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Struggle and Resistance: Using International Bodies to Advance Sexual and Reproductive Rights in Peru

Camila Gianella† and Alicia Ely Yamin††

ABSTRACT

Peru is often highlighted as an example of the internationalization of sexual and reproductive health and rights (SRHR) norms, through supra-national litigation. Yet, the impact to petitioners and other similarly situated women in Peruvian society has fallen far short of expectations. This Article argues that the reasons underlying the need to use international SRHR litigation in the first place are indeed the same as those that give rise to poor implementation. Through an analysis of four cases—two that relate to indigenous women’s rights to be protected from abuses of SRHR and two that relate to women’s rights to access abortion under circumstances when it is legal—this Article traces the drivers, origins, and effects of these cases, on both litigants and broader population groups and institutions. In particular, we analyze the impact and limitations of these cases on SRHR norms in Peru.

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INTRODUCTION

This Article explores an apparent paradox. On one hand, Peru often serves as the pre-eminent example of the internationalization of sexual and reproductive health and rights (SRHR) norms, through the use of supra-national litigation. On the other hand, the material impact on petitioners and other similarly situated women in Peruvian society has been far less than what might have been anticipated. We argue here that this “paradox” between the successful use of supra-national litigation and limited results for Peruvian women is understandable and even predictable given the legal and political reasons underlying the need to use international SRHR litigation in the first place. By analyzing four cases—two that relate to indigenous women’s rights to be protected from abuses of SRHR, including involuntary sterilization, and two that relate to women’s rights to access abortion under circumstances when it is legal—we set out a narrative of the drivers and origins of these cases in Peru in the 1990s and 2000s, and their effects on both litigants and broader population groups and institutions.

In Part I, we present a brief overview of the socio-political and institutional context for the litigation, noting in particular the extreme social and economic fragmentation, exclusion of indigenous groups, and the extraordinary role of the Catholic Church. Peru is a middle-income country with extreme income inequality and social fragmentation. In the 1990s, the health system reflected (and continues to reflect) the fragmentation of society along economic and social lines,

as well as the exclusion of indigenous groups. As in many other countries, the health system has been largely insulated from political accountability. In addition to this lack of accountability, the overwhelming control that religious groups, especially the Catholic and Evangelical Churches, hold over the legislative and executive branches of government has blocked the advancement of SRHR reforms. Peru faced extreme levels of civil and political rights violations arising out of internal conflict during the 1980s and 1990s. Peru does not have the same sort of robust constitutional protections for Economic, Social, and Cultural (ESC) rights, nor has it incorporated international human rights law in versions of its constitution through “constitutional blocs” as have Colombia and Argentina, for example. Moreover, it still retains a reasonably formalistic judiciary. These factors have limited attempts to secure affirmative dimensions of ESC rights, including health rights, through national courts. Because of these blocked political opportunity structures, the presence of legally-trained human rights advocates in Peru, and presence of transnational networks of SRHR activists who wanted to use the supra-national bodies, women’s rights groups began taking cases to the Inter-American (I-A) System and to treaty-monitoring bodies in the 1990s.

In the remainder of the Article, Parts II-IV, we describe the opportunistic use of international tribunals by activists. These activists sought to set substantive standards for SRHR, set due process standards, and bring material relief to victims of violations. Peru has the largest number of cases (thirty-eight) in Latin America with a final judgment or decision delivered by the Inter-American Court of Human Rights (I-A Court).

Peru is also the only country to have had compliance orders issued by the I-A Court to follow up on implementation because of resistance to compliance at the national level. Women’s rights advocates also adopted these strategies to advance SRHR in the wake of visionary conferences at the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (Beijing), which set out new paradigms of development and population policy that focused on women’s rights and life decisions even though the declarations were not binding. In Peru, as elsewhere, advocates used domestic law to “vernacularize”—appropriate, adopt, and adapt—global conceptions of women’s rights to the Peruvian context.

In Part II, we analyze two cases brought to the I-A System. The first case, which involved involuntary sterilizations, included a broad array of groups, other mobilizations, and legal reform efforts. This case was also an important factor in changing foreign aid policy to Peru and beyond. The second case, addressing

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5. See Luisa Blanchfield, *Abortion and Family Planning-Related Provisions in U.S. Foreign*
sexual assault in a medical facility by a doctor, served as a test case for women’s groups to bring cases to international mechanisms. The combination of the subject matter of both cases, the narratives around abuses of women as sexual victims, and the particularly broad coalition of traditional human rights and women’s rights advocacy groups working on them made using the I-A System possible.

In Part III, we describe two abortion cases—K.L. v. Peru and L.C. v. Peru—which were deliberately not brought to the I-A system, as it was known to be markedly more conservative than other international bodies on sexuality and reproduction. Local women’s rights groups and the Center for Reproductive Law and Policy (CRLP), later known as the Center for Reproductive Rights (CRR), brought these cases to the UN Human Rights Committee (HRC) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), respectively. Compared with the sexual violence and forced sterilization cases, these cases involved a very different configuration of actors and different strategic decisions in selecting venues for advancing norms related to abortion. The abortion cases defined new normative understandings regarding SRHR. Rather than merely proving empirical facts and discussing the existence of a policy regarding sterilization, these cases focused on what was necessary for women to enjoy equal access to essential health care. Further, these women’s rights organizations deliberately chose to set standards through the UN treaty-monitoring bodies, rather than in the I-A System. Using these two cases, we review the relationship between international and local NGOs, as well as the innovative standards that were created.

Table 1: Cases Discussed

<table>
<thead>
<tr>
<th>Case</th>
<th>Body/ Mechanism</th>
<th>Petitioners</th>
<th>Topic</th>
<th>Submitted</th>
<th>Decision</th>
</tr>
</thead>
</table>


### Implementation

Implementation of the two sets of cases has also fared differently, as described in Parts II and III. The first two cases, which were both “friendly settlement” procedures, were accompanied by major law reform efforts and changes in foreign aid policy to Peru. Yet, the government’s compensation of victims reproduced many of the preconceived assumptions about indigenous women and their rights, which had underpinned the initial violations. The abortion cases, on the other hand, were met with frontal resistance by political organs of the government and spokespersons regarding religious and moral values as matters of rights, and boundaries of sovereignty between national and international domains. Only in the last few years has the government adopted therapeutic abortion protocols to implement CEDAW’s ruling in the case of L.C. It is unclear to what extent the protocols will be implemented in practice, and recent litigation threatens their very existence.7

In Part IV, we assess the overall impacts that these cases have had, directly and indirectly, in Peru and beyond. While domestic follow-up and implementation have been lacking, these cases have inspired further litigation of similar abuses of SRHR in Peru and other countries around the world. Based on a review of the literature and weeks of in-depth interviews with stakeholders in government, Congress, civil society, the health system, UN agencies, and with victims, we conclude that while the establishment of norms through these cases has had a critical impact on international law, they haven’t led to structural changes in

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7. In 2017, the NGO Ala Sin Componeda, the same organization that filed and won the case banning the free distribution of the emergency contraceptive pills, filed suit in the First Constitutional Court of Lima (Primer Juzgado Constitucional de Lima) asking for the abolition of the protocol, alleging the protocol was unconstitutional. ONG cristiana demanda al Ministerio de Salud para que retire la circulación de guía abortiva, La Resistencia (last visited 19 Apr. 2018), https://perma.cc/X6YD-MRUK; see also Ala Sin Componenda demandó al Minsa para dejar sin efecto la guía del aborto terapéutico, Pastores y Lideres (last visited 19 Apr. 2018), https://perma.cc/C6JV-Y9TF.
Peruvian institutions. This lack of structural change has meant that neither the victims of violations, nor similarly situated persons within Peru, have seen significant benefits.

In sum, this Article theorizes that the same forces that drove the demand for supra-national litigation in the abuse cases and the abortion cases also present substantial obstacles in the implementation of such judgments or friendly settlement agreements through national policy and programming. Further, the weak capacity of international bodies to follow up on structural recommendations is an impediment to obtaining more than formalistic compliance when issues of sexual and reproductive health and rights imply such profound challenges to institutional structures and social norms.

I. SOCIO-POLITICAL AND INSTITUTIONAL CONTEXT

A. General Social and Economic Context

Five aspects of the Peruvian context are especially important to understand the cases and implementation of the cases in the later Parts of this Article: (1) the internal violent conflict; (2) Fujimori’s autocratic rule and use of executive decrees; (3) Fujimori’s resistance to international critique; (4) the deep fragmentation of Peru during the 1990s along ethnic, social, and class lines; and (5) the religious conservatism that shaped (and continues to shape) politics.

During the 1990s Peru was governed by a democratically-elected but autocratic leader, Alberto Fujimori, who was subsequently charged with both corruption and crimes against humanity. Shortly after taking office, Fujimori instituted “Fuji shock,” a package of dramatic fiscal and monetary policies aimed at jump-starting economic growth. In April 1992, Fujimori dissolved Congress, the Court of Constitutional Guarantees, and the National Council of the Judiciary, arguing that these institutions blocked his attempts at controlling terrorist groups in Peru.

Although the country’s economic growth was lauded by international institutions during the decade, it did not benefit everyone. Wealth disparities among regions, as well as those based on gender and ethnicity, actually increased. Overall, poverty remained stagnant in rural areas. Indigenous people,

who disproportionately lived (and continue to live) in such areas and earned livelihoods from subsistence farming, remained at the bottom of the socio-economic ladder (see Table 2 below). By 1994, “59 [percent] of the national population was living in poverty; poverty among women was even higher.”

<table>
<thead>
<tr>
<th>Year</th>
<th>Classification</th>
<th>Total Population (%)</th>
<th>Indigenous (defined by mother tongue) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>Poverty</td>
<td>45.2</td>
<td>62.3</td>
</tr>
<tr>
<td></td>
<td>Extreme Poverty</td>
<td>14.7</td>
<td>28.6</td>
</tr>
<tr>
<td>1997</td>
<td>Poverty</td>
<td>41.8</td>
<td>61.4</td>
</tr>
<tr>
<td></td>
<td>Extreme Poverty</td>
<td>11.4</td>
<td>24.7</td>
</tr>
<tr>
<td>2000</td>
<td>Poverty</td>
<td>46.5</td>
<td>62.8</td>
</tr>
<tr>
<td></td>
<td>Extreme Poverty</td>
<td>11.7</td>
<td>22.2</td>
</tr>
</tbody>
</table>

The particular social vulnerability of indigenous women must be understood within the context of historic and intersectional discrimination, based on gender and ethnicity together with the implementation of structural adjustments policies during the 1990s. Three factors in particular shaped the social vulnerability of indigenous women during this time period. First, the combination of rising prices and cuts in public expenditures had a severely negative impact on population groups that were more dependent on public services to cover basic needs. Second, internal armed conflict (1980-2000) disproportionately affected rural and indigenous populations: 75 percent of victims were campesinos (rural small landowners). Overall, more men died during the internal armed conflict, which led to an increase in female-headed households. Third, and relatedly, the internal armed conflict also destroyed the livelihood of many campesinos and forced the displacement of people from rural areas to the cities, where they faced major

14. Trivelli, see note 12, at 119-220.
challenges in adapting to their new environment. Displacement and loss of livelihoods further impacted their economic prospects and made them more reliant on government support programs, including health.

Two core features of Fujimori’s regime are relevant to understanding the cases analyzed in this Article. The first is the administration’s systematic use of state violence to control political adversaries. This was justified as an internal security measure to quell members of Shining Path (Sendero Luminoso), a Maoist organization committed to bringing down Peru’s government through violence. The second is Fujimori’s use of executive decrees to produce institutional reforms while circumventing democratic processes in every domain, from health sector reforms to efforts to block attempts to seek justice for crimes perpetrated by state agents. Both features engendered a closing of potential spaces and opportunities for political, legal, and social reforms at the domestic level.

A third relevant factor in understanding the response to and implementation of supra-national decisions is the open resistance to any foreign critique of the government’s human rights abuses that characterized Fujimori’s government, including observations by the I-A Commission and the I-A System. Indeed, Fujimori actually attempted to withdraw Peru from the jurisdiction of the Inter-American Court in 1998, signaling his disdain for the interference of the Court in internal matters.

B. Health System Reform

In understanding the context for the specific cases brought on SRHR in Peru, it is important not just to grasp the social and economic context generally, but also the health system in which the abuses actually took place. The intersectional discrimination and inequities in Peruvian society were both reflected and exacerbated by the health system, and as a result, poor women and children experienced exclusion, marginalization, and abuse.

As part of a broader structural adjustment policy at the beginning of the

1990s, the Fujimori regime initiated significant health system reform.24 One of the main characteristics of the health sector reform was its “targeting” approach, which reflected one of the World Bank’s recommendations of focusing on those identified as the neediest rather than resources for universal programs.25 The government programs were designed in keeping with World Bank and Inter-American Development Bank guidance, among other things, to advance its poverty alleviation and economic growth agenda.26

Family planning was a core part of the basket of services provided to poor populations, through programs such as “Basic Health for All” (Salud Básica Para Todos).27 This program targeted the population living under the poverty line, and offered a package of services prioritized by the government including vaccines for infants, ante-natal checkups, family planning, and growth monitoring for children.28 Access to more complex care for the overwhelming majority of the Peruvian poor depended on the ability to pay out-of-pocket expenses. This approach also established health care coverage as the main indicator of the health care system’s performance and success, neglecting supervision, quality, and other key components of health services. Few efforts were allocated to systematically assess the quality of care the National Family Planning Program, as it lacked even a monitoring system that was capable of providing reliable assessments on quality of care.29

The health system reforms implemented under Fujimori’s regime were situated within a broader neoliberal policy of shrinking government programs. Cost effectiveness, which was narrowly defined with respect to interventions in the abstract, was heavily prioritized.30 Thus basic health care programs were

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28. See Ewig, Neoliberalismo de la segunda ola, see note 23, at 188.

29. See Federico León, Peru: Providers’ Compliance with Quality of Care Norms (FRONTIERS in Reproductive Health, Population Council, 1999) (providing one example of a study that examined the extent to which health providers complied with quality of care standards as part of Peru’s National Family Planning Program).

30. See Ewig, “Health Sector Reform in Peru,” see note 24, at 80; Ewig, Neoliberalismo de la
funded vertically (program by program), which did little to advance the broader
goal of improving and strengthening the health system as a whole. In fact,
despite the government’s commitment to vertical, stand-alone family planning
policies, Perú’s overall public expenditure in health remained one of the lowest in
the region.

These health sector reforms during the 1990s were largely executed through
executive decrees. Perú’s health system was historically fragmented between a
public system for the poor, a second system for workers employed in the formal
sector, and a third system for members of the military and certain special
populations. At the same time, the government decentralized the health system
in keeping with World Bank prescriptions, and Inter-American Development
Bank and World Bank projects were instituted to support health reform by the
government (Programa de Apoyo a la Reforma en Salud or PAR Salud). Thus,
poor women and children experienced exclusion and marginalization within
society, as well as outright abuse at the hands of a system that was meant to
provide for their care and healing.

C. Sexual and Reproductive Health and Rights (SRHR) Policies

The Fujimori regime’s record on reproductive matters was mixed, at first
seeming to protect secular interests and women’s autonomy against the
conservative elements of the Catholic Church. It was only later that women’s
bodies and their reproductive capacities were revealed as externalities in family
planning policies that were viewed as part of a broader development plan.

On one hand, Fujimori often stood up to the extraordinarily powerful
Catholic Church. For example, the 1991 penal code penalized marital rape and

segunda ola, see note 23; Peabody, “Economic Reform and Health Sector Policy,” see note 24, at 827.
31. See Ewig, Neoliberalismo de la segunda ola, see note 23, at 143.
32. Ministerio de Salud del Perú, Lineamientos de políticas en salud, sec. 2.1.1 (1998),
http://www.minsa.gob.pe/publicaciones/pubs/lineamientos/index.htm; Fritz De Bois et al.,
Programas sociales, salud y educación en el Perú: Un balance de las políticas sociales, 45-
47 (Instituto Peruano de Economía Social de Mercado, 2004).
33. Juan Arroyo Laguna, Salud, La Reforma Silenciosa: Políticas Sociales y de Salud en el Perú
de los 90, 49, 141-150 (Universidad Peruana Cayetano Heredia, 2000).
34. See generally Hernán Montenegro et al, Pan-American Health Organization, Integrated
Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas (2011); Ewig, Neoliberalismo de la segunda ola, see note 23,
at 37, 46.
35. Ewig, “Health Sector Reform in Peru,” see note 24, at 238-241; see Christina Ewig, Gender
Equity and Neoliberal Social Policy: Health Sector Reform in Peru (2001) (PhD Dissertation,
University of North Carolina at Chapel Hill).
36. Giulia Tamayo, Bajo la Piel: Derechos Sexuales, Derechos Reproductivos, 82-84 (Centro de
la Mujer Peruana Flora Tristán, 2001); Ewig, Neoliberalismo de la segunda ola, see note 23,
at 224-27; Alicia Ely Yamin, Power, Suffering and the Struggle for Dignity: Human Rights
Frameworks for Health and Why They Matter, 177-79 (University of Pennsylvania Press,
introduced the term of offenses against sexual liberty. In 1997, the law which exempted a rapist from penalty if he or she married the victim was repealed.

Fujimori’s administration also explicitly included family planning within policies aimed at alleviating poverty, which contravened Church policies. The regime was committed to family planning policies that supported the use of modern contraceptives. This commitment was apparent in official policy targets, such as increasing the use of contraception by forty-five percent in a decade, as well as through symbolic measures, such as declaring 1991 the “Family Planning Year.”

Despite this commitment, the government’s family-planning program was unable to reach the targets for contraceptive use. In July 1995, President Fujimori declared that his government was committed to reinvigorating family planning policies. The government announced legal reforms permitting the inclusion of surgical sterilizations among the contraceptive offerings that would be freely provided at public health facilities. Despite the staunch opposition of the Catholic Church and conservatives, Congress enacted the National Population Law, allowing surgical sterilization as a family planning method.

The reform of the National Population Law signaled a change in family planning strategy. In 1996, Fujimori’s administration decided to prioritize permanent contraception methods, especially in rural and poor areas of the country, by setting targets for surgical sterilizations. These ended up being extremely coercive, without regard for the full and informed consent of the women involved. Women were told that they would receive a simple free health check-up at the clinic and were threatened with fines, denial of future medical care, or even imprisonment if they refused the procedure once aware of its nature. Between 1996 and 2000, approximately 231,774 people were surgically sterilized in Peru.

42. Ewig, “Health Sector Reform in Peru,” see note 26, at 130.
44. “Ministro Dice que se Han Realizado 40 mil Esterilizaciones este Año,” *La República*, 7 (17 Oct. 1995); Ministro de Salud Marino Costa Bauer, Oficio SA-DM-N° 0818/97 (6 Aug. 1997) (a notice from the ministry of health to President Fujimori stating that 64,831 sterilizations of the 150,000 sterilizations set as a target for 1997 had been performed from January to July of that year); Ministerio de Salud, *Comisión Especial sobre Actividades de Anticoncepción Quirúrgica Voluntaria (AOV)*, 101-02 (2002), https://perma.cc/B6G3-Q4R7.
as part of a national program of family planning.\(^{46}\) An overwhelming number of surgical sterilizations were performed on indigenous women living in rural areas belonging to the poorest quintiles of the population.\(^ {47}\) Many of the procedures were performed at facilities, which did not meet basic safety standards for anesthesia or infection control.\(^ {48}\)

The efforts of Fujimori’s government to connect population control with poverty alleviation aligned well with the agendas of international agencies, such as the US Agency for International Development (USAID), the UN Population Fund (UNFPA), and the UK Department for International Development.\(^ {49}\) USAID and UNFPA allocated grants to support the work of the Ministry of Health family planning programs in Peru. Between 1995 and 2000, Movimiento de la Mujer “Manuela Ramos” (Manuela Ramos), one of the largest women’s rights NGOs, received a major grant from USAID to implement the project “Reprosalud.”\(^ {50}\) This project aimed to strengthen the activities of the national family planning program, and was implemented by Manuela Ramos in coordination with the Ministry of Health.\(^ {51}\)

The adoption of a national family planning program and the allocation of resources to improve access to contraceptive methods in Peru was initially positively received by many women’s rights organizations because it apparently was in line with the UN Conferences promoting reproductive health and rights. Indeed, the guiding documents of the program adopted the discourse of the 1994 International Conference on Population and Development (ICPD) and the 1995 Beijing World Conference on Women’s Platform for Action (UNFPA, 1995; United Nations, 1995), which spoke to empowering women and guaranteeing their rights as full members of society.\(^ {52}\) Moreover, President Fujimori had personally participated in the Beijing World Conference on Women, where he delivered a speech declaring the commitment of his administration to improving access to modern contraception and signed the Beijing Platform for Action.\(^ {53}\) The

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47. See Bosch, “Former Peruvian Government Censured over Sterilizations,” see note 46; Miranda & Yamin, Frameworks, see note 39, at 179 (38.85 percent of the cases recorded by the Ombudsman’s Office in 1999 were from Ayacucho and Huanacavilca regions, two of the poorest regions in the country).
53. Maruja Barrig, “La Persistencia de la Memoria: Feminismo y Estado en el Perú de los 90,” in
government even participated in a technical committee to oversee the implementation of the ICPD’s Programme of Action, working with international agencies and women’s rights NGOs— all of which seemed to indicate that Fujimori was taking seriously the transformative ideas set out at these international forums and wanted to “vernacularize” reproductive rights.

The decision taken by some women’s rights organizations to collaborate with an authoritarian regime such as Fujimori’s must be understood in a context of polarization between left-wing, often religiously-oriented, mainstream human rights organizations and the government. The Peruvian human rights movement has historically had strong links with the progressive side of the Catholic Church, which courageously reported human rights abuses perpetrated by state agents. However, the progressive side of the Catholic Church also firmly opposed modern contraceptive methods. When the regime attacked Catholic Church leaders’ opposition to the family planning program, the “natural allies” of women’s rights, such as the human rights movement, and progressive leaders, reacted by defending the Catholic Church’s position, supporting the right of the Catholic Church in voicing opinions about public policies. Moreover, during debates regarding the incorporation of the death penalty in the 1993 Constitution, some key representatives of the human rights movement in Peru became aligned with Catholic human rights organizations. These organizations were vital in denouncing human rights abuses during the internal armed conflict. However, they were also firm in their opposition to abortion because they linked the death penalty with abortion. While expanded access to legal abortion was part of the agenda of women’s rights groups, it received little support from other civil society organizations. Ultimately, the constitutional process of 1993 ended up with a recognition of life beginning at conception. In general, despite the conferences in Cairo and Beijing, the Peruvian human rights movement neglected reproductive rights and other women’s rights issues until close to the turn of the millennium when the involuntary sterilizations had come to light.

Indifference to and a lack of support for legal battles over the right to abortion, a core piece of the women’s rights agenda, had existed since the 1970s.

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54. Coe, see note 49, at 56-69.
55. Barrig, La Persistencia, see note 55, at 586-87.
57. See Bueno-Hansen, see note 56, at 32, 44.
59. Id.
60. See, e.g. “Comunicado de la Coordinadora Nacional de Derechos Humanos al Gobierno,” La República, 13 (14 June 1998) (excluding discussion of reproductive or women’s rights issues from a list of key human rights demands made by a national association of 50 Peruvian human rights groups).
Therapeutic abortion—abortion to save the life and protect the health of pregnant women—had been legal in Peru since 1924. In practice, however, Peruvian authorities failed to develop and implement regulations and national-level guidelines for the application of therapeutic abortion, as well as training for health workers on when to perform one. This failure has been legally challenged in national courts as well as international bodies, as discussed below. There were also some congressional attempts to reform the legal framework to expand the grounds for legal abortion. However, in a political system that is particularly heavily captured by Catholic religious interests, none of these attempts succeeded.

D. Lack of Domestic Remedies

During most of the 1990s, the authoritarianism of Fujimori’s regime fueled an environment of impunity. Despite the efforts of institutions such as the Human Rights Ombuds Office (Defensoría del Pueblo) there was virtually no national accountability for abuses committed by the state. Moreover, the Ombuds Office did not have enforcement power as a court would; it could only make recommendations with respect to human rights violations.

Within this context of impunity and circumvention of democratic processes, Peruvian NGOs deliberately decided to turn to international quasi-judicial spaces. They chose to bring litigation to international bodies, mainly to the I-A System, and developed extraordinary competence in bringing such cases, achieving some important decisions in favor of the protection of human rights. The use of

63. See e.g. “Iglesia y el CAL se pronuncian contra ‘aborto sentimental’”; El Comercio (7 July 1990); “Médicos católicos también se pronuncian contra el aborto,” El Comercio (11 July 1990); “Fiscal Elejalde se pronuncia contra el proyecto de nuevo Código Penal,” El Comercio (11 July 1999); “Cuestionan pretendida legalización del aborto,” El Comercio (14 July 1990); “Comisión Episcopal de la Familia veta proyecto de ‘aborto sentimental,’” El Comercio (14 July 1990); “Comisión de Constitución aprueba normas innovadoras: Estado protegerá a madre y niño desde el momento de la concepción,” La República (2 Mar. 1993); “Congreso aceptaría aportes en torno al tema de la planificación familiar: CCD convoca a la Iglesia para ver si modifica normas sobre aborto,” La República (22 July 1993).
64. See note 63.
international bodies became crucial in the fight for human rights in Peru. It offered a useful strategy for a context where national courts and political bodies, including Congress, which was dominated by an absolute majority of Fujimori’s party, were under the control of the Executive. These supra-national norm-creating spaces were also useful for seeking justice in cases that created fierce resistance from powerful political actors, such as the Catholic Church, evangelical religious groups, and the “secular” organizations and politicians linked to them. As noted above, these groups often had the power to control and block debates in Congress, censor legislative initiatives issued by the Executive, and to speak directly to judges. This dynamic created a license to act with impunity, and simultaneously blocked the possibilities for open political debate on highly contested issues such as the right to abortion.

This environment helps to explain why there has been virtually no political debate on expanding access to legal abortion in Peru, in contrast to other Latin American countries such as Argentina, Brazil, Colombia, Chile, Mexico, and Uruguay. The relatively formalistic judiciary in Peru has further hindered policy development by focusing on interpreting black letter law in a vacuum and not in the context of different people’s lives. Nor has litigation within local courts provided a path to create new standards or modify extremely restrictive laws on abortion.

Although SRHR was not the area of expertise of Peruvian human rights organizations, and women’s rights lawyers were generally not involved in cases litigated at the I-A System on other issues, the use of international bodies came to be seen by women’s rights organizations as the path to follow for denouncing human rights abuses—and trying to make the newly-articulated concepts of SRHR from Cairo and Beijing meaningful in practice.

II. INTER-AMERICAN SYSTEM CASES

The two cases brought to the I-A System share several similarities: (1) both were landmark cases in terms of norms and fact patterns; (2) both involved poor women from indigenous backgrounds; (3) both were brought to a system which was well-known by state and civil society organizations; and (4) both resulted in friendly settlements at the Inter-American Commission. The friendly settlement mechanism is a “venue for dialogue” between the parties involved in a petition filed with the I-A Commission. Although the friendly settlement is not a decision on the merits of the case, it allows parties to reach agreement on reparations for the alleged victims involving “the State’s public acknowledgement and recognition of its responsibility, an investigation of the facts and the punishment of the perpetrators, payment of economic compensation, rehabilitation measures or medical treatment, and symbolic reparation measures.” These are key features

68. Id. at ¶ 4.
because they provide a mechanism for the victims to access reparations in a shorter period of time than a ruling by the I-A Court of Human Rights would provide. The efficacy of the friendly settlement mechanism, however, heavily depends upon the willingness of parties to implement reparation measures agreed upon and the close scrutiny of the Commission in supervising that the parties in fact do so.

A. Involuntary Sterilization

Twenty years after the Peruvian policy of forced sterilization came to light, the number of victims is still unknown. However, the testimonies of some of the identified victims provide valuable information regarding the patterns of the abuses.

In the national family planning program, Ministry of Health workers identified women as sterilization targets at their regular visits to health facilities or at health fairs organized by the Ministry of Health. At these fairs, health workers visited the communities to promote surgical sterilizations, inviting women of reproductive age to attend.

Some of the key components of the sterilization program were the physical and verbal violence perpetrated against victims, the lack of information, and the absence of informed consent to the surgical procedure, as well as the lack of proper medical examinations to rule out health conditions which contraindicated surgical interventions (such as pregnancy or urinary tract infections). As a result, many women experienced physical complications and some died. As the Ombudsman reported, during 1996 and 1997, the mortality rates due to sterilizations in Peru were 11.5 and 5.5 (number of deaths per 100,000 sterilizations). In comparison, the global mortality rate for sterilizations was between 1996 and 1997 was 7.35. Both of these rates were more than the then internationally accepted mortality rate of 4.0.

One of the victims of the national program regarding bilateral tubal ligations was María Mamérita Mestanza. In 1998, María was a 33 year-old mother of seven children who agreed, under coercion, to undergo surgical sterilization, after being


70. See Nada Personal, see note 50; The Quipu Project (last visited 4 March 2018), https://perma.cc/5VFW-CJNW.

71. See Nada Personal, see note 50, at 51; see also Defensoría del Pueblo, La Aplicación de la Anticoncepción Quirúrgica y los Derechos Reproductivos II: Los Casos Investigados por la Defensoría del Pueblo, Informe N° 27 Series Informes Defensoriales, 54, 104 (2000), https://perma.cc/TF6B-H3D2.

72. Anticoncepción Quirúrgica, see note 71, at 64-67.

73. Id. at 74-75.

74. Id.

75. Id.
subjected to various forms of harassment including threats against her and her husband, as well as fraudulent claims about fines by health workers from the Health Center of Encañada District. As in many other cases, the procedure was performed without a pre-surgery medical examination. María died as a result of the surgery, which was performed under very poor conditions.

After María’s death, the Ministry of Health offered to pay her spouse in an attempt to cover up the circumstances surrounding her death. Regional health authorities convened an Investigative Commission, which exonerated health personnel from responsibility. After hearing about the events surrounding María’s death, learning that no charges had been brought in the case or responsibility conceded, and investigating the policy and targets that were driving the family planning program, a group of Peruvian NGOs brought María’s case before the Inter-American Commission on Human Rights as an emblematic case. The NGOs included women’s rights groups and a mainstream NGO, Asociación Pro Derechos Humanos (APRODEH).

Petitioners alleged that the facts constituted a violation by the Peruvian state of the right to life, personal integrity, and equality before the law contained in the Constitution, the American Convention on Human Rights, and other international treaties. On February 22, 2001, the Peruvian government signed a joint press release with the I-A Commission on Human Rights, in which it agreed to pursue a friendly settlement of some cases before the I-A Commission, including this one, in accordance with Articles 48(1)(f) and 49 of the American Convention on Human Rights. A settlement between the petitioners and the Peruvian government was signed in 2003 in which the government acknowledged international legal responsibility and agreed to compensate María’s surviving husband and children. The Peruvian authorities also recognized the abuses committed under the family planning program and agreed to modify and implement recommendations made by Peru’s Human Rights Ombuds Office concerning sterilization procedures in Peru’s public health facilities. These

77. Id. at ¶ 11.
78. Id. at ¶ 11-12 (describing María’s death; the factual section does not describe the conditions of the surgery itself).
79. Id. at ¶ 12.
80. Id. at ¶ 14.
82. See Friendly settlement, María Mamérita Mestanza Chávez v. Perú, at ¶ 1.
83. Id. at ¶ 2.
84. Id. at ¶ 3.
85. Id. at ¶ 7.
86. Id. at ¶ 14 (“The Peruvian State pledges to change laws and public policies on reproductive health and family planning, eliminating any discriminatory approach and respecting women’s autonomy.” The State also promises to adopt and implement recommendations made by the Ombudsman concerning public policies on reproductive health and family planning . . . .”).
recommendations included the review of:

all criminal cases on violations of human rights committed in the execution of the National Program of Reproductive Health and Family Planning, to break out and duly punish the perpetrators, requiring them to pay the appropriate civil damages, including the state if it is determined to have some responsibility for the acts that gave rise to the criminal cases.87

The I-A Commission has regularly required Peruvian authorities to report on measures taken to comply with commitments made in friendly settlements. The reports show that some advances have been achieved: economic reparations have been paid to María’s husband and children, and the state guaranteed that María’s husband and children have been permanently enrolled in the Comprehensive Health Insurance system (Seguro Integral de Salud).88

Little has been done in terms of access to justice for the victims of sterilizations, however. After eighteen years of legal battles, the vast majority of victims of forced sterilizations have not had access to justice in relation to their cases. The investigation process into forced sterilizations has been closed three times (2009, 2014, and 2016) and only reopened in response to national and international pressure, including public statements and visits by the I-A Commission of Human Rights.89 In 2015, after a hearing at the I-A Commission of Human Rights, the Peruvian government committed to creating a registry of victims of forced sterilizations.90 The registry was created on December 2015.91 By May 2017, 3,453 victims of sterilizations were registered and the process continues.92

Despite widespread condemnation of his administration and the imprisonment of certain officials, former president Fujimori has retained extraordinary political power. Since 2006 Fujimori’s political party has been one of the strongest political forces in the country with a continuously strong representation in Congress.93 Indeed, on December 24, 2017, President Pedro

87. Id.
Pablo Kuczyncki officially pardoned him under questionable conditions (an alleged political negotiation was struck with Fujimori’s allies in Congress). Fujimori’s allies have also systematically blocked criminal investigations into involuntary sterilizations for years.

It is also worth noting that despite agreeing to do so as part of the friendly settlement, Peru has avoided providing adequate health care to the victims of forced sterilization. According to the Ministry of Health, the state cannot provide “special treatment” to the victims of forced sterilizations and the victims only have a right to the limited package of services provided by Seguro Integral de Salud (SIS). This package of services, however, is an entitlement of citizenship and is plainly not a reparation. The health consequences of forced sterilization are one of the main concerns of victims’ organizations as they negatively impact both the quality of life and the financial circumstances of victims and their families.

A handful of human and women’s rights NGOs have continued monitoring the cases of forced sterilizations, repeatedly asking the government to fulfill its responsibility to victims. However, such monitoring activities are costly in terms of human and financial resources, and lead to burnout among NGOs and victims’ associations. Their capacity to advocate with the government and at the I-A Commission is also constrained by lack of resources. Further, precisely because of the lack of state action, organizations that support victims have drained their already scarce resources by stepping in to provide for the immediate needs of the victims.

In short, the broad legal mobilization across mainstream human rights NGOs and women’s rights groups produced a significant friendly settlement in María Mamérita Mestanza’s case of forced and involuntary sterilizations. However, these achievements did not translate into meaningful reparations for the overwhelmingly poor and indigenous women who were affected by the policy and program, let alone political and societal changes to recognize their standing as fully equal citizens with rights.

98. Interview with 14080501 (5 Aug. 2014, Lima, Peru); Interview with 14080502 (5 Aug. 2014, Lima, Peru).
100. Interview with 14080501 (5 Aug. 2014, Lima, Peru).
B. M.M. v. Peru: Sexual Violence at Public Health Facility

On January 25, 1996, M.M., a 22-year-old woman, went to the Carlos Medrano Monge Hospital in Juliaca, Puno. She was suffering from especially strong headaches from a traffic accident she had had three months before. At the hospital, M.M. was treated by Dr. Gerardo Salmon Horna. Dr. Salmon convinced M.M. to go to his private office. While there, Dr. Salmon applied anesthesia to M.M. and raped her when she was unconscious. M.M. reported the abuse to the Carlos Medrano Monge Hospital; hospital staff responded to her report by ignoring and mistreating her. Despite this, M.M. went to the police and reported the rape. The police statements and the subsequent judicial case reached almost satirical levels of bias shown against the victim (such as statements that M.M. failed to prove her conduct to be irreproachable and a statement that M.M.’s vaginal hemorrhage caused by the rape was her menstrual period). By the end of October 1997, domestic remedies were exhausted. At every stage, the courts had acquitted Dr. Salmon.

The Comité Latinoamericano para la Defensa de los Derechos de la Mujer (CLADEM) and the then Center for Reproductive Law and Policy learned about the case and decided to provide legal support to M.M., bringing the case to the Inter-American Commission on the Prevention, Punishment, and Eradication of Violence against Women, known widely now as the Convention of Belém do Pará. Petitioners alleged several violations of the American Convention on Human Rights by the Peruvian state: (1) obligation to respect rights (Article A1(1)); (2) the right to humane treatment (Article 5); (3) the right to a hearing

104. M.M. v. Peru, see note 102, at 4.
105. Dr. Wilver Eyzaguirre Frisancho, Instituto de Medicina Legal del Perú “Leonidas Avedaño Ureta,” Certificado Médico No 000320 issued for Marina Machaca Apaza v. Gerardo Salmón Horna (Jan. 29, 1996); Marina Machaca Apaza v. Gerardo Salmón Horna, Segundo Juzgado Especializado en lo Penal [Second Criminal Court] (14 May 1996, Peru) (hereinafter Apaza v. Horna (Peru)). In addition, the forensic doctor refused to perform the medical examination on the victim. Contrary to the national regulation regarding complaints in cases of sexual abuse, the complaint was filed by the police at the equivalent of the District Attorney’s Office instead of in front of a judge. The District Attorney’s Office ordered case closed, arguing that there was no evidence of rape, and that the victim failed to demonstrate “impeccable behavior” (conducta intachable).
109. The current name of this organization is Center for Reproductive Rights.
111. Camila Gianella, interview with 15060401 (4 June 2015, Lima, Peru).
(Article 8(1)); (4) the right to privacy (Article 11); and (5) the right to judicial protection (Article 25). In addition, petitioners alleged violation of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Convention of Belém do Pará): (1) the right to be free from violence (Article 3); (2) the right to the recognition, enjoyment, exercise, and protection of all human rights and freedoms embodied in regional and international human rights instruments (Article 4); and (3) Articles 7, 8 and 9. Lastly, petitioners alleged violation of Articles 1 and 12(1) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Each violation was causally linked to harms M.M. suffered.

From an early stage in the case, Peru showed an interest in reaching a settlement, continuing with negotiations even during the period when the state attempted to withdraw from the I-A System (1999-2000). Petitioners had several concerns about a friendly settlement. First, petitioners feared that a friendly settlement would not set strong legal precedent to prevent similar cases from happening again. Second, the petitioners were concerned that a friendly settlement would not allow for the creation of jurisprudence at the Inter-American Court using the Convention of Belém do Pará. On the other hand, the petitioners were very much aware of the cost and potential negative impacts of a long judicial process on the victim.

Peru and the petitioners signed a friendly settlement agreement on March 6, 2000. The agreement included material reparations to M.M., as well as free access to health care at public health facilities. In terms of structural remedies, the state agreed to take corrective measures to ensure fully informed consent in the family planning program, as well as to improve quality of care, and thereby prevent similar events from happening in the future. The measures included changing judicial training to include topics related to gender and justice and created specialized services for the victims of sexual violence. Peru also stated that it would bring the matter to the Peruvian Medical Association, for the Association to pursue the appropriate professional sanctions against Dr. Salmon.

As in the case of M.M., the state awarded material reparations to M.M. in a relatively short time. The greater difficulty has been implementing reforms to prevent future abuses. For example, despite reports showing the systematic dismissal of rape allegations based on judges’ biases and harmful stereotypes of women, it was not until February 2012 that the Peruvian Judicial Academy (AMAG) included gender and justice as part of the basic training for judges in its curriculum, plans, and budgets.

114. M.M. v. Peru, see note 102, at 6.
These two I-A System cases highlight three key factors regarding the role and impact of supra-national SRHR litigation in Peru. First, they reveal the critical role of the expertise that the human rights community and civil society actors had developed in litigating in international tribunals. This expertise allowed the NGOs to increase access to international spaces and resources, and successfully frame strategies and claims. Second, they reveal the difficulty of ensuring cases aimed at protecting vulnerable and marginalized populations actually serve the victims’ pressing needs as legal procedures often take years to complete. As Justice Manuel José Cepeda wrote regarding a decision for the Colombian Constitutional Court on internally displaced persons in Colombia, “[t]he passage of time has an ethical dimension.” For victims in need of immediate protection, time is a luxury they cannot afford. The immediate needs of victims can lead parties to accept solutions that more directly attend to the needs of victims. However, as these two cases illustrate, the cases do not necessarily lead to public policy reforms that prevent future abuses. Third, these cases clearly show that the violation of SRHR is closely linked with class, race, and gender inequalities described above as characterizing the Peruvian context. These structural inequalities create critical barriers to the fulfillment of SRHR, which do not magically shift because of a friendly settlement—or of a favorable litigation outcome, as we see in the next section.

III. CASES BROUGHT TO TREATY-MONITORING BODIES REGARDING THERAPEUTIC ABORTION

The cases analyzed in this section were brought to UN human rights treaty-monitoring bodies. While they also relate to violence at public health facilities, the cases in this section are linked with access to therapeutic abortion. As part of a broader strategy to increase access to therapeutic abortion in Peru, these cases were accompanied by litigation in national courts, as well as campaigns aimed at informing public opinion on this issue.

A. K.L. v. Peru

In 2001, K.L. was seventeen years old and pregnant with a wanted pregnancy. Her fetus was diagnosed with anencephaly, an abnormality

inconsistent with survival. K.L.’s doctors at Archbishop Loayza National Hospital considered her pregnancy a life-threatening risk and she suffered severe psychological consequences after learning of the anencephaly. Encouraged by her doctors, K.L. sought a therapeutic abortion, but the procedure was denied by Peruvian health officials. One of the Peruvian health officials that denied her request was the director of Archbishop Loayza National Hospital, the then-president of the Peruvian Medical Association. K.L. was forced to carry her pregnancy to term, giving birth to a baby girl who died four days later. Tragically, while waiting for her baby to die over several days, K.L. was forced to breastfeed her baby. Following her daughter’s death, K.L. fell into a state of deep depression.

After learning about the case from the media, Estudio para la Defensa de los Derechos de la Mujer (DEMUS) contacted K.L. and offered her legal, medical, and psychological support. DEMUS also contacted the Latin American and Caribbean Committee for the Defense of Women’s Rights (CLADEM) and the now Center for Reproductive Rights (CRR) to confer regarding the best legal strategy. The three organizations decided to present the case at the international level due to the lack of legal mechanisms at the domestic level to enforce K.L.’s rights. The case was trail-blazing because it was the first petition regarding abortion considered by the UN human rights treaty monitoring system. K.L.’s case was also part of a broader strategy designed by these and other women’s rights organizations to employ supra-national litigation to: (1) ensure that national level legislation, policies, and jurisprudence were aligned with the international recognition of sexual and reproductive rights; and (2) to push for new standards in international law for the protection of reproductive rights.

In 2005, the United Nations Human Rights Committee (Human Rights Committee) issued a decision that recognized K.L.’s forced continuation of pregnancy as a violation of several rights under the International Covenant on Civil and Political Rights: the right to be free from cruel, inhumane, and degrading treatment (Article 7), the right to privacy (Article 17), and the right to special protection of the rights of a minor (Article 24). The Human Rights Committee also recommended that Peru implement non-repetition measures to prevent such

119. Id. at ¶ 2.2, 2.7.
120. Id. at ¶ 2.2.
121. Id. at ¶ 2.2, 2.3.
122. Id. at ¶ 2.1, 2.2, 2.3, 3.4.
123. Id. at ¶ 2.6, 3.4.
124. Id. at ¶ 2.6, 3.4.
125. Id. at ¶ 2.6.
128. HRC, K.L. v. Peru, see note 118, at ¶ 3.4-3.7.
cases from occurring in the future.\textsuperscript{129}

The Human Rights Committee’s “decision” (which is technically a “report of recommendations”) advanced the debate on the need for national guidelines on therapeutic abortion. Abortion, even therapeutic abortion, which had been legal since 1924, had become a contested issue in Peru’s political discourse with the heavy influence of conservative Catholic and evangelical Christian ideology.\textsuperscript{130} For example, the Ministry of Health required unprecedented approval for therapeutic abortion guidelines from different sectors, including the Ministry of Justice, which was asked to provide a judgment on the “constitutionality” of therapeutic abortion. It was not until 2013, after L.C.’s case had been brought,\textsuperscript{131} that the Ministry of Justice endorsed the guidelines. These guidelines were finally approved in June 2014, just before the deadline was set for compliance by the Human Rights Committee. Although deemed to be formally compliant, these guidelines can be construed to offer very narrow exceptions to criminalization based on requirements for ascertaining a threat to the life or physical health of the mother, as described below.

In contrast to the I-A System cases, resistance by the Peruvian state took a different form as a result of the Human Rights Committee decision in K.L.’s case. It took longer for the state to publicly admit its responsibility regarding K.L.’s case. To explicitly admit the violations in the case of K.L., Peru would need to: (1) admit the right existed; and (2) provide grounds for abortion in similar cases, including anencephaly and threats to the “mental health” of the mother.\textsuperscript{132} For almost ten years, Peruvian authorities avoided paying economic reparations on the grounds that the Human Rights Committee decision did not specify an amount.\textsuperscript{133} In December 2015, Peruvian authorities publicly admitted that denying K.L. access to therapeutic abortion was a violation of her rights, published the Human Rights Committee decision, and committed to paying economic reparations to K.L.\textsuperscript{134}

In addition to legal maneuvering by the government, resistance to the Human Rights Committee decision was strongly felt within the broader public. If courts are rarely able to impose rights that the public instead commonly understands as moral issues, supra-national bodies are even less likely to be able to do so. Mental health in particular was not a widely accepted basis for access to therapeutic abortion because it was perceived as opening a large loophole and allowing women to simply claim that they were depressed if they decided they did not want

\textsuperscript{129} Id. at ¶ 8.


\textsuperscript{131} See next section.

\textsuperscript{132} These would create exceptions to the criminalization of abortion under current interpretations of Peruvian law.

\textsuperscript{133} Camila Gianella & Alicia Ely Yamin, interview with 14080501 (5 Aug. 2014, Lima, Peru).

\textsuperscript{134} See ¡Histórico! 10 años después, el Estado peruano cumple el dictamen de Naciones Unidas por negar el aborto terapéutico a K.L., Demus (9 Dec. 2015), https://perma.cc/VZC7-39QJ.
to carry the pregnancy to term. Coupled with an amorphous social reticence, the delaying tactics and slow response from the Peruvian government demonstrates the limitations of pursuing remedies through the Human Rights Committee.

**B. L.C. v. Peru**

After K.L., Peru became a domain of the larger culture war over abortion rights that was being fought in international arenas and adjudicatory bodies and in other national contexts. K.L.’s case with the Human Rights Committee and the government’s lack of compliance had been extraordinarily frustrating to advocates, both within and outside of Peru. Thus, when CRR and the Centre for the Promotion and Protection of Sexual and Reproductive Rights (PROMSEX) brought a second case regarding access to therapeutic abortion in 2009, they deliberately brought it to the Committee on the Elimination of Discrimination against Women (CEDAW).

L.C. lived in Lima, Peru, and for years she was the victim of sexual abuse and rape by a man in her neighborhood. When she was thirteen she found out that she was pregnant and discovered that Peruvian law did not allow for abortion in the case of rape or incest. Scared and hopeless, she flung herself off a neighbor’s roof and suffered a serious spinal injury. Doctors could have operated soon after in order to prevent her injury from worsening, but did not operate due to her pregnancy. Even though the case qualified under Peruvian law for a legal therapeutic abortion, the abortion was denied. The pregnancy ended in a miscarriage. Nearly three and a half months after the doctor’s recommendation, L.C finally received the corrective spinal surgery. In large part due to the delay in receiving the surgery, it was not successful, and L.C. remained a quadriplegic.

For approximately three months, L.C. and her supporters worked with PROMSEX seeking a resolution within administrative mechanisms. After failing

135. See Razones psicológicas no aplican para aborto terapéutico, aclaró Minsa, América TV (30 June 2014), https://perma.cc/A7Z7-XPC3 (reporting on a statement from the Peruvian Vice Minister of Health that abortions may not be obtained for psychological or psychiatric reasons). But see, Brenda Alvarez, Caso Clínica el Golf: El Aborto Terapéutico y la Protección de la Salud Mental de las Mujeres, PROMSEX (8 Sep. 2017), https://perma.cc/V3K8-JC9T (explaining a case from a Peruvian administrative court, INDECOPI, ruling against a private clinic for denying the access to therapeutic abortion on mental health grounds).


137. See id. at ¶ 2.1.
138. See id.
139. Id. at ¶ 2.5.
140. Id. at ¶ 2.5-2.6.
141. Id. at ¶ 2.9-2.10.
142. Id. at ¶ 2.9-2.10.
143. Id. at ¶ 2.11.
to achieve an acceptable resolution, PROMSEX sought legal advice from CRR and they jointly decided to take the case to CEDAW in 2009. The lack of compliance in the K.L. case led PROMSEX and CRR to select CEDAW because they determined that the I-A System did not offer a favorable environment for abortion cases.\footnote{144 Camilla Gianella & Alicia Ely Yamin, interview with 14080402 (4 Aug. 2014, Lima, Peru).}

In 2011, CEDAW concluded that Peru had violated several of K.L.’s rights under the Convention on the Elimination of Discrimination Against Women: (1) an effective remedy (Article 2(c)); (2) non-discrimination and equal protection (Article 2(f)); (3) the state’s obligation to ensure the full development and advancement of women (Article 3); (4) the state’s obligation to eradicate discriminatory social and cultural practices (Article 5); and (5) the state’s obligation to eliminate discrimination in health care services (Article 12).\footnote{145 CEDAW, L.C. v. Peru at ¶ 9.} Among other things, CEDAW asked Peruvian authorities to “provide reparation(s) that include[d] adequate compensation for material and moral damages and measures of rehabilitation, commensurate with the gravity of the violation of her rights and the condition of her health, in order to ensure that she enjoys the best possible quality of life.”\footnote{146 Id. at ¶ 9(a).}

In its recommendations, CEDAW also called upon Peru to review and amend its laws in order to ensure that there is effective access to therapeutic abortion. Specifically, CEDAW recommended that Peru “review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse” (as was the case for L.C.).\footnote{147 Id. at ¶ 9(b)(iii).} CEDAW also recommended that the government take steps to ensure that the Peruvian health system followed the state’s obligations under the CEDAW Convention, including educating and training health care providers, adopting guidelines and protocols for rendering services accessible to adolescent women seeking reproductive health services, and addressing the health needs of victims of sexual violence.\footnote{148 Id. at ¶ 9(b)(ii).} Finally, CEDAW recommended that Peru review its restrictive interpretation of therapeutic abortion so as to comply with the General Recommendation No. 24, CEDAW's interpretation of the meaning of relevant articles under the Convention, and the Beijing Declaration and Platform for Action.\footnote{149 Id. at ¶ 9(b)(iv).} This landmark case not only recognized Peru’s long-standing history of denying women access to legal abortion, but also clearly stated that women’s reproductive rights are fundamental human rights.\footnote{150 Center for Reproductive Rights, United Nations Calls on Peru to Expand Access to Legal Abortion (25 Jul. 2014), https://perma.cc/LWT9-LMKH.}

As was true in the case of K.L., the state actively denied reparations to L.C.,
refusing to provide her with comprehensive health care.\(^{151}\) It was not until 2016, two years after the adoption of the guidelines and a protocol for therapeutic abortion, that the government publicly recognized the case of L.C. as a human rights violation.\(^{152}\) L.C.’s case has also been part of a campaign by PROMSEX and other NGOs to legalize abortion in the case of rape, which has not prospered despite it being cited as an exception to abortion criminalization in other countries in the region, such as Argentina.\(^{153}\)

It is unlikely, however, that the adoption of a protocol for therapeutic abortion in 2014 would have occurred without L.C.’s case being brought in the wake of K.L.’s case.\(^{154}\) Pressure from international bodies has removed the issue of abortion from the exclusive purview of the Ministry of Health and changed it into a matter of constitutionality and gender equality. The full implementation of that protocol is still in doubt, however, not only because of the evident lack of political will within the Ministry of Health, but also because of the way the Peruvian health system is organized.\(^{155}\) The limited training provided to health workers in rural parts of Peru on their technical and legal obligations renders it unlikely that the protocol for therapeutic abortion will be fully implemented.\(^{156}\)

The cases of K.L. and L.C. reveal how strategic litigation can support the policy-making process, as evidenced by the adoption of implementation guidelines and a protocol, which had been neglected by the Peruvian state for ninety years. Despite the state’s formal acknowledgement of human rights violations, however, one core characteristic of these two cases is the state’s assertion that the health conditions of the pregnant women did not put their “life” in danger, despite the fact that their physical and mental health may have been detrimentally affected. In K.L.’s case, for example, this consisted of carrying a fetus to term that she knew did not have a brain. For L.C., the health condition was her severe spinal injury. Indeed, health authorities have publicly declared that the

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154. Center for Reproductive Rights, see note 150.


guidelines do not include a risk to the mother’s mental health as a ground to request an abortion. Thus, even today, K.L. (who had an anencephalic fetus) would face major barriers to accessing a therapeutic abortion in Peru. The Ministry of Health guidelines require a “severe health threat” for an abortion to be available. It is, therefore, not even clear if a condition such as the spinal injury L.C. suffered would be considered severe enough to warrant a therapeutic abortion.

IV. ASSESSING IMPACT

In the sections above, we described the core elements of the four cases and the context in which the violations occurred. Given the combination of jurisprudential precedent, differing direct and indirect impacts, and the factor of time, it is complex to assess the overall impact of the leading Peruvian cases on supra-national litigation of SRHR. The framework we use to evaluate the impacts of these decisions complements those used by other scholars.

The framework integrates measurements of direct and observable effects of these quasi-judicial decisions with attention to transformative effects, such as the shaping of perceptions which may have a longer-term impact (see Table 4 below). The framework aims to include key contextual elements in the analysis and build on existing work on how social and political response to judicial orders are shaped by the political orientation of the government, public debate, and social mobilization. We do not conceptualize the strategies or reactions in terms of a closed and linear process. Rather, we attempt to foster a broader understanding of the strategies used by different groups and the manner in which contextual factors influenced these choices and the subsequent reactions of the state. Effects are understood in terms of changes in goals, values, decision-making processes, and in concrete policy outcomes in health service delivery and usage.

With this analytical framework, we hope to expand the understanding of contextual factors that have led to a lack of legal enforcement of SRHR in Peru by analyzing the direct, indirect, symbolic, and instrumental effects of different legal strategies.

157. See América TV, see note 135; Sigue la Polémica por la Guía Técnica del Aborto Terapéutico, Perú 21 (7 Jan. 2014), https://perma.cc/9UT4-FBZJ.
Table 4: Analytical Framework

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<td>b. Actors and power relations</td>
<td>ii. Processes of decision-making</td>
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Regardless of the legal strategy, we suggest that to understand the impact of a “decision,” we must examine not only the ultimate legal or political outcome, but also the intermediary mechanisms through which these effects are produced by supra-national judgments. These mechanisms function at one or more levels: (1) through institutional and organizational changes (adoptions of health protocols and policies); (2) changes in actors and power relations (as in decision-making about interventions); and (3) through changes in discourses (such as about the legitimacy of abortion under a variety of circumstances). Understanding the impact of legal strategies both in terms of outcomes and these intermediary mechanisms facilitates understanding the paradox of this supra-national SRHR litigation in Peru.

The state agreed to pay reparations to the individual claimants in the cases discussed in the I-A. The state has neglected to implement any institutional or organizational reforms, however. Judges continue to mistreat victims of sexual abuse. Women, especially indigenous women, are mistreated in health services. Moreover, most poor women do not have real access to contraception. Poor and indigenous women continue to face pervasive discrimination that treats them as less than full members of Peruvian society. This discrimination plays out in the health system through the abuses that these women face. The symbolic impact of the cases has done little to advance a self-conceptualization among indigenous women in Peru as full human subjects. Generally, in I-A System cases, human rights violations are acknowledged and claimants are afforded reparation. However, results are often trivial amounts or a

162. Mariella Bazán Maccera, Madre Nativa: Experiencias Acerca De La Salud Materna En Las Comunidades Ashaninkas y Nomatziguengas, 61 (Salud Sin Limites, 2008); Defensoría del Pueblo, Violencia Sexual, see note 115, at 10; María Elena Planas et al., ¿Existen Disparidades Éticas en la Calidad de Atención de los Servicios de Planificación Familiar en Perú?, Banco Interamericano de Desarrollo, https://perma.cc/N2GH-TCHD (finding aid provided by family planning services to be of extremely low quality, though no significant differences were apparent in the treatment of indigenous women compared to non-indigenous).
163. Bazán Maccera, see note 162, at 39, 79; Planas, see note 162.
right to “access to care,” which claimants were already entitled to under law.

The therapeutic abortion cases present a different scenario. Despite repeat findings by international treaty-monitoring bodies (and concluding observations regarding Peru in this regard as well), there is no consensus within Peruvian legal and political circles that Peru’s denial of therapeutic abortions to L.C. and K.L. violated their “rights.” Abortion is still considered to be a sensitive “ethical” issue, not a matter of fundamental constitutional rights. On the other hand, in contrast to the I-A System cases regarding forced sterilization and sexual assault, the abortion cases discussed above did lead to policy outcomes, such as the approval of the therapeutic abortion guidelines and protocols, and fostered a broader campaign to expand the grounds for therapeutic abortion in Peru. These policy changes were probably a result of the international pressure and women’s rights campaigns relating to abortion, which did not exist for involuntary sterilization. Thus, even though there was substantial outright political resistance, the therapeutic abortion cases redirected policy and public debate in both intended and unintended ways.

In circumstances such as Peru’s, it appears that decisions with clear orders and deadlines—like those issued in the therapeutic abortion cases—are more effective in terms of policy reform. Decisions with clear orders and deadlines also appear to have a greater impact on debates regarding social values. In contrast, friendly settlements in these cases and others have not been strong enough to engender policy reforms, or even in the instant case, to advance a state-sponsored investigation of forced sterilizations in the face of opposition from supporters of Fujimori’s regime. Yet, we should be cautious: it is not necessarily possible to extrapolate the particular ways in which these cases played out in contexts beyond Peru because of the particular political configurations of the actors and institutions involved.

However, it is fair to say that sustained and organized follow-up by litigants as well as by the oversight mechanism is crucial to implementation of reforms. In the case of therapeutic abortion, the international community’s fight for abortion liberalization created bad publicity for Peru, which can be considered a “cost” of non-compliance. Thus, one lesson from Peru is that international pressure and supervision from international bodies cannot end with the announcement of a judgment or a friendly settlement. Rather, technical and political follow-up is critical to translating an adversarial judgment into policy reform, and thereby creating meaningful impact.

The cases also reveal that new coalitions are necessary to advance compliance with supra-national cases, as well as SRHR issues more broadly. For example, Somos 2074 y Muchas Más (We Are 2074 and Many More) was the coalition created to follow up cases of forced sterilizations, and Déjala Decidir

164. See, e.g. Rossana Echeandía, “¿Contenido uterino?” El Comercio (8 Jul. 2014), https://perma.cc/DHK2-UHWL (arguing against access to therapeutic abortion, calling for the government to recognize the constitutional rights of the fetus).
(Let Her Decide) was a coalition that was created to expand the right to abortion. At the same time, conservative groups also formed in reaction to the cases of L.C. and K.L.: Marcha por la Vida (March for Life), and Pacto por la Vida y la Familia (Pact for Life and Family). Jurisprudentially, the transnational dimension of the cases is critically important. M.M., K.L., and L.C. were landmark cases that tested the capacity of some international mechanisms to deal with issues related to gender-based violence and abortion rights. Furthermore, the cases of K.L. and L.C. clarified the responsibility of the state with respect to the regulation of safe abortion, a procedure that women, and not men, most need access to. These cases have been referred to in countless other U.N. decisions and have helped build consensus at international levels for General Recommendations, such as CEDAW’s General Recommendation 24, which states among other things that “gender-based violence is a critical health issue for women” and that, “legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.” These cases have also informed national cases regarding similar issues in other countries. For example, L.C. v. Peru, L.M.R. v. Argentina, and V.D.A. v. Argentina, are three pivotal cases that addressed access to abortion and all cited K.L. v. Peru. Additionally, the case of L.C. v. Peru was cited by the Inter-American Court of Human Rights in the decision Artavia Murillo et al. v. Costa Rica. In the slow agglomeration that characterizes the building of standards under international law, these cases have been essential building blocks, one decision serving as a stepping stone for the next.

While Maria Mamérita Mestanza’s v. Peru was not part of a broader transnational litigation strategy on the issue of involuntary sterilization, it set important legal precedent by linking discrimination with the violation of women’s reproductive rights. The case has also been referenced in other cases dealing with forced sterilization at international bodies, such as I.V. v. Bolivia (2014), which has been sent by The Inter-American Commission of Human Rights to the Inter-American Court, as well as cases in other national jurisdictions.

On the other hand, it is also fair to say that regardless of the state’s formal
declarations regarding both TMB recommendations and the I-A Commission’s friendly settlements (as documented above), there has been a lack of willingness to implement the required institutional and organizational reforms (e.g. training of judges or adoption of a therapeutic abortion guidelines). For example, in the case of María Mamérita Mestanza, and involuntary sterilizations generally, Fujimori’s allies have returned to political power in the country. In the therapeutic abortion cases, anti-abortion rights groups have maintained their iron grip on political power. Peru’s deeply classist, racist, and sexist power structures were not ameliorated as a result of the cases discussed here. Indeed, even relatively minor institutional reforms that could lead to some shifts in decision-making within health systems to provide campesina patients with greater empowerment and autonomy have been blocked in many cases. Thus, while there have been important positive outcomes from the cases, they have not shifted institutional and political power relations, which facilitated the mistreatment and abuse of petitioners in the first place.

CONCLUSION

The story of Peruvian SRHR litigation in international tribunals has been one of struggle and resistance. In an effort to seek legitimate spaces to vindicate rights, advocates under the autocratic Fujimori regime were forced to take cases of abuse by medical practitioners, including sexual assault and forced sterilization, to international bodies. They chose to do so in the I-A System, where violations of bodily integrity and torture had already been firmly recognized. In these cases, advocates felt comfortable litigating issues that essentially clarified how well-established human rights norms applied in the context of abuses of women.

The therapeutic abortion cases were brought after Fujimori left office, but religious opposition to abortion at all levels of government still made it impossible for advocates to find deliberative process at the national level through which to resolve the cases. The cases brought to the Human Rights Committee and the CEDAW Committee as opposed to the I-A System were brought at a time and during an international context where supra-national mechanisms at the UN came to be used to create new norms relating specifically to SRHR. These new normative standards were set by reading existing international law through a gendered and less formalistic lens, which challenged widespread social views of abortion as merely a sensitive moral issue. K.L. and L.C. established ground-breaking precedents at the Human Rights Committee and CEDAW, respectively, and led to some policy reforms. And yet, the right to abortion—even therapeutic abortion—is contested at the most basic public discourse in Peru.

The texture of resistance in these various cases has been quite different and reveals the ways in which Peruvian society, and the health system in general, still “see” many people in society. Many Peruvians continue to believe that the largely indigenous campesina women were being done a favor by having their tubes tied, as it ostensibly allowed them to live without being unduly burdened by constant
child-bearing. Yet, if campesina women are to be treated as full members of Peruvian society, they need to have full rights to education, health, and equality, rather than having their goals curtailed by paternalistic population policies.

Abortion is quite different, as Peru has become a domain for a battle being played out across many national contexts. This battle is characterized by a struggle between progressive forces trying to establish as a fundamental right to the ability of women to obtain life-saving services and conservative forces defending narrow constructions of international and national law based on patriarchal views of the family and religious dogma. Here, ironically, pressure both internationally and domestically led to greater willingness to make policy reforms. Nevertheless, there still has not been any concession that therapeutic abortion is a real right in national legal and political discourse. In short, to the extent that these landmark decisions have acted as catalysts for other decisions and opportunities for SRHR movements, those same opportunities have not been matched by the opening of political and institutional spaces within Peru, nor have they led to material gains for Peruvian women and girls who continue to suffer the greatest abuses of sexual and reproductive health and rights.