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Peru
Poor and excluded women - Denial of the right to maternal and child health

1. Introduction

In 2001, a Truth and Reconciliation Commission (Truth Commission) was set up with a mandate to establish the circumstances surrounding human rights abuses and violations perpetrated between May 1980 and November 2000, during the internal armed conflict between the State and the armed opposition groups *Sendero Luminoso* (Shining Path) and the *Movimiento Revolucionario Túpac Amaru (MRTA).*[1]

In its *Final Report,* published in August 2003, the Truth Commission documented thousands of cases of serious human rights abuses by the armed opposition groups *Sendero Luminoso* and the MRTA, as well as serious human rights violations by state agents, in particular the Armed Forces which, at certain times and places during the conflict, were systematic and widespread and constituted crimes against humanity. Among the cases reported to the Truth Commission are 23,969 cases of persons who died or "disappeared", as well as thousands of cases of torture and cruel, inhuman or degrading treatment, sexual violence against women, violation of due process, abduction and hostage-taking, violation of the human rights of children and violation of the human rights of indigenous peoples.[2]

The analysis of the socio-economic profile of the victims of the internal armed conflict conducted by the Truth Commission reflects the well-known link between poverty and social exclusion and the likelihood of being a victim of violence. 85 per cent of the cases reported to the Commission related to individuals from the departments of Junín, San Martín, Ayacucho, Huánuco, Huancavelica and Apurímac.[3] These last four departments are among the five poorest in Peru.[4] In contrast, fewer than 20 per cent of those who died or "disappeared" were from the wealthier sections of society.[5]

According to the Truth Commission's analysis, the process of violence, combined with socio-economic gaps, highlighted the serious ethno-cultural inequalities that still prevail in the country. Most of the victims who died or who "disappeared" were from rural and peasant sectors (79 and 56 per cent respectively),[6] spoke Quechua or some other native language as their mother tongue (75 per cent),[7] and were educated to a lower level than the rest of the population (68 per cent of victims were educated to below secondary level in a country where only 40 per cent of the population were educated below that level),[8] that is to say, the victims of violence were from those sectors of society which are traditionally more excluded socially, with greater economic deprivation.

The Truth Commission observed that the veiled racism and contemptuous attitudes prevailing in Peruvian society against the indigenous, rural poor, contributed to the fact that the deaths of thousands of Quechua speakers went unnoticed by national public opinion.[9] Moreover, these ethnic and racial differences were cited by the perpetrators, both state agents and armed opposition groups, to justify action taken against their victims.[10]

The *Final Report* also revealed the effect that the internal armed conflict had on women, accentuating and intensifying a gender system characterized by inequality, hierarchy and discrimination. Women suffered greatly during the conflict because of their gender, and were victims of rape, used as a weapon of war to diminish them and subjugate them by using their bodies, as well as other forms of torture, including psychological torture, as a means of obtaining information about members of their families, or to forcibly recruit them for work or forced marriage and/or co-habitation.[11] Many of these women have complained of mental and physical health problems including reproductive health problems, as a consequence of the violence to which they were subjected.

Not only were women victims of abuse from the different parties to the conflict, they were also subjected to human rights violations for being the mothers, sisters or daughters of members of *Sendero Luminoso* and the MRTA, or for being the partners of members of the security forces. At times, in the climate of violence, ideological justifications were used to punish women who did not perform the submissive role assigned to them.[12]

The majority of these women were Quechua speakers from the southern highlands, young peasant women with very little education. In their case, racial discrimination was combined with gender-based discrimination.

A clear example of this dual discrimination is the fact that thousands of women of indigenous or peasant origin living in poverty are believed to have been sterilized without their consent or against their will between 1996 and 2000. These cases also reflect how economic, social and gender-based discrimination restricts the right of thousands of women to a life free from violence in Peru.[13]

The patterns of racial, ethnic and gender-based discrimination documented by the Truth Commission continue to limit the right of thousands of people in Peru to the enjoyment of their human rights. Until measures are taken to eradicate the serious inequalities and discrimination that persist in Peru today, the state will continue to be in breach of its international obligations to protect and promote the human rights, whether civil and political, or economic, social and cultural, of everyone, without distinction as to race or ethnic origin, gender or socio-economic condition.

Although the number of violations of many civil and political rights, as documented by the Truth Commission, has fallen significantly in Peru in recent years, many people continue to see their economic, social and cultural rights, as well as their civil and political rights, abused. Human rights are indivisible and states may not choose to protect only some of those rights, because they are all essential for human dignity and development. It is vital, therefore, that Peru creates the social, economic and political conditions and the legal guarantees for everyone to enjoy all their human rights in practice.

In February and July 2005, an Amnesty International delegation travelled to Peru to carry out research into the right to health for the country's marginalized or excluded communities, where inhabitants are people of peasant or indigenous origin, some of which are Quechua-speaking, with little formal education and limited financial resources. These are people who historically have been discriminated against because of their social, racial or ethnic origin and

their gender; and who for two decades have been victims of most of the serious and numerous abuses and violations of human rights committed during the internal armed conflict.

In this report, Amnesty International assesses some aspects of the Peruvian State's compliance with its obligation under international human rights legislation to promote, protect and facilitate the right to health.

In particular, the organization focuses on the obligations of the Peruvian State to ensure reproductive, maternal (prenatal as well as postnatal) and child health care, guaranteeing the equitable distribution of health facilities, goods and services; protecting the right of access without discrimination; providing appropriate training for health care personnel in relation to these duties and responsibilities; and guaranteeing the population access to information on major health problems, including the means of preventing and controlling them.

Access to information on maternal health and maternal health services is an important part of women's equal right to the enjoyment of the right to health and may, in turn, affect some other human rights of women. When women are denied access to such information and health services, their human rights to life, to physical and mental integrity, to security and freedom from discrimination, among others, may be at risk.

This document includes information from publications on health and the right to health produced by the Peruvian State, intergovernmental organizations and non-governmental organizations, as well as data and testimonies gathered during the two visits the organization made to the country in 2005, when it went to health centres in Lima, the capital, in the department of Huánuco, and in the department of Loreto. Amnesty International is grateful for the openness and transparency with which meetings and interviews were conducted, both with the authorities responsible for health at national and local levels, and with professionals and users with whom the organization had the opportunity to speak at the health establishments visited.

This report is not an exhaustive study of the situation regarding the right to maternal and child health in Peru. However, Amnesty International considers that, on the basis of the evidence obtained, it can assert with authority that, despite progress made, Peru still does not guarantee the availability, accessibility, acceptability and quality of reproductive, maternal (prenatal as well as postnatal) and child health care services for members of marginalized or excluded communities, without discrimination.[14]

According to estimates by Peru's Ministry of Health, 25 per cent of the population, that is to say around 6,500,000 people, have no access to primary health care.[15] According to official statistics, eight out of ten women see access to maternal and child health services as a problem.[16]

Amnesty International takes the view that the unequal distribution of health facilities, goods and services throughout the country, which continues to benefit the most powerful, financially privileged and politically influential sectors of society; and the economic, cultural and racial discrimination that persists in the health system, hinder access to health for people from excluded or marginalized communities, and women in particular.

2. Peru's international and national obligations with regard to the right to health

The right to enjoy the highest attainable level of physical and mental health (the right to health) is protected in both international legislation and standards on human rights and in Peru's national legislation. This legal framework is binding on the Peruvian State. Peru has also entered into a series of political commitments in international forums in relation to the right to health and, in particular, in relation to maternal and child health. One such commitment is to the United Nation's Millennium Development Goals, which include the pledge to reduce maternal and child mortality by 2015.

2.1 International norms and standards

The obligation of states to guarantee the right to health for all is recognized both in the Universal Declaration of Human Rights, [17] and in different international human rights instruments that Peru has undertaken to respect, having signed and ratified them. These include the International Covenant on Economic, Social and Cultural Rights,[18] the Convention on the Elimination of All Forms of Discrimination against Women,[19] the Convention on the Rights of the Child,[20] the International Convention on the Elimination of all Forms of Racial Discrimination; [21] International Labour Organization Convention no. 169 concerning Indigenous and Tribal Peoples in Independent Countries.[22]

The right to health is also protected by regional human rights instruments to which Peru is a state party, for example the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, "Protocol of San Salvador".[23]

According to the interpretation given by the United Nations Committee on Economic, Social and Cultural Rights (CESCR) on the article in the International Covenant on Economic, Social and Cultural Rights concerning the right to health,[24] this right should be understood as an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health. In other words, the right to health includes the right to enjoy a whole range of facilities, goods, services and conditions necessary to achieve the highest attainable level of health possible, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition, and housing, healthy occupational and environmental conditions, as well as access to health-related education and information, including on sexual and reproductive health. A further important aspect of this right, according to the Committee, is the participation of the population in all health-related decision-making at the community, national and international levels.

The Committee also establishes that the right to health should cover the following essential and interrelated elements:

Availability, in sufficient quantity, of public health and health-care facilities, goods and services and health care centres, as well as programmes. These services should include 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, as defined by the World Health Organization Action Programme on Essential Drugs.

Accessibility involves the elimination of barriers of all kinds, including physical and economic barriers and those that arise as a result of discrimination and lack of information. States must guarantee both physical accessibility and economic accessibility (affordability) to health facilities, goods and services, without discrimination, falling within the jurisdiction of the state party; as well as access to information, in particular for vulnerable groups and marginalized sectors of the population. Access to information includes the right to seek, receive and impart information and ideas, but should not impair the right to have personal health data treated with confidentiality. Health services must be accessible in law and in fact to all, which implies the elimination of both linguistic and cultural barriers.

Acceptability of health facilities, goods and services which 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.

Quality of health facilities, goods and services which must also be scientifically and medically appropriate and of good quality. This requires, amongst other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

2.1.1 The state's obligations with regard to the right to health

Under the terms of Article 2 of the International Covenant on Economic, Social and Cultural Rights, the full realization of the rights recognized in the Covenant, including the right to health, should be achieved progressively, by all appropriate means, through the adoption of measures, whether individually or through international assistance and cooperation, to the maximum of each of the states parties' resources.[25]

However, the fact that the full realization of the right to health can only be achieved progressively does not alter the nature of the legal obligation of states which requires that certain steps be taken immediately and others as soon as possible.[26] The United Nations Committee on Economic, Social and Cultural Rights states that there are obligations which the states parties to the Covenant must meet immediately. Among these obligations is the undertaking to guarantee that the rights of the Covenant will be exercised "without discrimination" and the obligation to take steps as quickly and effectively as possible with a view to achieving the full effectiveness of these rights.[27]

The Committee has, in addition, clarified the core obligation of states parties to ensure that at least the essential levels of each right under the Covenant are met, without delay. Even in times of severe resources constraints the most vulnerable members of society can and must be protected by the adoption of relatively low-cost programmes.[28] States must demonstrate that they have made every effort to use all the resources at their disposal to give priority to

meeting at least these basic levels of obligations in relation to each of the rights recognized in the Covenant.

The Committee considers the following core obligations to be the minimum to be met by states to ensure the right to health:[29]

- to ensure equitable distribution of all health facilities, goods and services and the right of access, without discrimination, to these health facilities, goods and services; as well as to provide essential drugs, as defined in the World Health Organization Action Programme on Essential Drugs;
- to ensure access to the minimum essential food, to basic shelter, housing and sanitation, and to an adequate supply of safe and potable water.
- to adopt and implement a national strategy and plan of action to address the health concerns of the whole population. These should be devised and periodically reviewed on the basis of a participatory and transparent process. Both the process by which the strategy and plan of action are devised, as well as their content, should pay particular attention to all vulnerable or marginalized groups.

According to the Committee, "a State Party in which any significant number of individuals is deprived of essential foodstuff, of essential primary health care, of basic shelter and housing or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant".[30]

The Committee also identifies obligations of comparable priority, including: ensuring reproductive,[31] maternal (prenatal as well as postnatal)[32] and child health care; to provide immunization against the major infectious diseases; to adopt measures to prevent, treat and control epidemic and endemic disease; to provide education and access to information concerning the main health problems, including methods of preventing and controlling them; and to provide appropriate training for health personnel, including education on health and human rights.

In relation to maternal health, the Committee states that reducing women's health risks, in particular lowering the rate of maternal mortality, must be one of the objectives of the national strategy that states have to devise with a view to promoting women's right to health and the prevention and treatment of diseases that affect this sector of the population. In this regard, the Committee establishes the need to remove barriers to women's access to health, education and information services, in particular in the area of sexual and reproductive health.[33]

The importance of ensuring reproductive, maternal (prenatal as well as postnatal) and child health is set out not only in the International Covenant on Economic, Social and Cultural Rights,[34] but also in the Universal Declaration of Human Rights.[35] Moreover, both the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women emphasize the importance of ensuring maternal and child health care, which illustrates the priority given to maternal and child health in international human rights legislation.[36]

The Committee on the Elimination of Discrimination against Women takes the view that states parties, such as Peru, should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and postpartum periods for women[37]. The Committee notes that it is the duty of states parties to guarantee women's right to free and safe motherhood and emergency obstetric services, allocating to these services the maximum available resources.[38]

2.2 Peru's political commitment in relation to reproductive, maternal (prenatal as well as postnatal) and child health care

In addition to Peru's international legal obligations in relation to the right to health, and in particular with regard to the health of mothers and children, Peru has, in the last decade, entered into a series of political commitments in international forums within the framework of the United Nations.

In 1994, at the International Conference on Population and Development in Cairo, the participating states, including Peru, recognized the need to continue to make progress to reduce the mortality rate of mothers, breast-feeding mothers and small children, and the difference between average mortality rates in the developed and developing regions, as well as disparities within countries, and those between geographical regions, ethnic and cultural minorities and socio-economic groups. In this context, the States undertook to guarantee for all and, in particular, for the most underserved and vulnerable groups, fair access to health care services, including family planning and mother and child health care services.

The Action Programme that resulted from the Conference states that all countries must expand the provision of maternal health services in the context of primary health care, respecting the concept of informed choice. These services should include education on safe motherhood; prenatal care that is focused and effective; maternal nutrition programmes; adequate delivery assistance and emergency obstetric provision; referral services for pregnancy and childbirth complications, prenatal care and family planning.[39]

Similar commitments were made in 1995 during the United Nations IV World Conference on Women in Beijing. Participating states, including Peru, recognized that in many parts of the world complications associated with pregnancy and childbirth were among the principal causes of mortality and morbidity of women of reproductive age and that the majority of such deaths, health problems and injuries were preventable through improved access to adequate health care services. In this regard, the states undertook to provide more accessible, affordable primary health care services of high quality, including sexual and reproductive health care, which includes family planning information and services and pay particular attention to maternity and emergency obstetric care, as agreed to in the Cairo Programme of Action of the previous year.[40]

In September 2000, in the context of the so-called United Nations Millennium Assembly, the Millennium Summit was held, when the "Millennium Declaration" was adopted, establishing points of agreement on various topics of global interest, together with concrete objectives. This process gave rise to the "Millennium Development Goals".

The Millennium Development Goals are eight global goals to be reached before 2015, which include measures to combat extreme poverty, promote gender equality, education and environmental sustainability. These goals are related to fundamental human rights such as the right to health, to housing, to safe drinking water and to sanitation; their achievement will represent a major step towards the full effectiveness of these essential rights for human development. The Millennium Development Goals include reducing infant mortality (Goal 4) and improving maternal health (Goal 5). In relation to these two objectives, states have undertaken, *inter alia*, to take steps to reduce by two thirds the mortality rate among children under five and by three quarters the maternal mortality ratio between 1990 and 2015.[41]

The implementation of the Millennium Development Goals through national strategies must be firmly rooted in a regulatory human rights framework and must take account of states' national and international obligations with regard to human rights. These aspects should be taken into account when overseeing progress in the implementation of the Millennium Development Goals.

2.3 The right to health in Peruvian national legislation

Peruvian legislation recognizes the right to health protection in the second chapter of the Constitution of 1993 which relates to Social and Economic Rights.[42]

The protection of this human right is regulated in the General Health Act (Law No. 26842), of July 1997, which establishes the inalienable right to health protection for all. This law sets out the duties of the Peruvian State to promote universal and progressive insurance of the population to protect it from health contingencies. It also establishes the state's duty to intervene in the equitable provision of health care services, to channel state financing into public health actions and to totally or partially subsidize health care for the financially disadvantaged. The Law also recognizes the right of all individuals to receive emergency medical and/or surgical attention in any health establishment when necessary and while there is a serious risk to that person's life or health.

The General Health Act also recognizes a person's right to the respect of his or her personality, dignity and privacy and the right to information, including information on reproductive health measures and practices.

With regard to Peru's obligation to secure maternal and child health care for women and children, Law No. 27604, which amended the General Health Act in December 2001, extends the right to emergency medical/surgical attention to attention during childbirth, where the life of the mother or child is at risk. This law makes repayment of any emergency care expenses conditional upon the user's resources, to be determined by a case assessment by Social Services and exempting destitute groups.

3. Inequalities in the realization of the right to reproductive, maternal (prenatal as well as postnatal) and child health

Although the *Lineamientos de la Política del Estado Peruano*, Health Policy Guidelines of the Peruvian State, for the period 2002 to 2012 emphasize the basic principles of, amongst others, equity, universality of access and quality of services, this policy does not give priority to the full realization of the state's core obligations in relation to the right to health. In particular, the right to maternal and child health, which includes: the right to health without discrimination, the provision of health facilities, goods and services which respect the cultures of ethnic or linguistic minorities and priority of access to these health services for the most vulnerable groups.

With regards to Peru's obligation to guarantee access to health, including maternal and child health, and its obligation to give priority to vulnerable groups, the authorities have, in recent years, created some mechanisms to meet this obligation.

The Ministry of Health Law (Law No 27657) of January 2002, created the decentralized body *Seguro Integral de Salud* (SIS), Comprehensive Health Insurance scheme, with the aim of ensuring access to basic health services for those living in poverty and extreme poverty.[43] The Comprehensive Health Insurance offers different care plans, such as: plan A, for children aged 0 to 4, which includes preventive care, care and treatment of diseases, care of babies infected with HIV/AIDS at birth, emergency transfers and cover for funeral costs; and plan C, which focuses on pregnant women and includes prenatal monitoring, attention during normal and high-risk deliveries, postnatal care, attention to other health problems, emergency transfers and funeral costs.

In districts where more than 65 per cent of families are living in poverty or extreme poverty according to estimates by the Ministry of Economy and Finance, the Comprehensive Health Insurance scheme provides universal free access to these plans. The only cost for persons affiliated to the Comprehensive Health Insurance scheme in such cases is the payment of 1 *nuevo sol* (US$0.30) to join the

Comprehensive Health Insurance scheme brochure with information about free health services for those living in poverty. © SIS

scheme. In districts where the percentage of people living in poverty or extreme poverty is lower than 65 per cent, a *Sistema de Identificación de Usuarios* (SIU), User Identification System, is applied, using a *Ficha de Evaluación Socioeconóica* (FESE), Socio-economic Evaluation Sheet, which assesses each person's ability to pay for treatment provided under the Comprehensive Health Insurance scheme. As well as the 1 *nuevo sol* payable on registration, these people must also pay all, part of, or none of the cost of the medical care they have received, depending on their purchasing power.[44]

In addition to this, in December 2005, Peru adopted its first National Human Rights Plan. Although this Plan has not yet been implemented, it includes priorities to guarantee the right to health, including: guaranteeing the right to information on health, with special emphasis on rural and indigenous communities, respecting cultural differences; strengthening human resources policies with a view to improving the skills and employment conditions of employees in the health sector, both in the performance of their functions and in promoting and protecting the right to health; pursuing advances in the quality of health services and their cultural adaptation; and developing finance mechanisms to guarantee access to comprehensive health care for low income groups.

However, in spite of the legal and political commitments that Peru has made, according to estimates made by Peru's Ministry of Health, 25 per cent of the country's population, that is to say around 6,500,000 people, do not have access to primary health care.[45] For eight out of every ten women, access to maternal and child health care services is seen as a major problem.[46]

Official maternal and child mortality rates in Peru are among the highest in the region. The most recent figures produced by the Pan American Health Organization show that the maternal mortality rate in Peru for the year 2000 was 185 women for every 100,000 live births,[47] which in absolute figures represents more than 1,250 deaths. The perinatal (stillbirths) and under-five mortality rate is said to be between 23 and 47 per 1000 live births respectively.[48] Other estimates put the maternal mortality rate at 410 per 100,000 live births.[49]

According to official statistics, 20 per cent of deaths among women in 2000 were attributable to maternity.[50] Other reports indicate that 45 per cent of deaths in the country are under fives, and that every 8 hours a woman dies as a result of pregnancy, confinement and postpartum complications.[51]

Although there has been a reduction in child and maternal mortality in recent years, according to the Ministry of Health there has been an increase amongst the poorest groups, which means that the national average improved only because infant and maternal mortality fell significantly in the higher income groups.[52]

Reports state that the majority of maternal and child deaths in Peru could be avoided if measures were implemented and proper medical attention given. For example, the chief causes of infant mortality are said to be perinatal: diarrhoea, malnutrition and acute respiratory infections. In the case of maternal mortality, this would be postpartum haemorrhage, infections, pregnancy-induced hypertension and the result of complications during abortions.[53]

Furthermore, these risks are greater in pregnant women who are undernourished and suffering from anaemia, the majority of whom are women from marginalized groups. Poor nutrition and maternal health also results in the birth of premature or low birth weight babies, who can die if basic care is not available. According to the Ministry of Health, in Peru 32 per cent of women of childbearing age are said to have anaemia and 13 per cent show signs of chronic malnutrition. In the case of children under five, 25 per cent reportedly suffer from chronic malnutrition, a figure which rises to 75 and 80 per cent in rural areas, and 50 per cent in the same areas reportedly suffer from anaemia.[54]

Lower income groups also have less access to the basic services which are the underlying determinants of health, and which, in particular, affect child health such as potable, piped water and access to education.

According to the *Defensoría del Pueblo* (National Ombudsman), 25 per cent of the country's population (6.8 million) have no safe drinking water. In addition, just over 42 per cent (11.5 million) have no sanitation. Those with the least access to water and sanitation services are rural populations (around 40 per cent without water and 70 per cent without sanitation).[55]

According to official statistics, women with no, or only primary, education are less likely to receive prenatal care from health professionals or give birth in health centres; this is particularly true of women of indigenous origin, of whom it is calculated that more than 40 per cent have no access to education, even at basic level.[56] Also, the lower the mother's level of education, the higher the neonatal and infant mortality rate.[57] Since 1997, the Committee on Economic, Social and Cultural Rights in its final comments on the initial report on Peru voiced concern at the mortality rate associated with maternity, which, according to the Committee, was ten times higher amongst poor, uneducated women.[58]

3.1 Availability of health facilities, goods and services

Peru has one of the lowest levels of investment in health in Latin America. In 2003, the level of public investment in the health system in Peru was only 2.1 per cent of gross domestic product, compared with 4.9 per cent in Costa Rica and 4 per cent in Colombia, countries with a per capita income similar to Peru, or 4.3 per cent in Bolivia, whose per capita income is less than Peru's.[59] Furthermore, according to the Special Rapporteur of the United Nations Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur on the right to health), per capita investment by Peru has declined in recent years from 95 *nuevos soles* (US$28) in 2001, to 78 (US$23) in 2003. This is despite the economic growth that Peru has experienced during that period, with an increase of 0.2 per cent in gross domestic product in 2001 and almost 7 per cent in 2006.[60] According to the Special Rapporteur on the Right to Health, "[t]he decrease in budgetary allocations to the health sector, in particular in light of … poor health indicators, is inconsistent with the state's international right to health obligations."[61]

The United Nations Committee on the Rights of the Child also voiced concern in January 2006 at the failure to provide a budget earmarked to meet the economic, social and cultural rights of children, including the right to health. The Committee recommended that the Peruvian State increase these budget allocations to guarantee the implementation of these

rights, especially for children belonging to economically disadvantaged groups such as indigenous children.[62]

3.1.1 Discrimination in the availability of health facilities, goods and services

In Peru it is the household, rather than the state, which invests most in health care. Households reportedly account for around 40 per cent of health spending, compared with 25 per cent by the state.[63] Amnesty International does not have statistics relating to health spending financed by the state and that financed by individual households in each of the 24 departments. However, Peru's limited investment in health would imply firstly, that even in departments where there is a large low income population, health centres depend to a great extent on payments made by users to finance health services. Secondly, that in those areas where the purchasing power of the population is lower, health centres receive less income and, consequently, the services they are able to offer users are more limited.

In addition to Peru's low level of health spending, there is the unequal distribution of the budget, which is not channelled towards lower-income groups. According to a study carried out by human rights organizations, whereas in Lima and Callao the state apparently allocated almost 169 *nuevos soles* (US$51) per capita in 2005, in some departments with larger low-income populations, such as Huancavelica, Ayacucho and Huánuco, this figure was less than 80 *nuevos soles* (US$24).[64] Reports state that only the department of Lima has substantially increased spending on health, whereas in the Andean departments of Puno, Huánuco, Junín¸ Pasco, and Ayacucho the average budget has been reduced by 18 per cent. In Amazonia, in departments including Loreto, Madre de Dios and Ucayali the reduction is said to be greater than 20 per cent.[65]

The health personnel resources that the state allocates to the different departments of the country are not uniform either. Whereas Lima has 22 doctors, 11 nurses and 3 obstetricians for every 10,000 inhabitants, in Ayacucho there are only 5 doctors, 7 nurses and 4 obstetricians for every 10,000 inhabitants; in Huancavelica the figures are 4, 3 and 2 respectively for every 10,000 inhabitants, and in Huánuco: 4, 5 and 3 respectively for every 10,000 inhabitants.[66]

A health system also requires a sufficient number of well-trained and motivated personnel, whose employment rights are respected. In Peru, according to testimonies gathered by Amnesty International during the organization's visits to health centres in February and June 2005, many health professionals, in particular those working in rural areas, have little job security. According to these same testimonies, many staff are employed on *Contratos por Servicios No Personales*,[1] working the same hours and doing the same work as appointed professionals, but at a lower salary and without right to holidays, insurance, sick leave or maternity leave. Furthermore, those health professionals contracted to provide health care for users covered by the Comprehensive Health Insurance are apparently employed on *Contratos por Servicios No Personales*.

[1] Personnel employed under this type of contract have no job security or employment rights; they are employed to fulfil a particular task but are not considered members of staff.

In the case of nurses, for example, according to the National Nursing Census carried out by the *Colegio de Enfermeras(os) del Perú*, Peruvian College of Nurses, 25 per cent of nurses employed by the Peruvian State have *Contratos por Servicios No Personales*. Almost 100 per cent of these nurses, despite working the same number of hours, if not more, earn less than what is considered to be adequate (income-related underemployment). The same census indicated that over 60 per cent of nurses earn less than 1,000 *nuevos soles* (US$298) a month.[67]

Other reports and testimonies received by Amnesty International indicate that the low salaries earned by professionals in rural areas, which do not take into account the cost of food, transport and other services which are higher than in more accessible areas, are a contributory factor in the demotivation of staff, giving rise to a high rate of turnover. In general, it is the least qualified health professionals, or those who have fewer contacts in the system, who are sent to rural and indigenous communities. The poor remuneration, working conditions and distance from their families means that, generally speaking, people try to be assigned to other locations wherever possible.

The uncertain working conditions of health personnel, the high turnover rate and the lack of appropriate training in adaptation and intercultural awareness to deal with the social reality of the communities – training which, even if provided, will be hindered when staff in rural and indigenous areas stay in post for such short periods – all have a negative impact on the quality of health services.

3.2 Accessibility of health services

After his visit to Peru in June 2004, the Special Rapporteur on the right to health voiced concern at the poverty, discrimination and inequalities existing in Peru, where 49 per cent of the population lives in poverty and more than 18 per cent in extreme poverty. These figures increase in rural areas to 70 and 35 per cent respectively, which has perpetuated major disparities in the enjoyment of the right to health between town and country, between regions and between different groups of the population.[68]

Similarly, in January 2006, the United Nations Committee on the Rights of the Child voiced concern at the discrimination that still exists in Peru against certain vulnerable groups, such as indigenous children and those children living in rural and remote areas. The Committee also expressed concern at the inadequate access to health and health services in these areas and the disparities in providing access to health care, highlighting the high maternal and child mortality rate in the country; and the lack of access to basic services, including health services, for children in indigenous communities.[69]

In 1997 and 1999 respectively, both the Committee on Economic, Social and Cultural Rights and the Committee for the Elimination of Racial Discrimination had already voiced concern at the close correlation between socio-economic underdevelopment and access to economic, social and cultural rights, including the right to health, and the phenomena of ethnic and racial discrimination in Peru.[70]

According to the Ministry of Health, state subsidies to guarantee access to health services for the most vulnerable groups do not give priority to the financially disadvantaged, who receive 20 per cent of state subsidies, whereas the wealthier sections of society reportedly have access to 21 per cent.[71] In hospitals, according to some studies, low-income groups have access to only 10 per cent of subsidies, which would mean that many have no access to care in hospital, where resources are concentrated and where, consequently, the number of specialist staff and the capacity to deal with emergencies, including emergency obstetric care, is greater.[72]

According to Comprehensive Health Insurance statistics, most people belonging to marginalized or excluded groups who do finally gain access to health services do so in health centres or health posts, whereas the wealthier sections of society receive attention in national or regional hospitals.[73]

However, the Ministry of Health reportedly channels 54 per cent of its expenditure into hospitals, in spite of the fact that these are located principally in urban centres and only meet 30 per cent of demand. On the other hand, only 33 per cent of its expenditure goes to health centres and health posts, which meet 70 per cent of demand and where, in most cases, the users are from rural areas.[74] Other studies also indicate that 24 per cent of the total health budget is devoted to national hospitals, which are attended mainly by patients from Lima, and a majority of wealthier patients.[75]

According to Peru's Ministry of Health, the likelihood of dying from maternity-related causes is twice as high for women from rural areas than for women from urban areas. It is in rural areas that there is a greater concentration of low-income groups and people of indigenous origin (around 15 per cent of the population in Peru speaks a native language as their mother tongue, with Quechua being the most common).[76] In 2000, in urban areas, where according to official statistics 63.7 per cent of the population lives, 203 women died as a result of maternity-related causes. In rural areas, where only 36.3 per cent of Peru's population lives, the number of maternal deaths in 2000 rose to 448.[77] According to the Pan American Health Organization, these deaths in rural areas occurred during childbirth or as a result of complications arising during abortions, carried out in unsanitary conditions and without professional health care.[78]

The latest available official statistics reveal, moreover, that while the infant mortality rate in urban areas is 28 per 1000 live births, and in Lima, the capital, it is 17 per 1000 live births, in rural areas this figure rises to 60 per 1000 live births, 84 in Cuzco and 71 in Apurímac and Huancavelica, some of the poorest departments in Peru.[79]

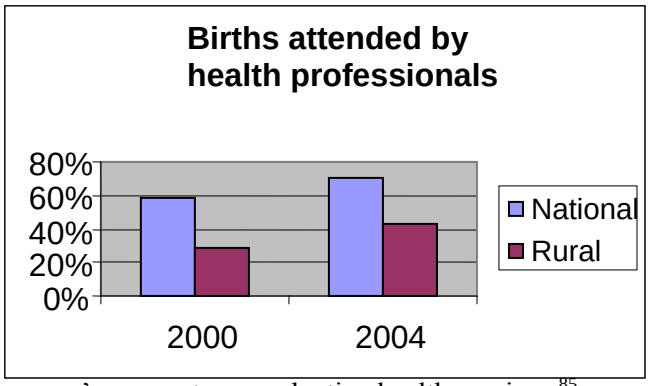
Peru's implementation of health programmes, such as the Comprehensive Health Insurance, designed to facilitate access to health for excluded and low-income groups, has reportedly contributed to improving access to health for this sector of the population. According to Comprehensive Health Insurance statistics, by May 2005 more than 8,500,000 people had signed up for the insurance. Half of these were from marginalized or excluded groups in rural areas and 20 per cent were from marginalized urban areas.[80]

However, in January 2006 the United Nations Committee on the Rights of the Child stated that, according to reports, a significant proportion of people living in poverty, including

women and children under eighteen are reportedly not affiliated to this insurance.[81] According to official statistics, inequalities in health and access to maternal and child health services continue to exist due to users' lack of resources and depending on their place of residence.

Although in recent years there has been an increase in the number of women who, according to the latest official statistics, have access to medical care during the prenatal period, delivery and postpartum period, differences persist between urban and rural areas. According to the World Health Organization, the percentage of births attended by trained health personnel and access to essential obstetric care are key reproductive health indicators.[82] In Peru, there are major disparities between rural and urban areas in terms of the care received by women in childbirth.

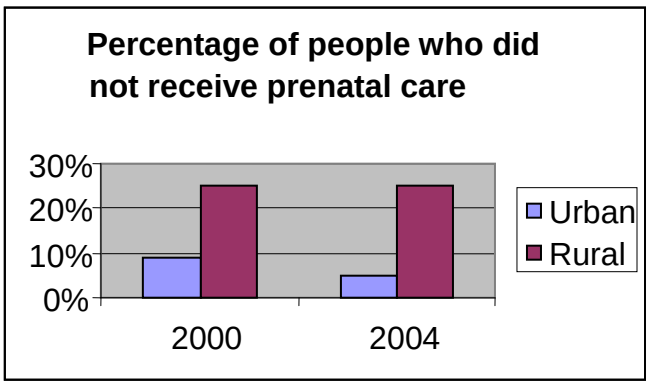
In 2000, only 59 per cent of births were attended by health professionals.[83] Although in 2004 this percentage had risen to 71 per cent, in rural areas it was still only 43 per cent.[84] Although this last percentage represents an improvement compared with the 29 per cent of births attended by health professionals in rural areas in 2000, however, it does reflect the difference that still exists between rural areas and urban areas in terms of women's access to reproductive health services.[85]



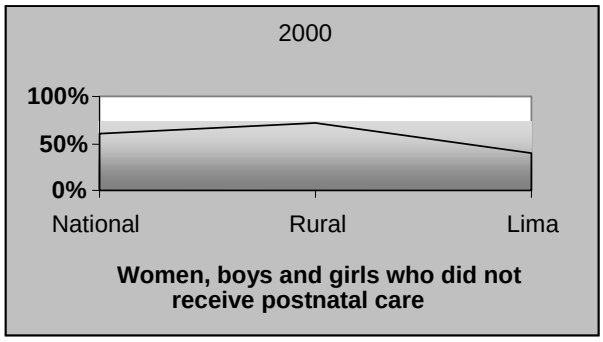
In regard to the rate of caesarean sections, one of the elements that must be included in essential obstetric care, the official figures in Peru also reveal disparities between rural areas and urban areas. In Lima, the average rate of caesarean sections is 26 per cent, and 17.5 per cent in other major cities,[86] which is higher than the maximum recommended by the World Health Organization. According to the WHO, a caesarean rate higher than 10 to 15 per cent cannot be justified, because the operation poses medical risks to the mother's health, including a maternal mortality two to four times greater than that for a vaginal birth.[87] In contrast, in rural areas of Peru the caesarean section rate is less than 4 per cent.[88] According to the WHO, the disparity between caesarean rates in urban and rural areas indicates that women in rural areas who have complications during childbirth do not have access to health services as a result of economic or geographical barriers and that the health facilities in those areas do not have the necessary infrastructure or training to deal with complications that might arise during childbirth.[89] Women in rural areas must have access to the medical care they need, and which is acceptable to them, during childbirth. This should include access to a caesarean section where necessary, as well as to a natural birth.

With regard to prenatal care, in 2000 just over 25 per cent of women in rural areas had no access to prenatal care, whereas in cities this figure was only 9 per cent.[90] In 2004, the percentage of women in rural areas still not receiving prenatal care or care from a health

professional remained at over 25 per cent, whereas in urban areas the figure had fallen to less than 5 per cent.[91]



The most recent statistics on postpartum and postnatal care also highlight the disparity between the medical care to which people in urban area and rural areas have access. In 2000, more than 60 per cent of women and children in Peru did not receive postnatal monitoring. In rural areas, this figure rises to 71 per cent, whereas in Lima the figure is reportedly less than 40 per cent. Of women who had health problems during the 40 or 42 days after delivery, only around half received postnatal care. In rural areas, only 35 per cent had access to such care. The number of women receiving postnatal care from a health professional is also higher in urban areas (46 per cent) than in rural areas (28 per cent).[92]



A study by Peru's *Instituto Nacional de Estadísticas e Informática*, National Institute of Statistics and Technology, published in 2002, shows that women who have greater access to reproductive and family planning health services are more educated, urban women, living in metropolitan Lima and the rest of the coast. On the other hand, the least educated, rural women have no access to reproductive health services to monitor their pregnancy and childbirth. This is in part due to a lack of financial resources, but also through fear of the secondary effects of contraceptives, embarrassment at the prospect of exposing their private parts, fear of being sterilized, or the cold or too brightly-lit environment of health facilities.[93]

3.2.1 Barriers to access to reproductive, maternal (prenatal as well as postnatal) and child health

The main barrier limiting access to health services, according to official statistics, is a lack of financial resources. According to a study carried out by the Peruvian Ministry of Health in 2002, 50 per cent of those interviewed said that they could not use health services for financial reasons, including the lack of financial resources to pay for the service, but also citing transport costs and the loss of time and income involved in attending.[94]

Official statistics for the year 2000 show that 65 per cent of women could not use health centres because of a lack of financial resources. This percentage rises in the poorest departments, including Huancavelica and Ayacucho (over 80 per cent) and in Huanuco and Apurímac (over 70 per cent).[95]

Although, according to official data, the percentage of people citing a lack of money as the principal cause for not attending a health centre has reportedly fallen in recent years, between December 2004 and February 2005 25 per cent of those interviewed nation-wide and just over 30 per cent in rural areas cited a lack of financial resources as a barrier to accessing health services. In addition, 69 per cent stated that it had not been necessary, or that they had used household remedies, and 10 per cent said they had no health insurance, all responses that could indicate the existence of financial restrictions.[96] In the most recent statistics published by Peru's National Institute for Statistics and Technology, 24.7 per cent of those interviewed nationally cited a "lack of money" as the reason for not attending a health centre when symptoms appeared or on feeling unwell, sick or having sustained an accident. This figure remains around 30 per cent in rural areas. In addition, 67.4 per cent nationally were still giving as a reason: "it was not necessary or they used a household remedy" for not attending a health centre.[97]

In terms of access to drugs, according to the Pan American Health Organization, 50 per cent of the population of Peru has no access to drugs. This figure is said to rise to 60 per cent in rural areas.[98] According to the Ministry of Health, only 45 per cent of patients obtain all of the medicines they need; this is because of the high price, limited purchasing power and low levels of subsidy. According to the same report, a third of the country's population has no access at present to essential drugs, which could have serious repercussions on the life expectancy and quality of life of these people. Statistics show that as long ago as 1999, 75 per cent of the cost of medical care was accounted for by drugs, the cost of which has continued to increase in recent years. This increase in price, according to the Ministry of Health's analysis, has resulted in the decline in the sale of drugs.[99]

In addition, according to reports received by Amnesty International, women who have no financial resources to access health services are often victims of various forms of discrimination. According to reports received and testimonies gathered, although maternal and child health care is free of charge through the Comprehensive Health Insurance scheme, the lack of resources in health centres means that the centres' budgets are to a large extent dependent on raising funds by charging users for services. This situation implies that priority is given to users who can afford this service to the detriment of those on low incomes who use

Association of Single Mothers of Nauta, Iquitos, and users of Comprehensive Health Insurance scheme. © AI.

the subsidies offered by the Comprehensive Health Insurance scheme.

"If you go badly dressed, they make you wait longer and the ones who arrive later but better dressed go first ... and if you complain, they treat you worse."[100]

According to women interviewed by Amnesty International in marginalized urban areas in Lima and in rural areas in Huánuco, in the Andes, and in Iquitos, in Amazonia, as well as reports received and studied by the organization, people on low incomes using health services often have to wait longer or are asked to pay for drugs, blood transfusions, gloves, cotton wool or other equipment and the cost of washing surgical gowns used during delivery and the postpartum rest period, the cost of which is reportedly not covered by the Comprehensive Health Insurance scheme budget. According to information to which Amnesty International has had access, the Comprehensive Health Insurance scheme reimburses health facilities the cost of medical care, but frequently health centres do not have sufficient funds to cover other types of expenditure incurred in providing care and treatment for their users.

According to these same testimonies and reports, users are sometimes told that the necessary care or drugs are not covered by the Comprehensive Health Insurance scheme, that the budget health centres receive from the Comprehensive Health Insurance scheme is exhausted, or that care under the scheme is limited to a few hours and that it is necessary to pay for the consultation, the transfer to hospital, the drugs or other equipment necessary for medical care.

Women in rural communities in Amazonia, in Iquitos, in the department of Loreto, where more than 60 per cent of the population's basic needs are unsatisfied,[101] stated that they are charged 1 nuevo sol (US$0.30) for a consultation and that under the Comprehensive Health Insurance scheme, babies can only be seen twice a week by a health professional and can only be given painkillers or analgesics; everything else has to be paid for.

Elisabet, resident of Huitoto Murauy, Iquitos, a rural community of indigenous origin where the entire population ought to be eligible under the Comprehensive Health Insurance scheme because of their precarious financial situation, took her baby to a health centre. With the exception of the analgesics that were given to her, she had to pay for the gloves used by the health personnel, the transfer to the regional hospital and 665 nuevos soles (US$200) for seven nights in hospital.

Residents of Huitoto Murauy, Iquitos, and users of Comprehensive Health Insurance scheme users. © AI.

Zoila, a resident of the same locality, had to pay 15 nuevos soles (US$4.50) for an ultrasound scan. As her baby was in the transverse position, she had to go to hospital, where they made her pay for drugs and gloves.

Ivone, from the same community, told Amnesty International how, at the nearest health centre, they only see Comprehensive Health Insurance patients until 1 o'clock in the afternoon, and after that they charge up to 8 nuevos soles (US$2.50).

In Nauta, Iquitos, the women interviewed by Amnesty International in July 2005 told of similar situations:

"They charged 1 [nuevo] sol (US$0.30) for my daughter's medical history .. she has mumps".

"They wanted to charge me for providing care for my 1-year-old, because it was not an emergency".

* *On 28 November 2004 Marlene, who lives in Huillca, Humari, Huánuco, went to Panao, Huánuco, to report the death of her 3-month-old baby to the authorities. At the request of the Prosecutor in Pachitea, Marlene went to the health centre there, carrying her baby's body on her back, so that an autopsy could be carried out. At the health centre in Panao, after charging her 30 nuevos soles (US$9), they refused to carry out the autopsy and told her to go to Tambillo. The family had to wait until 1 December 2004 for the autopsy to be carried out.*

Reports received by Amnesty International also show that access to health services for low income groups is hampered by other costs such as: the cost of travel to health centres, which sometimes also includes health professionals' travel costs to the user's home in emergencies; delays in both receiving the necessary treatment and registering as Comprehensive Health Insurance patients, which means a loss of earnings or the inability to look after the family; and registration costs. These costs, along with the unjustified charges, continue to restrict access to health services for lower income groups.

The organization has noted that in rural areas where the entire population is considered to be living in poverty or extreme poverty and, as a result, ought to be exempt from paying for maternal and child health care, health centres display price lists for services and drugs which should be covered by the Comprehensive Health Insurance and continue to charge for some of these services.

According to an analysis carried out in 2003 by the Pan American Health Organization and Peru's Ministry of Health, more than 40 per cent and 30 per cent respectively of the pregnant women affiliated to the Comprehensive Health Insurance scheme who attended Ministry of Health facilities in 2002 had to pay for examinations and X-rays, and 15 per cent paid for analyses and drugs.[102]

3.2.1.1 Identity documents and certificates of live birth

Posters with pricelists that include maternal-child health services covered by users of Comprehensive Health Insurance scheme, in health centres in Huánuco department. © AI.

One of the factors that hinders access to Comprehensive Health Insurance health services for people from marginalized and excluded communities is the fact that many people today still have no identity document. This not only violates their human right to an identity and a name,[103] it also places people who have no identity documents in a position of particular vulnerability by restricting their access to not only their civil and political rights, but also their economic, social and cultural rights. Not having identity documents limits, for example, the possibility of exercising their right to health, and in particular limits their access to health services and to the Comprehensive Health Insurance scheme, because in order to register as a user of this service it is necessary to produce an identity document.

As the Inter-American Court of Human Rights of the Organization of American States has established: "the right to recognition of juridical personality is a fundamental requirement for the enjoyment of all basic freedoms, since this right grants the individual recognition before the law". The Inter-American Court has also stated that the right to a name constitutes a basic and essential element of every person's identity, without which he or she cannot be recognized by society or registered by the State … States, within the framework of article 18 of the Convention have an obligation not only to protect the right to a name, but also to provide the necessary measure to facilitate registration of an individual, immediately after birth.[104]

Although there are no official statistics on the number of people in Peru who have no identity documentation, the Office of the National Ombudsman estimates the figure at more than three million. According to the *Equipo Técnico de la Comisión de Alto Nivel encargada de elaborar el Plan Nacional de Restitución de la Identidad: Documentado a las personas indocumentadas 2005-2009* [105], more than a million and a half people have no access to identity documents and over half a million under-eighteens have no birth certificate.[106] As established by the Truth and Reconciliation Commission, this situation mainly affects the poorer sectors of society.

According to the United Nations Committee on the Rights of the Child, despite the efforts of the Peruvian State to guarantee registration of all children, 15 per cent of the country's under-18s are still not registered, especially in rural and isolated areas. Based on estimates from Peru's National Institute of Statistics and Technology on the number of inhabitants by age, in 2005 15 per cent of the population aged between 0 and 19 would amount to around 1,320,000 people.[107] In January 2006, the Committee urged the Peruvian State to modernize, and allocate the necessary financial resources and trained personnel to guarantee the proper operation and maintenance of the Registrar's Office and make the system more accessible.[108]

According to UNICEF, 313,000 women in Peru do not have identity documents (birth certificate, national identity card or electoral card), and do not have the resources to pay for these documents. Over 40 per cent of these women who have no documents live in rural areas.[109]

The Office of the National Ombudsman has observed that one of the reasons these documents are difficult to obtain is the high cost of the National Identity Document, and this is a major barrier in native communities, where poverty levels are high. Another obstacle to obtaining these documents highlighted by the Ombudsman's office is the existence of fines for women who do not attend prenatal and postnatal checkups or who give birth at home, as well as the unjustified charges imposed in some health facilities for issuing a Certificate of Live Birth, which is one of the principal requirements for registration and the issue of a Birth Certificate.[110]

The testimonies of users and health professionals gathered by Amnesty International in health centres in rural areas, both in the Andes and in Amazonia, confirm that this practice is still widespread. According to these testimonies, health facilities impose fines of up to 50 *nuevos soles* (US$15) on women who have not attended pre- and postnatal checkups and whose children were born at home. They are denied a Certificate of Live Birth or access to medical care and other benefits, such as food, until this sum is paid. The Certificate of Live Birth issued in health centres and hospitals throughout the country is a requirement for obtaining a Birth Certificate. People who do not obtain a Certificate of Live Birth consequently have problems obtaining a Birth Certificate and, as they get older, experience problems obtaining their National Identity Card, which is compulsory.

***** *Fidencio, who lives in Centro Poblado Menor de Ycho-Yanuna, in Huánuco, has four young children, aged between five years and five months. They were all born at home. After the birth of his second son, Fidencio had to pay the health centre at Panao a fine of 10 nuevos soles (US$3) because his wife had not gone to the health centre to give birth. When the third daughter was born, the family had to pay a fine of 25 nuevos soles (US$8). For the most recent child, the health centre demanded 100 nuevos soles (US$30) from Fidencio's family. For Fidencio who, like most of the people of Huánuc, grows potatoes for a living, this sum is the equivalent of selling 1000 or 1200 kilos of potatoes. Fidencio went to the health centre to tell the doctor that he could not pay. The doctor reduced the fine by half. Fidencio explained that for him and his family this fine was still too much, to which the doctor reportedly*

replied: "this is the law and you can tell whoever you like [and we'll] explain that we are charging what is fair and laid down by law". The health personnel explained to Fidencio that if he did not pay the fine he might not be able to get a Birth Certificate, because he needed the confirmation of birth or a Certificate of Live Birth that had to be issued by the health centre. However, the health centre refused to let him have the document until he had paid the fine.

The testimonies gathered by Amnesty International from health professionals in rural areas show that fining women who do not attend prenatal checkups and/or do not give birth at the health facilities is viewed by health centre staff as a means of encouraging women to attend the centres.

However, these practices contravene Peruvian law and show a lack of awareness and lack of training on the part of health personnel with regard to national legislation in this area and, more specifically, their obligation to issue a Certificate of Live Birth free of charge. The Ministry of Health communication of December 2003, which stipulates which form is to be used for the Certificate of Live Birth, states that the health personnel (doctor, obstetrician, nurse, or other health personnel) who attend or confirm the birth will complete the Certificate of Live Birth form and that confirmation of births at home will be carried out by health professionals (doctor, obstetrician, nurse) within 30 days of the birth.[111]

Moreover, the Ministry of Health Resolution of April 2004 stipulates that a Certificate of Live Birth is free of charge. The Resolution states: "it is the State's duty to facilitate the right of the individual to an identity and to be registered in the appropriate Register", and in accordance with this "the Ministry of Health, through its regional health offices, shall issue Certificates of Live Birth to public and private health facilities free of charge". In this regard, "the issue of a Certificate of Live Birth shall be free of charge in all health facilities throughout the country, whether public or private, in the same way as those issued by the health professionals or health personnel who assisted at the birth". This means that there is a duty "to be responsible for issuing the first confirmation of birth, free of charge". [112]

3.2.1.2 Other obstacles to registration to guarantee poor people access to health services

The requirements and formalities necessary to identify people on low incomes in marginalized or excluded communities, who could be entitled to free health services, in many cases constitute one further barrier, obstructing and delaying access to these services.

At the present time, in departments where Peru's Ministry of Economy and Finance estimates that less than 65 per cent of the population is considered to be living in poverty or extreme poverty, or in urban areas, such as Lima, where there are variations in the economic conditions of the population, in order to be entitled to the health services offered by the Comprehensive Health Insurance scheme, users have to undergo a socioeconomic analysis the *Sistema de Identificación de Usuarios* (SIU), User Identification System, to determine who is entitled to these services free of charge.

In this regard, the Comprehensive Health Insurance scheme requires anyone wishing to use its health services to complete a wide-ranging and complex questionnaire known as the *Ficha de Evaluación Socioeconómica* (FESE), Socio-Economic Evaluation Sheet, with one of the social workers who work in health facilities. The sheet contains thirty questions including data on personal identity, housing, and employment situation.

Photo

According to reports gathered by Amnesty International in the health facilities that the organization visited in 2005, once the Socio-Economic Evaluation Sheet has been completed, the social workers must check that the information provided by the person who wishes to become affiliated to the Comprehensive Health Insurance scheme is genuine, by visiting his or her place of residence.

In addition to completing this Sheet, anyone wishing to be affiliated to the Comprehensive Health Insurance scheme must provide an identity document and 1 *nuevo sol* (US$0.30) per person in order to register and this, in the case of people on very low incomes and people who have no identity documents, represents one further barrier to accessing these services.

According to testimonies gathered by Amnesty International, the limited number, or complete lack, of personnel to complete affiliation formalities in health facilities, and the steps involved in corroborating and evaluating the information on the Socio-Economic Evaluation Sheet, delays the process of affiliation to the Comprehensive Health Insurance scheme. For people on low incomes, this constitutes an additional financial barrier, because they may lose income, or have to travel on more than one occasion to health centres, in order to complete all the formalities. For example, in some health facilities the organization had the opportunity to visit, there was only one social worker with responsibility for affiliation to the Comprehensive Health Insurance scheme, which meant that only ten people a day could be registered and dealt with at the centre. Some of the people the organization interviewed at health centres had travelled two or three times from distant locations and had still not had the opportunity to be seen by a health professional, in spite of needing medical attention.

In the conversations that Amnesty International had with the head of the Comprehensive Health Insurance scheme, he recognized that a shortage of personnel was one of the factors restricting the number of registrations that could be dealt with at each health facility. He stressed the need to increase the number of social workers with a view to raising the number of registrations, making them more effective and reducing the infiltration of people whose economic situation should not entitle them to access the services offered Comprehensive Health Insurance scheme.

According to nurses that the organization met in a visit to a health centre in Carabayllo, in Lima, a more efficient way of registering with the Comprehensive Health Insurance scheme could be by taking advantage of the home visits they make, to provide information about the Insurance scheme, carry out registrations and verify the information provided on the Socio-Economic Evaluation Sheet. These nurses make home visits each week to the areas most distant from the health facility to carry out vaccinations. Amnesty International agrees with the nurses interviewed that more effective use of the resources available to health centres

would help to speed up the registration process, ensuring that the Comprehensive Health Insurance scheme reached as many people as possible, and would facilitate equitable access to health services for poor people.

It is not necessary under the Comprehensive Health Insurance scheme to wait for verification of a person's socio-economic situation in order to effect affiliation in rural areas, where the majority of the population lives in poverty or extreme poverty (direct affiliation). Nevertheless, the majority of health professionals with whom the organization spoke, both in Lima and in Huánuco and Loreto, agreed on the need to simplify the Socio-Economic Evaluation Sheet. They also agreed on the importance of adapting it to take into account the actual situation of the different communities, especially marginalized or excluded communities, to speed up the affiliation procedure and guarantee more efficient use of the scarce resources available.

In the rural communities of Amazonia that Amnesty International visited in Iquitos, health personnel said that most of the questions on the Socio-Economic Sheet did not apply to the communities, where the entire population had no electricity, gas, running water or sanitation; and, in addition, lived in poverty. In some of the centres visited by the organization in these communities, health professionals said that they used their own, simplified, sheet and registered all users who attended the health facility, provided they were not contributing to other health insurance schemes.

Peru has the international human rights law obligations to guarantee equitable access to health services for the entire population, without discrimination, including discrimination based on economic status; and the immediate obligation to "…[grant] women appropriate services in connection with pregnancy, labour and the postpartum period, granting free services where necessary, and … [ensuring] adequate nutrition during pregnancy and lactation". In view of these obligations and given the financial barriers denying women from low income groups access to health services, and the consequences this could have on the health of rural, poor women and children in this situation, the organization considers that Peru should consider offering reproductive and child health services completely free of charge, giving priority to the most vulnerable.

3.2.3 Barriers resulting from a lack of access to information

During its visit to health facilities in rural areas in Amazonia and the Andes, and also in Lima, Amnesty International observed that in the majority of health centres visited there is a lack of clear and accessible information, both amongst health personnel and amongst users, on the right to health and to maternal and child health services which should be available to low income groups via the Comprehensive Health Insurance scheme. This lack of access to information for users means that women attending health centres are less likely to ask for such services and, as a result, restricts their right to maternal and child health care. This situation also infringes their right to information on health problems and the means of preventing and controlling them.

Moreover, the lack of clarity and information among health professionals in relation both to the population's right to health and to their rights and responsibilities, violates the Peruvian

State's basic obligation to provide adequate training for health personnel, including education on health and human rights.

Volunteers who participated in Huánuco's first pilot project to distribute information about free health services offered by the users of Comprehensive Health Insurance scheme to the poorest communities. © AI

Some local initiatives do exist, however, to guarantee access to information on health services for people who cannot pay for medical care. For example, on 22 July 2005 Amnesty International was invited to an event inaugurating a pilot project developed by the National Health Directorate and the Comprehensive Health Insurance office in Huánuco. This event was to welcome the first group of volunteers who will be participating in the project, visiting rural communities to provide inhabitants with information on the Comprehensive Health Insurance scheme, on the rights of users of the services provided under the Comprehensive Health Insurance and to help them to assemble the required documentation and complete the formalities necessary to become affiliated to it. The Health Directorate in Huánuco took this initiative when it became aware that most of the people living in poverty in that department did not know about the services offered by the Comprehensive Health Insurance scheme. Huánuco is one of the poorest departments in Peru, where, according to statistics, almost 80 per cent of people live in poverty and more than 60 per cent in extreme poverty.[113]

This type of project could serve as an example and be implemented or adapted to the situation in other departments, where high levels of illiteracy and poverty make it difficult to reach the inhabitants of native communities through written communication or the media.

The Huánuco initiative shows how, with political will on the part of the local authorities, and by listening to and involving civil society in seeking and implementing solutions, it is possible to improve access to health services and guarantee the right to health for the most vulnerable. To this end, it is necessary to adapt national policies to the socio-economic reality of these communities in order to optimize their implementation.

Poster calling on the population to register as a volunteer for Huánuco's pilot project. © AI

3.3 Unacceptability of maternal and child health services and cultural and racial discrimination

In addition to problems of implementation which continue to limit the access of marginalized or excluded communities to maternal and child health, in rural areas of the country there are also different cultural conceptions concerning health, especially prenatal and postnatal health. In this regard, the Ministry of Health believes that there are "signs of considerable mistrust of personnel in health centres and health posts, as well as of the techniques used during childbirth", which would explain why just over 21 per cent of women in rural areas give birth in health centres.[114]

According to official statistics, in 2000 it was estimated that 45 per cent of women did not use health services because there were no female personnel and 33 per cent because they did not want to go alone, which is an indication of problems of trust and acceptability.[115] In 2005, almost 20 per cent of people in rural areas gave the following as some of the reasons for not attending health centres: "it is a long way away, mistrust, or you have to wait" and 10 per cent gave reasons including "treated badly by health personnel".[116] In 2006, according to the latest statistics produced by Peru's National Institute of Statistics and Technology, just over 17 per cent of people in rural areas still gave the reason for not attending a health centre as "it is a long way away, mistrust, or you have to wait", and 11 per cent rejected the idea of attending a health centre for other reasons, including "treated badly by the health personnel".[117]

Reports received by Amnesty International show that among the reasons for home births is that women often are embarrassed to expose their genitals when they are being examined in the gynaecological position. In addition, there is a lack of trust, aggravated by the limited information given to pregnant women and their families, who fear the unknown. In some cases, pressure is exerted on users and their families, transferring the responsibility to them in the event of difficulty during delivery or in the postnatal period.

Other factors which contribute to the lack of trust in health services for childbirth are said to be the lack of support during delivery on the part of health personnel and being discharged the following day. This is in contrast with home births, where women have the continuous support of the midwife and their family members and they can rest for three or four days.

In the interviews conducted by Amnesty International with users of the Comprehensive Health Insurance scheme in the community of Huitoto Muray, Iquitos, in Amazonia, women stated that they preferred to give birth at home because of the cost of transport to the health centre; because health facilities discharged them shortly after having given birth so they are not able to rest; and because in health facilities their husbands or family members are not allowed to remain with them during delivery.

A study carried out in communities in the district of Río Santiago in the province of Condorcanqui, department Amazonas, where 95 per cent of the population belong to the Aguaruna and Huambisa ethnic groups, revealed that, of the 40 per cent of women who had not attended a prenatal check-up during their last pregnancy, over half gave reasons

associated with attitudes, customs and beliefs. These included: "embarrassment, don't like it, service provider is a man, mistrust and tradition".[118]

The same study states that although almost 60 per cent of women in the area attended prenatal checkups, only 6 per cent gave birth in health facilities. In addition, even among the women who are affiliated to the Comprehensive Health Insurance scheme, around 90 per cent had their babies at home, which would indicate that the reasons for not attending a health centre are not only financial, but also cultural. Most women said that "they prefer to give birth in a kneeling position, with a pole to grip onto", not lying on their backs as recommended in health centres; and more than 30 per cent said that they did not attend a health centre for reasons of tradition or embarrassment:

"… when someone is giving birth, they set up a pole to hold onto and they kneel down, they push hard and the baby is born". "When they give birth, they spread a plastic sheet out on the ground, and they hold onto a pole, they kneel down when the baby is being born, they have to push hard and the baby is born."[119]

It is also a widespread custom in some indigenous communities, including in the district of Río Santiago, that the placenta and umbilical cord are buried in the house, so that the newborn baby does not leave the house early.[120]

The majority of perinatal deaths in this area are reportedly due to infections or asphyxia, which could have been avoided, had the delivery taken place in a health centre. With regard to the health of mothers after the birth, according to this same study, although more than half of the women stated that they had had some sign of danger during the postpartum period, only those who gave birth in health centres had had a postnatal check-up. In other words a very small number of the population of Río Santiago.[121]

During interviews conducted by women's organizations in the departments of San Martín and Ucayali, in addition to economic factors, users cited treatment by health professionals, embarrassment at being examined, particularly by male health professionals, and incompatibility with cultural practices during childbirth as weaknesses of the care received at health centres:

"At the [health] post, we don't see what they do with the placenta, whereas at home my husband buries it."

"The midwife [during a home birth] gives the woman herbs [and] massages her belly. That is when they are being looked after and so that they don't get cold." "In hospital, they didn't cover me up at all, they didn't even give me my dressing gown … I was like that all night in pain and they still gave me an enema … five days in pain … I was crying, I was screaming, and I asked the doctor for help, the doctor came at seven in the morning …when he arrived they gave me an injection, the baby was born soon after … that's a very cold way of doing it."[122]

Mother tongue is another factor which determines women's access to health services, particularly during childbirth.[123] According to the World Health Organization and the Pan

American Health Organization, the health situation of people belonging to "native peoples" is even worse than that of the population whose mother tongue is Spanish.[124] Not only is the level of extreme poverty in populations of indigenous origin almost three times higher than in the rest of the population,[125] but also the financial difficulties they encounter are accompanied by cultural barriers, because few health personnel speak native languages and because the approach taken by these communities to care during childbirth, in particular, is very different.

In testimonies gathered by women's organizations, language is one of the factors that women stress as an important element if a health centre is to be acceptable to the community:

"the health personnel who come to our community should speak our language so that they can participate and understand us better. With respect to our culture."[126]

Other reports received identify the same problems with regard to use of language in other communities where the population, and women in particular, speak only indigenous languages.

According to some testimonies, in rural areas women of low income, who are illiterate or have little formal education, particularly those from groups of indigenous or peasant origin who speak only indigenous languages, are sometimes discriminated against in health centres. In the words of one obstetrician in Huánuco:

"It is difficult to reach women in rural areas who are illiterate or have very little education, no more than primary level ... we do not have sufficient personnel who speak the [indigenous] languages ... they are shouted at ... they are told they are dirty, that they don't wash ..."

"I took my 6 year old son who had a temperature of 37 and a swollen stomach and they told me that it wasn't fever, they shouted at me: why have you brought the baby? Why have you given him stale food?"[127]

Amnesty International has gathered information from women who, because of their cultural and ethnic origin and their socio-economic condition, have been denied a bed or had the sheet removed from the couch on which they were about to undergo a gynaecological examination. There are other cases where their right to access to information about medical treatment needed by themselves or their children has been violated.

* *María Luz is a young Quechua speaker who lives with her mother and brothers 7 kilometres from the health post at Huarichaca, in the department of Huánuco. The family lives in a one-room dwelling and has a smallholding where all the family members work. The smallholding is its main source of income. When María Luz was pregnant, she could not attend every prenatal check-up because she could not walk the distance to the health facility in her advanced state of pregnancy. On 20 December 2004, María Luz gave birth to a little girl. The baby was two months premature, which meant that María Luz was not able to make preparations to transfer to the health facility. When, shortly after birth, her daughter became ill, she went to*

the health post and was fined 50 nuevos soles (US$15) for not having attended prenatal checkups and for having given birth at home. The doctor told María Luz that the baby would have to be transferred to hospital in Huánuco, the capital of the department, and asked the family to pay 17 nuevos soles (US$5) for the journey to accompany the baby to hospital. At the hospital in Huánuco they simply told the family that the baby had an infection, but they did not explain how serious the newborn's situation was, or anything about her treatment and did not allow them to visit the baby. While her daughter remained in hospital, María Luz had to sleep on a mattress on the floor. At the hospital they charged for saline solution and tablets and asked for 500 nuevos soles (US$150) for a transfusion. When María Luz Espíritu insisted on knowing what was happening to her daughter, they doctor shouted at her: "why have children when you are so poor, stop bothering us … you should not have children if you are poor". The baby girl died twelve days after her birth. The family still does not know why she died.

María Luz and her family in their home. © AI

These testimonies from women of indigenous or peasant origin living in rural areas in Peru highlight the importance of adapting maternal and child health care to their culture as a way of ensuring the acceptability of these services and access to maternal and child health for low-income women and children.

As long ago as 1998, a study by the Ministry of Health on childbirth in the Andes and Amazonia identified some traditional practices which could be incorporated into their services and concluded that the nub of the issue is not the low level of demand for institutional care during childbirth, but rather the relationship between two different and often contradictory cultural and obstetric systems. This difficult relationship will have to be carefully reviewed and managed by the Ministry of Health, providing an opportunity to improve, refine and develop the existing common points between the two systems.[128]

In this regard, Amnesty International wholeheartedly welcomed the approval in June 2005 of the Ministry of Health's Technical Standard for Comprehensive Health care for Excluded and Remote Communities,[129] which includes measures to reduce the number of barriers to access to health, including maternal and child health care, for communities living in poverty and extreme poverty in areas of limited geographical accessibility to health services.

The organization also saw as a positive step the adoption in August 2005 of Technical Standards for Attending Delivery in an Upright Position to take account of Cultural Practices,[130] which also includes the opportunity for women to be accompanied by a family member or midwife during delivery, and adapting the environment with low level lighting, no light colours, materials appropriate to local conditions and a comfortable temperature, these being some of the preferences expressed by women in rural areas in reports received by Amnesty International. This standard also establishes the responsibility of health professionals to inform users why they are carrying out particular examinations with a view to gaining their trust, and guarantees freedom of expression and action for women in accordance with their local customs.

Amnesty International is aware of some positive experiences of cultural adaptation of sexual and reproductive health services. For example, the organization was interested to hear of the experience of the village of San José de Secce and the communities of Oqopeqa, Punkumarqiri, Sañuq and Laupay, in the district of San José de Santillana, in Huanta province, Ayacucho district, in the Andes. According to an assessment by non-governmental organizations there were various barriers to using health services in these communities, which had very high maternal mortality rates. In addition to the distance that had to be travelled to the establishment, the inability to pay for transport or care and the lack of health personnel and equipment, the main barrier was reluctance on the part of the population to use health facilities offered by the state. [131] This situation was reflected in the high percentage of women (94 per cent) giving birth at home, compared with 6 per cent who gave birth in health centres; and the number of deliveries attended by *parteras* [132] (78 per cent), compared with 21 per cent attended by health professionals.[133]

The resistance of these communities to using health facilities, according to information gathered by non-governmental organizations, had one of its origins in the mismatch between the health services on offer and the cultural expectations of village dwellers. The health services offered by the state did not take account of the way in which health and sickness were regarded in the culture of the inhabitants of this area, with the result that the population had no trust in the ability of the personnel or the services and viewed attending a health facility as inconvenient or risky.[134]

Woman giving birth according to her tradition in one of the health centres with culturally adapted delivery rooms. © Salud Sin Límites

Faced with this situation, between 1999 and 2001 and in consultation with the communities in question, a culturally-adapted project to provide sexual and

reproductive health services was put into effect, promoting communication between health professionals and the community, user participation, and a closer relationship between traditional midwives and health personnel. In addition, measures were adopted in health centres to adapt the environment of the delivery room, as well as care given during prenatal checkups, delivery and the postnatal period to make them culturally sensitive, and provide facilities to accommodate the companions of women giving birth in health facilities. These measures included creating a private environment, with curtains, to keep out draughts and anyone not associated with the birth, with a bed and a sturdy rope, so that women could give birth in an upright position, or squatting, gripping the rope, as they wished. As well as a kitchen, so that husbands and/or family members could participate in preparing household remedies.

The protocol for care also stipulated that spouses, and/or family members would be allowed to attend prenatal checkups, as well as the delivery, and that the person attending the birth should speak Quechua and preferably be female. Health professionals were trained to be understanding and patient with users and not reprimand them, even if the user had several children. Emphasis was also placed on the importance of explaining to users the need for examinations and procedures, such as the vaginal examination, for which the user's prior consent had to be obtained; allowing them to expose only the stomach during prenatal examinations and to give birth in their everyday clothing, instead of a gynaecological gown; and allowing them and/or a family member to carry out all hygiene procedures. In addition, in accordance with the beliefs of the communities, the protocol included the requirement to deliver the placenta to the family member present so that it could be buried, and the opportunity for the user to remain in the health facility for up to eight days.

Users were informed of this culturally-sensitive model of maternity care through workshops, posters and radio programmes broadcast in the Quechua language. An assessment of the project by non-governmental organizations in 2003 showed that 90 per cent of users interviewed said they had felt well cared for, that they would recommend the service to a family member or neighbour and confirmed that their next child would be delivered at the health post. 80 per cent also confirmed having understood everything that was said, because the procedure was conducted in Quechua.[135] According to the same assessment, after the project was implemented, 67 per cent of women had reportedly given birth at the health centre, representing an increase in hospital deliveries of 21 per cent, and almost 100 per cent of births took place with the knowledge of the health personnel of the establishment.[136]

Poster promoting culturally adapted health centres. © Salud Sin Límites

"Before, they used to take them to a room, shut the door and not let their families in. They did not have the rope or the chair as they do today, but were made to lie on a bed with their legs open; they were shouted at and they did not like that, they were attended to in a noisy, laughing, manner and they did not like that either."

"Now they treat us in the way we like, whether in bed or sitting on the chair, holding onto the rope. Our husbands put their arms around our waist and we like that; because that's what we are used to on the farm. We would like it to continue like this, boiling herbs, making household remedies just like at home."[137]

Amnesty International considers that the experience of the village of San José de Secce and the communities of Oqopeqa, Punkumarqiri, Sañuq and Laupay shows how, through consultation and communication with users of health facilities, and making easily-implemented and low-cost changes, sexual and reproductive health services can be made acceptable to the communities, who then have confidence in them, thus promoting improved take-up of maternal and child health care services provided by health professionals, which contributes to a reduction in the maternal and child morbidity and mortality rates.

4. Conclusions

Although the Peruvian State has implemented policies to facilitate access to maternal and child health for people on low incomes, Amnesty International considers that financial barriers continue to exist which limit the access of many financially disadvantaged women and children to health services. The continuing existence of these barriers is a violation of Peru's immediate obligations to guarantee access to maternal and child health, without discrimination, giving priority to the most vulnerable groups. The organization believes that the Peruvian state should take the necessary steps to ensure that its obligations in relation to the right to health are put into practice.

The authorities should also monitor and evaluate the operation of the Comprehensive Health Insurance scheme and adopt initiatives to improve its efficiency and make it relevant to the situation and needs of the different communities, especially in rural areas. As part of this process, Amnesty International believes that account should be taken of the initiatives and opinions of the local authorities, health professionals and social workers involved in these areas, as well as that of the communities themselves and users.

Amnesty International takes the view Peru's failure in its obligation to: provide reproductive, maternal (prenatal as well as postnatal) and child health care; guarantee equitable distribution of health facilities, goods and services; and protect the right to health without discrimination is reflected in the great disparities that persist today in terms of access to maternal and child health in Peru. These disparities exist between rural and urban areas and between the highest and lowest income groups, in both urban and rural areas or amongst people who belong to indigenous or peasant communities.

Furthermore, although initiatives exist to disseminate information on health services provided by the state to people in excluded or marginalized communities, large numbers of people still have no clear or accessible information on these services, or receive contradictory information about them. This violates people's right to information on the principal health problems, including the means of preventing and controlling them, in this case maternal and child health, and to services accessible to persons of low income living in excluded or marginalized communities, contravenes both article 24.2(e) of the United Nations Convention on the Rights of the Child, and article 14.2(b) of United Nations Convention on the Elimination of All Forms of Discrimination against Women.

Moreover, the lack of information among health professionals on the right to health and the services offered by the state to guarantee access to health for marginalized and excluded communities is, in Amnesty International's view, an indication that Peru is not fully meeting its basic obligation to provide adequate training for health personnel, including education on health and human rights.

Amnesty International considers that the information and testimonies it has received from women living in indigenous or peasant communities concerning the unacceptability of basic maternal and child health services offered by the state to these communities, reflect the state's failure to tailor these health services to the culture of the users belonging to these communities.

Peru has committed itself by both signing and ratifying international human rights treaties, to respect, protect and promote the right to health; and to immediately guarantee maternal and child health care and access to health services without discrimination, giving priority to the most vulnerable groups. Similarly, by entering into political commitments in international forums, Peru has undertaken to reduce child mortality by two-thirds and maternal mortality by three-quarters by 2015. Amnesty International believes that these strategies for implementing the Millennium Goals should be based on the human rights obligations incumbent upon states. Until Peru gives priority to the health needs of poor communities, of women and children belonging to communities of indigenous or peasant origin and of others who live in rural areas, Peru will continue to be in breach of its international obligations and commitments.

As the Special Rapporteur on the Right to Health, Paul Hunt states in his report on Peru, international human rights law proscribes any discrimination in access to health care, and the underlying determinants of health, and States have an obligation to take special measures to remove obstacles to the enjoyment of the right to health for vulnerable groups. In this regard, the Special Rapporteur has urged the Peruvian authorities to formulate an equitable health strategy and policy in favour of poor people underpinned by the right to health, in order to address inequities, inequality and discrimination.[138]

If Peru genuinely intends to step boldly into this new millennium towards a future in which all of its population, regardless of their socio-economic condition, gender, racial or ethnic origin, can exercise all of their human rights, whether political and civil, economic, social or cultural, priority must be given to measures to guarantee the respect, protection and promotion of each

of these rights on every political agenda. Guaranteeing the right to health without discrimination, in particular for the most vulnerable, is one of these steps.

The human rights enshrined in the United Nations' Universal Declaration of Human Rights are indivisible and universal. Without guaranteeing protection for one, it is not possible to fulfil the others and, often, the violation of some of these rights involves the violation of others. During the 20 years of internal armed conflict in Peru, the majority of those people who were the subject of extrajudicial executions, "disappeared", were tortured or wrongfully convicted on false charges relating to terrorism, belonged to the most socially-excluded and financially-disadvantaged sectors of society. Their right to physical integrity and life was violated with impunity because they belonged to the most excluded sectors of the population, with no access to economic, social or cultural rights, which placed them in a situation of particular vulnerability when seeking protection for their civil and political rights. Today, the economic, social and cultural rights of these people continue to be violated, in particular the right to health, which results in a high number of deaths which could be avoided.

5. Recommendations

Amnesty International urges the Peruvian authorities and, in particular, the Ministry of Health to ensure that the state meets both its national and international obligations to respect, protect and promote the right to health for everyone, in particular in relation to maternal and child health, guaranteeing the equitable distribution of health facilities, goods and services; protecting the right of access without discrimination; and eliminating both economic and cultural barriers. The organization also urges the Peruvian authorities to guarantee access to information on the principal health problems, including the means of preventing and controlling them; and to provide adequate training for health personnel on these rights and responsibilities.

In particular, the organization recommends that the Peruvian State take the following steps to guarantee the right to maternal and child health for vulnerable groups:

- To implement legislation currently in force, continually reviewing it with a view to improving it and to guarantee that barriers to access to maternal and child health for vulnerable groups are eliminated.
- Allocate the necessary budget to basic health services, in particular those maternal and child health services that are free of charge for excluded or marginalized communities.
- At the earliest opportunity distribute accessible and clear information, in the relevant languages and format for the communities in each areas, especially in health facilities which offer care for low-income members of marginalized or excluded communities, on user rights in relation to the right to health; and on the responsibilities of health

professionals, including responsibilities relating to the right to access to maternal and child health services free of charge.

- To implement mechanisms to permit users of health services to complain when their rights are violated; and to promote and distribute information in relation thereto.
- To implement measures to monitor compliance with employment rights for health professionals; and to create mechanisms to guarantee the participation of health professionals in health policy.
- To review procedures for identifying those users who are entitled to health services free of charge and implement monitoring mechanisms to guarantee that the requirements and procedures to access health services free of charge are unambiguous and accessible, both for users and health professionals, and that they do not unnecessarily delay the identification process.
- At the earliest opportunity, to instruct health facilities in their obligation to ensure they issue Certificates of Live Birth for all newborns free of charge, regardless of where the birth took place or attendance at pre and postnatal checkups; and to send clear guidelines to health facilities to desist from charging for a Certificates of Live Birth and imposing fines on women who give birth at home; and to put into practice mechanisms to monitor compliance with these guidelines.
- Proactively to promote the participation of communities in topics relating to their right to health, in particular guaranteeing the participation of inhabitants of communities of indigenous or peasant origin to ensure that health services are tailored to their cultural beliefs and are acceptable to all.
- To draw up policies and plans to develop and implement the recently approved National Human Rights Plan to ensure that the human rights of every man, woman and child in Peru are guaranteed, respected and promoted, without discrimination.

[1] *Sendero Luminoso* launched its armed offensive in 1980. In recent years, it has reportedly operated sporadically in the Apurímac/Ene valley, in the Amazon jungle. The MRTA started its armed campaign in 1984 and has now ceased operations.

[2] For more information on Amnesty International's concerns during the internal armed conflict in Peru (1980-2000), see *Peru: Torture and extrajudicial executions*, AI Index: AMR 46/29/83/s, August 1983, *Peru: Violations of Human Rights in the Emergency Zones*, AI Index: AMR 46/25/88/s, August 1988, *Peru: Human rights in a state of emergency*, AI Index: AMR 46/49/89/s, August 1989, *Peru: Human rights since the suspension of constitutional government*, AI Index: AMR 46/13/93/s, May 1993**,** *Peru: Summary of Amnesty International's concerns 1980-1995*, AI Index: AMR 46/04/96/s, February 1996, *Peru: Human Rights in a Time of Impunity*, AI Index: AMR 46/01/96/s, May 1996, *Peru: Prisoners of Conscience*, AI Index: AMR 46/09/96/s, May 1996, *Peru: Legislation is not enough - torture must be abolished in practice*, AI Index: AMR 46/17/99/s, September 1999; y *Peru: The Truth and Reconciliation Commission - a first step towards a country without injustice,*, AI Index: AMR 46/003/04/s, August 2004.

[3] *Final Report*, Volume I, 'The Faces and Profiles of Violence', p.158.

[4] Ibid.

[5] Ibid, p.159.
[6] *Final Report* Volume VIII, 'General Conclusions', p.316.
[7] *Final Report*, Volume I, 'The Faces and Profiles of Violence', p.160.
[8] *Final Report*, Volume VIII, 'General Conclusions', p.316.
[9] Ibid.
[10] *Final Report*, Volume VIII, 'The factors which made violence possible", pp.101-105.
[11] The CVR took the view that rape was a common practice, frequently used principally by the Armed Forces, committed almost exclusively against women. During its mandate, the CVR documented more than 500 cases of sexual violence; in only 11 of these cases was the victim a man. *Final Report*, Volume VIII, 'The factors which made violence possible", pp.45 and 48.
[12] Ibid, pp.72-73.
[13] For more information on sterilization without consent or against a person's will, see Amnesty International Report *Peru: The Truth and Reconciliation Commission – a first step towards a country without injustice*, AI Index: AMR 46/003/2004/s, 26 August 2004.
[14] For an explanation of these components of the right to health services, see sub-para. '2.1 International Norms and Standards', of this report.
[15] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.14. The United Nations Committee on Economic, Social and Cultural Rights defines primary health care as dealing essentially with common and relatively minor illnesses, delivered by health professionals and/or non-specialist doctors who provide services within the community at relatively low cost (see United Nations Document E/C.12/2000/4 of 11 August 2000).
[16] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.125.
[17] Article 25 of the Universal Declaration of Human Rights states: "1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
[18] Article 12 of the International Covenant on Economic, Social and Cultural Rights, ratified by Peru in April 1978, states: "1. The States Parties … recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
b) The improvement of all aspects of environmental and industrial hygiene;
c) The prevention, treatment and control of epidemic, endemic, occupational or other diseases;
d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."
[19] Article 12 of the Convention on the elimination of all forms of Discrimination against Women, ratified by Peru in 1982, states: "1. 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 health care services, including those related to family planning.
2. … [T]he States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".
[20] Artícle 24 of the Convention on the Rights of the Child, ratified by Peru in 1990, states: "1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and

to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
a) To diminish infant and child mortality;
b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
c) To combat disease and malnutrition within the framework of primary health care, through, *inter alia*, the application of readily-available technology and through the provision of adequate nutritious food and clean drinking water, taking into consideration the dangers and risks of environmental pollution;
d) To ensure appropriate prenatal and postnatal health care for mothers;
e) To ensure that all segments of society, in particular parents and children, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
f) To develop preventive health care guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries".

[21] Article 5 of the International Convention on the Elimination of all Forms of Racial Discrimination, ratified by Peru in 1971, states: "… [T]he States Parties undertake to prohibit and eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: … The right to public health, medical care, social security and social services; …".

[22] Article 25 of Convention 169, ratified by Peru in 1994, states: "1.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.
2. 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.
3. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.
4. The provision of such health services shall be coordinated with other social, economic and cultural measures in the country".

[23] Article 10 of the "Protocol of San Salvador", ratified by Peru in 1995, states:
"1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social wellbeing.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:
a. Primary health care, that is, essential health care, made available to all individuals and families in the community;
b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
c. Universal immunization against the principal infectious diseases;

d. Prevention and treatment of endemic, occupational and other diseases;
e. Education of the population on the prevention and treatment of health problems, and
f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable".

[24] See United Nations document E/C.12/2000/4 of 11 August 2000.

[25] See Article 2 of the International Covenant on Economic, Social and Cultural Rights.

[26] See *Maastricht guidelines on violations of economic, social and cultural rights*, Maastricht 22-26 January 1997.

[27] See United Nations document *The nature of States Parties' obligations (Article 2, para. 1 of the Covenant)* of 14 December 1990. CESCR General Comment 3.

[28] See United Nations document HRI/GEN/1/Rev.7, para. 12.

[29] See United Nations document E/C.12/2000/4 of 11 August 2000.

[30] See United Nations document HRI/GEN/1/Rev.7, para. 10.

[31] Reproductive health means that men and women have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth.

[32] In accordance with medical statistics, the term prenatal refers to the period which begins with the completion of 28 weeks' gestation and is variously defined as ending 1 to 4 weeks before birth. The term postnatal refers to the period after birth.

[33] See United Nations document E/C.12/2000/4 of 11 August 2000.

[34] Article 12.2 of the International Covenant on Economic, Social and Cultural Rights stipulates: "The steps to be taken by the States Parties … to achieve the full realization … [of the right to health, shall include]: … [t]he reduction of the stillbirth rate and of infant mortality and for the healthy development of the child".

[35] Article 25 of the Universal Declaration of Human Rights states: "Motherhood and childhood are entitled to special care and assistance".

[36] Article 24 of the Convention on the Rights of the Child urges States Parties to "take appropriate measures to diminish infant and child mortality". Article 12 of Convention on the Elimination of all Forms of Discrimination against Women states that States Parties should take appropriate measures to guarantee "women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

[37] The postpartum period refers to the period of approximately forty days after birth.

[38] See General Recommendation 24 of the Committee on the Elimination of Discrimination against Women, *Article 12 – Women and health*, 20th Session, 2 February 1999.

[39] See *Report of the International Conference on Population and Development*, A/CONF.171/13 of 18 October 1994.

[40] See *Report of the United Nations Fourth World Conference on Women*, A/CONF.177/20 of 17 October 1995.

[41] See www.un.org/spanish/millenniumgoals/.

[42] Article 7 of the Peruvian constitution states: "Everyone is entitled to the protection of his or her health, of the family and of the community and has a duty to contribute to the promotion and defence thereof. Anyone unable to care for themselves as a result of physical or mental disability is entitled to respect for their dignity and to provision under the law for their protection, care, rehabilitation and safety". Articles 9 and 11 include the State's obligations with regard to health: "[T]he State shall determine the national health policy. The Executive shall regulate and supervise its implementation. It

shall be responsible for drawing up and applying it in a pluralistic and decentralized manner to provide fair access to health services for all" (Article 9). "The State guarantees free access to health and pensions, through public, private or public/private bodies and shall supervise their effective operation" (Artícle 11).

[43] See Supreme Decree No 003-2002-SA, of 25 May 2002.

[44] According to the Peruvian Instituto Nacional de Estadísticas e Informática (INEI) (National Institute for Statistics and Technology) (see *Metodología para la Medición de la Pobreza en el Perú*, INEI, January 2000), poverty is the condition where the basic food needs of one or more persons are not being met. In this regard, the INEI gives the following definitions:

Absolute poverty: Includes those people whose household's per capita income or consumption is lower than the cost of basket of minimum essential goods and services. The minimum food basket is obtained by adjusting the actual average consumption of each region until 2,318 kilocalories per day are reached.

Extreme poverty: Includes people whose household's per capita income or consumption is lower than the cost of a minimum food basket. The value of the minimum basket is assessed taking account of actual prices paid by households where they live.

In addition to poverty according to level of income and expenditure, the INEI takes account of a broader concept of poverty according to Unsatisfied Basic Needs, using the following indicators: housing with inadequate physical characteristics, households living in overcrowded conditions, housing with no sanitation, households with at least one child not attending school, households whose head has not completed primary education, and with three or more people per breadwinner.

The INEI also uses other indicators, including: housing with mains water supply, electric light and household appliances (television, telephone), etc.

[45] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.14. The United Nations Committee on Economic, Social and Cultural Rights defines primary health care as dealing essentially with common and relatively minor illnesses, delivered by health professionals and/or non-specialist doctors who provide services within the community at relatively low cost (see United Nations document E/C.12/2000/4 of 11 August 2000).

[46] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.125.

[47] The Pan American Health Organization defines maternal mortality as the death of a woman, while pregnant or within 42 days of the 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.

[48] See *Health Situation in the Americas: Basic Indicators*, PAHO 2005; and *Iniciativa para mejorar la salud de la madre y del niño en zonas críticas del Perú*, PAHO/WHO – MINSA, October 2004.

[49] See *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA*, WHO, 2004.

[50] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.122.

[51] See *Hacia una reforma sanitaria por el derecho a la salud*, II National Health Conference, 2005, p.23.

[52] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.10.

[53] See *Acceso a servicios de salud y mortalidad infantil en el Perú*, CIES and Grade, 2001, p.22; *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.12; and *Iniciativa para mejorar la salud de la madre y del niño en zonas críticas del Perú*, PAHO/WHO – MINSA, October 2004.

[54] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.12.
[55] See *Informe Defensorial Nº 94 Ciudadanos sin agua: análisis de un derecho vulnerado*, p.80.
[56] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.16-18; and Cabria A., *Beyond Protectionism and Good Intentions – An Analysis of the Sexual and Reproductive Rights of Indigenous Women in Latin America: The Case of the Asháninka Women of Peru*, IWHC, p.4.
[57] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, pp.116-117, 128, 133 and 135.
[58] See United Nations document E/C.12/1/Add.14, of 20 May 1997, p.3, para. 16.
[59] See *Health Situation in the Americas: Basic Indicators*, PAHO, 2005.
[60] See statistics of the Instituto Nacional de Estadísticas e Informática de Perú (INEI) at www.inei.gob.pe/perucifrasHTM/in-eco/pro001.htm.
[61] See United Nations document E/CN.4/2005/51/Add.3, p.3, paras. 36-38.
[62] See United Nations document CRC/C/PER/CO/3, p.4, paras. 19 and 20 of 14 March 2006.
[63] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.21.
[64] See *La Equidad en la asignación regional del financiamiento del sector público de salud 2000-2005*, CIES, p.9.
[65] See *Cobertura y Financiamiento del Seguro Integral de Salud en el Perú*, ForoSalud y CIES, 2003, p.28.
[66] See *Perú: Compendio Estadístico*, INEI, 2003, p.203.
[67] See *Información Básica sobre las Enfermeras(os)*, Colegio de Enfermeras(os) del Perú, October 2002.
[68] See Press Release on US-Peru Trade Negotiations on a Free Trade Agreement: the Special Rapporteur on the Right to Health reminds parties of their human rights obligations, 5 July 2004; Report of the Mission to Peru of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, United Nations document E/CN.4/2005/51/Add.3 of 4 February 2005, p.7, para. 17.
[69] See United Nations document CRC/C/PER/CO/3 of 14 March 2006, pp.5, 9, 15 and 16, paras. 26, 46-47, 73-74.
[70] See United Nations documents E/C.12/1/Add.14, of 20 May 1997; and CERD/C/304/Add.69, of 13 April 1999.
[71] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.21.
[72] See *La investigación Económica y Social en el Perú Balance 1999-2003 y prioridades para el futuro*, Barrantes R. and Iguíñiz J.M., p.194.
[73] See *Estadísticas a mayo de 2005*, Seguro Integral de Salud, June 2005.
[74] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.21.
[75] See *La salud peruana en el siglo XXI Retos y Propuestas de Políticas*, Arroyo J. (ed.), p.48.
[76] According to figures produced by the Instituto Nacional de Estadísticas e Informática (INEI), in rural areas eight out of every ten inhabitants are living in poverty (78 per cent), while in urban areas this percentage is 42 per cent (See *INEI: La Pobreza en el Perú en 2001. Una visión departamental*, Herrera J., 2001). INEI establishes the level of poverty according to the capacity to access a minimum food basket of 2,318 kilocalories per capita.
[77] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, pp.14-15; and *Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.13.

[78] See Cabria A., *Beyond Protectionism and Good Intentions – An Analysis of Sexual and Reproductive Rights of Indigenous[Women] in Latin America: The case of the Asháninka Women of Peru*, IWHC, p.3.
[79] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, pp.114-117.
[80] See *Estadísticas a mayo de 2005*, Seguro Integral de Salud, June 2005.
[81] See United Nations document CRC/C/PER/CO/3 of 14 March 2006, p.9, para. 46.
[82] See *Reproductive Health Indicators - Guidelines for their generation, interpretation and analysis for global monitoring*, WHO, 2006, at http://www.who.int/reproductivehealth/publications/rh_indicators/guidelines.pdf:
[83] Ibid, pp.134-135.
[84] See *Encuesta Demográfica y de Salud Familiar ENDES Continúa 2004*, INEI, April 2005, pp.18-19.
[85] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.134.
[86] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.137.
[87] See http://www.childbirth.org/section/CSFact.html
[88] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, p.137.
[89] See http:// www.paho.org/english/gov/ce/spp/spp36-08-e.pdf
[90] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, pp.128-129.
[91] See *Encuesta Demográfica y de Salud Familiar ENDES Continúa 2004*, INEI, April 2005, p.19.
[92] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, pp.138-143.
[93] See *Accesibilidad a los servicios de salud sexual y reproductiva y contribución de los determinantes intermedios en los cambios de la fecundidad en el Perú*, INEI, 2002, p.103.
[94] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, pp.14-15.
[95] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, pp.125-126.
[96] See *Encuesta Nacional sobre Condiciones de Vida en el Perú*, INEI, February 2005, pp.104-105.
[97] See *Encuesta Nacional sobre Condiciones de Vida en el Perú*, INEI, February 2006, pp.89 and 107-108.
[98] See *Análisis de la Situación en Perú Programa Especial de Análisis de Salud*, PAHO, 2002, p.21.
[99] See *Lineamentos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.17; and *Impacto potencial del TLC en acceso a medicamentos*, MINSA, 2005, p.250.
[100] Testimony of a Comprehensive Health Insurance scheme user, gathered by Amnesty International in Nauta, Iquitos, in July 2005.
[101] See *Condiciones de Vida en los Departamentos del Perú*, 2002, INEI, p.62.
[102] See *Análisis y Tendencias en la Utilización de Servicios de Salud Perú 1985-2002*, MINSA/PAHO, 2003, p.53.
[103] The right to identity is recognized in article 6 of the Universal Declaration of Human Rights which states: "everyone has the right to recognition everywhere as a person before the law"; in article 3 of the American Convention on Human Rights, which deals with the recognition of every person's right to recognition as a person before the law, and in article 18 "every person has the right to a given name and to the surnames of his parents or that of one of them. The law shall regulate the manner in which this right shall be ensured for all, by the use of assumed names if necessary"; in article 7 of the Convention on the Rights of the Child: "the child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents" and in article 8 "States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations, as recognized by law without unlawful interference, "where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection with a view to re-establishing speedily his or her identity; and in the International Covenant on Civil and Political Rights,

in articles 16 "everyone shall have the right to recognition everywhere as a person before the law, and article 24.2 "every child shall be registered immediately after birth and have a name". The Peruvian Constitution also enshrines this right in article 2.1 "everyone shall have the right… to an identity".

[104] See judgement of the Inter-American Court of Human Rights in the case of the girls Yan and Bosico vs. the Dominical Republic, 8 September 2005, paras. 113 (a), 182 and 183, pp.54 and 70.

[105] Technical Team of the High Level Commission charged with drawing up the National Plan for the Restoration of Identity: Documents for the Undocumented 2005-2009

[106] See Informe Defensorial N° 100 El Derecho a la Identidad y la Actuación de la Administración Estatal, 2005, pp.4-5.

[107] See statistical table "Población total estimada y proyectada al 30 de junio de cada año, según sexo y grupos de edad" in the database Información Sociodemográfica - Población y Variables Demográficos at www.inei.gob.pe.

[108] See UN document CRC/C/PER/CO/3 of 14 March 2006, p.6, paras. 33 and 34.

[109] See *Cuestión de Estado*, N° 36, 'La indocumentación', p.41.

[110] See *Informe Defensorial N° 100 El Derecho a la Identidad y la Actuación de la Administración Estatal*, 2005, pp. 5-6.

[111] See Official Communication Nº 349-2003/DG-OGEI-OEE of the Dirección General de Estadística e Informática of the Ministry of Health approved by Operations Management Resolution Nº 030-2003-GO/RENIEC, of 4 December 2003.

[112] See Ministerial Resolution N° 369-2004-SA of April 2004.

[113] See *La Pobreza en el Perú en 2001 – Una visión departamental*, INEI, June 2002, p.14.

[114] See *Lineamientos de Política Sectorial para el Periodo 2002-2012*, Ministry of Health, July 2002, p.16.

[115] See *Encuesta Demográfica y de Salud Familiar 2000*, INEI, May 2001, pp.125-126.

[116] See *Encuesta Nacional sobre Condiciones de Vida en el Perú,* INEI, February 2005, pp.104-106.

[117] See *Encuesta Nacional sobre Condiciones de Vida en el Perú,* INEI, February 2006, pp.106-108.

[118] See *Desarrollo Humano: Desarrollo sostenible en el río Santiago,* Plan Binacional de Desarrollo de la Región Fronteriza Perú-Ecuador, p.86.

[119] Ibid, pp.95-99.

[120] Ibid, p.100.

[121] Ibid, pp.103-104.

[122] See *Escuchando a las mujeres de San Martín y Ucayali*, Manuela Ramos, 1999, p.119.

[123] See *Acceso a servicios de salud y mortalidad infantil en el Perú*, CIES and Grade, 2001, p.46.

[124] See *Análisis de la Situación de Perú*, WHO/PAHO, 2002, p.7; and *Análisis y Tendencias en la Utilización de Servicios de Salud Perú 1985-2002*, Ministry of Health /PAHO, 2003, p.23.

[125] See *Análisis and Propuestas*, Grade, December 2003.

[126] See *Escuchando a las mujeres de San Martín y Ucayali*, Manuela Ramos, 1999, p.176.

[127] Testimony of a woman from Nauta, Iquitos, gathered by Amnesty International in July 2005.

[128] See *El Parto en la vida de los Andes y de la Amazonía del Perú*, Ministry of Health, 1999.

[129] See Technical Standard N° 028 MINSA/DGSP V.01.

[130] See Technical Standard N° 033-MINSA/DGSP-V.01.

[131] See *Modelo de atención de parto con adecuación cultural*, Salud sin Límites, p.3 at http://www.saludsinlimitesperu.org.pe/docs/doc per cent20a1.pdf.

[132] Women from the communities who have years of experience supporting women during pregnancy and labour but who are not formally certified and trained.

[133] Ibid, p.5.

[134] Ibid, p.3.

[135] Ibid, p.14.
[136] Ibid, pp.15-16.
[137] Ibid, p.27.
[138] See UN document E/CN.4/2005/51/Add.3, pp.9 and 11, paras. 21 and 28.