the doctor of any responsibility because ostensibly Amancio, Francisca's husband, had not agreed to have his wife transferred to Huancayo, although he had desperately tried to find someone to take her but had no money and she was already brain dead at the time.⁷⁷ In Pabla's case, PHR was not informed of any administrative investigation that had even been launched into the possible culpability of the doctor who sent her home from the hospital when she arrived hoping to have a Cesarean section with a diagnosis of pre-eclampsia/eclampsia.

At the same time as there appears to be little real accountability within the health system itself, there is misdirected punishment of front-line health workers within the MINSA when maternal deaths occur. PHR learned that health workers who do not enjoy job security because they work on contract are often sanctioned or even summarily dismissed when a maternal death is recorded as having occurred in their establishment, even if they are not responsible for that death. This undermines true accountability and creates perverse incentives in the health system for workers to avoid treating women having obstetric emergencies.

For the last ten years, the Defensoría del Pueblo (Human Rights Ombuds Office) has been a critically important institution in relation to the enforceability of the right to health. With sustained financing for its new initiative of *Supervisión Defensorial* (“Ombuds’ Oversight”), the Human Rights Ombuds’ Office could play an even larger role in monitoring health establishments and could conduct more numerous investigations of issues relating to safe motherhood. For example, in the regional Hospital in Puno, PHR documented the practice of detaining women who cannot afford to pay for screening for blood transfusions they receive when hemorrhaging. This detention violates human rights under international and Peruvian law and an investigation into how widespread the practice is appears to be clearly warranted.

With respect to judicial accountability, potentially relevant remedies for acts relating to health rights include the *amparo* (protection writ); the *acción popular* (popular action); the *acción de cumplimiento* (compliance action), and civil suits for damages (*daños y perjuicios*). Some of these remedies call for specific requirements that may limit their applicability and accessibility in practice; others should be more widely disseminated to the public.

International Assistance and Cooperation

The contours of obligations of “international assistance and cooperation,” called for under the ICESCR and other treaties, are still not well-defined under international human rights law. It is clear, however, that States parties to international treaties such as the ICESCR, and even—as is the case with the United States—signatories, assume obligations in accordance with the Vienna Convention on the Law of Treaties “to refrain from acts that would contravene the object and purpose” of the treaty, an obligation that remains in force until such time as the State makes clear its intention not to become a party.⁷⁸

USAID has historically provided a significant percentage of funding for Peru’s sexual and reproductive health and family planning programs, through the government as well as through NGOs. However, the Mexico City Policy adopted by President Bush—commonly referred to as the Global Gag Rule—prohibits foreign NGOs that receive USAID family planning funds from using their own, non-US funds to provide legal abortion services, lobby their own governments for abortion law reform, or even provide information, counseling or medical referrals regarding abortion. This policy interferes with the ability of NGOs

to provide information that might reduce the incidence of unsafe abortions and of maternal deaths in Peru.

In addition, USAID has attempted to curtail even the provision of services that are “permitted” under the Mexico City Policy, including the dispensing of emergency contraception, which is not an abortifacient. Nevertheless, in 2005, NGOs documented a disturbing pattern of actions by USAID in Peru to exert undue influence on grantees to stop disseminating information about emergency contraception, which had been legalized and regulated, alleging incorrectly that such activities violated the Mexico City Policy.⁷⁹ Grantees were even required to return monies spent on such activities to USAID.

For their part, despite the centrality of family planning to the reduction of maternal mortality, the World Bank and the IDB did not include family planning in PARSalud I. In an interview with PHR in April, Ian Macarthur of the IDB called the subject controversial, saying therefore its inclusion in PARSalud II “would be a stretch.”⁸⁰

Another way in which donor governments affect Peru’s ability to address maternal mortality and achieve other health goals is through debt. The eight MDGs, which have been endorsed by the United States government, call for a global partnership for development which “makes clear that... it is absolutely critical that rich countries deliver on their end of the bargain with more and more effective aid, more sustainable debt relief and fairer trade rules, well in advance of 2015.”⁸¹ Obligations of donor countries under MDG 8 include “enhanced debt relief for heavily indebted poor countries, cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction.”⁸²

Peru is a highly indebted country. At the end of 2003, its foreign debt represented 38% of GDP.⁸³ The government spends more than four times as much on debt service annually as it does on health.⁸⁴ The amount of debt Peru is forced to pay limits its maximum extent of available resources to spend on health.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is currently promoting a Global Fund Debt Conversion (or debt-to-health initiative) wherein Peru and three other pilot countries will have certain bilateral debt forgiven, with the money saved going to health.⁸⁵ Germany has already agreed to join this initiative.

Most of Peru’s debt is held by international financial institutions, and the second most is held by Paris Club members,⁸⁶ including a substantial amount by the United States. The US government, on its own and through its membership in international organizations such as the IMF and Paris Club, could participate in the Global Fund’s debt-for-health conversion in Peru and, in turn, assist

Peru in meeting its international obligations with respect to safe motherhood and MDG5.

Conclusions

Lack of available, accessible, acceptable and quality healthcare, including EmOC, is a primary contributor to the ways in which women in Peru—and especially rural, indigenous women—experience poverty and exclusion. It is also a failure to uphold their right to the highest attainable standard of health under treaties that the government of Peru has voluntarily ratified.⁸⁷ The absence of available, accessible, acceptable and quality EmOC leads to delays in decisions to seek care, delays in arriving at care, and delays in receiving the appropriate treatment once at a health facility, which in turn lead to women dying.

As the UN Millennium Project Task Force Report on Child Health and Maternal Health states, “health claims—claims of entitlement to health care and enabling conditions—are assets of citizenship.”⁸⁸ The failure to provide access to adequate EmOC—as well as related reproductive and sexual health services—is a powerful indicator of how rural *campesinas* are not treated as full citizens in Peruvian society. The national reconciliation of a society so fragmented along class, ethnic and gender lines—which was called for by the Truth and Reconciliation Commission—has not occurred in Peru. Patterns of maternal mortality provide a vivid illustration of the pathologies of power that plague Peruvian society and the failure of the government, through the health system, to remedy them.⁸⁹

That is, general societal resources are not directed adequately to health in Peru, or to maternal health in particular. Furthermore, those resources that are spent on health are distributed inequitably with respect to both unmet basic needs and rural versus urban populations, resulting in a disproportionate impact on indigenous populations. Efforts to ameliorate exclusion of pregnant women based on income, such as through the SIS, have not adequately addressed cultural barriers to care. The counter-productive and punitive policies adopted by the Ministry of Health with respect to pregnant women, their families, and front-line health personnel have produced perverse incentives and undermine the possibility of sustained improvements in EmOC, as well as violating rights of both patients and healthcare workers.

After years of ineffectualness, PARSalud I appropriately emphasized the evidence-based interventions of EmOC and referral networks, which should remain the focus of PARSalud II. However, structural obstacles to reducing and preventing maternal mortality, not just as a public

health issue but as a human rights imperative, remain to be tackled. Addressing the problems in the health system that relate to maternal mortality—including inequitable access to EmOC and referral systems, cultural and economic barriers, and irrational and inequitable human resource regimes, would go a long way toward strengthening the health system overall. It would also permit the health system to function in its capacity as a core social system to promote greater democracy and equality in the overall society, and to facilitate Peru’s long-sought national reconciliation.

Selected and Summarized Recommendations

(See Chapter X for Full Recommendations)

Addressing maternal mortality requires concerted actions to strengthen Peru’s health system; discrete activities or vertical approaches have not proven successful in the past in Peru or elsewhere. The recommendations to the government of Peru and other actors fall into certain overarching themes that correspond to human rights principles set out in Chapters VI and VIII. In short, increased funding needs to be directed to the health system, and the resources spent need to be allocated equitably with regard to historic disadvantage as well as unmet needs. As part of this reallocation, priority in funding needs to be placed on making quality EmOC available and accessible (physically and economically) on a non-discriminatory basis. True availability, accessibility and quality require more than structures and equipment; they require trained personnel, 24 hours a day, and adequate communications and transportation, as well as the elimination of laws and policies that discriminate against women. Care also needs to be acceptable, which requires prioritization of programs and modifications in curricula to promote intercultural understanding and the rights of patients. Finally, accountability—financial, political, and legal—needs to be improved for the right to safe motherhood to become a reality in Peru.

Some recommendations are directed at multiple actors as responsibility for their implementation is shared.

To the Peruvian Government, including the Executive and Legislative Branches, as appropriate:

Devote Maximum of Available Resources

1. Modify legislation, regulations and enforcement to increase tax revenues to at least 15% of GDP,

in keeping with IMF recommendations, and use increased revenues to sustain increases in social spending (including health spending).

2. Increase percentage of national budget devoted to health care spending, including spending on maternal healthcare, to bring Peru in line with other middle-income countries in the region and make spending allocation information freely available to the public.

Demonstrate Adequate Progress: Devise, Adopt and Implement Plans of Action

3. Adopt by Supreme Decree and implement a National Concerted Plan of Action to Reduce Maternal Mortality, based on the best available epidemiological evidence relating to the keystone interventions to reduce maternal mortality. Such a Plan should be devised and periodically reviewed on the basis of a participatory and transparent process, which includes indicators and benchmarks by which progress can be closely monitored and which pays particular attention to the needs of marginalized groups, including indigenous populations.
4. In relation to the National Plan of Action on Human Rights, passed by Supreme decree 017-2005-JUS, adopt and implement a National Concerted Plan of Action to Address Human Resources in Health, which calls for modification of legislation and policies relating to healthcare workforce to ensure respect for both patients' and workers' rights and which promotes equitable allocation of services.

Eliminate Retrogressive Measures

5. Given that confidentiality is critical to promoting access to treatment for post-abortion complications and in turn reducing maternal mortality, eliminate reporting requirements for health professionals who suspect an induced abortion under Article 30 of the General Health Law.

Promote Meaningful Popular Participation

6. Follow the recommendation of the Committee on the Elimination of Discrimination against Women in its concluding observations of February 2007, to "expedite and facilitate the process of registration of women without documentation and issue birth certificates and identity documents" so that, *inter alia*, more rural women can participate in the political process and gain access to government benefits programs.

Eliminate Discrimination Based on Gender and Ethnicity, and Promote Equality and Women's Rights

7. In keeping with the 2006-2010 National Plan of Human Rights, institute cross-cutting human rights approaches and training throughout government ministries; these approaches and trainings should explicitly adopt a gender perspective that recognizes the interactions between gender inequalities, ethnic discrimination, and rural poverty in Peru.
8. Given that complications from illegal abortions are a leading cause of maternal mortality, revise Article 119 of the Penal Code to provide for exceptions to the criminalization of abortion in cases where the pregnancy is a product of sexual violence, in keeping with the concluding recommendations of CEDAW and the UN Human Rights Committee with respect to Peru.
9. Transform JUNTOS from a vertical hand-out program to a genuinely inter-sectorial program that collaborates with NGOs in order to empower women economically and educate them in relation to their sexual and reproductive health—including family planning, domestic violence, and safe motherhood—as well as child health.

Promote Accountability and Effective Remedies

10. Create programs to systematically educate judges and lawyers about the applicability and enforceability of certain claims relating to women's rights to health and life, and widely disseminate to the public in Spanish and local languages the existing mechanisms for seeking redress (administrative, judicial and through the Defensoría) in the event of violations of women's rights to health and life.

To the Ministry of Health:

Promote Available, Accessible, Acceptable, and Quality Care, including Adequate Transportation and Communications

1. Commit to funding and instituting evidence-based interventions and policies, including centrality of EmOC, skilled birth attendance and referral networks.
2. Ensure that healthcare goods, facilities and services, including FOEs and FOBs, are equitably distributed.
3. Recognize that independent of economic factors, significant cultural barriers to the use of healthcare,

and especially obstetric care, exist in Peru, and take concerted actions to address these barriers.

4. Create and fund radio spots in local indigenous languages relating to alarm signals for obstetric emergencies and steps to take to avert death in the event of an emergency.
5. Promote modified legislation to allow the delegation of anesthesia to general practice physicians and nurse anesthetists, and ensure appropriate training for general physicians and nurse anesthetists.
6. End the practice of retaining in hospitals women who have received blood transfusions until their relatives donate blood.
7. Develop a national campaign to obtain and store sufficient blood at FOEs.
8. Require vehicle purchases to comply with certain criteria to make them suitable for local terrain, such as four-wheel drive and heavy-duty suspension in the *Sierra*, and include budgeted monies for regular maintenance as well as fuel.
9. Given the lack of availability of ambulances, devise plans in conjunction with authorities from and members of rural communities for alternate transportation in the event of emergencies, including possibilities for rotating funds, identification of owners of private transport, and reimbursement mechanisms from the health sector.
10. Prioritize purchases of radios (and/or cell phones, where appropriate) for health posts and within communities, and consider credit schemes that enable women in communities to control cell phones and charge small fees for their usage.

Eliminate Discrimination Based on Gender, Class and Ethnicity; Promote Equality and Women's Rights

11. Ensure that under the re-designed social insurance scheme benefits are correlated with need, so that women from the poorest quintiles and historically marginalized populations are adequately covered.
12. Reinvigorate reproductive health and family planning services, including more funding, concerted strategies, training for providers, and staffing, and ensure the availability of a full range of contraceptive options, including injectables and emergency contraception, especially to rural, indigenous women and adolescents.

13. Given that complications from illegal abortions are a leading cause of maternal mortality, create a protocol for therapeutic abortion that recognizes the need to protect women's psychological health as well as their physical health, in keeping with CEDAW's General Recommendation 24 on Women and Health and the finding of the UN Human Rights Committee in the case of *Karen LL. v Peru*.

Demonstrate Adequate Progress: Plans of Action; Indicators

14. Devise and propose national (and in conjunction with DIRSESAs, regional) strategies and plans of action relating to maternal mortality and healthcare workforce, on the basis of a participatory process that includes input from health system users and health professionals, that are responsive to the needs of local populations, especially marginalized and rural populations.
15. Standardize and apply those process indicators that have been internationally endorsed as appropriate in order to continuously monitor progress in addressing maternal mortality, including those set out in the *UN Guidelines on Monitoring the Use and Availability of Essential Obstetric Care*.

Promote Meaningful Participation and Democratize Health Sector

16. Take steps to end the authoritarian and punitive culture in the health sector, which undermines both providers' and patients' rights and creates perverse incentives.
17. Revitalize the CLAS system through increased funding and modified contracts for salaries of health professionals working at CLAS facilities, so that staff respond to the expressed needs of the community, and ensure that CLAS councils always include women among their members.

Promote Accountability

18. Improve monitoring and accountability systems for the purchase of medicines and implement an automated system for purchases of medical equipment by requiring use of SIGA (*Sistema de Información de Gestión Administrativa*) and integration with SIAF (*Sistema Integral de Administración Financiera*).
19. Institute and maintain a transparent bidding process for all equipment and supply purchases, including ambulances, and make material information on criteria, as well as bids, open to the public.

20. Improve public access to information at the system and institutional levels, including information relating to programming and budgeting regarding reproductive and sexual health and performance of health personnel.

To the Regional Governments of Huancavelica and Puno, and the DIRESAs Huancavelica and Puno, as Appropriate:

Promote Available, Accessible, Acceptable, Quality Care, including Transportation and Communications; Eliminate Discrimination Based on Ethnicity and Gender and Promote Equality

1. Ensure that health care spending and priorities adequately reflect the needs and rights of rural populations, in particular indigenous women, and that emergency obstetric care (through FOBs and FOEs) is available, accessible, acceptable and of adequate quality.
2. Recognize that independent of economic factors, significant cultural barriers to the use of health-care, and especially obstetric care, exist, and take concerted actions to address these barriers.
3. Prioritize purchases of radios and/or cell phones where appropriate for health posts and communities and consider credit schemes that enable women in communities to control cell phones and charge small fees for their usage
4. Budget monies which are strictly dedicated for regular maintenance and fuel for ambulances, and require logs to be kept for mileage, to facilitate calculations of when and how many emergencies are attended.
5. Create and fund radio spots in local languages relating to alarm signals for obstetric emergencies and steps to take to avert death in the event of an emergency.

Demonstrate Adequate Progress: Plans of Action, Indicators

6. Devise and implement regional strategies and concerted plans of action (*planes concertados*) to reduce maternal mortality based on the best available epidemiological evidence relating to the keystone interventions to reduce maternal mortality, on the basis of a participatory and transparent process, that

include indicators and benchmarks by which progress can be closely monitored and that pay particular attention to the needs of marginalized groups, including indigenous populations.

7. Devise and implement regional strategies and concerted plans of action (*planes concertados*) relating to healthcare workforce, on the basis of a participatory process that includes input from health professionals and that are responsive to the needs of local populations, especially marginalized and rural populations.
8. Use the SIS forms that already exist to continuously collect data at the facility level regarding appropriate use of oxytocics, Magnesium Sulfate and antibiotics and utilize such data to improve programming.

Promote Meaningful Participation

9. Ensure participation of women and women's groups in Concerted Working Groups (*Mesas Concertadas*) in order to promote women's health issues and interests in the priorities and indicators selected for all of the Concerted Plans of Action (*Planes Concertados*).
10. Conduct an education and registration campaign to ensure that campesinos, and especially campesina women, have DNIs and are encouraged to vote in local elections and participate in regional political processes.
11. Include the strengthening of CLAS managing councils and technical assistance for CLAS association members on key maternal and reproductive health issues in local health plans.
12. Promote the involvement of municipalities in health system, e.g., expanding the healthy municipalities initiative (*Municipios Saludables*) from prevention to care, with the condition that women are adequately represented.

Promote Accountability and Access to Effective Remedies

13. Improve monitoring and accountability systems for the purchase of medicines and implement an automated system for purchases of medical equipment, *inter alia*, by monitoring the use of SIGA (*Sistema de Información de Gestión Administrativa*) and its integration with SIAF (*Sistema Integral de Administración Financiera*).
14. Assess the performance of the Regional Health Councils, including an analysis of the number and

content of proposals made and what follow-up there has been, as well as the extent of female representation and participation.

15. Investigate and sanction, administratively or judicially, as called for by law:
 - a. the use of police to coerce women to deliver at institutions
 - b. the imposition of *de facto* fines for birth certificates when children are not born in an institution
 - c. denials of care (including referral and transportation) due to a lack of ability to pay
 - d. the detention of women for failure to pay for blood transfusions and screenings
 - e. any act of discrimination against patients based on gender or ethnicity

To the World Bank and Inter-American Development Bank:

1. Insist upon technical and not political criteria in the design of PARSalud II, and the inclusion of only evidence-based interventions.
2. Include funds in PARSalud II for the *Registro Nacional de Identificación y Estado Civil* (RENIEC) to distribute, and ensure that everyone in rural areas has national identity cards, as a health-promoting measure.
3. Use outcome measures (e.g., Magnesium Sulfate usage, C-Section rates, oxytocin usage, existence of facilities with appropriate staffing) rather than spending indicators as indicators of progress.
4. Establish transparent bidding procedures for equipment purchases, including ambulances, whereby all material information is made public.
5. Select appropriate disaggregated data, including indicators set out in *UN Guidelines*, and invest in improved data collection to track Peru's record on maternal mortality for purposes of measuring progress on MDG 5.
6. Given that unwanted pregnancies are the highest risk factor for obstetric complications, incorporate family planning into PARSalud II.
7. Include a plan in PARSalud II to ensure availability of capacity for free blood screenings and transfusions in the event of surgery, including Cesarean sections.

8. Ensure greater financial accountability in PARSalud II, by, *inter alia*, sending representatives from the World Bank and Inter-American Development Bank to:
 - a. visit locations where monies are to be spent and review plans in detail
 - b. periodically visit and observe progress in spending, including quality of materials purchased, progress in training programs and maintenance of vehicles
 - c. publish spending broken down by department and institution
9. Make public all deviations from spending plans or violations of agreement terms, including fees and interest incurred for non-disbursed funds.
10. Ensure that PARSalud II is more transparent and participatory than PARSalud I, including:
 - a. publishing its studies and evaluations of progress
 - b. publishing its expenditures and the rubrics under which funds are spent
 - c. making publicly available its indicators, disaggregated by socio-economic status and geographic region
 - d. regularly presenting findings and information to groups from civil society and UN agencies,
 - e. regularly meeting with and gathering information and opinions from users of the health system in areas of PARSalud interventions

To the US Government and USAID, as Appropriate:

1. Participate in a debt-for-health conversion program in alliance with the Global Fund to Fight AIDS, TB and Malaria in order to expand resources available for health system, and for maternal health in particular.
2. Repeal the Global Gag Rule so that aid recipients can provide information and education with regard to the signs of and treatment for complications arising from abortions, which is a leading cause of maternal death in Peru.
3. Stop interference with provision of public information about emergency oral contraception by grantees in Peru.

4. Provide increased funding for the Human Rights Ombuds Office to expand and sustain its work in the area of health rights, reproductive and sexual rights, and safe motherhood in particular.
5. Reconsider role in relation to supporting Peru's health system under USAID's new funding parameters to identify mechanisms to provide increased support, rather than withdraw from funding for Peru's health sector.

Notes

- ¹ A maternal death is defined by the WHO as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." Lisa M. Koonin, M.N., M.P.H., Hani K. Atrash, M.D., M.P.H., Roger W. Rochat, M.D., Jack C. Smith, M.S. Maternal Mortality Surveillance, United States, 1980-1985 MMWR 12/1/1988; 37(SS-5):19-29.
- ² Bolivia has the highest maternal mortality ratio in South America.
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- ⁷ See: Torres C. "Etnicidad y Salud: Otra Perspectiva para Alcanzar la Equidad." in PAHO (editors) *Equidad en Salud: Una Mirada desde la Perspectiva de la Equidad*. Public Policy and Health Program – Division of Health and Human Development. Washington D.C: June 2001.
- ⁸ Despite the large number of Quechua and Aymara speakers in Peru, neither language is considered an official language. Schools lack bilingual programs and few judges or public attorneys speak indigenous languages. See: United Nations Commission on Human Rights. Deng F. "Human Rights, Mass Exoduses and Displaced Persons. Profiles in Displacement: Peru." E/CN.4/1996/52/Add.1. UNESCR. January 1996: 13, para 48.
- ⁹ Id., 5, para 9.
- ¹⁰ 72% is estimated to live in urban areas. See: "Biblioteca Virtual Salud Perú – Indicadores Nacionales, Población Urbana," note 6.
- ¹¹ Final Report of the Truth and Reconciliation Commission, general conclusion 6. available at www.cverdad.org.pe/ingles/ifinal/conclusiones.php.
- ¹² Id., general conclusions 170-171.
- ¹³ República del Perú. *Hacia el cumplimiento de los Objetivos de Desarrollo del Milenio en el Perú: Un compromiso del país para acabar con la pobreza, la desigualdad y la exclusión*. Informe 2004: 11. Available at: <http://www.cepis.ops-oms.org/bvsair/e/repindex/rep183/milenio/informes/peru-odm.pdf>. Accessed July 3, 2007. While 54.3% of overall population lives below the poverty line, approximately 63% of Peru's indigenous population is below the poverty line. See: World Bank. *Indigenous Peoples, Poverty and Human Development in Latin America: 1994-2004*. 2005. Available at: <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT,contentMDK:20505839~pagePK:146736~piPK:146830~theSitePK:258554,00.html>. Accessed July 3, 2007.
- ¹⁴ Institut Internacional de Governabilitat de Catalunya. *Perfiles nacionales de gobernabilidad: República de Perú*. July 2005: 28.
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- ²⁰ See "Annex Table 2c: Public Expenditure on Health and Education for Peru and Comparator Countries." In World Bank. *Peru: Country Assistance Evaluation. Report No.24898PE*. September 2002:33.
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- ²⁴ Estimaciones desarrolladas por Guillermo Vallenar, [ENDES II 1991 and III 1996], 1998. Watanabe Vara T. *Tendencias, Niveles y Estructura de la Mortalidad Materna en el Perú, 1992-2000*. INEI. 2002 in UNFPA Perú. "Razón de mortalidad materna, según departamentos (1993, 1997, 2000)." Available at: http://www.unfpa.org.pe/infod/mortalidad_materna/mor_mat_04.htm. Accessed May 10, 2007.
- ²⁵ According to the UN *Guidelines on Monitoring the Use and Availability of Essential Obstetric Care*, EmOC includes: the ability of health facilities to administer parenteral antibiotics, oxytocic drugs, and anticonvulsants, and to perform manual removal of the placenta, removal of retained products and assisted vaginal delivery. Comprehensive EmOC consists of the aforementioned services as well as the capacity to perform Caesarean sections and blood transfusions. See: UNICEF/WHO/UNFPA. *UN Guidelines on Monitoring the Use and Availability of Essential Obstetric Care*. August 1997:26.
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- ³³ Interview with Ian MacArthur, Sectoral Specialist, Inter-American Development Bank in Lima, Peru (April 11, 2007).
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- ³⁶ UN Millennium Project Task Force on Child Health and Maternal Health. *Who's Got the Power? Transforming health systems for women and children*. Millennium Project; 2005. Available at: <http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf>. Accessed July 9, 2007.
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- ³⁸ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; CEDAW. "General Comment 24." 1999.
- ³⁹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; paras 14 and 44; CEDAW. "General Comment 24." 1999; para art 12(2) 27. CEDAW notes that "it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources."
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- ⁵⁹ See: ENAHO 2003-IV in Vásquez E. *¿Los niños...primero? Volumen III. Niveles de vida y gasto pública social orientada a la infancia 2004-2005*. Save the Children Sweden:51.
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- ⁷² Interview with José Calderón Yberico, Vice Minister of Health in Lima, Peru. (April 12, 2007).
- ⁷³ See, e.g., LP Freedman, "Censorship and Manipulation of reproductive Health Information: An Issue of Human Rights and Women's Health," in *The Right to Know: Censorship, Women's Health and Human Rights*. London: Article 19 (1997).
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- ⁷⁵ Id., para 59; "General Recommendation 24." "Women and Health" [2 feb. 1999]. 20th session of the Committee on the Elimination of Discrimination against Women. para 17[CEDAW "General Recommendation 24"].para 15.
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- ⁷⁷ Interview with Amancio Cosichi Quispe, in Ahuaycha, Peru (Jan. 10, 2007).
- ⁷⁸ Vienna Convention on the Law of Treaties, May 23, 1969, art. 18, 1155 U.N.T.S. 331, 340, 8 I.L.M. 679, 692 [hereinafter Vienna Convention].
- ⁷⁹ See: CHANGE. "US Revokes Support for EC in Peru." Available at: <http://www.genderhealth.org/emergencycontraception.php>.
- ⁸⁰ Interview with Ian MacArthur, Sectoral Specialist, Inter-American Development Bank in Lima, Peru (April 11, 2007).
- ⁸¹ See Millennium Campaign, "About the Goals," Available at www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186389.
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- ⁸⁵ Pakistan, Kenya, and Indonesia are the other three countries. Eric Friedman, PHR Senior Global Health Policy Advisor, conversation with David Bryden, Communications Director for the Global AIDS Alliance.
- ⁸⁶ The 19 Paris Club members are governments with substantial claims on various other governments throughout the World. They have applied the terms of the Paris Club agreed minutes to their claims in the past. The Paris Club countries include: Austria, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, Norway, Russia Federation, Spain, Sweden, Switzerland, United Kingdom, and the United States.
- ⁸⁷ United Nations Committee on Economic, Social and Cultural Rights (CESCR). *The Right to the Highest Attainable Standard of Health*, "General Comment 14", UN CESCR. E/C.12/2000/4. 2000: para 12.
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IV. APPROACH TO INVESTIGATION AND METHODS

PHR obtained the information included in this report between January and June of 2007 during three trips to Peru. Additionally, Alicia Ely Yamin made a preliminary trip in October, 2006, to meet with local partners, conduct preliminary meetings and contract with a documentary film company to produce the video that accompanies this report. Between January and June, 2007, Alicia Ely Yamin and other representatives of PHR conducted investigations in Lima, Carabayllo, Huancavelica, and Puno, using multiple sources of evidence.

Puno and Huancavelica were selected as regions because they have two of the highest maternal mortality ratios in Peru (361 and 302 per 100,000 live births in 2000, respectively)¹. They also represent two of the eight regions where the World Bank and Inter-American Development Bank-sponsored health sector restructuring program (PARSalud I) was implemented and where the second phase (PARSalud II) will be implemented.

Within Puno and Huancavelica, the family members and women whose testimonies are contained in this report were identified by PHR's local partners, and final selection of cases was done in conjunction with PHR. Records from local health establishments, as well as the Regional Directorate of Health in the case of Huancavelica, were used to identify cases, as was information obtained from community members by local health promoters.

The seven cases selected involve what are statistically the leading causes of maternal mortality in Peru: postpartum hemorrhage, pre-eclampsia/eclampsia, and complications stemming from abortion. A case in which a woman survived an obstetric emergency is juxtaposed with cases of deaths in order to examine what factors led to her survival. Cases of deaths at home are included as is a death in a health facility.

All cases occurred in the three years prior to PHR's interviews. Five cases occurred between one and fourteen months prior to the interviews. However, two earlier cases were included because efforts were made to seek redress and the administrative and legal processes took considerable time to conclude. This range of time frames permitted an exploration of the possible effects of a woman's death on her family over time.

Cases were selected from different referral networks (*redes*) and different hospital catchment areas in both Huancavelica and Puno. Cases were selected from both the Quechua and Aymara zones of the department of Puno.

Informed consent was obtained through a series of conversations with individuals and community authorities about the nature and purpose of the investigation, what sort of organization PHR is, and willingness to participate in the investigation, as well as potential risks of appearing in photographs or video. Preliminary interviews or conversations were conducted with family members and community members (including community authorities) as well as other informants prior to PHR's fieldwork, at which time oral consent was obtained from participants and community authorities. In some cases, consent was denied and those cases are not included in this report.

In the cases where preliminary consent was obtained from family and community members, PHR then secured oral and written consent during its visit. All subjects were asked whether they wished to be filmed or photographed and were informed that their participation in the investigation was not dependent on being photographed, audio-taped, or videotaped. Some informants for this report chose not to be photographed or filmed. PHR also secured oral consent when interviewing government representatives and health professionals, and when filming in health facilities.

The reconstruction of each case included 1) multiple in-depth interviews with family and community members of women who died due to pregnancy-related complications, as well as with women who survived obstetric emergencies; 2) semi-structured interviews with health care personnel at health posts, health centers and district hospitals, and visits to the relevant wings and areas of those facilities to evaluate their resolution capacity in the event of obstetric emergencies; 3) review of relevant medical records, and in some cases, autopsy and other forensic medical reports and trial documents; 4) physical re-tracing of the path of events in each emergency, and 5) interviews with policymakers and key local informants in each department.

PHR interviews for each case took on average one to two full days, and in many cases preliminary interviews conducted by local partners required the same amount of time. PHR interviewed as many persons who were associated with the woman and events as possible, and no fewer than five adult informants were interviewed in each case. In the case of a maternal death stemming from abortion complications, the woman who died and the informants have all been de-identified.

In cases where family and community members were photographed and/or videotaped, those photographs and video clips were brought back to the individuals by PHR's local partners. Laptops were used to show the video clips to those persons, and photographs were left with them.

The seven case studies included in this report are not intended to be scientifically representative. There are limitations to drawing conclusions with respect to the social, cultural and systemic factors underlying maternal mortality across Peru because cases are drawn from Puno and Huancavelica only, and not from other parts of the *Sierra*, nor from the *Selva* regions of Peru, which also have high maternal mortality ratios and present extremely different circumstances. However, many of the issues explored are systemic in nature and not limited to one region.

The qualitative information in the case studies also provides a sense of the lives of individual women, the roles they played in their families and communities, and the impacts their deaths had on their families. Other work on maternal mortality has included case studies of women, most notably the joint MINSA/USAID publication, *Mujeres de Negro: La Muerte Materna en Zonas Rurales del Perú* (*Women in Black: Maternal Mortality in Rural Areas of Peru*), which included nine narratives of maternal deaths. This study differs in that it uses a human rights framework to analyze the reasons underpinning the delays leading to women's deaths, and to analyze the obligations of the state.²

In addition to the reconstruction of cases in Puno and Huancavelica, PHR conducted in-depth interviews with thirty-two key informants in Lima and Washington, DC. These interviews were conducted with current and former government officials and employees, including then Vice Minister of Health, José Gilmer Calderón Yberico; human rights and women's rights advocates; representatives from the World Bank and Inter-American Development Bank, USAID, and UNFPA; relevant professional associations; health economists; leaders of civil society coalitions, and representatives of health non-governmental organizations. Those informants who spoke under the condition of anonymity are de-identified in the report.

Additionally, to contrast experiences of rural women with urban and peri-urban residents, PHR conducted a focus group with nine women affected by obstetric emergencies and community health promoters in Carabayllo, outside of Lima. The focus group participants were identified by Socios en Salud, a sister organization of Partners in Health, based on pre-existing criteria set out by PHR in relation to their experiences with obstetric emergencies and childbirth.

Also, further field research was conducted in Loreto by MINGAPeru, based upon the instruments and criteria provided by PHR, to provide supplemental information on the *Selva* region of Peru.

To complement information gathered in the field, substantial additional research was conducted relating to the analysis of domestic budgets, policies, and legislation, as well as World Bank and Inter-American Bank loan documents.

The investigation was approved by an independent ethical review board, organized under the auspices of PHR. The research was conducted in accord with the Declaration of Helsinki, as revised in 2000.

This report was produced in conjunction with a video.

Notes

¹ See: Estimaciones desarrolladas por Guillermo Vallenás, (ENDES II 1991 and III 1996), 1998. Watanabe Vara T. *Tendencias, Niveles y Estructura de la Mortalidad Materna en el Perú, 1992-2000*. INEI. 2002 in UNFPA Perú. "Razón de mortalidad materna, según departamentos

(1993, 1997, 2000)." Available at: http://www.unfpa.org.pe/infosd/mortalidad_materna/mor_mat_04.htm. Accessed May 10, 2007.

² *Mujeres de Negro: La Muerte Materna en Zonas Rurales del Perú* (*Women in Black: Maternal Mortality in Rural Areas of Peru*), MINSA/Proyecto 2000, 2000.

V. CONTEXT: PERU AND THE PERUVIAN HEALTH CARE SYSTEM

In the region of the world with the greatest inequalities in income, Peru stands out for its disparities. Although it is a middle-income country, over half the population lives in poverty and almost a quarter—24%—lives in extreme poverty. Peru's indigenous population is disproportionately represented among the impoverished and especially the extremely impoverished. This population suffered the great majority of abuses during the armed conflict that wracked Peru from 1980–2000. Gender inequalities are also pervasive, and this combination results in the further marginalization of rural, indigenous women. Peru's social spending, including its health spending, is low in comparison with its Latin American neighbors. Furthermore, spending patterns in health reinforce rather than ameliorate underlying inequalities. These inequities are reflected in regions' maternal mortality ratios as well as in related process indicators, such as skilled birth attendance. After initial ineffectualness, health sector reform undertaken with loans from the World Bank and Inter-American Development Banks appropriately focused on emergency obstetric care and referral networks, but progress remains limited.

Socio-Demographic Overview

Peru had approximately 28 million inhabitants in 2005,¹ making it South America's fourth most populous nation.² The country's population is expected to approach 30 million in 2010.³ Roughly 47% of Peru's population is indigenous, and that population constitutes approximately 20–25% of all indigenous persons living in Latin America.⁴ There are 5 million Quechua speakers in Peru, many of whom are concentrated in the *Sierra*, or highlands, region, along with Aymara speakers, who are concentrated in the *Altiplano* region.⁵ A number of other native communities, representing 55 ethno-linguistic groups, live in the *Selva*, or jungle, region of Peru.⁶ Overall, however, Peruvians are heavily concentrated in urban areas.⁷ Indigenous populations are disproportionately represented in rural areas and especially among the rural poor.

The Truth and Reconciliation Commission (TRC), which was formed under the transition government of Valentín Paniagua to examine the brutal armed conflict

with Shining Path (*Sendero Luminoso*) between 1980 and 2000, underscored that it was these rural indigenous *campesinos* who had borne the brunt of the violence. Seventy-five percent of the nearly 70,000 victims in the armed conflict were indigenous, largely rural *campesinos* from the Quechua-speaking communities of Peru's poorest and most marginalized Andean departments, and Asháninkas from its jungle regions.⁸ The 2003 TRC report further concluded that “the tragedy suffered by the populations of rural Peru, the peasants, poor and poorly educated [of] Peru, was neither felt nor taken on as its own by the rest of the country. This demonstrates, in the TRC's judgment, the veiled racism and scornful attitudes that persist in Peruvian society almost two centuries after its birth as a Republic.”⁹ The TRC called for a national reconciliation based on “full citizenship for all Peruvians” oriented toward overcoming the historical fragmentation and discrimination in Peruvian society.¹⁰

As in other countries of the region, Peru's rate of population expansion has slowed over the past twenty years. The country's population growth rate reached 2.2 percent in 1985,¹¹ but declined steadily to 1.4 percent in 2005.¹² The growth rate is expected to drop even further, to approximately 1.3 percent by 2010.¹³

Decreasing fertility tracks the country's decreasing population growth. Peru's total fertility rate (TFR) declined from an average of 4.1 children per woman in 1986 to 2.9 children per woman in 2000.¹⁴ In 2005, women living in the *Selva* gave birth to 3.6 children on average, while women in the *Sierra* and *Costa* (coastal) regions had an average of 2.9 and 2.2 children, respectively.¹⁵ The country's birth rate for the period of 2000–2005 was 22.6 births per 1000 inhabitants,¹⁶ projected to decrease to 16.6 during the period 2020–2025.¹⁷ Declines in TFRs, however, mask significant disparities among regions.¹⁸

Peru's average life expectancy has increased by six years over the last twenty years.¹⁹ Peruvians born in 2002 can expect to live an average of 70 years: 72 years for women; 67 years for men.²⁰ However, as with other indicators, this progress also masks disparities: those born in cities that year will have an average life expectancy of 72 years, while those born in rural areas will have an average life expectancy of 65 years.²¹ Furthermore, while

those born in Lima have an average life expectancy of 78.4 years, people born in Huancavelica will live to be 61.4 years, on average.²²

Economic Overview

Despite being a middle-income country, poverty is widespread in Peru.²³ By measuring poverty according to the percentage of the population living on less than USD\$1 per day, Peru's socioeconomic situation parallels that of countries such as Kenya, India and Senegal rather than its Latin American neighbors.²⁴ Over half of Peru's population lives under the national poverty line while nearly a quarter—24%—lives in “extreme” poverty.²⁵ Half of the rural population lives in extreme poverty, while only 10% of the urban population does.²⁶

Although Peru has enjoyed favorable economic growth and trade surpluses in recent years, the fruits of that prosperity have not been enjoyed by most of the population, due in large measure to its high national debt and low tax revenues.²⁷ The country's overall GDP grew 6.7% in 2005,²⁸ and the public sector deficit was projected at 1% of GDP in 2006.²⁹ Moreover, Peru's current trade balance is a surplus of some \$5.2 billion, or 6.8% of GDP. Nonetheless, its current account surplus hovers at \$1.03 billion, primarily as a result of the country's debt service.³⁰ For example, in 2004, the government spent almost 13.2 billion *nuevos soles* (approximately USD 4.1 billion) on its national debt, while only 3.4 billion *nuevos soles* (approximately USD 1 billion) were allocated towards health programs.³¹

Although the economy has improved and inflation has been brought under control, Peru's tax revenues remain

very low, keeping social spending far below the regional average.³² In 2006, Peru's tax revenues constituted only 13.3% of its GDP. In contrast, Bolivia's tax revenues were 15% of its GDP, Chile's were 15.9% and those of Argentina—despite still recovering from a massive economic crisis—amounted to 14.2% of its GDP.³³ The International Monetary Fund (IMF) recommends that “For countries with low ratios of government revenue to GDP, broadening the tax base and improving tax administration are likely to be important objectives. For low-income countries, a tax ratio of 15% of GDP should be seen as a minimum objective.”³⁴ Peru's low and unpredictable tax revenues have been attributed to “a legacy of repeated tax amnesties which perpetuate noncompliance and fail to bring in the revenues needed to combat poverty.”³⁵ The World Bank (the Bank) has concluded that “the principal reason for low social spending in Peru is that tax revenues as a percentage of GDP are low in comparison with other Latin American countries.”³⁶

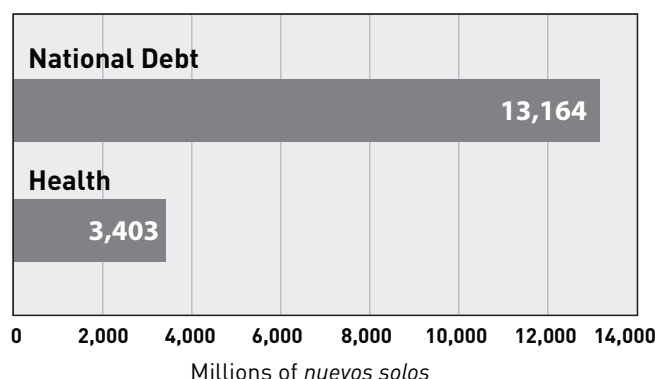
The Bank also finds that there is a low priority on anti-poverty programs and social spending in Peru.³⁷ In its 2006 report, *A New Social Contract: An Agenda for Improving Education, Health and the New Social Safety Net in Peru*, the Bank forcefully concludes that “given that it will be extremely difficult for Peru to find additional savings through further cutbacks of public funding, it has no option but to increase its social spending *pari passu* through greater tax collection and the reassignment of the budget.”³⁸

In the year 2000, Peru allocated only 2.9% of its GDP to education and 1.4% to health system, while Bolivia, South America's poorest nation, spent 6.3% of its GDP on education and 3.7% on health.³⁹ In fact, health spending in Peru has decreased proportionally in recent years, and only 0.9% of its GDP was allocated toward health programs in 2005, down from 1.4% in 2001.⁴⁰ At the same time, more of the annual budget has been apportioned towards alleviating the national debt.⁴¹

Extractive sectors have grown steadily in recent years and constitute not only an important part of Peru's economy but also a potentially important source of revenue for social spending. The mining and hydro-carbon sector grew by close to 7% annually in recent years, constituting a significant factor in GDP growth.⁴²

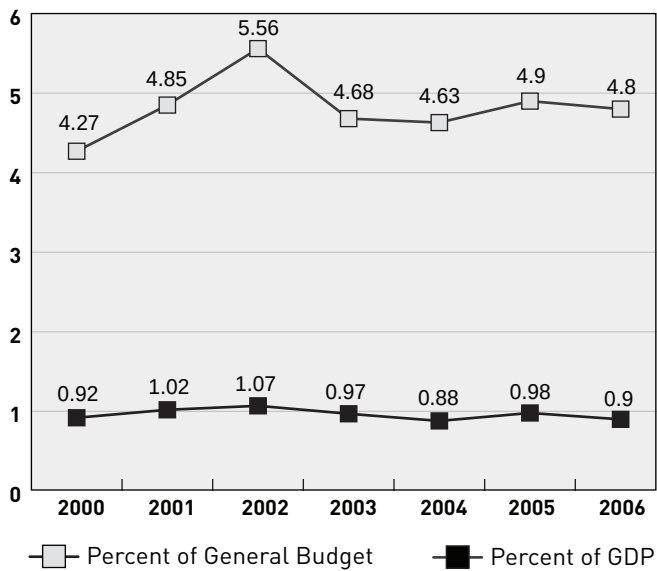
The allocation of social spending and use of tax revenues is especially important in Peru because income distribution in the country has been inequitable for many years.⁴³ The country's GINI coefficient—a measure of income inequality—was 54.6 when it was last calculated in 2002, ranking Peru as the 15th most inequitable of the 177 countries surveyed.⁴⁴

Figure 1: Government Spending on Debt Service and Health Programs, 2004



See Vásquez, E. (2004:24) *Presupuesto público y gasto social: La urgencia del monitoreo y evaluación*. Lima: Centro de Investigación de la Universidad del Pacífico – Save The Children Sweden.

Figure 2: Health Spending as a Proportion of GDP and Total Government Expenditure (2000–2006)



Source: Ministry of Economics and Finance (2007).

In 2000, the wealthiest 10% of the population earned 36% of the nation's annual income, while the poorest 10% earned only 0.8%.⁴⁵ Although Peru ranked 82 of 177 countries according to the UNDP Human Development Index (HDI),⁴⁶ sub-national calculations of the HDI reveal vast disparities among Peru's departments.⁴⁷ Lima's HDI was calculated at .710 in 2005 while Huancavelica's measured at only .492 and Puno's at only .547.⁴⁸

At the same time, the proportion of the national budget that departments receive does not correspond with their respective levels of poverty.

As evident from the chart above, spending is generally highest along the highly urbanized coast—where levels of unmet basic needs hover between 50% and 60%—while spending is a fraction of that in areas with highly indigenous populations, such as Huancavelica, where over 90% of the population has unmet basic needs.

Unmet basic needs mean, *inter alia*, lack of access to adequate food, potable water and basic sanitation. For instance, two-thirds of the population in the lowest quintile do not have adequate access to potable water while such coverage is universal in the wealthiest quintile.⁴⁹ Peru's inequalities regarding severe childhood stunting, which is caused by malnutrition over a long period of time, are alarming. For every child in the wealthiest quintile that suffers from severe stunting—with its life-long implications for learning, development and health reproduction—there are 59 severely stunted children in the poorest quintile. Unmet basic needs also translate

into unnecessary child mortality and, not surprisingly, there are also deep disparities relating to child mortality rates in Peru. More than five children under age five from the lowest income quintile die for every child that dies in the wealthiest quintile.⁵⁰

Gender Inequality

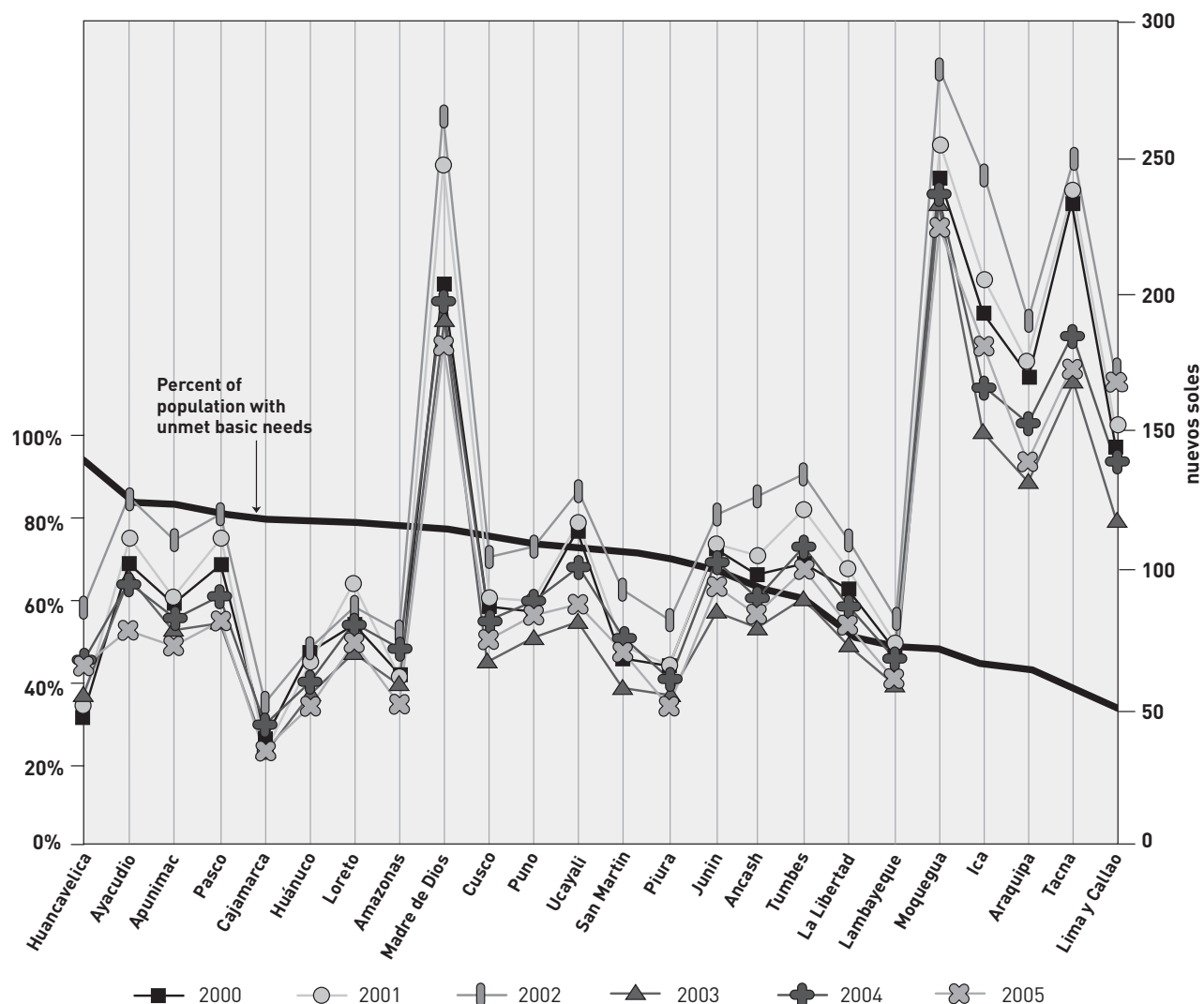
Gender inequality pervades Peruvian society and interacts with poverty and ethnic discrimination. For example, in 2002, girls living in extreme poverty attended secondary school at a rate of 80% that of boys living in extreme poverty.⁵¹ That is, in practice, poverty means that families tend to sacrifice the education of girls, which leads to greater probabilities of exclusion in the future.⁵² In the *Sierra*, these differences are even starker. In 2002, girls had access to secondary education and higher education at a rate of 65% and 62% that of boys, respectively.⁵³ According to data from 2004, in the *Sierra*, 17% of girls and women over the age of six had no education whatsoever, while almost 40% had not finished primary school.⁵⁴ The median number of years of education for women in the *Sierra* was 4.2, while among women in the poorest quintile it was 2.3.⁵⁵

Women in the *Sierra* also reported the lowest amount of control over decisions affecting their health in the 2004 National Demographic and Family Health Survey (ENDES, *Encuesta Demográfica y de Salud Familiar*). Over one-third of women in the *Sierra* reported that they do not have sole or joint control over decisions affecting their health (35%).⁵⁶ In rural areas, 40% of women reported not having such control, while in urban areas, 22% reported not having such control.⁵⁷

Lack of agency is reflected in ideas about sexual autonomy among women in Peru. For example, among women who do not have control over daily household decisions, such as purchases as well as those affecting their health, only 70% believed that it is justifiable for women to refuse sexual relations for any of the following reasons: a woman is tired, she has recently given birth, she knows her husband is unfaithful and she knows her partner has a sexually transmitted disease. Only slightly more than 40% of women with no education believed all such reasons for refusing sexual relations were justified.⁵⁸

Over two-thirds (68%) of Peruvian women surveyed by the ENDES in 2004 admitted that their husbands exercise some form of control over them, including most frequently insisting on knowing every place she is going and becoming jealous if she spoke with another man.⁵⁹ Forty-two percent of women reported having suffered some form of physical violence by their partner

Figure 3: Per Capita Government Funding (in *nuevos soles*) and Percentage of Population with Unmet Basic Needs, 2000–2005



Source: SIAF-MEF in Portocarrero AG. *La Equidad en la Asignación Regional del Financiamiento del Sector Público de Salud, 2000–2005*. CIES: 9.

or husband over the duration of the relationship.⁶⁰ Over a third of women—and 47% in the *Sierra*—reported that their partner or husband had pushed, shaken or thrown something at them; twisted their arm or slapped them; kicked or dragged them; threatened to attack or attacked them with a knife, pistol or other weapon, or forced them to have sexual relations when they did not want to do so or did not approve of the kind of sexual relations.⁶¹

In the last twelve months, over 10% of women in Peru and approximately 20% of women in the *Sierra* reported having suffered such forms of violence.⁶² Eighteen percent of women in the *Sierra* reported being forced to have sexual relations when they did not want to do so or did not agree to the form of sexual relations.

Despite these numbers, only 13% of women who

reported suffering such abuse went for help to a state institution.⁶³ Uneducated and impoverished women are the least likely to seek help, and indigenous women are the most unlikely population to seek help.⁶⁴ A 2006 report by a coalition of women's rights groups reports that indigenous and Amazonian women experience especially high levels of domestic violence and are the least able to seek recourse, noting that: "Domestic violence and sexual violence are expressions of discrimination suffered by indigenous and native Amazonian women currently, which do not receive a sanction either under customary law or under state law."⁶⁵

Gender-based violence can put women at direct risk of maternal death by physically causing miscarriage and complications. It can also put women at risk by isolating

Gender-based Violence and Maternal Mortality: A Case from Loreto⁶⁶

Adela⁶⁷ and her husband arrived in San José de Lupuna a few months ago and settled in the community of Río Nanay. The couple did not have any family in this area, but they were forced out of their community in la Cuenca del Río Momón due to the violent behavior of Adela's husband.

When Adela was three months pregnant, she began hemorrhaging because her husband kicked her in the stomach. He did not want any more children and preferred for her to have an abortion. Adela had four children from a previous marriage in which she had been widowed and a daughter from her current marriage. She didn't tell anyone that was pregnant. Her husband forbade her from going to the health post in San José de Lupuna because he did not want people to know that he mistreated her.

Adela continued to bleed for two more months, at which point she could no longer walk or even get out of bed. The couple then decided to go to the health center in Moronacocha, but after two days they were forced to return home because they did not have enough money to pay for her treatment. The afternoon that she arrived home, Adela's condition worsened. Her only friend and the friend's mother brought her to the Regional Hospital in Iquitos, where she soon died. Adela's husband tried to block the autopsy, because he did not want the doctors to discover that he had abused her.

After her death, Adela was buried by her neighbors, and her husband fled from the community, leaving his children behind. Three of the children were very young, the two youngest of which are being cared for by the eldest daughter. Their current whereabouts are unknown.

them from other community members and from the health system. Violent men often exercise inordinate control over their abused partners, preventing them from speaking to friends or health workers. Isolation can turn deadly in the event of an emergency.

The Peruvian Health Care System

In the WHO's *World Health Report* from 2000, Peru ranked 119 of 191 countries in terms of the equity of its health system, ranked from most fair to least, and 184 out of 191, in terms of fairness of financial contributions—placing it closer in ranking to countries such as Somalia, Myanmar and Sierra Leone than to its regional neighbors.⁶⁸

Like many countries in the region, Peru's health-care system is characterized by a patchwork of institutions, which are organized according to individual employment status. The healthcare system includes the Ministry of Health (MINSA), the social security system (ESSALUD), health services for the police and armed forces, private insurance and providers, and nonprofit institutions.⁶⁹ ESSALUD provides coverage to state employees and those with formal employment, and is funded primarily by employers and employees under the authority of the Ministry of Labor.⁷⁰ Fewer than 2% of Peruvians have private insurance while 1.3% have coverage through military or police plans.⁷¹ The MINSA is responsible for the remainder—approximately 75%—of the population.⁷²

There are three classifications of healthcare establishments within the public health care system. Slightly more

than two-thirds of healthcare establishments in Peru are health posts (*puestos de salud*), which are supposed to offer primary care.⁷³ Twenty-five percent of the establishments are classified as health centers (*centros de salud*), meant to provide more specialized services than *puestos de salud*.⁷⁴ The most specialized care is found in hospitals, which constitute the remaining 6% of health-care establishments.⁷⁵ In practice, however, there is wide variation among the technical capacities of establishments that are classified according to these different levels. In 2001, the public health sector accounted for 51% of Peru's hospitals, 69% of health centers and 99% of health posts.⁷⁶

In the 1990s, Peru underwent health sector reform. The armed conflict staged by the Shining Path in the 1980's had destroyed the health system.⁷⁷ By the beginning of 1990s, Peru had only about 1,000 functioning health facilities.⁷⁸ The absence of health facilities was most notable in areas of the *Selva*, as well as the *Sierra*, where the conflict had been most acute, including Ayacucho, Puno and Huancavelica.

In 1994, a large-scale health care reform effort began, directed at increasing primary care infrastructure and reducing Peru's high levels of maternal and infant mortality, which had attracted the attention of donor states and international institutions, including the US Agency for International Development (USAID), the World Bank, and the Inter-American Development Bank (IDB).⁷⁹ Under the Fujimori administration (1990-2000), health sector reform projects focused on maternal-

child health included the Health and Basic Nutrition Project (PSNB, *Proyecto de Salud y Nutrición Básica* 1994–2000), financed partially by the World Bank, and Project 2000 (*Proyecto 2000*, 1995–2000), financed partially by USAID.⁸⁰ PSNB focused on primary care capacities, including prenatal care, while Project 2000 specifically included goals relating to maternal mortality but focused on institutional deliveries rather than EmOC specifically.⁸¹ The IDB also financed a pilot program for public maternal-child health insurance in 1997. Between 1994 and 2000, more than half of MINSA's budget for maternal-child health and infectious diseases, and an even higher percentage for maternal health, came from these three institutions.⁸²

Despite increases in prenatal care coverage, however, maternal mortality remained stubbornly high during this time, as little attention was paid to creating functioning referral systems and other key components of emergency obstetric care.⁸³ In 1997, the release of joint reports by the WHO and the Pan American Health Organization highlighting Peru's high maternal mortality ratios coincided with a scandal that erupted in the Ministry of Health over the National Family Planning Program (*Programa Nacional de Planificación Familiar*).⁸⁴

Investigations by the Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), other non-governmental organizations, and the Human Rights Ombuds Office, revealed that the government was engaging in a campaign of systematic sterilization, often without full consent. Numerical goals for surgical contraception (primarily tubal ligation) performed by health providers, and systematic supervision of the achievement of such goals, were set directly by the central government. The targeted numbers for the surgeries increased every year, and in order to achieve these goals, "productivity" quotas for the performance of surgical contraception were assigned to health institutions and personnel. In several locations, CLADEM found evidence of pressure, incentives and threats against health personnel to induce the performance of surgeries, e.g., offering money for each user, use of or threat of use of promotion or demotion in relation to compliance with quotas. Health establishments were being evaluated on the basis of productivity criteria rather than quality of care, which generated perverse incentives for health care providers. In some cases CLADEM found setting of conditions for treatment, slanted and incomplete information, absence of any kind of guarantees in the process of decision-making, and mistreating of health system users if they refused.⁸⁵

Revelations of the sterilization campaign caused reverberations throughout the government as well as USAID, which had provided funding to the program.⁸⁶ Under the Toledo administration, an opposite trend—toward chilling family planning services—took place.⁸⁷ Two successive ministers of health from 2001–2003—Luis Solari, a member of the *Sodalicio de Vida Cristiana*, and Fernando Carbone, who had formerly been a representative for Human Life International, an anti-choice lobbying group—"left their mark on policy orientations."⁸⁸ New Health Policy Guidelines 2002–2012 prioritized maternal child health within a framework of "respect for human life, starting at conception."⁸⁹

In 2001, with the ostensible notion of ensuring comprehensive care, the National Family Planning Program was discontinued as an independent program and family planning services were to be included in care generally. Subsequently, women's rights groups as well as health professionals have collected evidence of widespread shortages of contraceptive methods, lack of policy and budgetary priority on family planning, and lack of training for physicians in placing IUDs and performing tubal ligations.⁹⁰

In addition to the politicization of reproductive and sexual health, the Peruvian health system has faced challenges with respect to, *inter alia*, centralization, establishing relations with the community, human resources, and economic barriers to care.

In the post-Fujimori period, there has been a trend toward decentralization of the health sector. The government took a major step toward increasing decentralization of health care delivery in 2005, with Supreme Decree 052-2005-PC.⁹¹ The decree set out functions to be transferred to regional and local governments, including the formulation of regional policies according to national guidelines; the formulation and execution of regional health development plans; the "transfer of resources for reimbursement for services"; the responsibility to "control, monitor and evaluate the fulfillment of insurance processes, attention plans, application of fees, coverage goals and health care service standards... to organize and implement healthcare services," and "to be responsible for the dissemination of useful information to the population on administration and services."⁹²

In addition to decentralization—which in theory provides for a more democratic health sector—Local Health Administration Committees (CLAS) were originally intended to create avenues for local participation in decision-making about health.⁹³ The CLAS were actually begun in the 1990s under Fujimori, although

the government proved ambivalent with respect to their operation. While there were approximately 600 CLAS operating in the late 1990s⁹⁴, there are now well over 2,000 CLAS facilities operating in Peru,⁹⁵ accounting for 25% of all primary healthcare facilities nationwide.⁹⁶

Each CLAS consists of an Association and a Managing Council. The Association is made up of six members of the community who are representatives of grass-roots organizations. The Managing Councils are elected for a period of three years to oversee and participate in the health centers' operation. Three of these individuals are approved by the Regional Directorate of Health (DIRESA). The members of the Managing Council (president, speaker/secretary, and treasurer) are elected from within the Association. There has been gender inequity in the past with only one woman for every two men on the Managing Councils of the CLAS.⁹⁷ These elected officers are charged with overseeing the facility's daily performance.

In addition to other differences, CLAS workers originally operated under a different labor regime than other health personnel in MINSA establishments. The Association hired the head doctor or manager of the health center. This individual was to work closely with the Council.⁹⁸ The CLAS were reorganized under the Toledo administration and do not function in the way they were originally designed. Among other things, as more and more doctors work on contracts with MINSA, the ability of the Council and Association to play a supervisory role over the operations of the health facility has lessened.

CLAS personnel fall under one of many categories for healthcare workers in Peru. Indeed, Peru's complex labor regime and multiple categories for healthcare workers pose another constellation of challenges to equity in the system. There are appointed health workers who are on payroll, have full benefits packages and are not subject to performance reviews, and there is also an array of short-term contract arrangements.⁹⁹ These range from non-personal service contracts (*servicios no personales*), which include no benefits and are subject to summary dismissal, to private contracts for CLAS workers that do include some benefits. Healthcare workforce employed through any of the four categories of JUNTOS employees, the SIS, or Salud Básica Para Todos (Basic Health for All), work on contracts with no benefits. Other than the CLAS, any given health establishment may have a number of workers subject to entirely different labor regimes, with substantially different protections and benefits. In addition to these regimes, there are "SERUM istas"

(*Servicio Rural en Medicina*), who are doing their year of rural service. In practice, at a given health establishment, there may also be aides, nurses, midwives and even physicians who are working on "propina"—literally a "tip" or nominal stipend—because of the dearth of paying jobs in health care, especially in rural areas.

In his interview in April, 2007, then Vice Minister of Health José Calderón Yberico, conceded that there was "total chaos" in human resources and asserted that the MINSA had proposed a project to the Ministry of Finance for 80 million *nuevos soles* per year (approximately USD 25 million) to create 486 new health teams for rural areas. Each team would be composed of a doctor, nurse and midwife with 2-to-3 year contracts and some benefits, and salaries tied to productivity goals.¹⁰⁰ Aside from such *ad hoc* measures, Vice Minister Calderón did not address any possible MINSA plan to systematically rationalize human resources in healthcare.

The low level of government funding for health (4.8% of the national budget in 2006), as well as conditions attached to loans from international financial institutions (IFIs) that partially finance the health care system, have resulted in so-called user fees being imposed on patients. According to figures from MINSA and the National Health Accounts, as of 2004, 37% of health services and medicines were paid for via out-of-pocket user fees.¹⁰¹ While the fees are designed to bolster the healthcare system through increased revenues, they have been more harmful than helpful. Their application is often arbitrary, and many indigent patients cannot afford (or refuse to pay) even the nominal fees they are charged for drugs and certain services.¹⁰² As of December 2004, 25% of people surveyed by the National Household Survey (ENAH0, *Encuesta Nacional de Hogares*) cited the reason for not visiting a health establishment as lack of money.¹⁰³

For the last eight years, the centerpiece of the government's efforts to reduce economic barriers to care had been the creation and expansion of public health insurance schemes, which began with mothers and children (*Seguro Escolar and Seguro Materno Infantil*) in the late 1990's and was later denominated the *Seguro Público de Salud* (Public Health Insurance) during the transition government of Valentin Paniagua in 2000. In 2001, the Toledo administration replaced the SPS with the SIS (*Seguro Integral de Salud*, or Comprehensive Health Insurance).¹⁰⁴ The SPS had provided coverage for all uninsured women between fifteen and 49 years of age. In contrast, the SIS provided benefits only to expectant mothers through one of its seven plans, each of which was directed at different sub-populations.

Plan C of the SIS provided coverage for prenatal care, normal and high risk deliveries, transfers during obstetric emergencies, coverage for costs related to funerals, care for 42 days after delivery, and care for various other health problems related to pregnancy.¹⁰⁵ The SIS law mandated that these services be free to everyone in districts where greater than 65% of the population lives in poverty. Individuals in these districts, however, paid one *nuevo sol* (approximately USD .30) to register as a SIS member.

In less impoverished districts, individuals had to navigate the User Identification System (SIU, *Sistema de Identificación de Usuarios*), used to screen applicants based on need. Depending on the SIU determination of an applicant's purchasing power, she may have to pay some or all of the costs of medical fees.¹⁰⁶

Although SIS has been successful in expanding health care coverage for the poor, the program suffers from a number of problems. For example, the money received from the Ministry of Economy and Finance (MEF) fails to cover the costs of production overhead,¹⁰⁷ and inefficient management led the program to lose about 48 million *nuevos soles* (approximately USD 15 million) in 2004, allowing it to cover only 37% of the children it had been intended to cover.¹⁰⁸ Much of the inefficiency stems from the fact that the benefits of the program fall to many who are not classified as poor.¹⁰⁹

Another significant problem has been an overall lack of funding for the SIS. Healthcare centers are generally running a deficit. In an evaluation of its efforts to eliminate barriers to accessing safe maternal delivery in Peru, USAID's Policy Project wrote, "As a result of this funding

shortfall, facilities frequently ask clients to pay for drugs and supplies as well as lab tests. The situation is further exacerbated by up to three-month delays in reimbursements, causing some facilities to suspend the provision of services under SIS for several weeks."¹¹⁰ When services are suspended in this manner, patients are charged for services, regardless of their ability to pay, serving as a deterrent to the use of obstetric services.¹¹¹

In April 2007, the Garcia administration introduced a new kind of social insurance, passed by Supreme Decree N° 004-2007-SA,¹¹² to replace the seven SIS plans for sub-populations such as infants and pregnant women, with two plans to cover the entire population: subsidized and semi-subsidized. The intention, according to then Vice Minister of Health, José Calderón Yberico, was to convert the SIS from a reimbursement scheme to a true insurance scheme with co-payments and, as had occurred under the SPS, to insure the whole person rather than the condition of pregnancy.¹¹³ However, the broader introduction of co-payments and premiums will, in practice, present the same challenges to equity as user fees and may recreate the same barriers to care.

Under the new social insurance, persons with incomes of less than 700 *nuevos soles* per month (approximately USD 221) will pay 10 *nuevos soles* per month (approximately USD 3) as a premium, and persons with incomes between 700 and 1,000 *nuevos soles* (approximately USD 221-316 USD) will pay 20 *soles* per month (approximately USD 6). There will be co-payments for services as well. Extremely poor persons—an estimated 25% of the total, according to Vice Minister Calderón—will be exempt from co-payments and premiums. The new social insurance will reportedly place priority on preventive health and health promotion, rather than care, which could signal a move away from funding emergency obstetric care and referral systems. When asked to provide examples, Vice Minister Calderón mentioned nutritional counseling, family planning, and cancer screening.¹¹⁴ At the same time, however, Vice Minister Calderón estimated that the new insurance scheme would cover 48% of the burden of disease, in comparison with 19% covered under the previous SIS scheme.¹¹⁵ PHR was told that by 2011, the administration intends to mandate health insurance for everyone living in Peru, presumably requiring people to purchase either private or public insurance.¹¹⁶

Maternal Mortality

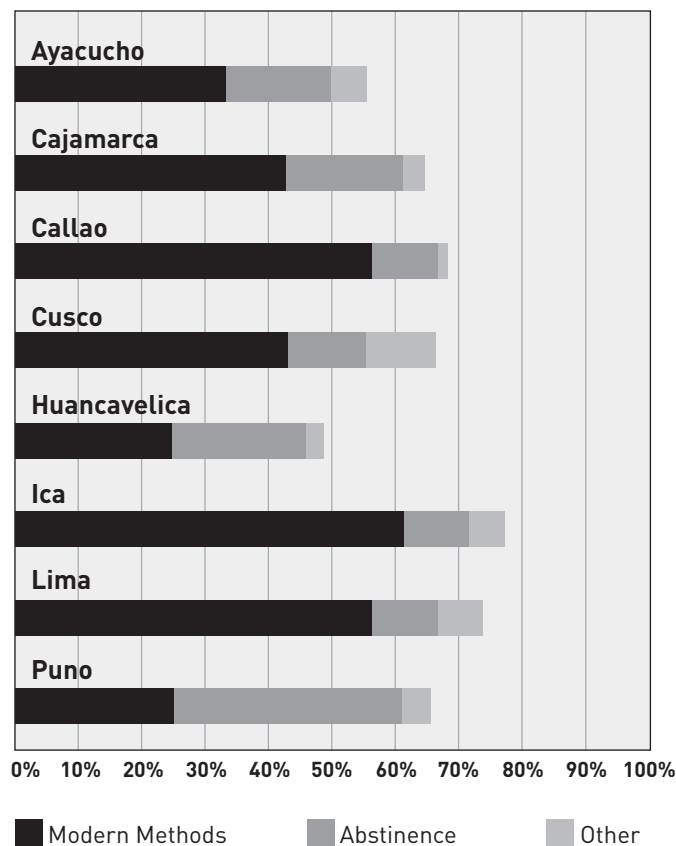
Peru has the second highest maternal mortality ratio (MMR) in South America, after Bolivia. The government claims that the MMR was 168 per 100,000 live births in

Table 1: Causes of Maternal Mortality in Peru, 2000 to 2005

General Diagnosis	Year					
	2000	2001	2002	2003	2004	2005
Hemorrhage	45.8	50.0	50.5	57.3	53.1	45.7
Infection	11.5	8.9	15.3	7.3	6.2	6.6
Toxemia	15.5	15.0	27.8	20.0	17.1	26.5
Abortion-related	5.4	6.1	4.1	6.8	7.6	7.3
Obstructed birth	5.0	2.8	0.0	0.5	0.3	0.3
Other	16.1	16.6	2.4	8.2	15.7	13.6
Can't be determined	0.6	0.6	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100

Source: Fichas de Investigación epidemiológica de la mortalidad materna – Dirección General de Epidemiología – MINSA

Figure 4: Use of Contraceptives, 2000

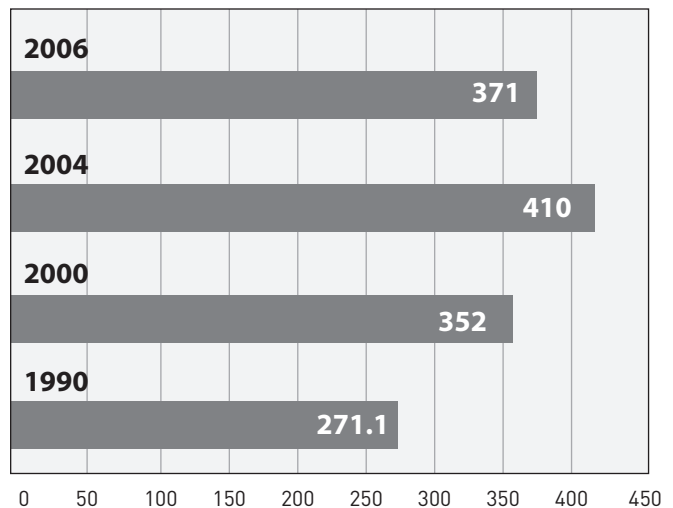


Source: See ENDES 2000 in United Nations Development Group. *Hacia el cumplimiento de los objetivos de desarrollo del milenio en el Perú*. National MDG Reports. 2004:65. Available at: http://www.undg.org/archive_docs/5504-Peru_MDG_Report_-_MDGR.pdf. Accessed June 26, 2007.

2005. In 2000, the government claimed an MMR of 185 while for the same year, the WHO, UNFPA, and UNICEF arrived at an estimate of 410 per 100,000 live births.¹¹⁷ Most experts on maternal mortality in Peru—and even its own 2004 progress report on achieving the Millennium Development Goals—do not believe that the official MMRs are a reliable way to track progress and that there is a serious sub-estimation of maternal deaths.¹¹⁸

Nonetheless, disparities in MMRs can illustrate broad truths about inequity—if not point to specific programming responses. Thus, while the MMR for Lima was 52 per 100,000 live births in 2000, the MMR for Huancavelica and Puno were 302 and 361, respectively.¹¹⁹ Likewise, use of contraceptives correlates with socioeconomic status, and in more impoverished regions such as the *Sierra* and *Selva*, the use of modern methods of contraceptives is only 35% and 46%, respectively; while in Lima, 55% of women use some modern form of birth control.¹²⁰ In both Puno and Huancavelica, contraceptive preva-

Figure 5: Estimated Number of Induced Abortions in Peru, 1990–2006 (in thousands)



Source: The Alan Guttmacher Institute (AGI) 2000, 2004, 2006, in Ferrando D. "El aborto en el Perú." *Jornada Feminista*. Feb. 6, 2007.

lence stands at 20%.¹²¹ The leading causes of maternal mortality in Peru are the same obstetric complications responsible for the great majority of maternal deaths around the world. They are hemorrhage, 45.7% (and in particular, postpartum hemorrhage); toxemia (pre-eclampsia/eclampsia), 26.5%; abortion-related complications, 7.3%, and infection, 6.6%. The category "Other" in Table 1 refers to indirect causes of death, such as malaria and tuberculosis.

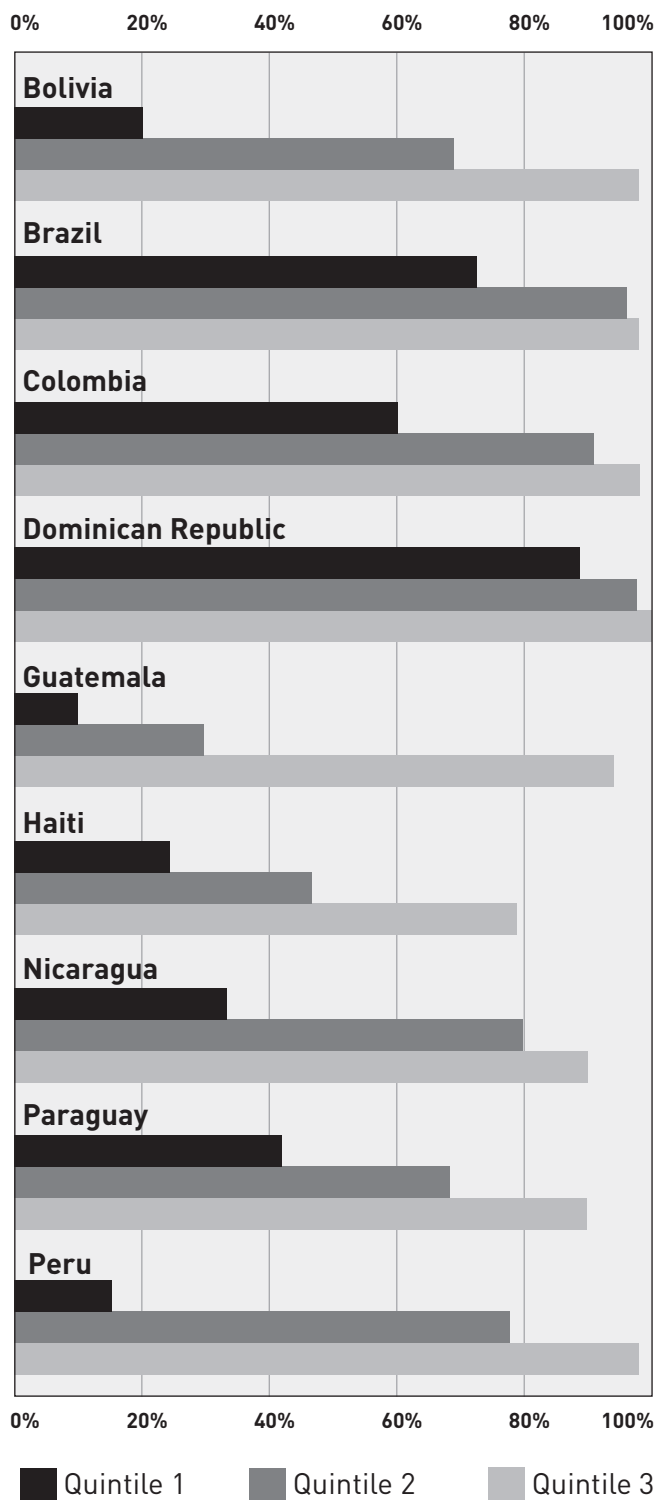
Although the government claims that complications stemming from clandestine abortions account for only 7.3% of maternal deaths, many experts in the health field believe that such complications, which can produce sepsis or hemorrhage and may be recorded as such, may actually be responsible for as many as 10 to 30 percent.¹²²

A study done by the Allan Guttmacher Institute estimated that in 2006, there were an estimated 371,000 induced abortions in Peru. Abortion is illegal in Peru except to preserve the life or health of the mother.

Obstetric complications, including those stemming from incomplete abortions, require access to emergency obstetric care (EmOC).¹²³

In Peru, there are deep inequities in relation to access to EmOC, skilled birth attendance and referral networks, all of which are internationally recognized to be the keystone interventions to prevent maternal mortality.¹²⁴ For example, despite overall coverage that is comparable to some of its Latin American neighbors, the disparities between rich and poor in access to skilled birth atten-

Figure 6: Births Attended by Skilled Health Personnel per Income Quintile



See World Bank "Inequality in Latin America. Breaking with History?" 2004 in Batthyány K, Cabrera M, and Macadar D. *La pobreza y la desigualdad en América Latina*. Social Watch. September 2004: 37. Available at: <http://www.socialwatch.org/en/informelmpreso/images/otrasPublicaciones/ZOOM-04-esp.pdf>. Accessed February 24, 2007.

dance are greater in Peru than in any other country in South America.

When looking at the data by department, it becomes clear that income combines with other factors to create accumulated disadvantage with respect to these interventions. Thus, the extremely low percentages of women attended by skilled professionals in Huancavelica (21%) and Puno (27.8%) relate not just to the high levels of poverty of the population but also to the high percentage of indigenous populations that live disproportionately in rural areas. Nationwide, in rural areas, 74% of women give birth in their homes, while 90% of women in indigenous communities do so.¹²⁵

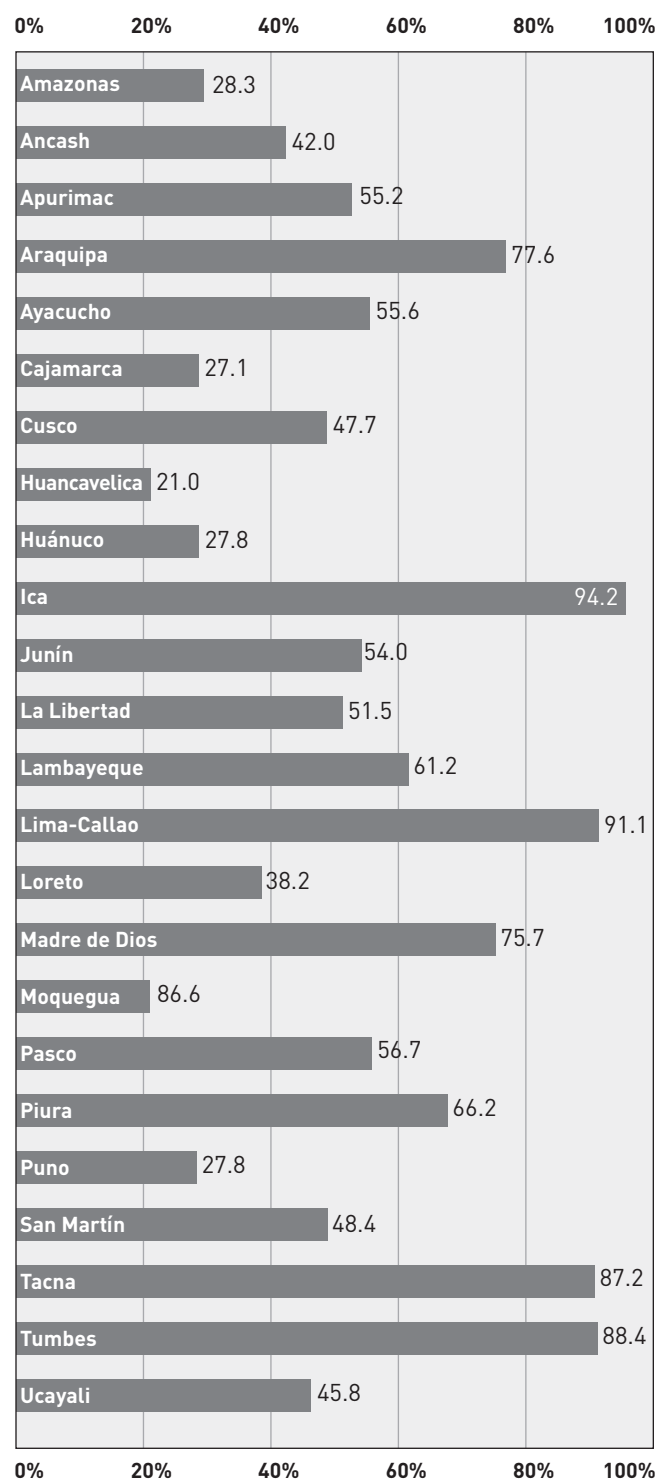
Not all aspects of EmOC are systematically monitored and disaggregated in Peru. However, one indicator of the disparities in access to comprehensive EmOC, which includes access to surgery and blood transfusions, is the enormous variation in Cesarean section rates across departments. The WHO/UNICEF/UNFPA *Guidelines on Monitoring the Availability and Use of Essential Obstetric Care (UN Guidelines)* state that Cesarean section rates should fall between 5 and 15%.¹²⁶ At least 5% of pregnant women can be expected to develop complications that require this life-saving surgery; however, above 15% can indicate an over-reliance on surgery for other reasons, including financial incentives of physicians and institutions.

In 2000, the Cesarean rate was 24.4% in Lima, with much higher rates reported at private clinics. At the same time, in both Huancavelica and Puno, the Cesarean section rates stood at 3.0% in both departments. Tumbes had the highest rate of Cesarean sections, at 26.7%, while Huancavelica and Puno had the lowest rates.¹²⁷ The 2004 ENDES (National Survey on Demographics and Family Health), which does not report Cesarean section rates by department, did however state that the Cesarean rate among the richest quintile of the population was 34%, while among the poorest quintile, the rate was only 4%.¹²⁸ These figures suggest that women in the richest quintile are having unnecessary Cesarean sections while women in the poorest quintile are dying for lack of access to this life-saving surgery.

Most Recent Health Sector Reform and Maternal Mortality

The initial phase of the most recent loan from the World Bank and the IDB was approved in 1999 and was originally intended to close in 2003.¹²⁹ Since much of the money had yet to be disbursed and many of the significant goals had not been accomplished by 2003, the loans were extended through 2006.¹³⁰

Figure 7: Percentage of Births Attended by Skilled Health Professionals According to Department, 2000



Source: United Nations Development Group. *Hacia el cumplimiento de los objetivos de desarrollo del milenio en el Perú*. National MDG Reports. 2004:62. Available at: http://www.undg.org/archive_docs/5504-Peru_MDG_Report_-_MDGR.pdf. Accessed June 26, 2007.

As originally envisioned, the general objective of the loan was to facilitate the “gradual process of modernization and reform of the health care system in Peru.”¹³¹ This process of modernization and reform was to improve the overall health of the Peruvian population through expanded access to efficient and quality health care services.¹³² For the first three years of the program, the general, overly broad objectives laid out by the government, in conjunction with the Banks, failed to produce any tangible outcomes. The process of decentralization exacerbated failures to define priorities and implement the loans, as the MINSA in effect received “wish lists” from regional directorates of health (DIRESAs) all over the country.¹³³

After the loans were extended, the goal of the Program to Support Health Sector Reform (*Programa de Apoyo a la Reforma del Sector Salud*, PARSaI) was narrowed to focus in large measure on maternal and child health and the reduction of maternal mortality as a means of improving the overall health sector.¹³⁴ PARSaI, which totaled approximately USD 87 million, focused on eight regions in particular that were among the worst in terms of both maternal and child health indicators: Puno, Cusco, Apurimac I, Apurimac II, Ayacucho, Huancavelica, Huánuco and Bagua.¹³⁵

PARSaI organized its maternal/child health program into three components: 1) increasing demand for services, 2) improving the services it supplies, and 3) modernizing MINSA.¹³⁶ First, in order to increase demand, PARSaI focused, among other things, on the development of strategies intended to reduce economic barriers to healthcare access for the poorest sectors of the population.¹³⁷ This was to be accomplished primarily through the SIS. The primary indicator used by both PARSaI and SIS to evaluate whether they were reaching the goal of increasing demand involved measuring institutional births, disaggregated by income quintile. From 2002 to 2005, the proportion of such births had remained at approximately 60%. When the data is disaggregated to look only at the poorest quintiles of the population, institutional births show an increase from around 40% to closer to 60%.¹³⁸ Despite this information, recent reports state that in the poorest regions of Peru, such as Puno and Huancavelica, fewer than 30% of births take place in health establishments and/or are assisted by medical professionals.¹³⁹

Second, the primary focus in terms of improving services involved the development and improvement of health care infrastructure and equipment, and spending indicators were used to measure progress. The PARSaI report on its progress lists, for example, the number of ambulances

acquired in the past year. According to this self-reporting, these various acquisitions, as well as renovations to hospitals and clinics, have served to benefit 7,360,850 people.¹⁴⁰ Approximately 30% of funds are currently spent on equipment, as required by the Banks.¹⁴¹

After its initial ineffectualness and overly broad mandate, PARSalud I took the important step of emphasizing referral systems and capacities to respond to obstetric emergencies through the institution of the *Funciones Obstetricas Basicas* (FOB, Basic Obstetric Functions) and *Funciones Obstetricas Esenciales* (FOE, Essential Obstetric Functions). FOBs refer to the capacity of health establishments to administer parenteral antibiotics, oxytocin, and anticonvulsants; manually remove placentas and retained products, and attend to normal deliveries. FOEs refer to the capacity of health facilities to perform Caesarian sections and blood transfusions in addition to the procedures performed at FOBs. A third category of FOPs (*Funciones Obstetricas Primarias*) refer to the capacity to attend imminent deliveries and provide first aid in emergencies, such as IV fluid resuscitation.

FOEs, FOBs and FOPs do not correspond to hospitals, health centers and health posts, respectively. The use of this classification system in effect acknowledged that health posts, health centers and hospitals have disparate capacities to respond to obstetric emergencies, and therefore, simply increasing institutional births was not an adequate strategy to address maternal mortality. With this classification system, it should be possible to determine whether the allocation of emergency obstetric care is equitable based on population needs, a prerequisite for addressing maternal mortality in Peru.

In order to determine whether obstetric emergencies are being handled in an improved manner, PARSalud I also analyzed the proportion of births in which caesarian sections were performed, as well as the number of health-care centers with the capacity to handle obstetric complications. Although the overall number of caesarian sections has increased, this is not true for the poorest sectors of society, in which there has been little, if any, change.

Another indicator used was the proportion of births in which oxytocin was administered to a woman within one minute after delivery, a practice intended to prevent postpartum hemorrhage. This number has increased between 2002 and 2005—from almost 0% to over 50%—regardless of income level.¹⁴² At least one key informant argued that this increase may explain at least some of the decline in the percentage of maternal deaths due to hemorrhage relative to other causes¹⁴³

However, other process indicators have not met with

this same success. The use of Magnesium Sulfate to treat pre-eclampsia had not been included in the SIS protocol and is not yet widespread, despite the clear benefits that would result from its use. Magnesium Sulfate requires training and sustained observation to implement its usage. Similarly, the standardization of antibiotic use to manage infections related to pregnancy and childbirth remains elusive.¹⁴⁴

Finally, “institutional modernization” focused primarily on the improvement of mechanisms to better facilitate efficient decentralization. These mechanisms included the provision of technical assistance to the various regional directives, as well as an attempt to have centralized information on health statistics relating to maternal mortality.¹⁴⁵ However, in practice, this has proven difficult. For example, USAID has pointed out the problems of working with both the centralized and decentralized aspects of the Peruvian health system due to frequent changes in leadership.¹⁴⁶

PARSalud I also emphasized better financing regulation and the development of a better sector within the government to deal with finance and lending.¹⁴⁷ Attempts to improve financial administration and accountability met with some success through the implementation of a new standardized accounting system. SIGA (Information System for Administrative Management, *Sistema de Información de Gestión Administrativa*) has helped to decrease corruption, particularly in the purchase of medicines. Once installed, SIGA should be integrated with SIAF (Comprehensive System for Financial Administration, *Sistema Integral de Administración Financiera*) and used by the MEF in order to allow the federal government to see how much money is left in the budget at any given point.¹⁴⁸

The total amount of PARSalud I was approximately USD 87,000,000, with the Peruvian treasury contributing slightly over one-third of the funds. Under the original financial specifications of the loan, Peru was required to pay a fee of 1% of the loan at its initiation as well as a .75% on the principal not yet withdrawn during each year of the loan. According to the amortization schedule, the loan was to be repaid in sums of \$1,125,000 per year starting in 2005. Interest on the amount withdrawn was payable semiannually based on the LIBOR base rate (London Interbank Offered Rate).¹⁴⁹

Currently, negotiations are in process to draft the second phase of PARSalud. The government has delayed submitting a concept note to the World Bank and IDB. Both the Ministry of Finance (MEF) and Ministry of Health have been slow to move on the necessary negotiations. The change in administration with the recent presiden-

tial elections has also slowed down this process. The contracts for PARSalud II should be finalized in 2008 despite these delays.¹⁵⁰ PARSalud II is slated to include more regions of the country than PARSalud I (although it will definitely include Puno and Huancavelica) and could amount to more than USD 100,000,000.¹⁵¹

In PHR's interviews with key informants, PARSalud I was heavily criticized for not engaging with civil society organizations or the general public. As of April 2007, no consultations with UN agencies, health system users, or civil society organizations had been carried out with respect to the design or content of PARSalud II.¹⁵²

PARSalud is a Loan, Not Aid

As virtually no funds were drawn down for at least the first two years of PARSalud I due to the government's inability to define priorities, Peru incurred hundreds of thousands of dollars in debt simply based on the commitment fees. Adding the initial fee to the commitment charges means that Peru incurred somewhere in the neighborhood of USD one million in debt before receiving any tangible benefit whatsoever from PARSalud I.¹⁵³

Notes

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⁶ UN Commission on Human Rights. Deng F. "Human Rights, Mass Exoduses and Displaced Persons. Profiles in Displacement: Peru." E/CN.4/1996/52/Add.1. UNESCR. January 1996: 5, para 9.

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[disticas/estadisticas/indicadoresNac/fecundidad.asp](http://www.minsa.gob.pe/estadisticas/estadisticas/indicadoresNac/fecundidad.asp). Accessed January 20, 2007.

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¹⁷ Id.

¹⁸ Ferrando D. "El aborto en el Perú." *Jornada Feminista*. Feb. 6, 2007.

¹⁹ MINSA. "Biblioteca Virtual Salud Perú – Indicadores Nacionales, Esperanza de Vida al Nacer." Available at: <http://www.minsa.gob.pe/estadisticas/estadisticas/indicadoresNac/esperanza.asp>. Accessed January 20, 2007.

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²² See: INEI. "Proyecciones Departamentales de la Población 1995-2025." Lima: 1996 in "Perú: Esperanza de vida al nacer por quinquenios, según departamentos (1915 - 2015)." UNFPA Peru. Available at: http://www.unfpa.org.pe/infosd/esperanza_vida/esp_vida_05.htm. Accessed June 22, 2007.

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- ⁵⁶ Id., para 43.
- ⁵⁷ Id.
- ⁵⁸ Id., para 45.
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- ⁶² Id., para 163.
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- ⁶⁵ CLADEM/Flora Tristán/Manuela Ramos/DEMUS. *Informe Alternativo al Sexto Informe Periódico del Estado Peruano al Comité de la CEDAW.* Lima: November 2006: 177.
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VI. OVERVIEW OF MATERNAL MORTALITY AS A HUMAN RIGHTS ISSUE

Reducing maternal mortality levels in Peru has long been touted as a public health priority by the government; it is also a human rights imperative. The government of Peru has assumed obligations under both domestic law and the international treaties it has ratified to address different factors that sustain high levels of maternal mortality. This chapter sets out some of those obligations, focusing on those relating to the right to health. It also explains that normative obligations under international law are to be construed in light of the best epidemiological evidence relating to the key interventions to reduce maternal mortality, including EmOC. Under international law, a government's obligations with respect to the right to health include providing available, accessible, acceptable and quality EmOC. Failures to meet such criteria result in delays in the decision to seek care, delays in arriving at EmOC, and delays in receiving appropriate treatment, which, in turn, lead to maternal deaths.

International Legal Framework; Focus on the Right to Health

Obligations for reducing and preventing maternal mortality are set out in international treaties to which Peru is a party, as well as in Peru's constitution and domestic legislation. Relevant international law includes the International Covenant on Civil and Political Rights (ICCPR);¹ the International Covenant on Economic, Social and Cultural Rights (ICESCR);² the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention);³ the Convention on the Elimination of All Forms of Racial Discrimination (Race Convention);⁴ the Convention on the Rights of the Child;⁵ the American Convention on Human Rights;⁶ the Additional Protocol to the American Convention on Human Rights on Matters Relating to Economic, Social and Cultural Rights (Protocol of San Salvador),⁷ and the International Labor Organization's Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries (ILO Convention 169).⁸ These treaties form a human rights framework from which to examine a state's obligations to prevent and reduce maternal mortality.

Additionally, at the United Nations Millennium Summit in 2000, States—including Peru—adopted the Millennium Declaration. The Millennium Declaration and the Millennium Development Goals (MDGs), which are drawn from the Declaration, include a commitment to reduce maternal mortality by three-quarters from 1990 levels by the year 2015 (MDG 5). Additionally, MDG 8 expresses a commitment to form a global partnership for development, whereby developed States use international development assistance to help developing countries achieve their development goals. The Millennium Project Task Force Report on Child and Women's Health forcefully recognizes the crucial importance of human rights in both understanding the underlying elements of MDG 5 and in achieving it.⁹

Addressing maternal mortality implicates many human rights directly and indirectly, including the right to life; the right to health; the right to bodily integrity; the right to education; freedoms of information, association and movement; equal protection under the law, and the right to political participation. Moreover, the enjoyment of these different rights is inextricably intertwined. For example, women need to have education to be able to use information to which they require access, and they require freedom of movement to be able to access the health services which ultimately can save their lives. Without the right to political participation, women cannot effectively express their interests with respect to the decisions that have impacts on their well-being, and without equal protection rights, they cannot obtain effective redress in the event of violations. Non-discrimination is fundamental to women being able to achieve all of their rights, including their rights to be free of avoidable maternal mortality.

International law has evolved in recent years to make clear that these rights are truly "interdependent and indivisible."¹⁰ For example, the "inherent right to life" enshrined in the International Covenant on Civil and Political Rights (ICCPR), among other treaties, cannot be interpreted restrictively or in isolation from the positive measures required to fulfill the right to health.¹¹ The United Nations Human Rights Committee (Human Rights Committee), which is the body charged with the

interpretation of the ICCPR and to which Peru is a party, has clarified that “persistently high levels of maternal mortality put states on notice that they may be in breach of their obligations to take effective measures to protect women’s right to life.”¹² Indeed, it was in the case of *Karen Llantoy v. Peru*, which involved a woman forced to carry to term an anencephalic fetus, that the Human Rights Committee stated that access to safe abortion services is sometimes necessary to preserve the right to life.

International Obligations to Respect, Protect and Fulfill the Right to Health

Recognizing that no right can be realized in isolation from others, PHR focuses in this chapter primarily on the obligations of the Peruvian government to respect, protect and fulfill the right to health so as to be able to clarify those obligations. However, as discussed in Chapter VIII of this report, “Applying a Rights-Based Approach to Address Maternal Mortality in Peru,” a rights-based approach to health policy and programming will require legislative, policy and other measures that relate to other human rights as well. Moreover, as also set out in Chapter VIII, the right to health not only places obligations on Peru, but on other donor states as well. That is, international law calls for international assistance and cooperation enabling countries with limited resources to meet their obligations.¹³ The United Nations Special Rapporteur on the Highest Attainable Standard of Health (UN Special Rapporteur) has specified in this regard that “Developed states should ensure that their international development assistance, and other policies, support health systems’ strengthening and other relevant policies in developing countries.”¹⁴

Under international law, the obligation to *respect* the right to health requires that States refrain from actions that interfere with women realizing their rights to health. For example, the United Nations Committee on Economic, Social and Cultural Rights (ESC Rights Committee), which is the treaty body charged with the ICESCR and to which Peru is a party, states in this regard that:

States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people’s participation in health-related matters.¹⁵

For its part, the Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW), which

oversees the implementation of the Women’s Convention and to which Peru is also a party, states:

The obligation to *respect rights* requires States parties to refrain from obstructing action taken by women in pursuit of their health goals...For example, States parties should not restrict women’s access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.¹⁶

Such medical procedures include safe abortion services. In relation to abortion, respect for women’s rights to health requires respect for the doctor–patient relationship. CEDAW notes in its General Recommendation 24, which provides authoritative guidance to States parties on their obligations regarding women and health, “While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for ... incomplete abortion.”¹⁷

The obligation to *protect* the right to health requires that States prevent third parties from interfering with the enjoyment of the right to health. According to the ESC Rights Committee, the obligation to *protect* the right to health includes the requirement that “States ensure that harmful social or traditional practices do not interfere with access to pre-and post-natal care and family-planning.”¹⁸ It also includes the obligation “to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people’s access to health-related information and services.”¹⁹

The obligation to *fulfill* the right to health requires States to adopt appropriate measures, whether legislative or otherwise, as a means to the full realization of the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” as the right is phrased in the ICESCR.²⁰ Under the ICESCR, this includes the requirement that States parties create the “conditions which would assure to all medical service and medical attention in the event of sickness.”²¹ In the

context of maternal health, “[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth.”²²

Article 12 of the Women’s Convention also sets out important substantive standards to meet in relation to the fulfillment of women’s right to health: “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to healthcare services.”²³ More specifically, “States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary.”²⁴ Read in conjunction with Articles 14 and 16 of the Women’s Convention, it is clear that access to healthcare services, including family planning, constitutes part of women’s right to full participation in decisions affecting their well-being.²⁵ Moreover, the requirement of non-discrimination in the context of health care is not formalistic, but rather clearly recognizes that women have different health needs than men, particularly in the context of reproductive health.²⁶

Both of these treaties assert that States parties must take all appropriate steps or measures to “the maximum available extent of [their] resources” to assure the fulfillment of the right to health including “medical attention for all in the event of sickness” (such as obstetric complications) and to “eliminate discrimination in health care, including special measures for pregnant women,” respectively.²⁷

The reduction of maternal mortality is explicitly mentioned in the 1999 General Recommendation by CEDAW on “Women and Health,” and in the 2000 General Comment by the ESC Rights Committee on “the Right to the Highest Attainable Standard of Health,” both of which clarify States parties’ obligations under the Women’s Convention and the ICESCR, respectively. The ESC Rights Committee General Comment 14 states that, “A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality.”²⁸ For its part, CEDAW states in its General Recommendation 24 that States’ parties must report on the measures they have taken “to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period” and in particular should include information on “the rates at which these measures have reduced maternal mortality and morbidity in their countries.”²⁹

These two committees also state that obstetric services must be provided and made accessible to women in fulfilling a State’s obligations. The ESC Rights

Committee has singled out obstetric services as an important component of States parties’ obligations with respect to the right to health in its General Comment and has stated that the provision of maternal health care constitutes part of a State’s essential or core obligations.³⁰ In its General Recommendation “Women and Health,” CEDAW notes that “it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.”³¹

Of course, EmOC cannot be provided in isolation from women’s other reproductive and sexual health needs. The ESC Rights Committee recognizes the importance of access to a full range of “sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”³² CEDAW is even more specific, requesting, for example, that in their reports, “States parties should state what measures they have taken to ensure timely access to the range of services which are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning.”³³

Although not a binding treaty, the Programme of Action that emerged from the International Conference on Population and Development (Cairo Programme of Action), which Peru signed, provides interpretive guidance on the crucial importance of family planning (as well as health care services) to reproductive health:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.³⁴

The five-year review document on the Cairo Programme of Action called on governments to “[e]nsure that the reduction of maternal morbidity and mortality is a health sector priority and that women have ready access to essential obstetric care, well-equipped and adequately staffed maternal healthcare services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary, post-partum care and family planning. In health sector reform, the reduction of maternal mortality and morbidity should be prominent and used as an indicator for the success of such reform.”³⁵

The International Convention Against All Forms of Racial Discrimination (Race Convention), to which Peru is also a party, calls on States parties to eliminate racial discrimination and “guarantee the right of everyone, without distinction of race, colour, or national or ethnic origin” the enjoyment of, among other rights, “the right to public health, medical care, social security and social services.”³⁶

Components of maternal health are also specifically recognized as a human right in the Convention on the Rights of the Child, to which Peru is a party.³⁷ Furthermore, it should be kept in mind that in many cases of maternal mortality, the mother is under the age of 18, and therefore defined as a child under the Convention.³⁸

Article 25 of the ILO Convention 169, which Peru has ratified, most specifically addresses the rights of indigenous persons to health: “Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.”³⁹

At the regional level, the American Declaration on the Rights and Duties of Man (American Declaration) mentions the right to health in Article XI.⁴⁰ The Inter-American Commission and Inter-American Court on Human Rights have both broadly interpreted the protections of the right to life in the American Convention on Human Rights (American Convention), to which Peru is a party, to include dimensions of health and well-being necessary to human survival and flourishing.⁴¹ Further, the Protocol of San Salvador, to which Peru is also a party, specifically includes the right to health in Article 10, as well as special protections for women during pregnancy and childbirth in Article 15.⁴²

Domestic Law

Article 55 of the Peruvian Constitution states that international treaties form part of domestic law.⁴³ Specifically in relation to human rights, the Fourth Final and Transitory Disposition to the Constitution (*Disposición Final y Transitoria Cuarta*) enacted in 2004 clarifies that “the norms relating to rights and liberties recognized in the Constitution are to be interpreted in accordance with the Universal Declaration of Human Rights and the human rights treaties and agreements that have been ratified by Peru.”⁴⁴

Article 7 of the 1993 Peruvian Constitution establishes that “Everyone has the right to protection of his health...”⁴⁵ Article 11 states that the government guarantees freedom of access to health care...through public, private or mixed entities. [The government also] supervises the effective functioning [of the health system].”⁴⁶

The General Health Law (*Ley General de Salud*) also guarantees the right to health as part of the public interest and public responsibility of the State. All citizens have the inalienable right to the protection of their health. Responsibility for health is a shared responsibility among the individual, society and the State. The law states that the government has a responsibility to take care of maternal health problems.⁴⁷ The General Health Law was modified in 2001 and now includes rights more specifically related to pregnancy and maternal health. In response to outrage over women being retained at health facilities after giving birth because of their inability to pay, every woman who seeks care at a health facility at the moment of giving birth has the right to receive the necessary medical attention as long as there is a risk to her life or the life of the child. After receiving the requisite attention, she will only be required to reimburse the health facility for the costs which she is able to pay.⁴⁸

In December of 2005, the Peruvian government issued a Supreme Decree enacting the National Plan on Human Rights 2006-2010. That National Plan, which as a Supreme Decree is actionable in court, includes 15 provisions relating to the right to health and the organization of Peru’s health system.⁴⁹

Peru’s domestic law also includes provisions harmful to women’s health. The General Health of 1997 includes a reference to abortion, which contravenes provisions in CEDAW’s General Recommendation 24 with respect to confidentiality. Article 30 states that a doctor who provides medical care to a woman when there are “indications of a criminal abortion” is obligated to report such fact to the “competent authority,” which in practice means the public prosecutor’s office.⁵⁰

Abortion is “criminal” in Peru except when “it is the only means of saving the life of the pregnant women or to avoid a grave and permanent harm to her health,” in which case it is considered therapeutic abortion.⁵¹ In all other cases, Article 114 of the Penal Code imposes a sentence of not more than two years in prison or between 52 and 104 days of community service on women who induce abortions.⁵² A person performing an abortion with the woman’s consent shall be subject to a prison sentence of between one and five years, except in the event of the woman’s “foreseeable death” resulting from the abortion, in which case the sentence shall be between two and five years.⁵³ Doctors, midwives, pharmacists and health professionals who “abuse of his science or art to cause an abortion” are subject to said punishments as well as to the suspension of their licenses.⁵⁴ The sentence for having undergone an abortion are reduced to not more than three months when (1) the pregnancy is the result of sexual violence outside of marriage or artificial insemination without consent which occurred outside of marriage, as long as the facts have been denounced and investigated by the police, or (2) it is probable that the fetus will be born with grave physical or psychic deformities, as long as a medical diagnosis exists to that effect.⁵⁵

“Progressive realization” to the “maximum extent of available resources”; Defining “appropriate” means and measures in light of evidence

According to Article 2 of the ICESCR: “Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by *all appropriate means*, including particularly the adoption of legislative measures”⁵⁶ (emphasis added). For its part, CEDAW emphasizes State obligations “to take *appropriate* legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care”⁵⁷ (emphasis added).

Some obligations—in particular many relating to the obligations to respect and protect—are of immediate effect and are not subject to the constraints of progressive realization and resource availability.⁵⁸ For example, failure

to uphold the right to non-discrimination in the provision of health services—whether directly by the government or by a third-party private provider—constitutes a violation of the right to health under international law.⁵⁹

Moreover, multiple guidelines on the interpretation of international law relating to economic and social rights suggest that the obligation of progressive realization “requires states to move as expeditiously as possible towards the realization of the rights” as well as establish that the state bears the burden of proof to demonstrate measurable progress toward the realization of the given right.⁶⁰

Similarly, a State is not free to make arbitrary decisions as to what constitutes the “the maximum extent of its available resources.” According to the ESC Rights Committee, “States parties have a core obligation to ensure the satisfaction of, at the very least, *minimum essential levels* of each of the rights enunciated in the Covenant, including essential primary health care (emphasis added).”⁶¹ CEDAW has stated that “studies such as those that emphasize the high maternal mortality and morbidity rates worldwide ... provide an important indication for States parties of possible breaches of their duties to ensure women’s access to health care.”⁶² For his part, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health (UN Special Rapporteur) has clarified with respect to the allocation of available resources that “In many countries, health systems are chronically under-funded and in a state of collapse. Increased expenditure and policies which strengthen health systems and give priority to maternal health are essential for reducing maternal mortality.”⁶³

The UN Special Rapporteur has specifically stated that “Progressive realization does not mean that a State is free to adopt any measures that are broadly going in the right direction.”⁶⁴ On the contrary, both the ICESCR and the Women’s Convention call for the realization of the right to health and elimination of discrimination in health care to be achieved by *appropriate* means and measures (emphasis added).⁶⁵ CEDAW further states in its General Recommendation 24 that States’ parties must report on the measures they have adopted “to ensure women *appropriate* services in connection with pregnancy, confinement and the post-natal period” and how these measures have reduced maternal mortality⁶⁶ (emphasis added). The appropriateness of a State’s means or measures cannot be evaluated in a vacuum but must be judged in relation to the best available evidence from the public health, including epidemiology.

Epidemiologic evidence reveals that the overwhelming preponderance of obstetric complications that lead to

approximately three-quarters of maternal deaths can neither be predicted nor prevented.⁶⁷ However, they can be treated. There is now an international consensus in the public health field that access to emergency obstetric care, skilled birth attendance and referral networks are the cornerstone interventions to reduce maternal mortality.⁶⁸ Indeed, it is precisely in light of this consensus that the ESC Rights Committee has singled out obstetric services as a basic component of States parties' obligations.⁶⁹ For its part, CEDAW asserts the inextricable link between safe motherhood and emergency obstetric services and states that "it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources."⁷⁰

Furthermore, the critical components of Emergency Obstetric Care (EmOC) have been defined under guidelines which were jointly issued in 1997 by the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and UNICEF (*UN Guidelines*).⁷¹ Basic EmOC includes IV or injection antibiotics; IV or injection anti-convulsants; IV or injection oxytocics; assisted vaginal delivery; manual extraction of the placenta, and removal of retained products. Comprehensive EmOC includes these six signal functions as well as the capacity to perform blood transfusions and surgery (caesarian sections). For the most part, the Peruvian health care system's classifications of FOBs and FOEs track the definitions of Basic EmOC and Comprehensive EmOC, respectively, which are set out under the UN Guidelines, except that assisted vaginal delivery is not included in FOB functions and is virtually never performed in Peru.

Based upon the best available evidence, these signal functions arguably define what *appropriate* services are "in connection with pregnancy, confinement and the post-natal period"⁷² and, in turn, provide specific guidance for governments' programming and spending priorities. On the other hand, in relation to a government's stated goals of reducing maternal mortality, policies and programs that have shown little evidence of success based on published literature, such as training of Traditional Birth Attendants (TBAs) in the absence of a functioning referral network or programs aimed at assigning risk status to pregnancies to predict complications, should not be considered reasonable or appropriate means to realize women's rights to health.⁷³ As a matter of human rights law, governments are not free to disregard scientific evidence about what appropriate measures and means are, nor can political or politicized criteria be substituted for such evidence.

That is, human rights norms impose both duties and limitations on the political branches of government. For example, the ESC Rights Committee in its General Comment 14 has specifically called for governments to devise national strategies and plans of action "on the basis of epidemiological evidence" and the UN Special Rapporteur has stated that a right to health approach is "evidence-based."⁷⁴

Courts that have examined social policies relating to economic and social rights have typically employed "reasonableness," "appropriateness" and "adequacy" tests to assess the compatibility of legislative and other measures undertaken by the State with the rights enshrined in human rights instruments and their domestic constitutions.⁷⁵ In doing so, courts have relied upon scientific evidence to determine what is "reasonable" or "appropriate."

For example, in the leading case of *South African Minister of Health v Treatment Action Campaign*, the South African Constitutional Court addressed the adequacy of the government's efforts to prevent the transmission of HIV from mothers to their newborn babies.⁷⁶ At the time, studies by the WHO and South Africa's own Medicines Control Council had shown that the administration of a single dose of the anti-retroviral drug, Nevirapine, to mother and child at birth safely prevented the mother-to-child transmission of HIV in the majority of cases. Nevertheless, the state refused to make the drug widely available, choosing instead to limit its use to 18 pilot sites for an indeterminate period of time. The Constitutional Court, examining obligations of the legislative and the executive under South Africa's constitution, held that the state's refusal to make Nevirapine available more widely, together with its failure to have a comprehensive plan of action with respect to mother-to-child transmission of HIV, was "unreasonable" and breached the rights to health of indigent mothers and their babies. In arriving at its conclusion, the Court specifically cited the endorsement of Nevirapine for the purpose of preventing mother-to-child transmission of HIV by both the WHO and the South African Medicines Control Council.

Courts in other countries have also looked to epidemiological evidence to guide their assessments of the "reasonableness" of state measures to promote and protect health rights. In Argentina, where international human rights form part of domestic law, courts have done so with explicit reference to treaty language.⁷⁷

In short, the inquiry into what *appropriate* measures are required under international human rights law cannot be separate from what is known from public

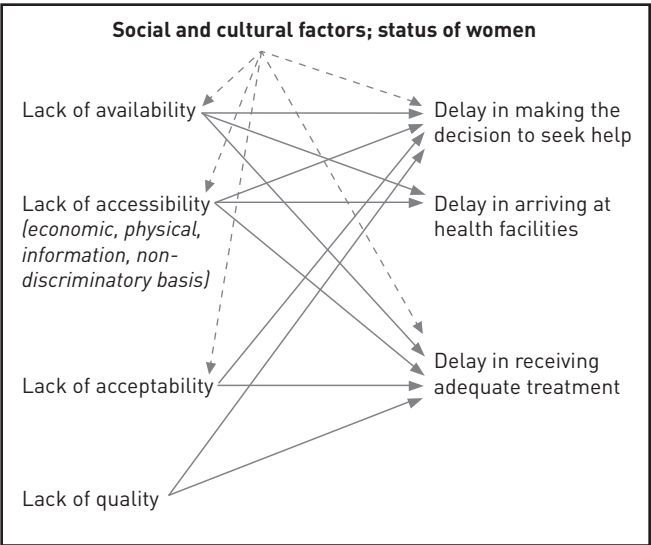
health and medicine. Rather, scientific evidence should be used to infuse specific programmatic content into normative obligations while human rights transforms best practices into the basis for legal and political claims of entitlement.

**The Three Delays Model;
Available, Accessible, Acceptable,
and Quality Care**

If empirical evidence from public health indicates that EmOC, skilled attendance and referral networks are the keys to preventing and reducing maternal mortality, human rights law indicates that these aspects of care are to be made available, accessible, acceptable and of adequate quality for the entire population on the basis of non-discrimination.⁷⁸

Given that the great majority of obstetric complications can be treated with a set of interventions that have been known since 1950 (listed as signal functions of EmOC), it is understandable that, as Deborah Maine and colleagues first set out, maternal deaths overwhelmingly occur due to three delays: the delay in the decision to seek care; the delay in arriving at care; and the delay in receiving appropriate care.⁷⁹ These delays are closely linked to the lack of available, accessible (economically and physically, information and on a basis of non-discrimination), acceptable (culturally and ethically), and quality health care.

Figure 8: The Three Delays Model and Lack of Available, Accessible, Acceptable and Quality EmOC



Adapted from Maine D. *Safe Motherhood Programs: Options and Issues*. Center for Population and Family Health. Columbia University. 1991.

Women’s low social status is a factor in delays in the decision to seek care, perhaps primarily because women rarely play a role in the decision-making process. It also undoubtedly factors into the political priority placed on making EmOC available, accessible, acceptable and of adequate quality. Thus, as the UN Special Rapporteur has stated, “Preventing maternal mortality and enhancing access to maternal health care is not simply about scaling up interventions or making them affordable. It is also vital to address social, cultural, political and legal factors which influence [and indeed limit or preclude] women’s decisions to seek maternal or other reproductive healthcare services. This may require addressing discriminatory laws, policies, practices and gender inequalities that prevent women and adolescents from seeking good quality services.”⁸⁰

In addition to undertaking such multi-pronged efforts to raise the status of women and their agency within both the household and the public sphere, providing concrete content to the normative requirements of women’s rights to health requires understanding the contextually-bound ways in which the availability, accessibility, acceptability and quality of services are at play in the decision to seek care, arrive at care and receive adequate treatment in Peru and elsewhere.

Availability

Under international law, the realization of the right to health requires that a sufficient number of health-care facilities, goods, and services be made available throughout a country’s territory. The ESC Rights Committee has stated that “The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.”⁸¹

A lack of availability can influence the decision to seek care when, for example, health facilities are so scarce that distance is a discouraging factor. The same lack of availability can make travel to a health facility long and arduous and produce delays in arriving at treatment. Without available transportation and communications (*i.e.*, means to call for transportation), women face long delays in arriving at treatment. At the same time, lack of available medical personnel and shortages of equipment, medical supplies, or drugs can influence delays

in receiving adequate treatment once at a facility.⁸² In terms of health facilities, availability means that a certain number of healthcare facilities should be in place for a given population.

In relation to the reduction of maternal mortality, there are public health indicators that can be used to judge availability. That is, according to the *UN Guidelines*, for a population of 500,000 there should be a minimum of four facilities offering basic EmOC and one facility offering comprehensive EmOC.⁸³ This level of availability of obstetric services, if equitably distributed across the population, has been demonstrably linked to a better capacity to address problems of maternal mortality.

Availability also speaks to the availability of human resources, or trained medical and professional personnel who are capable of responding to obstetric emergencies. This is a critical point; staffing health facilities with unskilled workers or achieving 24-hour “coverage” e.g., by including dentists in rotations, does not ensure availability of care. Much basic EmOC can be provided by properly trained midwives, and some can be provided by nurses.

In addition to the availability of properly trained medical and professional personnel, a full range of necessary services must be provided. For international law to be consistent with the best evidence from public health, the content of these services should be judged in reference to the signal functions defining EmOC, in accordance with the *UN Guidelines*.

An adequate supply of drugs and other medical supplies must also be made available for patients. In addition to those necessary to meet the signal functions of EmOC, a full range of contraceptive options should be offered and available at healthcare facilities.

Accessibility

Under international law, accessibility encompasses four overlapping dimensions: physical accessibility; economic accessibility; accessibility without discrimination, and information accessibility. According to the ESC Rights Committee, “Barriers include requirements or conditions that prejudice women’s access, such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and the absence of convenient and affordable public transport.”⁸⁴

Lack of accessibility on any of these dimensions can increase delays. That is, lack of physical accessibility due to distance or difficult terrain can factor into delays in the decision to seek care. At the same time, distance

combined with poor roads and infrastructure can also delay arrival at care. Both explicit and implicit costs of health care, including transportation costs, fees for health services (formal user fees), medication costs, and opportunity costs, can amount to lack of economic accessibility and also influence delays in deciding to seek care. Failure to recognize signs of obstetric emergencies requiring medical attention can reflect lack of access to information and lead to critical delays in seeking care. Overall distribution and location of healthcare facilities can reflect discrimination in accessibility.⁸⁵

Physical/Geographic Accessibility

The ESC Rights Committee has explained that “health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.”⁸⁶ According to the *UN Guidelines*, healthcare facilities offering EmOC should be equitably distributed across the population, which, in turn, would make lack of geographic accessibility less of a barrier for women. Accessibility in practice also requires adequate transportation in light of the terrain.

Economic Accessibility (Affordability)

Under international law, healthcare goods and services should be affordable for all members of the population. The ESC Rights Committee states, “Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.”⁸⁷

Accessibility on a Non-Discriminatory Basis

According to the ESC Rights Committee, “[H]ealth facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”⁸⁸ In this regard, health facilities, goods and services “must be sensitive to gender and to the rights and cultures of minorities and indigenous peoples.”⁸⁹

Information Accessibility

In keeping with the ESC Rights Committee’s General Comment 14, “accessibility includes the right to seek, receive and impart information and ideas concerning health issues.”⁹⁰ Information includes an awareness of

the warning signs for obstetric emergencies, as well as information on one's personal medical history and institutional and systemic information relating to maternal health statistics and spending.

Acceptability

According to the ESC Rights Committee, "all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, *i.e.*, respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned."⁹¹ According to CEDAW, "acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."⁹²

Lack of acceptability influences delays in decisions to seek care as well as delays in receiving appropriate treatment once at a health facility. Perceived cultural insensitivity of medical personnel is a form of lack of acceptability that can make women and their families hesitate to seek care. Similarly, lack of cultural sensitivity and language barriers, as well as outright discrimination, can delay treatment when a woman is already at a facility.

Quality

The ESC Rights Committee states, "health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."⁹³

Populations are generally far more aware of quality of care than health planners appear to recognize. Poor quality of care at health facilities, especially when it leads to the death of someone in the community, can lead to reluctance to seek care at a health facility. Inadequate training of medical personnel and/or poor quality of equipment, medical supplies, or drugs can, in turn, produce delays in a woman receiving adequate treatment once at a health facility.

The *UN Guidelines* provide only one rough indicator of quality: case fatality rates, which should be below 1% for the treatment of women with obstetric emergencies at EmOC facilities.⁹⁴ However, other evidence-based process indicators can be used to supplement case fatality rates, such as the percentage of pre-eclampsia/eclampsia cases treated with Magnesium Sulfate.

If care is available, accessible, acceptable and of adequate quality, many of the delays associated with maternal death can be avoided and, as a result, a government could be reasonably expected to meet the other indicators set out under the UN Guidelines.

Under the *UN Guidelines*, 100% women estimated to have obstetric complications should be treated in EmOC facilities. This indicator of "Met Need for EmOC" differs from institutional birth indicators in that not all institutions are EmOC facilities and not all women who give birth in institutions have obstetric emergencies. For example, in a study by CARE Peru in 2000 in the department of Ayacucho, 30.4% of met need for EmOC was found. This means that approximately 70% of women suffering from obstetric emergencies did not receive the care they needed. After a sustained intervention, CARE was able to increase this to 75.9% by 2005.⁹⁵

Notes

¹ ICCPR, Dec. 16, 1966, 999 U.N.T.S. 171, 173 (ratified by Peru Aug. 8, 1977) [hereinafter ICCPR].

² UN CESCR. ICESCR., Dec. 16, 1966, 993 U.N.T.S. 3, 5 (ratified by Peru Aug. 8, 1977).

³ CEDAW. Women's Convention, Dec. 18, 1979, 1249 U.N.T.S. 13 (ratified by Peru July 23, 1981).

⁴ CERD. ICERD. Dec. 21, 1965, 660 U.N.T.S. 195 (ratified by Peru July 22, 1966).

⁵ UN Committee on the Rights of the Child (UN CRC). "Convention on the Rights of the Child [Children's Convention]." Nov. 20, 1989, 1577 U.N.T.S. 3 (ratified by Peru Jan. 26, 1990).

⁶ American Convention on Human Rights, Nov. 22, 1969, 1144 U.N.T.S. 123 (ratified by Peru July 28, 1978).

⁷ Organization of American States (OAS). *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights: Protocol of San Salvador*. OAS Treaty Series No. 69: 1988. (ratified by Peru May 17, 1995).

⁸ International Labor Organization (ILO). *Convention concerning Indigenous and Tribal Peoples in Independent Countries* (ILO No. 169). 1989: art. 25.

⁹ UN Millennium Project Task Force on Child Health and Maternal Health. *Who's Got the Power? Transforming health systems for women and children*. Millennium Project; 2005. Available at: <http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf>. Accessed July 9, 2007.

¹⁰ World Conference on Human Rights. *Vienna Declaration and Programme of Action*. June 1993.

¹¹ UN CCPR. "The Right to Life, General Comment 6" A/37/40. 1982.

- ¹² Cook RJ. "Human Rights Law and Safe Motherhood." *European Journal of Health Law*. Vol 5(4); 1998: 357, 36.
- ¹³ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 67; UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; paras 38-42.
- ¹⁴ United Nations General Assembly. "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. September 2006: para 20.
- ¹⁵ UN CESCR. "General Comment 14." E/C.12/2000/4; 2000: para 34.
- ¹⁶ CEDAW. "General Recommendation 24." 1999. Art 12(1) para 14.
- ¹⁷ Id., Art 12(1) para 12(d).
- ¹⁸ UN CESCR. "General Comment 14." E/C.12/2000/4; 2000: para 34.
- ¹⁹ Id.
- ²⁰ UN CESCR. ICESCR. 1966: art. 12.
- ²¹ Id.
- ²² UN CESCR. ICESCR. 1966: art. 10(2).
- ²³ CEDAW. "Women's Convention." 1979: art. 12(1).
- ²⁴ Id., art. 12(2).
- ²⁵ CEDAW. "General Recommendation 24." 1999; para 2.
- ²⁶ Id., art 12(1), para 11-12; Yamin AE, Maine D. "Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations." *Human Rights Quarterly* Vol.21(3);1999:563,585.
- ²⁷ UN Women's Convention. 1981: arts 1, 12; UN CESCR. ICESCR. 1966: arts. 1, 12.
- ²⁸ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; paras 14 and 21.
- ²⁹ CEDAW. "General Recommendation 24." 1999; para 26.
- ³⁰ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; paras 14 and 44.
- ³¹ CEDAW. "General Recommendation 24." 1999; para art 12(2) 27.
- ³² UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 14.
- ³³ CEDAW. "General Recommendation 24." 1999; para art 12(1) 23.
- ³⁴ International Conference on Population and Development (ICPD). "Cairo Programme of Action (Cairo Consensus)." A/CONF.171/13/Rev.1. 1994: para 7.2.
- ³⁵ Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, UN Doc. A/RES/S-21/2 (1999), para. 62.
- ³⁶ CERD. ICERD. 1965: art 5 (iv).
- ³⁷ UN CRC. "Children's Convention." 1989; art. 24(2)(d).
- ³⁸ Yamin AE, Maine D, 1999; note 26, paras 563, 584; UN CRC. "Children's Convention." 1989; art. 1.
- ³⁹ ILO. (ILO No. 169. 1989: art. 7(2). This article states: "The improvement of the ...levels of health...of the peoples concerned, with their participation and cooperation, shall be a matter of priority in plans for the overall economic development of areas they inhabit. Special projects for development of the areas in question shall also be designed as to promote such improvement."
- ⁴⁰ Article XI. *American Declaration on the Rights and Duties of Man*. Bogotá: 1948. Approved in the IX Inter-American Conference of the Organization of American States (OAS).
- ⁴¹ OAS. *American Convention on Human Rights: Pact of San José, Costa Rica*. Approved at San José, Costa Rica, November 22, 1969. art 4, para 1. Available at: <http://www.oas.org/juridico/english/Treaties/b-32.htm>. Accessed November 8, 2005.
- ⁴² OAS. *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights: Protocol of San Salvador*. OAS Treaty Series No. 69: 1988. Entered into force 1998.
- ⁴³ Congreso de la República del Perú. Constitución Política del Perú 1993; art. 55.
- ⁴⁴ Disposición Final y Transitoria. Cuarta de la Constitución. Política del Peru. Noviembre 2004. Available at: <http://www.tc.gob.pe/legcon-peru/constitucion.html>. Accessed July 31, 2007; Communication with Mario Ríos Barrientos, Secretario General de APDS, Consultor del Proyecto "Sistemas Regionales de Protección de Derechos de las Personas Usuarias de los Servicios de Salud" on July 31, 2007.
- ⁴⁵ Congreso de la República del Perú. Constitución Política del Perú 1993; art. 7.
- ⁴⁶ Id., art. 11.
- ⁴⁷ Ley General de Salud [General Health Law] §178, Ley No.26842 (1997).
- ⁴⁸ Ley que modifica la Ley General de Salud N° 26842, respecto de la Obligación de los Establecimientos de Salud a dar atención médica en casos de Emergencias y Partos [Law that modifies the General Health Law in respect to the Obligations of Health Facilities to provide medical attention in cases of Emergencies and Births], art. 2, Ley No.27604 (2001).
- ⁴⁹ Decreto Supremos N° 017-2005-JUS. *Plan nacional de derechos humanos del Perú*. Lima; 2005: 94-6, 3.2.3 R 1.
- ⁵⁰ Ley General de Salud [General Health Law] §178, Ley No.26842 (1997), art 30.
- ⁵¹ Código Penal. Decreto Legislativo N° 635. 1991; art 119.
- ⁵² Id., art 114.
- ⁵³ Id., art 115.
- ⁵⁴ Id., art 117.
- ⁵⁵ Id., art 120.
- ⁵⁶ UN CESCR. ICESCR. 1966: art. 2.
- ⁵⁷ CEDAW. "General Recommendation 24." 1999. Art 12(1), para 17.
- ⁵⁸ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28 .2007: para 63.
- ⁵⁹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 30.
- ⁶⁰ *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, adopted 8 Jan. 1987, UN CESCR, Committee on Human Rights., 43rd Sess., Agenda Item 8, UN Doc. E/CN.4/1987/17/Annex. 1987; *reprinted in* "The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights." *Human Rights Quarterly*. Vol 9(122); 1987 ; "The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights." *Human Rights Quarterly* Vol 8(20); 1998: 691, 694.
- ⁶¹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 43.
- ⁶² CEDAW. "General Recommendation 24." 1999. Art 12(1), para 17.

- ⁶³ "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. Note 14, para 19.
- ⁶⁴ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 66. See also UN CESCR. "General Comment 14." E/C.12/2000/4. 2000.
- ⁶⁵ UN CESCR. ICESCR. 1966: art. 2.
- ⁶⁶ CEDAW. "General Recommendation 24." 1999. Para 26.
- ⁶⁷ Maine D. "What's So Special about Maternal Mortality?" In: Berer M, Sundari Ravindran TK, eds. *Safe Motherhood Initiatives: Critical Issues*. Reproductive Health Matters; 1999:175-82.
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- ⁶⁹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; paras 14, 44.
- ⁷⁰ CEDAW. "General Recommendation 24." 1999. Art 12(2) para 27.
- ⁷¹ WHO/UNICEF/UNFPA. *Guidelines for Monitoring the Availability and Use of Obstetric Services*. 1997.
- ⁷² CEDAW. "General Recommendation 24." 1999. Art 12(2) para 26.
- ⁷³ Campbell O and Graham W. "Strategies for reducing maternal mortality: getting on with what works." *The Lancet*. 368(9543). October 2006: 1284-1299.
- ⁷⁴ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 43; United Nations General Assembly. "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. September 2006: para 29.
- ⁷⁵ The formula for scrutiny vary but courts generally assess whether the means employed are appropriate in relation to the stated constitutional or other goals, and whether limitations imposed on rights are compatible with their nature and solely justified by the purpose of promoting the general welfare in a democratic society. See Limburg Principles, principles 46-57; Constitutional Court of South Africa, *The Government of the Republic of South Africa and others vs. Irene Grootboom and others*, 2001 (1) SA 46 (CC), October 4, 2000. [State had a legal duty at least to have a plan in terms of which to deal with the plight of "absolutely homeless" people; State's housing policy focused on providing long term, low-cost housing and took no account of the basic need of homeless people for temporary shelter and was therefore unreasonable.]
- ⁷⁶ See Constitutional Court of South Africa, *South African Minister of Health v Treatment Action Campaign*, 2002 (5) SA 721, July 5, 2002. Under section 39 of the Constitution, the Court was obliged to 'have regard to international law' but was not bound by it. South Africa had not ratified the ICESCR and the court expressly did not adopt the minimum core approach of the ESC Rights Committee.
- ⁷⁷ See e.g. Argentine Federal Administrative Court of Appeals, Chamber IV, Viceconte, Mariela, July 02, 1998, where a Federal appellate court in Argentina considered epidemiological evidence regarding the efficaciousness of combating Argentine Hemorrhagic Fever through a vaccine versus other means.
- ⁷⁸ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 12.
- ⁷⁹ Maine D. *Safe Motherhood Programs: Options and Issues*. Center for Population and Family Health. Columbia University. 1991.
- ⁸⁰ "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. Note 14, para 17, annotation added.
- ⁸¹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 12(a). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 68.
- ⁸² Maine D., 1991; note 79, paras 16-7.
- ⁸³ WHO/UNICEF/UNFPA. *Guidelines for Monitoring the Availability and Use of Obstetric Services*. 1997 ; para 25; World Health Organization, *Reproductive Health Indicators: Guidelines for their generation, interpretation and analysis for global monitoring*. 2006;28. Available at: http://www.who.int/reproductive-health/publications/rh_indicators/guidelines.pdf. Accessed July 9, 2007.
- ⁸⁴ CEDAW. "General Recommendation 24." 1999. Art 12(1) para 21.
- ⁸⁵ Maine D., 1991; note 79, paras 15-6.
- ⁸⁶ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 12(b).
- ⁸⁷ Id.
- ⁸⁸ Id.
- ⁸⁹ "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. Note 14, para 17(c).
- ⁹⁰ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000: para 12(b).
- ⁹¹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; paras 12(c) and 27. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 74.
- ⁹² CEDAW. "General Recommendation 24." 1999. Art 12(1) para 22.
- ⁹³ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 12(d). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 75.
- ⁹⁴ WHO/UNICEF/UNFPA. *Guidelines for Monitoring the Availability and Use of Obstetric Services*. 1997; para 25.
- ⁹⁵ MINSA/CARE/Averting Maternal Death and Disability Program (Columbia University). *Impact of the FEMME Project in Reducing Maternal Mortality and its Significance for Health Policy in Peru*. 2006. Available at <http://www.care.org.pe/websites/femme/index.htm>.

VII. CASE STUDIES

The WHO estimates that at least fifteen percent of pregnancies can be expected to result in serious obstetric complications.¹ Not all of those women die, but in Peru each year over 1,200 do.² Thousands of others come close to dying and are left with life-long debilitating complications. Behind each death and “near miss”, there is a woman with a story. In this section of the report, PHR puts faces to the numbers, tells their stories and gives voice to their families.

The report also traces back the paths that led to these women’s deaths (and in one case, the saving of a women’s life), and analyzes obstacles to reducing maternal mortality at the level of the household and community, the health center, the regional government, the national government, and ultimately international actors such as the World Bank and Inter-American Development Bank, which are playing a fundamental role in the restructuring of Peru’s health sector through PARSaIud. Thus, it is possible to understand that these deaths are not random biological events but the foreseeable result of systematic policy, programming and budgeting decisions, as well as social and cultural factors. In each case, the factors leading to the woman’s death (and to the survival of one woman) are analyzed explicitly in terms of the human rights obligations relating to the right to health that Peru has assumed under international law as set out in the previous chapter, including the obligation to provide available, accessible, acceptable and quality EmOC.

Although the following seven cases are drawn from Puno and Huancavelica, many of the issues that relate to the emotional, as well as physical, distance between the population and the health system, interactions between gender and ethnic discrimination in exclusion of rural women, and structural deficiencies in the health system, confirm findings of other studies and illustrate challenges faced across Peru in realizing women’s rights to safe motherhood.³ The case studies also permit a glimpse into the lives of individual women, the roles they played in their families and communities, and the impacts of their deaths on their partners and children.

A. Puno



Puno’s population represents roughly 5% of the national population and the department is divided into 13 provinces with 108 districts. Only 3% of Puno’s land is arable; nonetheless, the region derives most of its wealth from farming and livestock.⁴ Mining is also a significant source of income for the department.

Despite its mineral resources, Puno’s population is very poor and highly indigenous; it is divided into two major ethnic groups: Quechua and Aymara. Puno contributed only 3% of Peru’s GDP in 2001⁵; 45% of its population is considered to be poor, with 52% lacking access to proper sanitation.⁶

While 62% of Peru's overall population lives in areas with access to potable water and 72% with access to electricity, only 32% and 52% of Puno's population has access to these, respectively.⁷ In addition, approximately two-thirds of the population lives in houses with dirt floors⁸ and only 3.6% of households have a telephone.⁹ Although Peru has undergone a process of intense urbanization over the past forty-two years, roughly 57% of Puno's population still resides in rural areas.¹⁰ Furthermore, while 48% of Puno's urban population has unmet basic needs, 67% of rural residents do.¹¹

Educational statistics for the department also lag behind the national average. In 1993, 22% of Puno's population (and 29% of its rural population) was illiterate, in contrast to 13% of the national population.¹² Although literacy rates have improved slightly in the last decade, the 2005 national census showed that roughly 16% of Puno's population is still unable to read or write—with 22% of its female population being illiterate in contrast to 11% of its male population.¹³ While school attendance in 1993 was reported at 87% for children ages 6-14, this percentage dropped to 60% for children between the ages of 12 and 19.¹⁴ According to the 2005 census, only 19% of men in Puno and 13% of women have completed their secondary education.¹⁵ In contrast, approximately 28% of men and 26% of women living in Lima have completely their secondary education.¹⁶

The negative correlation between age and school attendance in Puno is largely attributable to the department's dire socioeconomic situation, which forces many families to choose which among their children will receive an education or contribute through work to sustain the family. At the same time, Puno's educational system serves to reinforce cultural hierarchies and inequalities by offering classes only in Spanish, thus perpetuating the social exclusion of girls and women who are fluent only in Quechua or Aymara.¹⁷ Of the women interviewed in Puno for the 1996 Demographic and Health Survey (ENDES III), 26% spoke only Quechua and another 26% spoke only Aymara.¹⁸

In 2000, Puno had the highest maternal mortality ratio in Peru: 361 per 100,000 live births.¹⁹ According to the data of the Regional Directorate of Health (DIRESA), maternal deaths have not decreased in Puno in recent

years. There is reason to believe that the DIRESA's numbers are underestimated; for example, in one week, PHR's team identified a maternal death which had not been recorded by the DIRESA.

Related process indicators also remain among the worst in Peru. For example, although the MINSA claims that the number of obstetric professionals in Peru has increased by 80% over the last twenty years²⁰, in 2004, Puno had only 224 midwives²¹ for a population of 1,297,103.²² As of 2002, there were only 3.3 health facilities, 8.4 beds, 3.5 doctors, and 3.5 nurses for every 10,000 inhabitants.²³

According to results from the regional ENDES 2000 for the department of Puno, 87% of the 1,283 women in Puno surveyed had received some form of prenatal care; however, only 28% received some form of medical attention during their delivery.²⁴ Similarly, only 29% of women in Puno received postnatal care, far below the national average of 47%.²⁵ Seventy-nine percent of births in the previous five years had occurred in women's homes.²⁶ By 2003, the number of institutional births (41%) had increased but was still low by national standards.²⁷

In the ENDES 2000 for Puno, over 90% of women surveyed from all age groups cited at least one significant barrier to access to health services (97% in rural areas v. 91% in urban areas). Two-thirds of rural women cited distance to facilities and transportation as major barriers, whereas approximately one-third of urban women cited those factors. Rural women were more likely to cite lack of money (90%) than urban women (75%).²⁸

As the region that borders Bolivia, Puno also acts as a main entry point for contraband entering the country. In 2001, an estimated two-fifths of Peru's contraband entered through Puno, totaling USD 79.2 million in value.²⁹ Contraband—including but not limited to illegal pharmaceuticals, the sale of which brings in approximately USD 40 million annually³⁰—presents a serious challenge to the regional government's efficient and transparent use of resources, including those relating to healthcare and reform of the health system.³¹ The problems are not unique to Puno, but Puno was the last DIRESA in the PARSalud I intervention to agree to using computer programs to better monitor the use of antibiotics and other medicines.³²

Table 2: Reported Maternal Deaths between January 1, 1999 and March 31, 2007

Year	1999	2000	2001	2002	2003	2004	2005	2006	Jan.–Mar. 2007
Number	86	79	59	60	63	56	52	56	15

Source: Regional Directorate of Health in Puno

“If Only...”: Antonia

Antonia Pacco Cabana was 40 years old when she died of post-partum hemorrhage due to uterine atony at her home in Tococoni Choquechambi on April 6, 2007.



Family photo of Lorenzo and Antonia with three of their children

Antonia's Life

Antonia was the oldest of eight children. When Antonia's mother, Josefa, was 40, her husband died and left Josefa to raise the children alone. Josefa recounted how she, in turn, relied on Antonia to help her with the rest of the children. Antonia grew up in the small community of Tococoni Choquechambi and came to know Lorenzo Quispe Vargas, who was from the same community. Neither of them went past primary school and Antonia was just 14 when she began to date Lorenzo.

Shortly thereafter, they moved in together in a house not far from Antonia's mother, and formed a common-law marriage (*convivencia*).³³ At the time of PHR's interview, their house was made of four small adobe structures with thatched roofs; they had no running water or electricity and not even a latrine.

Similar to virtually everyone in the community, Lorenzo is a subsistence farmer. The family had some animals—sheep and pigs mostly, and a few cows—and farmed small plots of land where they managed to grow some potatoes and quinoa, a hardy grain that grows at extremely high altitudes and is widespread throughout the Peruvian Altiplano. Antonia helped Lorenzo with everything in the house and tended not just their animals but also

Where Does the Money Go?

In the Regional Hospital of Puno, PHR visited a new Obstetric Center which had been constructed ten months earlier with funds from PARSalud I. The Obstetric Center has both air conditioning and heating, newly refurbished labor and delivery rooms and brand new equipment, including a fetal monitor. The Regional Hospital in Puno is one of two major reference hospitals for the department and was sorely in need of new equipment and greater capacity.

However, PHR was informed that the Obstetric Center is rarely used because it does not receive a steady supply of running water. Located on the third floor of the hospital building, water runs with difficulty up through old pipes with little pressure. When there is no water pressure, physicians and other health professionals wash their hands in barrels filled with standing water. PHR was informed that surgeons and anesthesiologists prefer to use the general operating room on the first floor.

The misuse of funds goes beyond the lack of running water, which could be resolved with the placement of a water tank on the roof to allow water to run downward.

Poor decision-making and inefficiencies are notable throughout the facility. The sink to wash hands in the Obstetric Center is located directly next to where bloody cloths and materials are sterilized. Further, there is no ventilation system in the new Obstetric Center. Additionally, some equipment purchased with the monies from PARSalud I, such as a sterilizer, arrived broken and were sent to Lima for repair; ten months later, they had yet to be returned.

The location of the Obstetric Center on the third floor, aside from the water, requires women in labor and/or obstetric emergencies to be taken through the hospital and up two flights of stairs, or if it is functioning and available, placed on a small elevator. Finally, despite being newly refurbished, the Obstetric Center does not offer the possibility of having traditional vertical deliveries, thereby failing to comply with Technical Norm 033 issued by the MINSA in 2005.

PHR was informed that no representative from PARSalud I, or the Banks themselves had ever inspected the Obstetric Center to see how the funds were used.



Antonia and Lorenzo's home.

the neighbors' livestock. In discussing Antonia's death, Lorenzo told PHR, "I feel as if I've lost my right arm."³⁴

Antonia and Lorenzo settled into their life together and began to form their own family. They had six children together, ranging in ages from 18 to the most recent baby who was a month old at the time of PHR's interview. A seventh child had died in infancy. All of her pregnancies were normal and she gave birth at home in every case.

In at least two of the deliveries, a local *curandero* who was also a traditional birth attendant, Gerónimo, attended Antonia in addition to Lorenzo. At the time of PHR's interview, Gerónimo was 85 years old and hard of hearing, but he had delivered most of the women in the area and was still attending births at the time of Antonia's last pregnancy.³⁵

Gerónimo had received two trainings from UNICEF and had attended more than 300 deliveries in the over thirty years that he had been doing this work. He had received a certification from the nearest hospital in Azángaro and, although highly unusual for a community health promoter in Peru, Gerónimo reportedly had access to and routinely used the drug ergotrate, which he knew when to administer to help the uterus to contract.³⁶ Gerónimo appeared truly saddened by Antonia's death, and he talked about what a good person she had been.

Indeed, it seemed that Antonia was well-liked by virtually everyone. Family members and neighbors alike spoke of what a "good" and "good-hearted" person she had been. Through tears, Hermelinda Abado, the midwife at the local health post in Hanajquia, said "[Antonia] was such a good person... she was so good ...perhaps that's why it was her fate to die."³⁷

Antonia was loved by her husband as well, and she in turn apparently loved him. Throughout their marriage, Lorenzo had high blood pressure and Antonia worried

about his health. She would talk to her cousin Lis about how she worried about Lorenzo, how she was afraid that he could die and leave her widowed with the children as her own mother had been.³⁸ Lorenzo also said that she had worried about him and took care of him. They both always expected that he would die first. Lorenzo said repeatedly to PHR, "It wasn't supposed to be this way; she wasn't supposed to leave me alone."³⁹

Lorenzo had assisted with Antonia's previous deliveries and he accompanied her on all of her prenatal visits during this last pregnancy. They went together for seven prenatal check-ups to the Hanajquia health post—slightly over a kilometer away on very bad roads—where Hermelinda Abado, the midwife, saw them. The midwife noted that it was exceptional that a husband would accompany his wife to all her prenatal check-ups, especially when this was her eighth pregnancy. The midwife recalled that Antonia's pregnancy was entirely normal, except for the minor issue of developing varicose veins in her right leg.

However, during the prenatal visits the couple was told that Antonia's pregnancy was considered high-risk because she had had so many previous deliveries. They were also told that Antonia should plan to give birth in the hospital and they went over a birth plan for her to do that, although that plan was never formally signed. Technically, Antonia's community belonged to the jurisdiction of Azángaro hospital and therefore she was supposed to be receiving prenatal care at and planning her delivery for that hospital. However, the health post was closer and the midwife did not want to turn her away knowing how hard it was for Antonia and Lorenzo to make the time to go to the prenatal check-ups at all.



Alicia Ely Yamin interviewing Lorenzo and Gerónimo, the *curandero*.

After the fourth prenatal checkup, the midwife at the health post did send Antonia to the hospital in Azángaro—approximately 35 minutes away by car—for a routine ultrasound and told them that they should sign the birth plan with staff at the hospital. Antonia was given an ultrasound but they were not asked to sign a birth plan, and they were not registered in any way with the hospital.

A Fateful Series of Events and Circumstances

Three weeks before her due date, on Good Friday (April 6, 2007), Antonia began feeling labor pains in the afternoon. That morning, Lorenzo went to Azángaro to buy some food for Good Friday dinner. When he returned at approximately 10 a.m., Antonia was still fine. She had been dealing with the pigs that morning and they shared some bread and fruit for lunch.

At about 3 p.m. on that day—April 6th—her contractions began. Lorenzo wanted to go immediately to the hospital in Azángaro as he had been instructed by the staff at the health post in Hanajquia, to alert them to send an ambulance, but Antonia grabbed him by his shirt and begged him not to leave her. She was afraid of being alone during the delivery. Her mother, Josefa, whom they had called, had hurt her hand and could not deliver the baby. As it was Good Friday, none of the neighbors were around since they had all gone to top of the mountain to collect the sacred herbs, as is the tradition in that part of the Peruvian Altiplano. As a result, Antonia and Lorenzo were alone with their children and her mother.

Lorenzo decided he could not leave his wife. He did not go to fetch Gerónimo, the *partero* (traditional birth attendant), whose house was nearby, because Gerónimo was also away due to a surgery his own wife had just had.

So he and his mother-in-law prepared for the delivery by themselves, preparing *mates* (herb teas) and a stew for after the delivery. They warmed and prepared the room as is traditional in that area of Peru, where it is essential for the room to be warm and dry.

They managed to make the room reasonably warm despite the fact that it had rained the day before and continued to rain that day, becoming stronger in the afternoon and evening. It was a cold, drenching rain that turned everything to mud.

At approximately 6 pm the baby, Adolfo, was born. After half an hour passed and the placenta had not been delivered, Lorenzo left Antonia with her mother and went to get help. He jumped on an old motorbike and drove away from the house quickly over the treacherous and roads muddied by the rain. After perhaps ten minutes, Lorenzo reached a fork in the road. He could have chosen to turn toward the health post, Hanajquia, which was approximately ten minutes further down the road, to try to find help there. Alternatively, he could take the other fork and proceed to the hospital in Azángaro, which was at least 25 minutes further away on the motorbike when road conditions were good. They were not that night. Believing that no one would be at the health post after 6 p.m. on the night of Good Friday, Lorenzo chose to go to the hospital.

As it turned out, some members of the staff—including the midwife, Hermelinda Abado Sucapuca—were at the health post in Hanajquia that night, even though it was after hours and Good Friday. Although the health post is a rudimentary facility without electricity or running water, the staff was equipped to be first responders in the event of an obstetric emergency. Hermelinda stated that she

The Carlos Cornejo Rosello Hospital in Azángaro

The Azángaro Hospital is the reference hospital for the Anzángaro red (network) and is classified as an FOE, which ostensibly means that it is capable of providing essential obstetric services, including surgeries and blood transfusions 24 hours a day. In theory, the hospital has two operating rooms; however, only one is equipped. PHR was informed that Cesarean sections are often referred to the larger hospital in Juliaca because the one equipped operating room had not been sterilized. At the time of PHR's visit, the hospital had only two units of blood on hand. Of the twelve physicians on staff, two were general surgeons, one was a pediatrician and nine were in general practice. Ten were appointed (*nombrados*) and two were working on

contracts. There are no anesthesiologists and when a Cesarean section is performed at the hospital, nurses are required to administer the anesthesia. PHR was told that doctors generally refuse to do so because of fears of possible adverse events. The nurses—who are untrained—are not given an option as to whether they want to administer the anesthesia.⁴⁰

The Azángaro hospital only had one functioning vehicle to use as an ambulance which was over ten years old and frequently in disrepair, according to staff. Equipment purchased with funds from PARSalud I had begun to fail and there was no money for repair, nor had there been training in the use of purchased equipment.

could have administered intravenous fluid resuscitation and oxytocin, to replace blood volume and to promote uterine contractions so as to alleviate bleeding and promote delivery of the placenta, respectively.⁴¹

The trip to the hospital was very difficult because the road is in a poor state and two days of rain had made it virtually impassable. The old motorbike broke down. Lorenzo left it by the side of the road and begged people in the nearest community, Macaya Piripirini, to lend him a bicycle. After a delay of half an hour or so, Lorenzo did manage to borrow a bicycle and continued on his way to Azángaro, but the travel was slowed now that he was on a bicycle.

When Lorenzo reached the Carlos Cornejo Rosello Hospital in Azángaro, neither the doctor on call nor the ambulance driver was there. The night guard on duty called Dr. Hector Vilca and the ambulance driver, who reportedly did not want to make the drive. Lorenzo implored them, “For the love of God, my wife is dying...” After another delay of approximately 30 minutes at the hospital, Dr. Vilca and a midwife from the hospital, Maria Caira Pineda, headed out toward Lorenzo’s house with him in a truck, which was being used as an ambulance since the hospital’s ambulance was in disrepair. Although

Antonia was insured under the SIS, which entitles polycholders to two free pairs of gloves for each delivery, Lorenzo was required to pay 1.50 *nuevos soles* (approximately US 50 cents) for rubber gloves before they left.

While Lorenzo was seeking help, Antonia was with her mother and her children. Shortly after Lorenzo left, the placenta was expelled, but Antonia continued to bleed. The uterus was not contracting. Josefa, Antonia’s mother cries as she recounts how events unfolded: “She started to turn blue. I stayed with her, hugging her the whole time... I didn’t leave her for a minute. She kept saying her back hurt; she didn’t say anything else.... The kids were all there, crying ‘Mama, Mama’...”⁴² She tried to feed Antonia *mates* (herb teas) and *caldo de chuño* (a stew with dried potatoes, vegetables and meat that is traditional for after deliveries in this region of Peru), but she could not eat. Josefa says she kept telling her daughter to hang on, that Lorenzo would be back with the doctor any minute and that everything would be all right.

Some time around 9 p.m., the vehicle arrived at the community but got stuck in a field of mud at the bottom of the hill where the house is. This caused further delays. Lorenzo and the doctor got out to push the truck in the mud. At that time, Josefa saw them and yelled down to hurry, that Antonia was fading.

Lorenzo and Dr. Vilca, who was wearing boots, then left the ambulance and made their way through the deep mud and vast puddles and climbed up the hill to the house. The midwife, who was wearing other shoes, did not. Dr. Vilca examined Antonia, who was still in Josefa’s arms. Josefa recalls the doctor said “She’s run out of blood—don’t hold her anymore.”⁴³ Desperate and frantic, Lorenzo screamed at Antonia “You need to wake up.”⁴⁴ But she did not. The children exploded in tears; the eldest son, Abel Mateo, ran out and went up the hill behind the house to cry by himself.

After Antonia’s Death

The next day, Dr. Vilca returned to perform the autopsy on Antonia. The cause of death was determined as cardiac arrest due to hypovolemic shock from hemorrhage. The cause of the hemorrhage was uterine atony, a condition in which the muscles of the uterus fail to contract. At the time of autopsy, Antonia’s uterus was 28 cm long and 14 cm wide.

Lorenzo was president of the community, an elected position that rotates among community authorities. When Antonia died, the community helped pay for food at the funeral but could not afford to provide the family with further assistance.



Photo: Marion Brown

Josefa Pacco, Antonia’s mother.

The baby, Adolfo, was at first breastfed by a sister-in-law of Antonia's who had her own nursing child, but soon that relative decided she could not produce enough milk for both children. Antonia's cousin, Lis, then took the baby with her to her home in Azángaro and was taking care of him at the time of PHR's interview. Adolfo was being fed formula, which cost approximately USD 10 per can, and which Lorenzo could not afford. Lis stated that she planned to return the baby to Lorenzo when he was three months old but it was unclear how Lorenzo was going to be able to take care of the infant.⁴⁵

Lorenzo described for PHR his days now that Antonia is gone. He gets up by 4 in the morning to make breakfast and wash the children's clothes. By 8 a.m., the children leave for school and he tends to the animals and cares for the livestock. At around 4 p.m., he comes back from dealing with the livestock to cook dinner. Then he washes and cleans and puts the children to bed in the tiny bedroom that the entire family shares. He does not get to sleep until after 9 p.m. "I'm so tired," Lorenzo said, but when asked, he agreed that this is the schedule Antonia had kept every day when she was alive.⁴⁶

When Lorenzo told PHR that since Antonia's death "my heart hurts;" he was referring not only to his profound grief but also to a physical condition. He complained of chest pains and told PHR he had been treated for high blood pressure and had also been diagnosed with gastric discomfort, possibly stemming from an ulcer. He had been prescribed medicines at the hospital in Azángaro, but as he was not insured under the social insurance scheme, he had to pay for them and said he doubted he could afford to continue.

At the time of PHR's visit, the children were clearly suffering as well. They had stopped going to school regularly. The younger children had stopped eating and were prone to long crying jags. Lis told PHR that when the second grader went to school she would race home hoping to find her mother and would collapse in tears when she was not there.⁴⁷

The older children were also deeply affected, perhaps in particular the oldest son, Abel Mateo, who had an exceptionally close relationship with his mother. Despite her lack of education, Antonia's dream for him was to go to university. Indeed, Abel Mateo was completing his fifth year of secondary school and had talked to his mother about going to the city of Arequipa to continue his studies. Now that she was gone, Abel Mateo not only missed her terribly but also realized his future plans had been dashed. He had to stay at home to care for his five younger siblings, especially as his father was not in



Photo: Marion Brown

Antonia's mother, newborn, husband, and three of her other children outside of their home.

good health.⁴⁸

Abel Mateo took some of his anger out on his father, blaming him for her death—not because of what he did or did not do on April 6th, but by asking whether he didn't have enough children already and why did he have to go and get her pregnant again. Lorenzo and Antonia used no form of family planning, not even the rhythm method. Indeed, Lorenzo told PHR that Antonia had been tired of having children, telling him "I'm practically in menopause and here you have me pregnant."⁴⁹

The baby, Adolfo, had not been issued a birth certificate because he was born at home. Despite the awareness of Dr. Vilca and the midwife of the circumstances of the delivery, Lorenzo was being asked to pay a "fine" to obtain the baby's birth certificate because he had been born at home rather than in a health facility. As a result, Adolfo had not received his first vaccinations and was not eligible for any assistance through the hospital in Azángaro. PHR learned that three of Lorenzo's other children did not have birth certificates either. The PHR team intervened on their behalf so that all of their birth certificates were being processed, and with the application for a birth certificate, the baby was allowed to be vaccinated.

Analysis

On one level, Antonia's death is the result of a tragic confluence of events and circumstances that painfully illustrates how each of the three delays contributes to maternal deaths. If only it had not been Good Friday, or her mother had not injured her hand, Antonia might have been willing to let Lorenzo seek help immediately in the hospital when her labor pains began because there would have been someone to stay behind and help with the birth. If only Gerónimo had been at his house as



Lis Rosana Quispe Quea, Antonia's cousin, with Adolfo.

usual, he would have been able to attend the delivery and administer ergotrate, which would have bought her time to get further assistance. If only Lorenzo had decided to go to the closer health center at Hanajquia, the midwife would have been able to administer oxytocin and IV fluids until further help could be sought. If only Lorenzo's motor bike had not broken down, he would not have been delayed while seeking to borrow a bicycle, or slowed by using a bicycle rather than a motorbike. If only the ambulance driver and Dr. Vilca had been ready and willing to leave immediately when Lorenzo arrived at the hospital, another critical delay would have been averted. If only it had not been raining so much, the ambulance could have made it back to the house more rapidly and would not have gotten stuck in the mud, causing yet another fateful delay.

Yet behind all of that seemingly terrible "luck" lie policies and structural factors that led to Antonia's death as well. For example, the care at the Azángaro Hospital was not readily available or accessible. When Antonia and Lorenzo were referred to Azángaro for the ultrasound, they were not attended to and not registered at the hospital. When Lorenzo arrived the night of April 6th during Antonia's emergency, he was forced to wait for

the guard to reach Dr Vilca and the ambulance driver. Lorenzo had to beg the ambulance driver to drive to the community, and he was required to pay for gloves, even though they are covered under the SIS.

The apparent apathy and indifference of the individual hospital employees coexist with broader systemic issues. First, the one ambulance at the Azángaro hospital was in disrepair the night that Lorenzo arrived and was substituted by a make-shift truck. Second, there is no budget for gasoline, which therefore has to be paid for by the patient or assumed as a cost by the health establishment. Third, the roads are in terrible condition, which was exacerbated that night by the days of rain that had created vast puddles and washed-out areas. There is no justification for health personnel being insensitive to the urgency of the situation; however, as a systemic matter, health establishments require functioning ambulances with budgets for maintenance and fuel in order to ensure accessibility of care. Moreover, although not a directly health-related intervention, investment in infrastructure (*i.e.*, roads and bridges) improvement can greatly contribute to reducing delays in arriving at emergency obstetric care, and in facilitating access to the health care system generally.

The lack of available and accessible care is also evidenced in the irrational distribution of health facilities in this region of Puno. For example, the Hanajquia health post, while approximately 35 minutes by car from the town of Azángaro, falls under the jurisdiction of San José, which is located a great distance away. The health post at Hanajquia is an FOP, a facility that is not equipped to provide basic obstetric care or certified to have women deliver there, and there is no FOB nearby. Women are therefore expected to seek prenatal care and deliver in Azángaro, even if they live at a considerable distance.



A lot filled with broken ambulances outside of the Azángaro Hospital.

This distribution of facilities results in the imposition of an informal user fee in the case of prenatal care and can mean the difference between life and death in the event of an obstetric emergency. That is, but for the midwife at Hanajquia being compassionate toward Lorenzo and Antonia, they would have had to seek prenatal care at Azángaro for all of her prenatal visits because they fell within the hospital's jurisdiction. For Antonia and Lorenzo to travel the significant distance to the hospital in Azángaro would have cost them money in addition to the opportunity cost of being away from their farm. The money for transportation is not covered by the SIS. The transportation costs, coupled with the opportunity costs, represent an informal user fee which can be a substantial economic barrier to accessible care. This barrier is not unique to the case of Antonia, nor to Puno. A national study by GRADE in 2006 found that "distance from health facilities increases the cost of access to professional care, both because time spent reaching the nearest facility may represent a significant opportunity cost, especially for those living in remote and isolated rural areas, and because distance tends to isolate the hospital from the benefits and externalities of access to information."⁵⁰

Furthermore, in this case, when Antonia went into labor she could not bear for Lorenzo to leave her to go all the way to Azángaro and back to seek help, knowing he would be away at least a couple of hours. If there had been an FOB located closer to the house, she might well have been less reluctant and the tragedy might have been averted.

Lack of trained personnel presents one significant obstacle to having more FOBs in Puno and elsewhere. Dr. Juan Carlos Calla Apaza told PHR that, since 2004, the DIRESA's strategy to reduce maternal mortality had included contracting with midwives and nurses for the health centers and in particular, health posts. Although health posts cannot meet the criteria for FOBs, midwives and nurses are crucial for providing basic obstetric care and can certainly provide a first response in cases of obstetric emergencies. It is likely that Hermelinda Abado, the midwife at the Hanajquia health post, who showed exceptional dedication in being at work on the night of Good Friday, could have saved Antonia's life had she arrived at Antonia's home in time.

However, the strategies Dr. Calla Apaza touted are undermined by the starkly inequitable remuneration and labor contracts under which many of the staff at peripheral establishments, in particular, are forced to work. As a midwife who is paid through the SIS on a contract that

provides for termination at will, Hermelinda Abado began receiving 300 *nuevos soles*/month (approximately USD 93). In 2005, her "salary" was raised to 500 *nuevos soles* (approximately USD 155), but 50% of that salary was to be earned through "productivity." If she does not attend enough women in prenatal check-ups, her remuneration declines, and she routinely takes home only between 60 and 250 *nuevos soles* a month (approximately USD 18-78). Meanwhile, midwives who are appointed (*nombradas*) earn between 1800 and 2000 *nuevos soles* (approximately USD 563 - 625), work fewer hours, and have benefits and job security.

This situation violates the labor rights of healthcare professionals across Peru. It affects midwives in particular, as there is no foreign labor market for Peruvian midwives—which means there is not the same skills drain as is seen with nurses, for instance. This situation affects the capacity of the Peruvian healthcare system to provide available, accessible, acceptable, and quality EmOC. Contracts are short-term and lead to high turnover at health facilities, which affects the possibility for building trust and relationships with the population. Lack of job security often leads to perverse incentives to avoid dealing with obstetric emergencies for fear of being fired punitively in the event of a maternal death. Delays in reimbursements under the SIS for salaries exacerbate the poor working situations. In short, the labor conditions of healthcare workers on the front lines need to be rationalized in order to address maternal mortality in a sustainable and equitable fashion.

As in so many other cases, if there had been a means of communication between the community and the hospital, many of the delays Antonia faced in receiving care could have been avoided. The Director of the Azángaro Hospital, Dr. Juan Carlos Calla Apaza, told PHR that 90% of the health posts and health centers were equipped with radios. However, he conceded that few communities in the area have radios or access to cell phones. If health posts are routinely closed after 6 p.m., it is not effective as a matter of policy to rely on radios in those centers to communicate emergencies.

The fact that a fee was being imposed for obtaining the baby's birth certificate is unfortunately all too typical throughout rural Peru. Indeed, the Defensoría del Pueblo (Human Rights Ombuds Office) conducted a nation-wide investigation into this practice in 2004-05 and issued a scathing report. As a result of that report, a new MINSA norm outlawing the fines was enacted.⁵¹ Unfortunately, PHR found that actual implementation of this new norm has been haphazard,⁵² highlighting the Defensoría's lack

of enforcement mechanisms. Since the publication of the new MINSA norm, it is followed in some locations. Others, however, have never heard of the new norm. Upon having the new requirements brought to their attention, some health centers have ceased charging for birth certificates. Some have even become proactive in terms of disseminating the new information. As PHR documented, others continue to charge for birth certificates, even after learning about the MINSA norm.

This practice, which is intended to provide incentives to the family to give birth at facilities, is both violative of the child's rights and coercive. Further, when the family cannot afford to pay the fee—which appears to range from 10 to 50 *nuevos soles* (approximately USD 3-16)—the child does not receive vaccinations and is excluded from programs such as JUNTOS, a cash-transfer program for certain indigent families.

These coercive policies appear to stem from the widespread belief in the formal health sector that women need to be convinced—by any means necessary—to give birth in health facilities. Productivity indicators based on numbers of institutional births also appear to create distorted incentives.

When asked what the primary causes of high maternal mortality in the area were, Dr. Calla Apaza told PHR that “maternal mortality is a social problem.... their customs, the idiosyncrasies of their cultures, make the work of health professionals very difficult.”⁵³ The director of midwifery at the hospital, Maria Rondinel Lopez, added, “The population of this area of Azángaro is rebellious,” alluding perhaps to the role of Azángaro in the Peruvian revolution as well as during the Shining Path insurgency in the 1980's.⁵⁴ Both Dr. Calla Apaza and Maria Rondinel Lopez were from Puno, so apparently they were distinguishing themselves from the largely indigenous population the hospital served. The cultural insensitivity of many health professionals creates delays in the decision to seek care at facilities in the case of emergencies and, at other times, constitutes a significant barrier to care.

Cultural insensitivity is reflected not only in the discriminatory attitudes manifested by the director of the Azángaro hospital and its head of midwifery, but also in the equipping of the health facilities themselves. For example, the Azángaro hospital did not have a traditional birthing room where women could give birth in the traditional vertical position on an animal skin, as it should to be in compliance with norms on vertical birthing which were issued by the Ministry of Health in 2005.⁵⁵ Azángaro is not alone; PHR found no major hospital in Puno that was equipped to permit vertical birthing and

was informed that the DIRESA in Puno has not issued a protocol for the implementation of vertical birthing practices, in violation of the MINSA norm.⁵⁶

More generally, PARSaI included funds for trainings on “interculturality.” However, PHR was informed by representatives of the World Bank that no formal evaluation was done with respect to the success of those trainings.⁵⁷ PHR found that there was a generalized lack of intercultural training and understanding, preventing care from being culturally acceptable in accordance with international human rights standards. Indeed, it appeared that “intercultural” accommodation was often done without consultation with or participation from women themselves.

A Double Injustice: Melania

Melania Yucra Gonzales was 22 years old when she died of post-partum hemorrhage while giving birth to her first child on September 6, 2004. She lived in the community of Puquis.

A Promising Future

Melania and Francisco had been dating for three months before they got married. Everyone in both families was very happy about the union. The couple seemed well-suited to each other and at the time of the wedding, she was already pregnant, which is not uncommon in rural Peru. They were married in the nearby town of Taraco and the festivities lasted an entire week. First, Melania's parents gave them a party and then Francisco's parents did as well. Finally, the guests all went to the house of the couple's *padrinos* (godparents), who kept a video of the wedding and parties almost three years later. “Melania had a good character; she knew how to do everything



Family photo taken in front of room where Melania (second from right in rear row) later died while giving birth

on the farm and she was hard-working... this marriage will work well,”⁵⁸ remembers thinking Eulogia Mamani Inkahuanaco, the couple’s second godmother. (As is typical in this region, the couple had not one but two sets of godparents to provide guidance and financial support). Francisco’s mother, Jovita Parisuana, recalls that Melania was very sweet and that “she was like another daughter” to her.⁵⁹

As newlyweds, Melania and Francisco lived in a small adobe house with Francisco’s parents. Francisco’s brother also lives nearby; all the family members are subsistence farmers who cultivate quinoa and beans, among other things. Puquis is a relatively densely populated community with small adobe houses and the traditional cone-roofed *putucos* (rounded adobe structures) dotting the quinoa fields.

Melania did not have an easy pregnancy. She had terrible morning sickness from the beginning and Francisco remembers in particular a trip they took to the city of Puno early on in her pregnancy, where she ended up vomiting most of the trip. He had bought her hard candies to try to settle her stomach.⁶⁰

At three months they began to go to the local health post, which is a CLAS (Local Health Administration Committee) for prenatal checkups. Melania was nervous about the pregnancy, but she did not speak Spanish and did not want to go to the health post alone. Francisco always accompanied her to the check-ups, taking her on his bicycle to the post which was approximately one kilometer from the house. On the second prenatal check-up, the midwife at the post, Maria Magdalena Condori Apaza, gave Melania some pills for the nausea. The midwife told them they would be fined five *nuevos soles* (approximately USD 1.30) if they missed any prenatal check-ups and they did not. They went to eight prenatal check-ups in total before Melania went into labor.

During these visits they were not informed of any potential complications or signs of emergency. However, Melania was told of her due date and they agreed on a birth plan with the midwife, which was recorded in the prenatal record. The couple planned to deliver the baby in their home with Maria, the midwife, attending the birth. Francisco states that they perceived the birth plan to be a contract with the health facility and with Maria, in particular.

During the pregnancy, Melania and Francisco were always attended by the same person, Maria Magdalena Condori Apaza, the midwife. She repeatedly reassured Melania that all women are scared in their first pregnancies, but that everything was normal and that she



Photo: Marion Brown

Woman beating quinoa that has just been harvested.

would be fine. Melania began to relax more and to trust the midwife. Francisco says they also had confidence in Maria because she had attended the delivery of his sister-in-law and everything had turned out well.

The Due Date Arrives

When Melania’s contractions began on her scheduled due date, she left for the health post on foot while Francisco went to look for the *curandero* in the community to read the coca leaves in order to see how the birth was going to go. In this region of Peru, it is traditional for a traditional healer or *curandero* to “read the coca leaves”—similar to reading tea leaves—before a delivery.

Francisco did not find the *curandero* at his home, and headed to meet Melania at the health post. But as he rode his bike toward there, he found her already on her way home. Maria had told Melania to go home because her contractions were not strong enough yet. According to Francisco’s mother, Maria told Melania to prepare everything for the birth.⁶¹ Melania told Francisco that Maria would come to attend to her in their house a bit later, as they had agreed in accordance with their birth plan.

Maria never came. By 6 pm, Melania went into active labor. Melania’s father went to look for Maria at the health post but no one was there by then. Maria had apparently gone home.

Melania’s father returned to the house where Melania was with Francisco and his parents and her mother. The family members gave her *mates* (herbal teas) to help her dilate and wrapped a band around her around the top of her waist, which is traditionally done to place downward pressure on the uterus and later on the placenta. At 9 p.m., the pains became unbearable as she entered into the transition phase, and at approximately 10 p.m., the baby, Humberto, was born. Francisco and his mother

helped deliver the baby. They set the baby down next to Melania and tied the umbilical cord. But as they were waiting for the placenta to be expelled, Melania began hemorrhaging. She looked at Francisco and mumbled “take your son because I’m in a bad way...”⁶² She then stopped speaking and her mother-in-law remembers that she just gurgled some sounds.⁶³

Panic-stricken as he saw Melania losing more and more blood, Francisco left with his father-in-law and brother, Gerardo, to try to get help. They went back to the health post and even to the considerably farther health center in Taraco. But no one could be found.⁶⁴ Melania died from post-partum hemorrhage due to retained placenta at approximately 3 a.m.

Afterward

Later that day the family notified the Lieutenant Governor (the highest community authority) and also the health post in Puquis. The midwife, Maria, was not at the health post that next day either. Dr. Manuel Itusaca came to conduct the autopsy, which by law is always performed in cases where the woman gives birth at home. However, in this case, the autopsy was performed in the home rather than the health post, as would have been normal. Also, Francisco paid for the autopsy and all of the funeral costs, even though these should have been covered by the SIS, as part of Melania’s insurance coverage under Plan C.

At the time of the autopsy, Dr. Itusaca asked Francisco for the prenatal check-up card (*carne de control*), which recorded the birth plan on it. When he asked for it back, the doctor did not return it. Later, it turned out that Melania’s entire medical record, as well as her registration in the SIS and other documents, had gone missing.⁶⁵

The whole community went to the health post in Puquis to denounce the lack of attention in the CLAS and to ask that they change all of the health personnel. Inexplicably, the CLAS changed all except Maria, the midwife, whose contract they extended for three months. Despite this, Maria was unable to return to work because the community rejected her presence and refused to see her, even harassing her. She was transferred to another position and currently lives in the city of Juliaca. In the course of this investigation, multiple attempts were made to contact and interview Maria but PHR received no response.⁶⁶

By all accounts, Francisco was utterly devastated by Melania’s death. He was also furious that Maria, the midwife, had not shown up at the home as they had agreed. He took the unusual step of filing a formal complaint against the midwife with the police and the public prosecutor in the town of Huanacán, where the closest court is located.

The criminal complaint alleged a “crime against life, the body and health in the form of abandoning a minor or person suffering a disability” pursuant to Article 125 of the Code of Criminal Procedure.⁶⁷ Francisco’s claim alleged that Maria knew that Melania was in labor and that she had a moral and legal obligation to attend the birth as they had agreed in the birth plan.

Maria, the midwife, filed a motion to dismiss (*excepción a causa*) which argued that her working hours were from 8 a.m. to 6 p.m. and that during those hours, Melania was not in a condition that would make her incapable of taking care of herself, nor was she in any imminent danger of serious harm or death. Therefore, Maria argued that she could not be accused of abandonment.⁶⁸ Dr. Itusaca provided testimony supporting Maria’s motion to dismiss.⁶⁹ Key to Maria’s motion was her claim that “no document exists that indicates that the injured party was under my care or protection, much less in danger of death and under my care.”⁷⁰ However, the birth plan, which formed the basis of Francisco and



Francisco with Humberto.

Photo: Marion Brown

Melania's understanding that Melania was under Maria's care and protection, had mysteriously disappeared, along with all other medical records. Neither Maria nor Dr. Itusca Mamani, nor anyone else from the health system, was charged with obstruction of justice.

Maria's motion to dismiss was rejected in Huancañé and the public prosecutor proceeded with the case. However, Maria then appealed the decision to the court in Juliaca, which upheld her motion and dismissed the case without setting out its reasoning. Numerous people involved in the trial told Francisco that he had no hope because Maria had money and would buy off the system, which is plausibly what happened.

Francisco was devastated a second time when the final decision came out in February, 2007, seemingly betrayed by both the justice system and the health system. The trial process took a huge toll on Francisco. It went on for two and a half years and he spent all of his money in the process, selling his livestock and other goods. Copies of official trial documents can cost 30-50 *nuevos soles* (approximately USD 9-15) each, in addition to other fees Francisco was required to pay.

During the drawn-out trial process, Francisco remarried. He formed a common law union with a young woman from the community, Juana, and they had a son together last year. Francisco told PHR through tears that having remarried did not make the loss of Melania any easier to take.

Humberto, Francisco's son with Melania, continued to live with Francisco's mother, Jovita, even after Francisco remarried. On multiple occasions, Francisco had tried to take Humberto to his house but almost always ended up coming back in the middle of the night because Humberto would be crying for his grandmother. At the time of PHR's interview, the toddler, Humberto, was clearly very attached to his grandmother as he followed her around the small farm while she milked the cows and attended to other chores.

In 2005, Francisco visited ReproSalud, a program run by the women's rights group, Movimiento Manuela Ramos, to learn about pregnancy and delivery and to understand why his first wife died. He, in turn, gave trainings to other men in the community. Francisco says that he learned that "complications cannot be predicted, and hemorrhage cannot be controlled by us. We can't do anything if a women starts to hemorrhage..."⁷¹ When Juana, his new wife, went into labor, he was not going to take any chances; he physically escorted a midwife from the health post in Puquis to his home to help with the delivery.

Analysis

There was a lethal absence of quality care in this case. Had Maria attended the delivery, Melania probably would not have died. Midwives in Peru are trained and equipped to administer intravenous fluid resuscitation and to administer oxytocin, which causes the uterus to contract and expel the placenta. They are also supposed to be trained in uterine massage and manual extraction of the placenta. Had she received such care, Melania would in all likelihood have been stabilized sufficiently to take her to the hospital in Juliaca, which is approximately one hour away by car.

The delay in the decision to seek alternate care was the direct result of Francisco and Melania's reliance on Maria's agreement to attend the birth and their confidence in her prediction that all would turn out well. In rural Peru, birth plans (*planes de parto*) are treated as contracts and are described as such by health professionals in discussing them with patients. PHR was told by multiple health professionals that the birth plans are used to document the commitment by the couple, as well as the health facility, to ensure that the birth will be attended by skilled personnel. Indeed, PHR learned that such birth plans are usually not only signed by the parties involved but also signed—or at least witnessed—by family members and often community authorities.

In this case, Maria knew that Melania was in labor and had told her to prepare for the delivery at home. No explanation was ever provided to Francisco as to why Maria did not show up at the delivery. It appears that she simply went home. In her appeal, Maria stated that "she had no obligation to stay in the health post after hours because there were no alarm signals." As obstetric complications are unpredictable and can arise suddenly during and after labor, this course of conduct reflected a disregard for her patient on the part of the midwife, with fatal consequences.

The structural factors that permitted this disregard go beyond the individual, Maria. For example, Dr. Itusaca submitted supporting documents on behalf of Maria in the lawsuit and wrote in a report for the hospital that "the

"I learned complications cannot be predicted, and hemorrhage cannot be controlled by us. We can't do anything if a women starts to hemorrhage..."

Francisco Yucra Yucra, whose wife died of hemorrhage, describing what he had learned after participating in trainings offered through ReproSalud, a project of Movimiento Manuela Ramos.

health post hours were 8 a.m. to 6 p.m. and that therefore, the deceased [Melania] was attended in accordance with respective procedures ...”⁷² Such procedures—which ignore agreements with and needs of patients—are patently inconsistent with the aim of making quality emergency obstetric care available and accessible to all women in Peru.

However, health care workers cannot be expected to work 24 hours a day, seven days a week. Compensation structures ought to take into account the unpredictability of obstetric emergencies and reward overtime. In the event of an after-hours labor, patients should have alternative plans that are agreed upon with the health facility and put in place, including specific steps to communicate with the nearest FOB facility and secure transportation, which needs to be paid for by the SIS. Despite a signed birth plan, no such alternate plan was in place in this case. In fact, despite detailed questions in birth plans as to how the woman will give birth (including how she will get to a health facility when that is agreed upon), the means to actually take such actions during an emergency are often lacking—which raises questions about the value of birth plans to address maternal mortality.

That is, there was no available means of communication in this case, as in so many others. Francisco has subsequently acquired a cellular phone, but at the time neither he nor anyone else in the community had one. There are no landline telephones in Puquis. Similarly, although Francisco sought care at the health post and the nearest health center, lack of transportation is another factor which impeded the family from even making the decision to transport Melania to the hospital in Juliaca. Had they decided to try to move Melania, Francisco and his family would have had to carry her out to the nearest road—at least a half-kilometer away—and flag down a truck or car happening to pass by in the middle of the night, in order to transport her to Juliaca, by which time she may well have been dead.

The systemic absence of communications and transportation precludes a functioning referral system and inhibits access to care across Puno. Dr. Carlos Barrientos, Director of the Carlos Monge Medrano Hospital in Juliaca, stated to PHR that communications and transportation must be two of the highest priorities in addressing maternal mortality in Puno.⁷³ For example, in the San Roman network (red), which comprises the Carlos Monge Medrano Hospital, a reference hospital classified as an FOE; ten health centers, four of which are classified as FOBs; and thirty-seven health posts, there are only four or five functioning radios at health centers (not all of

which are FOBs) at any given time, and only one telephone. The Carlos Monge Medrano Hospital has only one functioning ambulance, although the parking lot is filled with vehicles that no longer function.⁷⁴ Furthermore, placing radios and telephones in health establishments does not guarantee that people in communities will be able to use them during an emergency; had the CLAS Puquis had a radio in this case, it would not have helped Francisco or Melania at all.

The aftermath of this case illustrates a systematic problem with accountability in Peru. It appears that there was collusion on the part of health personnel to make the pertinent documents in the case disappear. Nevertheless, no one was prosecuted for obstruction of justice, even though the mysterious disappearance of documents played a determining role in the case.

Access to the justice system in Peru poses the same kinds of barriers—economic, geographic and cultural—that access to the health system does. In this case, Francisco used up all of his assets pursuing a lawsuit for over two years in which it appears that the midwife was able to buy her exoneration. In addition, Maria was not administratively sanctioned in any way; she still practices as a midwife in the department of Puno.

The mobilization of the community in the aftermath of Melania’s death is notable in this case, as is the fact that the community was unable to secure the removal of Maria. The health post in this case was a CLAS—a Local Health Administration Committee. It should have been relatively easy for the community to have exercised a voice in the removal of staff because this facility was a CLAS. However, as more and more CLAS doctors and health professionals work on contracts with MINSA, the ability of the Council and Association to influence the CLAS facility, and the managing doctor specifically, has greatly decreased. The CLAS no longer function in substantially different ways than regular health establishments. This was evidenced in this case by the CLAS decision to renew Maria’s contract, despite the community’s outrage.

As the CLAS become more of a formality rather than a genuine mechanism for providing participation in health care decisions by communities, one potential avenue for involving the community in decisions affecting their health status, including evaluation of health personnel, is becoming foreclosed, not just in Puquis or Puno, but throughout Peru. PHR learned that the CLAS have been systematically under-funded and that this experiment in promoting community participation in health is at risk of disappearing in Peru.⁷⁵

Placing Blame Where It Belongs: Pabla

Pabla Roberta Arizanca Barrientos was 35 years old when she died at home in the community of Ramis, after giving birth to her fifth child; the autopsy listed the cause of death as placenta accreta.

Pabla's Life

Pabla was by all accounts a sad woman. She had had a hard life and it had apparently taken its toll. Her own mother died in childbirth—giving birth to twins—and Pabla had been forced to assume many responsibilities around the house to help her father, including taking care of her three siblings. As a result, she dropped out of school, stopping after the second year of primary school. Pabla never learned to read or write.

As a teenager, Pabla entered into a common-law union and had two children, a boy and a girl. Pabla and her first partner lived together in the house Pabla had grown up in, a tin-roofed one-room building across from a small *putuco*, or rounded adobe structure. That relationship did not last, however. Her partner left her and took the son with him, leaving Pabla with her daughter, Clara, a toddler.

Approximately eleven years ago, Pabla started dating Agustín Limahuaya Quispe, who was from the same community of Ramis. Ramis is a thickly settled community of seven sectors, and the sector that Pabla lived in has approximately 100 members. Almost everyone in Ramis, including Agustín, is dedicated to subsistence agriculture.

It was at least two years before Agustín moved into Pabla's house—the house she had lived in with her former partner, the house she had grown up in, the house where her mother had died giving birth. He told PHR that he had been initially reluctant to take on the responsibility of a woman who already had a child. But he was eventually won over; “Pabla was very hard-working,” he said—a trait that is highly valued in a wife or partner in the *Sierra* of Peru.⁷⁶

Agustín and Pabla quickly began to have their own children. The couple had two girls, Yudith Rosalía and Yennifer Rocío, who were aged 8 and 3 respectively at the time of PHR's interview. Agustín had also adopted Clara, the daughter from the first union. He paid for Clara's clothing and school materials and apparently did not mistreat the child.

But there appear to have been tensions between Agustín and Pabla. Allegedly he was resentful of her having had a previous union—although it may have been



Photo: Marion Brown

Agustín and Yennifer (3) at their home.

something else. There is no indication that Agustín abused Pabla verbally or physically. However, Pabla appeared to be suffering from something. She was reportedly quiet to the point of being depressed, and physically, she appeared malnourished to the personnel at the health post in Ramis. Agustín denied that she was malnourished.

In 2005, when Pabla went to the health post—a mere 100 meters from the house—she complained of stomach pains. Her period was also late and the nurse at the health post in Ramis, Isabel Quenta, gave her a pregnancy test. When Pabla was told she was pregnant she began to cry. She was desperate not to be pregnant, according to the nurse.⁷⁷ Agustín and Pabla used no family planning method due to his preferences. He stated to PHR that, although she and her previous partner had used birth control, with him she did not.⁷⁸

When Pabla returned for her second prenatal check-up a month later, she had calmed down somewhat. She told the nurse that she hoped it was a boy, as that would please her husband. Pabla continued to complain of stomach pains and the midwife, Yaneth Araujo, detected a hernia-like lump in her abdomen.

Pabla went to seven prenatal check-ups—always alone, unaccompanied by her husband. She told the midwife that she had no appetite and that her stomach pains grew worse when she ate. Pabla also developed pre-eclampsia, a serious condition that can lead to convulsions and sometimes death if untreated. The nurse and the midwife at the health post wanted to send Pabla to the hospital in Juliaca, which is approximately an hour away by car, for an ultrasound and tests. They also wanted her to deliver in the hospital by c-section due to her pre-eclampsia.

Isabel Quenta, the nurse at the health post, told PHR, “women here don't do anything without permission; the

man gives permission to go to the doctor, the man is the one who knows the date of her last period...so I had to explain the situation to him [Agustín] so she could go to Juliaca.”⁷⁹

Isabel knew that Agustín would be skeptical. He had had bad experiences with SIS before. In a prior pregnancy, Pabla had hurt her hand and had not been treated at the hospital despite being covered by Plan C of SIS. Similarly, his daughter had fractured her foot in an accident a year or so earlier and had also not been treated, despite being insured through a different plan of the SIS. Agustín was reluctant to go to the hospital and had little trust in the system.

But Isabel explained to Agustín that the pregnancy was high risk. She managed to convince Agustín that they should go together to the hospital, that when Pabla delivered she should have a c-section and, as they did not want more children, she should have a tubal ligation performed at the same time.

Agustín agreed to go with Pabla for the ultrasound and tests, and the midwife was to meet them there. Unfortunately, there was a miscommunication. The midwife, Yaneth Araujo, went to the hospital in Juliaca where she was waiting for them there all day. Agustín and Pabla understood that they were to go to the health center in Taraco—a town closer to Ramis than the city of Juliaca is—and were, in turn, waiting for the midwife for hours there. This misunderstanding may be attributable to the fact that the midwife speaks only Spanish and Agustín, while he speaks some Spanish, is far more comfortable speaking in Quechua. Pabla spoke only Quechua and the entire communication was between the midwife and her husband. Pabla came into the health post later that day and cried to the nurse, who does speak Quechua, believing that they had made them wait “just for kicks.”⁸⁰

At 37 weeks gestation, Pabla did go to the hospital in Juliaca with her sister-in-law. She took an SIS referral from the health post in Ramis. Pabla was sent with a diagnosis of pre-eclampsia, anemia, a hernia in her abdomen, and depressive syndrome. As she was full-term and had pre-eclampsia, Pabla went to the hospital expecting to stay and to deliver her baby there by Cesarean section and then to have a tubal ligation. She packed a small bag with clothing and other belongings and went to Juliaca, accompanied by her sister-in-law.

Juliaca is a large city of several hundred thousand people, teeming with traffic and mototaxis. The Carlos Monge Medrano Hospital is a gigantic structure that occupies the equivalent of at least a full city block and which may well have seemed quite imposing to someone



Photo: Marion Brown

Carlos Monge Medrano Hospital, Juliaca.

from the countryside, unfamiliar with the city, illiterate, and unable to speak Spanish. Yaneth, the midwife from Ramis, accompanied Pabla but left her at the hospital because apparently the doctors do not like it when health personnel accompany the patients.⁸¹

At the hospital, Dr. Perez performed the ultrasound on Pabla that day in March, 2006, and then she went for a consultation with Dr. Emilio Machicao. Dr. Machicao is an appointed (*nombrado*), i.e., tenured, physician who has been at the Juliaca hospital for many years. An OB/GYN by training, Dr. Machicao has for years taught subjects relating to obstetrics and gynecology at the local university. Dr. Machicao told Pabla that the ultrasound indicated that she was having a boy. Despite her elevated blood pressure and other signs of pre-eclampsia, he also told her that everything seemed fine and sent her home. Dr. Machicao reportedly does not speak Quechua.

It is unclear whether Dr. Machicao ever actually examined Pabla fully or reviewed her blood and urine tests. PHR was told by another OB/GYN at Juliaca hospital, Dr. Santiago Quispe Vilca, that it is hospital protocol to either immediately deliver women with pre-eclampsia by Cesarean section or to hospitalize them and keep them under observation until such time as they can be delivered by Cesarean section. “They are never sent home,” Dr. Quispe stated to the PHR team, “It is too dangerous.”⁸² At 37 weeks, Pabla was full term and could have had a Cesarean delivery and been kept under observation at the hospital.

The PHR team was given a tour of relevant areas in the Juliaca hospital,⁸³ including labor and delivery rooms, the maternity ward and the Intermediate Care Unit, where PHR’s team observed a woman who was being treated for pre-eclampsia. Several nurses were assigned to this one patient and were monitoring her blood pressure, urine

output and performing a physical exam on a regular basis. Indeed, the Director of the Juliaca Hospital, Dr. Carlos Barrientos, stated that this care was provided even though the Intermediate Care Unit was not recognized as such by the SIS because they lacked certain equipment, and that therefore without SIS reimbursement, the hospital was absorbing the costs of this care.

Apparently, Pabla returned home more depressed than ever. She told the nurse at the health post what had happened and that her husband was calling her a “*mañosa*”—a whiner. “The doctor says you’re fine so stop complaining and worrying,” she said Agustín told her.⁸⁴ When asked how he felt when Pabla returned from the hospital, Agustín told PHR that he was confident because the doctor said everything was OK, and he was happy because the doctor had said the baby was going to be a boy.⁸⁵

The Crisis

Just days after she returned from the hospital in Juliaca, on March 18, 2006, Pabla’s labor pains began. Pabla was at home with the three girls, Yennifer, Yudith, and Clara from her first union, who was then 14. Agustín was working in the fields during the day and then went to a community meeting. He did not return until after nightfall. By that time, the contractions were already strong. The health center was closed and it was after 8 o’clock p.m. when Agustín went to fetch Felix Yucra Yucra, a *partero*—traditional birth attendant—who was well-known in the community and had attended the birth of their previous child. In that earlier delivery, Yennifer was born with the umbilical cord wrapped around her neck, but Felix had removed it and the baby was fine, so Agustín had confidence in him.



Photo: Marion Brown

The family’s putuco, where Pabla and her mother both died while giving birth.

Felix had attended over 180 deliveries and was also well-known by the workers at the health post in Ramis. He had the cell phone number of Bonifacio, the nurse’s aide at the health post, who spoke Quechua, and was instructed to call whenever there was a case that required transport or medications. Felix did not have access to any medications to dispense, but he did seem to have knowledge of potential complications and the need to refer cases in the event of complications; he had conducted numerous trainings on pregnancy and childbirth in the community.⁸⁶

Agustín returned to the house with Felix. Agustín’s mother, Maria Rosario Quispe Iño, and a neighbor were there with Pabla. Pabla was laboring in the *putuco*, as is traditional, because it is usually the warmest part of any house. Agustín had placed a sheepskin on the floor and Pabla was lying on it as a fire burned, filling the tiny room with the heavy smoke caused by burning dung. This was the same *putuco* where Pabla’s mother had given birth to her, and where she had died in childbirth when Pabla was still a young child.

Felix was displeased that Agustín had waited until after the labor had already started to fetch him, although he conceded that he had been out purchasing notebooks for his children earlier. Felix told PHR that he would have prepared the *putuco* better. When he got there, he claims it was damp and cold—which is considered to be very dangerous for the delivering mother, as the cold can enter into her body causing great harm.⁸⁷ Agustín disputes that it was damp or cold inside.⁸⁸ Felix said that he had to get the fire going and heat up cloths (*pañños*).

By 9 p.m., the contractions had become very strong. The baby, Cesar Orlando, was born approximately two hours later. Felix told Agustín, “Be happy, it’s a boy.”⁸⁹ The baby was large, but Pabla was a tall woman. Felix cut the umbilical cord and tied it around her knee so it would not go back into her body, as the placenta had not come out.

Pabla’s mother-in-law tried to feed her *mate de chancaca negra* (an herb tea), as is traditional after childbirth, and then even pulled her hair to try to get a reaction from Pabla.⁹⁰ However, almost immediately it became apparent that something was desperately wrong.

Pabla began to convulse violently.⁹¹ Agustín tried to hold Pabla’s head and chest while Felix tried to hold her legs, but Pabla was too strong. Her arms became rigid and she could not be held down as she writhed and kicked spastically. Her eyes became glazed. She had by all indications gone into eclamptic seizures. Between 15 minutes and half an hour later, Pabla was dead.⁹² There was very little bleeding, but the placenta was never delivered.

The Autopsy and Afterward

At approximately 1:30 a.m. on Sunday morning, Agustín and Felix went to alert the Lieutenant Governor, the highest community authority. They then went to the nurse's house all the way in Juliaca to tell her. Isabel, in turn, talked to the hospital so they could send a doctor to perform the autopsy. The community members protested the plan to have the autopsy conducted by strangers; they said it would bring terrible luck down upon them and cause their crops to fail. In this part of Peru there is a strong belief that cutting the woman open will not allow her to rest in peace and as a result she will haunt the family and community. The thought of strangers cutting her open was particularly offensive to them.

The autopsy went forward, however, and was conducted in the health post in Ramis by a Dr. Percy Casaperalta. The autopsy concluded that Pabla had had placenta accreta, a condition in which the attachment plane of the placenta to the uterus is abnormal resulting in an inability of the placenta to separate and be delivered. When asked about the diagnosis by the staff at the health post, a Dr. Hurtado told them that one could not tell from the ultrasound that there was placenta accreta and it was not their place to tell the doctor how to make a diagnosis.⁹³ Remarkably, no mention was made in the autopsy report of pre-eclampsia or eclampsia.

The night after the autopsy was conducted it began to hail. According to members of the community, it was not an ordinary hail. Rather, it was an unusually hard hail that devastated their potatoes and other crops. The community immediately blamed the health workers of the health post for the hail, and the health personnel were afraid to go to work for several days. In fact, Isabel Quenta related that she and Yaneth Araujo, the midwife, went to Juliaca for a while until things had calmed down in the community.⁹⁴

There was blame spread around for Pabla's death as well. Pabla herself was blamed for her placenta accreta because "she sat in the sun too much," which caused the placenta "to stick to her back."⁹⁵ Agustín was blamed for not having the *putuco* warm enough, some neighbors saying that Pabla died from the cold.⁹⁶ Felix was questioned by the health post staff as to why he had not notified the nurse's aide at the health post to seek help. The staff at the health post was questioned—if not directly blamed—for allowing a maternal death to occur in their jurisdiction. Isabel Quenta, the nurse at the Ramis health post complained, "Everyone blamed us. But did they say the patient went to the hospital and because of negligence was sent back?... No, that they never mentioned....

And to me they said, 'don't say anything else, don't throw logs on the fire, it's better for you to shut up.' The only thing I said then was that the midwife should have job security and then I shut up and I felt so powerless. I didn't know what to do..."⁹⁷ No one from the community or from the hierarchy of the health system, however, seemed to blame Dr. Machicao.

The baby, Cesar, was taken by Pabla's sister-in-law, who had two small children of her own. However, she was not nursing and Cesar was being fed canned milk, which is much less expensive than formula. When they changed the brand of milk he was receiving—from Leche Nan to Leche Gloria—Cesar fell ill with diarrhea and died of dehydration on July 5, 2006.⁹⁸ He is buried in a small tomb next to his mother.

Clara, Pabla's daughter from her first union, was taken to Lima to live with Pabla's brother. Agustín stayed with his two daughters and moved in with his mother, who cared for the young girls. Agustín's mother, Maria Rosario, is a frail woman of 70 who is obviously in extremely poor health.

Maria Rosario is responsible for all of the chores around the house and for getting Yudith and Yennifer to school. She says she often carries the younger girl to and from the *wawa wasi*, or communal daycare, and that she simply does not have the strength to do so anymore.⁹⁹

Perhaps especially because of the scandal over the autopsy, Agustín did everything he could when it came time for Pabla's burial. Agustín spent almost all of his money on his wife's funeral and tomb, and on the traditional party that is thrown for a deceased person on All Saint's Day, November 1st. Pabla's tomb, as well as that of Cesar, has a hand-carved and designed tin cross instead of the less expensive paper ones on some gravesites. Agustín sold his livestock to pay for the celebrations



Pabla and Cesar's tombs.

Photo: Marion Brown

conducted 8 days after each of their deaths and on November 1st. These celebrations are intended to send off the deceased on their journey to the next world and to honor and remember them, respectively.

Analysis

Placenta accreta is a difficult condition to detect, although it can sometimes be detected by a skilled ultrasound examination. Oxytocin and other medications that cause the uterus to contract cannot resolve placenta accreta. Treatment requires surgery—almost always a hysterectomy to remove the uterus with the placenta so as to prevent or stop hemorrhage. Pabla would have required transfer to an FOE—e.g., the hospital in Juliaca—in order to save her from death due to placenta accreta.

However, from multiple eye witness testimonies as well as her pre-existing diagnosis of pre-eclampsia, which went untreated, it seems apparent that Pabla's death was also—and perhaps most directly—due to eclamptic convulsions. The onset and death from convulsions was so rapid—at the most half an hour—that once the decision had been made that she would give birth at home, there would have been no way to save her.

Unlike the case of Antonia, in which multiple possibilities might have saved her, the only way that Pabla's life could have been saved was for her to have been delivered at the Juliaca Hospital (or another FOE). First, Pabla had a known diagnosis of pre-eclampsia, which should have resulted in her being hospitalized, given anti-seizure medications and being delivered, as delivery is the definitive treatment for pre-eclampsia. At the very least, her hospitalization would have allowed her to receive therapeutic administration of anti-seizure medications when the convulsions started. Second, Pabla was diagnosed with placenta accreta postmortem, which is almost always associated with life-threatening postpartum hemorrhage. Hemorrhage associated with placenta accreta is only treatable by surgery and most often by removal of the uterus (hysterectomy). With each of these diagnoses, recognition and rapid intervention would have been critical to her survival. Therefore, Dr. Machicao's failure to retain Pabla in the hospital, in violation of hospital protocol, was in all likelihood the proximate cause of her death.

Agustín's possible inattention to the conditions in the *putuco* does not mean he is responsible for her death. Felix could not have had her transferred in the short time before Pabla died. The staff at the health post in Ramis appropriately sent Pabla to Juliaca with a diagnosis of pre-eclampsia and a referral form. The midwife even

personally accompanied her to Juliaca. And, although the causes of placenta accreta are not well understood, Pabla did not bring about her own death by "sitting in the sun too much." Despite her depression and anemia and abdominal pain, she went not once but twice to Juliaca and fully intended to deliver her baby in the hospital there.

That the autopsy report omitted eclampsia and mentioned only the placenta accreta effectively exonerated the only person who is, in all likelihood, responsible for Pabla's death: Dr. Machicao. As it is plausible that an ultrasound would not have detected the placenta accreta, there is no reason for Dr. Machicao to have insisted that Pabla stay at Juliaca hospital for treatment on that account. However, Yaneth Araujo, the midwife, clearly indicated in her prenatal record that she had pre-eclampsia. It was hospital protocol to keep women with pre-eclampsia at the hospital and to deliver them by Cesarean section if possible.

When discussing this case and maternal mortality in the region generally, Dr. Carlos Barrientos, the Director of the Carlos Monge Medrano Hospital in Juliaca, said that he did not deny that there were some bad doctors who had been around too long.¹⁰⁰ He did not mention any one doctor by name. There is no indication that any administrative investigation was ever launched into Dr. Machicao's role in Pabla's death. If there was such an investigation, PHR was not informed of it by anyone in the Juliaca hospital or the Ramis health post.

Dr. Machicao has an appointment at the Carlos Monge Medrano Hospital. In general, appointed physicians as well as other health professionals with appointments have virtual impunity for their behavior. Health professionals on contract, however, live in fear of being fired by a punitive health system just for mere association with a maternal death. As pointed out in other cases, appointed physicians also earn far more than their counterparts who work longer hours and do not receive benefits. While an appointed doctor at the Juliaca hospital earns approximately 2800 *nuevos soles* per month (approximately USD 875), a doctor working on contract earns approximately 1000 *nuevos soles* per month (approximately USD 312.50).

The midwife at Ramis, Yaneth Araujo, said in this case, "the self-esteem of health workers is largely tied to their salaries, and we often don't feel devoted to our work because we don't feel we're properly recognized for what we do. We aren't given set schedules and SIS pays us 350.00 *nuevos soles* per month (approximately USD 110) for which we work all day. At other times we have to work overnight with no pay while our bosses meanwhile

criticize us. For these reasons, few are inclined to work in the communities. In the hospital, they tell us to refer high-risk pregnancies, and when we do they don't treat them well and they make them come back and tell us, how is it possible that you make that woman pay for the transportation if she's fine and then we look bad with the patient—and that's what happened with Pabla."¹⁰¹

This highly inequitable labor situation systematically undermines the possibilities for sustained improvements in care for pregnant women, such as building an effective referral system and improving communication among the patients and different levels of the health system. It also eliminates the possibility of appropriate accountability in the event of negligence or wrongdoing within the healthcare system.

This case also illustrates the strains and distance between communities and the health system, even when the health post was located only 100 meters from the house. Emotional and cultural distances can create barriers to trust and, in turn, to care. Not enough health professionals—especially midwives and physicians—speak the language of the local population, which can lead to disastrous consequences and misunderstandings, as in this case. In the absence of their local midwives or nurses accompanying women at the hospital in Juliaca, there is no one to advocate or mediate between the formal medical system and the women who come from the countryside and do not speak Spanish. A 2006 report by Grupo de Analisis para el Desarrollo (GRADE) on economic and non-economic barriers to prenatal care among Peruvian women, found that language represents an important barrier to health care access for indigenous minorities: "Even in multicultural settings, often health personnel are not trained in cross-cultural communication, ignore the native language, and tend to have a patronizing attitude toward ethnic minorities."¹⁰²

The cultural and emotional distance between the populations and the health system is related to the reasons that indigenous families so frequently turn to *parteros*, or traditional birth attendants, to deliver women. The *partero*—in this case, Felix—shares the same customs and beliefs, has a prior relationship with the family, and even though he is an "authority" during the birth, he is otherwise an equal. The atmosphere for the birth is familiar and filled with rituals. In the formal health system, on the other hand, the provider is a "specialist" who assumes a particular, purely functional role, and the relationship is characterized by asymmetrical power and knowledge.¹⁰³ The rituals of western medicine are not compatible with the traditional rituals of their communi-

ties: the separation from their world and placement in an isolated and different world of bright lights and cold rooms, the removal of clothing and personal effects, and the reduction to being merely a patient and sometimes an object on which the provider performs, are wholly alien to them. The paternalistic attitudes on the part of many health providers do not help to bridge the divide.¹⁰⁴

The controversy over the autopsy is another illustration of the dramatic disconnect between the community and the health system. All maternal deaths that do not occur in health establishments are subject to autopsy. This practice is established by law in Peru. But it also is used to induce families to decide to have institutional deliveries precisely because cutting open the woman's body is contrary to indigenous beliefs. Dr. Barrientos told PHR bluntly, "we use the threat of the autopsy to pressure them to give birth in establishments."¹⁰⁵ Rather than engage in sustained dialogue and education with the communities served, the health system essentially takes advantage of the community's fears in order to pressure them to do what the doctors want. It was reported to PHR that in a case such as this one, where there are two entirely different cosmologies clashing over the performance of the autopsy, the imposition of the health system's will is perceived as virtual re-colonization by these rural indigenous communities.

Andean Birthing Rituals

Among the indigenous communities of the Andes, many rituals surround reproductive health, and in particular, the birthing process. It is believed that women should give birth in a warm and dark environment, shielded from the cold and light by blankets and curtains. The woman in labor is supposed to lie on the floor on a black sheepskin and burn herbs to make incense. She should be fully clothed and have a cloth on her head to prevent her from fainting, and a band around her waist to help expel the baby from the womb. While dilated, she should drink *mates* to help diminish the pain and speed the birthing process. It is believed that smelling a burning cowhide can also help to speed the delivery. After delivering the baby, no one is supposed to touch her or the newborn until the placenta has been delivered, and the band around her waist should be tightened to encourage delivery of the placenta.

— adapted from L. Estrada. "Ritos andinos en el Parto." Retamas y orquídeas. *Proyecto ReproSalud* – Manuela Ramos. Lima: June 1996.

Pabla's sad story also illustrates the effects of inequalities in gender relations. Pabla was forced to give up school at an early age because she was a girl and needed to care for her siblings, while her brothers went to school. As a result, she was not only illiterate but also unable to speak Spanish. She was abandoned by her first partner and, although fortunate to be living in her parents' home, had no way to support herself and her daughter. In her relationship with Agustín, she was unable to determine the number or spacing of her children. Pabla had few choices in her life and on the rare occasions when she did exert agency—such as when she took her belongings to Juliaca hospital to deliver her baby and have a tubal ligation—she was met with discrimination and indifference, which, in the end, proved deadly.

The Not-So-Secret Killer: Carolina

Carolina X was 37 years old when she died in her home as a result of inducing an abortion.¹⁰⁶

Carolina's Life

When her period was late, Carolina knew that she did not want to have another child. She already had four children: a 12 year-old boy who had just begun at secondary school in the nearby city, and three younger children ranging in age from 10 to 7, who attended the local primary school. She was 37 years old and her husband, Manuel, reportedly drank heavily. In addition to his drinking, Manuel was frequently away, as his work took him to Tacna—the eponymous capital of another Peruvian department.

At first, the notion of commerce does not seem to jibe with the bucolic community Manuel and Carolina were from, with its small adobe houses with tin roofs dotting the Altiplano. The community is quite densely populated and the houses are close together. It is near Lake Titicaca, the highest lake in the world, and the Lake is an important source of food for the local population.

But commerce is a major source of income in this region of the department of Puno, which borders on Bolivia. Many men travel frequently, leaving their wives at home to care for the *chacras* (farms). PHR did not learn what sorts of goods Manuel sells. However, among the goods purchased and distributed to different cities in the interior of Peru, there is a high percentage of contraceptive items brought over the border—everything from cars and car parts to food items to medicines—which are smuggled to avoid taxes and tariffs.

Carolina must have felt somewhat alone and isolated in this community and in her life in general. She reportedly got along with her in-laws who lived next door and with other neighbors, but apparently did not interact much with other women in the community. A neighbor said of her, "She was always alone but I didn't feel I could ever ask her why. She was a good woman and made sure her kids were always in school."

After her last son was born, Carolina had gone to the health post to ask about family planning methods. She decided to use Depo-Provera, an injectable form of contraception, but was bothered by the occasional headaches it caused and was interested in pursuing other options. However, when the midwife at the health post discussed the available options with the couple, Manuel did not want Carolina using any contraception. He said she had grown fat on the Depo-Provera and, in any case, contraception was unnecessary. "I don't want her using any of that crap (*cochinadas*). I am a businessman and I travel. I can keep track of the calendar. That's what we'll do." Thus, in 2004, Manuel and Carolina had stopped using any modern method of contraception.

Carolina and Manuel and their children spent long periods of time in Tacna in 2004 and 2005. During those periods, Carolina reportedly became pregnant, not once but twice. She learned in Tacna about a "safe" method of abortion. She was told there was a pill, misoprostol, that she could get in the pharmacy and all she had to do after taking the pill was "wait for the problem to go away." According to what she told her neighbors, Carolina successfully used misoprostol both times she was pregnant to abort the fetus.

Misoprostol is a prostaglandin that is commonly used to treat stomach ulcers. It is sold under the brand name, Cytotec in the United States and is prescribed in combination with mifepristone in cases of early medical abortions. Mifepristone blocks the hormone progesterone, which is needed to maintain the pregnancy, and misoprostol causes contractions resulting in a miscarriage. Upon taking misoprostol, cramping, bleeding, and clotting may begin as soon as 20 minutes. Within the next 6 to 8 hours, most women will miscarry. Bleeding is generally heavier than a menstrual period with large clots. Side-effects, even when taken as medically prescribed, may include heavy bleeding, headache, nausea, vomiting, diarrhea, and heavy cramping.¹⁰⁷

According to her neighbors, Carolina became confident that she knew how to carry out an abortion. She even talked to other women in the community who were pregnant and did not want to have the children. She told

them she knew what to do, explaining that they were to take two tablets of misoprostol vaginally and two orally, and that they should be prepared for the bleeding to begin within hours. This is a far higher dose than is medically recommended. It is unclear whether other women in Carolina's community followed her instructions. At least one woman went to the health post and asked the midwife whether the method was safe. The midwife discouraged her.

Another health professional involved in the case noted to PHR that despite abortion being illegal in Peru and it being a highly Catholic country, "among *campesina* women, inducing abortion is not construed as immoral. It is more like removing a tooth." However, despite abortion being reasonably common among *campesinas* in Peru, it remains the secret that everyone knows but few speak about openly. When she decided to abort for a third time, Carolina planned it very carefully so that no one would know.

That Day

Carolina had told no one that she was pregnant—not her husband, not her neighbors, not the midwife, nor the nurse at the health post. She waited for a day in which she knew she could have the house to herself. She had a considerable time to wait and was already at the end of the first trimester when a suitable day arrived. Her husband, Manuel, had stopped at the farm on the way to Tacna that morning and would not be back for at least several days. It was a Friday, and as is traditional in that part of Puno, her parents-in-law and sister-in-law and the neighbors had all gone to Lake Titicaca to fish and collect *llacho*—the roots from the *titora* reeds in the lake—which is used to feed the cows. She knew they would be gone most of the day. Carolina waited until her children left for school—around 8 a.m.—and she was finally alone.

From the evidence found later, she must have prepared carefully. She had done this before and evidently knew what she would need. She had a piece of plastic in which to put the fetus and later dispose of it. She had cloths to clean up the blood. After she inserted two six-sided white tablets into her vagina and swallowed two more, she waited for them to take effect. Some time later, the fetus was expelled and Carolina wrapped it in the plastic as she had planned and set it aside under some cloths in a corner of the bedroom.

At some point, when the placenta failed to be expelled, panic must have swept over Carolina, as she realized something had gone terribly wrong. She also could not stop vomiting.

When her three youngest children arrived home from school at slightly after 2 p.m., they found their mother on the bed, sitting up but under the covers. They did not see any blood but realized immediately she was not well. Carolina told them she felt sick to her stomach, and sent them to the health post to get some medicine for the uncontrollable vomiting.

The two boys and girl headed to the health post on foot, which was between their school and the house—approximately one kilometer away on a dirt road. The children arrived at the health post at approximately 3:30 p.m. It was vaccination day so the health post was filled with patients, and they had to wait quite a long time to be attended by the staff.

When the 10-year-old boy explained that their mother had an upset stomach, the midwife asked them why Carolina had not come herself and whether Carolina was pregnant. The boy said his mother was vomiting a lot and could not come but told her she was not pregnant, having no reason to believe she was. The midwife gave the children two medications for her, instructed them on the dosage, and told them to have their mother come in on Monday. The midwife prescribed dimenhydrinate (an anti-emetic) and ranitidine (an antacid).

The children raced back home as quickly as they could and gave their mother the medications. Carolina took the pills but immediately vomited them up. She could barely talk by this point and was lying down.

The children, evidently scared at seeing their mother in such a condition, ran to tell their neighbors that their mother was very ill. By this time it was almost 5 p.m. and the neighbors had returned from the lake with their *llacho* for the cows. Carolina's oldest son had also returned from school.

Carolina's father-in-law, Francisco, came home from the lake to find a group of neighbors in front of his house. He did not know what had happened and asked his oldest grandson. The neighbors who had come to the house found Carolina barely conscious. They lifted the covers on the bed and found her lying in a pool of blood that had seeped into the bed.

One neighbor, Enrique, took off on his bicycle to the health post. He arrived at a few minutes after 5 p.m. and the midwife immediately took a motorcycle and returned with him to the house, which was only a few minutes away on the motorbike. By the time they arrived back at the house, however, Carolina was completely drained of color. When the midwife examined her, she realized Carolina was dead.

After Carolina's Death

That night, health personnel at the closest hospital were notified of the death and went to the community to conduct an autopsy. The police were notified as well but did not go.

The health personnel arrived at approximately 8:30 p.m., and by that time a crowd of people had gathered outside. Apparently, the community initially thought that Carolina had died because of the medications that the midwife at the health post had prescribed. They soon realized what had happened, however.

Inside the house, the health personnel found the fetus wrapped in plastic. There was little blood on the floor and even much of the vomit had been cleaned up. Under the bed, they found soaked rags that Carolina had evidently been using to clean up after herself as she bled and vomited, possibly in an effort to cover up what was happening and not alarm her children.

The autopsy revealed that Carolina had been 12-13 weeks pregnant and died due to an incomplete abortion. The placenta had been retained and she had begun to hemorrhage and had gone into hypovolemic shock. A health professional who had been present at the autopsy told PHR that Carolina had completely ex-sanguinated; there was no blood left in her internal organs. There was evidence of prostaglandins found during the autopsy.

Carolina's father-in-law, Francisco, called Manuel in Tacna and told him what had happened.

The family continues to live in the same house. Now the children are cared for primarily by their grandparents. Manuel continues to travel frequently to Tacna. A neighbor said of Manuel "he's now an alcoholic and is very neglectful; he's completely abandoned his kids and their grandparents." The children still sleep in the same small room where Carolina died, the same room where they saw her die.

When asked about the incident, Francisco, the grandfather, said in Aymara, "I was shocked; it was as if she had been killed by a car, it happened so suddenly. My son is now alone, left with four children to care for. His depression causes him to drink and we, the grandparents, are left alone to care for the grandchildren." He also reflected, "We have experienced the misfortune that many women living here have experienced. "

Analysis

Carolina's case illustrates that an unwanted pregnancy is a high-risk pregnancy. As abortion is almost always illegal in Peru, Carolina was forced to carry out her plan in secrecy. She could not even bring herself to

have her children alert the health post when they first arrived from school, when she knew things had gone awry. Care for incomplete abortions requires many of the same capacities as those included as signal functions in EmOC, including IV or injection oxytocics. However, this delay in Carolina's decision to reveal the truth and seek appropriate care was directly related to the illegal status of the act she had undertaken.

Clandestine abortions are common throughout Peru and are a leading cause of maternal mortality. Abortion is criminalized in Peru except when necessary to save the life or health of the mother. Article 30 of the General Health Law requires health professionals to breach their duty of confidentiality and report cases of suspected induced abortion to the police.¹⁰⁸ Women who undergo abortions and the people who perform them are subject to prison sentences.¹⁰⁹

As in other countries where abortion has been criminalized, the procedure has been pushed underground. Studies estimate that there were approximately 371,000 induced abortions in Peru in 2006.¹¹⁰ A recent study published by the Peruvian Society of Obstetrics and Gynecology concluded that criminalization had not reduced the practice of abortion in Peru.¹¹¹

Some cases of incomplete abortions end up in health establishments. For example, between January and March of 2007, hospital data from the Regional Hospital in the city of Puno indicate that there were 119 abortions, of which the Chief of Obstetrics and Gynecology, Dr. Luis Enriquez, estimated that a high percentage were induced abortions, rather than spontaneous abortions (i.e., miscarriages).¹¹² In the much smaller hospital in Ilave, PHR was told that there is at least one case of abortion per day. The hospitals in Azángaro and Juliaca did not provide numbers on abortions, but staff at both establishments acknowledged that complications from incomplete abortions were commonly seen in the hospitals.

In the city of Juliaca, PHR observed entire blocks filled with small medical offices that announce "pregnancy tests." PHR was informed that these private offices offer abortions to women whose pregnancy tests are positive and who do not want the children. An abortion in the department Puno reportedly costs approximately 100 *nuevos soles* (approximately USD 30) in cash, but providers also routinely accept jewelry, radios, television sets and other electronics.¹¹³

Many abortion providers are wholly untrained and unscrupulous. PHR learned that in addition to older methods of abortion, some of these providers offer the ostensibly "safe" manual aspiration technique. Manual

vacuum aspiration (AMEU by its Spanish acronym) abortion is a surgical procedure, and may also be called a menstrual extraction. This abortion can be done between 3 and 8 weeks from the date of the first day of a woman's period, although some physicians use the procedure up to the 12th week of pregnancy. An AMEU can be done at a physician's office or in a hospital setting, since it does not require electricity or complex equipment and can be performed under local anesthetic. However, PHR learned that the widespread use of AMEU by untrained persons has led to cases of perforated uteruses.¹¹⁴

Despite abortion being illegal, it was easy to find advertisements for abortion services in the *Correo de Puno* newspaper, and PHR was informed that these are also frequently run in national tabloids, such as *Ajá*.

In fact, there appears to be little enforcement of abortion laws in Peru. One key informant told PHR that Article 30 of the General Health Law, which requires doctors to denounce abortions to the police, provides an opportunity for doctors to extract money from poor women by threatening to denounce them if they do not pay.¹¹⁵ Another key informant told PHR that the police also use the criminalization of abortion as an opportunity to extort money from poor women who cannot afford to go to private clinics, hanging around public hospitals waiting for a likely case or being tipped off by health professionals on the staff.¹¹⁶ Women in a focus group PHR conducted in Carabayllo stated that this occurred at the Hospital Collique in Lima.

One senior physician stated to PHR "Article 30 [of the General Health Law] is a real problem. We don't follow it except in cases where the woman will likely die because then we know there will be a police investigation. But it is still on the books. Article 30 needs to be changed."

Numerous key informants told PHR that it was easy to obtain an abortion in a private clinic or in a private contractual arrangement with a physician if a woman has economic resources. The criminalization of abortion in Peru, in practice, punishes poor women and puts them at risk of dying due to complications.

There is currently a vigorous debate in Peru about the definition and protocol for "therapeutic abortions," which are defined very restrictively under present law. In February 2007, CEDAW recommended that Peru "review its restrictive interpretation of therapeutic abortion, which is legal, to place greater emphasis on the prevention of teenage pregnancies and to consider reviewing the law relating to abortion for unwanted pregnancies

A focus group conducted by MINGA Peru in Loreto with health promoters in April, 2007, identified a high percentage of unwanted pregnancies resulting in abortions as being attributable to sexual violence as well as to a lack of access to contraception. Abortion rates are believed to be particularly high among adolescents in Loreto.

with a view to removing punitive provisions imposed on women who undergo abortion."¹¹⁷

The failure to treat abortion as the true public health problem that it represents in Peru is also reflected in the SIS, which does not explicitly include post-abortion complications under what was Plan C. The term "obstetric emergencies" under the former Plan C of the SIS requires clarification with respect to the inclusion of treatment for incomplete abortions.

Dr. Enriquez, the chief of Obstetrics and Gynecology at the Regional Hospital in Puno, stated that he believed that the widespread availability of misoprostol was responsible for a recent increase in the number of abortion cases.¹¹⁸ On the national level, estimates indicate that induced abortions have increased from 352,000 in 2000 to 371,000 in 2006.¹¹⁹

Another possible reason for the large number of abortions is the lack of available contraception, a key component of women's rights to reproductive health care. In this case, Carolina had stopped using contraception because her husband forbade her.

In addition, however, studies have documented a decrease in contraceptive use and availability since the National Family Planning Program was restructured to become a component of Women's Health Care in 2001. Key informants described to PHR how family planning had lost priority, personnel, resources and dynamism, and as a result, how there had been serious problems in the provision of reproductive health services and in particular, family planning services.¹²⁰ Distribution of contraceptive methods to establishments was slow, erratic and delayed. PHR observed a shortage of Depo-Provera in particular, which is consistent with national data indicating that in 2003, half of the health care establishments lacked injectables.¹²¹ Numerous reports have been issued that detail the problems in availability of and access to family planning.¹²²

Carolina's tragic story illustrates the lack of agency that women have over their own bodies. She desperately did not want more children. Her husband drank and left her to deal with the house and farm and children for

long periods of time. Carolina was certainly the victim of emotional violence, if not physical violence. Her husband forced her to stop using contraception and Carolina had no control over when and whether she had sexual relations. Her lack of autonomy over her body led directly to her unwanted pregnancy and, indirectly, to her death.

There is a dearth of institutional support for women such as Carolina in Peru. ENDES data from 2004 indicates that a minority of women suffering from domestic violence ever seek help from anyone, let alone institutions. Women who are uneducated and poor are even less likely to do so.¹²³ Poor indigenous women face the same economic, physical, and cultural barriers to institutional support for domestic violence as they do to EmOC and too often the two dimensions of exclusion work in unfortunate synergy to put them at increased risk of maternal death.

B. Huancavelica

By many measures, Huancavelica is Peru's most impoverished department and it has one of the highest maternal mortality ratios in the country, with 302 deaths per 100,000 live births in 2000.¹²⁴ The department's population was approximately 460,000 in the year 2004,¹²⁵ with just over 70% residing in areas classified as rural.¹²⁶ This stands in stark contrast to Peru as a whole, where approximately 70% of the population lives in urban areas. The average family in Huancavelica has 6.5 children—also far higher than the national average—and 56% of the population is under 19 years old. As recently as 2000, 52% of the region's population was female¹²⁷ and significantly undereducated, with illiteracy levels reaching 48% among women.¹²⁸

The statistics on poverty in this highly indigenous department are sobering. According to INEI, 88% of Huancavelica's population lived in poverty in the year 2001.¹²⁹ Seventy-four percent of the population lived in extreme poverty that year.¹³⁰ As many as 89% of households had unmet basic needs,¹³¹ corresponding to 92.2% of the entire population in the year 2000.¹³² Malnutrition affects more than 70% of the department's population,¹³³ and roughly 72% of the department's primary school-age children suffer from chronic malnutrition.¹³⁴ An average of 107 children per 1000 die before their first birthday.¹³⁵ The region had one doctor for every 15,000 inhabitants in the year 2000,¹³⁶ although another source reports that there were 122 doctors working in the department—that is, roughly one in every 3,800 inhabitants—in the year 2005.¹³⁷

Huancavelica's oppressive poverty is particularly shocking in light of the fact that it supplies approxi-

mately one-third of Peru's electricity. At the same time, less than one third (31%) of its population has access to electricity.¹³⁸ The poverty of the population also contrasts starkly with the mineral wealth of the department.¹³⁹ In addition to reserves of zinc, lead, iron and copper, Huancavelica ranked seventh nationally among regions in both gold and silver production from January 2005 to February 2006.¹⁴⁰ Nonetheless, Huancavelica's share of revenues from the mining sector has been low given the extreme poverty afflicting the region. The department received just 0.5 percent of the mining royalties distributed in 2005.¹⁴¹

Huancavelica, unlike Puno, is in the middle of the country. It is not accessible by commercial air flights. In fact, not all commercial bus lines operate in Huancavelica, which is marked by treacherous, winding roads. From Lima, it is an approximately seven-hour bus ride to Huancayo, the capital of the neighboring Junin, and another few hours in a four-wheel drive vehicle to Huancavelica, the eponymous capital of the department. One consultant to PARSalud I who had worked in both Cusco and Huancavelica noted that in contrast to Cusco, which has an airport and attractive tourist destinations, no one from the IDB (The regions were divided and Huancavelica was assigned to the IDB under PARSalud I) had ever come to Huancavelica to inspect how PARSalud I monies were spent: "Where no one ever goes—that's where the truth is in this country."¹⁴²

Death Strikes Twice: Evarista

Evarista Paquiyauri Osorio was 33 years old, when she died at home on November 19, 2006, of postpartum hemorrhage due to retention of the placenta.



Alejandro Noa Huincho.

Photo: Carlos Cárdenas Tovar

Alejandro's Life Before and With Evarista

Alejandro Noa Huincho is a subdued forty-two year old man who completed primary school and supports himself through subsistence agriculture. He speaks some Spanish but is more comfortable in Quechua.

Alejandro moved to the village of Cieneguilla from a neighboring community eighteen years ago, shortly after Cieneguilla was founded. He had moved along with his family and that of his older brother, Odilón, in hopes that they could get a bit more land to farm. Cieneguilla is several hours away from the department capital by car. It is a community of about three hundred residents, divided into different sectors, typical of communities in the Peruvian Andes. It was founded 20 years ago and its inhabitants are virtually all subsistence farmers like Alejandro. Cieneguilla can be reached by walking for approximately two hours up a steep hillside from the slightly larger town of Carhuapata, which is also the location of the nearest health post. The village itself is surrounded on three sides by steep mountains. Although Cieneguilla can be reached in a car or truck from the poorly maintained dirt road, few of its residents have access to such means of transportation, making the location yet more remote.

Alejandro met Evarista Paquiyauri Osorio eleven years ago when she was working on a nearby farm. Evarista was originally from another village about an hour away from Cieneguilla. She was almost ten years younger than he was and had a pretty face, according to Alejandro. Alejandro recalled Evarista as cheerful and even playful, which must have appealed to him.

Evarista and Alejandro dated each other briefly before deciding to live together. They did not formally marry, but entered into a common-law marriage (*convivencia*), as is common in the southern Sierra of Peru. At the time of their union, Evarista was already pregnant with their now ten-year old son, Marino. They subsequently had three other children together: Braulio (3), Santa Elena (2), and the baby, Maria Isabel (1½ months at the time of the interview). Another child died in infancy.

Evarista was Alejandro's second common-law marriage. He entered into his first union at the age of 18, and had two children with his first wife. But in the seventh month of her third pregnancy, Alejandro's first wife fell ill. She suddenly started complaining of terrible headaches and nausea, and he remembers that she may also have had some diarrhea. Alejandro made her different *mates* (herb teas) for the headaches and bought her aspirin but nothing seemed to alleviate her pain. According to Alejandro, he did not take her to the health post because, "at that time, we didn't have an

obligation to go to the health post, even though we now have that obligation."¹⁴³

In the early 1990's, no social insurance scheme existed in Peru and health posts were equipped with fewer resources than they are today. His first wife had no relationship with the health post, had not delivered either of her children there, and Alejandro apparently saw no reason to take her to the health post when she fell ill. The headaches became worse and she died after a few days, quickly, and there was no evidence of bleeding, fever or other symptoms. The precise cause of his first wife's death is unclear; an autopsy was never performed and she was never evaluated by a health professional. However, given her complaints it is plausible to surmise that she may have been suffering from pre-eclampsia, which then escalated to eclampsia.

When Alejandro's first wife died, he was left alone to raise two small children. In fact, according to Alejandro, he married Evarista so that she could take care of his children from his first marriage. Often a second partner will shun or neglect children from a previous union, although this was apparently not the case with Evarista. According to both Alejandro and Godifredo, his son from his first marriage, Evarista always treated the children as her own, and they came to think of her as their mother and cared for her a great deal.

By all accounts, Evarista was both cheerful and hard-working (*trabajadora*), which is considered an essential trait in a woman in indigenous communities in the rural Andes.¹⁴⁴ Her family described her as a good cook, and said that she did a good job of taking care of the children and helping with the farming. She did everything around the house—cooking, cleaning, laundry, and child care—and would also come out and help Alejandro with their *chacra* (farm).

The couple lived together with their children in a small home near the center of one sector of the village, while the fields farmed by Alejandro were located further up the mountain. Like many houses in the area, their home consists of a few small adobe buildings surrounding an open courtyard in which many daily activities are carried out. Although they have certain amenities such as electricity, the buildings all have simple dirt floors and thatched roofs. The village church and school are both within a few blocks of the house.

Unlike many families in the area, however, Alejandro and Evarista had a videocassette player. In the evenings, he and Evarista would chew on coca leaves and watch videos with the children. Evarista only watched videos in Quechua, as she did not speak or understand Spanish.



Alicia Ely Yamin and the family of Alejandro and Evarista outside their home.

Also, she did not like the fact that so many of the Spanish-language videos were filled with violence. She preferred the videos in Quechua, which had singing and dancing, and would watch those over and over again in the tiny bedroom they shared with the children.

Evarista's four children were all born at home without any problems, although one later died. According to Alejandro, Evarista went for prenatal checkups during all of her pregnancies.¹⁴⁵ She was insured through Plan C of the SIS, the social insurance scheme and, according to the medical records, she had three prenatal visits in her fifth and last pregnancy.¹⁴⁶ She attended the prenatal check-ups alone; Alejandro did not accompany her to the health post in Carhuapata.

Evarista planned to give birth at home, despite reported admonishments from the staff at the Carhuapata health post to plan to deliver at a health facility. Evarista had no signed birth plan, which would have indicated that she and the personnel at Carhuapata, where she received her prenatal care, had agreed upon the terms of where she was going to give birth.

Evarista Gives Birth, but a Crisis Quickly Emerges

On the night Evarista gave birth, she had spent the day with Alejandro in Lircay. Alejandro had gone to vote in the municipal elections, and they had eaten lunch out in a restaurant. After walking the considerable distance back home and feeding the animals, they retired to bed. At that time, everything seemed normal and calm to Alejandro; Evarista was simply chewing coca leaves as she typically did in the afternoon and evening.

In the middle of the night, at approximately 2 a.m., Evarista awoke in a great deal of pain; the contractions

had started. Alejandro gave her oregano tea for the pain and put warm salve on her back and wrapped a wide band (*faja*) around her, as is typical of home births in the Andes. The band is meant to keep the uterus from moving up and gives women some sense of security.

Their baby, Maria Isabel, was born about an hour later, just after 3 a.m. When the placenta did not come out, Alejandro knew something was wrong. However, he did not immediately go to seek help at the health facility. Instead, he went to get his brother, Odilón, who lived nearby. Seeing the situation, Odilón told his brother that they should immediately notify the health post. There was no phone or radio in the community, so at approximately 3:30 a.m., Alejandro dispatched his son from his first union, Godifredo, to the health post to notify them of the emergency.

It had rained most of the night and Godifredo walked all the way down the steep, rocky mountainside to the health post in Carhuapata because there was no other means of transportation available. It took him approximately ninety minutes to reach the health post. He moved as quickly as he could, but the journey was particularly difficult because it was still dark outside and he did not have even a flashlight to assist him. In addition, the muddy conditions from the rain must have made the journey particularly challenging.¹⁴⁷

The Carhuapata health post is classified as an FOP. It is equipped to provide routine prenatal care and attend to uncomplicated vaginal deliveries that are already in process. However, the collective abilities and resources at the post are limited with regard to responding to obstetric emergencies such as that experienced by Evarista.

When Godifredo arrived at Carhuapata at approximately 5 a.m., the night guard called to Isabel, the nurse's aide, who was on call and came within a few minutes. He told her what had happened and that he was worried Evarista would die. Despite the emergency and the fact that the doctor and midwife live next door to the health post, neither of them were awakened to assist with the emergency. Instead, Isabel left with Godifredo to try to find a vehicle to return to the home.

While Godifredo was going to the health post, Alejandro went to find the community's traditional birth attendant/community health promoter, Mauricia. Meanwhile, Odilón, who had come to the house with his wife, Albina, stayed with Evarista, and Odilón held her in his arms. Evarista's condition continued to worsen; she was losing blood and the placenta still did not come out.¹⁴⁸ Growing desperate, Albina ran out of the house and called out to Alejandro to come back because she and Odilón were



View from Cieneguilla towards town where the Carhuapata health post is located.

afraid Evarista was about to die. Alejandro hurried back to the house and the traditional birth attendant/community health promoter, Mauricia, arrived approximately 40 minutes later but was unable to do anything for Evarista. Mauricia told PHR, “She was already gone by then.”

Isabel, the nurse’s aide from the health post, arrived at their home in Cieneguilla a few minutes after Mauricia, at around 6 a.m. Although it should only have taken Isabel 30–40 minutes to arrive, her trip was delayed because the health post is not equipped with an ambulance or any form of transportation. Isabel and Godifredo had to wake up a man who lives in Carhuapata, who drives a taxi and is often willing to use his car to drive for health emergencies. In this case, he agreed to take Isabel and Godifredo and they headed back up the mountain to the house. However, about halfway there, the car punctured a tire. Their arrival in Cieneguilla was delayed for approximately twenty minutes more as they stopped to repair the punctured tire.

After arriving at Evarista’s and Alejandro’s home, Isabel attempted to insert an IV tube into Evarista’s veins, but they had already hardened.¹⁴⁹ She told the family that Evarista had already died. According to Alejandro, Isabel scolded him, saying that his wife had died because he had waited too long to take her to the health post.¹⁵⁰

Alejandro’s Life Without Evarista

Evarista’s body was taken to Lircay for two days for the autopsy to be performed at the health center there. Although an autopsy is required by Peruvian law when a person dies at home rather than at a health facility, it is unusual that it had to be carried out in Lircay, rather than at the closer health post in Carhuapata. As a result, Alejandro had to pay for his transportation and room and

board in Lircay while his wife was being autopsied. None of those expenses were covered by the SIS.

The cause of death was recorded as hemorrhage due to retention of the placenta. Evarista’s body was then returned home to be buried in the crowded village cemetery in the mountains above their home. Alejandro owns only one photo of his wife from their wedding day, mounted on cardboard, which he keeps inside their small bedroom, a bedroom he now shares with the children.

Just a little more than a month after her death, Alejandro remembered Evarista as a good wife and missed her greatly. He did not know how he would manage with the four children he now has to raise. Asked how he understood or made sense of having lost not one, but two wives—and in all likelihood both to pregnancy-related complications—Alejandro bowed his head and paused before replying that “Destiny—God—determines when a woman dies, when anyone dies.” But he added that he was filled with remorse for not having done everything possible to save Evarista and kept asking himself what more he could have or should have done.”¹⁵¹ The staff at the health post had made him feel that her death was entirely his fault.

Because Maria Isabel was not born at the health post, Alejandro had difficulty obtaining a birth certificate for the infant. Alejandro was told repeatedly at the Carhuapata health post that obtaining a birth certificate would cost 50 *nuevos soles* (approximately USD 16), because it had been a home birth, although this is contrary to Peruvian law. Without a birth certificate, Maria Isabel cannot be registered in the SIS, and cannot get access to vaccinations or government benefit programs. As an adult, she would not be able to obtain a national identity document, or DNI, and therefore could not vote.

The health professionals at the Carhuapata health post asserted to PHR that the previous community leaders (who had subsequently changed) were in agreement that Alejandro had to be punished for his behavior. The health post staff alleged that he had let his first wife die and now he had let his second wife die, because he failed to notify the health post as soon as she went into labor. The imposition of a fine for the birth certificate, they explained, was a means of “teaching him a lesson.” Three of the newly-elected village leaders (*autoridades*) did not seem to be in agreement with this policy. These community authorities told PHR that the imposition of fees to obtain birth certificates was a widespread practice at the health post and was essentially a fine for delivering at home.

Alejandro received a birth certificate when investigators from the PHR team argued on his behalf at the

Carhuapata health post and on behalf of Maria Isabel, whose right to identity was being denied.¹⁵² Maria Isabel was subsequently vaccinated, as she had not been accepted for vaccination previously.

Alejandro is now faced with taking care of four small children, ranging in age from infancy to ten years old, on his own. A little over a month after Evarista's death, he told PHR the children were not eating well. He said they were so sad that they had lost their appetites. He, himself, was overwhelmed with the burden he had to bear as well: "I do everything alone. I cook, I wash the children's clothes, I take them to school, I do everything and I feel totally alone." In particular, "now that my oldest sons [from my first union] are leaving to work in the jungle, I am going to be very, very alone. I miss her a great deal."¹⁵³

Godifredo and his brother planned to leave for the jungle to do logging work in the days or weeks following the interview with Alejandro. It was clear that they were Alejandro's principal support. Godifredo's wife, Tomasa—Alejandro's daughter-in-law—was helping to breastfeed the baby, Maria Isabel. She had stopped breastfeeding her own baby over a year before but after days of frustrated nursing with the newborn, her milk started to flow again with Maria Isabel. Tomasa told PHR that she would like to adopt her and raise her as her own.¹⁵⁴

Alejandro and Evarista's other daughter, Santa Elena, who is only two years old, seemed to be having the hardest time coping with her mother's death. She was tearful and had stopped eating well.

A little more than a month after losing his second wife, PHR was told that Alejandro was already thinking of finding another woman to raise his children, because it was simply not possible to manage alone.

Analysis

A variety of factors resulted in Evarista being unable to receive the necessary medical attention in time to treat her obstetric emergency. There were delays in making the decision to seek care, delays in having care arrive and delays in receiving treatment. Underlying those delays are deficiencies in communication and transportation, cultural distance between the health establishment and its users, and questions relating to gender roles and inequality.

In this case, intravenous fluid resuscitation, manual removal of the placenta, and medications that contract the uterus, may have been lifesaving if Evarista had received them sooner and she had been transferred to another facility capable of providing basic EmOC. However, there were other factors relating to the availability, accessibility, acceptability and quality of care that led to the delays in the decision to seek care and the long time that it took Godifredo to arrive at the health post.

First, there is a significant lack of outreach within the community that would ensure that couples are aware of and prepared for complications, should they arise during pregnancy or delivery. Families are often unable to recognize and plan for obstetric emergencies, and they may even be afraid of visiting the health post. Given Evarista's *grandmultipara* status (this was her fifth pregnancy), both she and her husband should have been educated as to the possibility of having a complicated delivery. It is unclear whether such a discussion occurred at the time of her prenatal visits. Alejandro asserted that they never planned to deliver in the health post, although the staff at the health post claimed that they stressed to Evarista and to all patients the importance of delivering in a facility. However, based on her prenatal record, there was no documented plan for her to give birth at the health post instead of at home (*plan de parto*).

There is a general question about the utility of these birth plans, given the lack of communications and transportation to put them into effect in the event of an emergency. Further, it is reasonable to wonder whether the health system would really have the capacity to provide care for all pregnant women if they somehow managed to arrive at the nearest FOB or FOE.

In this case, however, despite having insurance coverage, Alejandro and Evarista never planned to give birth at the health post or at the health center in Lircay because they were afraid that Evarista would need a c-section and require an expensive transfer to Huancavelica, the capital of the department. Alejandro explained, "Evarista had always given birth normally at home, without problems. Because of this, we had confidence that this birth



Tomasa Huincho with María Isabel.

would also be normal. ... She didn't like to go to the health post, and I was afraid that they would cut her, operate, or transfer her to Huancavelica. Because of this fear, we did not go to the health post." Alejandro would have had to pay for any transportation other than an ambulance, which was not readily available.

Further, PHR confirmed previous studies that have found that many campesinos associate delivering at a health facility with having a c-section and do not seem to be aware of the indications for a Cesarean section.¹⁵⁵ The fear of Cesarean sections is prevalent. There is an enormous reluctance for a woman to be "cut" and a belief that after a Cesarean she will be "useless" or not able to work. Campesina women are valued for how hard-working they are—a quality that Alejandro mentioned several times to PHR about Evarista. This is understandable, as life is extremely hard in the mountainous and inhospitable terrain, and couples need to have both partners working very hard just to survive.¹⁵⁶

Very little, if any, effort seems to have been made to bridge these cultural distances with the health system and to allay these fears—in this case, to explain to Evarista and Alejandro the narrow circumstances under which a Cesarean section would be necessary, what the surgery entails, and what recovery would be like for Evarista in the event that such a surgery were required. Consequently, the relationship with the health post—and the health system in general—was one of extreme emotional distance and distrust, which certainly may have influenced Alejandro's decisions during Evarista's labor and as the crisis unfolded.

More broadly, this case points to the need for accessible information about maternal health and obstetric emergencies through targeted radio spots, radio soap operas and other means of mass media dissemination.¹⁵⁷ In particular, it would be useful to have programs relating to the signs of obstetric emergencies, and the importance of seeking assistance, if at all possible, when a woman's labor pains begin. Because post-partum hemorrhage can develop unpredictably and result in death very quickly (often within a few hours) once the hemorrhage begins, it can be too late if there are no means of communication and if transportation is not readily available.

As most people in rural Peru do not read newspapers or watch television, radio is the most effective means of communicating such messages.¹⁵⁸ According to data from the ENDES in 2004, 63.4% of the rural population listens to the radio at least once a week, in comparison with only 10.3% that reads a newspaper or magazine once a week and 28.3% that watches television once a

Bienvenida Salud ("Welcome Health")

Radio is an invaluable social communications tool throughout a country such as Peru, with such dispersed populations. In connection with PHR's investigation, MINGA Peru is launching a radio notice on its program, "Bienvenida Salud," soliciting callers to share their personal experiences related to the theme of maternal mortality. The results of the investigation are also being presented through a radio serial segmented into 25 episodes, which will be aired three times per week to an audience of approximately 65,000 listeners in the Amazon regions of Loreto, San Martín, Huanuco and Pucallpa.

week.¹⁵⁹ NGOs have found that social communication is more effective when based on and derived from the realities of listeners, through radio soap operas for example, rather than prescriptive announcements.

This case points to more than a lack of information with respect to obstetric emergencies and their treatment. There appears to be an overarching poor relationship between the workers at the health post and the surrounding communities the health post is intended to serve. Alejandro pointed out that his neighbors also avoid the health post. From the perspective of the workers at the health post, Dr. Yoshira Zamora Salas argued that they lack support from the community elders, and, as all of the staff at the health post are women, they struggle with machismo in the communities.¹⁶⁰ The community elders interviewed by PHR did not even want to accompany the team back down to the health post to learn more.

This case is typical of many across Peru, where there is a failure of communication and understanding between the health system and the community.¹⁶¹ It illustrates how cultural and emotional distances exist between health system users and health establishments, which can create significant barriers to access, above and beyond financial ones. PHR found that in this case, as in others, health professionals were quick to ascribe reluctance to give birth in health facilities to "cultural beliefs" and "idiosyncrasies," while at the same time making no systematic efforts to engage in dialogue with communities about what their preferences for childbirth are, or how the health establishments might compromise on the way in which care is delivered to meet the community half way.

The staff at the Carhuapata health post described the lack of dialogue and communication with community members and authorities as a key obstacle to treating

obstetric emergencies and preventing maternal mortality. Notably, this lack of dialogue was present (and noted by the community members as well) even though the doctor and other staff members at the Carhuapata health post spoke Quechua. This indicates that sharing the language is a necessary but not sufficient condition to establishing good communication, and that communication involves more than the transmission of information, but rather a relationship.

Such a relationship was starkly absent in the case of Carhuapata and is often lacking in rural areas of Peru. As a result, descriptions of education and training relating to maternal health that were provided to PHR by health professionals in Carhuapata and elsewhere in Huancavelica, largely involved health professionals “talking at” community members or individual couples, rather than engaging in horizontal dialogue with community members to understand their apprehensions, needs and perceptions.

PHR documented a punitive attitude toward patients within the health system itself. In this case, for instance, Isabel told Alejandro that it was “all his fault” that Evarista had died. The staff at the health post felt that he needed to be punished for failing to notify the health facility immediately when Evarista went into labor. Consequently, they were withholding Maria Isabel’s birth certificate until he paid a *de facto* fine. They also believed that the community elders should separately punish Alejandro by imposing a sanction (*sanción*) on him, which would generally take the form of a separate fine or communal labor.

As noted in other cases, the imposition of *de facto* fines on women who have home births as a means of coercing institutional births, is widespread in Peru. PHR found that community members asserted that the Carhuapata health post followed this practice; it is also common in many areas of rural Peru. Indeed, the report issued by the Defensoría del Pueblo (Human Rights Ombuds Office) after its 2004-05 investigation found the practice “widespread.” As a result of that report, a new MINSA norm outlawing the fines was enacted.¹⁶² However, enforcement of the norm has been highly variable and in many health establishments, the staff does not even seem to be aware of it.

At the same time as these coercive measures are applied to patients and health system users, the professionals working in the health system are, themselves, subject to a punitive and irrational system. Isabel, the nurse’s aide who attended Evarista that morning, was either fired or transferred immediately after Evarista’s death, despite the fact that it is unlikely she could have

done anything more than she did.¹⁶³ This is typical of what happens in cases of maternal death, where someone tends to be scape-goated. PHR found that in Huancavelica and elsewhere, health professionals who work at periphery establishments on contracts that provide for termination at will are routinely subject to summary dismissal when they are associated with a maternal death. This was the case with Isabel. These widespread practices are not related to true accountability and tend to create perverse incentives for people working at health establishments to avoid handling cases of emergency for fear of being fired.

Another factor of note in this case is not so much that Evarista’s husband delayed his decision to seek care from the health post, but that all the necessary decisions were made by male members of his family. Evarista’s family was entirely absent as she had moved from her community to Cieneguilla to live with Alejandro.

Apparently believing it would be a normal delivery, when Evarista’s labor pains started, Alejandro did not seek medical care for his wife. Nor did he immediately seek care when the placenta did not come out. Instead, it took the urging of his brother to provide the impetus to seek care after waiting at least half an hour. Significantly, only men were consulted in the eventual decision to seek care. Alejandro consulted with his brother, Odilón, but never with females either in the household or community. Evarista herself had no vote in the decision-making process from the outset, even though it fatally affected her. This dynamic has been documented in prior studies of Peru’s maternal mortality problem as well.¹⁶⁴ In times of crisis such as obstetric emergencies, although mothers-in-law can play important roles, husbands and the other men of the family tend to take control of the decision-making. This reflects a basic divide in gender roles, as well as the fact that the men of the family typically control its economic resources, which often become necessary in times of crisis.

But male domination of women’s bodies and reproductive decisions begins long before an obstetric emergency. Decisions regarding contraception and use of health-care are often made by men in rural communities in Huancavelica and elsewhere in Peru. In Evarista’s case, despite being informed of family planning at the health post, Alejandro had not wanted to use any family planning method and therefore they did not utilize any, including the rhythm method. According to Dr. Zamora, it is difficult to get women to come into the Carhuapata health post or to use family planning because their husbands make these types of decisions for them.¹⁶⁵

This case also highlights critical elements impeding access to and delivery of care once a decision is made to seek care. That is, there was no means of communication between Cieneguilla and the health post and there was no readily available means of transportation to or from the health post.

There is no radio or similar means of communication available to the residents of Cieneguilla. Therefore, in cases of obstetric or other emergencies, residents cannot immediately communicate with the health post in Carhuapata. Had there been a radio in Cieneguilla, Alejandro would have been able to communicate with the health post and Godifredo's treacherous hour-and-a-half walk down the steep muddy hillside would have been averted. With that savings of time, it is possible that Evarista could have been stabilized by the nurse's aide from the health post long enough to transfer her to a larger health facility where she could have received treatment.

In this regard, the situation in Cieneguilla is all too typical. PHR found, and confirmed with key informants and health professionals, that it is rare in Huancavelica and elsewhere in rural Peru for there to be a radio or other means of communication, such as a telephone or cellular phone, available to a community. According to the ENDES in 2004, only 3% of rural households across Peru had telephones.¹⁶⁶ In Huancavelica, the situation is particularly stark, with only .62 telephone lines per 100 residents, in comparison with Lima which has 34.38 lines per 100.¹⁶⁷ There are no telephone lines in Cieneguilla and no cellular phone coverage.

Radios and telephones are more likely to be available at health posts, but there is a significant delay in communicating an emergency when, as in this case, the health post is located at some distance from the community itself. Health professionals with whom PHR spoke repeatedly noted that lack of communications was a major obstacle in treating obstetric emergencies in a timely manner. Yet until now neither public monies nor health sector restructuring funds through PARSalud I have been used to purchase radios for communities in Peru.

The lack of communication was compounded by an equally serious lack of transportation, a factor that everyone involved from the community and the health post cited as a major obstacle to addressing maternal mortality. Like most residents of Cieneguilla, Alejandro did not have any means to reach the Carhuapata health post other than simply walking. Therefore, his son Godifredo was forced to walk for one-and-a-half hours in complete darkness down a rocky and muddy mountain-

side in the rain.¹⁶⁸ The health post does not have a ready means of transportation and instead relies on a nearby resident to make himself and his car available.¹⁶⁹ This resident works as a taxi driver and often is not available to the staff at the health post. The nearest ambulance is located at the health center in Lircay, over an hour away. In this instance, the nurse's aide managed to convince the man to take her in his car, but additional maintenance was necessary before they could make the trip back up the mountain to Cieneguilla. The disrepair of the road also led to a punctured tire, further impeding the prompt arrival of medical assistance. By the time medical care arrived at the house, Evarista had already passed away.¹⁷⁰

Additionally, the health post did not send its most extensively trained personnel to manage the obstetric emergency. Neither the doctor, who has worked there for three years and is appointed, nor the midwife or nurse, went to attend the emergency. Instead, Isabel, a nurse's aide, was dispatched to Cieneguilla, despite the fact that there are significantly varying levels of training. It is unlikely, for example, that Isabel would have been able to manually extract the placenta, which she knew from Godifredo's description to have been retained. In this case, Evarista had died by the time that Isabel arrived, but it is distressing that the health post did not mobilize its most qualified personnel—Dr. Zamora—to deal with such a stark emergency.

Finally, it is notable in this case that Alejandro and Evarista had come from voting in the municipal elections in Lircay on the day she went into labor. Several studies done in Peru have found that rural women often do not vote because they lack identity documents.¹⁷¹ Political participation is a necessary, but admittedly not sufficient, condition to express a voice in policies that affect health and well-being. In Huancavelica, as elsewhere, capture of the regional government by urban elites is replicating the disparities that exist at the national level.¹⁷²

A Precarious Success: Tomasa

Tomasa Talpe Vargas was 40 years old when she survived complications due to retained placenta in her tenth pregnancy. She lives with her family in the Community of Tantaccato and is part of the Chopcca nation.¹⁷³

Tomasa and Lucio

Tomasa and Lucio have grown up together. Tomasa is shy at first and defers to Lucio and wants to be interviewed only with him present. He smiles recalling how pretty she was when they first met, and she smiles too. They were



Tomasa and Lucio in their bedroom.

both twenty years old when they were joined in a common-law marriage and had already been dating for two years at that point. Their parents arranged the union for the couple. Tomasa and Lucio grew up together in the small community of Tantaccato in the Chopcca nation—a distinct ethnic group of Quechua-speaking indigenous people—and subsequently lived there until moving up the mountain to their present location. Their move was prompted by a desire to be closer to Tomasa’s aging parents, who could no longer take care of themselves well.¹⁷⁴

Tomasa, Lucio and their seven children live on an extremely remote mountainside in a compound made up of four small buildings. Their home is at one of the highest elevations possible on a windswept mountain top (puna). The small villages below are not even visible from their home, and their house can only be reached via a steep and narrow dirt road.

All the buildings have dirt floors and thatched roofs. There is no running water, radio or electricity. In order to get water, Tomasa and her children have to walk down the mountain to Tantaccato and carry the water back up the mountain, which can be an arduous journey.¹⁷⁵ Even during the day, the houses are extremely dark since they lack both windows and electricity.

Tomasa and her family plant only a few crops, mostly potatoes, on the steep mountainside outside their home. They have a few animals in their pasture, mostly sheep. With such meager resources, there is not enough food to eat three meals a day. The children eat breakfast and dinner, usually a watery soup based on potatoes. They rarely eat meat, as it is simply too expensive to use their animals for food instead of selling them.¹⁷⁶

Tomasa completed only two years of primary education, is illiterate and speaks only Quechua. Her family did not have enough money to continue sending her to school.

Now, except for the eldest, Nancy—herself a teenage single mother—all of Tomasa’s school-age children still attend school daily, despite having to get up at 5 a.m. to complete the two-hour walk down the mountain. Even with limited financial resources to support her children’s continuing education, one of Tomasa’s dreams for them is to complete their education, as she was unable to do so.¹⁷⁷ Lucio echoes this sentiment, saying, “As parents, we want them to study more than anything. But we are poor, and lack the resources [to pay for years of schooling and school supplies].”¹⁷⁸

Tomasa and Lucio have seven children, ranging in age from 16 to the baby, who was six months old at the time of PHR’s interview. Although this was her tenth pregnancy, her first three children died in infancy due to complications from acute respiratory infections. At that time, the nearest health post was much farther away from their home, and no public insurance scheme existed to help defray the costs of care and medicines. In each pregnancy, Tomasa had given birth at home; she had not experienced any complications previously. Lucio helped deliver all the children and commented to PHR that they were normal.¹⁷⁹

During her most recent pregnancy, Tomasa went to the health post in San Juan de Ccarhuacc for prenatal checkups. This was the first pregnancy for which she sought and received prenatal care. She visited the health post a total of six times and had a good relationship with the health aide (*técnico*), who spoke Quechua. When she went in for her last check-up just a few days prior to giving birth, the midwife told her she was a very high-risk patient and urged her to contact the health post immediately upon onset of labor pains.¹⁸⁰ She explained the alarm signals to both husband and wife. According to Lucio and Tomasa, the midwife also threatened that if they did not come to the health facility, they would have to pay for the birth certificate of the child.

Life-Threatening Complications While Giving Birth

At 10 p.m., on the night of June 23, 2006, Tomasa’s first labor pains started. Heeding the advice of Isaías, the midwife and health aide from Pantachi Sur in whom both Tomasa and Lucio had substantial confidence, their oldest daughter Nancy sought help at the Pantachi Sur health post, which is located down a treacherous mountainside from the house. However, not having even a flashlight, she was scared to leave until there was enough light outside to safely make the journey, which was at approximately four in the morning. Upon arriving at the health

post, Isaías was not there. Nancy tried to use the radio to call for help to other health facilities, but the call was not heard for some reason.

At approximately 5 a.m. on June 24th, Tomasa's son, Daniel, was born. Initially, everything appeared to be normal, and they waited for the placenta to be delivered. When this had not occurred within thirty minutes of giving birth, Lucio knew that something was very wrong. Their home's extreme isolation with no surrounding neighbors or means of communication suddenly became very ominous. Lucio was scared; he quickly jumped on his bicycle and managed to ride to the nearby health center in Ccohaccasa to seek additional help.¹⁸¹

Although Ccohaccasa was the nearest health center, Tomasa and Lucio's home was not in their jurisdiction. Rather than setting out on foot or bicycle with Lucio to the house (the health center did not have a vehicle), the health center staff decided to transfer the case to the Ccassapata health center, which was at least two hours from Tantaccato by car.¹⁸² In contrast, the Ccohaccasa health center is approximately a half-hour from Lucio and Tomasa's house on foot.

From Ccohaccasa, the personnel alerted by Lucio radioed the health center in Ccassapata. Dr. Javier Wilfredo Tasayco heard the message and he immediately dispatched a midwife and health promoter from a health post between Ccassapata and couple's home in San Juan de Ccarhuacc. Paulino, the health promoter, drove Elizabeth Apolinario, the midwife, to the house, cutting across the paths to get there more quickly. At the same time, Dr. Tasayco sent the health center's ambulance driver to the scene. The driver, Fortuna Tortunato, took a large pick-up truck because the ambulance, although new, was being serviced. Dr. Tasayco, also worried about how far away Tantaccato was and that the patient might die, jumped onto on a motorbike in order to arrive more quickly than the ambulance. It had rained recently and the route for the ambulance driver in the pick-up truck was quite muddy, but he drove as quickly as possible.¹⁸³

In the meantime, Tomasa remained at home with the rest of her children. Her children were all huddled around her in the small bedroom of the house. The smaller ones began to cry as their mother was fading before their eyes. Tomasa recalls being terrified, not knowing what Lucio would do if she died and how her children would get on.¹⁸⁴

The midwife from San Juan de Ccarhuacc, Elizabeth Apolinario, arrived with Paulino at approximately 2 p.m. They found Tomasa unconscious, surrounded by a large puddle of blood. They checked her vital signs and gave her two intravenous infusions of fluid and plasma. Elizabeth

was just beginning to attempt to manually extract the placenta when Dr. Tasayco arrived. Dr. Tasayco had passed Lucio on his bicycle returning to the house. The doctor took over, explained to Lucio that he had to extract the placenta, and was able to extract most of it.¹⁸⁵ However, pieces remained inside and he decided to transfer her back to the health center in Ccassapata in the pick-up truck for further treatment and evaluation.¹⁸⁶

After the Crisis – Tomasa's Health Improves, but Fears Remain

Once Tomasa was transferred to the health center, she remained under 24-hour observation for a total of three days. Lucio accompanied her to the health center and stayed by her side the whole time. Their oldest daughter, Nancy, stayed with the rest of the children.

Upon arrival, Tomasa received further intravenous hydration and underwent a sharp curettage for the extraction of the retained placental fragments. She remained on antibiotics for the length of her stay. On the third day, she was discharged in stable condition with five more days of oral antibiotics to prevent infection and iron supplements to treat her anemia.¹⁸⁷ She was not charged for any of the care or for the ambulance. All these costs were fully covered by SIS.¹⁸⁸

The health center in Ccassapata is a newly-remodeled and adequately-supplied facility that received significant funding through PARSalud I. It is certified as an FON B, or a facility capable of providing basic obstetric care. Dr. Tasayco estimated that the health center attended approximately 80 deliveries a year, half of them emergencies. It has adequate resources from the standpoint of personnel (including anaesthesiologists, which is rare in rural Peru), minor surgical supplies, necessary medications, means of transportation, and communications equipment. This



Photo: Carlos Cárdenas Tovar

Tomasa with her son, Daniel.

situation contrasts sharply with the neighboring health center in Ccochoccasa. The personnel associated with Ccassapata had the knowledge and ability to perform the needed life-saving curettage procedure that allowed Tomasa to avert childbirth-associated mortality.

Tomasa says that she was weak, both physically and mentally, for quite some time after the emergency. She could not walk for long distances without resting, and she still has difficulty with particularly long journeys, including those needed to fetch water for the family.

She remains deeply frightened by everything that happened to her and does not want to have any more children. The doctor and midwife told her that she may die if she gets pregnant again. Although the personnel at both the health post and health center have told her about family planning methods, she and Lucio currently are not using any modern methods. They are using only the rhythm method.

Analysis

As a woman in her tenth pregnancy, Tomasa was at significant risk for pregnancy-related complications. It is appropriate that she was encouraged to deliver at a health facility rather than at home, and the fact that Tomasa and Lucio had a pre-existing positive relationship with the health promoter was important to their decision to notify the health facility as soon as she went into labor. However, because they had no flashlight and the mountainside was extremely steep, Nancy could not leave their home until it started to get light, approximately six hours after Tomasa's first pains. From the onset of pain to delivery of baby, seven hours had elapsed. In light of the circumstances, their decision to seek care was prompt, but they could not execute that decision in a timely way.

Their attempts to seek care were further thwarted by a lack of transportation and immediate means of communication, as well as by jurisdictional barriers within the public health system. Geographic barriers raised by the difficult mountain roads also slowed Tomasa's access to care.

Even so, they had no radio access nearby, and Nancy was forced to walk to the Pantachi Sur health post to make what was in the end, a failed attempt to radio for help. Only Lucio was able to reach a working radio, which was used to call for help to Ccassapata. This case is typical in that the absence of radio or other means of communication closer to the home is a systemic impediment to dealing with obstetric emergencies and addressing maternal mortality in Peru.

Tomasa and Lucio's ability to identify and reach a medical facility was further complicated by the fact that there was a facility located closer to them than the one that ultimately responded. That facility, the health center in Ccohaccasa, was in a different jurisdiction than Tomasa's home, and no efforts were made to cross jurisdictional barriers in order to assist her, even in this emergency, although radio assistance was provided. The health center failed to provide assistance even though a doctor could have reached their home on foot in approximately forty minutes, while calling for the ambulance from Ccassapata. PHR was told that jurisdictional boundaries that limit the ability of health professionals to respond in the most efficacious manner are commonplace in Peru.¹⁸⁹

Once appropriate communication was made with the Ccassapata health center in Tomasa's jurisdiction, immediate attempts were made to respond to the emergency. Unlike the case of Alejandro and Evarista, the guard on duty at Ccassapata immediately communicated with the staff, including the ambulance driver, and they were effectively mobilized. The dedication of the health professionals involved in this case should be applauded and rewarded.

In spite of the timely response by the staff at Ccassapata, the attempts to assist took several hours because of the long distances involved and the poor quality of the mountain roads. However, the combination of radios, motorcycles, and an ambulance ensured that Tomasa reached the health center in time to save her life. Again, unlike Evarista's case, each of the health posts reporting to Ccassapata also had its own vehicle—a motorbike.

Nevertheless, there remains a dearth of easily-accessible means of communication in the area, which is a widespread obstacle to addressing obstetric emergencies in Huancavelica and rural Peru. The significant jurisdictional issues, which in this case impeded Tomasa from receiving care from the health center in nearby Ccohaccasa, remain. Furthermore, although the Ccassapata health center is currently well-equipped due to recent PARSalud

Reflecting on her story, Tomasa asserted that many pregnant women would benefit from an improved system of communication in the health system. "There are many pregnant women. I don't want what happened to me to occur again, I don't want them to have these emergencies," she told PHR. She said she was lucky because her family lives reasonably near a road; if she had lived farther away, she thinks she would have died.

funding, there is not a budget for the maintenance and replacement of such equipment.¹⁹⁰ In this case, Tomasa was extremely fortunate that, in addition to the ambulance and motorbikes purchased through PARSalud I funds, the health center also had a pick-up truck. The ambulance was not functioning, and but for the pick-up truck, Tomasa may very well have died. This is unfortunately all too common.

In February of 2007, a scandal erupted concerning ambulances purchased by the Ministry of Health in 2005 as part of PARSalud I. Press reports estimated that as many as half of the ambulances were inoperable within three months of purchase due to failing ventilation systems and broken springs.¹⁹¹ Furthermore, the bidding process for the ambulances was non-transparent and apparently had not been done in compliance with Peruvian law.¹⁹² According to then Deputy Secretary of Health Diego Fernández Espinosa, who resigned in the aftermath of the scandal, the negotiations favored the automobile distributor Gildemeister, which receives almost all government contracts.¹⁹³ The former Minister of Health, Pilar Mazzeti, also resigned after the scandal broke. Mazzeti, who was appointed as Interior Minister in 2006, was initially criticized for the overpriced purchase of 469 police cars from the same company.¹⁹⁴

In April of 2007, Vice-Minister of Health José Calderón assured PHR that new procedures were being put in place for all international bidding and purchases.¹⁹⁵ However, the facts revealed in the scandal—as well as the countless cemeteries of broken-down ambulances that can be found at hospitals and health centers around rural Peru—attest to the need for greater financial accountability on the part of the international donors as well as the Peruvian government.

The World Bank and International Development Bank (IDB) encourage the purchase of equipment in their loans, and approximately 30% of funds are currently spent on equipment such as ambulances. In fact, the IFIs use procurement indicators to measure the achievements of their loans. However, spending indicators do not always yield results that are desired—for example, they do not reflect corruption in use of ambulances—and can be highly politicized; as a result, there is little accountability. Currently, a receipt is all that is required to show that an ambulance was purchased, but the vehicle may have been re-sold or may be used for some other purpose and not available at the facility. There is a clear need to improve the monitoring and accountability systems for the purchase of equipment.

Maintenance poses perhaps an even larger problem. That is, as the cost of capital and depreciation are not included in calculations of the cost of births in rural areas, the financing is largely unsustainable. Therefore, even though PHR was assured by the IDB that maintenance schedules are contemplated for all the equipment purchased pursuant to PARSalud,¹⁹⁶ in reality when equipment breaks down—as was the case with the ambulance at the health center in Ccassapata—the SIS is not able to cover the cost of financing repairs. The SIS pays only a fixed rate for equipment purchased by different DIRESAs, such as Huancavelica. This fixed rate does not recognize the cost of delivering equipment to rural areas, and does not provide for maintenance or fuel.¹⁹⁷

Finally, the situation is precarious in terms of staffing. The key players in this obstetric emergency—the midwife and Dr. Tasayco—are particularly dedicated to their work, but PHR learned that their contracts were to end shortly after PHR's interviews and both planned to leave the region. PHR learned that high staff rotation is a constant problem in Huancavelica and elsewhere in Peru. Doctors such as Dr. Tasayco, who is fortunate to be appointed, spend a minimum amount of time in rural areas in order to then be able to pursue specializations. Most of the other personnel at the Ccassapata health center worked on contracts, either in conjunction with the rural service (SERUM) or through other arrangements that have no benefits. The average timeframe of a contract is 1-2 years for FOBs, such as at the Ccassapata health center.

Health facility staffing is highly variable and irrational across Peru; there is both over-staffing and under-staffing at FOBs.¹⁹⁸ In interviews with the World Bank, PHR was told that this is due primarily to the *Ley de Nombramiento Médico*, which allow newly “appointed” (*nombrados*) doctors to select where they want to work.¹⁹⁹ However, maintaining a system whereby doctors have neither benefits nor job security is not a sustainable solution to rationalized staffing. Peru urgently needs a region-by-region staff rotation strategy that is respectful of healthcare workers' rights. Such a strategy should concentrate on FOBs. Addressing high turnover in staff and rationalization of healthcare workforce is integral to ensuring that the necessary skill sets and care are available to women experiencing obstetric emergencies—a key factor in reducing maternal mortality.

In sum, Tomasa was extremely fortunate, but this case should not be considered an example of systemic success.

Escaping Conflict To Face Tragedy And Injustice: Francisca

Francisca Ccente Quispe died at the Health Center in Pampas on April 24, 2004, from a cerebral hemorrhage resulting from preeclampsia/eclampsia. She was 38 years old.

Francisca and Amancio's Life Together

Francisca and Amancio were married when she was 18 and he was 22. Their parents arranged the marriage, but they were from the same community and had met at a young age. Amancio cannot speak about Francisca without crying. She was, in his view, the light of his life, his one hope for happiness.

The couple was originally from Ayacucho but moved to Huancavelica in 1984 to escape the escalating violence near their home.²⁰⁰ Ayacucho was at the epicenter of the violent conflict that broke out in 1980 between the Maoist terrorist group, Shining Path (*Sendero Luminoso*), and the government. Forty percent of the fatalities during that conflict came from Ayacucho. The overwhelming preponderance of those killed, disappeared and raped during the armed violence were indigenous campesinos such as Amancio and Francisca. The area of Huancavelica, where Amancio and Francisca settled, was also deeply affected by the conflict, but they felt safer there than in Huanta, in the department of Ayacucho.

Ever since their arrival in Pampas, Francisca and Amancio had lived on a very small plot of land, which Amancio still owns. There is just enough room for their house and a tiny yard, so they do not farm or have their own animals, unlike most of their neighbors. This tiny area appears in stark contrast to the surrounding homes, almost all of which have relatively large green plots of land to farm as well. Instead, there are just a few chickens roaming Amancio's property, most of which is covered by dirt rather than grass. Amancio says that he and Francisca missed the chacra, or farm, tremendously. Her dream had been to return to Ayacucho after this baby was born; she had talked about returning with increasing frequency during her last pregnancy.

Amancio does not live in an extremely remote location like many of the other individuals interviewed by PHR. His home in Ahuaycha is quite close to the larger town of Pampas. In fact, there is a well-traveled dirt road leading right past his house and there are numerous cars and trucks on the more traveled highway visible in the distance.

Because he does not have land on which to farm, Amancio earns a living by driving a mototaxi every day.



Family members outside of home.

It costs 10 *nuevos soles* (USD 3) to rent the vehicle and he typically earns a profit of five to seven *nuevos soles* (approximately USD 1.30-2.30) after paying the rental fee. He is willing to do any other sort of work and sometimes manages to find odd jobs, but it is quite difficult since he is illiterate and has few marketable skills. Although he recently tried to get a job with the city of Pampas, he was told he would not be hired because he had not supported the mayor's election campaign.

Amancio remembers Francisca as very tender and loving, particularly with their children. He said that she loved him a lot and he tears up every time he talks about her. She especially enjoyed cooking and often made things like soup and homemade rolls for the family. She bought oranges as special treats for the children as often as she could.

Amancio and Francisca had four children together, ranging in age from eight to 22. All four were born without complications at the health center in Pampas with the exception of Virginia, the oldest, who was born at home. Throughout her most recent pregnancy, Francisca received prenatal care at the nearby health post in Ahuaycha.²⁰¹

Records from Francisca's second pregnancy in 1994 reveal evidence of hypertension. Intervening records indicate a return to normal blood pressure during non-pregnancy related visits and in other gestations.²⁰² Given these facts, she likely had pre-eclampsia in her second pregnancy and was therefore at risk of redeveloping it in future pregnancies.

During this pregnancy, Francisca received prenatal care from a physician, midwife and aide (*técnico*). Her first visit occurred in her second trimester and was followed by eight further visits, ending at 35 weeks. She was designated as a high-risk pregnancy, although no actual complications occurred during her prenatal



Amancio in his mototaxi in Pampas.

care.²⁰³ However, those records contrast with the information from Dr. Alex Zandro Ascencio, who reported that Francisca exhibited evidence of pregnancy-induced hypertension during her prenatal controls.²⁰⁴ Despite this evidence, she was not transferred to another facility for further follow-up and did not receive any treatment for high blood pressure.

Failures at the Pampas Health Center

When Amancio arrived home from work on the night of April 23, 2004, Francisca was already in bed experiencing a great deal of pain, particularly around her waist and belly. Amancio quickly realized the danger, and together they started walking to the health center in Pampas. Although it is usually a thirty-minute walk, it took them almost two hours due to Francisca's condition.²⁰⁵ They arrive at the health center at approximately 11 p.m.

At the health center, the doctor on duty—a young resident by the name of Cesar Miyahira Yataco, doing his rural service (SERUMista)—examined Francisca and gave her an injection, after which she calmed down and was able to rest.²⁰⁶ The young doctor's girlfriend was visiting the health center at the same time, which, according to another physician employed there at the time, led him to pay little attention to Francisca.²⁰⁷ He simply gave Francisca the injection and returned to the on-call room with his girlfriend.²⁰⁸ According to the examination records, Francisca's vital signs were all within normal ranges with the exception of her blood pressure, which was elevated at 160/100 mmHg (normal is $\leq 140/90$). She arrived complaining of persistent pain in her abdomen and an intense headache, as well as vaginal bleeding.²⁰⁹

The exam was relatively unremarkable, with the exception of her elevated blood pressure, the presence of sporadic contractions, and a cervical exam of 5 cm dila-

tion and 90% effacement. She was admitted to the health center with a primary diagnosis of full-term pregnancy at 35 weeks and a secondary diagnosis of pregnancy-induced hypertension.²¹⁰ Treatment included hospitalization and admittance to the center's obstetric service, as well as the administration of a dose of an anti-hypertensive, Nifedipine, under her tongue.²¹¹

According to a report conducted into her death by Dr. Cesar Vera Donayres, head of the micro-network Pampas Tayacaja, Francisca was monitored by a midwife, Lic. Leocadia Canales.²¹² However, according to Amancio, she was not monitored closely and they were often left for long periods. Approximately two hours after their arrival, Francisca's pain came back, and no one came to check on her, even though there were people constantly walking around the health center. The pain continued, but there was no further treatment offered and Amancio was unable to locate the doctor.²¹³

Early the next morning, Francisca was taken to the birthing room; Amancio was not allowed to enter. After waiting for what he described as a long time, Amancio was told that the baby had died in utero.²¹⁴ At this point, Amancio was allowed into the room where he saw his wife with her legs still in the stirrups. He quietly recalls the scene, saying, "She was empty." She did not speak, but she did look at him. When he tried to touch her, the doctors and nurses yelled at him.²¹⁵

Even after the placenta was expelled, Francisca's condition failed to improve. Hours later, at 7 a.m., Dr. Miyahira reported that Francisca was not reacting to stimuli and had rigidity of decerebration, probably related to a stroke.²¹⁶

It was only then that medical personnel decided that she required transfer to another facility.²¹⁷ At that



Pampas Health Center.

time, Drs. Matamoros and Miyahira told Amancio that he needed to go to Ahuaycha to get her prenatal health records. He left to find the health professional who had performed the prenatal check ups, but was unable to find anyone present at the health post.²¹⁸

At the last minute, Amancio was told to find a car to take her to Huancayo because the health center's ambulance was, according to the driver, Demetrio Paitan, "not in condition to make long trips."²¹⁹ However, no one would take him without being paid a greater sum than Amancio had available. Despite the fact that Francisca was insured by the SIS, the health center did not give Amancio cash to pay, nor did it help him secure transportation.²²⁰

Francisca was pronounced dead at 10:15 a.m., although she was brain dead by the time Dr. Matamoros arrived at 7 a.m., apparently before they tried to transfer her to Huancayo.²²¹ Francisca's death certificate was signed by Dr. Matamoros, who was the Director of the Health Center at the time of PHR's interview. The listed causes of death were (1) Intracranial Hemorrhage occurring over 5 minutes, (2) Arterial Hypertension occurring over 1h; and (3) Pregnancy occurring over 9 months. In a separate report, eclampsia was also specifically listed as a cause of death.²²²

Amancio's Life Without Francisca

After Francisca's death, Amancio had to pay for gasoline to bring her body home, as well as for an autopsy, even though the SIS should cover these costs. Moreover, without explanation, the autopsy was performed in his home rather than the health center, as is typical.²²³ Francisca is now buried in the cemetery in Pampas.

Since Francisca's death, Amancio has considered returning to his home in Ayacucho, but the move is too expensive. He recalled to PHR that it was Francisca's dream to return to Ayacucho along with their children.²²⁴ Despite his soft-spoken manner, Amancio paints a bleak picture of his current life, saying "I'm a poor person, and furthermore, I've been affected by violence and displaced...I don't have a farm or anything...I need to work, I want to work."²²⁵

Amancio has since remarried so that there is someone to take care of his children, and he has another child, Hector, with his new wife, Gloria.²²⁶ However, Gloria appears to have intellectual and psychological disabilities, which are confirmed by Amancio. Moreover, she reportedly mistreats Amancio's other children, even abusing them physically at times. Francisca's children clearly prefer spending time with their older sister, Virginia. Virginia, however, cannot care for them all the



Photo: Christopher Drake

Alicia Ely Yamin interviewing Amancio in front of his home.

time, since she is currently married with two children of her own and has a job.²²⁷

The children receive assistance through the JUNTOS program, which provides cash transfers to extremely poor families for performing tasks such as immunization and school enrollment. However, Amancio complains that the staff there tends to berate him for not properly dressing the children or ensuring that they are clean.

The children encounter similar problems at school, which they try to attend as often as possible. The teachers chastise the children, who have been having difficulty in school since their mother's death. Amancio says that his neighbors lack compassion and do little, if anything, to help; in fact, his closest neighbors are in the process of trying to evict Amancio from what little land he owns.²²⁸

Almost three years after her death, Amancio continues to blame the health center for the way they took care of Francisca. He also blames the health post for never warning him about the possibility of complications during her pregnancy. He wishes that someone had told him to take her to Huancayo earlier. He would have done everything possible to take her there.²²⁹

In addition to the administrative complaint, Amancio wanted to bring a lawsuit against the health center for negligent homicide. However, he did not have the resources to see the lawsuit through. As noted in the case of Melania, access to the judicial system in Peru is plagued by many of the same barriers as access to the health system, including financial, cultural and geographic ones.

Analysis

The significant delays leading to Francisca's death center on the care she received during her prenatal visits to the health post and, most especially, during the obstetric emergency which brought her to the health center in Pampas.

Upon arriving home, Amancio immediately recognized the need to take Francisca to the health center. Due to a lack of transportation and her pain, it took them two hours to walk to the closest health center, as opposed to their usual 30 minutes. Nonetheless, they arrived well prior to her delivery and the onset of eclampsia, which led to her death.

During her prenatal visits at the health post, Francisca should not only have been advised of her high risk status, but also offered transfer to a trained specialist; and she should have been counseled about warning signs of obstetric emergencies. High-risk issues included her advanced maternal age, four prior pregnancies, prior history of apparent pre-eclampsia, and elevated blood pressure evidenced in her prenatal visits.

The Pampas Health Center is not only an FOB but also a reference center (*cabeza de micro-red*). In fact, at the time of PHR's interview, it was in the process of being reclassified as an FOE—and advertises itself as such despite not yet having the capacity to perform Cesareans under appropriate conditions or to bank blood.²³⁰ This false advertising to draw patients into the facilities is cynical misrepresentation that often backfires in a loss of trust with the population.

However, with six doctors, five midwives and seven nurses on staff at the time of Francisca's emergency, it should have been in a position to provide 24-hour basic care to the four districts, with an estimated 50,000 population, that it serves. Nevertheless, upon Francisca's arrival at the health center to deliver her child, quality EmOC was not available.

First, the staff at the facility apparently lacked the requisite training to recognize and immediately treat her pre-eclampsia so it would not progress to eclampsia. The best way to prevent eclampsia is by detecting pre-eclampsia and treating it appropriately. In this case, the medical team failed to administer an anti-convulsant such as Magnesium Sulfate, which would have prevented eclamptic seizures.

However, the deficiencies in care can be traced to more structural factors, as well as to the negligent conduct of the staff of the health care center. Magnesium Sulfate is still not widely used in Peru, let alone at the time of Francisca's death in 2004. In 2004, the use of Magnesium Sulfate became part of the healthcare norms of the country, and in turn, was available through the MINSA; this was well after the international consensus that it was the best way to treat pre-eclampsia and eclampsia. When the norms first entered into force, there was close to 0% use of the drug.²³¹ Although the use of Magnesium

Sulfate has now increased significantly, disaggregated data continue to show a lack of understanding of its use. The use of Magnesium Sulfate is greatly impeded by the fact that there is also a lack of training in its use. Magnesium Sulfate requires constant observation of the patient by trained staff—generally by more than one nurse or midwife—to monitor dosing, urine output and vital signs. This training is rarely done for staff at FOBs, and the lack of training is exacerbated by the high rotation of personnel in rural health centers such as Pampas.

Third, in addition to the inadequate recognition of Francisca's urgent condition, it also appears that she received very little attention from the physician on call, Dr. Miyahira. The midwife, Lic. Leocadia Canales, documented her blood pressure and uterine activity on an hourly basis. However, there is very little documentation from the physician on duty, pointing to a lack of oversight on his part, particularly when coupled with the allegations that he spent this time with his girlfriend in the on-call room.

Overall, there was also a lack of awareness of her labor state and the state of the fetus by the medical team. For example, Francisca was admitted in "latent" labor despite her regular uterine activity and cervical exams being consistent with active labor. In addition, the vaginal bleeding and meconium-stained fluid should have been indicators of fetal distress. However, a Cesarean delivery was not a possibility at the Pampas health center. The nearest facility at which a Cesarean section could have been performed was Huancayo. Had Francisca been stabilized immediately and appropriately with Magnesium Sulfate, she could have—and should have—been immediately transferred to Huancayo for a C-section. Instead, the medical team waited hours—until she was brain dead—to recommend transfer.

Not only was the necessary decision to transfer her to the hospital in Huancayo made far too late, it was prohibitively costly and logistically difficult for Amancio. Amancio was forced to find his own transportation, as the health center's ambulance was neither adequately maintained nor available for the long trip. As noted in other cases, this points to the significant problems faced by rural health centers in financing the maintenance of equipment such as ambulances. It is also inexplicable that a reference center, such as the Pampas health center, would not have some contingency plan in place, including funds to be made available to the patient, in the event of an emergency transfer.

The individual staff members and the institution were responsible for not having done whatever was neces-

sary to find the funds required to transport Francisca to Huancayo on a timely basis. Yet here again, systemic policy decisions may have played a role. The SIS provides 90 *nuevos soles* (approximately USD 26) for transfers in the cases of emergency. However, the SIS does not contemplate differing costs for transfers in rural areas where distances are long. In this case, gasoline for a vehicle to go to Huancayo and back would have cost several hundred *nuevos soles* (approximately USD 100). Furthermore, transfers across departmental lines are not covered by the SIS.

In this case, the closest tertiary care facility was Huancayo, in the department of Junin, rather than Huancavelica, the capital of the department of the same name. The fact that the facility would not have been reimbursed for expenses spent on the transfer may well have played a role in the decisions made by health personnel in this case. Dr. Matamoros noted the severe problems with reimbursements from the SIS for supplies and salaries in his interview with PHR.²³²

It was only after it became apparent that Francisca was going to die that the staff decided to transfer her to Huancayo. This is not uncommon, as health establishments do not want to be associated with maternal deaths. PHR was repeatedly told that in Peru moribund women are routinely transferred to hospitals so that the death is not “counted against the health center.”²³³

In a health system that seeks to scapegoat any association with maternal death, staff has incentives to try to avoid responsibility in any way they can. In this case, Amancio was blamed for Francisca’s death. PHR was told that Amancio’s inability to find transportation was taken as a “refusal” to transfer her. According to Dr. Matamoros, this “refusal” was in turn used to exonerate the attending SERUMista, Dr. Miyahira, from any blame in the case in the administrative investigation that was carried out. It was also evidently used to exonerate all of the other doctors, including Dr. Matamoros himself.

Overall, the health system failed because it did not recognize or acknowledge the severity of Francisca’s condition. Because of this oversight, appropriate care was not provided in the form of anti-convulsants or transport to a better-equipped facility. Even if her severity and that of the fetus was detected earlier, the health center in Pampas would not have been able to provide adequate care, as they lacked needed resources such as magnesium, Cesarean delivery capabilities²³⁴ and transportation.

A broader failure with the health system was manifested in the insensitive and discriminatory treatment received by Francisca and Amancio. Throughout the crisis and afterward, the health staff treated Francisca and Amancio as though they were receiving charity and should be grateful to them. Any demand for attention to his wife was met with reproaches, and Amancio was ordered around to obtain prenatal records and seek transportation—while his wife was dying. This speaks to a fundamental problem in the relationship between the health system and the patient population, whereby patients’ rights are not acknowledged.

On the contrary, PHR heard repeatedly that patients are treated as objects of programs, and are often manipulated into behaving in certain ways in order to meet vertically imposed quotas or numerical goals, such as numbers of institutional births. Dr. Matamoros informed PHR that, until recently, indigenous women had been reluctant to give birth in health centers. However, since they had begun to use police to threaten to incarcerate them and/or their husbands, there had been a higher rate of institutional births in the catchment area of the Pampas health center.²³⁵ Such policies call out for investigation. In light of the scandalous history of the National Family Planning Program’s involuntary sterilizations, it is particularly shocking that such coercive measures, which flagrantly violate women’s rights, are still being used today in Peru’s health system.²³⁶

Notes

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- ⁵ Mesa de concertación para la Lucha Contra la Pobreza. "Región – Puno." Presentation given by DIRESA in Puno October 20-21, 2006.
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- ⁷ Id.
- ⁸ INEI. *Censos Nacionales 2005: X de Población y V de Vivienda*. Available at: <http://www.inei.gob.pe/home1.asp>. Accessed February 7, 2007.
- ⁹ INEI/UNICEF. *Encuesta Demografica y de Salud Familiar (ENDES IV) / Departamento de Puno*. Lima; 2001: 12.
- ¹⁰ *Gerencia Regional de Planeamiento, Presupuesto y Acondicionamiento Territorial: Plan de Desarrollo Regional Concertado 2006 y Presupuesto Participativo*. December 2005; note 6.
- ¹¹ Mesa de concertación para la Lucha Contra la Pobreza. "Región – Puno." Presentation given by DIRESA in Puno October 20-21, 2006.
- ¹² *Gerencia Regional de Planeamiento, Presupuesto y Acondicionamiento Territorial: Plan de Desarrollo Regional Concertado 2006 y Presupuesto Participativo*. December 2005; note 6, para 6.
- ¹³ *Censos Nacionales 2005: X de Población y V de Vivienda*, note 8.
- ¹⁴ *Gerencia Regional de Planeamiento, Presupuesto y Acondicionamiento Territorial: Plan de Desarrollo Regional Concertado 2006 y Presupuesto Participativo*. December 2005; note 6, para 6.
- ¹⁵ *Censos Nacionales 2005: X de Población y V de Vivienda*, note 8.
- ¹⁶ Id.
- ¹⁷ *Gerencia Regional de Planeamiento, Presupuesto y Acondicionamiento Territorial: Plan de Desarrollo Regional Concertado 2006 y Presupuesto Participativo*. December 2005; note 6, para 6.
- ¹⁸ INEI. *Puno: Población, Mujer y Salud, Resultados de la encuesta demográfica y de la salud familiar, 1996*. Available at: <http://www.inei.gob.pe/biblioineipub/bancopub/Est/Lib0236/Libro.htm>. Accessed February 7, 2007.
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- ²⁴ *Encuesta Demográfica y de Salud Familiar*. 2000; note 4, p. 17.
- ²⁵ INEI/UNICEF. *Encuesta Demográfica y de Salud Familiar 2000 (ENDES IV) / Departamento de Puno*. Lima; 2001: 132.
- ²⁶ Id., para 126.
- ²⁷ See MINSA – Oficina General de Estadística e Informática. "Perú: Nacidos vivos registrados e informados, por persona que atendió el parto, sitio de ocurrencia y peso del recién nacido, según lugar de inscripción 2003." Available at: <http://www.minsa.gob.pe/estadisticas/estadisticas/Nacimientos/042001DP21.htm>. Accessed July 13, 2007.
- ²⁸ INEI. *Encuesta Demográfica y de Salud Familiar 2000 (ENDES IV) / Departamento de Puno*. Lima; 2001:122.
- ²⁹ INS – Gerencia de Estadística. *Una posible aproximación del nivel del contrabando en el Perú*. 2001: 2.
- ³⁰ It is estimated that 10-30% of all medicine sold in Peru is illegally obtained. In light of this problem, Peru's Ministry of Health announced the formation of a group, Contrafalme, in May of 2006, which will develop a National Plan Against Contraband, Illegal Commerce, and Falsification of Pharmaceuticals and Related Products. Since 2005, 18 tons of pharmaceuticals have been confiscated in Peru, valued at approximately USD \$5 million. Although much of this contraband enters through Puno, only 10% of these imports remain in the department, and the majority continues on to major cities such as Lima or Arequipa. See: International Medical Products Anti-Counterfeiting Taskforce (Impact). *Counterfeit Medicines: an update on estimates*. November 15, 2006. Available at: http://www.ifpma.org/Issues/Content/pdfs/IMPACT_counterfeit_estimate_15Nov06.pdf. Accessed February 8, 2007.
- ³¹ Superintendencia Nacional De Administración Tributaria. INS – Gerencia de Estadística. *Una posible aproximación del nivel del contrabando en el Perú: 2001*: 16. Available at: <http://www.aduanet.gob.pe/aduanas/infoaduanas/contrabando.pdf>. Accessed February 7, 2007.
- ³² Interview with a former government official in Lima, Peru. (April 13, 2007).
- ³³ Interview with Josefa Cabana in Tococori Choquechambi, Peru (May 9, 2007).
- ³⁴ Interview with Lorenzo Quispe in Tococori Choquechambi, Peru (May 9, 2007).
- ³⁵ Interview with Geronimo Jove Calcina in Tococori Choquechambi, Peru (May 9, 2007).
- ³⁶ Ergotrate belongs to a class of drugs called ergot alkaloids, which are usually given to stop excessive bleeding that sometimes occurs after abortion or a baby is delivered; they work by causing the muscle of the uterus to contract.

- 37 Interview with Hermelinda Avado Sucapuca in Hanajquia, Peru (May 10, 2007).
- 38 Interview with Lis Rosana Quispe Quea in Tococon Choquechambi, Peru (May 9, 2007).
- 39 Interviews with Lorenzo Quispe Vargas in Tococon Choquechambi, Peru (May 9 & 10, 2007).
- 40 Ketamine is generally used as the anaesthesia, which is a drug to which the majority of coca-using women in the region are resistant. Large doses of Ketamine can drive up women's blood pressure and newborns can be born depressed, an occurrence which is not infrequent according to nurses PHR interviewed.
- 41 Interview with Hermelinda Abado Sucapuca in Hanajquia, Peru (May 10, 2007).
- 42 Interview with Josefa Pacco in Tococon Choquechambi, Peru (May 9, 2007).
- 43 Id.
- 44 Interview with Lorenzo Quispe Vargas in Tococon Choquechambi, Peru (May 9, 2007).
- 45 Interview with Lis Rosana Quispe Quea in Tococon Choquechambi, Peru (May 9, 2007).
- 46 Interview with Lorenzo Quispe Vargas in Tococon Choquechambi, Peru (May 9, 2007).
- 47 Interview with Lis Rosana Quispe Quea in Tococon Choquechambi, Peru (May 9, 2007).
- 48 Interview with Abel Mateo Quispe in Tococon Choquechambi, Peru (May 10, 2007).
- 49 Interview with Lorenzo Quispe Vargas in Tococon Choquechambi, Peru (May 9, 2007).
- 50 Jaramillo M. *Does public health insurance secure access to care? Economic and non-economic barriers to prenatal care among Peruvian mothers: race, geography and power relations within the household*. Grupo de Análisis para el Desarrollo (GRADE). September 2006:5. Available at: http://ctool.gdnet.org/conf_docs/Jaramillo_paper_parallel_2.1.pdf. Accessed July 10, 2007.
- 51 Defensoría del Pueblo. *Supervisión a los servicios de planificación familiar IV: Casos investigados por la Defensoría del Pueblo*. 2005. Available at: http://www.ombudsman.gob.pe/modules/Downloads/informes/defensoriales/informe_90.pdf. According to that resolution (published April 2004), "la expedición del certificado del nacido vivo es gratuita en todos los establecimientos de salud del país, públicos y privados, así como los que sean expedidos por los profesionales o personal de salud que haya brindado la atención." Resolución Ministerial [Ministry Resolution] No 389-2004/MINSA, April 23, 2004.
- 52 Amnesty International. *Peru: Poor and excluded women – Denial of the right to maternal and child health*. AMR 46/004/2006. July 2006. Available at: [http://web.amnesty.org/library/pdf/AMR460042006ENGLISH/\\$File/AMR4600406.pdf](http://web.amnesty.org/library/pdf/AMR460042006ENGLISH/$File/AMR4600406.pdf). Accessed February 12, 2007.
- 53 Interview with Dr. Juan Carlos Calla Apaza in Azángaro, Peru (May 9, 2007).
- 54 Azángaro is the location of one of the first battles for independence from Spain, and was also a hotbed of activity by Shining Path insurgents during the civil conflict of the 1980's.
- 55 Ministerio de Salud, Perú. Norma técnica para la atención del parto vertical con adecuación intercultural. N.T.N°033-MINSA/DGSP-V.01. Lima: Ministerio de Salud; 2005.
- 56 Interview with a women's health expert in Puno, Peru. (May 14, 2007).
- 57 Interview with Jose Pablo Gomez-Meza, Senior Economist for Health, World Bank and Livia Benavides, Senior Social Sector Specialist, World Bank (participated in interview via video conference from Lima) in Washington, DC. (February 27, 2007).
- 58 Interview with Eulogia Mamani Inkahuanaco in Puquis, Peru (May 13, 2007).
- 59 Interview with Jovita Yucra Parisuana in Puquis, Peru (May 13, 2007).
- 60 Interview with Francisco Yucra Yucra in Puquis, Peru. (May 12, 2007).
- 61 Interview with Jovita Yucra Parisuana in Puquis, Peru (May 12, 2007).
- 62 Interview with Francisco Yucra Yucra in Puquis, Peru (May 13, 2007).
- 63 Interview with Jovita Yucra Parisuana in Puquis, Peru (May 13, 2007).
- 64 Interview with Gerardo Hallasi Quispe and Francisco Yucra Yucra in Puquis, Peru (May 13, 2007).
- 65 Interview with Francisco Yucra Yucra in Puquis, Peru (May 13, 2007).
- 66 PHR's team telephoned and even went to her home and spoke with her husband, but she never responded to requests for interviews.
- 67 Juez Mixto de la Provincia de Huancané, Expediente No 2004-091; dictamen parcial No. 16-2005-MP-FPM-H. 25 de mayo de 2005.
- 68 Exp. 2004-091, Dictamen parcial No. 16-2005-MP-FPM-H (Puno) 25 de mayo de 2005.
- 69 Id.
- 70 "No existe documento alguno que indique que la agraviada se encontraba bajo mi cuidado o protección, menos se encontraba en peligro de muerte, bajo esas circunstancias." Exp. 2004-091, Dictamen parcial No. 16-2005-MP-FPM-H (Puno) 25 de mayo de 2005.
- 71 Interview with Francisco Yucra Yucra in Puquis, Peru (May 12, 2007).
- 72 Informe remitido, Hospital Carlos Monge Medrano, Oficio No. 213-DG-HCMM-REDES-SR-J (2004).
- 73 Interview with Dr. Carlos Barrientos, Director Carlos Monge Medrano Hospital in Juliaca, Peru (May 11, 2007).
- 74 Id.
- 75 Interview with Ariel Frisancho, National Coordinator for the Program on the Right to Health at CARE-Peru in Lima, Peru. (May 8, 2007).
- 76 Interview with Agustín Limahuaya Quispe in Ramis, Peru (May 11, 2007).
- 77 Interview with Isabel Quenta in Ramis, Peru (May 11, 2007).
- 78 Interview with Agustín Limahuaya Quispse in Ramis, Peru (May 11, 2007).
- 79 Interview with Isabel Quenta in Ramis, Peru (May 11, 2007).
- 80 "por gusto" Interview with Isabel Quenta and Yaneth Araujo Chan in Ramis, Peru (May 11, 2007).
- 81 Interview with Yaneth Araujo Chan in Ramis, Peru (May 11, 2007).
- 82 Interview with Dr. Santiago Quispe Vilca in Juliaca, Peru (May 13, 2007).
- 83 PHR toured parts of the hospital on two separate days: May 11 and May 13, 2007.

- ⁸⁴ Interview with Isabel Quenta in Ramis, Peru (May 11, 2007).
- ⁸⁵ Interview with Agustín Limahuaya in Ramis, Peru (May 11, 2007).
- ⁸⁶ Interview with Felix Yucra Yucra in Ramis, Peru (May 11, 2007).
- ⁸⁷ Id.
- ⁸⁸ Interview with Agustín Limahuaya in Ramis, Peru (May 11, 2007).
- ⁸⁹ “Alégrate, es varón.” Interview with Felix Yucra Yucra in Ramis, Peru (May 11, 2007).
- ⁹⁰ Interview with Maria Rosario Quispe in Ramis, Peru (May 11, 2007).
- ⁹¹ Interview with Felix Yucra Yucra in Ramis, Peru (May 11, 2007).
- ⁹² Time estimates varied between eye witnesses.
- ⁹³ Interview with Isabel Quenta and Yaneth Araujo Chan in Ramis, Peru (May 11, 2007).
- ⁹⁴ Interview with Isabel Quenta in Ramis, Peru (May 11, 2007).
- ⁹⁵ Interview with Felix Yucra Yucra in Ramis, Peru (May 11, 2007).
- ⁹⁶ Interview with Eucevio Callata Ramis, Peru; May 11, 2007. Interview, Felix Yucra Yucra in Ramis, Peru (May 11, 2007).
- ⁹⁷ “Todos nos echaron la culpa, acaso dijeron que la paciente fue al hospital y por negligencia de ellos la regresaron a la paciente eso ni siquiera hablaron y a mi me dijeron no hables nada mas, no echas más leña al fuego es mejor que te calles, lo único que dije esa vez fue que les den más estabilidad a la Obstetrix y me calle me sentí tan impotente que no sabía que hacer.” Interview, Isabel Quenta in Ramis, Peru (April 17 & 18, 2007).
- ⁹⁸ Interview with Maria Rosario Quispe Iño in Ramis, Peru (May 11, 2007).
- ⁹⁹ Id.
- ¹⁰⁰ Interview with Dr. Carlos Barrientos, Director Carlos Monge Medrano Hospital in Juliaca, Peru (May 11, 2007).
- ¹⁰¹ Interview with Yaneth Araujo Chan in Ramis, Peru. (May 11, 2007).
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- ¹³³ Uccelli FA. *Poverty Alleviation in Peru: The search for sustainable social development*. 1997: 11. Available at: <http://136.142.158.105/LASA97/Uccelli.pdf>.
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- ¹⁴³ Interview with Alejandro Noa Huincho in Cieneguilla, Peru (Jan 7, 2007).
- ¹⁴⁴ Alicia Pinzás, *Jerarquías de género en el mundo rural*. Centro de la Mujer Peruana, "Flora Tristán": 2001, p. 79.
- ¹⁴⁵ Interview with Alejandro Noa Huincho in Cieneguilla, Peru (Jan 7, 2007).
- ¹⁴⁶ Evarista Paquiyaui Osorio, prenatal records.
- ¹⁴⁷ Interview with Godifredo Huincho in Cieneguilla, Peru (Jan. 7, 2007).
- ¹⁴⁸ Interview with Alejandro Noa Huincho in Cieneguilla, Peru (Jan 7, 2007).
- ¹⁴⁹ Interview with Mauricia in Cieneguilla, Peru (Jan. 7, 2007).
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- ¹⁵³ Id.
- ¹⁵⁴ Interview with Tomasa Huincho in Cieneguilla, Peru (Jan. 7, 2007).
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- ¹⁶⁰ Interview with Dr. Yoshira Zamora Salas in Carhuapata, Peru (Jan. 7, 2007).
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- ¹⁶² Defensoría del Pueblo. *Supervisión a los servicios de planificación familiar IV: Casos investigados por la Defensoría del Pueblo*. 2005. Available at: http://www.ombudsman.gob.pe/modules/Downloads/informes/defensoriales/informe_90.pdf. According to that resolution (published April 2004), "la expedición del certificado del nacido vivo es gratuita en todos los establecimientos de salud del país, públicos y privados, así como los que sean expedidos por los profesionales o personal de salud que haya brindado la atención." Resolución Ministerial [Ministry Resolution] No 389-2004/MINSA, April 23, 2004.
- ¹⁶³ Despite questions in this regard, PHR was unable to determine definitively whether she was fired or merely transferred.
- ¹⁶⁴ *Mujeres de negro: La muerte materna en zonas rurales del Perú. Estudio de casos*. Lima; 1999; note 3, para 60; See also, *Informe de la Encuesta. Percepciones, conocimientos y prácticas para la disminución de muertes maternas y perinatales en Churcampá*. Calandria/Salud Sin Limites 2005: 13.
- ¹⁶⁵ Interview with Dr. Yoshira Zamora Salas in Carhuapata, Peru (Jan. 7, 2007).
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- ¹⁶⁷ República del Perú. *Hacia el cumplimiento de los Objetivos de Desarrollo del Milenio en el Perú: Un compromiso del país para acabar con la pobreza, la desigualdad y la exclusión*. Informe 2004: 64. Available at: <http://www.cepis.ops-oms.org/bvsair/e/repindex/rep83/milenio/informes/peru-odm.pdf>. Accessed July 3, 2007.
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- ¹⁷² Interview with a former government official in Lima, Peru. (April 12, 2007).
- ¹⁷³ Chopcca is a particular ethnic group of Quechua-speaking indigenous people.
- ¹⁷⁴ Interview with Tomasa Talpe Vargas in Tantaccato, Peru (Jan. 8, 2007).

- 175 Id.
- 176 Interview with Tomasa and Lucio in Tantaccato, Peru (Jan. 8, 2007).
- 177 Interview with Tomasa Talpe Vargas in Tantaccato, Peru (Jan. 8, 2007).
- 178 Interview with Lucio in Tantaccato, Peru (Jan. 8, 2007).
- 179 Interview with Tomasa and Lucio in Tantaccato, Peru (Jan. 8, 2007).
- 180 Interview with Tomasa and Lucio in Tantaccato, Peru (Jan. 8, 2007).
- 181 Id.
- 182 Interview with Elizabeth Apolinario in Tantaccato, Peru (Jan. 8, 2007).
- 183 Interview with Dr. Javier Wilfredo Tasayco in Ccassapata, Peru (Jan. 8, 2006).
- 184 Interview with Tomasa Talpe Vargas in Tantaccato, Peru (Jan. 8, 2007).
- 185 Id.
- 186 Interview with Elizabeth Apolinario in Tantaccato, Peru (Jan. 8, 2007).
- 187 Information from the medical documents.
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- 198 Id., April 13, 2007.
- 199 Interview with Jose Pablo Gomez-Meza, Senior Economist for Health, World Bank and Livia Benavides, Senior Social Sector Specialist, World Bank (participated in interview via video conference from Lima) in Washington, DC. (February 27, 2007).
- 200 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 201 Id.
- 202 Prior prenatal records. They indicate a blood pressure of 150/70 mmHg at approximately 37-39 weeks gestation.
- 203 Prenatal record.
- 204 Report #002 RED III Tayacaja-DISA, HVCA by Dr. Alex Zandro Ascencio.
- 205 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 206 Id.
- 207 Interview with Dr. Isaias José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007).
- 208 Id. The SERUM was later exonerated.
- 209 Emergency room medical records.
- 210 Despite having a full-term 40 week pregnancy by dates, ultrasound evaluation at that time revealed a fetus of approximately 35 weeks size and subsequently, the pregnancy was dated with that information.
- 211 This information is confirmed by the inquiry report as well.
- 212 Informe No. 021-2004/CSPT informe de Dr. Cesar Vera Donayres re: muerte Materna, Pampas, April 21, 2004. (Report No. 021-2004/CSPT by Dr. Cesar Vera Donayres regarding a maternal Death in Pampas, Medical records).
- 213 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 214 Id. (However, Dr. Matamoros says that she pushed too fast. He also said that the baby was born alive).
- 215 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 216 Medical records.
- 217 Id. At 9:00am, there is further documentation by on-call Dr. Isaias Matamoros Curipaco that Francisca was not responding to questions or stimuli. Her pupils did not react to light and with painful stimuli she only showed signs of decerebration. Her patellar reflex was hyperactive.
- 218 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 219 See Informe (Report) 021-2004/CSPT, paragraph 4 (Medical records).
- 220 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 221 Interview with Dr. Isaias José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007).
- 222 The report "Epidemiológica de Muerte Materna. Direccion Regional De Salud Huancavelica" confirms date of death as April 4, 2004 with a time of 10:15am. Causes of death were cited as (1) Intracranial hemorrhage, (2) Eclampsia and (3) Pregnancy induced hypertension.
- 223 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007). This is verified in her health records. However, according to Dr. Matamoros, no autopsy was performed. Interview with Dr. Isaias José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007). There are no autopsy records available.
- 224 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 225 Id.
- 226 Id.
- 227 Interview with Virginia in Ahuaycha, Peru (Jan. 10, 2007).
- 228 Interview with Amancio Cosichi Quispe in Ahuaycha, Peru (Jan. 10, 2007).
- 229 Id.
- 230 In his interview with PHR, Dr. Matamoros claimed that he did perform c-sections, despite not having received training in administering anesthesia; he also claimed to perform fistula repairs, which can be complicated surgeries, although he had never received any

training. In this case, however, Dr. Matamoros arrived after the delivery and never attempted to perform surgery on Francisca. Interview with Dr. Isaías José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007).

²³¹ Interview with a former government official in Lima, Peru (Jan. 12, 2007).

²³² Interview with Dr. Isaías José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007).

²³³ Interview with Dr. Luis Enriquez, Chief of Obstetrics and Gynecology, Regional Hospital in Puno, Peru (May 14, 2007); Interview with Dr. Carlos Barrientos, Director Carlos Monge Medrano Hospital in Juliaca, Peru (May 11, 2007).

²³⁴ Again, it should be noted that Dr. Matamoros claimed to perform Cesarean sections routinely at the Pampas health center, despite the fact he had never received training in administering anesthesia and the center was not certified to do so.

²³⁵ Interview with Dr. Isaías José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007).

²³⁶ See Chapter IV of this report.

VIII. APPLYING A HUMAN RIGHTS-BASED APPROACH TO ADDRESS MATERNAL MORTALITY IN PERU

The Peruvian government has assumed obligations related to addressing maternal mortality under international human rights law, as set out in Chapter VI. Pursuant to the MDGs, it has also assumed a specific obligation to reduce maternal mortality by 75% from 1990 levels by the year 2015. The Millennium Project Task Force Report on Child and Maternal Health makes it clear that human rights will be integral to achieving that goal.¹

As set out in detail in the narratives in Chapter VII, Peru is not currently providing EmOC that is available, accessible (physically and economically, on a non-discriminatory basis and with respect to information), acceptable (culturally and ethically) and of adequate quality. PHR documented how this lack of EmOC on various dimensions leads to delays in women deciding to seek care, arriving at care, and receiving appropriate care once at a health facility. These delays, in turn, kill women, and leave many more with lifelong disabilities.

In addition to highlighting the centrality of Peru's obligations to provide available, accessible, acceptable and quality EmOC, human rights law contains principles that can be used to evaluate Peru's efforts to address maternal mortality, and can also guide future policy-making and programming. These principles, taken together, can highlight concerns and inform actions taken by regional governments and the national government, as well as third-party governments—such as the United States—and the World Bank and IDB, which play a large role in the ability of women in Peru to realize their rights to safe motherhood. It is now widely agreed that human rights-based approaches to health policy include at least the following principles: non-retrogression and adequate progress; non-discrimination and equality; participation; accountability, and international assistance and cooperation.² This chapter examines the record of the Peruvian government and other actors with respect to these criteria and suggests measures to adopt in pursuing a rights-based approach to reducing maternal mortality.

Non-retrogression and Adequate Progress to the Maximum Extent of Available Resources

In language that is echoed in the provisions of other treaties, the ICESCR obligates Peru and other States parties to “take steps” toward the “progressive realization” of all of the rights contained in the Covenant, including health to the “maximum” of its “available resources.”³ Although the right to health cannot be implemented from one day to the next, it has been repeatedly established by treaty-monitoring committees, as well as bodies of experts, that governments have an obligation to demonstrate adequate progress in fulfilling all treaty rights to which they have subscribed, including the right to health.⁴ The ESC Rights Committee has clarified that adequate progress, while there is no one standard, means establishing realistic targets, benchmarks and timetables, and making appropriate efforts—through laws, policies, administrative and budgetary measures—to reach those targets. Furthermore, there is a strong presumption that retrogressive measures are inconsistent with international law.⁵ In addition, as discussed in Chapter VI, the Peruvian government does not have unlimited discretion in construing what constitutes its “maximum available resources” that can be devoted to the realization of the right to health under international law.

Peru has not met these criteria. There is not an adequate National Plan of Action to Reduce Maternal Mortality or to address healthcare workforce rationalization. The appropriate indicators and benchmarks have not been universally applied. There has been retrogression with respect to the family planning program and the availability of contraception; coverage of the poor under the SIS; and provisions of the General Health Law relating to abortion. Moreover, the government does not reflect health as a priority in its budget and does not use its fiscal power to collect revenues sufficient to increase the “extent of its available resources.”

Plans of Action: Maternal Mortality and Healthcare Workforce

Although Peruvian law guarantees the right to health, the specific steps necessary for its realization have not been fully developed. Notably, despite rhetorical statements by President García and numerous other officials, Peru lacks a National Plan of Action to Reduce Maternal Mortality, in keeping with its core obligations as a State party to the ICESCR. That some of the policies of the State (*Políticas del Estado del Acuerdo Nacional*) bear on maternal mortality is not sufficient.

In accordance with paragraph 43 (f) of ESC Rights Committee General Comment 14, this national public health strategy and plan of action, “should be devised on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”⁶

Thus, to be consistent with the ESC Rights Committee’s statement of States parties’ obligations, the National Plan of Action that Peru’s government devises should be based upon epidemiological evidence regarding effective interventions to reduce maternal mortality, and the process for devising that plan should be participatory and transparent.

This plan should be devised as part of or in relation to the National Plan of Action on Health called for under the National Plan on Human Rights 2006-2010, which stipulated that such a plan was to be prepared and implemented “considering the expressions and interests of local populations, with special emphasis on the poorest and most vulnerable populations of the country” and with a “cross-cutting focus on human rights, equality between men and women, interculturality.”⁷

The National Plan of Action on Human Rights also called for “strengthening human resources aimed at improving competencies and work conditions of the workers in the health sector, in order to improve the quality of the performance of assigned functions and promote and protect the right to health of the population.”⁸ PHR documented the gross inequities that exist between appointed physicians and health professionals and those working on different short-term contracts with no benefits, who are subject to summary dismissal. In addition to inequity within the

health system, the labor regime promotes inequities with respect to care, leading to high staff turnover particularly in rural establishments, undermining the possibility of fostering improvements in EmOC and realizing a functioning referral network. Given this situation, such “strengthening” calls for a systematic review of laws and policies relating to healthcare workforce, and the dedication of part of a National Plan of Action on Health or the creation of a separate national plan of action specifically addressing human resources health, which takes into account regional variation. Such a plan should be devised in a participatory fashion and include input from health professionals, as well as health system users.

Indicators

In order to track the adequacy of progress, the Peruvian government will require both reliable data and the right indicators. Official estimates of maternal mortality ratios in Peru are widely considered to be unreliable.⁹ In the government’s own progress report on the MDGs in 2004, it notes that “in addition [to having one of the highest maternal mortality ratios in Latin America, the numbers] reveal grave problems of under-recording...Such sub-registration impedes the design and implementation of policies and programs that effectively address the problem...”¹⁰

For its part, CEDAW has criticized the lack of disaggregation in Peru’s important health indicators, such as maternal mortality, by rural and urban areas and by ethnicity (as well as gender where relevant). In its response to Peru’s sixth periodic report in 2007, it noted “The Committee is concerned that the limited availability of such detailed data may also constitute an impediment to the State party itself in designing and implementing targeted policies and programmes, and in monitoring their effectiveness in regard to the implementation of the Convention.”¹¹

With regard to indicators, the UN Special Rapporteur has noted that “a right-to-health approach requires appropriate indicators to monitor progress made and to highlight where policy adjustments may be needed.”¹² Although maternal mortality ratios show overall trends, process indicators can be monitored continuously and are of greater relevance in terms of making “policy adjustments where needed to reduce maternal deaths.” According to an Inter-American Development Bank report, “[m]onitoring selected process indicators, for example the proportion of births under institutional care, can show more reliably whether or not the [SIS] is working, since the greater the use of good maternal

and child health care services, the lower the rate [sic] of maternal mortality...These process indicators, carefully selected and collected in a timely manner using valid methods, will serve to develop, implement, and evaluate the guidelines and strategies of the [SIS].”¹³

Although they will not indicate all that the government should be doing, the *UN Guidelines* set out indicators that can be used to evaluate whether the Peruvian government is progressively adopting appropriate measures to avert unnecessary maternal mortality, including EmOC. These include both indicators of supply, e.g., basic and comprehensive EmOC facilities per population, and indicators that combine supply and demand, e.g., met need for EmOC.

PARSalud I used a series of indicators to track progress in reducing maternal mortality through the SIS, which were principally related to quality of care within health facilities. These included:

- The proportion of pregnant women in extreme poverty who have affiliated with Plan C of SIS
- The increase in coverage of institutional births (tracking urban and rural areas separately, as well as quintiles separately)
- The increase in coverage of institutional births in the regions specifically targeted by PARSalud
- Proportion of institutional births among those women affiliated with SIS¹⁴
- Proportion of births using Cesarean sections
- Proportion of births using oxytocin
- Proportion of births using Magnesium Sulfate
- Proportion of births using antibiotics
- Proportion of births attended by doctors or midwives¹⁵

Importantly, these indicators can in turn be used in order to determine whether the requisite number of FOBs, FOEs, and FOPs are available—i.e., a similar indicator to the number of EmOC facilities—and also to determine how well the reference/counter-reference system is functioning.¹⁶ Some of these indicators, such as oxytocin use within one minute of delivery, may have driven improvements in quality of care, which are reflected in a decline in the proportion of maternal deaths due to hemorrhage.¹⁷

Other critical indicators, however, such as proportion of births by Cesarean section, have not evidenced progress due at least in part to a shortage of capacity to store blood. PHR found in both Huancavelica and Puno that even at facilities classified as FOEs, limited blood

Detained Because She Needed Blood

In the Regional Hospital of Puno, PHR witnessed the perverse results of the lack of a national plan for banking blood. A woman who recently gave birth had been detained in the hospital because her family members had not been able to pay the expenses for blood screening. The SIS does not cover those costs and PHR was informed that the hospital does not have funds to cover systematic screenings.

Therefore, when women require blood, their family members are asked to donate. However, screening for HIV and other diseases costs 90 *nuevos soles* (approximately USD 27) for each bag of blood, which the family is also asked to pay.

In this case, the woman had suffered a postpartum hemorrhage and had gone into hypovolemic shock; she had received two bags of blood and the family had only been able to collect 90 of the 180 *nuevos soles* they owed. At the time of PHR’s visit, this woman had been detained for over a week.

supplies often meant that, in practice, women were transferred or were subject to long delays as blood was brought to the facility from elsewhere. In an interview with PHR, representatives from the World Bank acknowledged that the situation of blood banks and blood availability was critical throughout rural Peru and should be addressed in the next phase of PARSalud.¹⁸

Furthermore, some indicators, such as proportion of institutional births, appear to have produced distorted incentives in practice, in that health centers use coercive methods to increase institutional births, even when their health centers do not possess the capacity to resolve obstetric emergencies. For example, at the Pampas Health Center in Huancavelica, PHR was told that police were used to threaten incarceration if indigenous women did not give birth at the health center.¹⁹ However, when Francisca did go to the Pampas health center, quality care was not available.

PHR also documented widespread use of *de facto* fines as a coercive mechanism to increase institutional births. PHR’s findings related to tying compensation to “productivity” measured in terms of institutional births—regardless of EmOC capacity and patient choice—raise serious questions about the use of this indicator to measure adequate progress.

Additionally, crucial indicators that get at questions of demand, such as met need for EmOC, are missing. That is, increases in institutional births reveal nothing

about whether women who need emergency obstetric care are actually receiving it. An increase in institutional births may be attributable to increases in normal vaginal deliveries, while delays in deciding to seek care, arrive at care and receive care during emergencies persist, and as a result women are still dying.

In an interview in April, 2007, with then Deputy Minister of Health José Calderón Yberico, PHR was told that in the restructuring of the SIS and PARSalud, the MINSA would likely focus on demand and social determinants of health rather than, or in addition to, supply-side indicators. In this case, in keeping with its obligations under international law to take *appropriate* measures, all indicators chosen to measure the government's progress (and the interventions they measure) should be based on the best available evidence of what actually reduces maternal mortality, including the different components of EmOC.²⁰

Retrogression: Family Planning; Abortion; SIS Coverage of Poorest Income Groups

Under international treaties to which Peru has voluntarily adhered, there is a strong presumption that retrogressive measures are inconsistent with a State's obligations. In at least three respects, there has been retrogression in relation to aspects of the right to health that bear on the reduction of maternal mortality: family planning, regulations relating to abortion, and SIS coverage of the poorest populations.

First, in the aftermath of the scandal involving involuntary surgical contraception, the Toledo government reorganized the National Family Planning Program in 2001. It was discontinued as a separate program and family planning was integrated into a comprehensive care approach. However, the idea of integration never worked according to key informants. In addition to ideological opposition to family planning from the highest levels of the MINSA under both Luis Solari and Fernando Carbone, there were management problems as well.²¹ For example, Dr. Victor Zamora, then Assistant Representative for Peru at UNFPA, stated that "High rotation of staff and diffuse responsibility led to the bureaucratization of accountability. Reproductive health lost priority as well."²²

Availability of contraception has fallen dramatically as a result. PHR's findings relating to systematic shortages of family planning methods in health establishments in Puno and Huancavelica confirm those of national studies. The availability of modern methods of birth control within the public sector decreased by an average of 10% between 2000 and 2005.²³ Shortages

translated into public health establishments imposing fees for contraceptives they purchased on the private market, which in turn created reduced economic accessibility and reduced usage.²⁴ Dr. Miguel Gutierrez, then President of the Peruvian Society of Obstetrics and Gynecology, told PHR that since 2001, modern methods have fallen and the practice of surgical contraception has fallen sharply.²⁵

Further, it is not enough to provide the methods. Health professionals must be trained in their application and patients must be counseled in relation to their use. Neither surgical contraception (AQV, by its Spanish acronym) nor counseling for the use of contraception was included in the SIS. Dr. Gutierrez noted that doctors are no longer trained to place IUDs or perform tubal ligation. The explosion of medical schools has led to a lack of quality control and fewer opportunities to practice.²⁶

There are currently 29 accredited medical schools in Peru, two of which function without accreditation. The glut of doctors graduating from these schools is in part responsible for a recent law which was passed to create the National System on Accreditation and Education (SINEACE, *Sistema Nacional de Acreditación en Educación*). It is unclear how this system, which replaces another body, will ensure quality control in reproductive health or more generally.

A second form of retrogression was evidenced in Article 30 of the General Health Law passed in 1997, which included a new requirement that doctors are obligated to denounce indications of a criminal abortion to the "competent authority."²⁷ This legislation is contrary to CEDAW's General Recommendation 24 on "Women and Health," which notes that a lack of respect for confidentiality may deter women from seeking advice and treatment and adversely affects their well-being. "Women will be less willing, for that reason, to seek medical care for ...incomplete abortion."²⁸ This legislative change created an additional barrier to accessible EmOC in Peru and should be rescinded.

A third form of retrogression can be observed in the coverage of the poorest populations under the social insurance scheme, SIS. Rather than extending coverage of the SIS, between 2003 and 2005, there was a reduction in coverage for those in the lowest income quartiles.²⁹

Such retrogression in coverage translates into more women who are faced with economic barriers to accessible care. It is still unclear whether the government's new plan for universal insurance will increase coverage among the poor or will actually decrease it through the proposed premiums and co-payments.

Table 3. Percent of Population Covered by SIS by Income Quartile, 2003 and 2005

Level of Poverty*	2003	2005
Extreme Poverty	35.0	28.0
Poverty	27.2	20.3
No Poverty	14.2	10.6

*Based on unmet needs

Source: Barrón M, Bazán M, and Castillo R. *Barreras económicas en el acceso a servicios de salud de calidad: diagnóstico y políticas para su superación*. CIES, CARE. Lima: July 2006:27. Available at: http://www.consortio.org/observatorio/informes/Barreras_economicas_servicios_salud.pdf. Accessed February 24, 2007.

Maximum Available Resources

The ESC Rights Committee has stated that “In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.”³⁰ By objective measures, Peru is not currently devoting the maximum extent of available resources to realize its core obligations relating to the right to health, or maternal health concerns in particular. As compared with other countries with comparable GDP per capita, Peru’s health system faces a dramatic shortage of funding. Calculations differ, but conclusions do not. According to MINSA, Peru spent USD 102.80 per capita annually on health care in the period 1995 – 2000,³¹ considerably less than its South American neighbors of Brazil (\$267), Venezuela (\$233), and Colombia (\$186).³² According to the Economic Commission for Latin America and the Caribbean (ECLAC), Peru spends amounts of no more than USD180 per capita per year on social spending, including health, whereas the regional average stands at USD 610 per capita per year.³³

According to a UN report, Peru’s per capita health care investment declined from 95 *nuevos soles* in 2001 to 78 *nuevos soles* in 2003 (from approximately USD 28 to USD 23).³⁴ However, this decrease in health care spending was accompanied by a positive GDP growth,³⁵ indicating that the availability of resources was not the source of such decreases. When considering the period between 2000 and 2005, although the health sector’s annual budget increased in absolute terms, it decreased in relative terms, despite government commitments to increase social spending as part of the National Agreement

In its 2006 report, *A New Social Contract: An Agenda for Improving Education, Health and the New Social Safety Net in Peru*, the Bank forcefully concludes that “given that it will be extremely difficult for Peru to find additional savings through further cutbacks of public funding, it has no option but to increase its social spending *pari passu* through greater tax collection and the reassignment of the budget.”

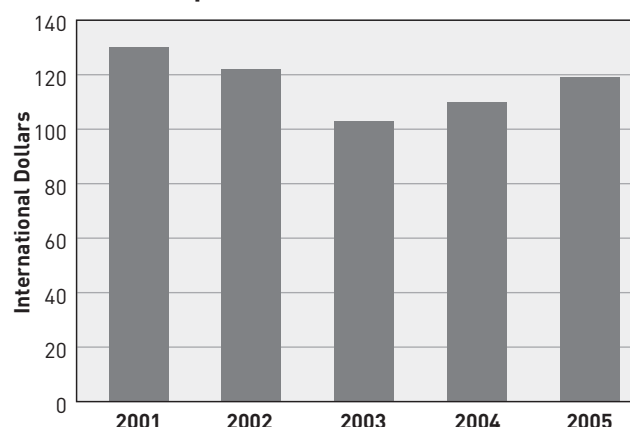
(*Acuerdo Nacional*) signed by former President Toledo in 2002.

As noted in Chapter V, Peru’s low health spending is, in part, a factor of raising lower revenues than other countries and less than that recommended by the IMF. Peru’s tax revenues currently constitute only 13.3% of GDP, while the IMF recommends that they constitute at least 15%. Thus, the Peruvian government’s failure to increase the extent of resources that it devotes to health, and maternal health in particular, reflects political choices and a lack of political will, rather than absolute resource constraints.

At the regional level, regulations regarding tax revenues from mining and other sources of revenue that could be channeled to health care are not because of a lack of clarity in regulations. For example, tax proceeds on mining and petroleum (*canon minero* and *canon petrolero*, respectively) are not interpreted to explicitly include spending on infrastructure that would improve health care referral systems.

The Peruvian government distributes 50% of mining taxes to sub-national governments as royalties.³⁶ The allocation of royalties depends on a variety of criteria,

Figure 9: General Government Expenditure on Health Per Capita (in International Dollars)



Source: PERU - *National Expenditure on Health*. 2007. Available at: <http://www.who.int/nha/country/PER-E.pdf>. Accessed June 27, 2007.

notably the population density, infrastructure development, access to basic necessities, and the quantity of mining products a given subdivision yields.³⁷ The Ministry of Economy and Finances has changed the distribution criteria several times, most recently in September 2003³⁸ and the middle of 2004.³⁹ By law, the regional government is to dedicate a percentage of the royalties received from mining revenues to “social investment.” However, social investment has until now not been interpreted explicitly to include investment in health care infrastructure and referral systems.

The mining and hydrocarbon sector has seen substantial growth in revenues in recent years, expanding by close to 7% for several years and constituting a principal reason for Peru’s GDP growth.⁴⁰ In many of the departments where maternal mortality is highest, including Puno, Huancavelica, and Cajamarca, the regional government derives significant resources from mining or petroleum. By simply making explicit that “social investment” includes such factors, these regional governments could expand their available resources to devote to health and maternal health, in particular.

Non-discrimination and Equality

Under international law, all human rights, including the right to health, are to be guaranteed “without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”⁴¹ Under the Peruvian Constitution: “No one should be discriminated against on the basis of origin, sex, language, religion, opinion, economic condition or for whatever other reason.”⁴² According to the Peruvian Constitution, the state must guarantee access to health care on a non-discriminatory basis. Under international law, discrimination need not be intentional nor *de jure* but merely needs to have the “effect of nullifying or impairing the equal enjoyment or exercise” of the right to health to constitute a violation of various relevant treaties.⁴³

The UN Special Rapporteur has clarified that “The right to health principles of equality and non-discrimination have three important roles to play in policies to reduce maternal mortality. First, they underpin programmes that promote more equitable distribution of health care, including provision in rural or poor areas or areas with high indigenous or minority populations. Second, they underpin prioritization of interventions—such as emergency obstetric care—that can guarantee women’s enjoyment of the right to health on the basis of non-discrimination and equality. Third, policies which

promote non-discrimination and equality—as well as dignity, cultural sensitivity, privacy and confidentiality—in the clinical setting, can improve patient-provider relationships and encourage women to seek health care.”⁴⁴

High maternal mortality levels in Peru reflect multiple levels of combined discrimination based on gender and race/ethnicity.

Ethnic Discrimination and Inequality: Individual, Institutional and Structural

The UN Special Rapporteur on the Right to Health has called on governments to make “health facilities, programmes and projects, and health-related information [available] in languages spoken by indigenous peoples”, institute “training of indigenous health workers to conduct outreach services to and health care in indigenous communities,” and institute “training of health professionals to ensure that they are aware of, sensitive to, issues of ethnicity and indigenous culture.”⁴⁵

PHR found evidence of widespread discriminatory attitudes among individual healthcare providers in Huancavelica and Puno that mirror the findings of other studies.⁴⁶ Healthcare providers described indigenous customs to PHR as “idiosyncracies,” “backwards,” or “ignorant.” Providers asserted to PHR, in relation to the indigenous populations, that “they need to be taught” or “they lack a lot of education.” Upon further clarification, these references to “lack of education” seemed related almost exclusively to indigenous cultural beliefs and resistance to the mode of delivery provided in the formal healthcare system. Dr. Luis Antonio Maldonado Neyra, the then Director General of the Regional Directorate of Health of Puno, said to PHR that “maternal mortality is a cultural problem; it’s in their heads.”⁴⁷

Coercive practices targeted at indigenous populations, documented by PHR, appear to be rooted in these discriminatory attitudes. For example, PHR found examples of outright coercion targeted at indigenous populations to give birth in health establishments, such as the use of police and threats of incarceration in the Pampas health center in Huancavelica. Other practices, such as the imposition of fines for obtaining birth certificates when deliveries occurred at home, have a disproportionate impact on indigenous populations in practice.

PHR also observed manipulation of information explicitly because health system users were indigenous. For example, one nurse in Puno told PHR that she will tell the indigenous population whatever it takes to get them to follow her instructions. “For example, I’ll tell them they’re making the babies stupid when they wash them

in cold water. That's their tradition, to wash a newborn in cold water, but I will yell at them that they are killing neurons and that's why they are all so stupid."

Cultural insensitivity bears directly on both accessibility and acceptability of care. According to CEDAW, "acceptable services are those that are delivered in a way that ...is sensitive to her needs and perspectives."⁴⁸ According to the ESC Rights Committee, "[H]ealth facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."⁴⁹ In this regard, health facilities, goods and services "must be sensitive to gender and to the rights and cultures of minorities and indigenous peoples."⁵⁰

This degree of cultural insensitivity can only be remedied by a wholesale change in attitudes among health professionals. The brief training modules for health providers funded through PARSalud I in "interculturality" are radically insufficient in both their coverage and their content. Rocío Gutiérrez of Manuela Ramos told PHR that, in the ReproSalud trainings her organization had conducted in Puno, Huancavelica and other departments, they had had some success working with women and men from the communities, as well as with health providers, but that true intercultural training takes time. She noted that even the mapping of pregnant women (*radares de gestantes*) are "often used to monitor and then persecute them so that they come in for institutional births.... health providers generally have no consciousness of women having rights."⁵¹

For his part, then Vice Minister of Health José Calderón Yberico noted in an interview with PHR that the State is not good at teaching interculturality and that NGOs and civil society groups should be the ones to do so.⁵² The participation of civil society, and in particular the actual population groups with whom intercultural communications are sought, is a prerequisite for effective, rights-based training.

However, the State cannot abdicate its responsibility to provide culturally-acceptable care. Basic education for health professionals in Peru should include training in inter-cultural communication and human rights, in accordance with the ESC Rights Committee's General Recommendation 14, which states that a basic obligation of the State is "to provide appropriate training for health personnel, including education on health and human rights."⁵³ Such training should be required for licensing and should also be required for accreditation of health professional schools, including medical schools.

At the institutional level, PHR found that many health establishments did not permit traditional vertical birthing positions or other traditional practices, which in practice reduced accessibility of care, and is also contrary to regulations of the MINSA.⁵⁴ Even when facilities had been recently remodeled, such as the Obstetric Center in the Regional Hospital in Puno, they had not been equipped to permit vertical delivery. The Regional Hospital in Huancavelica had previously permitted vertical delivery but had reversed course because in the director's words "it was easier for the attending doctors to deliver on the metal tables." Signs on the outside of the

Does SIS Implementation Create Discrimination?

PHR learned of discrimination against patients with SIS coverage in urban and peri-urban areas where not all patients have SIS coverage. In effect, women in a focus group in Carabayllo described a two-tiered system of health care, whereby women with other forms of payment were treated first and better than those who only had social insurance. Many women told PHR of having to wait hours at prenatal appointments, when women who had private insurance or were paying in cash were ushered in hours ahead of them and given more complete examinations.

Such discriminatory treatment extended to obstetric emergencies. For example, one focus group participant recounted a recent story of having been made to wait at least twenty minutes at the emergency room door of the Hospital Collique when she arrived, having

just given birth to a very premature infant in a taxi, the placenta still attached to her.

Structural incentives factor into discrimination against SIS patients. Inadequate and slow reimbursement means that the health establishments lose money on SIS patients. Health promoters in the focus group stated that health centers in peri-urban areas such as Progreso, north of Lima, are under pressure to try to minimize SIS patients, because the MINSA determines how many slots are allocated for patients in PLAN C of the SIS in localities with less than 65% percent of the population classified as indigent. However, such allocations rarely correlate with real needs.

Another focus group participant said, "In Peru, health care is what you can pay for and who you know. Having the SIS means you can't pay and you don't know anyone."

Huancavelica hospital advertising that vertical deliveries were permitted had not been changed, however. PHR observed in a number of establishments that other indigenous rituals surrounding childbirth—such as darkened rooms, warmer environments, and allowing women to drink herbal teas and eat soups, were also not followed, and accommodations were not implemented.

Additionally, the absence of health personnel who speak the local language, coupled the lack of any other form of accommodation, such as interpreters, constitutes a form of discrimination and a systemic barrier to accessible care. In two of the departments with the highest concentrations of indigenous people, PHR found only a small minority of health professionals and an even smaller percentage of doctors who spoke the local languages. PHR's findings confirm key informants' statements that it is extremely rare for doctors across Peru to speak Quechua, Aymara or other indigenous languages. Few doctors come from the areas where these languages are spoken, and they are not taught at any medical school in Peru. Without a system in place at the institutional level to provide for interpreting in all provider-patient interactions, this absence of language skills decreases both accessibility and quality of care.

Communication, however, is not merely a matter of expressing facts, but also of interpreting information and interacting in culturally-appropriate ways. Intercultural training is not part of the required curriculum in any medical school, nor is such training required for licensing.⁵⁵ Even at provincial medical schools which serve local populations, such as the Universidad Nacional del Altiplano, PHR was told that training is divorced from local context. According to representatives from the DIRESA in Puno, this education system produces an existential contradiction in health professionals from the department of Puno itself.⁵⁶ PHR witnessed such an existential contradiction in the attitudes of many health professionals in Puno who spoke about the population as though they were fundamentally different from them.⁵⁷

On another level, structural inequality is pervasive in the Peruvian health system. The ESC Rights Committee has made it clear that "States have a special obligation ... to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt."⁵⁸ The ESC Rights Committee has also stated that a core obligation of States parties includes ensuring "the equitable distribution of all health facilities, good and services."⁵⁹

In Peru, such structural factors result in *de facto* discrimination against ethnic minorities in a number of ways. Although many indicators are not disaggregated by ethnicity, which is itself a problem for tracking equity, there are greater health-related resources available on a per capita basis to Peruvians in areas with low indigenous populations, such as Moquegua and Tacna, as compared with areas, such as Huancavelica, Ayacucho and Puno, with high indigenous populations.⁶⁰

This inequity translates into fewer health facilities, doctors and specialists per capita—including anesthesiologists who are critical to Cesarean sections—with the "effect of nullifying or impairing the equal enjoyment or exercise" of the right to health for many women in Peru.⁶¹

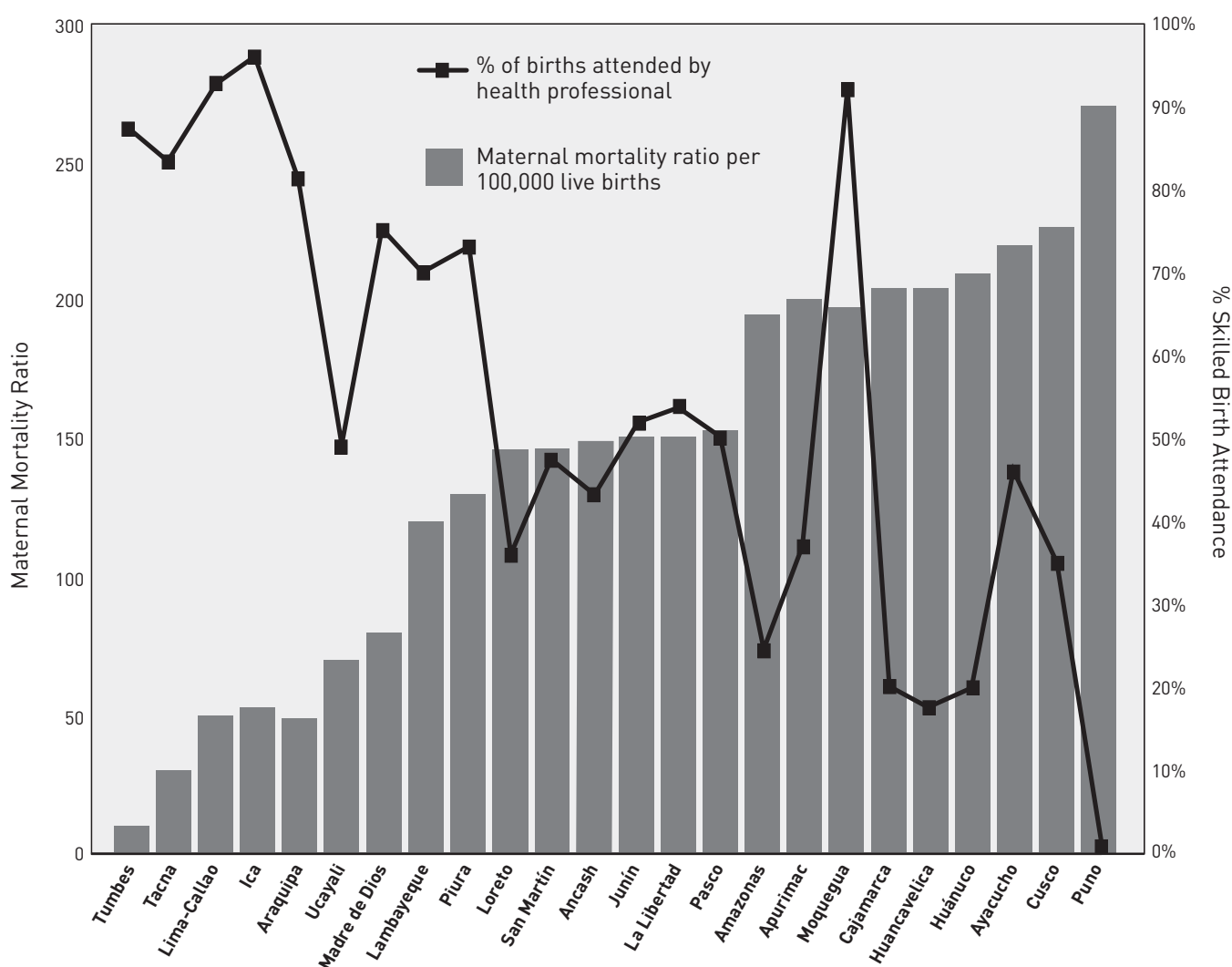
Such spending inequity results in measurably less availability and accessibility of care necessary to reduce maternal mortality, including skilled birth attendance, in regions such as Puno, Huancavelica, Cajamarca, and Huanuco, all of which have significant indigenous populations.

This resource dichotomy—and the attendant implications for availability, accessibility and quality of care—is replicated within the departments themselves, with significantly more resources devoted to healthcare facilities

Delegation of Anesthesia

Availability of anesthesia presents a particular problem in Peru. At the time of PHR's investigation, there were no anesthesiologists in Cerro de Pasco for example, and a shortage in Huancavelica and Puno. Under Peruvian law, no norm permits anyone other than an anesthesiologist to administer anesthesia. In locations where anesthesiologists are scarce, *i.e.*, the highly rural areas where indigenous populations are disproportionately represented, this constitutes a barrier to access to life-saving Cesarean surgeries. A rights-based approach concerned with increasing access to EmOC among marginalized and disadvantaged groups such as indigenous populations requires that, first, regulations be promulgated that allow general practice physicians and nurse-anesthetists to administer anesthesia, thereby resolving attendant liability issues that prevent them from doing so now. Second, to avoid the ad hoc practices that occur across rural Peru today, these health professionals need be provided with adequate training in the administration of anesthesia, in order to provide adequate quality of care.⁶²

Figure 10. Maternal Mortality Ratio and Access to Skilled Birth Attendance According to Region, 2002



See: ENAHO 2003-IV trimestre elaborated by CIUP in Vásquez E. *¿Los niños...primero? Volumen III. Niveles de vida y gasto pública social orientada a la infancia 2004-2005*. Save the Children Sweden:51.

ties in the more urbanized areas of these departments and fewer to rural areas, where the indigenous populations overwhelmingly reside. Although decentralization of the health sector has given greater power to regional governments, many of the rural poor, who are overwhelmingly indigenous, are not represented in regional decisions related to their own health. For example, PHR observed that the Regional Hospital in the capital city of Huancavelica has the capacity to perform laparoscopic surgeries with high-tech equipment, and women routinely receive three ultrasounds in every pregnancy, while indigenous *campesinas* in rural areas go without access to even the most basic EmOC in many cases.⁶³ This is particularly striking given that over two-thirds

of the population in Huancavelica live in rural areas; yet the government is responsive not to their needs but to those of urban elites.

In Puno, the ENDES 2000 found glaring disparities that mirrored rural-urban disparities at the national level.⁶⁴ For example, the study showed that women in urban areas and those with higher education are more likely to have received more thorough prenatal care, including blood and urine tests during their exams.⁶⁵ In addition, Caesarian sections were three times more frequent among women with higher education than among those with only primary education or below, who were disproportionately from rural areas.⁶⁶

Peru's own progress report on the MDGs acknowl-

edges the continuum of marginalization of rural, disproportionately indigenous women: “the data reflect the persistence of enormous inequities that permeate the country.”⁶⁷

Gender Inequalities and Discrimination

Gender inequality in Peru is inextricably linked with ethnic discrimination and rural poverty. In its Concluding Comments on Peru’s sixth periodic report under the Women’s Convention, CEDAW stated that it was “concerned about the situation of rural, indigenous and minority women which is characterized by precarious living conditions and lack of access to justice, health care, education, credit facilities and community services. The Committee is concerned that widespread poverty and poor socio-economic conditions are among the causes of the violation of women’s human rights and discrimination against rural, indigenous and minority women.”⁶⁸

PHR observed in Puno and Huancavelica that women continue to remain disempowered as decision-makers in their own right to seek health care. In different ways, Carolina, Evarista, Pabla, Tomasa and Antonia all lacked control over decisions relating to their bodily integrity and reproductive health. Even in cases of emergency, PHR found that the men in the family make life-changing health decisions for their wives or other female relatives, as in the case of Evarista’s death in Huancavelica. The ability of women living in Carabayllo and surrounding peri-urban areas outside of Lima, who had access to resources to make their own health care decisions, contrasted sharply with the behavior of indigenous women in the *Sierra*.⁶⁹ Studies done elsewhere in Peru among native and indigenous populations have also found that men assume the decision-making role.⁷⁰

Virtually all of the case studies included in this report reflect the ineluctable connections between the lack of agency women have in their private lives—relating to bodily integrity, choice of sexual relations, birth spacing, etc—and the lack of agency they have in the public sphere. The relationship goes in both directions. For example, inequalities in education between men and women translate into more women being monolingual and illiterate—evidenced in every case PHR studied except that of Carolina—and therefore having greater barriers to access to healthcare and greater dependency on their husbands.⁷¹ Greater dependency on male partners creates more barriers to care, as noted above.

Furthermore, government health and other social programs aimed at providing assistance to women and children in poverty tend to reinforce stereotyped roles

of women as caregivers and sexual objects, rather than fostering gender equity and treating women as rights-holders. For example, the JUNTOS program, a joint program coordinated by the MINSA, the Ministry of Education, and the Ministry of Women and Social Development (MIMDES, *Ministerio de la Mujer y Desarrollo Social*), makes cash transfers conditional on certain behaviors; the program operates with a substantial budget of approximately 100 million *nuevos soles* a year (approximately USD 30 million). According to Rocío Gutiérrez of Manuela Ramos, JUNTOS routinely makes aid to women conditional on their giving birth in institutions or on leaving health establishment with some form of birth control.⁷² Additionally, women—who are assumed to have “free time”—are required by JUNTOS to comply with certain tasks within certain timetables, including bringing children in for vaccination and enrolling them in school. When they do not comply, they are removed from JUNTOS, at least temporarily.⁷³

Gender discrimination is also reflected in laws and policies that have a detrimental impact on women’s health. For example, under Peruvian law, abortion is illegal except when necessary to preserve the life or health of the mother. Both the woman who undergoes the procedure and the health professionals who perform it are subject to sanctions in all cases except therapeutic abortions.⁷⁴ However, the definition of such “therapeutic abortions” has been interpreted narrowly to exclude situations where the woman’s mental health is at risk. The United Nations Human Rights Committee found in the case of *Karen Llantoy v Peru*, involving a teenager who was forced to carry an anencephalic fetus to term and suffered grave psychological damage as a result, that the right to health includes both physical and mental health and that Peru’s law was overly restrictive and violative of women’s human rights.⁷⁵ This decision is binding upon the Peruvian government.

More generally, a 2004-05 study done by the Peruvian Society of Obstetrics and Gynecology found widespread confusion about the legal status of abortion among gynecologists and a need to reform the law.⁷⁶ The study concludes that “restrictive laws on abortion have not diminished its practice. In Lima, one denunciation is made out of every 1080 abortions. Gynecologists have no knowledge of the legal situation. There is a legal gap or double interpretation on the pregnant female treatment with an anencephalic fetus [sic]. It is necessary to modify the Penal Code by introducing the term of pregnancy of an anencephalic fetus as therapeutic abortion, or legalizing eugenic abortion.”⁷⁷

CEDAW has stated that “laws that criminalize medical

procedures only needed by women and punish women who undergo those procedures” constitute “barriers to women’s access to appropriate health care” and are discriminatory.⁷⁸ In this case, as the Human Rights Committee held in a binding decision, the overly restrictive interpretation of therapeutic abortion not only presents a barrier to appropriate care but is directly damaging to women’s health.⁷⁹ In other countries in the region where abortion is generally illegal, such as Argentina, there is movement on the part of courts, local ministries of health, and the national legislature to clarify that therapeutic abortions include cases where the mental health of the mother is at stake.⁸⁰ Similar actions are necessary in Peru.

Meaningful Participation

A rights-based approach to addressing maternal mortality affects process as well as results. Meaningful participation by those who are affected by laws, policies and programs is crucial in all spheres of decision-making and implementation. According to the ESC Rights Committee, an “important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system, and in particular, participation in political decisions relating to the right to health taken at both the community and national levels.”⁸¹ For its part, paragraph 17 of article 2 of the Peruvian Constitution sets out the right to “participate as individuals and in association with others in the political, economic, social and cultural life of the nation,” and as elsewhere it is recognized as a matter of public interest, health arguably constitutes one domain of such participation.⁸²

A rights-based approach to addressing maternal mortality in Peru calls for the democratization of the entire health sector, with a transfer of planning and decision-making power to the individuals and communities the health system is supposed to serve, as well as the health professionals who work within the system.

Community Participation, Especially in Indigenous Communities

Article 25 of ILO Convention 169 specifically stresses the need for community participation in the organization of indigenous peoples’ health services: “Health services shall, to the extent possible, be community-based. These services shall be planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care healing

practices and medicines.”⁸³ Examples such as Evarista’s case in Carhuapata, Huancavelica, and the aftermath of Pabla’s death and autopsy in Ramis, Puno, illustrate how starkly absent this cooperation between the formal health sector and indigenous communities has been in Peru, as well as how traditional beliefs and practices are not taken into account.

Cooperation with community leaders and community health promoters could be extremely important in addressing maternal mortality in relation to such specific factors as arranging for communication and transportation, evacuation plans in emergencies, and the use of funds for emergencies, as well as more structural factors relating to the design and quality of care.

The UN Special Rapporteur calls specifically for “the active and informed participation of indigenous people in the formulation, implementation and monitoring of health policies and programs.”⁸⁴ Additionally, although not a binding treaty, Article 31 of the Draft Declaration on Indigenous Peoples explicitly connects health to self-determination: “Indigenous peoples, as a specific form of exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, including...health.”⁸⁵ In Peru, PHR found just the opposite to be true. As other studies have pointed out, the health system is perceived across many indigenous communities as a westernizing, colonizing force that does not respect indigenous cultural traditions and preferences.⁸⁶ Even when explicit norms exist, such as the 2005 MINSA norm regarding vertical birthing, these appear to be selectively observed in practice.

Although not particularly targeted at indigenous populations, the CLAS potentially provide a mechanism to increase indigenous control over the way their health care is delivered. The CLAS were ostensibly implemented in the 1990’s to facilitate community participation, including control over healthcare priorities at the local level. Doctors are supposed to be held accountable to community members who sit on the managing council who are responsible for drawing up local health plans and allocating budgets. In practice, it is not clear that the CLAS have truly served their intended purpose. Women are under-represented on the associations and managing councils of the CLAS and therefore women’s health needs tend to be neglected. Some studies even point to the potential of the CLAS to recreate the surrounding environment of racism and power inequities.⁸⁷

In theory, however, “by encouraging a community to feel ownership and responsibility for a facility, and by encouraging a facility to view its first line of account-

ability as being to the community it serves, the result will be *sustained* high quality, responsive, rights-sensitive services.”⁸⁸ According to multiple key informants, the real problem with the CLAS has been in implementation. Under the Toledo administration, the CLAS mechanism was modified and facilities denominated as CLAS were increased without attending to the community participation role. Since 2002, the CLAS have also been systematically under-funded, leaving few resources for the community members to prioritize or allocate. Further, as doctors work on contracts with the MINSA, they are increasingly less accountable to the community members who sit on the council, and rather, behave as would any other MINSA employee. The history of the midwife from the CLAS Puquis in Puno, in Melania’s case, demonstrates what happens when a CLAS is no longer responsive to the community.

Political Participation, Especially by Rural Women

The ability to participate in political processes, including but not limited to voting, is a necessary condition to exercising active citizenship, which is closely tied to the enjoyment of the right to health. As the World Bank recognizes, “active citizenship facilitates collective action, which can yield more effective and better targeted public services. Community involvement is particularly effective in managing such local public goods as water supply, sanitation, forests, roads, schools and health clinics.”⁸⁹ The UN Special Rapporteur has stated that “the right to health includes an entitlement to participate in health policymaking at the local, national and international levels. Participation by relevant stakeholders, including women, will help develop more effective and sustainable programmes, reduce exclusion and enhance accountability.”⁹⁰

However, numerous studies have found that many rural Peruvians, and in particular *campesina* women, do not possess the identity documents required to vote or participate in programs.⁹¹ The Human Rights Ombuds Office (Defensoría del Pueblo) estimates that more than three million people do not have the National Identity Documents (DNIs) necessary to vote and to gain access to other programs.⁹²

Recent studies done by the Center for the Peruvian Woman “Flora Tristán” and the governmental National Registry of Identification and Civil Status (RENIEC, *Registro Nacional de Identificación y Estado Civil*) reveal that, for example, in Piura, 59% of women surveyed did not have a birth certificate and 89% did not have a military identification, which is universal and unrelated to

whether a person does military service.⁹³ In Cajamarca, the percentages were 47% and 80%, respectively. Consequently, as many as 98% of women surveyed did not have and could not obtain DNI’s, thus precluding the exercise of civic participation and limiting their ability to access certain social benefits and services, including through the social insurance scheme.⁹⁴

The reasons underlying this lack of identity documents for rural women include economic barriers, lack of availability and coverage of services by the RENIEC, cultural barriers and mistreatment (discrimination against women and against children born to unwed mothers), and destruction of registries due to the civil violence in certain departments.⁹⁵ Without the ability to vote—and without other fora to assert their voices—these rural residents (and in particular women) are left invisible and uncounted when policies and budget allocations are made. Organized political participation through direct voting, as well as through the creation of fora for rural women to negotiate on their own behalf, are important steps in and of themselves and as means to foster more responsive governmental policies and allocation of healthcare budgets, including those relating to EmOC.

This is particularly true in the context of decentralization, which has been endorsed by the World Bank and IDB. In Peru, the downside of decentralization has been the replication of patterns of exclusion between urban and rural areas that already exist on a national level. Regional governments are easily captured by local elites, who almost invariably reside in local capitals or major cities in departments, while residents in rural areas consistently fail to have their voices heard because there are no organized fora in which to express their interests, and they are unlikely to vote.⁹⁶

Regional governments should encourage the active participation of rural women in policy discussions and permit participation of a broad diversity of women’s groups in policymaking processes. The national government needs to ensure that all citizens have appropriate identity documents and can exercise their right to political participation. This requires taking affirmative outreach measures to increase accessibility and availability of registration, and ensuring that obstacles to obtaining such documents are removed, including illegal discrimination against children of unwed parents (*convivencias*), common in the *Sierra* and other parts of rural Peru, and the imposition of *de facto* fines for seeking birth certificates for children born at home, a practice PHR documented in Huancavelica and Puno.

The World Bank and IDB should include additional funding for DNI production and distribution through funding for the RENIEC in PARSalud II.⁹⁷ Such funding, accompanied by meaningful efforts to increase voter participation among rural residents, especially women, could serve to increase the accountability of regional governments, improve monitoring efforts, and possibly help to restructure social insurance payment mechanisms.

Participation by NGOs and Civil Society Groups

The “entitlement to participate in health policymaking at the local, national and international levels” and “participation by relevant stakeholders” called for by the UN Special Rapporteur must go beyond voting to include other more direct forms of participation.⁹⁸ For example, the ESC Rights Committee calls for a national strategy and plan of action to be “devised, and periodically reviewed, on the basis of a participatory and transparent process.”⁹⁹

Since the end of the Fujimori regime, Peru has seen a broad array of processes and institutions aimed at fostering participation, principally the *Mesa de Concertación para el Alivio de la Pobreza* (Concerted Working Group for Poverty Alleviation), *Consejos de Coordinación Regional y Local* (Regional and Local Coordination Councils), and the *Presupuesto Participativo* (Participatory Budget). These councils are made up of a combination of elected representatives and civil society organizations. Key informants note, however, that by and large, women did not participate in these processes, and that women’s issues, including sexual and reproductive health, were absent from these agendas.¹⁰⁰

Other networks have been created exclusively among civil society organizations. The largest may be the Civil Society Forum on Health (*Foro de la Sociedad Civil en Salud, Foro Salud*), which is made up of 17 regional Fora and has functioned as an important actor in monitoring health policy at various levels. Other networks that function, often in collaboration with ForoSalud, include the Coalition for the Right to Health (*Coalición por el Derecho a la Salud*), which has proposed patients’ rights legislation, and the Round-Table to Monitor Sexual and Reproductive Health (*Mesa de Vigilancia de Salud Sexual y Reproductiva*), which has focused on countering ideological assaults on family planning and reproductive health.

Nevertheless, despite these processes, civil society institutions exercise little power over policy or budgetary decisions. The World Bank comments that:

Commonly, the participatory budget ends up with a proposal that reflects the interests of the participants. The proposal is subsequently cut down by

the local government and many specific proposals are rejected by the National System of Public Investment. In consequence, the final approved budget resembles little the proposal formulated by the Participatory Budget. In addition, many of the proposals are not implemented, either deliberately or because of lack of capacity of local governments.¹⁰¹

The World Bank goes further, arguing that the lack of clarity in roles and the great energy invested in these activities could be producing “participation fatigue,” or worse, that all efforts are focused on the design of budgets and plans with no attention paid to monitoring of implementation.¹⁰² In this regard, Dr. Ariel Frisancho, ForoSalud National Directorate’s member and civil society representative in the Nation Health Council in Lima, notes that Foro Salud, an NGO comprising many individuals and institutions working on health, had propelled dialogues on health policies in twelve regions of the country. However, there were weak mechanisms for follow-up and as a result there has been virtually no implementation.¹⁰³

The World Bank itself, together with the IDB, was heavily criticized by numerous key informants for the lack of transparency and participation in PARSalud I. Susan Thollaugh, Office Chief for the USAID Peru Country Office, stated that PARSalud had worked very little with other agencies, such as AID and UNFPA.¹⁰⁴ Victor Zamora, former Assistant Representative for Peru at UNFPA, added that “if PARSalud did achieve advances, I don’t believe it can show them because it has not done so.”¹⁰⁵ Pedro Francke, former Coordinator of Foro Salud put it similarly: “if PARSalud was successful, no one knows about it.”¹⁰⁶ As far as PHR could learn, there was no civil society participation in the evaluation of PARSalud I.

PARSalud I’s emphasis on FOE’s and referral systems was extremely important as a step to enable the determination of the equitable allocation of EmOC. Furthermore, Doniska Tarco, a former consultant for PARSalud, stated that PARSalud I had achieved some progress that could be evidenced in some regions, but the documents were published internally and not known publicly.¹⁰⁷ Luis Cordero, another consultant for PARSalud at the national level, also argued that PARSalud had achieved progress on certain indicators.¹⁰⁸ It may be that publishing and publicizing the achievements did not occur because the end of the program coincided with a change in political administration. In any case, it is clear that PARSalud I missed an opportunity to leverage evidence of public

health achievements into the basis for broader dialogue and political commitment by following a closed process lacking transparency.

As of April, 2007, when PHR met with Ian MacArthur, Sector Specialist of the IDB, no consultations had been held with UN agencies, user groups, or NGOs on the design of PARSalud II.¹⁰⁹

Participation Within the Health Sector

Peru's health sector is highly autocratic and vertical, and retains highly centralized planning despite the decentralization process. In an interview with PHR, then Vice minister of Health José Calderón Yberico criticized the *Planes Concertados* (Concerted Plans for Health). He argued that the MINSA should "start with what we determine to be national priorities" rather than collecting regional priorities. Calderón said "the MINSA can't be negotiating with local governments."¹¹⁰ PHR found that this autocratic attitude and policy-making is reproduced within the regional directorates of health as well.

Health professionals who work in establishments have little control as to how funds are to be spent or what policies their establishments follow. PHR encountered numerous health professionals in Puno and Huancavelica—at all levels—who were deeply frustrated by decisions that had been taken regarding the allocation of funds without regard to the needs of their patients. Heads of departments and hospital directors in both Puno and Huancavelica had made proposals for funds from PARSalud I but the DIRESA had changed those proposals without consultation.

There are systemic policies that influence the ability of front-line health workers to have a voice in how decisions are made as well. For example, despite the disastrous consequences of quotas when imposed in the family planning program under Fujimori in the late 1990's, the MINSA still imposes quotas for institutional births and prenatal controls on front-line health workers. The use of numerical targets, if not quotas themselves, is at least tacitly endorsed by the World Bank and IDB as a means of measuring health workers' "productivity."

In addition to the women in the population who bear the consequences of the perverse incentives created by such policies, the health professionals on short-term contracts without benefits suffer most from such quotas. Health workers such as those PHR met at the Hanajquia health post in Puno are left with unlivable salaries if they fail to meet arbitrarily-set productivity quotas, into which they have had no say or input whatsoever.

Information

In order for people to participate and evaluate programs and policies to reduce maternal mortality, it will be necessary for them to have access to adequate information, including budget numbers and health statistics—making it apparent that the right to health is interdependent on the right to information.¹¹¹ Information regarding health at the individual, institutional or systemic level is not widely accessible in Peru, and even much less so to persons for whom Spanish is not their first language.

Under Peruvian law, a woman—or in the case of her death, her family—has the right to her medical record. However, individual establishments often make it extremely difficult for these records to be obtained. Further, medical records and other health documents, such as SIS inscriptions, are especially difficult to obtain when in the context of a claim or dispute. The case of Melania in Puquís, Puno, sadly illustrates how medical records are sometimes made to disappear when a family is pursuing legal redress.

At the societal level, policies make it difficult to obtain access to information in institutions or with respect to spending and policies. For example, the World Bank notes that the eligibility criteria and benefit packages under the SIS "now appear to be a well-guarded secret."¹¹² As the Bank suggests, this information should be widely disseminated and available in every clinic and hospital. The program planning goals and evaluation indicators used in each region should be published on a quarterly or periodic basis and made publicly available as well.¹¹³

Some recent laws might provide transparency and access to public information. In 2001, the transition government of Valentín Paniagua issued an Executive Decree requiring that all public agencies of the Executive Branch incorporate Unified Texts on Administrative Procedures (*Textos Unicos de Procedimiento Administrativo*, TUPAs) into their regulations in order to facilitate access to information.¹¹⁴ Ley N° 27806, the *Ley de Transparencia y Acceso a la Información Pública* (Law of Transparency and Access to Public Information) was later enacted and has been modified to extend access to public information. According to this law, citizens have the right to solicit and receive information from any public administration and under no circumstances must they state their reason for exercising this right.¹¹⁵

Unfortunately, in practice, the existence of the *Ley de Transparencia* has not been made widely known; consequently, it has not substantially increased public access to information. One of the goals set out in the National Plan of Action on Human Rights, adopted by Supreme

Decree in 2005, includes strengthening these legal advances and replacing the “culture of secrecy with the culture of transparency and free access to information”¹¹⁶ Another activity outlined in the National Plan of Action on Human Rights, which relates to language of information as well as culture, refers to “guaranteeing the exercise of the right to information in health, with special emphasis on the population of rural and indigenous communities, with respect to cultural differences.”¹¹⁷

Accountability; Access to Effective Remedies

The UN Special Rapporteur has stated that “the right to health demands accountability of various stakeholders, including healthcare providers, local health authorities, national Governments, international organizations, and civil society. Accessible and effective accountability mechanisms, including courts, tribunals, health ombudsmen, impact assessments, and policy review processes—can all help enhance access to health care.”¹¹⁸

Accountability includes important dimensions of financial and political accountability, which are facilitated through transparent access to information and meaningful popular participation. Despite the existence of laws containing provisions intended to promote such public accountability on the part of various levels of government, including the Law of Regional Governments (*Ley de Gobiernos Regionales*), the Law of Municipalities (*Ley de Municipalidades*), and the Law of the Bases of Decentralization (*Ley de Bases de Descentralización*), PHR was informed that in practice some governmental entities dispatch their responsibilities with a mere webpage—often an inaccessible or poorly organized one at that.¹¹⁹ PHR also documented poor mechanisms for accountability for purchases of equipment and use of funds from PARSalud I.

Accountability is also closely linked to effective remedies. According to the Universal Declaration of Human Rights, “Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.”¹²⁰ Under the ICESCR, which is a binding treaty, “a State party seeking to justify its failure to provide any domestic legal remedies for violations of economic, social and cultural rights would need to show either that such remedies are not “appropriate means”...or that, in view of the other means used, they are unnecessary. It will be difficult to show this and the Committee considers that, in many cases, the other means used could be rendered

ineffective if they are not reinforced or complemented by judicial remedies.”¹²¹

Both General Comment 14 and General Recommendation 24 from the ESC Rights Committee and CEDAW, respectively, have stressed that any person or group who is victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.¹²² General Comment 14 from the ESC Rights Committee makes it clear that all victims of violations “should be entitled to adequate reparation, which may take form of restitution, compensation, satisfaction or guarantees of non-repetition.”¹²³ For its part, CEDAW’s General Recommendation 24 calls specifically for the enactment and enforcement of laws to provide sanctions for, among other things, discrimination in access to health care, gender-based violence which has health impacts, and sexual abuse of women patients by health care professionals.¹²⁴

The existing mechanisms for redress in Peru are largely focused on individual errors, rather than institutional and systemic factors, and are therefore inadequate to provide accountability in the context of maternal mortality, where underlying causes are generally systemic. A malpractice or negligence case rises to the level of a human rights violation only when there is some institutional or systemic failure to provide accountability. Sometimes, an overemphasis on individual fault can in fact detract attention away from problematic policies and programs.

Additionally, although some existing mechanisms could prove important to protecting safe motherhood rights in Peru, their use is subject to many of the same financial, physical and cultural barriers as access to health care, in addition to a lack of familiarity on the part of lawyers and judges.

Under Peruvian law, there are essentially three avenues for enforceability of health rights, including those relating to maternal health: administrative, judicial, and through the Human Rights Ombuds Office (*Defensoría del Pueblo*), the last of which is not a remedy *per se*. When domestic remedies are not available or have been exhausted, petitioners can also bring cases before international adjudicatory bodies, such as the Inter-American Commission on Human Rights.

Administrative remedies proceed either through complaints to the director of the health establishment or to the Executive Office of Transparency and Health Defense (*Oficina Ejecutiva de Transparencia y Defensoría de la Salud*, OETDS), which is part of the MINSA and has its office in Lima. A soon-to-be published study on regional systems for the protections of the rights of

health system users found that administrative procedures are rarely utilized for investigating patient abuse or denial of health rights.¹²⁵ The study asked those in charge of administrative proceedings in the departments of Ayacucho, Junín, San Martín, and Ucayali to report the number of open administrative processes for mistreatment of patients and/or the denial of rights to persons using the health system. In all of 2006, there were no open proceedings.¹²⁶

The under-utilization and ineffectiveness of administrative remedies to resolve health rights violations were illustrated in the cases of Francisca in Pampas, Huancavelica and Pabla in Ramis, Puno. Francisca received little, if any, attention from the doctor on duty at the time of her emergency. The subsequent investigation, however, cleared the doctor of any responsibility because ostensibly Amancio, Francisca's husband, had not agreed to have his wife transferred to Huancayo. In fact, the medical records show that this suggestion was made after Francesca was already brain dead. Furthermore, Amancio actively sought but was unable to obtain transportation for his wife because no one would agree to transport her without being paid, and Amancio could not afford to pay anything but a nominal amount.¹²⁷ In Pabla's case, PHR was not informed of any administrative investigation that had ever been launched into the possible culpability of the doctor who sent her home when she had been diagnosed with pre-eclampsia/eclampsia.

At the same time as there appears to be little real administrative accountability within the health system itself, there is misdirected punishment of front-line health workers within the MINSA when maternal deaths occur. PHR learned that health workers who do not enjoy job security because they work on contract are too often summarily dismissed when a maternal death is recorded as having occurred in their establishment. In the case of Evarista in Carhuapata, the nurse's aide was fired. In Ramis, the nurse and midwife had been explicitly threatened if they did not stay quiet with regard to the death of Pabla in Ramis, even though they had correctly diagnosed her with pre-eclampsia and followed up appropriately. This undermines true accountability and creates perverse incentives in the health system for workers to avoid treating women experiencing obstetric emergencies.

The Defensoría del Pueblo is a critically important institution in relation to the enforceability of the right to health, and it can and ought to play a larger role in making healthcare providers and the health system itself accountable to the population they serve, including in the

context of safe motherhood. Thus far, the Defensoría has played an important role in investigating and bringing to light human rights abuses, including the widespread practice of fining families who give birth at home when they seek birth certificates for their newborns. In light of this investigation, the Defensoría was able to influence the creation of a new MINSA norm outlawing the fines.¹²⁸ Unfortunately, actual implementation of this new norm has been haphazard, highlighting the Defensoría's lack of enforcement mechanisms.¹²⁹

The Defensoría could usefully investigate other practices found by PHR. For example, based on PHR's interview with Dr. Isaías José Matamoros Cuipaco in Pampas in the department of Huancavelica, further investigation is necessary regarding the use of police coercion to force women to use healthcare facilities. According to Dr. Matamoros, there is little difficulty in getting indigenous women to come into the health center for care because the local police have agreed to threaten their husbands or families if they do not seek care.¹³⁰ If this practice of police coercion is widespread, it is cause for serious concern. Any use of police to threaten or coerce women into giving birth at establishments constitutes a human rights violation. Similarly, in the regional Hospital in Puno, PHR documented the practice of detaining women who cannot afford to pay for screening for blood transfusions they receive when hemorrhaging. This detention violates human rights under international and Peruvian law and an investigation into how widespread the practice is appears to be clearly warranted.

In addition to its own investigations, the Defensoría can be instrumental in facilitating legal cases relating to maternal health through the judicial system. Indeed, as evidenced in the case of Melania in Puno, campesinos seeking access to judicial remedies face the same hurdles—economic, geographic—as they do with respect to health care. In that case, Melania's husband, Francisco, liquidated his assets to pursue a case in which the midwife appears to have bought her exoneration.

Potentially relevant judicial remedies for acts relating to health rights include the *amparo* (protection writ); the *acción popular* (popular action); the *acción de cumplimiento* (compliance action); civil suits for damages (*daños y perjuicios*), and criminal complaints for negligence, negligent homicide, and abandonment. Some of these remedies call for specific requirements that may limit their applicability and accessibility in practice. For example, civil suits for damages that include the Minister of Health or regional director of health as defendants generally require *averiguaciones previas*, a discovery

process that is usually conducted in a prior criminal case against the authorities. Criminal cases, on the other hand, require convincing the public prosecutor's office to open the case and to pursue it. The story of Francisco in Puno, who spent over two years on the case of his wife Melania's death, illustrates how difficult it can be for an impoverished *campesino* to continually pressure a public prosecutor in a criminal case.

The *amparo* (protection writ), *acción de cumplimiento* (compliance action), and *acción popular* (popular action) are three mechanisms for challenging policies and institutional conduct. The *amparo* is a mechanism that permits a woman to challenge the denial of care at an institution, for example. As important as it is, the application of the *amparo* is limited in that it does not establish binding precedents and cannot be used collectively to challenge practices on behalf of a group of similarly-situated people. Thus, even when a policy is found to be discriminatory in one case, it may be applied in others with similar fact patterns. The *acción popular* sets out a number of prerequisites, including the requirements that the harm is imminent and that the petition is supported by a large number of signatories, for injunctive relief to be provided. The *acción de cumplimiento* (compliance action) is potentially one of the most useful mechanisms for demanding systemic accountability from the government with respect to its health rights obligations, and in particular those relating to addressing maternal mortality. The use of the *acción de cumplimiento* should be widely disseminated among the Peruvian public. For example, it can be utilized to demand that an official or public authority a) comply with a legal norm or execute and administrative action, or b) issue an administrative resolution or regulation when legal norms so require.¹³¹

In practice, not only are judicial processes long, cumbersome and often prohibitively expensive, but also judges and lawyers in Peru are often poorly trained in understanding the right to health and the enforceability of aspects of the right to health. The Constitutional Tribunal's jurisprudence relating to health-related rights has been framed in terms of the right to life. Although aspects of the right to health entail programmatic obligations, violations of specific regulations relating to the government's obligations with respect to health give rise to individual rights, and should be enforced according to the same criteria as other constitutionally-protected rights.¹³²

Moreover, the same economic, physical and cultural barriers to accessibility of the health system in the

first place exist with respect to access to remedies. For example, in 2004, the first year of its existence, the OETDS received during 288 complaints regarding violations of the right to health.¹³³ In the same year, the Defensoría del Pueblo received 391 complaints regarding violations of the right to health. In an interview with PHR, however, Luz Esther Herquinio Alarcon, the Comisionada de la Defensoría del Pueblo in Puno, stated that the great majority of people do not file complaints, including with respect to maternal health. "The problem is that people have to go to Juliaca or Puno or call the free telephone line or file their complaint on the web page—but the very people who need to, don't have access."¹³⁴

"In Peru, the exercise of citizenship is quite restricted and precarious. In regard to health, people have the idea that it is a service that the State provides, and that as a result a high degree of tolerance is required with respect to meeting existing needs, and resignation with respect to the low quality. This means that the task of converting health system users into health citizens— into people who, knowing their rights, position themselves in front of the State, not to ask for a favor, but as citizens demanding compliance with its obligation to guarantee the right to health—is still pending."¹³⁵

A recent study on the enforceability of health rights in Peru concluded that "the State does not facilitate channels of information to disseminate its obligations with respect to the right to health. At the same time, the citizenry is unfamiliar with the mechanisms that exist for the enforcement of these obligations."¹³⁶

International Assistance and Cooperation

Pursuant to article 2 of the ICESCR, each State party undertakes to take steps, "individually and through international assistance and co-operation" to achieve the full realization of the rights in the covenant, including health.¹³⁷ According to the UN Special Rapporteur, "In addition to obligations at the domestic level, developed States have a responsibility to provide international assistance and cooperation to ensure the realization of economic, social, and cultural rights in low-income countries. This responsibility arises from recent world conferences, including the Millennium Summit, as well as provisions of international human rights law."¹³⁸

Donor countries assume human rights obligations

directly and as members of international organizations, such as the World Bank, IMF and IDB. In this latter regard, the ESC Rights Committee has affirmed that “States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.”¹³⁹ The UN Special Rapporteur has also asserted that donor states need to “ensure that their actions as members of international organizations take due account of the right to health.”¹⁴⁰

The contours of obligations of “international assistance and cooperation” are still not well-defined under international human rights law. It is clear, however, that States parties and even—as is the case with the United States—signatories to the ICESCR, assume obligations in accordance with the Vienna Convention on the Law of Treaties “to refrain from acts that would contravene the object and purpose” of the treaty, an obligation which remains in force until such time as the State makes clear its intention not to become a party to the ICESCR.¹⁴¹

Sexual and Reproductive Health Issues

The UN Special Rapporteur recognizes explicitly that donor countries “provide important funding for sexual and reproductive health care in many low-income countries” and urges those countries providing assistance to adopt a rights-based approach to their policies and programmes. For example, their funding should promote access to a wide range of services needed for the enjoyment of the right to sexual and reproductive health, including services and information that reduce the incidence of unsafe abortions.¹⁴²

The US Agency for International Development (USAID) has historically provided a significant percentage of funding for Peru’s sexual and reproductive health and family planning programs, through the government as well as through NGOs. However, on January 22, 2001, President Bush issued an Executive Memorandum directing USAID “to reinstate in full all of the requirements of the Mexico City Policy in effect on January 19, 1993” on USAID’s population program. This policy—commonly referred to as the Global Gag Rule—prohibits foreign NGOs that receive USAID family planning funds from using their own, non-US funds to provide legal abortion services, lobby their own governments for abortion

law reform, or even provide information, counseling or medical referrals regarding abortion. This policy clearly interferes with the ability of NGOs to provide information that might reduce the incidence of unsafe abortions and abortion-related maternal deaths in Peru.

In addition, USAID has attempted to curtail even the provision of services that are permitted, including the dispensing of emergency contraception. Emergency contraception acts to prevent pregnancy and is not an abortifacient. Nevertheless, the Center for Health and Gender Equity (CHANGE) and the Peruvian NGO, Center for the Promotion and Defense of Sexual and Reproductive Rights (PromSex), documented a disturbing pattern of actions by USAID in Peru after the legalization of emergency contraception. In November 2005, the USAID office gave oral warnings to two local grantees, the Defensoría del Pueblo and the Movimiento Manuela Ramos, for supposedly using without authorization the funds from USAID in educational activities that included emergency contraception. On November 30, 2005, USAID Peru sent a letter to its local grantees stating that emergency contraception is “a controversial subject” in Peru and prohibiting the use of its funds to inform women regarding emergency contraception as a method of family planning available through the MINSA. Shortly thereafter, USAID sought reimbursement from Manuela Ramos and the Defensoría del Pueblo for funds used to promote emergency contraception.¹⁴³ PHR learned that Manuela Ramos had to return the monies spent and USAID’s posture has had a chilling effect on activities relating to emergency contraception conducted by grantees.¹⁴⁴ USAID’s interference with the right of women to receive family planning, including emergency contraception, undermines the rights to health and safe motherhood of Peruvian women.

The World Bank and IDB have not imposed measures that directly interfere with women’s access to health-care information or services. However, unfortunately, PARSalud I did not include family planning. In an interview with PHR in April, Ian Macarthur of the IDB called the subject controversial, saying therefore its inclusion in PARSalud II “would be a stretch.”¹⁴⁵

Debt

The eight MDGs, which have been endorsed by the United States government, call for a global partnership for development that “makes clear that it is the primary responsibility of poor countries to work towards achieving the first seven Goals. They must do their part to ensure greater accountability to citizens and efficient use of resources.

But for poor countries to achieve the first seven Goals, it is absolutely critical that rich countries deliver on their end of the bargain with more and more effective aid, more sustainable debt relief and fairer trade rules, well in advance of 2015.”¹⁴⁶ Obligations of donor countries under MDG 8 include “enhanced debt relief for heavily indebted poor countries, cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction.”¹⁴⁷

Peru is a very indebted country. At the end of 2003, its foreign debt represented 38% of GDP (and its internal debt 10% of GDP).¹⁴⁸ The total public debt of over 28.9 billion is close to what international financial institutions consider “risky.”¹⁴⁹ Moreover, as much as 40% of Peru’s foreign debt is in variable interest rate instruments and 63% is in US dollars, which makes the government extremely vulnerable to exchange rate and interest rate risks.¹⁵⁰ The government spends more than four times as much on debt service annually as it does on health.¹⁵¹

The amount of debt Peru is forced to pay limits the extent of available resources it can spend on health. Peru is not alone in this regard; a survey by UNICEF found that in 30 developing countries, governments consistently under-invest in social services, in part because of the fiscal burden imposed by servicing debt.¹⁵² WHO literature points to the same conclusion. For example, in 2001, a WHO commission called for governments to increase health sector spending as a long-term development strategy. However, Dr. Sergio Spinaci, Executive Secretary of the Coordination of Macroeconomics and Health Support Unit of the WHO, acknowledged the challenges posed by debt burdens: “It is not easy within present budgetary constraints to invest more in health,

especially if you have a large proportion of the budget invested in debt repayments and a macroeconomic policy focused on containing even minor inflation and setting rigid spending ceilings for the social sectors.”¹⁵³

In the region, international lending institutions have been experimenting with debt forgiveness as a type of targeted funding to particular sectors, including health. For example, in March 2007, the IDB agreed to cancel \$4.4 billion in debt and interest owed by five of the poorest Latin American and Caribbean countries: Bolivia, Guyana, Haiti, Honduras, and Nicaragua.¹⁵⁴ The freed-up money is to be channeled to health care, education, and infrastructure development in the countries.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is currently promoting a Global Fund Debt Conversion (or debt-to-health initiative), whereby Peru and three other pilot countries will have certain bilateral debt be forgiven, with the money saved going to health.¹⁵⁵ Germany is the first country to agree to forgive debt through this initiative. This conversion can result in some additional money for the Peruvian health system, and could, for example, be used to promote rationalization of and equitable salaries among the healthcare workforce.

Most of Peru’s debt is held by international financial institutions; Paris Club members,¹⁵⁶ including the United States, are the next largest debt holders. The US government, through its membership in international organizations such as the IMF and Paris Club, as well as through the treasury, could contribute to the Global Fund debt conversion in Peru and in turn assist Peru in meeting MDG5 and other MDGs.

Notes

¹ UN Millennium Project Task Force on Child Health and Maternal Health. *Who’s Got the Power? Transforming health systems for women and children*. Millennium Project; 2005. Available at: <http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf>. Accessed July 9, 2007.

² See, e.g.: United Nations Development Programme, *Poverty Reduction and Human Rights*. New York, June 2003, p. 5 available at [www.undp.org/governance/docs/HRPN_\(poverty\)En.pdf](http://www.undp.org/governance/docs/HRPN_(poverty)En.pdf); For a discussion of how these criteria relate to measurement of programs, see UN Economic and Social Council. Special Rapporteur’s Report on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. E/CN.4/2006/48, para 25.

³ ICESCR. 21 G.A. Res. 2200 (XXI), UN GAOR, Supp. (No. 16) 49, UN Doc A/6316/1966, Art. 2; See also Article 24 (2)(d), *Convention on the Rights of the Child* (Children’s Convention), G.A. Res. 44/25, 44 UN GAOR, Supp. No 49, UN Doc A/44/736 (1989). In the Inter-American system there is also the *Additional Protocol to the*

American Convention on Human Rights in the Area of Economic, Social and Cultural Rights “Protocol of San Salvador,” OAS Treaty Series No. 69 (1988), entered into force 1998, art 10.

⁴ See UN CESCR. “General Comment 3” (Fifth Session, 1990), UN doc. E/1991/23, Annex III, at para. 32.[ESC Committee General Comment 3]. See also: “The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights.” *Human Rights Quarterly* Vol 8[20]; 1998: 691, 694. para. 7 (“Maastricht Guidelines”); *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/CN.4/1987/17, Annex reprinted in 9 Hum. Rts Q 122,125 (1987).

⁵ Id.

⁶ UN CESCR. “General Comment 14.” E/C.12/2000/4. 2000: para 43(f).

⁷ Decreto Supremos N° 017-2005-JUS. Plan nacional de derechos humanos del Perú. Lima; 2005: 94-6, 3.2.3 R1, A 1.

⁸ Id., A 9.

- ⁹ Interview with a former government official in Lima, Peru (Apr. 13, 2007); Interview with Ariel Frisancho, National Coordinator for the Program on the Right to Health, CARE Peru, Lima, April 11, 2007; Interview with Cecilia Olea Mauleón, Program Coordinator for Sexual Health Rights, and Pilar Arce Hernández, Sexual Health Rights Program, Flora Tristán, Lima, April 13, 2007; Ferrando D. "El aborto clandestino en el Perú: Nuevas evidencias." Pathfinder International and Flora Tristán. 2007.
- ¹⁰ República del Perú. *Hacia el cumplimiento de los Objetivos de Desarrollo del Milenio en el Perú: Un compromiso del país para acabar con la pobreza, la desigualdad y la exclusión*. Informe 2004: 64. Available at: <http://www.cepis.ops-oms.org/bvsair/e/repindex/rep83/milenio/informes/peru-odm.pdf>. Accessed July 3, 2007.
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- ¹² United Nations General Assembly. "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. September 2006: para28(e).
- ¹³ IDB. *Health Sector Development Program Maternal and Child Health Care Coverage (PE-0146)*, Available at: <http://www.iadb.org/exr/doc98/apr/pe1208e.pdf>.
- ¹⁴ PARSalud, *Principales indicadores de resultados y desempeño con los que trabaja el PARSalud: Indicadores de la Demanda*. Available at: http://www.parsalud.gob.pe/Transparencia/archivos/Indicadores_Demanda.pdf.
- ¹⁵ Id.
- ¹⁶ Id.
- ¹⁷ Interview with a former government official in Lima, Peru (Apr.13, 2007); Fichas de Investigación epidemiológica de la mortalidad maternal – Dirección General de Epidemiología – MINSA.
- ¹⁸ Interview with Jose Pablo Gomez-Meza, Senior Economist for Health, World Bank and Livia Benavides, Senior Social Sector Specialist, World Bank (participated in interview via video conference from Lima) in Washington, DC. (February 27, 2007).
- ¹⁹ Interview with Dr. Isaías José Matamoros Cuipaco in Pampas, Peru (Jan. 10, 2007).
- ²⁰ "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338, note 12: para 29.
- ²¹ Stephanie Rousseau reports that Carbone "attempted to alter the list of contraceptive methods accepted by MINSA's family planning program, arguing among other things that the IUD was abortive." Stephanie Rousseau, *The Politics of reproductive health in Peru: gender and Social Policy in the Global South*. Spring 2007, *Social Politics: International Studies in Gender, State & Society* 2007; para 113.
- ²² Interview, Victor Zamora and Esteban Caballero, UNFPA, April 12, 2007.
- ²³ See: INEI. ENDES 1986, 1991-92, 1996, 2000 and ENDES Continua 2004 in Ferrando D. "El aborto en el Perú." *Jornada Feminista*. Feb. 6, 2007.
- ²⁴ Stephanie Rousseau, 2007; note 21, para 113.
- ²⁵ Interview with Miguel Gutierrez in Lima, Peru (April 11, 2007).
- ²⁶ Id.
- ²⁷ Ley General de Salud [General Health Law] §178, Ley No.26842 (1997), Art 30.
- ²⁸ CEDAW. "General Recommendation No. 24." 1999: para 12(d).
- ²⁹ Barrón M, Bazán M, and Castillo R. *Barreras económicas en el acceso a servicios de salud de calidad: diagnóstico y políticas para su superación*. CIES, CARE. Lima: July 2006:26.
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- ³⁸ Id.
- ³⁹ Id.
- ⁴⁰ *Hacia el cumplimiento de los Objetivos de Desarrollo del Milenio en el Perú: Un compromiso del país para acabar con la pobreza, la desigualdad y la exclusión*. Informe 2004; note 10, para 11; Sociedad Nacional de Minería, Petróleo y Energía. *Informe Quincenal de la SNMPE*. December 2004:3. Available at: http://www.snmpe.org.pe/pdfs/Informe_Quincenal/EEES-IQ-09-2004-IA.pdf.
- ⁴¹ UN CESCR. ICESCR. 1966: art. 12(2).
- ⁴² Art 2(2) Peruvian Constitution.
- ⁴³ "The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights." para. 11.
- ⁴⁴ United Nations General Assembly. "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. September 2006: para 28(b).
- ⁴⁵ Report by Paul Hunt, Special Rapporteur to the Commission on Human Rights, on "The Right of Everyone to the Highest Attainable Standard of Physical and Mental Health," submitted in accordance with Commission resolution 2004/27. UN Doc. A/59/422. October 8, 2004, para 58.
- ⁴⁶ Amnesty International. *Peru: Poor and Excluded Women – Denial of the Right to Maternal and Child Health*. July 2006. Available at: [www.amnesty.org.ru/library/pdf/AMR460042006ENGLISH/\\$File/AMR4600406.pdf](http://www.amnesty.org.ru/library/pdf/AMR460042006ENGLISH/$File/AMR4600406.pdf). Accessed July 5, 2007.
- ⁴⁷ Interview with Dr. Luis Antonio Maldonado Neyra, Director General de la Dirección Regional de Salud de Puno in Puno, Peru (May 14, 2007)

- ⁴⁸ CEDAW. "General Recommendation 24." 1999; art 12(1) para 22
- ⁴⁹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 12(b).
- ⁵⁰ United Nations General Assembly. "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338. September 2006: para 17(c).
- ⁵¹ Interview with Rocío Gutiérrez, Director of Program on Sexual and Reproductive Rights, Manuela Ramos in Lima, Peru (Apr. 12, 2007)
- ⁵² Interview with José Calderón Yberico, Vice Minister of Health in Lima, Peru (Apr. 12, 2007)
- ⁵³ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 44(e).
- ⁵⁴ Ministerio de Salud, Perú. Norma técnica para la atención del parto vertical con adecuación intercultural. N.T.N°033-MINSA/DGSP-V.01). Lima: Ministerio de Salud; 2005.
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- ⁵⁶ Dr. Alfredo Torres Basurco, Director de Salud Individual; Roel Oré Quispe, Responsable Salud Sexual y Reproductiva. Dr Luis Antonio Maldonado Neyra, Director General, DIRESA, Interview with DIRESA Puno (May 14, 2007)
- ⁵⁷ See e.g. case of Antonia and statements by Dr. Juan Carlos Calla Apaza, Director of Azángaro Hospital.
- ⁵⁸ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 19.
- ⁵⁹ Id., para 43(e).
- ⁶⁰ A. Portacarrero, *La Equidad En La Asignación Regional Del Financiamiento Del Sector Público De Salud 2000 – 2005*, CIES, available at http://www.consortio.org/observatorio/alertas/docs/ALERTA_01.pdf.
- ⁶¹ UN CESCR. "General Comment 14." E/C.12/2000/4. 2000; para 18.
- ⁶² Freedman L. "Shifting Visions: 'Delegation' Policies and the Building of a 'Rights-Based' Approach to Maternal Mortality." *Journal of the American Medical Women's Association* (JAMWA). Vol 57(3). Summer 2002: 155.
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- ⁶⁴ INEI. *Encuesta Demográfica y de Salud Familiar 2000 (ENDES IV) / Departamento de Puno*. Lima; 2001: 127.
- ⁶⁵ Id., para 125.
- ⁶⁶ Id., para 129.
- ⁶⁷ *Hacia el cumplimiento de los Objetivos de Desarrollo del Milenio en el Perú: Un compromiso del país para acabar con la pobreza, la desigualdad y la exclusión*. Informe 2004; note 10, para para 64.
- ⁶⁸ CEDAW. Concluding comments of the Committee on the Elimination of Discrimination against Women: Peru. CEDA/C/PER/CO/6. February 2007; para 36.
- ⁶⁹ A recent study by GRADE confirms these findings: "empirical evidence shows that women with little power in household decisions demand less health services. This is because the male has a dominant position in the decision-making process and values his wife's reproductive health less than she, herself, does. Contrastingly, women with some share of household assets have greater influence on reproductive health decisions compared with women with no assets." See: Jaramillo M. *Does public health insurance secure access to care? Economic and non-economic barriers to prenatal care among Peruvian mothers: race, geography and power relations within the household*. Grupo de Análisis para el Desarrollo (GRADE). September 2006:4-5. Available at: http://ctool.gdnet.org/conf_docs/Jaramillo_paper_parallel_2.1.pdf. Accessed July 10, 2007.
- ⁷⁰ See e.g. *Informe de la Encuesta. Percepciones, conocimientos y prácticas para la disminución de muertes maternas y perinatales en Churcampa*. Salud Sin Limites/Calandria. October 2005: 13.
- ⁷¹ CEDAW. Concluding comments of the Committee on the Elimination of Discrimination against Women: Peru. CEDA/C/PER/CO/6. February 2007; para 26.
- ⁷² Interview with Rocío Gutiérrez, Director of Program on Sexual and Reproductive Rights, Manuela Ramos in Lima, Peru (Apr. 12, 2007)
- ⁷³ CLADEM/Flora Tristán/Manuela Ramos/DEMUS. *Informe Alternativo al Sexto Informe Periódico del Estado Peruano al Comité de la CEDAW*. Lima: November 2006: 27.
- ⁷⁴ Código Penal. Decreto Legislativo N° 635. 1991; arts 114, 115.
- ⁷⁵ UN Human Rights Committee (HRC). Karen Noelia Llantoy Huamán v. Peru, Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003. 2005.
- ⁷⁶ One out of 4 gynecologists surveyed believed that abortion was illegal in all cases, while fifty percent believed that abortion in the case of anencephaly is legal. 23% of the gynecologists surveyed believed that abortion should be legalized and 75% felt that it should be legalized in some cases, including anencephaly.
- ⁷⁷ José Sandoval Paredes. *El aborto: análisis de la situación legal*. Sociedad Peruana de Obstetricia y Ginecología. 2005. Available at: <http://www.spog.org.pe/articulos.php?articulo=48>. Accessed July 2, 2007.
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- ⁷⁹ UN Human Rights Committee (HRC). Karen Noelia Llantoy Huamán v. Peru, Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003. 2005.
- ⁸⁰ See <http://defensoria.gov.ar/areastematicas/doc/salud02.doc> for a report on the pertinent legislation in Argentina and the city of Buenos Aires.
- ⁸¹ UN CESCR General Comment Relating to the Right to the Highest Attainable Standard of Health, 20th Session .May 2000 (ESC Committee General Comment No. 14), para 17.
- ⁸² Communication with Henry Armas, JD, Universidad Peruana Cayetano Heredia, October, 2006.
- ⁸³ ILO Convention 169, art 25.
- ⁸⁴ Hunt P. "The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health." Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Submitted in accordance with CHR resolution 2004/27, UN Doc. A/59/27: September 2004 (advance edited version); para. 58(b).
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- ⁸⁷ See, e.g., DFID, *Alliances Against Poverty: DFID's Experience in Peru 2000-2005*, (2005), available at <http://www.gsdr.org/docs/open/ds53.pdf>.
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- ⁹² Defensoría del Pueblo. *El Derecho a la Identidad y la Actuación de la Administración Estatal: Problemas verificados en la supervisión defensorial* (2005) Available at: http://www.ombudsman.gob.pe/modules/Downloads/informes/defensoriales/informe_100.pdf.
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- ⁹⁶ See e.g., ForoSalud, *Derechos Humanos en Salud en el Perú: Balance 2004-2006 desde la sociedad civil, a dos años de la visita del Sr. Paul Hunt, Relator Especial de Naciones Unidas sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental* 53 (2006).
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- ¹⁰⁵ Interview with Victor Zamora, Assistant Representative for Peru, UNFPA in Lima, Peru (April 12, 2007)
- ¹⁰⁶ Interview with Pedro Francke, Professor, Pontificia Catholic University of Peru, in Lima, Peru (April 11, 2007)
- ¹⁰⁷ Interview with Doniska Tarco, former consultant to PARSaLud, in Lima, Peru (April 11, 2007)
- ¹⁰⁸ Interview with Luis Cordero, former consultant to PARSaLud, in Lima, Peru. (April 11, 2007)
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- ¹¹⁰ Interview with José Calderón Yberico, Vice Minister of Health, in Lima, Peru. (April 12, 2007).
- ¹¹¹ See e.g., LP Freedman, "Censorship and Manipulation of reproductive Health Information: An Issue of Human Rights and Women's Health," in *The Right to Know: Censorship, Women's Health and Human Rights*. London: Article 19 (1997).
- ¹¹² *A New Social Contract: An Agenda for Improving Education, Health, and the Social Safety Net in Peru*. March 2006; note 101, para 90.
- ¹¹³ Id.
- ¹¹⁴ In accordance with the TUPAs, any citizen can demand relevant public information from the MINSA or any other public agency. In the event that such a request is denied, the person can go to the Defensoría del Pueblo or to the judicial system by filing a writ of Habeas Data. See: Decreto Supremo No. 018-2001-PCM, [T.297,§260] 27 febrero 2001.
- ¹¹⁵ Ley de Transparencia y Acceso a la Información Pública. Ley N° 27806; art 7. Available at: http://www.transparencia.org.pe/documentos/ley_27086_ley_de_transp.acceso_informacion_publica.pdf. Accessed July 17, 2007.
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- ¹¹⁸ "Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health." A/61/338, note 12: para 28(d).
- ¹¹⁹ Email communication, national health policy advocate, July 23, 2007.
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- ¹²² Id., para 54, UN Doc. E/C.12/1998/24 [1998]; "General Recommendation 24." "Women and Health" [2 feb. 1999]. 20th session of the Committee on the Elimination of Discrimination against Women. para 17 [CEDAW "General Recommendation 24"]. para, 15.
- ¹²³ ESC Committee "General Comment 14", para 59.
- ¹²⁴ CEDAW "General Recommendation 24".para, 15.
- ¹²⁵ Mario Ríos Barrientos, Secretario General de APDS, Consultor del Proyecto "Sistemas Regionales de Protección de Derechos de las Personas Usuarías de los Servicios de Salud".
- ¹²⁶ Id.
- ¹²⁷ Interview with Amancio Cosichi Quispe, in Ahuaycha, Peru (Jan. 10, 2007).
- ¹²⁸ Defensoría del Pueblo, Supervisión a los servicios de palnificación familiar IV: Casos investigados por la Defensoría del Pueblo (2005) available at http://www.ombudsman.gob.pe/modules/Downloads/informes/defensoriales/informe_90.pdf. According to that resolution (published April 2004), "la expedición del certificado del nacido vivo es gratuita en todos los establecimientos de salud del país, públicos y privados, así como los que sean expedidos por los profesionales o personal de salud que haya brindado la atención." Resolución Ministerial [Ministry Resolution] No 389-2004/MINSA, April 23, 2004.
- ¹²⁹ Amnesty International. *Peru: Poor and excluded women – Denial of the right to maternal and child health*. AMR 46/004/2006. July 2006. Note 46.
- ¹³⁰ Interview with Dr. Isaias José Matamoros Cuipaco, in Pampas, Peru (Jan. 10, 2007).
- ¹³¹ For example, the *acción de cumplimiento* could be used to obligate health establishments to provide contraceptive methods which the MINSA is legally obligated to provide. Non-compliance with the terms of the National Plan of Action on Human Rights, which was passed by Supreme Decree in December of 2005 and includes a number of activities relating to health rights that are relevant to the reduction of maternal mortality, could be challenged with an *acción de cumplimiento*. Similarly, the *Ley de Presupuesto del Sector Público*, passed in 2006 for 2007, sets out twelve spending priorities

- that the state is obligated to follow and according to article 11.2 (b), attention for pregnant women is a strategic priority. Lack of prioritization of attention to EmOC and other maternal health care can be challenged pursuant to an *acción de cumplimiento*. Similarly, if a National Plan of Action for Addressing Maternal Mortality were issued by Supreme Decree, non-compliance with its terms could be challenged with an *acción de cumplimiento*. Interview with Jennie Dador, Project Coordinator for Manuela Ramos in Lima, Peru (Apr. 13, 2007).
- ¹³² July 31, 2007 email correspondence with Mario Ríos Barrientos, Secretario General de APDS,
- ¹³³ Corcuera R, Hidalgo C, Quintana A. *Exigibilidad del derecho a la salud: Acceso a atención, tratamiento e insumos en salud sexual y reproductiva y VIH-sida*. Consorcio de Investigación Economía y Social, Observatorio del Derecho a la Salud. Lima; 2006: 14.
- ¹³⁴ Interview with Luz Esther Herquinio Alarcón, Defensoría del Pueblo in Puno, Peru. (May 12, 2007)
- ¹³⁵ Corcuera R, Hidalgo C, Quintana A. *Exigibilidad del derecho a la salud: Acceso a atención, tratamiento e insumos en salud sexual y reproductiva y VIH-sida*. Consorcio de Investigación Economía y Social, Observatorio del Derecho a la Salud. Lima; 2006: 27.
- ¹³⁶ Id.
- ¹³⁷ UN CESCR. ICESCR. 1966, art. 2(1).
- ¹³⁸ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 60th Sess., Agenda Item 10, UN Doc. E/CN.4/2004/49 (2004), para 45.
- ¹³⁹ Id.
- ¹⁴⁰ Id., para 46.
- ¹⁴¹ Vienna Convention on the Law of Treaties, May 23, 1969, art. 18, 1155 U.N.T.S. 331, 340, 8 I.L.M. 679, 692 [hereinafter Vienna Convention].
- ¹⁴² Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 60th Sess., Agenda Item 10, UN Doc. E/CN.4/2004/49 (2004), para 45.
- ¹⁴³ Center for Health and Gender Equality (Change). *La extrema derecha, USAID y anticoncepción oral de emergencia en el Perú*. Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX). January 2006. Available at: <http://www.genderhealth.org/pubs/TimelineECinPerus.pdf>. Accessed July 17, 2007.
- ¹⁴⁴ Communication with Serra Sippel, Acting Director of the Center for Gender and Health Equality (CHANGE). July 23, 2007.
- ¹⁴⁵ Interview with Ian MacArthur, Sectoral Specialist, Inter-American Development Bank in Lima, Peru (Apr. 11, 2007).
- ¹⁴⁶ See Millennium Campaign, "About the Goals," Available at www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186389.
- ¹⁴⁷ Id.
- ¹⁴⁸ *Hacia el cumplimiento de los Objetivos de Desarrollo del Milenio en el Perú: Un compromiso del país para acabar con la pobreza, la desigualdad y la exclusión*. Informe 2004; note 10, para 13.
- ¹⁴⁹ Id., para 14.
- ¹⁵⁰ Id.
- ¹⁵¹ Vásquez, E. (2004:24) *Presupuesto público y gasto social: La urgencia del monitoreo y evaluación*. Lima: Centro de Investigación de la Universidad del Pacífico – Save The Children Sweden.
- ¹⁵² G. Hutton. *Charting the path to the World Bank's "no blanket policy on user fees."* Department for International Development Health Systems Resource Centre. 2004: 46. Available at: <http://www.eldis.org/ds/docdisplay.cfm?doc=DOC19555&resource=healthsystems>.
- ¹⁵³ "Macroeconomics and Health Commission findings become reality," 82 Bulletin of the World Health Organization 957 (2004).
- ¹⁵⁴ Press Release, Inter-American Development Bank, "IDB Governors approval \$4.4 billion in debt relief for Bolivia, Guyana, Haiti, Honduras and Nicaragua." (March 16 2007).
- ¹⁵⁵ Pakistan, Kenya, and Indonesia are the other three countries. Communication with David Bryden, Communications Director for the Global AIDS Alliance.
- ¹⁵⁶ The 19 Paris Club members are governments with substantial claims on various other governments throughout the World. They have applied the terms of the Paris Club agreed minutes to their claims in the past. The Paris Club countries include: Austria, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, Norway, Russia Federation, Spain, Sweden, Switzerland, United Kingdom, and the United States.

IX. CONCLUSIONS

Lack of available, accessible, acceptable and quality healthcare, including EmOC, is a primary way in which women in Peru—and especially rural, indigenous women—experience poverty and exclusion. It is also a failure to uphold their right to the highest attainable standard of health, under treaties to which the government of Peru has voluntarily adhered.¹ The absence of available, accessible, acceptable and quality EmOC leads to delays in decisions to seek care, delays in arriving at care, and delays in receiving the appropriate treatment once at a health facility, which in turn leads to women dying.

PHR found in Puno and Huancavelica that the rural indigenous women who die and the families they leave behind are in effect often blamed for their deaths because there is a delay in the decision to seek care and that delay is ascribed to “cultural preferences” or “idiosyncrasies.” Upon closer examination, however, all of these deadly delays, including the delay in the decision to seek care, are related to systemic inequities in Peruvian society and in the Peruvian health care system. For example, delays in the decision to seek care can be attributable to the inequitable distribution of healthcare facilities, goods and services that make EmOC both unavailable and physically inaccessible. This investigation found that it can also be attributable to economic barriers to access for these impoverished families that persist in spite of the SIS, including the costs of transportation. PHR also documented how the lack of cultural sensitivity including language barriers and lack of respect for traditional birthing customs at health facilities, factor into delays in the decision to seek care. Perceptions of poor quality care can also produce delays in deciding to seek EmOC at health establishments.

As the UN Millennium Project Task Force Report on Child Health and Maternal Health states, “health claims—claims of entitlement to health care and enabling conditions—are assets of citizenship.”² The failure to provide access to adequate EmOC and related reproductive and sexual health services is a powerful indicator of how rural *campesinas* are not treated as full

citizens in Peruvian society. The national reconciliation of a society so fragmented along class, ethnic and gender lines—which the Truth and Reconciliation Commission called for after the country’s brutal internal conflict killed nearly 70,000 people who were overwhelmingly rural *campesinos*—has not occurred in Peru. Patterns of maternal mortality provide a vivid illustration of the pathologies of power that continue to plague Peruvian society, and of the failure of the government, through the health system, to remedy them.³

That is, general societal resources are not directed adequately to health in Peru, nor to maternal health in particular. Furthermore, those resources that are spent on health are distributed inequitably with respect to both unmet basic needs and rural-versus-urban populations, resulting in a disproportionate impact on indigenous populations. Efforts to ameliorate exclusion of pregnant women based on income, such as through the SIS, have not adequately addressed cultural barriers to care. The counter-productive and punitive policies adopted by the health sector with respect to pregnant women and their families and front-line health personnel, have produced perverse incentives; they undermine the possibility of sustained improvements in EmOC and violate the rights of both patients and health care workers.

After years of ineffectualness, PARSalud I appropriately emphasized the evidence-based interventions of EmOC and referral networks, which should remain the focus of PARSalud II. However, structural obstacles to reducing and preventing maternal mortality, not just as a public health issue but as a human rights imperative, remain to be tackled. Addressing the problems in the health system that relate to maternal mortality—including inequitable access to EmOC and referral systems, cultural and economic barriers, and irrational and inequitable human resource regimes, would go a long way toward strengthening the health system overall. It would also permit the health system to function in its capacity as a core social system to promote greater democracy and equality in the overall society, and facilitate Peru’s long-sought national reconciliation.

Notes

- ¹ United Nations Committee on Economic, Social and Cultural Rights (CESCR). *The Right to the Highest Attainable Standard of Health*, "General Comment 14," UN CESCR. E/C.12/2000/4. 2000: para 12.
- ² UN Millennium Project Task Force on Child Health and Maternal Health. *Who's Got the Power? Transforming health systems for women and children*. 2005:11. Available at: <http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf>. Accessed June 22, 2007.
- ³ Paul Farmer uses the term pathologies of power in a book of the same title. See: Farmer P. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. University of California Press; April 2003.

X. RECOMMENDATIONS

Addressing maternal mortality requires concerted actions to strengthen Peru's health system; discrete activities or vertical approaches have not proven successful in the past in Peru or elsewhere. The recommendations to the government of Peru and other actors fall into certain overarching themes that correspond to human rights principles set out in Chapters VI and VIII. In short, increased funding needs to be directed to the health system, and the resources spent need to be allocated equitably with regard for historic disadvantage as well as unmet needs. As part of this reallocation, priority in funding needs to be placed on making quality EmOC available and accessible (physically and economically) on a non-discriminatory basis. True availability, accessibility and quality require more than structures and equipment; they require trained personnel, 24 hours a day, and adequate communications and transportation, as well as the elimination of laws and policies that discriminate against women. Care also needs to be acceptable, which requires prioritization of programs and modifications in curricula to promote inter-cultural understanding and the rights of patients. Finally, accountability—financial, political, and legal—needs to be improved for the right to safe motherhood to become a reality in Peru.

The following recommendations, although not all-inclusive, attempt to address many of the factors underlying maternal mortality in Peru. PHR hopes that the comprehensiveness and specificity of the recommendations will facilitate appropriate actions to be taken by the relevant actors, in keeping with a rights-based approach to addressing maternal mortality. Some recommendations are directed at multiple actors as responsibility for their implementation is shared.

To the Peruvian Government, Including the Executive and Legislative Branches, as Appropriate:

Devote Maximum Available Resources

1. Modify legislation, regulations and enforcement to increase tax revenues to at least 15% of GDP, in keeping with IMF recommendations, and use

increased revenues to sustain increases in social spending, including health spending.

2. Increase percentage of national budget devoted to healthcare spending, including spending on maternal health care, to bring Peru in line with other middle-income countries in the region; make spending allocation information freely available to the public.
3. Provide explicit interpretive guidance regarding the use of tax proceeds from extractive industries (*Canon Minero* and *Canon Petrolero*) to ensure that “social investment” is construed to include projects to improve the regional health system, including the referral system for obstetric and other emergencies; and ensure adequate monitoring and accountability of such projects, which by law should have “departmental and regional impact.”

Demonstrate Adequate Progress: Adopt and Implement Plans of Action

4. Adopt by Supreme Decree and implement a National Concerted Plan of Action to Reduce Maternal Mortality, based on the best available epidemiological evidence relating to the keystone interventions to reduce maternal mortality, and devised and periodically reviewed on the basis of a participatory and transparent process that includes indicators and benchmarks by which progress can be closely monitored and that pays particular attention to the needs of marginalized groups, including indigenous populations.
5. Implement the National Plan of Action on Human Rights, passed by Supreme Decree 017-2005-JUS, and in particular Point 3.2.3 relating to the right to health, which includes strengthening human resources.¹
6. In relation to the National Plan of Action on Human Rights, adopt by Supreme Decree and implement a National Concerted Plan of Action to Address Human Resources in Health that calls for modification of legislation and policies relating to healthcare

workforce to ensure respect for both patients' and workers' rights and promotes equitable allocation of services that includes:

- a. modifying the *Ley de Nombramiento Médico* (Law of Medical appointments), the *Ley de Trabajo de la Obsteriz* (Labor Law of Midwives), the *Ley del Trabajo de la Enfermera(o) Peruano* (Labor Law of Peruvian Nurses), and other related legislation to ensure quality of care for patients and dignified labor conditions for health personnel
- b. eliminating personal services contracts that do not provide benefits and allow termination at will (*servicios no personales*) for all health personnel (doctors, nurses, midwives, and technicians)
- c. introducing performance criteria for all healthcare personnel that address users' needs, expectations and preferences and promote user choice and autonomy
- d. providing substantial financial and educational incentives for health personnel to serve in rural areas, with compensation and points for residency applications tailored proportionally to the degree of isolation
- e. requiring physicians to perform 2-3 years of rural service before being eligible for specialization
- f. exploring the use of alternating rotations (e.g., two physicians alternating 2 weeks in a rural hospital; 2 weeks elsewhere) for some specialists, such as anesthesiologists

Eliminate Retrogressive Measures

7. Given that confidentiality is critical to promoting access to treatment for post-abortion complications and in turn reducing maternal mortality, eliminate reporting requirements for health professionals who suspect an induced abortion under Article 30 of the General Health Law.

Promote Meaningful Participation

8. Follow the recommendation of the Committee on the Elimination of Discrimination against Women in its concluding observations of February 2007, to "expedite and facilitate the process of registration of women without documentation and issue birth certificates and identity documents,"² so that, *inter alia*, more rural women can participate in the political process and gain access to government benefits programs.

Eliminate Discrimination Based on Gender and Ethnicity, and Promote Equality and Women's Rights

9. In keeping with the 2006-2010 National Plan of Human Rights,³ institute cross-cutting human rights approaches and training throughout government ministries; these approaches and trainings should explicitly adopt a gender perspective that recognizes the interactions between gender inequalities, ethnic discrimination and rural poverty in Peru.
10. Given that complications from illegal abortions are a leading cause of maternal mortality, revise Article 119 of the Penal Code to provide for exceptions to the criminalization of abortion in cases where the pregnancy is a product of sexual violence, in keeping with the concluding recommendations of CEDAW and the findings of the UN Human Rights Committee.⁴
11. Transform JUNTOS from a vertical hand-out program to a genuinely inter-sectorial program (MINSA, Ministerio de Educación and MIMDES) that collaborates with NGOs in order to empower women economically and educate them in relation to their sexual and reproductive health, including family planning, domestic violence, and safe motherhood, as well as child health.

Promote Accountability and Effective Remedies

12. Support expanded parameters for *Sistema Defensorial de Supervisión de la Salud Materna* of the Defensoría del Pueblo (Ombuds' System for the Supervision of Maternal Health), to include:
 - a. increased investigations into institutional and structural violations of women's rights to health and safe motherhood, including monitoring of implementation of norms and monitoring of selected institutions
 - b. public education campaigns about maternal mortality as a human rights issue, including outreach in communities where deaths have occurred, to facilitate administrative and judicial accountability
 - c. holding public hearings for the Ombuds' Office to report on its findings to the public and to health authorities
 - d. monitoring selected judicial cases relating to the enforcement of women's rights to safe motherhood

- e. promotion of and education with respect to judicial mechanisms to establish systemic accountability, including *acción de cumplimiento*
13. Create programs to systematically educate judges and lawyers about the applicability and enforceability of certain claims relating to women's rights to health and life, to include:
- a. civil suits for damages (*daños y perjuicios*) against a Regional Director of Health or Minister of Health in the event of institutional failures, such as the lack of availability of ambulances to transport women
 - b. *amparo* (protection writ) in the event of denial of care based on discrimination or lack of funds
 - c. popular action (*acción popular*), in the event of imminent collective harm caused by a policy or directive
 - d. *acción de cumplimiento* (compliance writ) in the event of failure to follow or implement a law
 - e. *habeus corpus* actions, e.g., in the event a woman is detained in a facility for failure to replace or pay for blood transfusions she has received
 - f. *habeus data* actions, in the event of a denial of relevant health information by a public official or agency
 - g. other claims relating to discrimination in the health sector
14. Widely disseminate to the public in Spanish and local languages the existing mechanisms for seeking redress (administrative, judicial and through the Defensoría) in the event of violations of women's rights to health and life, including through:
- a. radio and television spots
 - b. websites
 - c. print media
15. Establish a congressional task force to examine possibilities for improving accountability in the event of violations of women's rights to health, addressing:
- a. physical, economic and other barriers to the justice system, including distance, costs and irregularity of transport, language differences, fear of discrimination, and lack of financial resources to hire attorneys

- b. slowness and lack of capacity in the judicial system to provide timely relief, including prohibitively long delays associated with Habeus Corpus writs
- c. lack of knowledge of general public about accountability mechanisms
- d. inadequacy of causes of action (*figuras legales*) to secure redress in matters of economic and social rights, including the right to health

To the Ministry of Health:

Promote Available, Accessible, Acceptable, and Quality Care, Including Adequate Transportation and Communications

1. Commit to funding and instituting evidence-based interventions and policies, including centrality of EmOC, skilled birth attendance and referral networks.
2. Ensure rational coverage of EmOC through the equitable distribution of FOEs and FOBs.
3. Recognize that independent of economic factors, significant cultural barriers to the use of healthcare, and especially obstetric care, exist in Peru, and take concerted actions to address these barriers, including:
 - a. expanding and transforming inter-cultural training programs from discrete modules to ongoing programs that include and continuously respond to input from affected communities, and especially women
 - b. ensuring that maternal waiting houses (*casas de espera*) are designed in keeping with cultural traditions and are established and utilized in consultation with local communities
 - c. ensuring that more health workers are proficient in the native languages of the local population through educational and other incentives and the employment of health workers from local communities
 - d. modifying the 2005 *Norma Técnica de Atención del Parto Vertical* (Technical Norm for Vertical Delivery Care) to require that vertical delivery positions are affirmatively offered at health facilities and do not have to be requested by women

- e. expanding the use of *salas de parto tradicionales* (traditional birthing rooms) and other culturally appropriate modes of health care, with full input into the design and evaluation of such initiatives from local communities, and especially women
 - f. ensuring that all FOEs and as many FOBs as possible have a “patients’ rights advocate” who is fluent in local languages and versed in local traditions, and whose role it is to advocate on behalf of pregnant women for scientifically and culturally acceptable care
4. Create and fund radio spots in local indigenous languages relating to alarm signals for obstetric emergencies and steps to take to avert death in the event of an emergency.
 5. Expand the use of the 2007 MINSA Guides to Clinical Practice for Obstetric and Neonatal Emergencies (*Guías de Práctica Clínica para la Atención de las Emergencias Obstétricas y Neonatales*).
 6. Continue and expand the use of the Code system for emergency kits to respond to hemorrhage, sepsis and eclampsia.
 7. Promote modified legislation to allow the delegation of anesthesia to general practice physicians and nurse anesthetists, and ensure appropriate training for general physicians and nurse anesthetists.
 8. End the practice of retaining women in hospitals who have received blood transfusions until their relatives donate blood.
 9. Develop a national campaign to obtain and store sufficient blood at FOEs.
 10. Create a task force to study feasibility and effectiveness of training providers in and offering assisted vaginal delivery at FOBs.
 11. Require vehicle purchases to comply with certain criteria to make them suitable for local terrain, such as four-wheel drive and heavy-duty suspension in the *Sierra*, and include budgeted monies for regular maintenance and fuel.
 12. Given the lack of availability of ambulances, devise plans in conjunction with authorities from and members of rural communities for alternate transportation in the event of emergencies, including possibilities for rotating funds, identification of owners of private transport, and reimbursement mechanisms from the health sector.
13. Prioritize purchases of radios (and/or cell phones, where appropriate) for health posts and within communities, and consider credit schemes that enable women in communities to control cell phones and charge small fees for their usage.

Eliminate Discrimination Based on Gender, Class and Ethnicity; Promote Equality and Women’s Rights

14. Ensure that healthcare spending is equitably distributed and directed at populations to redress historical neglect of certain areas and populations, and in particular indigenous women.
15. Ensure that under the re-designed social insurance scheme, benefits are correlated with need, so that women from the poorest quintiles and historically marginalized populations are adequately covered. This includes:
 - a. redesigning the reimbursement scheme so that transfers in the event of emergency are correlated with realistic costs in rural areas
 - b. restructuring coverage based on best evidence from public health, e.g., eliminate coverage of multiple ultrasounds but ensure all components of basic essential obstetric care are underwritten for all women, including those living in remote areas
 - c. providing Magnesium Sulfate, and continual training on its appropriate use, as part of coverage in the event of pre-eclampsia and/or eclampsia
16. Consider eliminating all co-payments for pregnant women under the re-designed social insurance scheme and, at a minimum, ensure that exemptions are provided according to standardized criteria that do not present undue burdens to families to demonstrate indigence, which could discourage use of the health system by pregnant women.
17. Clarify in the revised social insurance scheme regulations that “obstetric emergencies” includes complications from incomplete abortions.
18. Ensure the steady availability (through the social insurance scheme or otherwise) of a full range of contraceptive options, including injectables and emergency contraception, especially to rural, indigenous women, and adolescents.

19. Expand coverage under the revised social insurance scheme to include counseling for adolescents on sexuality and sexual and reproductive health.
20. Reinvigorate reproductive health and family planning services, including more funding, concerted strategies, training for providers, and staffing.
21. Given that complications from illegal abortions are a leading cause of maternal mortality, create a protocol for therapeutic abortion that recognizes the need to protect women's psychological health as well as their physical health, in keeping with the finding of the UN Human Rights Committee in the case of *Karen LL v Peru*⁵

Demonstrate Adequate Progress: Plans of Action; Indicators

22. Devise and propose national (and in conjunction with DIRSESAs, regional) strategies and plans of action relating to maternal mortality and healthcare workforce, on the basis of a participatory process that includes input from health professionals; such plans must be responsive to the needs of local populations, especially marginalized and rural populations, in order to, *inter alia*:
 - a. standardize the number and level of personnel at different health facilities and ensure staffing for 24 hours per day/365 days per year at FOEs and FOBs
 - b. ensure appropriate training of health personnel involved in responding to obstetric emergencies
 - c. reduce staff turnover that undermines training and relationships with communities
 - d. promote equity in remuneration, benefits, and work hours among health care workers
 - e. systematically promote improved relationships with community health advocates
23. Standardize and apply those process indicators which have been internationally endorsed as appropriate, including those set out in the *UN Guidelines on Monitoring the Use and Availability of Essential Obstetric Care*⁶, in order to continuously monitor progress in addressing maternal mortality.
24. In the revised social insurance scheme, use the SIS forms that already exist to continuously collect data at the facility level regarding appropriate use of oxytocics, Magnesium Sulfate and antibiotics, and utilize such data for improving programming.

Promote Meaningful Participation and Democratize Health Sector

25. Take steps to end the authoritarian and punitive culture in the health sector that undermines both providers' and patients' rights and creates perverse incentives. These steps should include:
 - a. removing the imposition of sanctions for maternal deaths that are not attributable to negligence or malpractice
 - b. de-linking compensation from the number of births attended, which can lead to health personnel failing to refer complicated cases appropriately
 - c. removing quotas for institutional births, which can lead to coercive tactics being used with pregnant women
 - d. removing the stipulation that institutional delivery is a pre-requisite for cash transfers under the JUNTOS program, as it can prove counterproductive and dangerous in the absence of a functioning referral system and resolution capacity
 - e. creating internal ombuds offices in each DIRESA to receive and investigate staff complaints relating to unjust dismissal, sanctions, discrimination and other forms of mistreatment
26. Revitalize the CLAS system, through increased funding and modified contracts for salaries of health professionals working at CLAS facilities, to facilitate staff response to the expressed needs of the community, and ensure that the CLAS councils include women among their members.
27. Promote the involvement of municipalities in health system, *e.g.*, by expanding the healthy municipalities initiative (*Municipios Saludables*) from prevention to care, with the condition that women be adequately represented.
28. Require participation of women and women's groups in the development of priorities and indicators selected for the *Planes Concertados* (Concerted Plans of Action).

Promote Accountability

29. Improve monitoring and accountability systems for the purchase of medicines and implement an automated

system for purchases of medical equipment by requiring use of SIGA (*Sistema de Información de Gestión Administrativa*) and integration with SIAF (*Sistema Integral de Administración Financiera*).

30. Institute and maintain a transparent bidding process for all equipment and supply purchases, including ambulances, and make material information on criteria as well as bids open to the public.
31. Increase enforcement of administrative sanctions on providers in cases of proven negligence, abuse and malpractice, including when providers are tenured (*nombrados*).
32. Improve public access to information at the system and institutional levels, including information relating to programming and budgeting regarding reproductive and sexual health and performance of health personnel.

To the National System on Accreditation in Education (SINEACE, *Sistema Nacional de Acreditación en Educación*), the National Commission on Medical Residencies (CONAREME, *Comisión Nacional de Residentado Médico*), the Peruvian Association of Medical Faculties (ASPEFAM, *Asociación Peruana de Facultades de Medicina*), and the Commission on the Accreditation of Medical Faculties (CAFME, *Comisión de Acreditación de Facultades de Medicina*), as Appropriate:

1. Institute more rigorous accreditation standards for medical schools and rigorously enforce failure to meet standards.
2. Improve the Board certification process to ensure that it accurately measures skills and competencies.
3. Institute regular Board recertification for physicians and specialists to improve monitoring of quality and professional skills.
4. Promote revised curricula in medical schools that include meaningful modules on both “interculturality” and human rights, including the notion of doctors in the public sector acting as public servants.

5. Monitor and rate the institutional training of physicians (in medical schools and in residencies) in key aspects of reproductive health, such as placement of IUDs, performance of tubal ligations, and the management of obstetric complications, including the use of Magnesium Sulfate.
6. Create a task force to study feasibility and effectiveness of training providers in assisted vaginal delivery.

To the Regional Governments of Huancavelica and Puno, and the DIRESAs Huancavelica and Puno, as Appropriate:

Devote Maximum of Available Resources

1. Dedicate a substantial portion of “social investment” funds realized through the taxation of mining income (*Canon Minero*) to benefit the health system, in particular, the infrastructure necessary for the referral system for obstetric and other emergencies; ensure adequate monitoring and accountability of such projects which by law should have “departmental and regional impact.”

Promote Available, Accessible, Acceptable, Quality Care, including Transportation and Communications; Eliminate Discrimination Based on Ethnicity and Gender and Promote Equality and Women’s Rights

2. Ensure that healthcare spending and priorities adequately reflect the needs and rights of rural populations, in particular indigenous women, and that basic obstetric care (through FOBs and FOEs) is available, accessible, acceptable and of adequate quality. This includes:
 - a. the availability of 24-hour a day care, medicines and transportation
 - b. care and medicines that are within reasonable geographical distance (physical access) and affordable (economic access)
 - c. health care and services that are both scientifically sound and culturally acceptable, including, where applicable, healthcare providers who speak an indigenous language and offer vertical birth positions and other traditional practices
 - d. adequate training in the use of life-saving medications and procedures

3. Recognize that independent of economic factors, significant cultural barriers exist to the use of healthcare, and especially obstetric care, and take concerted actions to address these barriers, including:
 - a. expanding and transforming inter-cultural training programs, from discrete modules to ongoing programs, that include and continuously respond to input from affected communities, and especially women
 - b. ensuring that more health workers are proficient in the native languages of the local population through educational and other incentives and employ health workers from local communities
 - c. ensuring that vertical delivery positions are affirmatively offered at health facilities and do not have to be requested by women
 - d. expanding the use of *salas de parto tradicionales* (traditional birthing rooms) and other culturally-appropriate modes of health care, with full input into the design and evaluation of such initiatives from local communities, and especially women
 - e. ensuring that all FOEs and as many FOBs as possible have a “patients’ rights advocate” who is fluent in local languages and versed in local traditions, and whose role it is to advocate on behalf of pregnant women for scientifically and culturally acceptable care
4. Prioritize purchases of radios and/or cell phones where appropriate for health posts and communities and consider credit schemes that enable women in communities to control cell phones and charge small fees for their usage.
5. Budget monies for ambulances that are strictly dedicated for regular maintenance and fuel, and require logs to be kept for mileage, facilitating calculations of when and how many emergencies are attended.
6. Expand the use of the new MINSA Guides to Clinical Practice for Obstetric and Neonatal Emergencies (*Guías de Práctica Clínica para la Atención de las Emergencias Obstétricas y Neonatales*).
7. Continue and expand the use of the Code system for emergency kits, which has been developed to respond to hemorrhage, sepsis and eclampsia.

8. Create and fund radio spots in local languages relating to alarm signals for obstetric emergencies and steps to take to avert death in the event of an emergency.

Demonstrate Adequate Progress: Plans of Action; Indicators

9. Devise and implement regional strategies and concerted plans of action (*planes concertados*) to reduce maternal mortality based on the best available epidemiological evidence, on the basis of a participatory and transparent process that includes indicators and benchmarks by which progress can be closely monitored, and that pay particular attention to the needs of marginalized groups, including indigenous populations.
10. Devise and implement regional strategies and concerted plans of action (*planes concertados*) relating to healthcare workforce, on the basis of a participatory process that includes input from health professionals, that are responsive to the needs of local populations, especially marginalized and rural populations, in order to, *inter alia*:
 - a. ensure rational coverage of EmOC through the equitable distribution of FOEs and FOBs
 - b. standardize the number and level of personnel at different health facilities and ensure staffing for 24 hours per day/365 days per year at FOEs and FOBs
 - c. promote equity in remuneration, benefits and work hours among healthcare workers
 - d. provide financial incentives, job recognition and advancement for health workers who serve in rural and isolated areas
 - e. systematically promote improved relationships with community health promoters
11. Use the SIS forms that already exist to continuously collect data at the facility level regarding appropriate use of oxytocics, Magnesium Sulfate and antibiotics, and utilize such data for improving programming.

Promote Meaningful Participation

12. Ensure participation of women and women’s groups in *Mesas Concertadas* (Concerted Working Groups) in order to promote women’s health issues and interests in the priorities and indicators selected for all of the *Planes Concertados* (Concerted Plans of Action).

13. Conduct an education and registration campaign to ensure that campesinos, and especially campesina women, have DNIs and are encouraged to vote in local elections and participate in regional political processes.
14. Provide support for local organizations and NGOs to conduct grass-roots workshops and community outreach for women and men on gender and health.
15. Include the strengthening of CLAS managing councils and technical assistance for CLAS association members on key maternal and reproductive health issues in local health plans.
16. Promote the involvement of municipalities in health system, *e.g.*, by expanding the healthy municipalities initiative (*Municipios Saludables*) from prevention to care, with the condition that women are adequately represented.

Promote Accountability and Access to Effective Remedies

17. Improve monitoring and accountability systems for the purchase of medicines and implement an automated system for purchases of medical equipment, *inter alia*, by monitoring the use of SIGA (*Sistema de Información de Gestión Administrativa*) and its integration with SIAF (*Sistema Integral de Administración Financiera*).
18. Assess the performance of the Regional Health Councils, including an analysis of the number and content of proposals made and any follow-up activity, as well as extent of female representation and participation.
19. Investigate and sanction, administratively or judicially, as called for by law:
 - a. the use of police to coerce women to deliver at institutions
 - b. the imposition of *de facto* fines for birth certificates when children are not born in an institution
 - c. denials of care (including referral and transportation) due to a lack of ability to pay
 - d. the detention of women for failure to pay for blood transfusions and screenings
 - e. any act of discrimination against patients based on gender or ethnicity

Additionally, to the Regional Government of Puno and the DIRESA Puno:

1. Purchase a water tank and pump for Regional Hospital of Puno to enable the Obstetric Center on third floor to function properly.
2. Purchase equipment necessary to permit the Intermediate Care Unit (*Unidad de Cuidados Intermedios, UCI*) in Carlos Monge Medrano Hospital in Juliaca to be certified by SIS as an official UCI, so that care can be reimbursed.
3. Carry out full investigations into the possible negligence and abandonment, respectively, of
 - a. Midwife Maria Magdalena Condori Apaza in the case of Melania Yucra Gonzales, and
 - b. Dr. Emilio Machicao in the case of Pabla Roberta Arizanca Barrientos, and make those findings public and available to the family members.
4. Issue a protocol for the implementation of the MINSA norm relating to vertical birthing.

Additionally, To the Regional Government of Huancavelica and the DIRESA Huancavelica:

1. Carry out a full investigation into the possible negligence and abandonment in the case of Francisca Ccente Quispe at the Pampas Health Center and make those findings public and available to the family members, and
2. Issue a protocol for the implementation of the MINSA norm relating to vertical birthing.

To the World Bank and Inter-American Development Bank:

1. Insist upon technical and not political criteria in the design of PARSalud II, and insist upon the inclusion of evidence-based interventions only.
2. Include funds in PARSalud II for the Registro Nacional de Identificación y Estado Civil (RENIEC) to distribute, and ensure that everyone in rural areas has a DNI card as a health-promoting measure.
3. Use outcome measures (*e.g.*, Magnesium sulfate usage, C-Section rates, oxytocin usage, existence

of facilities with appropriate staffing) rather than spending measures as indicators of progress.

4. Establish transparent bidding procedures for equipment purchases, including ambulances, whereby all material information is made public.
5. Require vehicle purchases to comply with certain criteria to make them suitable for local terrain, such as four-wheel drive and heavy suspension in the *Sierra*, and require evidence of periodic maintenance, in accordance with pre-established terms.
6. Invest in improved data collection to track Peru's record on maternal mortality for purposes of measuring progress on MDG 5.
7. Use process indicators to complement maternal mortality ratios, including the indicators set out in *UN Guidelines for the Monitoring of the Availability and Use of Essential Obstetric Care*, which can assist in evaluating the availability, equitable distribution, and use of the interventions needed to address maternal mortality.
8. Given that unwanted pregnancies are the highest risk factor for obstetric complications, contemplate family planning needs as part of the reduction of maternal mortality in PARSalud II.
9. Include a plan in PARSalud II to ensure availability of capacity for free blood screenings and transfusions, in the event of surgery, including Cesarean sections.
10. Carefully consider what will remain institutionalized after the PARSalud II ends, including:
 - a. not undertaking or adding any new interventions that are not evidence-based
 - b. not hiring a parallel staff or creating a parallel administration to the MINSA
 - c. utilizing MINSA's own systems, *e.g.*, medicines, information, logistical coordination, etc.
11. Ensure greater financial accountability in allocating funds through PARSalud II by, *inter alia*, sending representatives from the World Bank and Inter-American Development Bank to:
 - a. visit locations where monies are to be spent and review plans in detail
 - b. periodically visit and observe progress in spending, including quality of materials purchased,

progress in training programs, maintenance of vehicles

- c. publish spending broken down by department and institution
12. As Peruvian taxpayers are paying for PARSalud II (as they paid for PARSalud I), make public any deviations from spending plans or violations of agreement terms, including fees and interest incurred for non-disbursed funds; significant deviations should be investigated by Congress.
13. Ensure that PARSalud II is more transparent and participatory than PARSalud I, including:
 - a. publishing its studies and evaluations of progress
 - b. publishing its expenditures and the rubrics under which funds are spent
 - c. making publicly-available its indicators, disaggregated by SES and geographic region
 - d. regularly presenting findings and information to groups from civil society and UN agencies
 - e. regularly meeting with and gathering information and opinions from users of the health system in areas of PARSalud interventions
14. Incorporate into PARSalud II specific proposals to operationalize "short term" and "long term" objectives with respect to citizen participation in design and implementation.

To the US Government and USAID, as Appropriate:

1. Participate in debt-for-health conversion programs in alliance with the Global Fund to Fight AIDS, TB and Malaria in order to expand resources available for health system, and for maternal health in particular.
2. Repeal the Global Gag Rule so that aid recipients can provide information and education with regard to the signs of and treatment for complications arising from abortions, which is a leading cause of maternal death in Peru.
3. Stop interference with provision of public information about emergency oral contraception by grantees in Peru.
4. Provide increased funding for the Human Rights Ombuds Office to expand and sustain its work in

the area of health rights, reproductive and sexual rights, and safe motherhood in particular.

5. Reconsider its role in relation to supporting Peru's health system under USAID's new funding

parameters to identify mechanisms to provide increased support, rather than withdraw from funding for Peru's health sector.

Notes

- ¹ Plan Nacional de Derechos Humanos 2006-2010 elaborado por el Consejo Nacional de Derechos Humanos. Decreto Supremo No. 017-2005-JUS. The National Human Rights Plan contains, in total, fifteen recommendations directed towards protecting the right to health.
- ² CEDAW/C/PER/CO/6. Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Peru. February 2007: para 33.
- ³ Plan Nacional de Derechos Humanos 2006-2010 elaborado por el Consejo Nacional de Derechos Humanos. Decreto Supremo No. 017-2005-JUS.

- ⁴ See CEDAW/C/PER/CO/6, paras 24-25.; CCPR/CO/70/PER, Concluding Observations of the Human rights Committee: Peru. November 2000: para 20.
- ⁵ The case of KL v Peru involved a woman who was forced to carry to term an anencephalic fetus and suffered grave psychological distress as a result. Human Rights Committee, Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003 (2005). See CEDAW/C/PER/CO/6. Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Peru. 2 February 07, paras 24-25.
- ⁶ UNICEF/WHO/UNFPA. *UN Guidelines on Monitoring the Use and Availability of Essential Obstetric Care*. August 1997.

XI. GLOSSARY OF TERMS AND ACRONYMS

Altiplano: The high plain region of southeastern Peru and western Bolivia, which includes Puno. The height of the Altiplano averages about 3,300 meters, although some areas are far higher, and the climate is cool and semi-arid to arid.

Anticonvulsant: A medication used to stop or prevent seizures. The WHO/UNFPA/UNICEF *Guidelines for Monitoring the Availability and Use of Obstetric Services* require basic essential obstetric care facilities (EmOC facilities) to have the capacity to administer IV or injection anticonvulsants.

Aymara: A native ethnic group indigenous to the Andes and Altiplano regions of South America. The majority of the Aymara live in Peru and Bolivia near the Lake Titicaca basin.

Campesino/a: Refers to a person living in a rural region, often someone who lives from subsistence agriculture.

CEDAW General Recommendation 24: A recommendation drafted by the Committee on the Elimination of Discrimination against Women which focuses on women and health, and obligates States parties to remove barriers blocking women's access to appropriate health care.

Chacra: A small farm, usually intended to provide sustenance for the family.

CLAS: (*Comités Locales de Administración en Salud*) Local Health Administration Committees, which are jointly administered by elected community members and the medical staff of the facility.

Curandero: A traditional healer or shaman who uses herbs and other natural remedies to cure illnesses. In many cases, the curing power of curanderos is thought to be supernatural since many indigenous populations believe that illnesses are caused by evil spirits or curses. Sometimes, curanderos are also traditional birth attendants (TBAs).

Department: An administrative division. Peru is divided into 24 departments.

DIRESA: The Regional Directorate of Health, which is in charge of setting some health policies and disbursing funds within the administratively-defined health region or department.

ENDES: (*Encuesta Demográfica y de Salud Familiar*). National Survey on Demographics and Family Health.

EmOC: Emergency Obstetric Care functions defined by WHO, UNICEF and the United Nations Population Fund in their jointly issued *Guidelines for Monitoring the Availability and Use of Essential Obstetric Care* (1997).¹ Reproductive health services are grouped into Basic EmOC and Comprehensive EmOC. Basic EmOC refers to the ability of health facilities to administer parenteral antibiotics, oxytocic drugs, and anticonvulsants, and to perform manual removal of the placenta, removal of retained products and assisted vaginal delivery. Comprehensive EmOC consists of the aforementioned services as well as the capacity to perform Caesarean sections and blood transfusions. These signal functions are similar but not identical to the definitions of FOB and FOE, as, e.g., FOB does not include the capacity to perform assisted manual delivery (with forceps or vacuum).

FOB: (*funciones obstétricas básicas*) A facility fulfilling "Basic Obstetric Functions," defined as the capacity of health establishments to administer parenteral antibiotics, oxytocin, and anticonvulsants, manually remove placentas and retained products and attend to normal deliveries.²

FOE: (*funciones obstétricas esenciales*) A facility fulfilling "Essential Obstetric Functions," defined as the capacity of health facilities to perform Caesarian sections and blood transfusions, in addition to the procedures outlined in basic obstetric care (FOB).

FOP: (*funciones obstétricas primarias*) A facility fulfilling "primary obstetric functions." Refers to the minimum maternal and perinatal activities health establishments must be able to perform. These activities include providing prenatal consultations; assisting in delivery only when the baby's birth is imminent; providing first aid assistance to mothers, including IV fluid resuscitation

and oxytocin; providing basic medical attention to babies; referring women in the case of obstetric complications, and providing birth control after delivery.

JUNTOS: A public welfare program initiated in 2005 that temporarily provides 100 *nuevos soles* per month to pregnant women, widowed fathers, and appointed guardians caring for children below the age of fourteen, in exchange for certain behaviors, such as bringing children to be vaccinated or weighed and measured.

Magnesium Sulfate: An anticonvulsant drug used in obstetrics to prevent pre-eclampsia from becoming eclampsia or to stop the convulsions of eclampsia.

Mate: herbal tea

MDG: Millennium Development Goal. There are eight MDGs to be achieved by 2015 that respond to some of the world's main development challenges. The MDGs are drawn from the actions and targets contained in the Millennium Declaration adopted by 189 nations, and signed by 147 heads of state and governments, during the United Nations Millennium Summit in September 2000. MDG 5 is to improve maternal health with a target of reducing levels of maternal mortality by 75% from 1990 levels by the year 2015.

MEF: (*Ministerio de Economía y Finanzas*) Ministry of Economics and Finance.

MINDES: (*Ministerio de la Mujer y Desarrollo Social*) Ministry for Women and Social Development

MINSA: (*Ministerio de Salud*) Ministry of Health.

Misoprostol: A drug that was approved by the FDA for the prevention of gastric ulcers but is commonly used and approved in other countries to induce labor and for medical abortions.

MMR: Maternal Mortality Ratio, measured as deaths per 100,000 live births.

Oxytocic Drugs: Drugs used to induce uterine contractions, which are administered to expel the placenta if it is retained or to compress bleeding vessels in the area where the placenta was attached. These medicines are useful in preventing and treating post-partum hemorrhage. The WHO/UNFPA/UNICEF *Guidelines for Monitoring the Availability and Use of Obstetric Services* require basic emergency obstetric care facilities (EmOC facilities) to have the capacity to administer IV or injection oxytocic drugs.

Parenteral: Administered intravenously or by injection.

PARSalud I: (*Programa de Apoyo a la Reforma del Sector Salud*) The first phase of a joint World Bank/Inter-American Development Bank loan program aimed at improving Peru's health sector. The regions targeted by PARSalud I were Amazonas II, Huanuco, Huancavelica, Ayacucho, Apurimac I, Apurimac II, Cuzco and Puno; they were selected based on their high levels of maternal and infant mortality.

PARSalud II: The second tranche of the World Bank /IDB's loan to Peru to reform its health sector, which is slated for implementation sometime in 2008. This second phase is expected to focus on the regions of Amazonas, Cajamarca, Huanuco, Ucayali, Huancavelica, Ayacucho, Apurimac, Cusco, and Puno.

PHR: Physicians for Human Rights. References to the "PHR team" include people from our local partner, CARE Peru, who participated in the fieldwork.

Placenta accreta: A condition during which the placenta attaches too deeply in the uterine wall but does not penetrate the uterine muscle. This condition often leads to premature deliveries. Severe hemorrhaging can also occur since the placenta has difficulty separating from the uterine wall and must be detached manually.

Postpartum hemorrhage: Excessive bleeding following the delivery of a baby. If untreated, blood loss can cause a severe drop in blood pressure and lead to shock and death. Postpartum hemorrhages can occur up to six weeks after delivery and often occur if the uterus does not contract strongly enough after the placenta is delivered or if the placenta is retained.

Pre-eclampsia/eclampsia: Pre-eclampsia is a condition that occurs after the 20th week of pregnancy wherein women develop elevated blood pressure and protein in their urine. This condition is also known as toxemia or pregnancy-induced hypertension.

Putuco: A rounded adobe structure commonly found in certain parts of the Peruvian Altiplano, which is traditionally the warmest part of the house. Women who deliver their babies at home in certain areas of the generally cold Altiplano traditionally give birth in the putuco.

Quechua: An indigenous group in South America. The majority of Peru's Quechua population lives in the *Sierra* region.

RENIEC: (*Registro Nacional de Identificación y Estado Civil*) National Registry of Identification and Civil Status. This government agency is in charge of national identification documentation and registers births, marriages, deaths, etc.

Selva: Refers to the jungle region, primarily located in northeastern Peru. The *Selva* accounts for two-thirds of Peru's land and is divided into two zones: the *High Selva*, containing mountains and valleys and the *Low Selva*, which is home to the tropical rainforests of the Amazon.

Sierra: Refers to the mountainous highlands of Peru. The *Sierra* region of Peru includes all areas of the Andes above 2,000 meters; 60 percent of its population resides in rural areas, many of whom are indigenous and rely on subsistence agriculture. Huancavelica is located in the *Sierra* region.

SIS: (*Seguro Integral de Salud*) Comprehensive Health Insurance, a form of public health insurance that has been offered by the national government since early 2001. Plan C of SIS's Comprehensive Health Insurance scheme focuses on maternal health and provides coverage for prenatal care, normal and high risk deliveries, transfers during obstetric emergencies, coverage for costs related to funerals, care for 42 days after delivery, and care for various other health problems related to pregnancy.³ As of April 2007, the SIS was restructured to create two programs: a subsidized one for people without any form of income and a partially subsidized one for people earning less than 1,000 *soles* per month. For the latter, those making less than 700

nuevos soles per month pay 10 *soles* monthly and those earning between 700 and 1,000 *soles* pay 20 *soles* per month for health coverage.⁴

Skilled birth attendance: Refers to a delivery attended by a medical professional (doctor, nurse, midwife) who has been trained in the skills necessary to manage normal deliveries as well as diagnose and refer obstetric complications.

Traditional Birth Attendant (TBA): A community-based provider who assists with childbirth. Traditional birth attendants are not licensed in Peru and most have acquired their skills through apprenticeships or are self-taught. Some have received training from the local health sector or a non-governmental organization and have received a "certificate." The degree to which TBAs communicate with the local health sector varies greatly. According to the World Health Organization, TBAs, even when trained, are excluded from the category of skilled birth attendants.

UN: United Nations

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

Uterine atony: Failure of the uterus to contract strongly after the delivery of a baby or the placenta, which leads to a postpartum hemorrhage of the uterus. During a normal delivery, uterine contractions compress blood vessels and stop the bleeding of the uterus.

WHO: World Health Organization

Notes

¹ In a revised, soon-to-be published version of these guidelines, they refer to emergency obstetric care rather than essential obstetric care. Therefore, this report refers to emergency obstetric care (EmOC) throughout.

² Facilities are simultaneously classified according to their neonatal functions, denominated by an 'N.' Thus, a facility will be categorized as a FON B, FON E OR FON P, when referring to all of its functions.

³ Barrón M, Bazán M, and Castillo R. Barreras económicas en el acceso a servicios de salud de calidad: diagnóstico y políticas para su superación. CIES, CARE. Lima: July 2006:60.

⁴ "Seguro para todos los peruanos." *El Peruano*. March 17, 2007.

