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# FATAL FLAWS

## BARRIERS TO MATERNAL HEALTH IN PERU

MATERNAL HEALTH IS A HUMAN RIGHT

**AMNESTY INTERNATIONAL**



Amnesty International is a global movement of 2.2 million people in more than 150 countries and territories who campaign to end grave abuses of human rights. Our vision is for every person to enjoy all the rights enshrined in the Universal Declaration of Human Rights and other international human rights standards. We are independent of any government, political ideology, economic interest or religion – funded mainly by our membership and public donations.

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*Cover photo:* Indigenous women breastfeeding whilst waiting outside a rural health post in San Juan de Ccarhuacc in Huancavelica province, one of the poorest regions in Peru, September 2008.

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# **FATAL FLAWS BARRIERS TO MATERNAL HEALTH IN PERU**

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Criselda and Fortunato,  
September 2008

FORTUNATO SALAZAR SUTACURU

Fortunato Salazar Sutacuru is 21 years old and lives in San Juan de Ccarhuacc, Huancavelica province. He told Amnesty International about the pain and distress his wife, Criselda, experienced over the loss of their first baby in 2008. At the time Fortunato was away working in Lima due to the lack of employment opportunities in Ccarhuacc.

“We have our animals. She had taken them to the field to graze. That’s where she slipped and fell. That must be where the baby died. Already in the evening, when she came back, she started to have light pains. They weren’t too strong. Then she went to the [health] post. In the [health] post they told her the baby was alive ... Two days later the baby died.”

Fortunato and Criselda believe that the baby may already have been dead and that one of the problems that women face in accessing health care is lack of communication. “For example, here there are women who don’t speak Spanish ... and they [the women] don’t understand.”

According to Fortunato, another problem in rural areas is the lack of adequate transport. “There is no ambulance when there is an emergency. To go from here it takes us two or three days and sometimes they die right here because there is no vehicle nor ambulance.”

Interview with Amnesty International, September 2008

## METHODOLOGY

Amnesty International delegates visited Peru in July 2008. They met officials from the Ministry of Health, the National Institute of Statistics, the Public Health Insurance Scheme (Seguro Integral de Salud, SIS), and representatives of professional medical bodies and national NGOs working on the issue of maternal mortality. Discussions focused on gathering information about the progress made in Peru's efforts to reduce preventable maternal mortality since the publication of Amnesty International's 2006 report, *Peru: Poor and excluded women – Denial of the right to maternal and child health* (Index: AMR 46/004/2006).

Amnesty International UK and Amnesty International Peru also visited the community of San Juan de Ccarhuacc in the Andean province of Huancavelica, to speak to women, their families and health professionals about the challenges they face in accessing the information and services they need in order to experience pregnancy and childbirth safely and with dignity. Huancavelica is one of the poorest regions in Peru and has one of the highest maternal mortality ratios in the country.

This report draws on these discussions as well as the findings of a number of national and international bodies, such as the United Nations Population Fund, Peru's National Ombudsperson's Office, and reports published by local and international NGOs since 2006, which deal with various aspects of pregnancy, maternity and preventable maternal mortality in Peru.<sup>1</sup>

As in Amnesty International's 2006 report, this report examines Peru's efforts to reduce maternal mortality in the light of human rights standards and the findings of international human rights bodies.

Amnesty International welcomes 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 in the health facilities visited.

## TERMINOLOGY

Maternal death	The World Health Organization defines a maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
Maternal mortality rate	The number of maternal deaths per 100,000 women in the 15-49 age group.
Maternal mortality ratio	The number of maternal deaths per 100,000 live births.
Seguro Integral de Salud (SIS)	The SIS is the Public Health Insurance Scheme which aims to ensure access to basic health services for those living in poverty and extreme poverty. It works by reimbursing the cost of health care provided to priority groups.
Maternal waiting houses	Buildings (usually rooms) where women who live a long way from health centres can stay in the period leading up to the birth. They are supposed to be designed to be culturally appropriate to the communities they serve in order for women to feel comfortable using them.
Vertical birth method	Giving birth while standing, sitting, kneeling or crouching. The health professional stands in front of or behind the woman to assist her during labour. Women often hold onto a rope while giving birth using this method and are physically supported by their husband or a relative.
Health promoters	Men and women who, on a voluntary basis, provide support, information and education on health issues to poor, rural and Indigenous communities across Peru.
Pre-eclampsia/eclampsia	A pregnancy-specific disorder characterized by high blood pressure and protein in the urine (proteinuria); when convulsions also occur, it is known as eclampsia.
Quechua	Indigenous language learned as a mother tongue by 13.2 per cent of Peru's population. In rural areas this percentage goes up to 30 per cent of the population. <sup>2</sup>



Indigenous women breastfeeding whilst waiting outside a rural health post in San Juan de Ccarhuacc in Huancavelica province, one of the poorest regions in Peru, September 2008.



# 1/INTRODUCTION

Peru remains one of the countries with the highest maternal mortality ratios in Latin America, despite considerable levels of economic growth in recent years.<sup>3</sup> The current level of maternal mortality in Peru is disputed – the government puts the figure at 185 per 100,000 live births<sup>4</sup> while the United Nations Population Fund (UNFPA) states that 240 women die for every 100,000 live births.<sup>5</sup> However, while the figures may vary, the government and experts that Amnesty International has spoken to agree that the level is far too high.<sup>6</sup>

Maternal mortality is the single biggest cause of death among women of child-bearing age in developing countries. The overwhelming majority of these deaths are preventable. The reasons why pregnancy and childbirth continue to cost the lives of so many women are embedded in the violation of human rights. Accurate data on the extent of maternal mortality and morbidity (illness) is scarce. However, the information which is available shows that the highest maternal mortality rates<sup>7</sup> are invariably among women living in poverty.<sup>8</sup> Denied a voice in the allocation of resources and access to the type of health care that should be available, women living in poverty are dying and suffering on an alarming scale.

Preventable maternal mortality is a violation of women's human rights.<sup>9</sup> It violates women's right to life, to non-discrimination, to the highest attainable standard of health care and to information. In many cases it results from violations of women's right to freedom from gender-based violence and violations of their right to decide freely and responsibly on the number and spacing of their children. All of these rights are set out in international human rights treaties which Peru has signed and ratified.

The importance of reducing and preventing maternal mortality has been recognized on an international and national level. One of the UN Millennium Development Goals (MDGs) is the reduction by three quarters of the maternal mortality ratio between 1990 and 2015. In 2008, the Peruvian government announced that improving maternal and infant health was one of its five strategic goals for social policy in 2008 and that it hoped to reduce maternal mortality to 120 in every 100,000 births by 2015.<sup>10</sup>

In 2006 Amnesty International published *Peru: Poor and excluded women – Denial of the right to maternal and child health*.<sup>11</sup> This report assessed aspects of Peru's compliance with its obligation under international human rights law to ensure reproductive, maternal and child health care. The evidence obtained showed that, despite progress made, Peru still did not guarantee without discrimination the availability, accessibility, acceptability and quality of

reproductive and maternal health care services for women in communities that are marginalized or excluded from the rest of society through poverty and social discrimination.

Factors that prevent women from excluded or marginalized communities from getting the health care they need include the unequal distribution of health facilities, goods and services – and most importantly, emergency obstetric care. A disproportionate share of resources is targeted at the more affluent and powerful sectors of society.<sup>12</sup> For poor

or Indigenous women, these factors are compounded by the socio-economic, ethnic and gender discrimination which they face in accessing health care in Peru. In addition, women living in poverty are largely excluded from political decision-making processes. Their voices are rarely heard and their views rarely influence the state's laws and policies so that these violations of human rights pass largely unnoticed by society and by those in authority.

Since 2006, a number of positive measures have been taken by the Peruvian government, in particular the Ministry of Health and the Ministry of Finance, to reduce maternal mortality. This report looks at some of the progress made and at what remains to be done. Indigenous women, their families and health workers in San Juan de Ccarhuacc, in the Andean province of Huancavelica, described their experiences of pregnancy and childbirth to Amnesty International. Their stories reflect the experience of women living in poverty in many parts of Peru and highlight the urgent need for the state to live up to the human rights standards it has pledged to uphold. Amnesty International is indebted to those who agreed to share often deeply distressing experiences in order to take forward the struggle for women's human rights in Peru.



1 No. 3838 Rev. 3 UNITED NATIONS  
2004  
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Cartographic Section

## 2/MATERNAL MORTALITY AND HUMAN RIGHTS

When women die in pregnancy or childbirth because the government fails to address the preventable causes of maternal death, the government violates women's right to life. In turn, preventable maternal death and ill-health stem from violations of women's right to the highest attainable standard of health, which encompasses their right to have access to available, accessible, acceptable and good quality health care and services.

Women's right to information includes their right to information about sexual, reproductive and maternal health in order to enable them to decide whether and when to become pregnant and to give informed consent to contraception and sexual, reproductive and maternal health care.

When a woman is denied these rights because of her ethnic or socio-economic background, because of her age or because of her gender, then her right to equality and non-discrimination is also violated. When women are unable to decide on matters relating to their sexuality and reproductive lives free from coercion, discrimination and violence, then their sexual and reproductive rights are denied.

All of these are human rights and are protected in international and regional treaties on human rights to which Peru is a state party. These include:

- the International Covenant on Civil and Political Rights
- the International Covenant on Economic, Social and Cultural Rights
- the Convention on the Elimination of All Forms of Discrimination against Women
- the Convention on the Rights of the Child
- the International Convention on the Elimination of All Forms of Racial Discrimination
- International Labour Organization Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries
- The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)





Indigenous women waiting outside a health post in San Juan de Ccarhuacc in Huancavelica province. September 2008.

These rights are also protected in Peru's national legislation, in particular:

- Article 2 of the Constitution relating to the rights to life and non-discrimination
- Chapter 2 of the Constitution relating to social and economic rights
- General Health Law

Some key international standards are as follows.

## INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The UN Committee on Economic, Social and Cultural Rights is responsible for overseeing the implementation of the right to health set out in the International Covenant on Economic, Social and Cultural Rights, and issues guidelines on how the Covenant should be interpreted. The Committee has stated that the right to the highest attainable standard of health (Article 12) should be understood as an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health.<sup>13</sup> 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 and nutrition,
- an adequate standard of housing,
- healthy occupational and environmental conditions,
- 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 community, national and international level.

The Committee also established that the right to health should cover the following essential and inter-related elements:

**Availability** – public health and health care facilities, goods and services, and health care centres and programmes should be available in sufficient quantity.

**Accessibility** – health care facilities, goods and services, as well as information, should be accessible without discrimination. This requires the elimination of barriers of all

kinds, including physical and financial, that arise as a result of discrimination and lack of information.

**Acceptability** – health facilities, goods and services must be respectful of medical ethics, culturally appropriate and sensitive to gender and life-cycle requirements. They must be designed to respect confidentiality and improve the health of those concerned.

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

Under 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 co-operation, to the maximum of each of the states parties' resources.

However, the Committee has clarified a number of **core obligations** 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 constraints in resources, the most vulnerable members of society can and must be protected by the adoption of relatively low-cost programmes.<sup>14</sup> The Committee considers the following core obligations to be the minimum to be met by states to ensure the right to health:<sup>15</sup>

- 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.

The Committee also identifies obligations of comparable priority, which include ensuring reproductive<sup>16</sup> and maternal (prenatal as well as postnatal)<sup>17</sup> health care and providing appropriate training for health personnel, including education on health and human rights.<sup>18</sup>

## CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The UN Committee on the Elimination of Discrimination against Women, which is responsible for overseeing the implementation of the Convention, has stated that women's right to health requires governments to address the prevention and treatment of health conditions affecting women, to take action to end violence against women and to ensure that all women have access to a full range of high quality and affordable health care, including sexual and reproductive health services. The Committee has stated that in order to give effect to the right to health, governments must also prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality ratios through safe motherhood services and prenatal assistance.<sup>19</sup>

## MILLENNIUM DEVELOPMENT GOALS

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 UN's Millennium Development Goals (MDGs), which include a pledge to reduce maternal mortality by 2015. A powerful agenda for the mobilization of change, the MDGs are a set of internationally agreed development priorities. They include the reduction of the maternal mortality ratio and universal access to reproductive health (MDG 5) and the promotion of gender equality and the empowerment of women (MDG 3).<sup>20</sup>

### MILLENNIUM DEVELOPMENT GOAL 5: IMPROVE MATERNAL HEALTH

REDUCE BY THREE QUARTERS, BETWEEN 1990 AND 2015, THE MATERNAL MORTALITY RATIO

Indicators:

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

ACHIEVE, BY 2015, UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

Indicators:

- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage (at least one visit and at least four visits)
- Unmet need for family planning

Source: United Nations, Millennium Development Goals Indicators. The official United Nations site for the MDG indicators:

<http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>, accessed 5 February 2009





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Family outside their home in Occopampa, Churcampa province in the region of Huancavelica, June 2007.

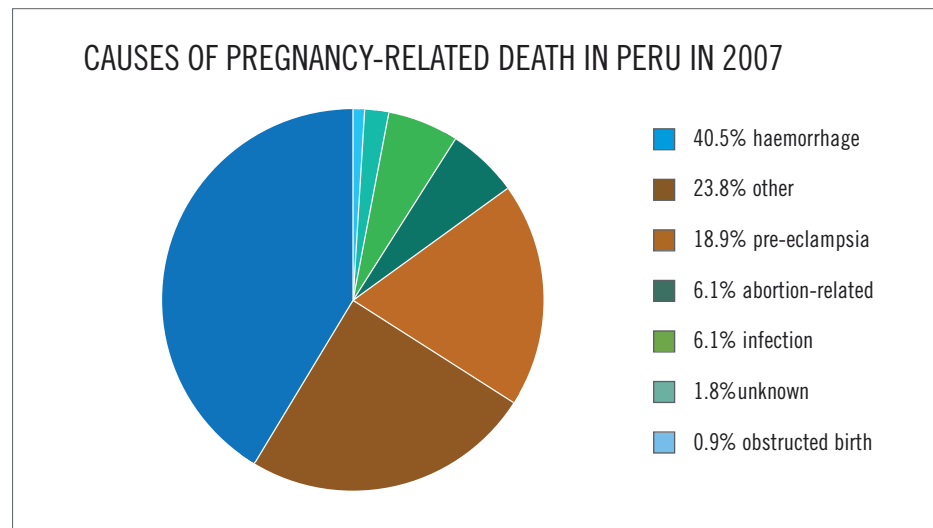
According to the United Nations Population Fund (UNFPA), although maternal mortality ratios are declining globally and in all regions, the decline is too slow to meet the target of MDG5. Meeting that goal would have required an annual drop of 5.5 per cent, whereas the recorded declines have been less than 1 per cent.<sup>21</sup> In addition, the figures collected by the UNFPA do not show which parts of the population are experiencing a reduction in maternal mortality ratios. Peru is expected to report on the progress it has made towards meeting the MDGs in September 2009.

## CAIRO COMMITMENTS

2009 marks the 15th anniversary of the 1994 International Conference on Population and Development in Cairo, Egypt. The Conference adopted a Programme of Action that affirmed the centrality of human rights to the attainment of development goals. It committed states to “strive to make accessible through the primary health-care system, reproductive health to all individuals [of all ages] as soon as possible [and no later than the year 2015]”. This included family planning and counselling information, education, communication and other services; education and services for prenatal care, safe delivery and postnatal care; abortion to the full extent of national law, including the management of the consequences of abortion; and information, education and counselling on sexuality, reproductive health and parenthood. The Cairo commitments reinforce the MDGs.

## 3/CAUSES AND REMEDIES

Peruvian government statistics for 2007 show that 27 per cent of deaths of women from pregnancy-related causes occurred during pregnancy; 26 per cent occurred during the birth itself; and 46 per cent during the first six weeks after giving birth.<sup>22</sup> The five main causes of pregnancy-related deaths in Peru are: haemorrhage, pre-eclampsia,<sup>23</sup> infection, complications following abortion and obstructed birth.



Figures given to Amnesty International by the Peruvian Ministry of Health's Department of Epidemiology (Dirección General de Epidemiología) in July 2008

It is important to note that according to recent studies on the prevalence of clandestine (illegal) abortions in Peru and the impact of these abortions on women's health, it is estimated that one in seven women who undergo abortions are hospitalized for complications arising from the abortion. A variety of different reasons can account for this, including lack of complications, self-treatment or treatment obtained privately, and death before reaching the health facility. It is also estimated that there is a 10 per cent rate of omission of cases reported because of under-reporting or inaccurate reporting.<sup>24</sup> Therefore, the recorded total of deaths from abortion cannot be relied upon as accurate. The same studies put abortion as the third biggest cause of maternal deaths in Peru.<sup>25</sup>

Most maternal deaths can be prevented. International studies have shown that women are continuing to die because of a series of barriers, or delays, that prevent them from having access to the health services that they need, when they need them.<sup>26</sup> These barriers disproportionately affect certain groups of women, particularly those living in poverty in rural areas and Indigenous women.

## EDUARDO LUCAS CRISÓSTOMO

'The main cultural problem for access to health is language. The main disagreements with the community are about cultural issues...

Before, out of 10 women, only four or five went to get check ups during the pregnancy. The mothers and grandmothers refused to let their daughters have check ups in the health post. Now, 98 per cent of pregnant women are seen in the health post. [The main reason for this improvement is] training, interventions by some NGOs, the Reposalud programme.<sup>27</sup> There have been presentations to the whole community, talking about types of pregnancies, dangers and risks, about the possibility of complications or of death as a result of complications during birth.

The most common factor preventing women from going to the health centre is fear, dread... Also the illiteracy of the mothers. They don't know what kind of treatment is given, what the examination is like... If the women were educated, well-informed, it would be better.

[The main problem in terms of good service] is transport. In the whole jurisdiction, with seven health facilities, we only have one ambulance. Sometimes, there are two or three emergencies at the same time. We get the patients out with our own resources, renting private vehicles, with all the risks that this implies, to try and save a life. The ambulance is missing a lot of technical equipment. More than anything, to attend emergencies, the ambulances need to be fully equipped. The one here serves as transport, but not to deal with emergencies...

[Another thing which would help improve the situation is]...more staff for the areas furthest away and in extreme poverty. What we need is support in human resources.'

Eduardo Lucas Crisóstomo, a health technician at the health post in San Juan de Ccarhuacc, Huancavelica province, September 2008

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These barriers are more often than not the result of government action or omission and therefore can be overcome. The solutions – in the fields of law reform, public health and women's empowerment, among others – are well known and have been shown to work in practice. They are multifaceted and require comprehensive government action relating to women's status and decision-making and their access to health care.

Many experts have identified the key importance of access to emergency obstetric care: "After considerable debate, a much more focused approach to the reduction of maternal deaths has

taken shape. Different groups focus on different aspects – emergency obstetric care, skilled care by skilled attendants, unmet obstetric need – but all of them have at their core a recognition that without the ability to treat women with obstetric complications, maternal mortality cannot be substantially reduced.”<sup>28</sup>

The lack of access to this care is a violation of women’s human right to the highest attainable standard of health. The right to health in practice means that women’s entitlement to health care has to be acknowledged and implemented. The health care should be available, accessible, adequate and of good quality.

Denial of **access** is one of the central barriers to reduction of maternal death and ill-health: access to a health centre or a health professional, or to the equipment and medicines required to treat a particular health condition; access to transport to get to health centres, to get home from them or to be referred to a higher-level facility where more complex treatment can be provided; and access to information about health problems and their symptoms, treatment options and the availability and accessibility of health care.

Many women in rural Peru live either too far away from a health centre or in areas that have no adequate roads or means of transport to travel there easily in an emergency. Often the nearest health centre does not have the right equipment or medicines or trained professionals to give the women the treatment they need, particularly in cases of emergencies. This lack of **availability** is also a barrier to access to health care.

Even when health care is available, lack of information means that many women do not know what health care they can access or what symptoms they need to be alert to. Many different languages are used by Peru’s 71 different ethnic groups, and for a significant proportion of the population Spanish is either a second language or is not spoken at all.<sup>29</sup> This particularly affects Indigenous women, who are less likely to speak Spanish than Indigenous men as they tend not to travel outside their communities. Despite this varied and complex linguistic heritage, information about health care is still overwhelmingly in Spanish. Interpreters are not readily available. Many health professionals in rural areas speak only Spanish and so may not understand the women they treat.

Another important barrier that many Indigenous women face is that the health care available is not provided in a way that is **acceptable** to them. In other words, they do not feel comfortable or safe using the services provided and so prefer not to use them. Women interviewed by Amnesty International reported that they had been treated badly or disrespectfully for being poor and/or Indigenous and said that such treatment was a common experience in their community. In addition, the health facilities and techniques used for giving birth can be disturbing and even frightening for women accustomed to different traditional birthing procedures. The result is that many women choose the real and known risk – giving birth in the community – over another possible, unknown risk – being treated in an environment they are frightened of and in ways which they consider alien to their culture.



A doctor treating a pregnant woman in the San Juan de Ccarhuacc health post, Huancavelia province, September 2008.

The Peruvian government has to address these barriers if its maternal mortality reduction policies are to be effective. The barriers are not insurmountable, but they have to be acknowledged in order for the appropriate measures to be taken to reduce and remove them.

Some measures are key to reducing maternal mortality. These include access to skilled attendants during birth and emergency obstetric care.

Access to skilled health workers during birth has a significant impact on maternal mortality and has been identified as one of the indicators in the MDGs: "Assistance by appropriately trained health personnel, with proper equipment and referral options in case of complications, must be standard practice during deliveries if there is to be a noteworthy drop in maternal deaths."<sup>30</sup> Peruvian government figures indicate that over half of births in rural areas are still not attended by a health professional.<sup>31</sup> Although many women all over the world give birth without a health professional in attendance, it is widely recognized that access to skilled attendants during birth is one of the key factors in ensuring a safe delivery. This access is essential when complications arise during birth.

Most obstetric complications occur unpredictably around the time of delivery, affecting about 15 per cent of all pregnant women.<sup>32</sup> Emergency obstetric care (EmOC) is therefore also key to preventing and reducing maternal mortality and morbidity. In 1997, the UN Children's Fund (UNICEF), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), adopted the UN EmOC Process Indicators, which recommend levels for the distribution and quality of facilities and services and for the extent to which women in need use them. The data obtained provides the means for setting benchmarks for assessing government efforts. (See Appendix.)<sup>33</sup>

A report published by Peru's Ombudsperson's office in 2008 found that the majority of health facilities with capacity to deal with obstetric emergencies 24 hours a day were in urban areas; most rural areas did not have health facilities that could provide emergency cover.<sup>34</sup>

The Peruvian government has taken steps over the past few years to address some of these inequalities and to reduce the barriers that poor, Indigenous and campesina (peasant farmer) women face in accessing maternal health care, barriers that women who are not poor or marginalized do not face. These include increasing facilities that are designed to bring women from rural communities closer to health centres, promoting the use of culturally appropriate birthing techniques, language training for health professionals and more targeted budgeting for health policies. The following chapters look at the impact of some of these initiatives on the protection and promotion of women's human rights during pregnancy, childbirth and the early weeks of motherhood.

## 4/POVERTY AND DISCRIMINATION

**‘[Another thing which would help improve the situation is]... more staff for the areas furthest away and in extreme poverty. What we need is support in human resources. Two people are not enough [to staff a health post].**

**Poverty is a variable, a consideration. Economic circumstances influence whether a woman can be transported and attended to in bigger health centres, in Huancavelica. The decision of the husband [to seek transport or health care in other health facilities], according to his economic circumstances, is very important.’**

Eduardo Lucas Crisóstomo, a health technician at the health post in San Juan de Ccarhuacc, Huancavelica province, September 2008

In Peru, most poor and marginalized women live in rural or Indigenous communities. Government figures for 2008 state that, although only just over a third of Peru’s population lives in rural areas, the rural population makes up over 57.7 per cent of those living in poverty. Eight out of 10 people living in situations of extreme poverty live in rural areas of the country.<sup>35</sup> Poverty is a determining factor in whether a woman will survive pregnancy. The overwhelming majority of women who die from pregnancy-related causes worldwide are from poor and marginalized backgrounds.<sup>36</sup>

Figures provided by the National Institute of Statistics and Information (INEI) highlight stark inequities in the provision of health services to women living in poverty. INEI figures state that in 2007, only 36.1 per cent of the women in the poorest sectors of society who gave birth between 2002 and 2007 stated that the last time they had given birth was in a health facility. The comparable figure for women in the richest sectors of society was 98.4 per cent. Similarly, during the same five-year period, only 35.9 per cent of women in the poorest sectors of society had been attended by a health professional during their most recent childbirth. The comparable figure for women in the richest sectors of society was 99.2 per cent.<sup>37</sup> The link between poverty and maternal mortality in Peru has been clearly shown, most recently in a report by the National Ombudsperson’s Office which highlights the fact that the poorest regions of Peru are also the regions with the highest number of pregnancy-related deaths.<sup>38</sup>



International law prohibits all forms of discrimination, whether intentional or in effect.<sup>39</sup> When health care or other public services are delivered in such a way that they have a disproportionate impact on a particular group or groups, the state has violated its obligation not to discriminate.

The patterns of racial, ethnic and gender-based discrimination that prevent women from accessing health care today have a long history, some of it documented in the Final Report of the Truth and Reconciliation Commission (Truth Commission), published in August 2003. The Truth Commission was set up in 2001 with a mandate to establish the circumstances surrounding the serious and widespread human rights abuses perpetrated during Peru's 20-year internal armed conflict, which ended in November 2000. The Final Report of the Truth Commission documented thousands of cases of serious human rights abuses committed by the armed opposition groups Sendero Luminoso (Shining Path) and the Túpac Amaru Revolutionary Movement (Movimiento Revolucionario Túpac Amaru, MRTA), and by the state security forces.<sup>40</sup> It concluded that at times these abuses constituted crimes against humanity and detailed abuses which were gender-specific in that they only affected women, for example cases of forced sterilization.<sup>41</sup>

Although some steps have been taken in recent years to address some of the abuses detailed by the Truth Commission, the patterns of racial, ethnic and gender-based discrimination it describes persist. Today, as in the past, discrimination, deprivation and exclusion are denying thousands of people their human rights.

For example, many people still do not have identity papers. This is in part a result of the period of internal armed conflict when many documents were destroyed. However, it has





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Occopampa, Churcampa province in the region of the Huancavelica, June 2007.  
*left:* Giving birth in a vertical position is a traditional method used in Andean Peru. In 2005 the Ministry of Health issued guidelines on the use of this method in order to ensure that health professionals offered this option to women.  
*centre:* Before and after the birth, women can rest in the company of their family in maternal waiting houses next to the health facility.  
*right:* A family leaving the health facility in Occopampa, with their new baby.

been perpetuated by the fact that people living in poverty do not have access to administrative processes that allow them to obtain legal identity documents. The lack of official documentation effectively restricts enjoyment of civil and political rights, such as the right to vote. It also denies people social and economic rights. For example, it limits access to the Seguro Integral de Salud (SIS, the Public Health Insurance Scheme) which allows women who live in poverty to access free maternal health care because identity documents are required to register with the SIS. The 2007 census of Indigenous Peoples reported that 14.9 per cent of the population aged 18 and above covered by the census did not have national identity papers. The percentage is higher for women (18.1 per cent) than for men (12.2 per cent).<sup>42</sup>

The legacy of widespread and gross abuses during the armed conflict continues to affect the lives of women today. Many have complained of mental and physical health problems, including concerning reproductive health, resulting from the violence to which they were subjected. It is only by understanding this legacy that the mistrust and fears that Indigenous and campesina women have of the authorities and of people from outside their community can begin to be understood. It is also against this background that the failure by the authorities to provide available, accessible, acceptable and good quality health care should be judged.

The 2007 national census of Indigenous Peoples reported that 59.1 per cent of the communities covered by the census did not have a health facility, and that of those that did, 45.4 per cent had no more than a first aid post, 42.3 per cent had a health post (one of the most basic classifications of health facilities) and 10.9 per cent had access to a health centre (the next more equipped type of facility after a health post).<sup>43</sup>

The death of a woman in pregnancy or childbirth, combined with the lack of adequate social policies, far too often means that her family is driven even deeper into poverty. Studies have shown that the effects on a family and on a community of the death of a mother in childbirth can be profound and long-lasting. The burden of looking after remaining children and compensating for the loss of one of the family's principal breadwinners generally falls either on older children or other family members. Often this means that the carers are themselves denied the opportunity to continue their education, curtailing their future life chances. Without access to education, children living in poverty are likely to become adults living in poverty... And so the cycle continues.

### JOSÉ MENESES SALAZAR

Twenty-four-year-old José Meneses Salazar from San Juan de Ccarhuacc, Huancavelica province, is the oldest of nine children. He told Amnesty International that his mother died in childbirth in 1999 when he was 15. She had not wanted to go to the health centre for check-ups because she feared the staff would not treat her well there. When she went into labour, the midwife at the San Juan de Ccarhuacc health post was on leave, so José's father and other relatives delivered the baby themselves. However, after the

baby was born, the placenta did not come out and they did not know what to do. Two hours later his mother died. The baby girl survived.

José described the huge impact that his mother's death had on the family. His father subsequently abandoned his family. His mother's death and his father's departure meant José had to take on responsibility for the family and for the smallholding, which in turn meant that he had to give up his education. His sister also had to give up school in order to help out. As a result, she can barely read or write.

José now lives with three of his younger siblings, his wife and two young sons of his own. As a result of his mother's experience, he has supported his wife in going for antenatal check-ups and taken her to the maternal waiting house before she gave birth. He told Amnesty International that the health

centre desperately needs more staff and equipment, especially a scanner so that they can see how the foetus is developing and predict more accurately when the baby will be born. He hopes that they will get permanent health workers who stay in the community. He also hopes there will be better provision for transporting women to other health centres in emergencies.



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## 5/COST AND TRAVEL

The cost of treatment, and difficult journeys to reach health facilities, are two important barriers to health care for people living in poor rural areas. As one health promoter said to Amnesty International, “There is no vehicle. Women arrive on rudimentary stretchers made with canes and blankets. This needs to improve. There needs to be a motorcycle, a car or an ambulance. There are cases where they are transporting the pregnant woman having contractions to the waiting house and she gives birth half way there. This is very dangerous.” In the case of obstetric complications, these barriers can prove fatal.

Free maternal and infant health care, as well as help with the payment of medical expenses, are available for those living in poverty in Peru. In certain areas, levels of poverty are such that the whole community is entitled to free medical care provided by the SIS. By law, people covered by the scheme should have to pay only 1 nuevo sol (US\$0.30) to join the scheme. No other payment should be asked of them. The SIS is the basis for the currently proposed “Universal Health Insurance” model. It is, therefore, vital that existing difficulties over scope, coverage and accessibility are identified and resolved to prevent future lack of coverage, mismanagement and abuse.

In 2006 Amnesty International highlighted the financial barriers that women living in poverty faced in accessing maternal health care. By 2008, evidence suggested that the number of people covered by the SIS had increased significantly.<sup>44</sup> However, some health providers were still reportedly telling women, contrary to the official policy, that “[coverage under] the SIS is only once a month. If you come for a second time, you have to pay.” In addition, the 2007 national census of Indigenous Peoples reported that 46.5 per cent of the population covered by the census was not covered by any type of health insurance.<sup>45</sup>

The SIS office has reportedly set up its own Ombudsperson’s Office to receive complaints about provision and coverage of the insurance. This is a relatively recent initiative on behalf of the SIS and Amnesty International is not aware of any official findings or reports from this office.

Informal transport costs can also act as barriers to accessing maternal health care. These include the cost of transport to and from health facilities. Even if families can cover the cost of transport, there is often no bus or ambulance to take them, or indeed no road. Spending on infrastructure in rural areas is low and this impacts directly on women’s access to health care. Transport costs for women who qualify for coverage are in theory covered by the SIS through the allocation of funds to health facilities, although in practice this does not appear





A pregnant woman at a maternal waiting house in Huancarani, on the outskirts of Cuzco, March 2008.



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Many women in rural areas in Peru face difficult journeys to health facilities either through lack of transport, poor roads or lack of money to pay for transport.

to solve the problem of access to transport by poor and rural communities. Maternal waiting houses,<sup>46</sup> an initiative promoted by the government, can be seen as a welcome attempt to address the problem, provided that they are set up appropriately. However, difficulties remain, such as transport to the waiting houses and the lack of facilities provided there (see Chapter 6). A 2007 Ministry of Health evaluation of a donor-funded project identified one of the key challenges as developing “agreements between different state sectors in order to improve the infrastructure of transport/roads and assign greater resources”.<sup>47</sup>

According to the INEI, data collected in March 2007 and again in March 2008 shows a decrease for the population as a whole in the number of people citing cost as a reason for not attending a health centre when they were – from 24.5 per cent in March 2007 to 19.9 per cent in March 2008. On the other hand, on the same dates, the number of people saying they did not attend a health centre because of distance, lack of confidence in health services, and/or delays in receiving treatment, went up from 11.8 per cent to 12.7 per cent.<sup>48</sup>

The reality is that each of these barriers is enough to prevent women accessing maternal health care, particularly in cases of obstetric emergency where the closest health facility may not provide the level of care required. If women can cover the costs of health care or there are no costs, but they cannot find any means of transport, they will not get to the services and care they need. On the other hand, if they find a means of transport but cannot pay for the health care or for essentials such as food, they will again be denied the care they need.

## YOLANDA SOLIER TAIPE

Yolanda Solier Taipe is 33 years old and pregnant with her seventh child. She lives about an hour away from the health post in Ccarhuacc on a track that cannot be used by cars.

“The greatest difficulty I have is the distance between my house and the health post. I’ve got to walk up the mountain to go to my pregnancy check up. Another difficulty is that I can’t move fast... that’s my difficulty, as well as the fact that my house is not near a road and I have to walk a lot. I would ask you to support us in the construction of roads and send this request to our authorities.

[...] I had my other children there [at the maternal waiting house], all of them. I walked there, but there we don’t have anything; neither food, nor anywhere to prepare our food; nor can we stay, those of us who have come from far away... it is only to give birth and not for any care after the birth.”

Interview with Amnesty International, September 2008

## 6/CULTURALLY APPROPRIATE SERVICES

In discussions with Amnesty International in July 2008, Ministry of Health officials, including the former Minister of Health, highlighted the following measures as key policies designed to increase the access of poor and Indigenous women to maternal health care:<sup>49</sup>

- an increase in the creation and use of maternal waiting houses,<sup>50</sup>
- an increase in promotion of the vertical birth method – including, the publication of guidelines,<sup>51</sup>
- a Quechua-language teaching programme for health professionals.

Women told Amnesty International that the maternal waiting houses, although welcome, did not always meet their needs. Casimira Taipe Sutacur, a volunteer community health promoter in San Juan de Ccarhuacc, Huancavelica province, told Amnesty International, “sometimes the husband takes on the role of father and mother during this time: cooks for the children, and for the wife who is at the health post, and he has to walk two or three hours to take her food there. And the food gets cold on the way and that smells bad. The woman gets ill... In the waiting house there is no food or kitchen to prepare hot food.”

According to government figures, the number of waiting houses in Peru has risen from 99 in 2000 to 390 in 2008.<sup>52</sup> However, the distribution of waiting houses remains uneven and inadequate as a means of facilitating access for women to necessary maternal health care and emergency obstetric care. An investigation carried out by the National Ombudsperson’s Office in 2008 highlighted the fact that a large number of maternal waiting houses have been built next to health facilities which do not provide the required level of maternal health care. In collecting information for its study, the National Ombudsperson’s Office visited 92 health centres, which, according to Peru’s classification of health facilities, would be in a position to provide the required level of maternal health care for childbirth and therefore should run an adjacent waiting house. Just over 30 per cent of these were in rural areas although those of the highest technical standard – such as regional hospitals – were all in urban areas. Of the 92 health centres, only 17 (18.5 per cent) had a waiting house attached and only eight of those were in rural areas. This means, therefore, that 21 of the health facilities in rural areas did not have a waiting house attached although they had sufficient technical capacity for the comprehensive provision of maternal health care.



The Ombudsperson's report concluded that not only should there be an effort to upgrade the technical standard of health facilities in rural areas, but there should also be a re-evaluation of the current location of the waiting houses. The study also found that, although all health professionals should be actively promoting the use of waiting houses, only 24 per cent of those interviewed were actually doing so.<sup>53</sup>

A 2007 Ministry of Health evaluation of the provision of maternal waiting houses acknowledged that one important difficulty was the risk that they were seen as "an intermediate health establishment". The study pointed to the need for the role of waiting houses to be more clearly defined "in order to avoid confusion and to identify responsibilities".<sup>54</sup> According to Amnesty International's findings, this does indeed occur in communities such as San Juan de Ccarhuacc, where women expect to give birth in the waiting house itself and where the health post to which it is attached is not of a classification high enough to actually support a waiting house in the first place and does not have the resources necessary to deal with cases of obstetric complications.

With regard to the vertical birth method,<sup>55</sup> the Ombudsperson's 2008 report stated that 80 per cent of the rural health centres it visited that were obliged to provide vertical birthing facilities did so. This showed an improvement in the cultural adaptation of public health facilities. However, health professionals and NGOs told Amnesty International that training in this technique is still not sufficiently widespread. The Ombudsperson's report also stated that 13.8 per cent of staff interviewed who should have known about the technique were not aware of the vertical birthing guidelines and more than 45 per cent said that they had not received training on their application.<sup>56</sup>

**¡Enseñales a cuidarse!**

¡Por qué me siento mal?

Esto te ayudará:  
- No cargues mucho peso.  
- Controla tu presión.  
- Aliméntate bien.

Identifica con tus pacientes los factores de riesgo durante el embarazo.

**¡Elas necesitan información!**

**¡Tu compromiso es importante!**

- Sé amable con ellas.
- Responde a sus preguntas.
- Respeta sus costumbres.
- Informa sobre el parto vertical.
- Elabora con ellas un PLAN DE PARTO.
- Enséñales a cuidarse.
- Ayúdalas a identificar los factores de riesgo.
- Promueve los controles pre-natales mensuales.
- Indaga si tu paciente es víctima de violencia.

**Reducir la mortalidad materna es un Trabajo Conjunto**

**¡Sé amable y ellas confiarán más en ti!**

Hola Ana, ¿qué gasto seboarte a ver?

Todas las pacientes esperan encontrar un trato amable y de calidad al visitarte.

**¡Trátalas bien!**

**¡Respeto sus costumbres!**

Pregunta y responde a tus pacientes con respeto y asegúrate de conocer bien sus preferencias en cuanto al parto.

**¡Escúchalas con atención!**

**¡Elabora con ellas un PLAN DE PARTO!**

Coordina las próximas visitas según las necesidades y disponibilidad de tus pacientes.

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A leaflet produced by the National (human rights) Ombudsperson's Office directed at health professionals and informing them of healthcare users' rights and how to interact with them effectively to reduce maternal mortality.

These concerns were echoed by a doctor interviewed by Amnesty International:

*"[T]he patients give birth almost crouching. The husband holds them up. I am nearly kneeling with my hands underneath the skirt... Vertical birthing is an ancestral tradition. It is faster and easier for the women... It would have helped if I had had more information before arriving in Ccarhuacc. About the situation and about the women's [health] records. It would be really good if there was training on vertical birthing."*

Although there have been government initiatives to provide Quechua-language training to health professionals, its use is not widespread. The resulting discrimination against women who cannot make themselves understood by the service provider when they are in pain or who cannot understand the advice and instructions of the doctor or health technician remains to be addressed.

Rosa Quichca Vargas is 24 years old and pregnant with her fifth child – two of her children died, one in childbirth and one in the first few days after birth, possibly of pneumonia. She lives almost an hour's walk away from the health post in Ccarhuacc on a road that cannot take vehicles other than possibly a motorbike.

*"The first time she [the doctor] didn't understand what I said to her. I went back and again she didn't understand. The third time she asked me for my family planning card and I went back with it... I couldn't speak [to her]... When we went with my husband, then he got the doctor to understand [that I was pregnant]."*

*"We're scared when they speak to us in Spanish and we can't reply... I start sweating from fear and I can't speak Spanish... what am I going to answer if I don't understand Spanish? It would be really good [if they could speak in Quechua]. My husband, when he goes to Lima, leaves me with the health promoters so that they can accompany me. They take me to my check ups and speak to the doctor."*

Interview with Amnesty International, September 2008

# 7/MONITORING AND INFORMATION GATHERING

Information on maternal mortality in Peru remains insufficient and incomplete. The information that is available does not sufficiently disaggregate the data in ways that would allow an analysis of the impact of poverty on maternal mortality. As a result, there is valid concern that the government's maternal mortality reduction efforts will remain insufficiently targeted and responsive to the realities of women in different localities and communities and will fail to have the maximum impact on redressing the current shortcomings of the health care system.

The responsibility for measuring maternal mortality ratios lies with Maternal Mortality Committees for the Prevention of Maternal and Neonatal Mortality (Comités de Prevención de Mortalidad Materna y Perinatal, more commonly known as Comités de Muerte Materna) which should exist in all local and regional health authorities.<sup>57</sup> All maternal deaths occurring in health facilities should be reported to these committees, which in turn report to the Ministry of Health. However, NGOs, health practitioners and the former Minister of Health<sup>58</sup> reported to Amnesty International in July 2008 that in practice these do not seem to work as consistently or as effectively as they should.

A fundamental problem in evaluating the maternal mortality ratio in Peru is the under-reporting of maternal deaths. This was highlighted by many of the people Amnesty International spoke to in 2008 and confirmed by the authorities, including the then Minister of Health. This under-reporting seems to be the result of a number of factors:

- lack of recording of deaths and/or causes of death for women who die outside a health centre;
- lack of accurate analysis of the causes of death of women who die in health facilities;
- lack of co-ordination between different monitoring bodies – such as the National Institute of Statistics and the Ministry of Health – in the collection and collation of data;
- health providers' fear of negative consequences when reporting a maternal death;
- lack of incentive or perceived purpose for health providers to report maternal deaths; and
- lack of accountability and monitoring of whether health providers report maternal deaths.

Most experts agree that measuring maternal mortality ratios, especially on a frequent basis and in a disaggregated manner, can be extremely difficult. However, there are other respected indicator frameworks that can also be used to measure progress in the reduction of maternal mortality, such as the UN process indicators for EmOC mentioned above.

In 2007, the Budget by Results (*Presupuesto por Resultados*) methodology began to be put into practice by the Ministry of Finance, with a timeline for implementation stretching to 2011. This methodology was adopted by law in 2004 and focuses on measuring the impact of policies rather than just the outputs of policies.<sup>59</sup> In 2008, five Strategic Budget Plans were created, which include indicators and medium- to long-term goals. One of these Strategic Plans is Maternal and Neo-natal Health. The budget allocated is the shared responsibility of the Ministry of Health, the SIS and regional authorities. The Maternal and Neo-natal Strategic Plan addresses many of the factors key to reducing maternal mortality.

The key aims of the plan are as follows:

#### **BEFORE PREGNANCY**

Increase public knowledge about sexual and reproductive health and access to family planning methods through:

- the establishment of “healthy” municipalities, communities, schools and families, which promote sexual and reproductive health; and
- increased availability and access to sexual and reproductive advice centres and family planning.

#### **DURING PREGNANCY AND THE BIRTH**

- increase the access of pregnant women to quality prenatal care, which includes timely diagnosis and treatment of any complications which arise during the pregnancy, such as anaemia, sexually transmitted diseases and urinary infections;
- increase the number of births attended by qualified health professionals;
- increase access to establishments with the capacity to deal with basic obstetric emergencies, both routine and those requiring more comprehensive care;
- increase access to the network of blood banks; and
- strengthen the referral system with regard to its organization, operation and funding.

#### **DURING THE NEONATAL PERIOD (FIRST 28 DAYS AFTER BIRTH)**

Reduce neonatal morbidity and mortality by:

- increasing the number of births attended by qualified health professionals; and

- increasing access to establishments with capacity to deal with basic neonatal emergencies, both routine and those requiring more comprehensive care.<sup>60</sup>

This plan will need to ensure that it links with other government initiatives for the reduction of maternal mortality, such as the newly approved National Strategy for the Prevention of Maternal Mortality (April 2009).<sup>61</sup> It is vital that the plan continues to be adequately funded, implemented and monitored in order to achieve any impact on the reduction of maternal mortality.

A key element to holding the responsible authorities accountable is the establishment of strong monitoring mechanisms that ensure the participation of local communities and guarantee that their views are fed back into policy-making. Bodies such as the National Ombudsperson's Office, and the reports that they produce, are essential for the monitoring and reviewing of government policies. Other such initiatives have been promoted in Peru in recent years between national and local government and civil society with the intention of monitoring social policy. These include the Mesa de Concertación para la Lucha Contra la Pobreza (Coordinated Forum for the Fight Against Poverty)<sup>62</sup>, the defensorías comunitarias (community ombudspeople) and consejos comunitarios locales (local community councils).

## 8/POLICY OMISSIONS

There are a number of important areas where legislation and/or government policy in Peru remain inadequate to reduce maternal mortality.

### FAMILY PLANNING

Accessible, available information is a vital part of enabling women to make informed decisions about their reproductive health. One of the key areas where information has been shown to make a significant impact on maternal mortality is around family planning. The importance of family planning in the reduction of maternal mortality has been highlighted by the addition in 2005 of further criteria for the attainment of MDG 5: to achieve, by 2015, universal access to reproductive health. Indicators include contraceptive prevalence rate and unmet need for family planning (see text of MDG 5 in Chapter 2).

Access to family planning information enables women to make decisions and informed choices about the timing and spacing of pregnancy and childbirth, reducing potential risks and maximizing the potential for having safe pregnancies and healthy children. According to the National Institute of Statistics (INEI), the use of contraception remains more prevalent in urban areas than in rural areas and the rate of adolescent pregnancy remains higher in rural areas and among women and girls who have lower levels of education.<sup>63</sup> The INEI also states that there are significantly more women with an unmet demand for contraception in poorer and more rural areas of Peru. Government statistics estimate that overall 10.2 per cent of women have an unmet need for contraception. When this is broken down into geographical areas, that figure is 8.7 per cent of women in urban areas compared with 13.3 per cent of women in rural areas. The same figures show that in the richest socio-economic quintile of society the percentage for unmet need for contraception is 7.4 per cent whilst in the poorest quintile it is 19.2 per cent.<sup>64</sup>

### THERAPEUTIC ABORTION

When continuation of pregnancy puts a woman's life or health at risk, access to safe, legal abortion is vital. Article 119 of the Peruvian Penal Code allows for such abortions when it is carried out by a doctor, with the consent of the pregnant woman or her legal representative and when it is the only way in which to save the life of the mother or to prevent grave and permanent damage to her health. However, many women who are entitled to access abortion services under the law are denied prompt access to therapeutic abortion.<sup>65</sup>

The provincial health authority in Arequipa province was the only health authority which established guidelines to help medical professionals decide in what circumstances a therapeutic abortion should be recommended. These guidelines were subsequently withdrawn following pressure from groups opposed to the provision of abortion services to women. The former Minister of Health told Amnesty International delegates in July 2008 that he objected to these guidelines because there should be national guidelines rather than a variety of provincial ones. However, to date, no national guidelines to regulate therapeutic abortion have been produced to inform the decisions taken by women or the advice of health professionals. As a result, women are still at risk of dying from pregnancies that are recognized by health professionals as posing a grave risk to their health.

In the absence of relevant protocols, Peru has failed to respond appropriately and in a timely manner to the November 2005 finding by the UN Human Rights Committee regarding the case of a 17-year-old girl compelled to carry to term an anencephalic foetus (a foetal disorder resulting in the absence of a major portion of the brain and the overlying skull and scalp). The Committee found that the government had violated the girl's rights to freedom from cruel, inhuman and degrading treatment, to privacy and to the special protection that must be accorded to children. It declared that the government had to redress the lack of effective remedy in cases where women were denied access to legal abortion and to take steps to ensure that violations of their rights to access legal abortion did not occur in the future.<sup>66</sup>

## AGE OF CONSENT

Health providers as well as NGOs to whom Amnesty International spoke have raised concerns about the impact of a change in the law in 2006 that raises the age of consent for sexual relations from 14 to 18 years. All acknowledged that this change in legislation was motivated by concern to prevent and respond adequately to the sexual abuse of children. However, its implementation is believed to have had negative consequences for the maternal health of girls under 18.

According to official figures, 183,017 babies were born to girls and young women between the ages of 15 and 19 in 2007.<sup>67</sup> The 2007 national census of Indigenous Peoples in Peru reported that 55.6 per cent of women covered in the census had their first child between the ages of 15 and 19.<sup>68</sup> The true figure is thought to be higher because this does not include girls who – as a result of stigma and the pressure brought about by the age of consent law reform – do not go to health centres because they fear they will be made to disclose the identity of the father of the baby. It is also not known how many girls undergo clandestine abortions. There are concerns that the 2006 law may also deter girls from attending prenatal check-ups and from giving birth at a health centre because of fear that this may result in legal proceedings against the father, which is provided for by the 2006 law reform.

Pregnancy at a young age significantly increases the health risks, both during pregnancy and childbirth. In order to ensure that pregnant girls and young women have access to the sexual, reproductive and maternal health information and services they need to make informed

decisions and protect their health and lives, the government has an obligation to address the detrimental side effects of the age of consent law.

## WORKING CONDITIONS OF HEALTH PROVIDERS

Many health professionals reported to Amnesty International, during research both for the 2006 report and for this current report, that the conditions in which they work often make it difficult for them to provide the necessary level of care. In addition, they frequently provide such care at great personal and/or professional cost to themselves. Some of the issues reported included the lack of employment security resulting from temporary contracts – nurses and health technicians who themselves are not always covered by health insurance or who face job insecurity due to the nature of their contracts. Another difficulty is the lack of government support to ensure family contacts when health professionals are posted to remote rural areas. Others cite obstacles such as lack of training and/or preparation for dealing with unfamiliar medical techniques such as vertical birthing or working with people who do not speak Spanish. As a result of difficult working conditions, many health professionals drop out of public service provision. This leads to lack of continuity of staff in remote health facilities and thus compounds the problem of lack of trust that women have in the health system.

Another concern is the situation of voluntary health promoters, who give their time willingly and without payment in return, visit users all over the countryside, and generally come from backgrounds as impoverished as those of the women they visit. Their work is highly valued by poor and rural communities, but although they are motivated by a genuine passion to help others, some told Amnesty International that their families often do not understand why they do this work and the conditions they carry out their work in are difficult. More support for their work and recognition of the important role that they play in supporting women through childbirth and in fostering links between health professionals and communities would undoubtedly make their situation easier.

*“I don’t know anything, can’t even read a word. That makes it difficult. You need to walk from house to house. Talking to the mothers. Without light, with candles. I’m retired now, because I’ve got work to do at home with my children.*

*There’s nothing, not even to eat or anything [talking about the voluntary nature of the work]. We have the desire to work. It’s like a gift being able to help other women in the community. In spite of the difficulties, I’ve worked for all of the different programmes for different NGOs or for the community ombudspeople. But I don’t receive anything for this work. It doesn’t pay. That is a problem with my husband; he feels that they are stealing time, without anything in exchange.*

*If I earned some money that would make the work easier. Because I wouldn’t have to face this problem. Some women still hope to receive something in exchange.*

*I accept the conditions of volunteering, but not my relatives.”*

Teodora Salazar Huanca, 54 years old, health promoter from San Juan de Ccarhuacc, September 2008.





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Teodora Salazar Huanca in front of the health post in San Juan de Ccarhuacc, Huancavelica province. September 2008.

## 9/CONCLUSIONS

At a national level, significant steps have been taken towards introducing government policy focused on reducing preventable maternal mortality in Peru. This includes the official promotion of culturally adapted birthing methods, the huge increase in the creation of maternal waiting houses, the increase in coverage of rural populations by the SIS, and the introduction of a targeted system of budget allocation centred on results obtained in the key target area of maternal health.

However, in the absence of a fully resourced and accountable plan of action which includes all relevant government ministries and local authorities, it is very difficult to assess to what extent Peru is meeting its human rights obligations towards women. In addition, although individual bodies such as the National Ombudsperson's Office and the National Institute of Statistics have made significant efforts to gather information on maternal health care and the implementation of government policy, there remains a distinct lack of national disaggregated data on maternal mortality.

In trying to obtain a clearer picture of the concrete results of these policies, Amnesty International has identified several ongoing flaws and key gaps which prevent the removal of barriers women face in accessing maternal health care essential to the elimination of preventable maternal deaths. The most worrying of these are: the apparent lack of **co-ordination** between the different government policies and initiatives; the lack of adequate **implementation** and **monitoring** of these policies and initiatives; and linked to this, the lack of clarity around **responsibility** and **accountability** for resourcing and implementation of these policies and initiatives.

The stark disparities between richer and poorer sectors of society, including Indigenous communities, persist. In Peru, as in many countries around the world, it is the human rights of women, particularly those living in poverty, that are at stake and poverty most often equates to rural and/or Indigenous populations. Nowhere is this clearer than in the lack of access to health care.

If the momentum towards reducing maternal mortality ratios in Peru is to be maintained and reinforced, then these obstacles need to be addressed urgently. This can only be done by political will and commitment, particularly in these times of economic uncertainty where it is all too easy for the voices of marginalized individuals and communities to be ignored by those with decision-making power. Above all, there is a need for political commitment to respond to the concerns women identify – especially women living in poverty in campesino and

Indigenous communities who have for so long been excluded from policy making – and involve them in devising ways of improving access to maternal health.

In April 2009, the Peruvian government approved a new strategic plan for the reduction of maternal mortality. In September 2009, Peru is due to report on its progress in meeting the Millennium Development Goals. However, Peru has made a number of such plans in the past and, as can be seen by the agreements the government has subscribed to at both national and international level, it is already committed to reducing maternal mortality. What remains to be seen is whether what is on paper can be implemented effectively in practice and actually result in a reduction in the number of women who die needlessly every year from preventable maternal deaths. Only then will it become clear that Peru is serious about respecting all human rights for all of its population.

# 10/RECOMMENDATIONS

## AMNESTY INTERNATIONAL MAKES THE FOLLOWING RECOMMENDATIONS TO THE GOVERNMENT OF PERU:

The government of Peru must co-ordinate existing government initiatives for the prevention and reduction of maternal mortality into a fully resourced and accountable plan of action which includes all relevant government ministries and local authorities. The plan must:

### **1) Allocate adequate resources to maternal and reproductive health care, prioritizing the poorest regions with highest mortality ratios, and in particular providing:**

- sufficient funding to implement all national policies for the reduction of maternal mortality;
- financial and technical resources to support regional authorities in fulfilling their responsibilities under all governmental policies for the reduction of maternal mortality;
- adequate resourcing of all health facilities and maternal waiting houses, according to their respective purposes;
- an increase in the number of 24-hour EmOC facilities and skilled birth attendants in areas of high maternal mortality;
- increased availability of contraceptive goods and services, to both men and women, in areas of high maternal mortality; and
- increased investment in adequate transportation and means of communications in areas of high maternal mortality.

### **2) Systematically reduce economic, physical and cultural barriers that prevent poor rural and Indigenous women from accessing life-saving reproductive and maternal health care, including by:**

- ensuring that rural women and others covered by the SIS can reach health facilities equipped to meet their maternal health care needs;

- increasing training of health professionals, particularly in traditional birthing practices, in order to implement government norms requiring respect and clinical support for these practices;
- providing language support in all health facilities attended by Indigenous women and their families – such as by providing professional interpreters or training bilingual members of the community to assist as interpreters;
- issuing and ensuring implementation of a regulatory protocol for health personnel on the use of therapeutic abortion; and
- ensuring that all government health policies for the reduction of preventable maternal mortality guarantee the labour rights of health providers in order to enable them to provide health care to the best of their ability.

**3) Ensure meaningful participation of women in decisions about maternal health care and in the evaluation and monitoring of current processes by:**

- ensuring that all women have identity documents in order to vote and participate in public discussion and decision-making forums;
- involving women, in particular poor rural and/or Indigenous women, in evaluating their local health facilities and identifying problems related to maternal health care in their communities, particularly related to access to skilled attendance at birth and EmOC, as well as in identifying solutions to these problems; and
- ensuring that these views are channelled back into health policy-making.

**4) Provide accessible information to women about their sexual and reproductive rights and the right to health by:**

- distributing accessible and clear information, in relevant languages and formats, on health services users' rights, and in particular, what costs are covered and what services are available under the SIS and where to report any complaints about its implementation;
- distributing accessible and clear information, in relevant languages and formats, about the availability of contraception and maternal health care services;
- ensuring that adequate and accessible information is provided to all women, their families and communities on different types of emergency obstetric procedures in order to reduce fear and increase trust in these procedures;

- ensuring that women, their families and communities are fully informed of danger signs for obstetric complications, both before and after the birth, and how to respond to these appropriately; and
- ensuring that adequate information is provided to all health professionals with regard to their labour rights, as well as their responsibilities towards users of health services.

**5) Ensuring adequate monitoring of government policy to reduce maternal mortality, in order to promote effective planning and accountability, by:**

- using clearly defined indicators, such as the UN process indicators on EmOC, to monitor the impact of government policies and initiatives aimed at reducing preventable maternal mortality;
- ensuring that data collected on maternal mortality ratios is disaggregated by geographic and socio-economic criteria;
- providing effective mechanisms to receive and investigate reports and complaints from both users of health services and from health providers about violations of their rights;
- ensuring that health policy development is responsive to the advice of health professionals and civil society;
- making public the information collected by the SIS ombudsperson on how the scheme is functioning; and
- monitoring and ensuring that regional governments incorporate national government policies on the reduction of maternal mortality as a priority in their plans.

# APPENDIX

## THE SIX UN PROCESS INDICATORS AND RECOMMENDED LEVELS<sup>69</sup>

UN PROCESS INDICATOR	DEFINITION	RECOMMENDED LEVEL
1. Amount of EmOC services available	Number of facilities that provide EmOC	Minimum: 1 Comprehensive EmOC facility + 4 Basic EmOC facilities for every 500,000 people
2. Geographical distribution of EmOC facilities	Facilities providing EmOC well distributed at sub-national level	Minimum: 100% of sub-national areas have the minimum acceptable numbers of Basic and Comprehensive EmOC facilities
3. Proportion of all births in EmOC facilities	Proportion of all births in the population that take place in EmOC facilities	Minimum: 15%
4. Met need for EmOC services	Proportion of women with obstetric complications treated in EmOC facilities	At least 100% [Estimated as 15% of expected births]
5. Caesarean sections as a percentage of all births	Caesarean deliveries as a proportion of all births in the population	Minimum: 5% Maximum: 15%
6. Case fatality rate	Proportion of women who die after being admitted to a health facility with obstetric complications	Maximum: 1%

# ENDNOTES

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- 2 Instituto Nacional de Estadística e Informática (INEI), *Perfil sociodemográfico del Perú - Censos 2007*, July 2008.
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- 9 Preventable maternal mortality is “where there is a failure to give effect to the rights of women to health, equality and non-discrimination. Preventable maternal mortality also often represents a violation of a woman’s right to life.” Paul Hunt and Judith Bueno De Mesquita, *Reducing Maternal Mortality: The contribution of the right to the highest attainable standard of health*, UNFPA and the University of Essex, 2007, p3.
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- 12 Amnesty International, *Peru: Poor and excluded women – Denial of the right to maternal and child health* (Index: AMR 46/004/2006).
- 13 See UN document E/C.12/2000/4, 11 August 2000.
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- 15 See UN document E/C.12/2000/4, 11 August 2000.
- 16 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.
- 17 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 between one and four weeks before birth. The term postnatal refers to the period after birth.
- 18 For more information please refer to Amnesty International, *Peru: Poor and excluded women – Denial of the right to maternal and child health* (Index: AMR 46/004/2006).
- 19 General Recommendation 24 by the Committee on the Elimination of Discrimination against Women (CEDAW), 1999, <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom1> accessed 5 February 2009.
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- 22 Figures given to Amnesty International by the Ministry of Health’s Department of Epidemiology (Dirección General de Epidemiología), July 2008.
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- 33** UNICEF, WHO, UNFPA, *Guidelines for Monitoring the Availability and Use of Obstetric Services*, August 1997, p25.
- 34** Defensoría del Pueblo, *Informe Defensorial 138: Derecho a una Maternidad Segura: Supervisión Nacional a los Servicios de Ginecología y Obstetricia del MINSA*, 2008.
- 35** INEI, *Informe Técnico: Situación de la pobreza en el 2008*, p32.
- 36** UNICEF, *The State of the World's Children 2009*, December 2008, pp15-16.
- 37** *Encuesta Demográfica y de Salud Familiar: Indicadores de resultado identificados en los programas Estratégicos: ENDES Línea de Base*, INEI, MEF, Measure DHS, August 2008.
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## FATAL FLAWS BARRIERS TO MATERNAL HEALTH IN PERU

Peru remains one of the countries with the highest maternal mortality ratios in Latin America, despite considerable levels of economic growth in recent years. Stark disparities persist between richer and poorer sectors of society, including Indigenous communities.

In Peru, as in many countries around the world, it is the human rights of women, particularly those living in poverty, that are at stake, and poverty most often affects rural and/or Indigenous people. Nowhere is this clearer than in the lack of access to health care.

Preventable maternal mortality is a violation of women's human rights. It violates women's right to life, to non-discrimination, to the highest attainable standard of health care and to information. Denied a voice in the allocation of resources and access to essential health care, women living in poverty are dying and suffering on an alarming scale.

The Peruvian government has taken some steps to reduce maternal mortality since 2006 when Amnesty International published *Peru: Poor and excluded women – Denial of the right to maternal and child health* (AMR 46/004/2006). But the state can and must do much more to eliminate the barriers that prevent poor, rural and Indigenous women from accessing life-saving reproductive and maternal health care.

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