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From Anti-Natalist to Ultra-Conservative: Restricting Reproductive Choice in Peru

Anna-Britt Coe

Program Director, Latin America, Center for Health and Gender Equity, Lima, Peru. E-mail: annab@terra.com.pe

Abstract: *This article examines Peru's population policy since the 1994 International Conference on Population and Development and assesses to what extent its policies and programmes have affected reproductive health and rights. It is drawn from data collected during ongoing monitoring of sexual and reproductive health policies and programmes in Peru since 1998 for the Center for Health and Gender Equity (CHANGE). Accomplishments since 1994 in Peru demonstrate good faith on the part of the government and foreign donors to make progress towards fulfilling the ICPD agenda by addressing key reproductive health concerns and promoting women's rights. Unfortunately, this progress has not been consistent. It has been overshadowed by two periods of anti-choice policies and interventions. The first, in 1996–97 under the Fujimori government, was a demographic approach that used numerical targets and undue pressure on women to accept sterilisation as the government's main poverty reduction strategy, which led to documented abuses. The second, in 2001–03 under the Toledo government, was a far-right approach that worked to limit access to essential services, including emergency contraception, condoms and post-abortion care. In spite of their contradictory nature, these two policy approaches have been the greatest obstacles to making long-lasting improvements to reproductive health and rights in Peru.*

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FOR women's health advocates, the consensus forged at the 1994 International Conference on Population and Development (ICPD) was the result of decades of hard work to shift the focus of population policies away from the fulfilment of demographic goals toward the promotion of reproductive health and rights. However, participants faced their greatest challenge when they returned to their home countries – ensuring that governments adopted and met the goals set forth in the new agenda. Concretely, governments must replace narrowly defined fertility reduction strategies with broader policies that work to enhance women's and men's capacity to exercise their

rights and address their reproductive health concerns, including but not limited to their need for contraceptives. This has proven to be far more difficult than expected, in part because many governments have limited technical and financial capacity to make and sustain the necessary changes. These changes also imply a long, slow process of transforming unwieldy bureaucratic structures and programmes.

However, the greatest obstacles to promoting the ICPD Programme of Action are policy positions that are frankly opposed to reproductive rights. These political positions may prevent governments from making a full-fledged commitment to achieving reproductive health and

rights objectives. Peru is a telling example of the complexities involved in developing a reproductive health and rights agenda. Until the early 1990s, the government gave little support to population issues and its public family planning programme was poorly organised and relatively ineffective.^{1–3} Since signing the ICPD agreement, the Peruvian government has taken several steps toward fulfilling reproductive health and rights objectives.^{3–5} Progress has been overshadowed, however, by two periods of adverse policy approaches – demographic (1996–1997) and far right (2001–2003).^{6–8} This article examines Peru's population policy since the ICPD and assesses to what extent the policies and measures adopted have enhanced or detracted from reproductive health and rights.

Methodology

The data are drawn from the author's ongoing monitoring of sexual and reproductive health policies and programmes in Peru since 1998 for the Center for Health and Gender Equity (CHANGE). The purpose of this monitoring has been to assess Peru's progress in implementing a reproductive health and rights agenda, including commitments agreed at ICPD, and the use and effectiveness of US foreign assistance in meeting this goal. It has consisted of two phases.

During the first phase, primary and secondary data were collected from key national-level stakeholders in reproductive health policies: women's rights groups, reproductive health NGOs, government institutions and international donor and technical assistance agencies. A total of 45 in-depth interviews and 15 key informant interviews were carried out with stakeholder representatives in April–June 1998 and October–December 2000 (Table 1). In-depth interviews were semi-structured using a topic guide with open-ended questions. Key informant interviews were designed to follow up on the same topics. Participant observation was used at public conferences, workshops and presentations organised by key stakeholders, and involving policymakers, programme directors and health care providers. Direct observations were made of service delivery in on-site visits in Ayacucho Department. Official documents and research studies produced by key stakeholders were reviewed.

Table 1. Sources of primary data

National level stakeholders

1. Governmental institutions

- Ministry of Health, Family Planning Programme
- Ministry of Health, Student and Adolescent Health Programme
- Ministry of Health, Maternal and Perinatal Health Programme
- Ministry for Promotion of Women and Human Development, Human Development Programme
- Ministry of Education, Sexual Education Programme
- Ombudsman's Office on Women's Rights
- Congressional Commission on Women

2. International donors

- USAID, Office of Health, Population and Nutrition
- USAID, Office of Human Rights
- UNFPA Peru
- DFID UK, Health and Population Programme

3. Women's rights groups/NGOs

- Centro de Estudios y Publicaciones (CESIP)
- Centro de la Mujer Peruana Flora Tristán
- Movimiento Manuela Ramos
- Red Nacional de Promoción de la Mujer
- Redess Jóvenes

4. Cooperating agencies

- Pathfinder International
- Policy Project

Ayacucho Department stakeholders

1. Governmental institutions

- Ministry of Health
- Family Planning Programme
- Student and Adolescent Health Programme
- STD/AIDs Control Programme
- Maternal and Perinatal Health Programme

2. Women's rights groups/NGOs

- Movimiento Manuela Ramos
- Centro de Trabajo con Mujeres Ayacuchanas
- Centro de Investigación, Promoción y Atención de la Madre e Infante
- TADEPA
- CARE
- VECINOS PERU

Site visits in Ayacucho health facilities

- Tertiary care hospital
- Urban health centre
- Urban health centre
- Rural health centre
- Urban secondary school

Interviews in Ayacucho health facilities

- Nurse-midwives
- Clinic directors
- Community and peer health promoters

Information was sought on the following issues:

- What are the priority reproductive health issues faced by women?
- How do the government and key international donors define population policy in Peru?
- What are the formal policies regarding population issues, family planning and contraceptive delivery, STIs and HIV, maternal mortality, cervical cancer and reproductive rights?
- What steps have been taken to develop policies that promote reproductive health and rights in Peru? What is the relationship between demographic goals and contraceptive delivery, including targets, fertility reduction and rhetoric vs. practice?
- What has been accomplished and what have the constraints been?
- What are the main issues concerning health services, including method mix, provider biases, use of integrated and innovative approaches, education and counselling, prevention and treatment, private vs. public sector services?
- What more is needed to improve the promotion of reproductive health and rights in Peru?

Data were processed, categorised and analysed by the author. Hand-written notes of observations and interviews were entered into a computer word-processing programme. Preliminary codes were given to the data at this stage based on the main themes and topics identified in the information. The data were analysed soon thereafter and preliminary codes were revised into first-level codes. Once first-level codes were assigned, the data were retrieved and sorted using the "find" key in the word-processing programme. A separate word-processing file was created for each main topic that emerged from retrieving and sorting the data according to first-level codes. Data in each file were analysed to identify patterns within the particular theme of the first-level codes. Patterns were given second-level codes and sorted using the "find" key in the word-processing programme. A separate word-processing file was created for each pattern that was identified through the second-level codes. Information and interview transcripts from different points in time were compared for continuity and

change. The author presented the data in two internal reports, July 1998 and in July 2001.

During the second phase, since 2001, I have participated on behalf of CHANGE in a coalition of civil society organisations in Peru, *Mesa de Vigilancia de Derechos Sexuales y Reproductivos* (Monitoring Group on Sexual and Reproductive Rights). This entity regularly shares and collectively analyses policy information and events on sexual and reproductive health in order to develop appropriate advocacy responses. Simultaneously, I have documented the alliance between far right actors in Peru and the US, and their assault on reproductive health programmes funded by the US government in Peru, through information obtained from key informants, the web pages of far right organisations and internal, confidential documents.

Key priorities for women's health in Peru

All key stakeholders repeatedly pointed to five priority sexual and reproductive health problems in Peru, backed by quantitative and qualitative data:

- unsafe childbirth and abortion
- unwanted pregnancy
- STIs/HIV
- cervical cancer
- gender-based violence.

The maternal mortality ratio, currently estimated at 185 deaths per 100,000 live births, is very high for the region, according to the Pan American Health Organization. Additionally, the national average masks the reality of far higher numbers of maternal deaths in rural and peri-urban areas, and in certain Andean and Amazonian departments. Unsafe abortion accounts for an estimated 16% of pregnancy-related deaths.⁹ Approximately 66 abortions occur for every 100 live births in Peru, where abortion is illegal and safe abortions rare.¹⁰ At least 30% of all abortions result in complications.¹¹

In Peru, 60% of all pregnancies are unwanted, and an estimated 25% of all sexually active women of reproductive age in Peru are not adequately protected against an unwanted pregnancy.¹¹ Despite consistent increases over the last decade in contraceptive prevalence rates, access to quality information and services varies widely according to socio-economic status, age

group and place of residence.¹² Adolescent girls are particularly vulnerable as they have the least access to contraceptive methods. Although there are insufficient data available to present a complete picture of the magnitude of STIs, including HIV, evidence shows that women are increasingly at risk of infection.¹³ A decade ago, women accounted for one out of 15 people infected with HIV; currently, they make up one in three.¹⁴ Women of reproductive age are most likely to die of cancer, and 48% of these deaths are due to a gynaecological cancer, mainly cervical or breast cancer.¹⁵

Social and cultural discrimination against women increases their risk of sexual and reproductive health problems and hampers their ability to address them. For example, men in Peru frequently exercise control over their female partners' sexuality and fertility, expecting to be provided with sex on demand and opposing their use of contraception or barrier methods for infection prevention.^{16,17} Male control is reinforced through intimate partner violence, which is commonplace. A recent prevalence study of gender-based violence found that half of all women in Lima, and almost two-thirds of all women in Cusco department reported having been physically and/or sexually abused by an intimate partner at least once in their lifetime.¹⁸

Early population policies 1980-92

Peru has a relatively short history of addressing population and reproductive health issues through specific policies and programmes. In 1979, at the end of a decade-long military regime, the new Constitution recognised the right of families and individuals to voluntarily regulate their fertility and proclaimed the state's support for responsible parenthood. The democratically elected governments that followed, led by presidents Fernando Belaunde (1980-85) and Alan Garcia (1985-90), were the first to demonstrate concern for population growth and unwanted fertility. In 1983, the Ministry of Health (MoH) began to offer public family planning services.² Not long thereafter, the government established a legal and policy framework for addressing population issues by passing the National Population Policy Law in 1985¹⁹ and formulating the first National Population Programme in 1987.²⁰

The National Population Policy Law, still in effect, calls for promoting a balanced relationship between population size, structure and distribution, and socio-economic development. Among other things, the law guarantees voluntary, informed choice regarding reproduction and contraceptive use, access to education and health services and protection of individual human rights. The 1987-90 National Population Programme sought to fulfill the law's objectives in practical terms through specific goals and interventions. However, only a few activities were implemented within the MoH's Family Planning Programme. Most of the National Population Programme was not implemented due to insufficient funding and political support, compounded by Peru's economic collapse and ensuing political crisis.^{2,3}

The second National Population Programme 1991-95, was formulated during Alberto Fujimori's first presidential term (1990-95). It sought to reduce the population growth rate (from 2.1% to 2%), the total fertility rate (from 3.5 to 3.3) and maternal and child mortality rates.² It also aimed to foster equitable socio-economic opportunities and cultural norms between women and men. To achieve these goals, the programme proposed the multisectoral co-ordination of eight inter-related strategies: reproductive health and family planning, communication and information dissemination, decentralisation of the population policy, education, production of research and statistics, advancement of women and youth, and environmental protection.² Nonetheless, a series of institutional and political constraints severely limited its implementation.^{1,3} For example, the National Population Council, the agency in charge of implementation, lacked sufficient power to carry out its functions. The public agencies responsible were not interested and were unwilling to co-ordinate efforts due to inter-institutional rivalries.¹

Furthermore, although Fujimori was initially extremely vocal in his support for family planning, he simultaneously faced a pervasive, violent internal conflict, a weak economy and spiralling inflation. To address these, his government desperately needed the backing of the Catholic Church, whose officials have long played a privileged and powerful role in Peru's public affairs and adamantly oppose access to modern contraceptives. Consequently, the

president toned down his promotion of contraception. Moreover, his government adopted a structural adjustment programme recommended by the International Monetary Fund of fiscal austerity and reduced social spending.

During these years, international donor assistance to population, family planning and health was extremely limited. UNFPA was the only foreign donor providing financial and technical assistance to the government. Apart from contraceptive donations to the public sector, the US Agency for International Development (USAID) directed all of its support to non-governmental family planning services. Until the early 1990s, Peru's population policy and public health services were weak and the public family planning programme poorly organised.¹

Progress towards reproductive health and rights: 1993-98

As preparations began for the ICPD, various factors came together to create a favourable policy environment for addressing unwanted pregnancy and related reproductive health concerns, and improving women's rights. First, the 1991-92 Demographic and Health Survey demonstrated a widespread desire among Peruvians to have fewer children and control their fertility, yet large sectors of the population lacked the conditions necessary to fulfill this desire.²⁰ Second, women's rights groups reoriented their advocacy efforts more effectively towards policymakers, to raise awareness of how gender inequalities work against women's reproductive health and proposed appropriate public policies to reduce disparities. Third, the political and economic situation was stabilised, allowing Fujimori's government greater leverage for making policy decisions contrary to the position of the Catholic hierarchy. Finally, foreign donors decided to shift the bulk of their investment towards strengthening government services after a UNFPA evaluation found that the public sector's large stock of contraceptive methods, mainly donated by USAID, were inadequately managed and often remained in MoH warehouses undistributed.

The confluence of these factors led the Peruvian government, in 1994, to sign the ICPD Programme of Action and reinforce its commitment to reproductive health and rights at

the Beijing Conference the following year.* At Beijing and in Peru, Fujimori openly promoted women's universal access to contraceptives. Official government discourse placed this issue within the context of social justice and reproductive rights: poor women deserved the same opportunity as wealthier women to regulate their fertility, and all women had the right to control their bodies and use contraceptives if they wished.²¹

For the first time, the Peruvian government adopted measures to expand reproductive choice and offered free contraceptive services in public health facilities. In September 1995, the Peruvian Congress, controlled by Fujimori's political alliance, legalised sterilisation. Soon thereafter, the MoH drafted its first comprehensive reproductive health programme and the Ministry of Education initiated an innovative sexuality education programme in public schools, in line with ICPD accords. For example, on paper, the reproductive health programme proposed addressing a range of women's health priorities by improving quality of care and increasing access to services.²²

"The programme's strengths include that reproductive health is conceptualised as a woman's right and abortion is considered a public health problem." (Programme manager, women's rights NGO, Lima, 1998)

In addition, government officials sought out the expertise and involvement of civil society groups and women's health advocates. For example, two women's rights groups, *Red Nacional de Promoción de la Mujer* and *Movimiento El Pozo*, were among the diverse institutions that validated the new teachers' guides for sexuality

*The official Peruvian delegation expressed two main reservations with regard to the Platform of Action at Beijing: abortion could not be included as a contraceptive method and sexual rights could only refer to heterosexual relations. Peru has also ratified international treaties for women's human rights, including the Convention for the Elimination of all Forms of Discrimination against Women (CEDAW, 1982), the Universal Declaration on of Human Rights (1993), the Inter-American Convention to Prevent, Sanction and Eradicate Violence against Women (1996) and the CEDAW Facultative Protocol (2001).

education.²³ Three women's rights organisations, *Movimiento Manuela Ramos*, *Centro de la Mujer Peruana Flora Tristán* and *CESIP*, worked with the social marketing agency, *APROPO*, to train schoolteachers in using the new guides.²⁴ Women's groups, including *Manuela Ramos*, *Flora Tristán* and *Consortio Mujer*, participated in the Working Group on Gynaecological Cancer that later devised the first national plan to address this issue.^{3,15}

Government measures also emphasised equal opportunities for women and men. In each branch of government, a public agency was set up to advance gender equity – a Ministry for the Promotion of Women and Human Development (PROMUDEH), a Congressional Committee on Women and a Public Ombudsman on Women's Rights. In addition, laws advancing gender equity were passed, including one that recognised domestic violence as a crime (1997) and another that allowed pregnant adolescents to finish secondary school (1998).^{25,26} Finally, at the initiative of women's rights groups, a Tri-Party Commission was formed in 1997 to monitor the implementation of the ICPD PoA, which included representation from government institutions, donor agencies, NGOs and universities:

“Its main achievements include prioritising what areas of the ICPD PoA to monitor (all related to reproductive health), creating a database of what activities each member institution is carrying out to address the priorities, and developing a system of indicators to monitor improvements in these areas.” (Programme officer, donor agency, Lima, 2000)

Foreign donors also stepped up their support. Between 1994 and 1998, USAID provided US\$85 million in population funding alone, three-quarters of all foreign assistance to Peru for such activities.²⁷ During this same period, UNFPA gave almost US\$14 million and the UK Department for International Development (DFID) contributed US\$7 million. Although their assistance remained centred on family planning, donors initiated the arduous task of redefining their own policies, moving towards a more comprehensive and user-centred approach to reproductive health. Prior to the ICPD, their programmes had sought mainly to achieve demographic objectives, without taking into consider-

ation local context or needs. The assumption was that as long as contraceptive methods are offered, women will automatically request and use them, which ignored the broader conditions that place women at a disadvantage for enjoying their sexuality and controlling their fertility.

Donor objectives in Peru shifted to focus on preventing unwanted pregnancies, improving women's health and protecting individual rights.²⁷⁻³³ In addition, they addressed other critical needs. For example, USAID funded the MoH to strengthen the STD/AIDS Control Programme, develop services tailored to adolescent needs, and lead a multisectoral working group to design the first National Prevention Plan on Gynaecological Cancer.²⁸⁻³⁰ DFID funded the expansion of post-abortion care to 43 hospitals and medium-sized facilities nationwide.³¹ Finally, donors directed funding for improvements to the broader social conditions to enable women to exercise reproductive choice. For example, UNFPA led efforts to develop a multisectoral population policy that would contribute to reducing poverty, social discrimination and gender inequities.^{32,33} Donors also worked to foster civil society participation in policy by channelling assistance to national women's groups, such as *Manuela Ramos*, *Flora Tristán*, and *Red Nacional*, to conduct advocacy campaigns and promote government accountability.

Re-emergence of a demographic approach: 1996-97

Despite these advances, in 1996 the government failed to approve an official National Population Policy, but it did return to a demographic focus early that year without making this information public. The policy shift emerged as a response to mounting international and domestic pressure to address deepening socio-economic disparities. Despite macro-level economic growth, market-oriented economic policies implemented during Fujimori's first term did not yield a decline in poverty or an increase in employment.³ The Fujimori government then made contraceptive services the core component of its mass poverty relief programme.^{3,34}

“The fertility rate among poor women is 6.9 children – they are poor and are producing more poor people. The president is aware that the

government cannot fight poverty without reducing poor people's fertility. Thus, demographic goals are a combination of the population's right to access family planning and the government's anti-poverty strategy." (Programme manager, MoH, Lima 1998)

The demographic rationale was that with fewer dependants the economic status of the poor would improve. The policy was to increase the use of modern contraceptives, especially sterilisation, largely among poor, disenfranchised women with little or no formal education.^{6,7} To achieve this goal, the government family planning programme focused on scaling up sterilisation services in an effort to meet a presumed large, latent demand. Previously, women could obtain sterilisation only if they had a health risk, four or more children, or were above a certain age, and they needed spousal permission.³⁵ According to the MoH, the total number of sterilisations performed annually within its facilities rose from less than 15,000 prior to 1995 to 67,000 procedures in 1996 and approximately 115,000 in 1997.* However, interviews with donor representatives revealed that the MoH did not have enough adequately trained medical personnel or appropriate equipment to make good quality sterilisation services that widely available in such a short period of time. Health care workers did not have the necessary counselling skills and were unable to provide quality information prior to procedures. As a main strategy, sterilisation campaigns were carried out in which surgical teams were dispatched for one day at a time to perform procedures in rural and isolated areas.^{6,7} This practice jeopardised service quality as well as follow-up care.

Public officials privately determined annual numeric goals and corresponding targets for programme personnel.^{6,7,36} To fulfil obligatory targets, many local and regional health facilities undertook measures that did not comply with obtaining informed consent. For example, temporary methods such as injectable and oral

*The 1996 DHS found that 5.9% of all women of reproductive age currently used sterilisation as a contraceptive method (9.5% of married women). The 2000 DHS found that 7.5% of all women of reproductive age currently used sterilisation, and 12.3% of all married women.²

contraceptives were intentionally withheld to promote sterilisation. Blatant deception, economic incentives and threats were also used.^{6,7}

"We were required to perform a certain number of sterilisations each month. This was obligatory and if we did not comply, we were fired. Many providers did not inform women that they were going to be sterilised - they told them the procedure was something else. But I felt this was wrong. I preferred to offer women a bag of rice to convince them to accept the procedure and explained to them beforehand what was going to happen." (Physician, former MoH service provider, Ayacucho Department)

"Both the public sector and civil society recognise the demand for family planning services. The government responded to this by massively extending services. But in the process, these services used coercion and abuse, violating individual rights. Sterilisation should be available, but not be prioritised. Sterilisation was prioritised by the government for economic reasons rather than to meet a demand for the service." (Programme manager, women's rights NGO, Lima, 1998)

"The government argued that programmatic goals were necessary for projecting and estimating how much stock and supplies were going to be needed. There are valid numeric goals for reproductive health, such as reducing the maternal mortality rate, reducing the prevalence of STIs and increasing the number of people who are adequately informed. But achieving a certain number of sterilisations is not a valid goal." (Programme manager, women's rights NGO, Lima, 1998)

These practices contradicted Peru's constitutional and legal protections, producing discrepancies between policies and their application. Moreover, the MoH did not (and still does not) have any institutional mechanism to provide redress to anyone mistreated by the public health system or to sanction clinic managers and providers who commit abuses. Although the Public Ombudsman on Women's Rights is charged with investigating human rights violations committed by public institutions against women, it was in the process of establishing itself and its role while these abuses were taking place. In addition, while it can make recommendations,

it has no authority to ensure the recommendations are adopted or to take action against rights violations.

As the government's demographic focus was incompatible with the current objectives of international donors in Peru, the donors pressured the Peruvian government behind closed doors to change its strategy. Some donors, including USAID, refused to support any activities related to sterilisation, while continuing to fund other aspects of the family planning programme. Other donors continued funding the family planning programme because:

"It is not a justifiable option to work apart from the MoH because it has a large network of facilities and good people working for it. There are a lot of problems, but our role is to help the MoH do what it is intended to do." (Programme officer, Donor agency, Lima, 1998)

Civil society organisations also became concerned when they learned about the problems with sterilisation, but obtaining concrete evidence to formulate a critique of government practices was blocked by the covert nature of the policy and the sharp contrast with the public discourse. Early critiques centred on the numeric goals being so high that they were bound to lead to abuses.³⁴ Next, women's organisations, specifically the *Centro de la Mujer Peruana Flora Tristán* and the *Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer* (CLADEM), gathered evidence from women on the use of coercion and other abuses in sterilisation services.^{6,37} They sent their findings and concerns to the Public Ombudsman on Women's Rights, which began to receive and investigate alleged complaints of abuses in mid-1997. The breaking point occurred in December 1997 when one of Peru's major daily newspapers, *La República*, reported their own investigative findings on the government's policy.³⁸

Re-endorsement of reproductive health and rights: 1998-2001

In early 1998, a heated debate erupted when the general public learned of the full extent of the Fujimori government's demographic policy, the systematic violations of informed consent and poor quality of care in sterilisation services.

Women's groups opposed the policy while advocating for the protection of individual rights to reproductive health information and services.³⁹ In January, the Public Ombudsman released a report of its investigation into alleged cases of rights violations and recommended a series of reforms to the family planning programme.⁷ Civil society organisations, medical and professional associations and foreign donors backed the report's findings and pressured the Peruvian government to adopt the reforms. In March 1998, the MoH agreed to reform sterilisation services* and make changes to the broader family planning programme. Most importantly, it eliminated numeric goals for contraceptive use, which led to discontinuation of sterilisation targets. Based on ongoing monitoring the Public Ombudsman said the blatant violations that occurred in 1996-97 were largely halted after the policy shift in 1998.^{40†}

All stakeholders interviewed explained that the remaining problems in contraceptive delivery centred on subtler forms of violation of informed choice. Counselling and information provision were weak or absent from contraceptive services.⁴¹ As part of the reforms, the family planning programme developed and published a manual on counselling methodology and increased training, particularly of nurse-midwives, who deliver approximately 70% of contraceptive services. UNFPA, USAID and DFID gave full technical and financial support to these reforms. In 1999, after a thorough review by women's health advocates, professional associations and donor agencies,⁴² the MoH approved new national guidelines for delivering family planning services, which were distributed to health facilities throughout the country and providers.⁴³

*Reforms included new counselling guidelines and consent form, two counselling sessions for candidates, a 72-hour waiting period between the second counselling session and sterilisation, 24-hour hospitalisation after surgery for those with difficult access to services and certification of qualified health facilities and physicians.

†Between 1998 and 1999, the Ombudsman investigated 157 cases of violations of informed choice and quality of care standards in MoH family planning services: 9 occurred before 1995, 112 between 1996 and 1997, 29 in 1998, and 1 in 1999.⁴⁰

PROMUDEH sought feedback from women's rights organisations, donor agencies and professional associations on its draft National Population Plan for 1998–2002. With these suggestions incorporated, the policy reflected key elements of the ICPD Programme of Action.⁴⁴ For example, in the earlier draft, the fertility-related goal had a demographic target of 2.5 births per woman, whereas in the final version, the goal was to reach a "total fertility rate compatible with individual reproductive intentions". The policy asserted that "reproductive health programmes should provide the widest array of services possible, without any type of coercion". In addition, the policy had a multi-sectoral approach, touching on population and poverty, gender inequity, sexual and reproductive health and education, environment and development and youth and adolescent needs.

Efforts to advance reproductive health and rights in Peru moved slowly due to several

obstacles, including the rise of the far right as a political force in Peru. When the problems in sterilisation services came to light in 1998, Catholic Church officials, leaders of rightwing lay Catholic groups and ultra-conservative policymakers used the evidence of abuses to advance their own agenda, calling for an immediate end to government-sponsored family planning services. They also targeted international donor agencies, particularly USAID, by working in concert with US anti-choice counterparts in the US Congress. For example, current Peruvian congressman Héctor Chávez Chuchón began to collaborate with the US organisation, Population Research Institute (PRI), in its effort to discredit US bilateral assistance for reproductive health in Peru. PRI claimed that USAID had funded the abuses, and a congressional investigation was ordered on USAID involvement in Peru's sterilisation abuses, which threatened to cut off US assistance to them.*

USAID subsequently demonstrated that its funding in Peru was not supporting these abuses. Nonetheless, over the next few years, these same far right actors sought to discredit and harass USAID's reproductive health programmes in Peru based on sterilisation abuses.⁴⁵ Moreover, the far right in both countries continued to gain ground and soon dominated both governments. Then, renewed political upheaval arose over the government's involvement in widespread corruption, election fraud and human rights abuses in mid-2000. Fujimori fled the country and his ruling political party disbanded. Notwithstanding, the transitional government that took office for nine months worked to promote human rights, including women's rights, and the MoH leadership supported reproductive health services already in place.

Development of a far right policy approach: 2001–03

Between 2001 and 2003, progress in promoting reproductive health and rights in Peru was

*The chief counsel of the Subcommittee on International Operations and Human Rights of the House International Relations Committee sent staff members to Peru to investigate the allegations and called on women who had registered complaints and representatives from the MoH and USAID/Peru to testify before the Subcommittee.



BRUCE GILDEN / MAGNUM PHOTOS

Protestors demand justice outside the Presidential Palace, Lima, Peru, 2000

overshadowed when newly-elected President Alejandro Toledo assumed office and appointed several ultra-conservatives to top government posts. For example, although the first Health Minister, Dr Luis Solari, only served in this position for six months, he filled key posts in the Ministry with opponents of reproductive choice, and left his colleague Dr Fernando Carbone at the helm of the MoH. Solari and Carbone both worked in concert with sympathetic legislators and with far right actors in the US such as Congressmen Chris Smith and Henry Hyde and US anti-choice groups, such as PRI and Human Life International.

The far right approach was not specific to Peru but part of a global fundamentalist movement of extremist groups from different religions, including Catholic, evangelical Christian and Muslim. According to a recent analysis of this period, the far right in Peru sought to apply strict interpretations of religious doctrine to broad-based public policies, with little regard for scientific or evidence-based interventions and no respect for individual choice. For example, all sexual relations – other than those between married heterosexual couples for the purpose of procreation – were characterised as immoral and sinful. Policy proposals stressed abstinence as the exclusive means to prevent STI/HIV transmission and natural methods for family planning. The far right position also held that an ideal family model, in which women's only role is motherhood, must be preserved at all costs.⁸ Rather than promote gender equality and women's rights, policy proposals sought to reinforce women's subordination.

The three ministries responsible for social policy, MoH, MoEd and PROMUDEH (now MIMDES), removed all objectives and strategies designed to advance gender equity and sexual and reproductive health from existing and new policy documents. For example, the MoH's Health Policy Guidelines for 2002-12 contain no reference to gender inequity. Moreover, the Ministry of Education stopped providing sexual education and the MoH refused to make public any information on the family planning and gynaecological cancer programmes. The MoH eliminated its STI/AIDs control programme and put HIV prevention in a "Risk Reduction" programme that included malaria, dengue and other diseases.

Health Ministers Solari and Carbone worked to impede access to services and information on modern contraceptives, the use of condoms to protect against STIs and HIV, and to treat complications from unsafe abortion. Specific steps included directives discrediting critical reproductive technologies, spreading dis-information in the mass media, and blocking the distribution of needed supplies. For example, in early 2002, Carbone attempted to remove the IUD from the MoH protocol for contraceptive services on the basis that it was an abortifacient, while at the same time touting the effectiveness of the Billings method.⁴⁶ He also deterred the use of manual vacuum aspiration for post-abortion care, despite it being the safest available method for treating incomplete abortion and miscarriage.^{46,47} In late 2002, health officials launched a dis-information campaign on condoms, characterising them as totally ineffective in preventing STIs and HIV because they contain spermicides. Around this same time, the monitoring efforts carried out by the Public Ombudsman's office uncovered evidence of barriers imposed by health services to prevent women from obtaining contraceptive methods.⁴⁸ Evidence from two recent studies confirm the negative impact of these policies, including decreases in access to and use of modern contraceptives and increased reliance on "natural" methods and unsafe abortion.^{10,49}

International donors have effectively been prevented from supporting reproductive health and rights in Peru since 2001. This has been compounded by the fact that both USAID and UNFPA have been under siege by reproductive rights opponents in the US Congress. The Bush Administration itself has been working actively to undermine reproductive health programmes such as Peru's globally,⁵⁰ and US foreign policy for Peru has changed from prioritising democracy and human rights to the war on drugs. Pursuing this goal has required Peru's full cooperation with the US State Department to design and implement an aggressive counter-narcotics strategy with little local input.⁵¹ USAID has also reshaped its entire development portfolio in seven coca-growing states.⁵² Confidential sources report that US officials in Peru have expressed willingness to sacrifice reproductive health assistance to appease the right and maintain good relations with the Toledo government.

In fact, USAID/Peru has limited its support for interventions to address unwanted pregnancy and unsafe abortion. Emergency contraception is a clear example. In 1992, emergency contraception was approved in Peru, though not distributed.* However, after USAID/Peru was first attacked by the far right in early 1998, officials responded by pressuring the MoH to remove emergency contraception from the approved list. In 2001, when the transitional government was in office, civil society organisations convinced health officials to reincorporate emergency contraception, for which USAID provided technical assistance.⁵³

However, USAID's support for emergency contraception was short-lived.⁵⁴ Under Toledo, health ministers Solari and Carbone refused to make it available in public health clinics, claiming it was abortifacient. This not only blocked USAID/Peru's support for public provision but also had a chilling effect on their support to the NGO and private sectors to integrate emergency contraception into their programmes. USAID/Peru has also refused to lend seed money needed to market Postinor-2, an emergency contraceptive product distributed by the social marketing organisation, *Apprende*, since 2002. US anti-choice pressure also remains high. In 2002, on a visit to Peru, US Congressman Chris Smith threatened USAID officials, "You better not be funding emergency contraception here."⁵⁴ Finally, political appointees at USAID in Washington have withdrawn institutional backing for emergency contraception, even if technical staff continue to favour the method. So although it remains an approved method in Peru and in the US, USAID/Peru will not support it.

Current context

During his first two years in office, President Toledo avoided publicly declaring his government's position on reproductive health and rights. In July 2003, after consistent pressure from women's groups, reproductive health and

*The following methods are also approved: IUD, male condom, oral contraceptives, injectables, Norplant, male and female sterilisation, vaginal suppositories, and rhythm/calendar and Billings methods. The diaphragm and the female condom have still not been incorporated into the method mix.

HIV/AIDS organisations and progressive medical associations, Toledo publicly resolved to back family planning policies according to the World Health Organization guidelines. He also replaced ultra-conservative cabinet members, including Health Minister Carbone, with professionals who endorse evidenced-based policies regarding reproductive health and rights.

Not surprisingly, far right leaders, particularly in the congress, continue to put intense pressure on the MoH to limit access to reproductive health services and technologies. Ultra-conservatives joined forces to have Chávez Chuchón appointed to the chair of the Congressional Health Committee for 2003-04. However, the current health minister, Dr Pilar Mazzetti, a neurologist appointed to the post in February 2004, is standing firm to reverse the far right policies in the MoH, taking concrete steps to improve sexual and reproductive health services, information and education and engage with civil society. For example, in July 2004, the MoH launched a new "Programme of Integrated Care in Sexual and Reproductive Health" and approved new national guidelines for services.⁵⁵ In addition, Dr Mazzetti responded resolutely to the dis-information campaign launched by the far right against emergency contraception, based on the scientific evidence that the method is not an abortifacient, and announced that it will at last be distributed in MoH services.⁵⁵ Finally, Dr Mazzetti met with 15 organisations from the *Mesa de Vigilancia en Derechos Sexuales y Reproductivos*, to discuss ways in which this civil society coalition can help promote sustainable public policies in sexual and reproductive health.

Conclusion

In spite of their contradictory nature, the demographic and far right policy approaches share an important characteristic: they are clearly not compatible with gender equality or reproductive rights and hinder progress towards achieving these goals in concrete ways. Under the demographic approach, many health care providers throughout Peru were pressured to perform sterilisations under inadequate conditions and without complying with standards of informed consent, or lose their posts. Meanwhile, under the far right approach, health

care providers were discouraged from delivering modern contraceptives, condoms and post-abortion care. These policy approaches are the greatest obstacles to making real and long-lasting improvements to sexual and reproductive health and rights.

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Résumé

Cet article examine la politique démographique du Pérou depuis la Conférence internationale de 1994 sur la population et le développement et évalue dans quelle mesure ses politiques et programmes ont influencé la santé et les droits génésiques. Il s'inspire de données recueillies lors du suivi des politiques et programmes de santé génésique au Pérou mené depuis 1998 pour le Centre for Health and Gender Equity (CHANGE). Les progrès enregistrés depuis 1994 prouvent la volonté du Gouvernement péruvien et des donateurs étrangers d'avancer vers les objectifs de la Conférence en s'attaquant aux principales préoccupations en matière de santé génésique et en protégeant les droits des femmes. Malheureusement, ces progrès n'ont pas été réguliers et ont été éclipsés par deux périodes de politiques et d'interventions opposées à l'avortement. La première, en 1996-1997, sous le gouvernement de Fujimori, était une approche démographique qui utilisait des objectifs numériques et faisait pression sur les femmes pour leur faire accepter la stérilisation comme principale stratégie gouvernementale de réduction de la pauvreté, ce qui a conduit à des violations avérées. La deuxième, en 2001-2003, sous le gouvernement Toledo, était une approche d'extrême droite qui souhaitait limiter l'accès aux services essentiels, notamment la contraception d'urgence, les préservatifs et les soins après avortement. Malgré leur nature contradictoire, ces deux approches ont constitué les principaux obstacles à des améliorations durables de la santé et des droits génésiques au Pérou.

Resumen

En este artículo se revisa la política de población del Perú desde la Conferencia Internacional sobre la Población y el Desarrollo, celebrada en 1994, y se evalúa hasta qué punto sus políticas y programas han afectado la salud y los derechos reproductivos. Se basa en los datos recolectados mediante un monitoreo continuo de las políticas y los programas de salud sexual y reproductiva en Perú, el cual se inició en 1998 para el Centro para la Salud y la Equidad de Género (CHANGE). Los logros alcanzados en Perú a partir de 1994 demuestran la buena voluntad del gobierno y los donantes extranjeros de hacer avances hacia el cumplimiento de la agenda de la CIPD abordando los aspectos clave respecto a la salud reproductiva y promoviendo los derechos de las mujeres. Desgraciadamente, los avances no han sido constantes. Se han visto eclipsados por dos períodos de políticas e intervenciones en contra del derecho a decidir libremente. El primero, durante 1996-97 bajo el gobierno de Fujimori, fue un enfoque demográfico que utilizó metas numéricas y ejerció presión indebida sobre las mujeres para que aceptaran la esterilización como la principal estrategia del gobierno para disminuir la pobreza, lo cual propició abusos que han sido documentados. El segundo, en el período 2001-03 bajo el gobierno de Toledo, fue un enfoque de extrema derecha que se propuso limitar el acceso a los servicios esenciales, incluida la anticoncepción de emergencia, el condón y la atención postaborto. A pesar de su naturaleza contradictoria, estas dos políticas han sido los mayores obstáculos al logro de avances duraderos en el campo de la salud y los derechos reproductivos en Perú.