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Time for Change: Promoting and Protecting Access to Information and Reproductive and Sexual Health Rights in Peru



January 2006

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The opinions expressed in this report do not necessarily reflect the point of view of the entities which support this publication.

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Foreword

Professor Paul Hunt

Special Rapporteur on the right of everyone to the enjoyment of the
highest attainable standard of physical and mental health

In 2002, the United Nations Commission on Human Rights decided to appoint a Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“right to health”), a post to which I was appointed later that year. Since my appointment, I have sought to raise awareness of health as a fundamental human right, clarify the contours and content of the right to health, and identify examples of good practice for the operationalisation of the right to health.

Health-related information is fundamental to the realization of the right to health. If individuals can access information on preventing and treating ill-health, they are empowered to make informed decisions about their health. The free flow of information about health is essential for building evidence-based health policies – it is a cornerstone of any health system that subscribes to the human rights and democratic principles of transparency, accountability, participation and equality.

Experience teaches us that there are particular obstacles to freedom of information that adversely affect the right to health. Chief among these barriers are poverty, discrimination and stigma that impede access to information - and consequently good health - for some of the most disadvantaged members of society, including indigenous persons, women and adolescents. The obstacles are often greatest where individuals seek information on health issues – such as sexual and reproductive health – that are considered sensitive within a particular culture. Regrettably, these obstacles persist despite evidence that this information enhances enjoyment of the human rights to health and life, and despite States’ international human rights commitments to promote access to health-related information.

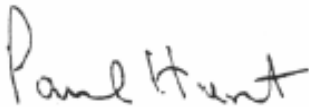
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In 2004, I had the opportunity to undertake a country mission to Peru at the invitation of the Government. During the mission, I was able to witness at first hand the impressive engagement of the Minister of Health, grass-roots organisations and many others in numerous initiatives to ensure the operationalization of the right to health, and other human rights. All these initiatives depend upon unfettered access to health information.

ARTICLE 19's report confirms that the right to freedom of information is a vital means to realise the right to health. It signals the opportunities presented by access to information legislation in Peru that will ultimately enable concrete improvements in the health sector to be achieved more readily. The report, which outlines international, regional and national legal protections of freedom of information and the right to health, provides valuable evidence of how these norms may be operationalized and enforced. The analysis will assist Governments, international organizations and civil society in their efforts to promote and protect the right to health.

As so often before, we are all indebted to ARTICLE 19 for another timely and innovative contribution to the promotion and protection of access to information.¹



Professor Paul Hunt

¹ While commending this report to all parties for their serious consideration, it should not be assumed that I adopt all the views and analysis presented in the text

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Foreword

Eduardo A. Bertoni²

Special Rapporteur for Freedom of Expression
of the Organization of American States

Principle 4 of the Declaration of Principles on Freedom of Expression, passed by the Inter-American Commission on Human Rights (IACHR), states that access to information in the hands of the State constitutes a fundamental right of individuals and that States are obliged to guarantee this right.

In compliance with the mandate conferred by the IACHR, the Office of the Special Rapporteur for Freedom of Expression has recommended that member States of the Organization of American States (OAS) incorporate access to information laws and effective mechanisms for their efficient use within their legislation, and has encouraged them to do so. Through its annual reports the Office of the Rapporteur has been working continuously to emphasize the importance of this subject within the inter-American system³.

As 2005 begins this work, together with the projects carried out by civil society and the political decision adopted by several States, has contributed to a more positive outlook for the situation in the Americas. From 2002 until the present, several States have passed

² Special Rapporteur for Freedom of Expression, Inter-American Commission of Human Rights, Organization of American States. Professor of Criminal Law and Criminal Procedure, School of Law, National University of Buenos Aires. Former fellow of the Human Rights Institute of the Columbia University Law School, New York, United States of America. For more information on the Office of the Special Rapporteur for Freedom of Expression see www.cidh.org/relatoria. The opinions expressed by the author do not necessarily reflect the official opinion of the OAS.

³ For example, see the 2003 Annual Report of the Inter-American Commission on Human Rights, Vol. III. Report of the Special Rapporteur for Freedom of Expression, Chapter IV: *Report on access to information in the hemisphere*, pages 135-154.

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laws on access to information, starting with Peru, Mexico and Panama in 2002, and ending with Ecuador and the Dominican Republic in 2004. To these States we can add many more that are in the early stages of or are currently driving forward legislative processes for legal sanctions. The political will of the States is in turn reflected in Resolutions 1932⁴ in 2003 and 2057⁵ in 2004, passed by the General Assembly of the OAS.

As mentioned, all of these factors allow us to feel optimistic. Nevertheless, exercise of the right of access to public information is not guaranteed solely by the passing of the laws which regulate it. To strengthen the process initiated in the region, it will be necessary to pay due attention both to the implementation of these laws and to education campaigns in the public sector and in civil society. As this is a question of new legal instruments, their use should demonstrate that they are suitable tools for increasing the transparency of government actions and for facilitating the exercise of other rights.

An effective access to information regime relies on the political will necessary to put it into practice; this requires the allocation of necessary public resources and the political will to develop educational public information programmes. Civil servants must be willing to adapt their way of working in order to reflect a culture of transparency.

The period subsequent to the passing of the Peruvian law provides the background for this report drawn up by ARTICLE 19. The need for information on topics associated with the right to health of individuals may serve to explain the importance of the exercise of the right of access to information in specific cases. The use of new legislation in specific cases may help to detect errors, both normative and practical. In turn, the report demonstrates how access to information in Peru facilitates the exercise of other rights; for example, the right to sexual and reproductive health.

⁴ AG/RES. 1932 (XXXIII-0/03)

⁵ AG/RES. 2057 (XXXIV-0/04)

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I believe that the report should be read in this constructive spirit. Without doubt, as the new laws passed in the region begin to be used, problems which may not have been considered at the time of drawing up the laws will appear. Nevertheless, it is necessary to identify these problems, as this report does, in order to strengthen and improve access to information.

Washington D.C., March 31 2005.

Chapter 1

Introduction

Reproductive and Sexual Health Rights in Peru: A Platform for Change

Bethan Grillo, ARTICLE 19

Introduction

In 2004, a member of the public in Peru began to tell us why she considered ARTICLE 19's work on access to information and reproductive and sexual health rights to be important. She explained that in December of the previous year, two young babies had died in circumstances that health practitioners on the hospital ward concerned had been unable to explain. They subsequently failed to investigate the cause of the deaths adequately and therefore to discover the presence of harmful bacteria until more than twenty babies had passed away.

Journalists demanded a full investigation into the babies' deaths and a public explanation of the practices that had allowed them to occur, but when their questions were left unanswered the news agenda soon drifted to other matters of local importance. The victims' families continued to pressure the health authorities to provide them with an explanation but none was forthcoming and they began to lose hope that they would ever penetrate the official silence that had begun to surround the matter.

Relatives were understandably distressed and frustrated at being unable to secure a full investigation into the incident and to make certain that hospital staff and management were held accountable for their children's deaths. Furthermore, they were concerned that the hospital's policies should be assessed and altered to help avoid the repetition of any

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similar incident in the future. However, according to our source, once the hospital closed ranks there was little they could do to satisfy their search for facts at the centre of the tragedy or to see those responsible properly sanctioned.⁶

Access to information is a vital component of any serious strategy to promote and protect the right to reproductive and sexual health and when it is absent, the consequences can be devastating. In 1995, ARTICLE 19 first began to analyse this relationship in our book *The Right to Know: Human rights and access to reproductive health information*. This publication was at the forefront of a new and dynamic approach to women's reproductive health and choice, where public health and international human rights law intersect. We argued that women can only make and act upon informed decisions about how to avoid unwanted pregnancies, space births and prevent the transmission of sexually transmitted diseases if they are provided with accurate information and have full access to medical services. We found that in countries ranging from the United States to Kenya and from Chile to Poland, women were constantly disadvantaged by the failure of governments to fulfil these minimum requirements.

Last year, ARTICLE 19 decided to revisit this area of our work and to apply our arguments in a practical context. In cooperation with two Peruvian organisations, IPYS and Flora Tristan, we have sought to test the impact of the new access to information law as it relates to sexual and reproductive health rights and the following report presents our collective findings. We have taken a more focused view of the main concerns that drove our work in the mid-1990s in order to raise awareness of the importance of this legislation within the health sector and ensure its more even and thorough implementation. Our research also aimed to identify the information needs of groups working with women in poor areas and to capture their experiences of using the legislation to date.

ARTICLE 19's experience to date has shown that by connecting the right to information to the right to health, the full potential of access laws for citizen empowerment can be

⁶ ARTICLE 19 has not investigated the facts of the case further.

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realised. Issues that are often taboo can be demystified and properly debated by governments, civil society groups, multi-lateral agencies and the public, thus ensuring the protection of and respect for the reproductive and sexual health rights of individual women more effectively. We hope that over time access to information laws are treated as integral to the package of reforms necessary to relieve poverty and improve reproductive and sexual health.

The access to information trend

Open societies have become the hallmark of democracy and the right to freedom of information is perhaps their most important dimension; it has long been recognised as a human right and the touchstone for the realisation of all other rights⁷. Access to information laws form a central pillar of the democratic system by helping to expand social citizenship and ensure a free flow of information to the public sphere that fosters vibrant and constructive public debate. This information is the lifeblood of civil society and informs its efforts to represent the interests of diverse social groups more successfully. The proactive publication of documents permits individuals an insight into the mechanics of government thereby laying bare institutions which in the past may have appeared to be self-interested and detached from the needs of the general population. Imaginative alliances are being forged as access to information activists are increasingly outward-looking and committed to sharing their expertise with groups working on a vast array of public interest matters. The trend towards greater openness is altering the political landscape and creating a new opportunity for citizens to take direct and effective action on some of the defining issues of our times.

⁷ On the 14th December 1946, during its first session, the UN General Assembly adopted Resolution 59(1) which stated: Freedom of information is a fundamental human right and ... the touchstone of all the freedoms to which the UN is consecrated.

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In recent years, Courts in Japan, India and South Korea, amongst others, have ruled that the constitutional right to freedom of expression includes the right to access information held by the State. Other more established democracies explicitly recognise the right to freedom of information within their constitutions and in the past decade, countries that are undertaking democratic transitions, such as Thailand, Nepal and the Philippines, have followed suit by incorporating this right into their constitutions. A number of African countries, including Malawi and South Africa, possess the constitutional right to access information whilst many Latin American constitutions tend to focus on one dimension to the right to information, *habeas data*. This is the right of anyone to access information about him or herself, whether held by public or private bodies and where necessary, to update or correct it.

The first access to information law was passed in Sweden in 1766 but it is only in the past twenty-five years that the global trend for adopting legislation has gathered pace. In the past five years, legislation has been passed in India, Fiji, Japan, South Africa, Panama, Ecuador, Mexico, the United Kingdom and a number of European States. In doing so, they join a range of countries that enacted laws some time ago, including the United States, Australia, Canada and the Netherlands. Dozens of countries across Latin America, Asia and Africa are in the process of debating draft laws and many are on the brink of approving legislation⁸. A wave of transparency legislation is sweeping the globe and fortunately, shows no sign of abating. Cross-regional networks have grown up around the issue as both advocates and governments work together on what has increasingly become an international agenda.

Access to information and poverty

Latin America shows the largest income disparity of all geographical regions; the richest 10th earn 48% of total income, the poorest 10th, 1.6%.⁹ Over half of Peru's population

⁸ For a full global survey of access to information legislation, please see David Banisar's piece found at www.freedominfo.org

⁹ Another Lost Decade, Scott Johnson, Newsweek, July 4 2004, p40
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currently live below the poverty line¹⁰; most of the total poor live in urban zones but the majority of those living in extreme poverty are concentrated in rural mountainous and jungle regions. People living in poor areas tend to enjoy less personal security, have few educational opportunities and possess only limited access to community public and private resources¹¹. The incidence of poverty is intimately connected to patterns of ethnicity and race; in Peru, poverty levels amongst indigenous and afro-descendent communities are twice the national average. Whilst historical explanations of slave labour partly account for the origins of this inequality, it is sustained today by discrimination, language barriers and geographical isolation which exclude these groups from mainstream social, political and economic life¹².

It is those communities most affected by poverty in Peru which are least able to obtain information, especially relating to basic services, thereby preventing them from demanding their rights and entitlements. Poor communities are amongst the most afflicted by environmental and social problems in Peru, which they are unable to tackle adequately due to a lack of public data on their true nature. They are often the passive objects of policy making and not treated as stakeholders who must be incorporated into important decision-making processes. As a result, poor people are often excluded from important debate, unable to participate in the public arena and prevented from influencing the decisions that have a profound effect on their everyday lives. Strategies to address the complex development issues affecting Peru can only be devised if there is adequate information compiled about their character and impact, information which is then made available to other governments, aid agencies, specialist groups, civil society and the public. Furthermore, information must be published about the programmes designed to tackle poverty in order to ensure groups can assess the extent to which they are well-conceived and effective. All development projects should be subject to the same level of analysis as the problems they are designed to address.

¹⁰ Toledo Speaks of Battle Against Poverty in Peru, Doug Gavel
www.ksg.harvard.edu/news/news/2002/toledo_speech_041302.htm

¹¹ Access to Information in Developing Countries (Working Paper) by Robert Martin and Estelle Feldman, April 1998, Transparency International www.transparency.org/working_papers/martin-feldman/5-why-develop.html p2

¹² DFID Latin America Regional Strategy Plan, August 2004
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Whilst there are many factors that contribute to the prevalence of poverty in Peru, it is impossible to discuss the phenomenon meaningfully without mentioning the caustic effect of corruption. The poor bear the greatest burden of the corruption that persists due in part to the lack of access to information about the acquisition and use of public funds which allows malpractice to continue unchecked. Corruption, broadly defined as ‘the abuse of public power for private gain’, allows inefficiency to endure and distorts the potential for growth. It discourages foreign investment and corrodes the budgets allocated to public procurement that enable basic infrastructure in poverty stricken areas to be built, such as roads, schools and hospitals. In a country such as Peru, where the tax-base is already small, and there is therefore only limited investment in social services, it is the poor who suffer most when corruption diverts economic benefits away from their communities. High levels of corruption both reduce the effectiveness of aid-funded projects and weaken public support for assistance in donor countries.

Access to information legislation is fundamental to efforts to eradicate poverty: economic resources to address poverty are not lacking, it is the political dimension to the problem that must be tackled. Extreme poverty has the potential to seriously erode the democratic institutional framework and when State institutions deteriorate, services such as health and education become privileges accessed primarily by those who already have resources and power. Poverty eradication requires the implementation of fundamental reforms to promote broader political participation, ensure accountability and transparency of government, and create a strong role for community groups in policy-making. The free flow of information is the basis for all of these processes and is key to ensuring the well-being, stability and progression of society. Good governance principles help ensure that States remain responsive to the needs of the general population and are accountable to different social sectors, including the poor. People are empowered by accessing public information that they can then apply in legal and political processes to safeguard their rights. Information enables communities to challenge the circumstances in which they find themselves and helps balance the unequal power dynamic that exists between people

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marginalised through poverty and their governments, which in Peru has recently found expression in considerable social unrest.

Access to information and reproductive and sexual health

Poor people, especially women and adolescents, face immense social and economic barriers to sexual and reproductive health. Every year, 529,000 women around the world die from complications associated with pregnancy and childbirth and 3 million children die in the first week of life. A woman's lifetime risk of dying due to maternal causes is one in 160 in Latin America, compared to one in 2,800 in developed countries¹³, and Peru has one of the highest rates of maternal mortality on the continent with an average of 900 women dying every year¹⁴. In Peru, HIV/AIDS is concentrated amongst the most vulnerable populations and it is estimated that there are approximately 80,000 adults aged between 15 and 49 living with the virus¹⁵. Although men make up the largest number of HIV/AIDS carriers, 27,000¹⁶ of these cases are women and the incidence of infection amongst women is rising.

As these statistics reveal, one of the most vulnerable groups in today's society is women, who continue to be constrained by systems of poverty, patriarchy and racism in Peru. Reproductive and sexual health choices are impacted by the large gap between women and the health system caused by differences in socio-economic conditions, culture, language, education and religion. With decisions about family planning policies being taken by politicians and heavily influenced by religious hierarchies and pharmaceutical companies, the views of women's groups are often overlooked. Public policy making plays a central role in shaping public opinion, social values, and even morality and,

¹³ DFID Strategy Paper, p6

¹⁴ www.unicef.org/peru/dialogo_3.htm

¹⁵ <http://hivinsite.ucsf.edu/global?pages=cr05.pe.00>

¹⁶ <http://hivinsite.ucsf.edu/global?pages=cr05.pe.00>

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accordingly, also in defining the parameters of women's reproductive and sexual health choices¹⁷.

Although there has been progress made in closing the gender gap in income in Latin America there remains an immense challenge ahead to eradicate gender inequality in its broadest sense. Discrimination is a human rights violation but rarely treated as such, with legislation in many countries creating an environment that is conducive to persistent inequality. Where legislation does exist, oftentimes it is not enforced and mechanisms for redress are uncommon. The difficulties faced by women are reaffirmed by practices that prevent them from taking control over their reproductive and sexual health lives. Some health establishments around the world, for example, require women to provide written permission from their husbands in order to obtain contraceptive methods. Sweeping patterns of social exclusion that reduce the decision-making power of women in the household, generate financial insecurity and deny women access to education and later employment, serve to limit the capacity of women to make full use of the health services available thereby exposing them to far greater health risks.

It is for this reason that a rights-based approach to reproductive and sexual health is crucial. By locating debates over health within a human rights framework, it is far easier to identify and address the many complex factors that prevent individuals from accessing basic care, within the context of arguments favouring greater social justice. In advocacy terms, it is a more powerful case to oblige governments to promote and protect the *right* to health as opposed to discussing the population's *needs* in a much more general sense. By working towards the realisation of the right to health, women living in poor areas will be better able to make their voices heard in the public sphere and therefore to demand and use the services to which they are entitled.

¹⁷ This argument was first made in ARTICLE 19's Publication *The Right to Know: Human Rights and access to reproductive health information*, ARTICLE 19 and University of Pennsylvania Press, 1995 and is developed further in section two of this report.

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At the heart of this process is the right to freedom of information. For hundreds of years, women died from infections as they observed rituals in which they did not clean themselves for a fixed period of time after childbirth. In some communities, people continue to believe that HIV and AIDS can be transmitted by mosquitoes or prevented by having sex with virgins. The myths surrounding the spread of HIV and AIDS have repeatedly undermined prevention programmes rendering millions of people vulnerable to infection. It is essential to build demand for sexual and reproductive health services by supplying poor people with information about reproductive and sexual health issues, giving them a greater say in decision-making processes and enhancing their capacity to hold providers accountable for the delivery and quality of services. Social policies and practices need to be buttressed by rights-based legal and policy frameworks in order to ensure their maximum impact and sustainability.

How can access to information laws be used to help reduce poverty by improving reproductive and sexual health?

Poverty is a significant factor in rendering people vulnerable to poor reproductive and sexual health and in turn, the experience of reproductive and sexual health problems can serve to impoverish individuals or even whole communities further. Local groups are increasingly using access to information legislation to obtain information related to key issues of concern in their countries including adolescent pregnancy, maternal and infant mortality, abortion and HIV/AIDS in order to halt this trend. There are four central ways in which this information is applied in order to strengthen reproductive and sexual health and therefore reduce poverty.

Firstly, civil society organisations are using the law to access budgetary information which is fed into **gender budget analyses**. These measure the gap between policy commitments in the field of reproductive and sexual health, the resources allocated to underpin public policies and the outcomes of particular policies. This in turn allows them to evaluate the extent to which policy making and public spending meet the needs of different social groups and helps ensure the equitable distribution of resources between

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men and women. Where it is discovered that public resources are misdirected, civil society organisations are using the legislation to hold public bodies to account and to expose corruption or inappropriate service delivery wherever it may exist.

Secondly, many groups are using the law in an attempt to obtain **current statistics and epidemiological information** which are used as a foundation for public policy-making, for designing health care programmes and to attend to the specific needs of local populations. This information may relate to the number of sterilisations carried out at a national level, the rate of HIV infection in a particular state or the principle causes of maternal mortality. In order to advocate changes to public policies, budgets or the delivery of health services, it is important to establish and assess the factual basis upon which they are constituted. This information can be used to help define policy making agendas and to engage with government in a constructive manner.

Thirdly, organisations are using the legislation to view **public policy indicators** which enable them to monitor the effects of policies once they are applied on the ground. This information may include the explicit objectives of a health program, a profile of the intended project beneficiaries, details of the institutions responsible for implementing government-led campaigns and the impact of health policies on different demographic groups. This information enables civil society organisations to research, monitor and highlight weaknesses in existing policies, and to make informed best-practice recommendations for reform.

Finally, groups are using the access to information law to obtain documents relating to the internal operation of government departments in order to assess the level of **transparency** within these institutions. This information may relate to staffing issues, government salaries, equipment, resource allocation and procedures for making decisions over health care development. As public bodies, health authorities must uphold principles of administrative transparency through their work and should make information about their own operation routinely available to the public (through websites, reports, media statements etc.) in order to promote accountability and earn public trust.

This last point has been of particular concern in Mexico where civil society groups have focused upon the need to root out and expose poor decision-making within central government. When a coalition of non-governmental organisations realised that 30 million pesos (approximately US\$3 million) had been directed away from HIV/AIDS prevention activities, they used the Freedom of Information Act to clarify where this funding had been channelled and why it had been pruned from the original budget. The coalition obtained a series of government documents which revealed that the 30 million pesos had been reassigned to women's centres closely connected to a pro-life committee. Further investigation confirmed that this decision was unlawful and the coalition has since filed a claim before the House of Representatives. This is the first time civil society groups have formally denounced the abuse of power by a Congress member¹⁸.

Report Overview

This report is structured by three main sections and a central empirical study. As it will illustrate, the right to have access to reproductive and sexual health information is firmly established under international law and various international bodies have identified a number of concrete obligations arising from international treaties that pertain to its full realisation. It is argued that Peru has taken a significant step towards protecting this right by passing an access to information law but there are many challenges ahead if it is to be implemented properly.

One of the most noteworthy of these obstacles is the lack of public awareness of the law and the deep-seated distrust of public institutions, particularly the judicial branch of government. As the report discusses, a huge percentage of people in Peru do not believe that laws apply to everyone due to the arbitrary nature with which they are often enforced. The judiciary is a widely discredited institution which does not inspire confidence in those who attempt to exercise their rights and until the government

¹⁸ Right of Access to Information in Mexico: A Diagnosis by Society *Citizens claim for transparency and accountability: Experience in public resources deviation monitoring*, p35.

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addresses these political and cultural difficulties, the right to access to information will be curtailed. The law itself also needs to be reviewed if the administrative procedures it establishes are going to facilitate rather than hinder access to public information and whilst considerable progress has been made within State health establishments, more resources and training are required to ensure that public officials are able to uphold their new responsibilities under the legislation on a day-to-day level.

The limitations on the right to access information in the past has had serious implications for the Peruvian health sector and it is important to capitalise on the window of opportunity created under the new Health Minister to develop reproductive and sexual health policies that are rooted in a respect for human rights. Domestic developments in Peru have been strongly impacted upon by the women's movement and new international agreements, and most recently the reintroduction of the 'global gag rule'¹⁹ under President Bush's administration which prevents overseas NGOs from receiving USAID co-financing for family planning services if they perform abortions in cases other than a threat to the life of the woman, rape, or incest; provide counselling and referrals for abortion or; lobby to make abortion legal or more available in their country. This measure has weakened the capacity of civil society and had a detrimental effect on reproductive and sexual health rights in Peru along with a large number of countries around the world.

Within this context, the access to information law has assumed an even greater significance. In the empirical study contained in this report, we examine the complex interplay of these issues in practice. The value of information in promoting consensus and empowering the public should give human rights NGOs and those working specifically with women, adolescents and people living with HIV and AIDS pause for thought. It is argued that organised groups are in a strong position to represent marginalised sectors of society, as well as to increase public interest in participation by driving forward an inclusive social agenda. Acting as a bridge between these communities and State bodies, grassroots groups are well placed to assist individuals in overcoming the psychological

¹⁹Officially called the Mexico City Agreement.

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and practical barriers that hamper their ability to participate in public life. The study exposes the need to ensure that accurate and unbiased information is actively publicised by the government and civil society groups so that individuals living in disadvantaged areas can take effective measures to protect their health and well-being.

This report is intended to provide resource material for the Peruvian Ministry of Health as it works towards implementing the access to information law throughout its institutional structure and civil society groups who are increasingly using the legislation to obtain public documents that can enable them to advocate the right to health in a strategic fashion. We hope the report facilitates a greater understanding between these two sectors as they rise to meet the challenges and opportunities created by the access to information legislation and provides a reference point for cooperation on a common agenda that can only benefit Peruvian society as a whole. It is our intention that the report and our continued work in this area will generate ‘lessons learned’ for other countries and contribute to a clearer insight into the practical application and effect of access to information laws in direct relation to the design and execution of public policy.

Chapter 2

The Right to Information on Reproductive Health under International Law

Peter Noorlander, ARTICLE 19

I. Introduction²⁰

This chapter will look at the extent to which the right to access information on reproductive health²¹ is protected under international law.

The right to access reproductive health information is a relatively recent right in international law that has strong roots in long-established rights such as the right to information. International courts and bodies set up to monitor the implementation of these rights, chiefly under the *Universal Declaration of Human Rights*²² and the main human rights conventions signed under the auspices of the United Nations in the 1960s and 1970s,²³ have supported the right to access reproductive health information as a necessary component for the establishment of the rights to life, health and information, amongst others. For example, the United Nations Committee on Economic, Social and Cultural Rights has said that the right to health means that States are under a specific legal

²⁰ This chapter draws significantly on a previous ARTICLE 19 publication on the subject, “The right to information necessary for Reproductive Health and Choice under International Law”, in S.Coliver ed., *The right to know: human rights and reproductive information*, ARTICLE 19/University of Pennsylvania Press 1995, pp. 38-83. This chapter updates this previous publication and provides specific comments relating to those international instruments that are relevant to Peru.

²¹ We will use the term “access to reproductive health information” as a basket term which encompasses access by private individuals or organisations to any information, whether held by public or private bodies, that is relevant to reproductive health. Examples would be information on family planning methods or information relating to sexual health.

²² UN General Assembly Resolution 217A (III), adopted 10 December 1948.

²³ The *International Covenant on Economic Social and Cultural Rights*, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entered into force 3 January 1976, ratified by Peru 28 July 1978; *International Covenant on Civil and Political Rights*, adopted and opened for signature, ratification and accession by UN General Assembly Resolution 2200A(XXI) of 16 December 1966, entered into force 23 March 1976, ratified by Peru 28 July 1978.

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obligation to provide information on reproductive health,²⁴ and the UN committees on women's and children's rights have made similar statements.²⁵

Explicit political recognition for the right to access reproductive health information came in 1994 when, meeting in Cairo for the International Conference on Population and Development, world leaders agreed:

Reproductive health implies that people ... have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed ...²⁶

This recognition was reaffirmed in 1999, when world leaders meeting to review the implementation of the 1994 Programme of Action referred to the “basic right ... to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so ...”²⁷

In this chapter, we will map out the body of international law that supports the right of access to reproductive health information. It identifies a number of treaty provisions that, read together with political declarations, court findings and statements by international bodies, support the notion that the right to access reproductive health information is now firmly established in international law. Finally, this chapter will identify a number of binding obligations on States that flow from the recognition of this right.

²⁴ General Comment No. 14 (2000), 11 August 2000, UN Doc. E/C.12/2000/4, paras. 11, 34-37, 44.

²⁵ Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 24 (20th session, 1999); Committee on the Rights of the Child, General Comment No. 4, Adolescent health and development in the context of the Convention on the Rights of the Child, U.N. Doc. CRC/GC/2003/4 (2003).

²⁶ Programme of Action of the International Conference on Population and Development, Cairo, 5-13 September 1994, UN doc. A/CONF.171/13, 18 October 1994, para. 7.2. The Conference was global, being attended by representatives from 183 countries, of whom 155 made statements (UN doc. A/CONF.171/13, 18 October 1994). This statement is replicated in paragraph 96 of the Beijing Platform for Action: Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995).

²⁷ Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, UN General Assembly Resolution of 8 November 1999, UN Doc. A/RES/S-21/2.

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II. International Standards

International law guarantees the right of access to reproductive health information explicitly in the *Convention on the Elimination of all forms of Discrimination against Women* (CEDAW)²⁸ as well as under a number of other separate, legally binding treaty provisions. Article 10(h) of CEDAW requires States to “take all appropriate measures to ... ensure, on a basis of equality of men and women, access to ... information and advice on family planning.” Broader legal obligations, outside the sphere of non-discrimination, are included under the rights to freedom of expression and information, health, life, privacy, dignity, liberty and security, and the right to decide on the number and spacing of one’s children. The right to access reproductive health information forms an integral part of all these rights, which are interlinked and each of which reinforces the others.

The following paragraphs discuss each of these rights in detail, mapping out the way in which they are linked and reinforce each other to protect the right to access reproductive health information. The two main rights discussed are the right to freedom of expression and information and the right to health. Both are long-standing rights that were included in the 1948 *Universal Declaration of Human Rights*, form part of customary international law²⁹ and have been included in a number of global and regional treaties. Statements of international courts and other bodies established to supervise the implementation of these treaties have made it clear that both rights directly support the right to access reproductive health information. In addition, the right to access reproductive health information finds indirect support through a range of other rights, including the right to life, the right to security, liberty and dignity, the right to a private life and the right to decide on the spacing of one’s children.

²⁸ Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979, entered into force 3 September 1981, ratified by Peru on 13 October 1982.

²⁹ See, for example, *Barcelona Traction, Light and Power Company Limited Case (Belgium v. Spain)* (Second Phase), ICJ Rep. 1970 3 (International Court of Justice); *Namibia Opinion*, ICJ Rep. 1971 16, Separate Opinion, Judge Ammoun (International Court of Justice); *Filartiga v. Pena-Irala*, 630 F. 2d 876 (1980) (US Circuit Court of Appeals, 2nd Circuit). Generally, see McDougal, M.S., Lasswell, H.D. and Chen, L.C., *Human Rights and World Public Order*, (Yale University Press: 1980), pp. 273-74, 325-27.

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Finally, the general principle of equality before the law and non-discrimination is crucial to the implementation of the right to access reproductive health information. In practice, sexual and reproductive health issues tend disproportionately to affect marginalised groups, such as (adolescent) women living in rural areas. The principle of non-discrimination and equality requires States to take active steps to ensure that information and education programmes reach everyone.

II.1 Freedom of Expression and Information

The right to freedom of expression and access to information has a rich pedigree in international law. Pioneered in the national law of countries as diverse as Sweden³⁰ and Colombia,³¹ it was recognised in the first session of the United Nations' General Assembly as “a fundamental human right and ... the touchstone of all the freedoms to which the UN is consecrated.”³²

Subsequently, freedom of expression and information has been guaranteed globally through Article 19 of the *Universal Declaration of Human Rights* and Article 19 of the *International Covenant on Civil and Political Rights*.³³ The latter, which is a legally binding treaty ratified by Peru in 1978, states:

2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art or through any media of his choice.

³⁰ The Swedish Freedom of the Press Act, 1766, which now forms part of the Swedish Constitution, decreed that “every Swedish citizen shall have free access to official documents.”

³¹ Code of Political and Municipal Organization, 1888.

³² UN General Assembly Resolution 59(1), 14 December 1946.

³³ Note 23.

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Freedom of expression is also guaranteed in regional human rights treaties, including the *American Convention on Human Rights* (ACHR),³⁴ ratified by Peru in 1978,³⁵ and the *European Convention on Human Rights* (ECHR).³⁶

Treaties such as these constitute ‘hard law’. States that have ratified them are legally bound to implement them in their national laws and practices. In interpreting the precise content and meaning of the rights guaranteed in these treaties, it is necessary to turn to the various international bodies set up to monitor and supervise their implementation, such as the UN Human Rights Committee, the Inter-American Court of Human Rights and the UN and OAS special rapporteurs on freedom of expression. Because of the many similarities between the UN, Inter-American and European human rights treaties, judgments and decision by authoritative bodies in one system can be used to help interpret the provisions of the other treaties.³⁷

It has become clear from statements made by these bodies and judgments handed down by international courts that the right to freedom of expression and information has a number of distinct components. In this chapter, we will focus on two of them:

1. the right of individuals to provide information and the right of others to receive that information; and
2. the obligation on States to provide information in key areas of public policy

We discuss these in turn.

II.1.1 The Right to Provide and Receive Information

³⁴ OAS Treaty Series No. 36, 1144 U.N.T.S. 123, entered into force July 18, 1978, Article 13.

³⁵ 28 July 1978.

³⁶ Adopted 4 November 1950, entered into force 3 September 1953.

³⁷ This is particularly important because the European human rights system is both the longest established one, and the most developed. The Inter-American Court of Human Rights has, for example, referred to European Court of Human Rights cases in deciding freedom of expression cases before it: see for example *Herrera-Ulloa v. Costa Rica*. Judgment of 2 July 2004, Series C. 107, para. 134.

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The right of every individual and group to impart information and the right of others to receive that information are core elements of the right to freedom of expression. Although the right is not an absolute one, international law treats freedom of expression as one of the most fundamental rights in democracy³⁸ and permits it to be restricted only in exceptional circumstances.

Article 19(3) of the ICCPR sets out the conditions States must overcome if they take actions that restrict the right to freedom of expression:

3. The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
 - (a) For respect of the rights or reputation of others;
 - (b) For the protection of national security or of public order, or of public health or morals.

This has been interpreted to set a very high threshold for any State actions that have the effect of restricting expression or information, crystallised in a three-part test.³⁹ First, the interference must be provided for by law. The law must be accessible and “formulated with sufficient precision to enable the citizen to regulate his conduct.” Second, the interference must pursue one of the legitimate aims listed in Article 19(3); this list is exclusive. Third, and most importantly, the interference must be “necessary” to secure that aim, in the sense that it serves a pressing social need, that the reasons given to justify it are relevant and sufficient and that the interference is proportionate to the legitimate aim pursued. This implies that restrictions must be narrow and effective. Restrictions which are overbroad, or which go beyond what is necessary to protect the legitimate aim, are not legitimate. Furthermore, restrictions which are not effective in securing the legitimate aim cannot be justified. International jurisprudence makes it clear that this is a

³⁸ E.g. *Laptsevich v. Belarus*, 20 March 2000, Communication No. 780/1997 (UN Human Rights Committee), para. 8.2.

³⁹ *Mukong v. Cameroon*, Communication No. 458/1991, U.N. Doc. CCPR/C/51/D/458/1991 (1994), para. 9.7. Similar formulations can be found in the European and American regional human rights treaties: see, for example, *Herrera-Ulloa Vs. Costa Rica*, 2 July 2004, Series C No. 107 (Inter-American Court of Human Rights), paras. 120-124.

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strict test, presenting a high standard which any interference must overcome. This is apparent from the following quotation, cited repeatedly by the European Court of Human Rights:

Freedom of expression, as enshrined in Article 10, is subject to a number of exceptions which, however, must be narrowly interpreted and the necessity for any restrictions must be convincingly established.⁴⁰

One of the early cases considered by the European Court of Human Rights is a good illustration of the kind of State action that would be considered to be an illegal interference with the right to provide reproductive health information. In *Open Door Counselling and Dublin Well Woman Centre and Others v. Ireland*,⁴¹ the Irish government had prohibited a number of organisations from providing pregnant women with information concerning abortion facilities abroad, on the basis that this was necessary to protect public morals. While it acknowledged that governments have some power to act to protect public morals, the European Court did not hesitate to find that a prohibition on the mere provision of information regarding abortion constituted a violation of the right to freedom of expression:

[T]he injunction limited the freedom to receive and impart information with respect to services which are lawful in other Convention countries and may be crucial to a woman's health and well-being.⁴²

The Court also stressed the negative consequences arising from the lack of availability of information:

[T]he available evidence, which has not been disputed by the Government, suggests that the injunction has created a risk to the health of those women who are now seeking abortions at a later stage in their pregnancy, due to lack of proper counselling, and who are not availing themselves of customary medical supervision after the abortion has

⁴⁰ *Sunday Times v. the United Kingdom (No. 2)*, 24 October 1991, Application No. 13166/87, para. 50.

⁴¹ 29 October 1992, Application No. 14234/88 and 14235/88 (European Court of Human Rights).

⁴² *Ibid.*, para. 72.

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taken place. Moreover, the injunction may have had more adverse effects on women who were not sufficiently resourceful or had not the necessary level of education to have access to alternative sources of information.⁴³

Courts have also held that the right to freedom of expression imposes a ‘positive obligation’ on States to ensure that persons wishing to provide information are not barred from doing so by others. In other words, the State has to ensure an environment within which everyone can exercise their right to freedom of expression freely. For example, in *Plattform Ärzte für das Leben v. Austria*,⁴⁴ the European Court of Human Rights held that the Austrian government had failed to protect the right to freedom of expression of a group of demonstrators whose marches had been disrupted by others. Within the Inter-American human rights system, the Commission has stressed “the freedom ... to express and impart ... ideas, as well as the complementary freedom of all citizens to receive such information without illegal or unjustified interference...”⁴⁵ The Inter-American Court has repeatedly emphasised the indivisible nature of the right to freedom of expression:

[T]he individual right [to] freedom of expression is not exhausted in the theoretical recognition of the right to speak or write, but also includes, inseparably, the right to use any appropriate method to disseminate thought and allow it to reach the greatest number of persons. In this respect, the expression and dissemination of thought and information are indivisible, so that a restriction of the possibilities of dissemination represents directly, and to the same extent, a limit to the right to free expression.⁴⁶

Moreover, the Court has emphasised that the right of the listener to receive information from others is as important as the right of the speaker to impart information:

[F]reedom of expression is a medium for the exchange of ideas and information between persons; it includes the right to try and communicate one’s points of view to others, but it implies also everyone’s right to know opinions, reports and news. For the

⁴³ *Ibid.*, para. 77.

⁴⁴ 25 May 1988, Application No. 10126/82.

⁴⁵ *Oropeza v. Mexico*, 19 November 1999, Report No. 130/99, Case No. 11.740, para. 53.

⁴⁶ *Baruch Ivcher Bronstein v. Peru*, 6 February 2001, Series C, No. 74, para. 147.

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ordinary citizen, the right to know about other opinions and the information that others have is as important as the right to impart their own.⁴⁷

In an earlier Advisory Opinion, the Court had already stated that “[freedom of expression] entails a collective right to receive any information...”⁴⁸

The government, as the guarantor of rights to its citizens, is thus under an obligation to ensure the effective exercise of the right to freedom of expression for all, which includes the right of citizens to receive information – including on reproductive health issues – that others are willing to impart.

II.1.2 State Obligations to Provide Information

The right to access information held by public authorities, sometimes referred to as ‘freedom of information’, is a crucial element of the right to freedom of expression. Commenting on Article 19 of the ICCPR, the UN Special Rapporteur on Freedom of Opinion and Expression⁴⁹ has noted:

The right to seek or have access to information is one of the most essential elements of freedom of speech and expression.⁵⁰

He returned to this theme in 1997 and since that year has included commentary on the right to freedom of information in each of his annual reports to the UN Commission on Human Rights. In his 1998 Annual Report, the Special Rapporteur declared that freedom of information includes the right to access information held by the State: “[T]he right to seek, receive and impart information imposes a positive obligation on States to ensure

⁴⁷ *Ibid.*, para. 148.

⁴⁸ Advisory Opinion OC-5-85, *Compulsory Membership in an Association prescribed by Law for the Practice of Journalism*, 13 November 1985, Series A, No. 5, para. 30.

⁴⁹ The Office of the Special Rapporteur on of Opinion and Expression was established by the UN Commission on Human Rights, the most authoritative UN human rights body, in 1993: Resolution 1993/45, 5 March 1993.

⁵⁰ Report of the Special Rapporteur, *Promotion and protection of the right to freedom of opinion and expression*, UN Doc. E/CN.4/1995/32, 14 December 1995, para. 35.

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access to information, particularly with regard to information held by Government in all types of storage and retrieval systems.”⁵¹ His views were unanimously welcomed by the Commission on Human Rights, of which Peru was a member at the time.⁵² The Special Rapporteur further developed his commentary on freedom of information in his 2000 Annual Report to the Commission on Human Rights, noting the fundamental importance of this right not only to democracy and freedom, but also to the right to participate and realisation of the right to development.⁵³

In 2003, the General Assembly of the Organisation of American States (OAS) also recognised the importance of access to information. In Resolution 1932, it affirmed that access to information is “a requisite for the very exercise of democracy” and reiterated that States are obliged to adopt legislative and other regulations in order to enable the right.⁵⁴ This echoed the Declaration of Principles on Freedom of Expression adopted by the Inter-American Commission on Human Rights, Principle 4 of which states: “Access to information is a fundamental right of every individual. States have the obligation to guarantee the full exercise of the right ...”⁵⁵

The right of freedom of information implies not only that States must provide information held by them on request, but also that they should take active steps to provide information in certain crucial areas, including information that is relevant to the protection of health. International courts such as the European Court of Human Rights have confirmed that States are under a strong obligation to provide information that is important to the health of those under their jurisdiction. Interpreting a provision in the European Convention that

⁵¹ Report of the Special Rapporteur, *Promotion and protection of the right to freedom of opinion and expression*, UN Doc. E/CN.4/1998/40, 28 January 1998, para. 14.

⁵² Resolution 1998/42, 17 April 1998, UN doc. E/CN.4/RES/1998/42, para. 2. Peru’s current period of membership runs from 1998-2006.

⁵³ Report of the Special Rapporteur, *Promotion and protection of the right to freedom of opinion and expression*, UN Doc. E/CN.4/2000/63, 18 January 2000, para. 42.

⁵⁴ AG/RES. 1932 (XXXIII-O/03), paras. 1-2. The General Assembly is the supreme organ of the Organisation of American States. All OAS Member States are represented in the General Assembly, including Peru.

⁵⁵ *Declaration of Principles on Freedom of Expression*, adopted by the Inter-American Commission on Human Rights on 19 October 2000. The Commission is a body made up of 7 human rights experts that has been established to promote the observance and the defence of human rights in the Americas. Its members serve in an individual capacity.

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guarantees the right to private life,⁵⁶ the Court found that the Italian State had violated the rights of the inhabitants of a small town by failing to provide them with adequate information relating to pollution emanating from a nearby factory.⁵⁷ The Court's reasoning can be extended to other categories of information that are crucial to the protection of life and health, and it has indicated in other cases that it considers the provision of reproductive health information to be particularly important.⁵⁸

II.2 The Rights to Life and Health

The right to life is at the core of all the major human rights treaties.⁵⁹ The scope of this right is a broad one and extends beyond the narrow right not to be deprived of one's life arbitrarily. In 1989, the UN Human Rights Committee stated:

The right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot be properly understood in a restrictive manner, and the protection of this right requires that states adopt positive measures.⁶⁰

In particular, the Committee recommended that States should implement "all possible measures" necessary to reduce infant mortality and increase life expectancy.⁶¹ The European Court of Human Rights and the Inter-American Court of Human Rights have affirmed this interpretation.⁶²

The implementation of "all possible measures" can be argued to include the provision of information on reproductive health, including information on family planning, sexually-

⁵⁶ Article 8 ECHR. Because of its different formulation – unlike Article 19 ICCPR and Article 13 of the ACHR, it does not guarantee a right to 'seek' information – the European Court has held that the freedom of expression provision in the ECHR does not guarantee access to information: *Sirbu v. Moldova*, 15 June 2004 (admissibility), Application no. 73562/01.

⁵⁷ *Guerra and others v. Italy*, 19 February 1998, Application No. 14967/89.

⁵⁸ See *Open Door Counselling and Dublin Well Woman Centre and Others v. Ireland*, 29 October 1992, Application No. 1423/88 and 142335/88. This case is discussed in section II.1.1.

⁵⁹ ICCPR, Article 6 and ACHR, Article 4.

⁶⁰ General Comment No. 6.

⁶¹ *Ibid.*, para. 5.

⁶² See, for example, *Godinez Cruz case*, 20 January 1989, para. 185 (Inter-American Court of Human Rights) and *Osman v. United Kingdom*, 28 October 1998, Application no. 23452/94, para. 115.

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transmitted diseases, safe contraception methods and general information relating to the risk of early pregnancy and closely-spaced pregnancies.

Similar obligations arise from the right to health, a human right that is protected in a range of binding international treaties, including under Article 12 of the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*⁶³ and Article 10 of the Protocol of San Salvador.⁶⁴

In 2000, the UN Committee on Economic, Social and Cultural Rights, the supervising body for the ICESCR, adopted a General Comment on the interpretation of the ICESCR in which it pointed out that the right to health is connected with and dependent on the realisation of other rights, including the right to information.⁶⁵ The Committee stated that right to access reproductive health information constitutes a core component of the right to health.⁶⁶ Furthermore, States are under the following specific obligations of relevance to the issue of access to information:

- States should refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information;
- States should adopt legislation or take other measures ensuring equal access to health care and health-related services provided by third parties;
- States should ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services;
- States should ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning;
- States should ensure that third parties do not limit people's access to health-related information and services; and

⁶³ Note 23, ratified by Peru on 28 July 1978.

⁶⁴ *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights*, San Salvador, 17 November 1988, OAS Treaty Series No. 69, ratified by Peru 4 June 1995.

⁶⁵ General Comment No. 14 (2000), 11 August 2000, UN Doc. E/C.12/2000/4.

⁶⁶ *Ibid.*, at paras. 11, 44.

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- States should implement sexual and reproductive health information campaigns, in particular with respect to HIV/AIDS.⁶⁷

The Committee explicitly lists “the deliberate withholding or misrepresentation of information vital to health protection or treatment” as a clear-cut violation of the right to health.⁶⁸

In 2002, the UN Commission on Human Rights set up the office of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁶⁹ In his 2004 Report, the Special Rapporteur included a section on the rights to sexual and reproductive health in which he outlined the crucial nature of access to information for the implementation of these rights.⁷⁰ He emphasised that women should have equal access, both in law and in fact, to information on sexual and reproductive health issues. He noted that even with scarce resources, States can achieve major improvements in the sexual and reproductive health of their populations, pointing at the example of Sri Lanka, where significant advances have been made by improving education, increasing literacy, enhancing the quality of the health care services and making them more accessible.⁷¹ The same point has been made by the UN Committee on Economic, Social and Cultural Rights, which has pointed out that access to health information and care is most important for those who are least privileged: “[E]ven in times of severe resource constraints ... the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes.”⁷²

The UN Special Rapporteur on Freedom of Opinion and Expression has also identified access to health information as an area where States are under a strong positive obligation to ensure that individuals receive sufficient information. In his 2003 Annual Report to the

⁶⁷ *Ibid.*, at paras. 34-37.

⁶⁸ *Ibid.*, at para. 50.

⁶⁹ Established by the UN Commission on Human Rights, in Resolution 2002/31, 22 April 2002, UN Doc. E/2002/23- E/CN.4/2002/200.

⁷⁰ 16 February 2004, UN Doc. E/CN.4/2004/49.

⁷¹ *Ibid.*, paras. 28-31.

⁷² General Comment No. 3.

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UN Commission on Human Rights, the Special Rapporteur elaborated on the importance of the positive obligation on the State to provide information in relation to HIV education and prevention.⁷³ He endorsed the United Nations International Guidelines on HIV/AIDS and Human Rights,⁷⁴ which provide guidance in interpreting international legal norms as they relate to HIV and AIDS. Guidelines 6 and 9 of these state:

States should enact legislation to provide for the regulation of HIV-related ... information, so as to ensure widespread availability of qualitative prevention measures and services, [and] adequate HIV prevention and care information

States should also take measures necessary to ensure ... the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions

States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.⁷⁵

The Special Rapporteur on Freedom of Opinion and Expression also stated:

The effective exercise of the right to freedom of opinion and expression, including the right to seek, receive and impart information, is of the utmost importance for ensuring effective education and information campaigns to prevent HIV/AIDS. As demonstrated by the examples given below, information and education on HIV/AIDS are the cornerstone of prevention programmes, and the Special Rapporteur believes that the exercise of the right to freedom of opinion and expression is a sine qua non condition of effective information and education campaigns.⁷⁶

⁷³ Report of the Special Rapporteur, *Promotion and protection of the right to freedom of opinion and expression*, UN Doc. E/CN.4/2003/67, 30 December 2002.

⁷⁴ UN Doc. E/CN.4/1997/37.

⁷⁵ Note 73, at paras. 39, 40.

⁷⁶ *Ibid.*, para. 41.

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An important component of these information campaigns would be to provide information on reproductive health generally.⁷⁷ Importantly, the Special Rapporteur has noted that there appears to be a strong link between the exercise of the right to freedom of expression and information generally and the success of HIV/AIDS awareness programmes, and he urged all States to review laws or regulations that impact on the effectiveness of these programmes and to bring them in compliance with the ICCPR right to freedom of expression.⁷⁸

II.3 The Right to Decide on Number of Children

The right to decide freely on the number and spacing of one's children was first declared a human right at the 1968 International Conference on Human Rights held in Teheran, which proclaimed that “[p]arents have a basic human right to decide freely and responsibly on the number and spacing of their children.”⁷⁹ This was followed in 1974 with a more detailed statement, adopted by the World Population Conference convened in Bucharest:

All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community.⁸⁰

The Bucharest language differed from the Teheran Proclamation in a number of ways. Importantly, it expanded the holders of the right from “parents” to “couples and individuals”; it stated that people should have the means, in addition to the information and education, to assert the right; and it provided some elaboration of the notion of responsible decision-making.

⁷⁷ See *ibid.*, para. 44.

⁷⁸ *Ibid.*, para. 53.

⁷⁹ Proclamation of Teheran, 13 May 1968, Article 16.

⁸⁰ Para. 14(f).

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Following these and other statements, in 1979 the *Convention on the Elimination of all Forms of Discrimination against Women* was signed.⁸¹ Ratified by Peru on 13 October 1982, the Convention includes, in Article 16, a legally binding obligation on States parties to,

take all appropriate measures to ... ensure on a basis of equality of men and women ... the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

The Convention also obliges States parties to take real steps towards making family planning services and information available to rural women, in particular, based on the recognition that rural women are at a higher risk of a range of life- and health-endangering conditions than urban women.⁸²

In 1993, the Committee on the Elimination of Discrimination against Women, which supervises the implementation of the Convention, issued a General Recommendation on Equality in Marriage and Family Relations which states that “women are entitled to decide on the number and spacing of their children.”⁸³ The Recommendation notes that the decision to have, or not to have, children is “preferably made in consultation with spouse or partner”, but declares emphatically that such decisions “must not ... be limited by spouse, parent, partner or Government”.⁸⁴ The Recommendation strongly implies that the right to decide on the number and spacing of one’s children entails a right “to make an informed decision about safe and reliable contraceptive measures” and that this right, together with Article 10(h) of the Convention, entitles women to “have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services”.⁸⁵

⁸¹ Note 28

⁸² Article 14(2).

⁸³ General Recommendation 21.

⁸⁴ *Ibid.*, para. 22.

⁸⁵ *Ibid.*

II.4 Privacy, and Dignity, Liberty and Security

The right to access reproductive health information finds further indirect support through the right to respect for private life and the right to dignity, liberty and security of the person. There is a strong information component to the protection of these rights as well as an important cross-over to the ‘general’ rights to health and freedom of information discussed in Sections 0 and 0, above.

The “inherent dignity of the human person” is the well-spring from which all human rights derive; the ICCPR acknowledges that recognition of this dignity forms “the foundation of freedom, justice and peace in the world.”⁸⁶ Article 1 of the Universal Declaration proclaims: “All human beings are born free and equal in dignity and rights.” The obligation to respect the inherent dignity of the human person is made concrete and legally binding via the prohibition of “inhuman and degrading treatment or punishment” found in the ICCPR as well as in the Inter-American and European Conventions and the *African Charter on Human and Peoples’ Rights* (ACHPR).⁸⁷ The link between the inherent dignity of the person and the prohibition of degrading treatment is particularly strong in the American Convention on Human Rights.

In October 2003, the Inter-American Commission accepted a friendly settlement in a case of forced sterilization that ultimately caused the death of the petitioner, with the respondent State (Peru) accepting responsibility for violations of the rights to life, personal integrity and equality before the law.⁸⁸ This followed strong reports from the

⁸⁶ ICCPR, note 23, preamble.

⁸⁷ Adopted at Nairobi, Kenya, 26 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986, Article 5; ICCPR, note 23, Article 7; ACHR, note 34, Article 5; ECHR, note 36, Article 3.

⁸⁸ Report N° 71/03[1], Petition 12.191, Friendly Settlement, *María Mamérita Mestanza Chávez v. Peru*, 22 October 2003. See also Article 7 of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women, 33 I.L.M. 1534 (1994), entered into force March 5, 1995.

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OAS Special Rapporteur on the Rights of Women condemning forced sterilization as a serious violation of a woman's rights;⁸⁹ and earlier jurisprudence from the European Commission on Human Rights which suggests that forced abortion or sterilization conflicts with the prohibition on degrading or inhuman treatment.⁹⁰

The right to dignity is also closely linked to the rights to liberty and security. The international and regional human rights treaties make clear that governments may not limit a person's liberty without just cause and process.⁹¹ National courts have ruled that restrictions on reproductive freedom may violate the right to liberty and security. For instance, in 1988, the Canadian Supreme Court ruled that Canada's abortion law was unconstitutional because it limited access to abortion in violation of the right to security of the person guaranteed by the Canadian Charter of Human Rights and Freedoms.⁹²

The inherent dignity of all people also requires respect for the right to make informed decisions about one's private and family life. This entails both the authority to make decisions and the ability to do so based on access to adequate information and means. All major international human rights treaties, except for the African Charter, include express recognition of the right to respect for one's private and family life.⁹³ The core of this right is the right to be free from arbitrary government interference but international courts have recognised that, in certain circumstances, governments may in addition have positive obligations to ensure respect for private and family life.⁹⁴ The right to make informed decisions about whether and at what age to have sexual relations, whether to use contraception and, if so, in what form, obliges governments both to refrain from coercion,

⁸⁹ See, for example, 2001 Annual Report.

⁹⁰ *X v. Denmark*, Application No. 1287/61, European Commission on Human Rights, unreported, cited in P. van Dijk, G.J.H. van Hoof, *Theory and Practice of the European convention on Human Rights*, 2nd edition, Kluwer: Deventer 1990.

⁹¹ ICCPR, note 23, Article 9; ACHPR, note 87, Article 6; ACHR, note 34, Article 7; ECHR, note 36, Article 5.

⁹² *R v. Morgentaler*, [1988] 1 SCR 30.

⁹³ ICCPR, note 23, Article 17; ACHR, note 34, Article 11; ECHR, note 36, Article 8.

⁹⁴ See, for example, *Rees v. the United Kingdom*, 17 October 1986, Application no. 9532/81 (European Court of Human Rights).

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undue inducement and interference with access to information and services;⁹⁵ and also actively to provide information that furthers the enjoyment of these rights.⁹⁶

II.5 Equality and Non-discrimination

While men also suffer from sexual and reproductive ill health,⁹⁷ it is acknowledged that women and adolescents are particularly at risk.⁹⁸ In 2000, some 529,000 women died from pregnancy-related causes, most of which were avoidable. About 80 million women annually experience unintended pregnancies, and some 45 million of them have abortions. Of these, 19 million women undergo unsafe abortions, resulting in 68,000 deaths, 13% of all pregnancy-related deaths. In addition, some 2 million young people aged 15-24 years become infected with HIV every year. In sub-Saharan Africa and South Asia, about 65% of young people living with HIV/AIDS are female.⁹⁹

While not all these cases come about as a result of violations of rights to health and information, it is likely that a significant number of them occur because the marginalized status in society of adolescents and women means that they are not provided with the appropriate education and/or information to make informed decisions about their sexual actions. The CEDAW Committee has noted: “Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health.”¹⁰⁰ International human rights law provides a legal means of addressing and campaigning against this situation. The prohibition of discrimination is among the most fundamental principles of international human rights law. As stated in the *Charter of the United Nations*, one of its four overarching purposes is “to achieve international cooperation... in promoting and encouraging respect for human rights and for

⁹⁵ See the European Court of Human Rights judgment in *Open Door Counselling and Dublin Well Woman v. Ireland*, note 58 and accompanying text.

⁹⁶ See, for example, *Gaskin v. the United Kingdom*, 7 July 1989, Application No. 10454/83 (European Court of Human Rights). See also *Guerra v. Italy*, note 57, discussed in Section 0.

⁹⁷ Sexual and reproductive ill health has been quoted as giving rise to 14% of the global burden for ill health for all men: Report of the Special Rapporteur on Health, note 70, para. 11.

⁹⁸ Report of the Special Rapporteur on Health, note 70, paras. 32-40.

⁹⁹ Figures quoted in the Report of the Special Rapporteur on Health, note 70, paras. 11-12.

¹⁰⁰ CEDAW General Recommendation 24, Article 12: women and health, UN Doc. A/54/38 Rev. 1, Part I (1999) 3, para. 18.

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fundamental freedoms for without distinction as to race, sex, language, or religion.”¹⁰¹ This principle is reflected in both the *International Covenant on Civil and Political Rights* and in the *Universal Declaration of Human Rights*.¹⁰²

The main treaty stating the various rights included within the overarching right of women to the enjoyment of human rights on an equal footing with men is the *Convention on the Elimination of all forms of Discrimination against Women (CEDAW)*,¹⁰³ which requires States “to pursue by all appropriate means and without delay a policy of eliminating discrimination against women” and “take ... all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality.”¹⁰⁴ Discrimination against women is defined in Article 1 as:

[A]ny distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

That definition has several distinctive features. First, it extends the principle of equality and non-discrimination to the enjoyment of rights in any field. Second, it extends to protection against measures that have the effect, of impairing women’s equal enjoyment of rights, regardless of their purpose. Third, particularly when read together with the ICCPR provisions on non-discrimination and equality, it requires States to take positive steps in order to eradicate inequalities where these persist, and to ensure equality in fact as well as in law.¹⁰⁵ The latter means that a government is under an obligation to ensure

¹⁰¹ 26 June 1945, entry into force 24 October 1945.

¹⁰² ICCPR, note 23, Articles 2, 3 and 26, and UDHR, note 22, Article 2.

¹⁰³ Note 28.

¹⁰⁴ *Ibid.*, Articles 2 and 3.

¹⁰⁵ See also the Human Rights Committee’s General Comment No. 18, Non-Discrimination, 10 November 1989, UN Doc. HRI/GEN/1/Rev.1 at 26 (1994).

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that discriminatory practices do not occur in health clinics or in health and education programmes that are not directly run by it.

The right of women to exercise their human rights on a basis of equality with men requires that women have access to education and information necessary to promote and protect their reproductive health. Article 12(1) of CEDAW requires States Parties to “eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.” The CEDAW Committee has stated that implementation of this right is “central to the health and well-being of women.” It has also pointed out that an approach is required that incorporates information campaigns with education, and that particular attention should be paid to ensuring access to adequate health care facilities and information for rural women. The Committee has made a number of specific recommendations for government action:

- women’s health services and issues should receive a share of the overall health budget comparable with that for men’s health, taking into account their different needs;
- all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health, should be removed;
- States should allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS;
- the provision of health services to women by public, non-governmental and private organisations should be monitored to ensure equal access and quality of care;
- specific health education for adolescents should address issues of gender equality, violence, prevention of sexually transmitted diseases and reproductive and sexual health rights.¹⁰⁶

¹⁰⁶ Note 25, paras. 29-31.

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The *International Convention on the Rights of the Child* protects both the right to health and the right to information.¹⁰⁷ Article 17 guarantees explicitly the right to receive information “aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health”. The Committee on the Rights of the Child, which supervises the implementation of the treaty, has frequently criticised the poor information and education programmes of State parties to the Convention, which it considers a violation of children’s right to health as well as their right to receive information.¹⁰⁸ In two of its general comments, on adolescent health and development¹⁰⁹ and on HIV/AIDS,¹¹⁰ it has emphasised the important role that information programmes play in ensuring a high level of reproductive health.

Crucially, States must ensure that adolescents are provided with accurate and appropriate information on sexual and reproductive health. In its General Comment on adolescent health, the Committee emphasises that, “[t]he right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations ... It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on ... safe and respectful social and sexual behaviours ...”¹¹¹ In particular, the Committee has stated:

States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early

¹⁰⁷ Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entered into force 2 September 1990, ratified by Peru 4 October 1990, Articles 13, 17.

¹⁰⁸ See, for example, its comments in relation to Lithuania (CRC/C/103 (2001)); Saudia Arabia (CRC/C/103 (2001)); Iran (CRC/C/97 (2000)); Djibouti (CRC/C/97 (2000) 96 at para. 555); and Egypt (CRC A/49/41 (1994)).

¹⁰⁹ Committee on the Rights of the Child, General Comment No. 4, Adolescent health and development in the context of the Convention on the Rights of the Child, note 25.

¹¹⁰ Committee on the Rights of the Child, General Comment No. 3, HIV/AIDS and the right of the child, U.N. Doc. CRC/GC/2003/3 (2003).

¹¹¹ Note 109, para. 10.

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pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent. It is essential to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys. To this end, States parties are encouraged to ensure that adolescents are actively involved in the design and dissemination of information through a variety of channels beyond the school, including youth organizations, religious, community and other groups and the media.¹¹²

The Children’s Committee, like CEDAW, has recognised that adolescent girls may be particularly at risk because of their often disadvantaged position in society. It has recommended: “Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs.”¹¹³

The UN Special Rapporteur on Health has also pinpointed adolescents and young people as being particularly at risk, and has endorsed virtually all the recommendations referred to above by CEDAW and by the Children’s Committee.¹¹⁴

III. Conclusion and obligations on States

The body of international law discussed in the previous paragraphs clearly supports the notion that the right to have access to reproductive health information has become firmly established under international law. The right has been established explicitly under the *Convention on the Elimination of All Forms of Discrimination against Women* and has been recognised as a necessary component of rights such as health, access to information and family planning. Moreover, various international bodies have identified a number of concrete obligations arising from these treaties that pertain to the full implementation of the right. These obligations can be summarised as follows:

¹¹² *Ibid.*, para. 28.

¹¹³ *Ibid.*, para. 31.

¹¹⁴ Note 70.

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States should not interfere with information that others are willing to impart

International law grants a strong right for people to receive information that others are willing to impart. States may limit this right only in narrow circumstances and on narrow grounds. Both the *American Convention on Human Rights* and the *International Covenant on Civil and Political Rights* allow for restrictions only if they are provided for by law and if they are necessary to protect such interests as national security or the prevention and detection of crime. The only ground that could conceivably be invoked to restrict the provision of reproductive health information is the protection of public morals but, as has been made clear by both the European and the Inter-American Courts of Human Rights, restrictions on this ground cannot be justified if the information is needed for a compelling reason. In the case of reproductive health information the weight of the rights at stake – including the rights to life and health – constitute a compelling need for the information.

States should take steps to provide adequate and accessible information, education and counselling about reproductive health, especially to adolescents, women in rural areas and those at high risk

Over the last two decades, the right to freedom of information – the duty on governments to provide information both on request and proactively – has become firmly established in international law. The duty to provide information necessary for independent and meaningful decision-making in matters pertaining to reproductive health flows, among other things, from the fundamental nature of the different rights that hinge on this information, including the right to life, the right to health, and the rights to private and family life and family planning. This duty also follows specifically from the children's and women's conventions, which require States to ensure that children, adolescents and women are provided with adequate information on reproductive health. The argument in favour of the provision of information is further strengthened by the relative ease with which information provision programmes can be instituted. Information can be made

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available in various ways, through health campaigns aimed at the general public, through health clinics or in schools, through the education system. States should take particular care to ensure that information programmes reach those who need it most – often, adolescent girls and women in rural or deprived communities.

Family-planning and reproductive health programmes may not discriminate in providing information and counselling to women, such as on the grounds that they are unmarried or too young

The prohibition of discrimination in international law is violated once it has been demonstrated that a distinction on impermissible grounds has a discriminatory impact or that a seemingly neutral distinction has such an impact on a category of persons who are entitled to equal treatment.¹¹⁵ The main human rights treaties prohibit discrimination on any grounds, including marital status and age. Not only does international law require States to refrain from enacting or implementing discriminatory measures themselves, it also requires them to take steps to ensure that programmes run by non-State actors do not discriminate. States should therefore take steps to ensure that no family planning and reproductive health programmes, regardless of who runs them, discriminate against unmarried women, adolescents, indigenous groups or any other groups or individuals.

States should take reasonable measures to prevent private groups or individuals from interfering with the provision of information necessary for reproductive health or choice

It is well-established in international law that States are not only under an obligation to refrain from restricting rights beyond what is permissible under international law, but they are also under a ‘positive’ duty to prevent private actors from interfering with the

¹¹⁵ Note that not all negative consequences are discriminatory. The Human Rights Committee has observed that not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant. See General Comment No. 18, note 105, para. 13.

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enjoyment of rights. This obligation applies, for example, to situations where people use threats or violence to intimidate people who seek information or counselling about family planning, abortion or other reproductive health matters. States are also under a duty to take steps to prevent third parties, such as pharmaceutical manufacturers, from publishing false information that could lead people to take actions that could harm their reproductive health.

States may not perform, encourage or permit medical interventions without free and informed consent

States' obligation not to perform or encourage (or indeed permit others to perform) medical interventions, including routine blood-tests, without the fully informed consent of the individual concerned derives from the right to information about matters relevant to health. Depending on the nature and result of the intervention, other rights may come into play as well, such as dignity, security of the person and, in extreme cases, the prohibition of degrading treatment and the right to life.

Chapter 3

A Legal Framework for Access to Information in Peru

Javier Casas, Instituto de Prensa y Sociedad

Introduction

The right to access public information is relatively new in Peru since it has only been recognised since the 1993 Constitution went into effect. This explains why its development has been weak, especially considering that it was, paradoxically, a clearly authoritarian government that promoted the inclusion of this right. The 1993 Constitution also incorporated the figure of habeas data as a legal guarantee for the exercise of the right to access public information. It is widely believed¹¹⁶ that these legal modifications had the main objective of easing international pressure on the Peruvian government to discourage the development of a possible dictatorship in classical terms.

As a recently recognised right, the right to access public information has received little dissemination and has not been incorporated into the daily life of Peruvians. One indicator of this reality is the limited or inaccurate information regarding the freedom of information law in Peru in the past 10 years. For example, public bodies have not collected or systematised individual requests for public information and the judicial branch does not have a statistical registry of habeas data petitions presented. Only the Constitutional Court has made an effort to compile this information, producing just one significant statistic: with just 25 petitions for habeas data, this type of petition is most likely the one least often presented to the Court. A second indicator is the absence of willingness of the Congress to regulate this right through a law. Until the end of the

¹¹⁶ This opinion is mainly that of social leaders or organisations that opposed the self-coup of 1992. Nevertheless, the coup had a high level of public support (more than 90%, according to the surveys carried out at the time) and in general the first term of the Fujimori administration enjoyed high popularity ratings.

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Fujimori government, the only bill on this issue was presented in 1996 and was definitively filed after having been ignored by the legislative committees. Attempts at regulating this right occurred only during the government administrations of Valentín Paniagua, from the executive branch, and of Alejandro Toledo, from the legislative branch.

However, after the enactment in 2002 of the new freedom of information law, the idea that the state would suddenly be forced to open up collided with reality. Legislators and the few organisations that participated in the preparation of the law could not fully comprehend at the time that the government is basically a complex community of personal relations regulated by written laws and customs, and that the law cannot override these norms without an ordered process. Likewise, what occurs within the government environment is simply a reflection of what takes place in the wider Peruvian society. In its work with different non-governmental organisations, the Institute for Press and Society (Instituto Prensa y Sociedad, IPYS) has found that even the most competent in their respective areas of intervention lack a clear understanding of the law promoting the right to information and its scope.

Socio-political context of the preparation of the freedom of information law

At the end of the Fujimori regime, Peruvians found themselves in what were probably unique circumstances in the 20th Century. Peruvian families watched on television how professionals, government officials and business executives, many of whom were considered the most respected in the country, colluded with the chief of the National Intelligence Service, Vladimiro Montesinos, for unlawful enrichment, political and legal favours, and even to obtain employment for their children. These public personalities, who in front of the camera applauded justice and decency, revealed their true nature in private, when they thought no one was looking.

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Faced with the sudden absence of government – Montesinos and Fujimori fled to Venezuela and Japan, respectively – the Congress declared a presidential vacancy in accordance with the procedure established in the Constitution¹¹⁷ and appointed the moderate Congressman Valentín Paniagua as the new president, who would be responsible for convening and guaranteeing new general elections. The interim government, concerned with improving the country's image, focused on ensuring elections in 2001. The new administration also modified two norms enacted by Fujimori to give tangible proof of the changes in terms of full disclosure: the Constitution and the framework law to promote private investment.¹¹⁸ This framework law established that full disclosure was a prerequisite for private investment. Ten years after its publication, the interim government developed regulations¹¹⁹ for this law establishing for the first time clear, mandatory rules for the public administration in an effort to promote the exercise of the right to access public information recognised in the Constitution.

The regulations had a significant impact from an official standpoint because public bodies introduced this new procedure in their bylaws;¹²⁰ nevertheless, the procedure's implementation was disorganised. The level of impact can also be explained by the political situation. During the interim government, it was politically correct to distance oneself as much as possible from the former government. One of the ways of doing so was to promote full disclosure standards, even as just a formality.¹²¹

In the spring of 2000, as Fujimori teetered on the edge of the political abyss due to his controversial third presidential term, the Peruvian Press Council, the most important press organisation in Peru, took advantage of this situation to announce a series of meetings promoting the right to access information. Members of the press and international

¹¹⁷ Article 113, paragraph 2 of the Peruvian Constitution. The congress declares that the president has vacated the office on grounds of permanent moral or physical incapacity.

¹¹⁸ Legislative Decree 757 of 1991 (legislative decrees are norms with the rank of laws issued by the executive branch pursuant to the delegation of legislative powers to this end).

¹¹⁹ Supreme Decree 018-2001-PCM.

¹²⁰ All bodies of the public administration were required to introduce a procedure of access to information in accordance with Supreme Decree DS 018-2001-PCM. This norm was subsequently repealed by the freedom of information law. The problem is that several major public bodies, such as those of the judicial branch, maintain these repealed procedures.

¹²¹ Article 2, paragraph 5 of the Peruvian Constitution.

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organisations were the main participants at these meetings, which ended in the summer of 2001 and resulted in the Lima Principles, a reference document on legislative procedures for disclosure of and access to public information. The interim government apparently took note of this document.

Later, presidential candidate Alejandro Toledo's campaign was centred on the fight against corruption. When he assumed office in July 2001, the whole world watched expectantly to see what decisions he would make to change the country's political direction. Likewise, legislators became familiar with the strong pressure of citizens demanding signs of change. A draft law had been presented during Fujimori's second term in office by congressman Carlos Ferrero, and was followed by proposals from a number of other politicians, among them Anel Townsend. From 2000 onwards a series of cross-sector meetings and public events drew attention to the need to pass access to information legislation; the main actors in this campaign were the Peruvian Press Council, the Ombudsman's Office and IPYS, and international support was provided by ARTICLE 19, the Carter Center and others. There is little evidence of wider civil society participation in this process, even in spite of the great demand for such a law to be passed.

The result was the publication in August 2002 of Law 27806 on Transparency and Access to Public Information, which was modified in February 2003 by Law 27927. Key changes included the specification in the new law of the assumptions underlying the classification of information, the expanded number of public bodies included in the ambit of the law, the partial streamlining of information access procedures and the inclusion of provisions obligating private bodies that offer public services to provide information. In addition, Law 27927 ordered the executive branch to develop regulations for the law.

Much water has gone under the bridge since then. President Toledo and his inner circle are increasingly directly affected by accusations of corruption. For its part, the political

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opposition, which controls many regional and local government posts, has not been exempt from these scandals.

Legal framework of the right to access information in Peru

The 1993 Peruvian Constitution recognises the fundamental right of all individuals to “request without express cause the information required and to receive it from any public body in the period established by law [after paying] the cost that the request entails. Exceptions include information that affects personal privacy and that is expressly excluded by law or for reasons of national security.” The subject of the right is an individual without distinctions of any type; consequently, adults and minors, Peruvians and foreigners are recognised in Peru. This right is also transferred to corporations that can solicit information through their representatives. The jurisprudence of the Constitutional Court of Peru considers this right a preferred freedom within a context of an equal hierarchy of rights. In cases in which a choice must be made between providing access to information and classifying information as confidential or reserved, the Constitutional Court has provided some referential elements in different cases. For example, it ruled that “when the exercise of the right to access public information contributes to the formation of free and informed public opinion, this has the status of a preferred freedom. This status (...) does not mean that there is a hierarchical order among the fundamental rights recognised in the Constitution, at the top of which is found or can be found the right to access information or other rights that are of an identical rank...”¹²²

The Constitutional Court also has established important precedents for judges who must interpret the obligation of the state with respect to information disclosure. For example, it has ruled that norms restricting the right to access information should be presumed unconstitutional “because they are a legislative intervention in a preferred freedom...” and that “...this presumption of unconstitutionality of the law that restricts this freedom means that the government and its bodies have the obligation to prove that it is in the

¹²² Rulings of the Constitutional Court of January 29, 2003 - Record N° 1797-2002-HD/TC, of January 21, 2004 - Record N° 1219-2003-HD, and of April 6, 2004 - Record N° 2579-2003-HD/TC.

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urgent interest of the public to maintain in reserve or secret the public information requested, and that only by maintaining this information secret can the constitutional interest that justifies it be effectively served.”¹²³

The Peruvian Constitution also establishes that a person requesting public information is not required to provide any justification to receive it. To the extent that this constitutes the exercise of a human right, that is, of the expression of an intrinsic characteristic of human capacity, no one can be forced to give explanations on the reasons for requesting public information. Regarding this point, the Constitutional Court declared that a characteristic of the right to access public information is “the absence of the expression of cause or justification of the reason for requesting the information... or the existence of an interest in the information requested...” and that “...any demand of this nature is simply unconstitutional...”¹²⁴

The mandatory observance by public bodies of a legal timeline and the pre-establishment of cost necessarily imply the regulation of the right through a law, since the Constitution only makes passing reference to these two considerations. In the case of Peru, Law 27806 of August 2002, later modified by Law 27927 of February 2003, establishes that the regular timeline for responding to an information request is seven working days. There is an exceptional extension of five working days and the possibility of appealing to a higher administrative body in the case of a negative response. Regarding costs to be assumed by the individual making the request, the law and regulations¹²⁵ state that they must be defined by the public body and must not in any case exceed “the direct costs exclusively related to the reproduction of the information requested. In no case shall these costs cover expenses for the remunerations or infrastructure that the delivery of information may entail, or for any other element unrelated to reproduction.”

¹²³ *Idem*

¹²⁴ Rulings of December 13, 2000 - File N° 950-00-HD/TC, and April 6, 2004 - File N° 2579-2003-HD/TC.

¹²⁵ Supreme Decree 072-2003-PCM of August 2003.

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Regarding the public bodies that the Constitution stipulates must deliver information in their control, the referential rule cited in the freedom of information law is Article 1 of the preliminary heading of Law 27444 of General Administrative Procedure. According to this norm, public administration refers to the executive branch, including the ministries and decentralised public bodies, the legislative branch, the judicial branch, regional governments, local governments, bodies to which the Peruvian Constitution and the laws confer autonomy, other agencies and entities as well as projects and programmes of the government, whose activities take place by virtue of the administrative authority and therefore are subject to the regular regulations of the public law, except by express mandate of the law that refers them to another regime; and corporations under private law that provide public services or exercise an administrative function, by virtue of concession, delegation or authorisation of the state, in accordance with the regulations on the subject. The subsequent modification of Law 27806 expanded the scope of the application to public companies and limited the obligation of private companies to providing information on the characteristics of their public services, rates and administrative functions.

The freedom of information law refers only in a negative sense to the content or quality of the responses of the bodies obligated to deliver public information, stating that all individuals can consider a request denied when the “requirement for information was not satisfied or the response was ambiguous.”¹²⁶ In the opinion of the Constitutional Court “...not only is the right to access information affected when its delivery is denied without constitutionally legitimate reasons, but also when the information provided is fragmented, outdated, incomplete, inaccurate, false, untimely or contains mistakes.”¹²⁷

Furthermore, the Constitution has limited the right to access information which “affects personal privacy and that is expressly excluded by law or for reasons of national security.” In addition, the Constitutional Court set parameters for interpreting these restrictions. For example, it ruled that the exercise of the right to access public

¹²⁶ Article 13, last paragraph of the Single Official Text of Law 27806.

¹²⁷ Sentence of the Constitutional Court of January 29, 2003 - File 1797-2002-HD/TC .

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information “is subject to limits or restrictions that can originate from the need to harmonise its exercise with other rights of the same class (for example, the right to personal privacy) or from the need to safeguard constitutionally relevant effects (for example, national security) as long as these are expressly stipulated by law.”¹²⁸ In the opinion of the Court, “information that affects personal privacy constitutes one of the restrictions to the right to access information (...). Access to information held by any public body does not include information that forms part of the private life of third parties (...), and (...) information on the health of a person (...) is included within the right to personal privacy.”¹²⁹

Evidence of an inadequate state policy to implement the law on access to information

Official figures indicate an optimal level of openness of the Peruvian government. According to the Presidential Office of the Peruvian Council of Ministers (PCM), during 2003, the first year the law was in effect, the government received 40,000 requests for information. This figure makes Peruvian society the best informed in Latin America considering that in Mexico, with a population four times larger than that of Peru, there were 24,000 requests for public information.

In addition, according to information provided to the PCM by public bodies,¹³⁰ 39,296 requests were received during 2003, “in the framework of the Single Official Text of Law N° 27806, Law of Public Information Disclosure and Access,” of which 37,522 (95.49% of the total) were resolved satisfactorily. Information was not provided in 1,774 cases (4.51%). The PCM report also stated that with respect to the requests denied, “approximately 19% of the requests were not fulfilled because the information was inaccessible; 11% because the payment established in the Single Text of Administrative

¹²⁸ Sentence *or Ruling?* of the Constitutional Court of January 21, 2004 - File 1219-2003-HD.

¹²⁹ Sentence *or Ruling?* of the Constitutional Court STC, July 15, 2003 - File 1480-2003-HD/TC.

¹³⁰ The PCM has stated that its report was prepared based on data provided by the bodies delivering public information. There are no comparable data between the number of government bodies that fulfilled their obligation and the total number of bodies subject to the law.

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Procedures (TUPA) was not made to the body; 48% because the information was unavailable, the person making the request did not pick up the requested information or a report is pending, among other reasons; and 20% did not specify the reasons they were not fulfilled.” Finally, the PCM reported that during 2003, 331 public bodies complied with appointing an official responsible for delivering public information.¹³¹

IPYS asked the PCM for a complete list of the requests registered. After examining this list, IPYS was able to confirm that many¹³² requests registered by the different bodies in their respective reports did not coincide with the legal definition of a request for public information. According to Article 10 of the Single Official Text¹³³ of Law 27806, public information is information which is created or obtained by a body, or is held by it or under its control, or has been prepared in full or in part with the government budget and has served for administrative decision making purposes. In contrast, the PCM report erroneously considered as requests for information requests for personal certificates, records, licenses, donations as well as congratulatory messages and invitations for public officials, proposals for investments and others. In other words, the list included services that the government provides through its different bodies to society as part of its regular duties.

Apparently, there are no clear, standardised government criteria for defining public information and classified information, or for determining the difference between a request for access to information and requests for government services. The differentiation of these concepts should be established in a law enforcement policy

¹³¹ The PCM does not specify the percentage of public bodies obliged to appoint an official responsible for delivering information.

¹³² It is impossible to determine the exact number of requests for public information based on the report since the classification made by public bodies is not standardised and the PCM did not correct this problem before presenting the report to Congress. The bodies provided the PCM with figures by filling out a form according to their own criteria. For example, with respect to the figures for the requests for information fulfilled, the PCM states that “cases exist in which the information mentioned by the bodies is not detailed in the annexes because the information was not accompanied by an electronic file or the file was damaged, thereby impeding its processing. In addition, the bodies occasionally included information corresponding to 2002. Information corresponding to 2004 was not considered in the totals.”

¹³³ Through the Single Official Text of a law, the different modifications it may have undergone throughout time are integrated into a single text of the law in effect.

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designed to promote the gradual opening of public bodies. The central government has not defined this policy, in other words, it has not established a budget or clear goals to this end and has not worked to disseminate the new right.

Besides the freedom of information law, which is a general law, there are previous laws in specific ambits that mention secret, reserved and confidential information in their regulations. These regulations are generally preferred over the freedom of information law since a public official that violates them can be sanctioned immediately. In contrast, the freedom of information law establishes a sanction against government officials violating the law only when the aggrieved party lodges a complaint.

There are also two major political challenges that the government has not resolved or has not proposed as core values to promote the openness of public bodies. The first is that it has placed the emphasis on the law rather than on education, without understanding that education can contribute more than the law to raising the standards of a society.¹³⁴ As a result, the problem of a lack of disclosure is cultural rather than legal. A 2002¹³⁵ national survey in Peru revealed that 50% of Peruvians believe that the laws do not equally apply to everyone because they are passed without taking into account the national reality, and because they are not respected. According to the same survey, this percentage is greater among populations whose native language is not Spanish. The first and most formidable obstacle the law faces for its implementation and use in Peru is that the population has little faith in the legal system.

The second concern is the suitability of the judicial branch to effectively guarantee full respect for the right to access information and its due exercise through a habeas data suit. IPYS encourages individuals to take legal action when public bodies do not respect their right. However, the judiciary is one of the most discredited institutions in Peru and does

¹³⁴ Law 27806 makes no reference to a government education policy to promote the right. It only obliges bodies to create mechanisms to disseminate it, without defining these mechanisms. The Constitutional Procedural Code which enters into effect in December 2004 states that the Ministry of Education must incorporate information on the use of constitutional guarantees (habeas data, petition for constitutional protection, etc.) in the school curriculum.

¹³⁵ 2002 Survey of the Suma Ciudadana Association.

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not instil confidence in those who require judicial services. At any rate, IPYS has noted a considerable difference in quality between the resolutions issued by the judicial branch and those of the Constitutional Court.¹³⁶ Judges are the officials that least understand and guarantee the right. IPYS has confirmed that judges in general have serious problems in issuing resolutions in accordance with the spirit of the Constitution and the freedom of information law.

Judges do not have access to information on this new right or are not prepared to correct the information classification systems developed by public bodies. Judges report that habeas data is seldom utilised and is perhaps the petition used least often by individuals requesting judicial services. For this reason, judges prioritise other processes over habeas data actions. Judges are not duly informed about their authority with respect to cases of habeas data, for which reason they consult the regulations of public bodies although it is precisely these regulations that need to be revised.

Habeas data petitions follow a procedure very similar to those for constitutional protection, which last for several months on average. This discourages the use of habeas data provisions. IPYS has been involved in a habeas data case involving the health sector for nearly a year. Although the case was declared admissible in the first instance, it is currently in the second instance due to a complaint filed by the Ministry of Health attorney. The judicial branch has promoted among its judges the rigid, exclusive adherence to the legal mandate, thereby discouraging interpretation. With respect to habeas data, this is a problem that can only be resolved in the medium or long term, and to the extent that an increasing number of petitions of this type are presented.¹³⁷

The PCM report indicates that the Ministry of Health has satisfactorily complied with the obligation to deliver public information. For example, according to the report, in 2003 the

¹³⁶ According to Article 201 of the Peruvian Constitution, the Constitutional Court reviews in last instance petitions for habeas corpus, habeas data, protection and compliance.

¹³⁷ The Constitutional Procedural Code seeks to encourage the presentation of information requests since in December 2004 citizens will not be required to have the legal assistance of a lawyer to present a habeas data suit.

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Ministry of Health responded to 370 information requests. However, as mentioned, this information is not in accordance with the freedom of information law. IPYS has determined that of the total requests resolved, 148 were for public information and 222 were requests for private information.¹³⁸ The Ministry also has officially declared that its offices did not respond to 98 requests.

The information collected by IPYS provides a different view. In general, the Ministry of Health faces serious problems in delivering information within the timelines established by law. In most of the cases registered by IPYS, it was necessary to inform the Ministry of impeding legal action to obtain information. More than 90% of the responses to requests made following the advice of IPYS were provided within the seven days established by law. In the case of the Ministry of Health, the information delivered was accurate and complete (in approximately 90% of the cases); however, it should be noted that most of the requests made directly by IPYS or non-governmental organisations occurred in Lima. If we compare these results with information requests made by young people to regional Ministry of Health offices,¹³⁹ the results are drastically different. IPYS found that in those cases, the Ministry did not respond to more than 60% of the information requests.

The analysis of the exercise of the right to access information reveals a series of legal, political and cultural difficulties. In the short term, efforts of the different sectors should focus on addressing the main problem: lack of knowledge of the law. However, it is not only a question of knowing of its existence since many people are aware that the freedom of information law was enacted but nevertheless do not use it. Within civil society, leading sectors in social development should begin to employ the law. In Peru, this sector could include non-governmental organisations, journalists and members of the business community. From the other side, the government has the most effective tools to promote comprehensive policies to develop this right. As the Constitutional Court has stated in

¹³⁸ This classification was developed based only on the data provided by the Ministry.

¹³⁹ During 2004, young leaders were trained in Chimbote, located 400 kilometres north of Lima. The objective of this IPYS project was to create awareness of the right in a sector whose rights are often threatened: minors.

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several of its rulings, the right to access information makes little sense if it is not understood as a relational right, in other words, a right that permits the exercise of other rights. The Constitution, the freedom of information law and habeas data should be viewed as perfectible tools that can contribute to a democratic state and society. The errors or defects that these norms may contain can only be identified through their use. For this reason, it is necessary to make contributions to a general strategy designed to end the vicious circle in which the government does not deliver public information, individuals do not have confidence in the legal system or do not know how to file complaints and as a result do not use the law or use it ineffectively.

Chapter 4

Reproductive and Sexual Health Rights in Peru: key concerns and policy initiatives

Susana Chávez, Anna-Britt Coe and Rossina Guerrero

Priority issues associated with sexual and reproductive rights.

While there are several issues directly associated with sexual and reproductive rights, public health experts and civil society organisations agree that maternal mortality and abortion; HIV/AIDS; physical and sexual violence against women; unwanted pregnancy; and unmet needs of adolescents are priorities in Peru. Quantitative and qualitative data coincide with these five priorities. Furthermore, their causes can be mitigated against and are clearly linked to social, economic, gender and cultural discrimination. Throughout the past 15 years, the Peruvian government has implemented diverse communication strategies designed to address these priorities. However, the success of such interventions in expanding access to information on health and rights among the Peruvian population has been directly affected by the policy positions held by government officials. As this section demonstrates, with the exception of short periods of reform (1999-2000, since 2004) these policy positions have generally not sought to promote peoples' informed decisions regarding their sexual and reproductive health by among other things ensuring access to unbiased, accurate and thorough information on sexual and reproductive health.

Maternal mortality and abortion

Maternal mortality has always been a major public health problem in Peru. Advances made to reduce this rate have largely been the result of global population changes (increased access to education, urbanization, increased control of fertility, etc.) rather

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than of health sector programmes. According to the Ministry of Health, maternal mortality declined by more than half between 1960 and 2000 (from 400 per 100,000 live births to 185 per 100,000 live births). However, this decrease has not been continuous—periods of decline were followed by periods of no change in the 1960s, for example, when the rate remained stable at 400 per 100,000 live births. During this period, the country was becoming increasingly urban. The largest decrease in the rate occurred in the 1970s and 1980s during the military dictatorship, when it fell from 390 to 318 per 100,000 live births. Progress again slowed between 1980 and 1990 (318 to 298 per 100,000 live births). As these figures demonstrate, Peru has a very high mortality rate¹⁴⁰

¹⁴¹ In addition, there has been no significant change in the leading causes of maternal mortality. Almost 85% of maternal deaths are due to direct causes and haemorrhaging.

Abortion is still among the leading three causes of pregnancy-related deaths, given the relationship between abortion and haemorrhage. Complications associated with abortion account for 10% to 12% of obstetric hospitalisations. It is estimated that every year, 410,000 women undergo an illegal abortion, many of which are performed in unsafe conditions. According to Ferrando,¹⁴² 48% of poor women who undergo an abortion are at risk of complications, while only 5% of women who are not poor run this risk. As a result of the serious shortages of contraceptives in public health facilities, which distribute 79.3%¹⁴³ of the country's modern contraceptive methods (National Demographic and Family Health Survey - ENDES 2000),¹⁴⁴ it is estimated by Ferrando

¹⁴⁰ WHO, UNICEF and UNFPA, *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA*, (2003).

¹⁴¹ A Ministry of Health technical report states that underreporting between 1977 and 1992 was between 57.2% and 50.7% (p. 24) and that the level of medical reporting in poor departments (now regions) was seriously deficient (less than 60%). Apurímac Department reported only an estimated 20% of maternal deaths (p. 39). Of the deaths recorded, it is estimated that an average of 5% were misdiagnosed, 15% of which corresponded to the poorest population (p. 47). Given the limited development of death reporting in Peru during the past five years, it is assumed that maternal mortality, because it is concentrated in the poorest regions and populations, is grossly underreported. Ministry of Health, *Análisis de la Situación de Salud en el Perú (ASIS 95)*. Informe Técnico N° 1, *Análisis de las Defunciones en el Perú*. 1996.

¹⁴² Ferrando D. *El aborto clandestino en el Perú: Hechos y cifras*, (Lima: Centro de la Mujer Peruana Flora Tristán and Pathfinder International, 2002).

¹⁴³ This figure comprises modern methods and does not include the provision of the natural methods, such as the Rhythm and Periodic Abstinence (bracelet and calendar method, etc.). Since the end of the 1990s the public sector also offers information and advice on the appropriate use of natural methods, which could increase this percentage of 79.3% to an estimated 85%.

¹⁴⁴ Reyes J and Ochoa LH. *Informe principal de la Encuesta Demográfica y de Salud Familiar 2000*, Lima: Instituto Nacional de Estadística e Informática, 2001)

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that the abortion rate increased from 5.2 in 2000 to 5.9 in 2003. This increase means an additional 44,000 abortions every year.

Another problem associated with abortion is the lack of legal abortion services. Abortion is legal in Peru if the pregnancy threatens the life and health of the woman, however only one hospital, located in Lima, is equipped to provide legal abortion care. In the past three years, only one legal abortion has been performed. A comparison of abortion data with maternal mortality figures suggests that the government is not complying with its own legislation since the lack of information and the absence of legal abortion services forces many women who could legally undergo the operation to have clandestine abortions, with all the health risks this implies.¹⁴⁵

HIV/AIDS

According to official data, approximately 13,000 cases of HIV or AIDS were reported in 2002. Nevertheless, after adjusting for unreported cases, it is estimated that the total number of HIV-positive individuals is between 70,000 and 100,000.¹⁴⁶ A large percentage of HIV-positive individuals are between the ages of 20 and 25. Although men account for 82% of reported cases, the male/female ratio has decreased from 27 infected men for every infected woman in 1987 to 2.3 men for every woman in 2001.¹⁴⁷ HIV/AIDS cases are concentrated in urban areas. Lima and Callao have 75% of all reported cases. Nevertheless, the number of HIV-positive individuals is on the rise in other coastal cities (Piura, Ica, Chiclayo) and in Arequipa, as well as in the Amazon Basin, especially in Iquitos.

¹⁴⁵ Chávez, Susana. "Dificultades de acceso al tratamiento del aborto legal desde las mujeres." Ponencia presentada en el Seminario-Taller Nacional Responsabilidad Médica frente a la interrupción legal del embarazo, celebrado en Lima los días 6 y 7 de agosto, 2004.

¹⁴⁶ R López and D Laporta, *VIH/SIDA y el sector salud* (Lima: GTZ Cooperación Técnica Alemana and Instituto de Educación y Salud, 2004).

¹⁴⁷ Bureau for Global Health, *Peru Country Profile: HIV/AIDS* (Washington DC: United States Agency for International Development, March 2003).

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Sexual contact continues to be the main method of HIV transmission (96%); however, vertical transmission (mother-child) rates are increasing. In 2000, two thirds of new cases occurred in heterosexuals.¹⁴⁸ Most HIV-positive women acquired the virus from their husband or stable partner.¹⁴⁹

As a beneficiary of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Peru should receive anti-retroviral therapy for 7,000 people. Although Peru has been a beneficiary since 2003, most of the affected population still did not have access to these medicines by late 2004 and many people have died as a result.

Physical and sexual violence against women

Widespread physical and sexual violence in the country also affects women's sexual and reproductive health. According to a study on gender violence carried out by the Flora Tristán Women's Centre and the Universidad Cayetano Heredia (2002), more than half of women in Lima and two out of three in Cusco Department have been physically or sexually abused by their partner.¹⁵⁰ This study found that 41% of women had been pushed, hit or otherwise physically harmed by their husbands or partners at least once. In addition, it reported that 50% of victims of physical violence suffered injuries such as wounds, dislocations, fractures, burst eardrums, burns and others. Fifteen percent of abused women went to a police station and 79% did not go to any sort of facility.¹⁵¹ The ENDES 2000 study also found high levels of physical violence nationwide. Currently, there is no inter-sectoral system to register cases of domestic and sexual violence. Moreover, incest is not duly typified in criminal legislation since it is considered only as an aggravating circumstance.

Unwanted pregnancy

¹⁴⁸ Ibid

¹⁴⁹ Ibid

¹⁵⁰ A similar level of prevalence was found nationwide by the National Demographic and Family Health Survey (ENDES) in 2000 (INEI 2000).

¹⁵¹ A Guezmes, N Palomino y M Ramos M, *La violencia fisica en contra de las Mujeres* (Lima: OMS, Universidad Cayetano Heredia y Flora Tristán, 2003).

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According to ENDES 2000, 56% of women of reproductive age and 31% of women with partners do not use any type of family planning method or do not use them correctly, even though they want to avoid pregnancy. Half of those who used a method stopped within a year. Almost one quarter of highland women with partners use natural methods, with little or no information as to their correct use. A total of 42.5% of all women who used the rhythm method and 31.6% who used the withdrawal method became pregnant within five years (ENDES 2000). According to 2001 data from the National Statistics Institute (INEI), 98% of women living in rural areas are familiar with some type of contraceptive; nevertheless, only 38% use a family planning method. As a result, women have nearly twice as many children as they actually want¹⁵² (INEI 2001).

According to the study carried out by Delicia Ferrando in 2002, it is estimated that 60% of all pregnancies are unwanted and 35% end in induced abortion. Furthermore, 25% (862,240) of women run the risk of unwanted pregnancy because they are not sufficiently protected (Ferrando 2003.) Despite the increased use of contraceptives, access to information and services is still insufficient and inequitable. Poor young women with little formal education who live in rural areas of the highlands and jungle are most affected by unwanted pregnancy.

Unmet needs of adolescents

Nationwide, 13% of adolescents are mothers or have been pregnant at least once. Fifty-six percent did not want children at the time they became pregnant. The adolescent fertility rate is extremely high in rural and jungle areas (25%). However, the real dimension of the problem is unknown since pregnant girls or mothers under age 15 are not included in national statistics. The adolescent fertility rate is the only fertility rate that

¹⁵² The global fertility rate of rural women in Peru is 4.3 children per woman, while the ideal average figure desired by rural women is 2.5 children per woman.

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has remained stable, unlike that of other groups of women of reproductive age. Specialists report that 60% of adolescent pregnancies are the result of rape. In addition, the population under age 20 has the highest rate of sexually-transmitted illnesses (STIs).

Evolution of sexual and reproductive health policies in Peru

Sexual and reproductive rights, as human rights referring to bodily integrity and health, have been incorporated into the country's health policies since the 1960s, especially with respect to reproduction, in keeping with the discourse of the time on population and sustainable development.

Advances in the development process have been strongly influenced by two key factors: civil society, in particular the women's movement which has always championed control over the body and the right to health; and international agreements (which began to focus on population and development issues). Although derived from different perspectives, these agendas have generated expectations, demands and agendas that are increasingly specific and inclusive. These were consolidated in the Plan of Action of the International Conference on Population and Development (ICPD, Cairo 1994). The Plan of Action linked reproductive rights with sexual and reproductive health, and thus had a major impact on the development of public policy. In an effort to present an overview of Peruvian public policy in the area of sexual and reproductive rights, four stages have been defined according to the different positions that shaped national legislation.

a) The first steps, 1960-1990

In the early 1960s, the issue of population and unwanted pregnancy became a priority in development policies. This emphasis was influenced by scientific advances related to the popularisation of contraceptive methods, together with the expectations of the populations affected and development models that called for smaller families. This led to

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the rise of new public and private institutions that addressed sexual and reproductive health issues from a perspective of maternal-child health and family planning.

In 1964, the Peruvian government created the Population and Development Study Centre which offered healthcare providers training in contraceptive methods. In addition, the first private family planning programmes were launched, including that of the Peruvian Family Protection Association (APPF), the Marcelino Institute and the Catholic lay organisations, which mainly promoted abstinence. These initial efforts ended in 1968 with the beginning of the military government (1968-1975), which was pro-natalist and opposed to family planning due to its firm conviction that Peru had sufficient natural resources to sustain the population.

In 1974, the population debate again came to the forefront with the World Conference on Population and Development in Bucharest. In 1976, the Peruvian government developed the first Population Policy Guidelines, which underscored the importance of family planning and maternal-child health. In 1979, after the fall of the military government, the new Constitution recognised the right of families and individuals to control their fertility and reiterated government support for responsible parenthood.

The National Population Council was created in 1980 during the presidential administration of Fernando Belaunde (1980–1985). It was established as an agency with influence at all levels to incorporate the issue of population into government affairs and public policy. During this period, the first figures on fertility and contraceptive use were collected in the country.

In 1981, the private sector was the main supplier of contraceptives (67.5%) while the public sector supplied the remainder.¹⁵³ In 1983, the Ministry of Health began to provide family planning services for the first time. These services were based mainly on

¹⁵³ L Sobrevilla and M Fukumoto, *Investigación en Planificación Familiar y Servicios de Salud*, (Lima: Consejo Nacional de Población, 1984).

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reproductive risk; in other words, contraceptive methods had to be prescribed for medical reasons and personal choice was not a major consideration.

Shortly thereafter, the Peruvian government established the legal and political framework that is still in effect today. In 1985, the Congress approved the National Population Policy Law, making a qualitative leap with respect to the traditional focus. For the first time, the government acknowledged full respect for the right of individuals to control their own fertility and to access a wide range of family planning methods (except tubal ligation and vasectomy).¹⁵⁴

In the late 1970s and early 1980s, several non-governmental organisations were established that made community participation a key strategy, taking the commitments of the Declaration of Alma Ata as a reference and the goal of health for all by 2000. This led to a community health movement, which developed mainly in poor urban and rural areas. The public health sector initiated community outreach; however, the focus was on using local human and other resources to fulfil some of the tasks normally carried out by the public sector. While this frequently permitted an effective response to health emergencies such as childhood disease and malnutrition, a by-product was that the local population became increasingly dependent on this relationship with the formal health services and therefore was unable to develop the skills necessary to hold them accountable.

b) The 1990s and the winds of health reform

In the early 1990s, the country's socioeconomic development continued to be concentrated in urban areas and family planning programmes responded mainly to the needs of the urban population. Poverty indicators were highest in rural zones of the highlands and jungle. Moreover, these areas were devastated by the internal violence of the 1980s and early 1990s, which destroyed villages and caused more than 69,000 deaths, according to a recent report of the Truth and Reconciliation Commission. The violence forced the Peruvian population to migrate, especially to coastal cities. Violence and

¹⁵⁴ Modification of Law 26626 (Ley ContraSida).

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underdevelopment significantly affected the functioning of health facilities in emergency zones. Thirty-two percent of health facilities in conflict areas were closed, thereby further widening gaps in access to healthcare.

The reproductive health situation in the country also suffered as a result of the violence. The ENDES 1991-1992 study reported that most Peruvian women wanted to have fewer children and to control their fertility. Nevertheless, many did not have access to services, information and technology to achieve their reproductive goals. This was especially true of women living in peri-urban and rural areas of the highlands and jungle. These areas have the largest percentage of poor, uneducated populations, as well as the highest maternal mortality and gynaecological cancer rates. To respond to this situation, the health sector, with aid from international cooperation agencies, began to expand health services in peri-urban and rural zones in the 1990s.

In this context, the International Conference on Population and Development took place in Cairo. The main contribution of the 1994 Conference was a new conceptual framework for sexual and reproductive health, which was officially incorporated into public policy and which promoted an integral approach to meeting the needs of women, adolescents and girls. The ICPD led to a major shift in public policy since much of the legislation generated after the conference reflected ICPD agreements. The policies go beyond health concerns to include new issues such as domestic violence and establish norms regarding girls' access to education and specialised services for adolescents.

New government institutions were established, such as the Ministry for the Promotion of Women and Human Development (PROMUDEH), which later became the Ministry of Women and Social Development (MIMDES); this Ministry strove to make gender a crosscutting focus of public policy. For its part, the Ministry of Health established a family planning and reproductive health programme and began to deliver contraceptive methods free of charge. At the same time, the Ministry of Education launched an innovative sexual education programme.

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During this period, maternal mortality was deemed a public health priority. The government developed a maternal mortality emergency plan. For the first time, the topic of sexual and reproductive health was broadened beyond the scope of family planning to include several interesting community participation initiatives.

Civil society also evolved as a result of the ICPD and the Fourth World Conference on Women, held in Beijing in 1995. Civil society organisations promoted the strengthening of cross-sector committees, networks, coalitions and other channels that furthered gender equality and the promotion and defence of sexual and reproductive rights, particularly those of women and the youth and adolescent populations affected by poverty and social exclusion. Civil society, particularly the women's movement, played a key role in the government's participation in the ICPD.

The conference agreements were the main reference for strengthening channels for coordination as well as for improving the programmes and interventions of non-governmental organisations. These organisations were able to broaden their interventions and knowledge from a perspective based on a respect for women's needs and gender equality: informed decisions, quality services, reducing domestic violence, etc. This process led to the development of new capacities within the sector as well as to the creation of more sensitive public policy indicators, which subsequently permitted the formation of a small but well-informed critical mass.

Although these processes were positive, they were often fraught with difficulties. The government's commitment to a democratic discourse and its championing of sexual and reproductive rights was undermined by its interventions which violated human rights.

The new General Health Law passed in 1997 under the government led by President Alberto Fujimori, for example, differentiated between collective needs and individual needs, which was interpreted to mean that the government was only responsible for public health actions. In the field of reproductive health, public policies shifted to a more demographic focus with the goal of reducing the number of children born to poor families

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by increasing the use of modern contraceptives, especially sterilisation, largely among poor, disenfranchised women with little or no formal education.¹⁵⁵ The Family Planning Programme soon became the centrepiece of the poverty reduction policy.

In an effort to expand the Family Planning Programme in order to limit fertility, health officials defined annual targets for the number of sterilisations and established specific quotas for health facilities.^{156 157} However, the Ministry of Health often did not have the qualified medical personnel and equipment necessary to perform these operations nationwide in such a short period.¹⁵⁸ Consequently, many establishments carried out these interventions under inhumane conditions and without informed consent. At least 18 women died as a result.

The human rights violations were denounced, initially by CLADEM and the Flora Tristán Women's Centre, and later by the Public Ombudsman's Office. In March 1998, in response to national and international pressure, the Ministry of Health adopted a series of reforms for its surgical contraception services, introducing mechanisms to guarantee informed consent and quality care, such as the mandatory period of reflection between counselling and surgical intervention. Shortly thereafter, the Ministry of Health approved the National Counselling Guide for all contraceptive methods. In 1999, the Ministry worked with the Public Ombudsman's Office, civil society and international co-operation agencies to develop the new Guidelines for Family Planning Services. These guidelines included clear measures to guarantee unrestricted respect for individual choice.

To guarantee access of the most vulnerable population to healthcare services, in 1997, the schoolchildren's health insurance scheme was launched to provide free healthcare to

¹⁵⁵ Anna-Britt Coe. "From Anti-Natalist to Ultra-Conservative: Restricting Reproductive Choice in Peru" *Reproductive Health Matters* 2004;12(24).

¹⁵⁶ Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), *Nada Personal: Reporte de los Derechos Humanos sobre la Aplicación de la Anticoncepción Quirúrgica en el Perú* (Lima: 1999)

¹⁵⁷ Defensoría del Pueblo, "La Aplicación de la Anticoncepción Quirúrgica Voluntaria: Los Casos Investigados por la Defensoría del Pueblo II" in *Informe Defensorial N°27*, (Lima: Defensoría del Pueblo, 1999).

¹⁵⁸ Coe op cit.

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children ages three to 17. In 1999, coverage was expanded with the child-maternal health insurance scheme.¹⁵⁹ These insurance systems were designed to channel spending to prioritised sectors and introduced a new concept of public spending in health: the separation of financing from service delivery. Unfortunately, the more focused health spending did not produce the expected results. At the end of the regime led by Alberto Fujimori, 20% of the population still did not have access to healthcare services.¹⁶⁰

c) 2000 to 2004: Policy Changes

The change in government to the current administration led by President Alejandro Toledo marked a new period in Peru's history with particular ramifications for reproductive and sexual health rights within the country. Between 2001 and 2003, Peru's Ministry of Health was run by two successive Health Ministers, Luis Solari and Fernando Carbone, who initiated a phase of policy making that was markedly conservative in nature. They developed policies that sought to prioritize the rights of the "unborn child" over those held by women by restricting individuals' access to essential sexual and reproductive health technologies and information. Moreover, they replaced skilled technical staff with individuals who shared their religious conviction but had little or no experience or competence in administering public health programs. During this period, the decision was taken to eliminate the Ministry of Health's Woman, Health and Development Programme, created in 1990 to raise awareness of women's health issues from a gender based perspective.¹⁶¹

There were also severe restrictions on public information related to sexual and reproductive health programmes. Between July 2001 and July 2003, only very limited public information on the Family Planning Programme was available. Furthermore information necessary for people to make informed choices over their reproductive and

¹⁵⁹ The insurance schemes have now been merged into the Integral Health Insurance (SIS) system.

¹⁶⁰ Ministry of Health, *Lineamientos de Política Sectorial para el periodo 2002-2012*.

¹⁶¹ Defensoría del Pueblo, "La Aplicación de la Anticoncepción Quirúrgica Voluntaria: Los Casos Investigados por la Defensoría del Pueblo III" en Informe Defensorial N°69, (Lima: Defensoría del Pueblo, 2002).

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sexual health was at times distorted. In late 2002, for example, the Ministry of Health's Directorate of Medications, Inputs and Drugs (DIGEMID) issued Alert N° 11-02, which urged the population to avoid the use of contraceptive products containing Nonoxinol-9 spermicide. The communication indicated that this product caused tearing of epithelial tissue, thereby facilitating rather than preventing HIV infection. The information disseminated by DIGEMID came from a WHO study, whose results were misrepresented and confused. The Ministry of Health warning did not clarify that the WHO study had been carried out with a high-risk population (sexual workers). Neither did it specify that vaginal suppositories and tablets containing Nonoxinol-9 were not designed to protect against HIV infection, but rather to prevent unwanted pregnancy.

Policy making in Peru has also been affected in recent years by external political influences. The decision of President Bush to reinstate the Mexico City Policy, better known as the global gag rule, has had a significant effect on civil society in Peru. This measure prohibits international non-governmental organisations that receive US cooperation funds for family planning programmes promoting policies to decrease the impact of unsafe abortion. The application of the gag rule in Peru has undermined civil society's ability to initiate serious debate on issues such as emergency oral contraception and treatment of incomplete abortion, considered to be grey areas of the gag rule. It has also stemmed the free flow of information to individuals about abortion.

d) 2004 – to date: a new day is dawning

The return to democracy brought with it high hopes for civil society participation. In recent years, changes in the political scenario have altered the relationship between civil society and the government and have created new expectations, at least on the part of civil society, whose base has expanded to include sectors such as the medical community. Although these groups still do not constitute a powerful force (the voice of those directly affected is lacking), there are several learning processes underway, suggesting that it is possible to build an informed community capable of exercising its human rights.

Although civil society organisations continue to be the most visible proponents, there is

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an increasing public awareness of the existence of sexual and reproductive rights as an integral component of human rights more generally.

Thus, citizen participation has also experienced distinct stages according to the different public policies that have been implemented by the government. Initially, it was considered simply as a useful extension of healthcare services. Later, civil society was recognised as an active agent in the development of public policy, participating in the definition of priorities, monitoring service quality and demanding greater investment in healthcare facilities and healthcare in general. Nevertheless, decision-makers can do more to acknowledge citizens' potential as interlocutors, especially in terms of sexuality and reproduction, issues whose public debate is often limited.

The new public health administration led by Minister Pilar Mazetti, which began in February 2004, faced not only new challenges, but also budgetary, technical and programmatic difficulties when it first came into being. One of the most important was the attempt to apply the comprehensive health, family and health promotion approach without understanding or designing an applicable service delivery model. A step towards addressing the crisis is the prioritisation of 10 health strategies on which the Ministry of Health organises its healthcare services in the framework of a rights-based, integrated, quality approach as well as respect for cultural diversity and gender equality.

There is considerable public support for the national health strategy on sexual and reproductive health, whose mandate is to restore sexual and reproductive health services. This initiative calls for the formation of a consultative committee that includes agencies, unions and scientific associations and non-governmental organisations. The strategy included the publication of the National Sexual and Reproductive Health Guide, whose content reaffirms the commitment of the government to sexual and reproductive rights and other human rights, as well as to the development of a gender focus. This Guide represents a step forward compared with earlier versions because it includes issues such

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as gender-based violence, the treatment of infertility and others issues that had not been addressed previously, such as the responsibilities of the health sector.

With respect to HIV/AIDS, the current health administration agreed to implement the activities of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which were approved in 2002. The HIV/AIDS component of the Fund has a five-year budget of US\$ 23,671,871 that seeks to achieve 4 integrated objectives¹⁶²:

- Promote healthy lifestyles among adolescents and youth by providing them with information on STIS/HIV/AIDS;
- Reduce the prevalence of HIV/AIDS among vulnerable population groups;
- Reduce mother-to-child transmission;
- Ensure quality, comprehensive health care for Persons Living With HIV and AIDS (men, women and children).

One of the main strategies involves rebuilding the Ministry of Health's capacity to address STI and HIV prevention and treatment. In addition, the Peruvian government will offer free ARV treatment for the first time,¹⁶³ thereby increasing anti-retroviral treatments from 1,100 to 7,000 during the first year and to 9,000 during the second year

An important event of the past year was the visit to Peru of the United Nations Special Rapporteur on the right to health in June. He met with government and civil society organisations. In his preliminary report, the Special Rapporteur acknowledged Minister Mazzetti's commitment to comply with national and international obligations regarding the right to health in Peru. However, he also expressed concern about the high maternal mortality rate and the punitive measures against women who undergo an abortion. The Rapporteur urged the government to guarantee access to treatment for STIs including HIV/AIDSs, as well as for uterine and breast cancer. Finally, he underscored the need for services for adolescents. Civil society in Peru will continue to work to address these

¹⁶² Murgía C et. al. "Fondo Global: un reto a nuestra capacidad de consenso." *Boletín Informativo N°11*. RedSida Peru: Lima. 2004

¹⁶³ The Global Fund will donate antiretroviral drugs for three years (2004-2006) until the Peruvian government assumes the cost of purchasing them

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concerns and to make the most of the new opportunity for change within the health sector.

Chapter 5
**Empirical Study: Access to Information on Reproductive and
Sexual Health in Cusco, Lima, Piura and San Martín**

Louise Finer, ARTICLE 19

Introduction

In this section, we will present the findings of our empirical study¹⁶⁴ which begins by analysing the political context in which the access to information was introduced and the opportunities and difficulties faced by public officials working in the health sector as they respond to the implementation of the legislation. The perspective and experiences of civil society groups which have begun to use the access to information law are outlined in the section of the study and specific difficulties in accessing public documents are discussed in the third section. We consider the impact of access to information issues on the ability of individual women to exercise their right to reproductive and sexual health in the fourth section. Finally, our conclusions draw upon key issues arising from the interviews and our wider knowledge of the current situation regarding access to information and reproductive and sexual health.

The political context

The election of a democratic government in Peru in 2001 was a major step towards institutionalising a system that proposed to rectify the wrongs of the past while simultaneously developing a new style of governance for the future. The political momentum initiated by the transitional government generated high expectations among the population for the newly-elected President Alejandro Toledo and his administration as well as for tidy closure to be brought to the suffering, hardship and corruption that had

¹⁶⁴ The methodology and background to this study can be found in Appendices 2-7.
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characterised the country's recent history. Toledo's electoral platform rested upon the need to respect human rights, broaden access to basic services, improve the standard of living of the extremely poor, and open up space for greater citizen participation in political life through a process of decentralisation.

At the time of the elections, public expectations were based on highly subjective interpretations of the country's recent history and emanated from a diverse society with often conflicting interests. The task of the new government to bring about change without exacerbating these divisions was daunting but ultimately guided by the many positive steps taken by the transitional government. Among the most significant of these initiatives were the establishment of a Truth and Reconciliation Commission and the increased political support for mechanisms dedicated to the eradication of corruption, such as parliamentary investigative commissions, special prosecutors' offices and proposed legislation to guarantee access to information.

To an extent, Alejandro Toledo's campaign platform reflected the goals of the civil society movement at the time, which stood in opposition to the powerful political groups whose links with corruption and human rights abuses became evident in the late 1990s. As such, his eventual election was seen as a vindication of the many demands made by civil society organisations in recent years, and created the possibility for a more inclusive social movement that could push for greater democratisation. Many activists accepted positions in State bodies under the new government, lending even greater credibility to its social agenda.

There is no doubt that because such high hopes were invested in the new, democratic administration's ability to put into place urgently needed reforms, the gradual yet steady decline in support for the current government has come as a grave, but probably inevitable, disappointment. A widespread lack of public confidence in the President, caused in part by his decision to change Ministers frequently and his inability to show evidence of the sweeping changes he promised, is matched by almost universal disillusionment with the way Congress, the Judiciary and other public institutions are

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managed. This devastatingly low public opinion of government institutions appears to be unaffected by attempts on the part of the government to introduce measures for social reform and improve its self-image, and new allegations of corruption serve only to ensconce the country's deep-seated distrust of its political leaders further.

Within this context, the approval of the access to information law stands out as an example of at least a tentative commitment to implement reform. The initial impetus for drafting the law given by the transitional government was capitalised upon by an informal coalition of progressive media representatives, the Ombudsman's Office and some politicians, although it enjoyed only limited civil society participation. As a result, the approval of the law in 2002 and its subsequent modification in 2003 passed relatively unnoticed by the country as a whole. Implementation of the legislation is therefore only of interest to a limited sector of society at present, even in light of the potential it has for addressing the crisis of confidence in government by promoting greater transparency and openness.

Basic compliance with the Access to Information Law¹⁶⁵

Ministry of Health

Since 2002, the Ministry of Health incorporated a special office to increase transparency within the institution. However its status has since been downgraded since it was first established and its shared function acting as a general Ombudsman's Office, where official complaints are received, means that its transparency work has often been a secondary priority. Its responsibilities do not include processing information requests, but rather proposing, implementing and monitoring ministerial policy on access to information.

Overall, basic compliance with the access to information law within the Ministry of Health has been moderate. A resolution published in October 2003¹⁶⁶ delegates the responsibility for information requests to the general directors of Ministry of Health bodies, but in many health establishments this function has been assigned to different public officials. This leads to a confusing situation both for the officials themselves and for requesters. It has not been possible to assess the extent to which public officials adhere to the time limits imposed by the law because few requests are actually formally registered. Although there is a manual system in place to register requests, this often contains requests that bear no relation to public documents and therefore provides an inaccurate impression of information requests responded to in a given period. A more reliable and efficient electronic system is reportedly being designed to address these problems. Moreover, since January 2004, the Ministry of Health has complied with publishing all categories of information required by the legislation on its institutional

¹⁶⁵ The main provisions of the Transparency and Access to Public Information Law that we will consider are as follows: the designation of the public official in charge of handing over information (Article 4); publication of specific categories of information on web pages (Articles 5 and 25); identification of the official in charge of the web page (Article 5); adherence with time limits established for response to information requests (Article 11b); reproduction costs incurred through information requests (Article 20); public bodies' compliance with reporting to the Presidency of the Council of Ministers on information requests received and processed (Article 22).

¹⁶⁶ Ministerial Resolution No. 1062-2003-SA/DM

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web-page. The Head of the Transparency Office admitted that there is only limited awareness within the Health Ministry of the appropriate costs relating to providing information although a memorandum has recently been circulated to inform staff members. When interviewed, the Head of the Transparency Office was engaged in writing a report for the Presidency of the Council of Ministers, as required by the legislation, with regard to information requests processed in all Ministry of Health dependencies. This report contained records of requests made across the country, and showed that a total of 1,034 requests had been received over the past year (2004).

EsSalud

In 2002, EsSalud named officials responsible for facilitating access to information¹⁶⁷ and published their contact details on the institution's website¹⁶⁸. In its regular monitoring of institutional web pages, the Peruvian Press Council¹⁶⁹ showed that until April 2003, EsSalud did not publish all categories of information required by the access to information law. However, in response to external criticism of this lack of transparency, the institution began to publish these categories in full¹⁷⁰. ARTICLE 19 has not been able to establish EsSalud's fulfilment of its obligation to provide the Presidency of the Council of Ministers with a record of information requests processed within the institution because a request we made for a copy of this document remains unanswered.

Another important step taken in 2002 was the establishment of the Transparency Roundtable [*Mesa de Transparencia*] to oversee the management of public procurements, especially those that fall under the category of emergency spending (urgent purchases require direct dealings with providers and are often the subject of scrutiny due to the large sums of money involved). The Transparency Table, headed by the EsSalud Ombudsman

¹⁶⁷ Resolution of the Executive Presidency [Resolución de la Presidencia Ejecutiva] No. 569-PE-ESSALUD-2002

¹⁶⁸ http://www.essalud.gob.pe/nservicios/funcionario_info.htm

¹⁶⁹ www.consejoprensaperuana.org.pe

¹⁷⁰ For a detailed study of financial transparency in EsSalud, see the bulletin published by Ciudadanos Al Día "*EsSalud: ¿Mas autonomía con menos información? Hacia un sistema de vigilancia ciudadana en EsSalud*" (Lima: February 2004).

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for Insurance Holders since 2004, includes representatives from universities and other public institutions, but only works on issues related to procurements and does not consider transparency related to EsSalud services or policy.

Regional Governments¹⁷¹

With the exception of San Martín, all regional governments in this study have fully complied with their obligations to create web-pages and publish certain categories of information, according to figures published by the Peruvian Press Council in September 2004¹⁷². However, few regional governments had established and consistently implemented procedures to receive individual requests. One official suggested that because regional governments are such new bodies, they have relatively little information to provide, particularly on functions that are proving slow to decentralise such as those related to health. It appears that in the short time regional governments have been in operation, establishing access to information procedures has not been considered a priority; the one clear exception to this rule, the regional government of Lambayeque, on the Northern coast, is not included in this study.

¹⁷¹ Our monitoring of regional governments' compliance with the Transparency Law has been limited, in part due to the abundance of material already created and collected by the *Vigila Peru* project that monitors regional government activity across the country. See

<http://www.participaperu.org.pe/vigilaperu/index.shtml> for more information. The Peruvian Press Council also monitors regional government webpages.

¹⁷² <http://www.consejoprensaperuana.org.pe/seguimientoportales/Mon.%20Gob.%20Regionales%20set.xls>

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The State – in practice

In this section ARTICLE 19 will examine four main aspects to the workings of the State that impact upon the ability of citizens to access information from government bodies. Firstly, we will examine the implementation of access to information procedures in parallel to the perceptions public officials have of these procedures in order to assess the extent to which they are observed in practice. Secondly, we will look at the way in which institutional culture supports or undermines the mechanisms in place to facilitate greater access to documents and finally, we examine the relationship between the State and civil society within the context of facilitating a greater free flow of information to the public.

Implementation of access to information procedures and the perceptions of public officials*Public officials' attitudes towards access to information*

According to interviews, the large majority of public officials committed to greater transparency and openness within their institutions expressed support for the access to information law. As one public official stated, “no-one should have anything to hide. If you cover something up it’s because you have something to hide”. Many of these same officials were actively promoting a culture change within their establishments, working hard to meet the new challenges presented to them by the access to information law and growing public demands for accountability. This was an encouraging trend and one that will do much to ensure the law is properly implemented and fulfils its potential as a mechanism for change.

Alongside this positive trend, our findings show that many public officials were unaware of the access to information law, particularly those working in remote areas and smaller government bodies. Even among those who knew about the existence of the legislation, many were unsure of what constituted an information request. This has undoubtedly impacted upon the ability of government and civil society groups alike to monitor the

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legislation's implementation, with some senior officials who compile statistics based on individual registers of information requests failing to draw a distinction between requests for public documents and internal requests for logistical support, staff leave and patient appointments. There is a clear need to prevent these problems from taking root by providing access to information training at all levels of the Ministry's structure, not just in the health establishments which report directly to the headquarters in Lima.

It was difficult to judge how internal procedures and attitudes to access to information had changed since the law was passed, mainly because of the transient employment of public officials. As ministerial changes are frequent and most officials are replaced or moved around according to temporary, politically-driven allegiances, there is little continuity within these establishments; one clear example of this is the Office for Transparency in the Ministry of Health, which during its short history has had a different head under each new Minister in office. Another by-product of these frequent changes is that investment in staff development, such as training on access to information, is not seen as a priority because those in the upper levels of government are aware of how short-lived the impact of such initiatives will be if they are not sustained.

The research also revealed frustration among officials in reaction to the time they were required to spend processing and channelling information, and many saw their role as administrators and bureaucrats ('paper pushers'). Even more worrying was the fact that to be given the responsibility for dealing with an institution's information requests was often viewed as a punishment. Among many concerns expressed in relation to the procedures for accessing information, the most widespread was that responding to information requests would become a burden for officials who already had a significant workload. Although few considered the current number of requests to be onerous, their apprehension was rooted in the expectation that the numbers of information requests generated by the public would increase in the future.

Procedures for receiving requests

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The means by which information requests were received by government offices was subjected to widespread uncertainty, with few officials clear about the formal procedures within their own establishments. Some officials believed that all information requests entered via an official document reception desk [*Mesa de Partes*] while many made reference to requests that they had received directly. In one regional directorate all requests were sent to the director who then handed them to the person he considered responsible. Few public officials in regional bodies had access to email, but even among those who did, none had received external requests for information by this means, and stated that they only used electronic communication for internal distribution of documents. In many cases, requests had been made in person and one official said that she “interviewed” anyone who arrived at her desk requesting information.

Quantity of requests

The research revealed large discrepancies in the number of information requests received, and also in the officials’ understanding of what constitutes a “large number” of requests. In one regional directorate the number of requests had reportedly decreased in the past year, and the official who dealt with them put this down to the public being less inquisitive as a result of the improvement in the “internal situation” in the Health Ministry. Many officials reported never having received information requests, particularly those in entities lower down the ministerial structure. Out of those who did consider themselves to receive a regular flow of information requests, the number they dealt with varied from four or five per month to five to ten weekly. Unsurprisingly, the offices dealing with issues of public interest and topical sensitivity such as reproductive health received larger numbers of requests. Perceptions of the work necessary to process information requests varied, with one senior official in the Ministry of Health headquarters defining the five to ten weekly requests he received as “loads of requests”, while a regional official heading a Health of the People office considered his average of one request per week as “frequent”.

Fees charged for information requests

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The charges associated with reproducing information were the source of some confusion among most members of staff within the health establishments we examined. Some officials believed that it was the responsibility of management to produce a set of fixed charges for information requests. In one Regional Directorate, some statistics and epidemiology staff members were convinced that their right to charge for information was established in the Health Ministry's internal regulations (TUPA). Others were unsure whether they could only charge for the reproduction of the information or whether the request itself could incur a cost. In one institution, an official commented that the charges were made through a central finance office, rather than by the individual managing the request, and that the cost was estimated according to the length of time it took to process. In another case an official claimed that for a CD copy of information the requester was usually charged ten soles, ten times the market cost of a blank CD. In several places, those deemed unable to pay and others who had a direct relationship with the institution or official handling their information request were apparently not charged. This internal confusion was underscored by the fact that the Ministry of Health publishes an out-of-date version of its TUPA on its website, in which the old guidelines for costs are laid out, seemingly justifying the continued practice of charging for requests.

Timeframes for processing information requests

There was a shared view amongst public officials that the timeframes established by the law for responding to information requests were too short, rendering it virtually impossible for them to comply with the legislation. Some officials claimed that most requests were answered within two days whilst others admitted that they often take much longer to process. The systems used by officials to prioritise certain requests were also unclear, and appeared to depend on the attitude of the official receiving the request, the apparent urgency of the request, or the effort it would take to collate the relevant documents. One official stated that information relating to family planning usually needed to be collected from a variety of sources, and as a result was particularly time-consuming. Officials were always required to assume responsibility for preparing

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information in addition to their usual workloads, and this was the source of some resentment. In one extreme example, an official suggested it was “an abuse to our situation that we have to stop doing things ... and try to provide this information”. Some officials blamed systemic constraints on their ability to provide information within the set timeframes; for example, the institutional structure and geographical considerations meant it could take an official as long as ten to fifteen days to obtain information needed from a lower level entity.

Obstacles to access to information

One of the main obstacles to providing better access to information and improving transparency within public bodies was considered to be the limitations on their budgets. These budgetary constraints were blamed for the failure of health establishments to proactively disseminate information of relevance to diverse communities. Officials complained that their budget for public awareness-raising was unfeasibly low and as a result they were required to seek multi-sector support to be able to undertake such activities. One regional director suggested that reductions in budgets for awareness-raising stemmed from the central Ministry’s reluctance to openly publicise certain areas of their work that was seen by many as sensitive, with reproductive and sexual health being the most obvious example. Some claimed that with so many competing demands, transparency is not a priority in the health service, “on this issue it is about complying [with transparency initiatives] as far as we can”.

Logistical limitations were seen as another of the most difficult hurdles to overcome in improving access to information. In many cases this was due to a lack of internal infrastructure necessary to ensure broad public access, particularly in health establishments located in geographically remote areas. Whilst the intention often existed to disseminate information, the systems were not adequate to carry this out in practice. Even the use of radio as a means of communications in remote rural areas was far from universal, and as a result many health establishments had to rely on occasional personal

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visits to communicate with their superiors. Another serious limitation was the absence of internet or email facilities in many health establishments.

The case for improving information dissemination – the provision of contraceptive methods and planning of services

Over the past years there have been many periods during which supplies of contraceptive methods have only arrived irregularly in provinces; at the same time information regarding these supplies and their delivery is scant and unreliable. The system by which different entities request supplies was seen as problematic on many levels. We were told by regional directorate staff that the quarterly requests they made took so long to pass through internal channels that they were out of date by the time they were processed. Others complained that unreliable sourcing of provisions meant that the supplies that eventually reached provinces rarely corresponded to what they had requested, and that they had no advance warning of this. Interviewees agreed that if central plans for the delivery of contraception were circulated to the outer provinces they could plan their services accordingly, as opposed to the current system which required them to incorporate a fallback period or a margin of error into their requests for supplies.

As a result of these deficiencies in the system, individual women seeking a repeat prescription in their local State health services have often found that their preferred contraceptive method is unavailable, and the Ombudsman's Office has noted cases in which the lack of provisions has resulted in unwanted pregnancies. Although the provision of contraceptive methods has improved under the current health minister, the nature of the system in place means that individual woman will often face uncertainty over her continued ability to obtain her preferred contraceptive method. Staff from local alternative health services that many women who fail to obtain their contraceptive methods from State clinics rely upon suggested that they would be able to plan their own supplies and coverage better, and thus meet individual women's specific and often urgent needs, if they had access to information about consignments received by local authorities and potential shortages.

Institutional culture

Several officials blamed an internal institutional culture for the secrecy that permeated public administration and the slow move towards openness and transparency. Many admitted that some staff members were over-protective of information: "there is jealousy or reluctance to hand over information". One network official suggested that staff felt their role was to tend to patients and as a result "they don't want to take on the process of consolidating information", which was considered a purely administrative responsibility. One official responsible for processing information requests suggested it was because "the understanding of what transparency means is still lacking, particularly in a sector that is sometimes problematic, like health".

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The difficulty of making a clean break from past practices was considered an obstacle by many officials, and one regional directorate staff member found it hard to forget the old rule that only the director (or other members of staff with his/her express authorisation) was allowed to give information. Some staff complained that it was their superiors who continued to place obstacles in the way of providing information to the public, while others with responsibility for handling requests found that it was staff lower down the hierarchy who did not help them find the information they needed to respond to requests. Although few blamed their colleagues' reluctance on any more than an institutional trend, one regional government official responsible for overseeing health issues reported wilful disruption to the process of instituting a transparent culture "we can't deny that within the bureaucratic apparatus itself there are people who do not share, damage and even sabotage the management".

The informality with which many procedures established by the access to information law are performed has created space for discretionary and often contradictory treatment at the expense of both those implementing the law and those using it. In many cases, the release of information to the public depends upon the disposition of the official at the time of receiving the request. The identity of the requester frequently influenced the decision of public officials to disclose information or not, with the existence of a personal affinity between the official and the requester being the best guarantee of success. In one government health network, officials commented that they were willing to process requests from students, but would refer the request to a senior member of staff if it was received from a journalist in order "to avoid the problem becoming any bigger".

The research revealed a widespread perception that officials could face negative repercussions for releasing information. An example of this was provided by a statistics official who had released figures documenting the number of AIDS cases in a particular region and who was then reprimanded by her line manager as a result. Where staff felt that they did not have the authority to make autonomous decisions in their work, the decision to reply to an information request was seen as a potentially risky move that could create problems for them within their workplace; this fear was confirmed by one

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older and more senior member of staff in a regional directorate who admitted that while he enjoyed the ability to speak out, his younger colleagues would jeopardise their jobs by so doing. Other officials felt that the very nature of their responsibilities (particularly those in charge of receiving complaints or implementing internal checks) meant they were constantly at risk and had to keep a low profile so as not to put their jobs on the line.

Staff spoke of political and personal allegiances within State bodies, particularly within their higher echelons, that led to rivalries among personnel and which prevented some staff members from progressing within their careers. One official also suggested that health institutions too are subject to changing political agendas and that the directors of these establishments sometimes appropriate information to support their own subjective agendas. The impact of changing political trends was particularly evident at a ministerial level, with a feeling that “the person who takes over pokes us and moves us”, but also within the Health of the People Directorate where the complaint was made that with every new director put in charge, radical changes were made in the formats and requirements for monitoring and information analysis.

Several public officials were unsure of how to deal with internal requests for information and whether or not they themselves could use the access to information law to obtain documents of interest from other departments or institutions. One health centre manager complained that the headquarters of the Ministry of Health was so hermetic it would not provide them with information, especially if related to budgets. Officials were keen for there to be greater transparency around internal budgets so they could monitor public expenditure but when they made inquiries, they felt that no-one would accept responsibility for releasing this type of information. In some cases, staff who had requested information on administrative matters had actually provoked such wrath among their superiors that they were threatened with dismissal and it was suggested that this was driven by a fear that the member of staff requesting the information could uncover corruption. Staff felt that any requests they made for information were seen as antagonistic. We found no examples of internal requests made citing the access to information legislation and in fact we were given the impression by many officials that to

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do so would be seen as an even more provocative act than if the request was made informally.

Political vacillations at central ministerial level were often blamed by lower ranking staff for the delays they experienced in the dissemination of documents relating to policy, programming and services. Senior officials, on the other hand, blamed logistical and budgetary limitations for these delays. The lack of opportune dissemination of such information meant that not only were staff uncertain in their work as a result, but they projected this uncertainty when dealing with patients.

External influences on policy generate a culture of insecurity that directly impacts local staff and service users

Some officials suspected that internal dissemination of new policies, and thus the updating of information systems and services based upon them, was often subject to informal pressures applied at the highest level of the political system. The approval in mid-2004 of new reproductive health policy incorporating emergency contraception into the range of methods to be provided by State health services, in the midst of fierce public and political debate, provides a clear example. Since the approval of the policy, emergency contraception supplies have yet to materialise, and even the distribution of the new National Guides for Sexual and Reproductive Health drawn up to guide the implementation of the new policy had yet to reach many areas we visited. Such guides are essential tools for staff implementing reproductive health services, and they feared that the ongoing polemic around emergency contraception, fuelled by reactionary political and religious groups, was the reason why they had yet to receive updated information or the promised supplies.

Local staff members were well aware that the issue of emergency contraception was still extremely sensitive at a central level, and as a result, they treated it with extra caution, showing reluctance to prepare their services to include emergency contraception until they were completely sure it would not cause a backlash. Some had been led to understand that emergency contraception would not be distributed until the debate around it died down and it could be done “on the quiet”, without stirring up further controversy. Likewise, up-to-date information about the new policy regarding emergency contraception was not provided externally, and so health services users who were well aware of the policy change from the commotion reported in the media, had no idea when or even if they would be able to access this method of contraception from State services.

It appears that information requests made to the Ministry of Health headquarters are generally made by private individuals, who may or may not have represented organisations, whereas in the regions we visited the majority of requests had come from higher education students doing coursework. Locally, some officials had also received requests from NGOs and suggested that as the “general public” was not interested in public matters, any requests made by private individuals were likely to represent a broader agenda. Many referred to inter-agency requests coming from municipalities,

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regional government, the Ombudsman's Office, education establishments and in some cases requests from journalists and Congress members had been received.

Patterns also emerged in relation to the nature of the information that officials reported to have been requested. While locally it appeared that information on reproductive and sexual health was not requested any more than other health issues, at a central ministerial level a large number of requests had been made directly relating to reproductive health services, statistics and performance. Most students were reported to request general statistics on morbidity and mortality or specific diseases while NGOs reportedly request documents relating to Ministerial strategies and action plans. One official said that journalists only ever requested information on public health matters, such as vaccination programmes or campaigns.

Other areas of interest motivating information requests had been the Integral Health Insurance (SIS) scheme, family planning users and supplies provided and the incidence of diseases such as TB and malaria. Few references were made to information requests relating to administrative, management or budgetary issues. One official did complain of "quirky" requests about how much a specific official earns and what responsibilities he/she has but in general, few requests strayed from the substantive issues of health services and statistics.

In relation to the public's use of the access to information law, one official with considerable experience of managing information requests had identified several issues that hindered his work. Although he commented that it was the Ministry's responsibility to make the public more aware of the way in which the law works, he also blamed some of the problems on the public's lack of understanding of the process. He had received a number of requests which did not include the contact details necessary to inform the requester that their information was ready for collection, and had encountered other cases in which requesters did not return to collect the information they had asked for, or who only did so several months after making the request. In some instances, members of the public had realised that they could not afford to cover the costs of reproducing the

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information they had requested only after the information had been collated, and his main concern in these situations was that the time he had already invested in the process was in effect wasted. One official (from a Statistics office) criticised individuals for requesting information that was published on the Ministry of Health's webpage, and expressed annoyance at the fact that the law obliged him to respond to the request in full rather than merely referring the requester to the website.

There was widespread criticism of journalists and the role taken by the media in local affairs. Journalists frequently requested topical information and subsequently failed to collect it due to a shift in the news agenda, while the media in general was seen as reluctant to represent the complexity of many issues, and over-reliant on internal "intelligence sources" as a means to access information, rather than respecting formal procedures. In light of this, several officials commented that they would like to establish a closer relationship with the media so that together they could better inform the public about health issues.

Many officials were concerned that by responding to some requests for information they could be presented in a negative light, and believed that this warranted the exercise of "special care" in the way they managed such requests. The very content of some of the information requested was seen by officials as having a dangerous potential, as it could expose shortcomings in services or serious public health problems; these officials believed that the dissemination of such information was necessarily unfair or prejudicial to their institutions. They believed that the desire to request such "negative" information was similar to that that compelled people to "distort" or "misuse" more positive figures. In either case, they feared the ways in which information would be used when put in the hands of a member of the public whose intentions were not aligned with those of the institution.

As a result, officials felt the need to ask requesters about their motives for seeking particular documents, which they then justified according to their own notion of "suitable use". In this way, information was seen as a tool with a potential to wield undue influence

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rather than as something neutral or instrumental in a positive sense. Officials were aware of the difficulty associated with balancing the need for openness with their desire to mitigate the effects of releasing information that could damage the image of their institution: “if you don’t want to alarm people you have to have a good deal of tact and not hide information, be careful and see who you give information to”. The level of trust of information requesters also depended on their perceived knowledge or stance on the issues involved, and as such one official told us: “we have to know how to manage the information and this depends on who the respective information is going to. If it is going to a technical entity like us it is different, everything is clear, but if it is going to a group of people who don’t have much knowledge of the sector, we have to manage the information better”.

The relationship with civil society and the public

In the context of so many new mechanisms for participation and coordination, it was worrying to hear several officials express concerns that the relationship between civil society and the State was, in their minds, antagonistic. Some health centre staff suggested that the damage inflicted on institutional noticeboards by members of the public waiting for treatment was representative of this undercurrent of bad feeling.

It was suggested, particularly by regional government officials, that the community at large did not know “how” to participate in public life. One was critical of community attitudes towards public hearings and the tendency of individuals to arrive at meetings with “a rosary of requests”. Although he suggested that a significant section of the population was not “accustomed” to participatory events, he did not suggest any strategy for ensuring they could participate more effectively in the future. There was a presumption that if communities were invited to participate in public life they would place too many demands on government, in line with what officials pinpointed as their unreasonable view that “the authorities arrive to solve everything and it is important to take advantage of this”.

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The CLAS system, well-established in many areas, does provide some positive examples of existing civil society and State relationships based on trust and power-sharing. However, alongside inspiring stories of enthusiastic local participation in assemblies held to discuss health centre administration matters, many interviewees, including CLAS staff members, community representatives and health service users complained that the relationship was not functioning as it should, and that in fact they felt that an environment of animosity resulted in the disillusionment of all sides in relation to their counterparts' behaviour and attitudes.

Civil Society and Access to Information in Peru

This section draws upon information gathered in our discussions with civil society groups in Cusco, Tarapoto, Piura and Lima. The information needs of these groups were identified through a series of focus group sessions which then looked at the extent to which their use of the access to information law to date had facilitated their work. This section examines the different motivations within civil society for using the access to information law and the difficulties they encountered in doing so. In all four geographical areas we encountered a diverse range of organisations and civil society initiatives working on health, gender and governance issues. Specific local problems gave rise to a variety of approaches and strategies on reproductive health matters in each region.

In accordance with traditional patterns of centralised power and participation, urban areas were home to more organised groups, and most nationwide civil society strategies are coordinated from the capital city. However, active citizen watch groups and community ombudsman schemes were present in many of the areas we visited, and were particularly focussed in some rural zones. Their work is carried out by word of mouth and builds on trust relationships, and “working like ants”, in order to empower and train peers in areas where the “rights culture” is incipient. Larger and more experienced organisations were playing an important role in capacity building. Citizen watch and monitoring strategies are gaining strength in many areas, but we were told repeatedly that initiatives based purely on monitoring activities were seen as a medium-term strategy, secondary to the more immediate need to gain access to basic services.

A tendency to form networks was particularly evident among women’s organisations, with many long-established initiatives now spawning new groups. In Piura several youth initiatives had formed strong networks among themselves and with other regions. An innovative approach to linking health and human rights discourse is being pioneered in Peru, and although it is led by Lima-based organisations, many have good networks and the new approach is influencing similar strategies in the regions, enabling local organisations to operate more effectively in the political sphere.

The degree of “activism” employed by organised civil society groups was often questioned, both by organisations themselves and by officials who were aware of their work. In order to work on reproductive and sexual health it was often seen as inevitable that an ostensibly “radical” stance be taken, as this was the only way of counteracting dominant official discourse. In fact, some activists even directly blamed the influence of the Church and religious NGOs for creating the environment that forced them to take often uncompromising positions. In terms of organisations’ strategies, some expressed pride at the propensity of their local communities to protest, particularly in Tarapoto where activists judged this to be a sign that a population who had lived under fear and curfews during the many years of terror in the region were at last overcoming their qualms about speaking out in an environment in which they felt powerless and even lacking in personal security.

Information needs of civil society organisations

We held focus groups sessions with a total of twenty three organisations in Cusco, Tarapoto and Piura in order to identify their information needs and the following is a summary of the key findings of these sessions and other interviews.

Statistics

It was widely held that there is a scarcity of reliable statistics, particularly those relating to individual cases that had not been treated within State health services. Most civil society organisations wished to obtain statistics on adolescents, abortion, sexually transmitted diseases, incidences of rape and maternal mortality.

Policy-related information

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There was a demand for information on how policies are drafted, the existing legal framework on which policies are based and the process for designing strategies to implement policies.

Service-related information

NGOs were interested to receive information on how decisions are taken on the services offered under particular policies, as well as information on treatment protocols, institutional strategies and the programmes being implemented by each health establishment. In relation to services offered in a particular health establishment, civil society groups demanded detailed information on family planning supplies and the coverage of the new Integral Health Insurance (SIS) scheme.

Administrative and financial information

This area of information was not a priority for any organisation, but following detailed discussion many decided it would be useful to their work. Specifically, they were interested in the budgets allocated to particular health establishments and programmes as well as the rationale for the assignment of resources, staff numbers and opening hours.

Staff-related information

Civil society groups were interested in receiving information about staff wages, the procedures in place for hiring staff as well as the background and expertise of those officials responsible for policy and decision-making at higher levels.

Performance-related information

This was one of the areas that organisations felt was most lacking in terms of the categories of information that actually existed. Interest was expressed in accessing

information relating to achievements and developments, quality of services and accountability procedures, particularly relating to cases of medical negligence

Individual information

Organisations felt it was important for service users to be given more information that could enable them to take informed decisions relating to specific contraceptive methods and basic reproductive health matters. They were adamant that patients be given access to their clinical histories. It was suggested on one occasion that the kind of information needed to exercise individual rights was different to that needed for collective rights.

Information from non-Ministry of Health sources

Organisations were keen to counterbalance State figures with others relating to private and traditional health care. Interestingly, one health campaigner called for greater coordination among NGOs who gathered and created a wealth of useful information but never shared it. This apparently led to duplication of work in many areas. Many regional NGOs said that they relied on publications distributed by larger NGOs to inform their work and so called for their wider circulation.

Format of information

There was some confusion over the difference between categories of information that could be made available and the format in which information should be presented. This was particularly noticeable among organisations who were less aware of their right to information, and among those working directly with communities who had a limited knowledge of the basic elements of reproductive and sexual health rights. Many of them called for information that was presented in a more suitable fashion for their community, and all were keen to have more educational and promotional materials about basic health matters, some of which were to be directed specifically at men. However, they only had a weak grasp of how official information could be fed into such materials. Great emphasis

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was also placed on the need for all available information to be current, reliable and clear. Furthermore, all groups considered it necessary for information to be disaggregated according to age and gender, and some wanted information that better identified the establishment or department responsible for producing particular statistics.

Obtaining information and use of the access to information law to date

All organisations were in agreement that there had been a significant improvement made in access to information on reproductive and sexual health in past months. Although in most cases their experiences were limited, they did demonstrate that there had been not only some procedural improvements facilitating greater access, but also a cultural change made towards greater openness.

The passing of the access to information law has marked a turning-point in the way information is treated by health establishments and viewed by the public. Many civil society representatives referred to the fact that reproductive health was considered a “restricted” subject until very recently and that in the past family planning was particularly taboo. Many had been charged disproportionate amounts for information and one local activist commented upon an occasion two years ago when she had been charged 50 soles (approximately £9) by her Regional Directorate for a CD copy of statistics relating to adolescent pregnancies and HIV/AIDS. Unfortunately there were also some negative experiences that had occurred since the passing of the access to information law in recent months. One of the local coordinators for this project was asked to pay for a list of officials in a local health centre: ironically she was requesting this information in order to prepare for the interviews that were to form part of this research.

The procedures employed by organisations to access information were not uniform; in the past they had predominantly used personal contacts to obtain documents they required, and continued to do so even after the law was in place. As one person stated, she had to plead with her well-positioned friends “please can you get me this piece of information” and hope that he/she would oblige. In such cases a verbal request sufficed and

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information, where available, was released speedily. For one private health care professional there was never any difficulty in obtaining information as she had worked in the Regional Directorate in the past.

Others had found that making information requests in the name of an organisation, or even better, as a network with several organisational members, was seen as a surer guarantee of receiving an answer. Those with experience of making formal written requests citing the access to information law had enjoyed greater success, particularly organisations who had received specific training by either the Ombudsman's Office or the Institute for Press and Society (IPYS). Nonetheless, using the access to information law was by no means a guarantee of success and most civil society representatives agreed that it is still easier to obtain public documents directly through personal contacts than through a formal written submission. Only in Piura, as a result of the intervention of IPYS in local requests, and in Lima, were any organisations beginning to initiate appeals processes in response to information requests being denied.

Information requested by civil society

Prior to making a request some organisations informally enquired if the information they were hoping to obtain existed and if so, if it was subject to public disclosure. Types of information that had commonly been requested in the past included statistics on births and deaths, mortality rates, incidence of diseases, programming of local services, abortions and related illnesses and stocks of contraceptive methods, though in many cases requesters were denied access or told that the information did not exist. All those that had requested budgetary or economic information had experienced greater difficulties than those groups requesting other categories of information. Some groups had attempted to ask “why” questions in their information requests, for example “*why* there was a limited supply of contraceptive methods”, and predictably had had little success. They found that a direct interview with a public official gave them more accurate answers to queries requiring a justification or explanation of a particular policy or practice.

Motives for Using the Law

The reasons motivating some civil society groups and individuals to have already employed the law in their work were not as straightforward as might be expected. We found that many understood that the act of requesting information could have a wider impact within the public body at the same time as giving them access to necessary information, but in practice this often led to their motives appearing antagonistic. One local community representative expressed enthusiasm for a law that would allow her to “scare” a particular official who was refusing to tend to certain patients. The desperation of many community activists to provoke change and combat irregularities in the absence of formal complaints channels led them to consider information requests as a way of making themselves heard or of issuing a threat to a particular official.

Nevertheless, discussions with a wide range of civil society groups provided clear evidence of their interest in accessing information for very definite and constructive purposes. The suspicion that corrupt practices were common in local hospitals, particularly in the implementation of the new Integral Health Insurance (SIS) scheme, led to interest in being able to access inventories in order to monitor: 1) the number and type of contraceptive methods allocated to regional health facilities; 2) the number and type of contraceptive methods reaching the regional health facilities; and 3) the number and type of contraceptive methods prescribed by doctors and nurses working in the regional facilities. In this way they would be able to affirm or quell their suspicions that staff members in these facilities were allegedly selling supplies and charging inflated prices for essential materials (eg sample pots, dressings, condoms etc). This would also allow them to keep a check on the functioning of the health centres, predict supply problems in advance, and investigate and expose corruption where they had found it to exist.

Difficulties in accessing information identified by civil society*Limited understanding of access to information legislation*

Many organisations communicated that they had only a limited capacity to use the access to information law, and commented that although they are aware of its existence, they do not yet use it. The findings show that the more community-based the organisation or civil society initiative, the less likely it is to be aware of the access to information legislation; although in some cases groups (such as the Community Ombudsmen in Cusco) were highly informed of the right enforced by the law, others had only a very vague understanding of it conceptually. Organisations supporting these community-based initiatives were more likely to have received training on issues such as the right to health and access to information, and admitted that the filtering down of this knowledge and experience to community members had been only sporadic. Some organisations were daunted by the access to information law and viewed it as a mechanism that should only be used as a “last resort”. They felt that they would need planning, specialist knowledge and expertise to invoke the legislation.

Distrust of public officials’ responses

Many of the reasons given by officials to avoid answering information requests were thought to be pretexts, including the claim that the information requested had just been passed on to another office, or that the official or the requester needed to consult with a higher authority before anything could be released. Other attempts to prolong the process, such as being told to return a day later as the information was not ready, were thought to be intentionally employed as a way of dissuading members of the public from requesting more information in the future. In other cases, civil society groups complained that officials refused to process their requests because they had not written a formal letter to accompany the request, despite the fact that the law specifies no such requirement.

Identity of the requester

Civil society groups perceived that in general, public officials do not trust individuals requesting information and that in the absence of any personal connections, the onus fell upon the requester to convince the official that the information would be put to good use. Many resorted to drawing attention to their professional and/or social status in order to compel officials to release the information they required. Although individuals presenting themselves without any institutional support were frequently denied information, local citizen watch committees attempting to monitor services in person were often required to present themselves in the guise of service users in order to be able to carry out their work.

The interviews with civil society organisations showed that those working closely with the State (typically the best-funded and longest-established, and international organisations) seemed to enjoy privileged access to information, even when it was not directly related to their particular project activities, and consequently considered that the use of the access to information law would be an unnecessary formality. One of these organisations suggested that they had “earned” this privileged treatment having engaged in a long process of building an honest and trusting relationship with local authorities. On the other hand, NGOs that were seen to take a radical stance on health issues enjoyed limited success in requesting information because, in their view, public officials feared the ways in which this information might be used because of the organisation’s perceived reputation.

Repercussions of making a request

One civil society representative was concerned that asking for official information would cause “friction and conflict”. Many worried that if an official suspected that the request was motivated by a desire to criticise his or her institution, the request would not only be denied but there could be a personal backlash against the requester at a later date. One NGO representative taking part in several initiatives relating to access to information referred to the appeals process for cases of denials, saying that although it was likely to

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be necessary in many cases, they saw it as overbearing, conflict-driven and prejudicial to personal and State-civil society relationships, and that in any case, few people had the money, time or expertise to initiate an appeal.

Costs

One of the most common obstacles faced by members of the public when accessing information was the imposition of charges. Some officials charged “for their efforts” and others forced requesters to visit several offices within a particular establishment, each of which tried to charge them for a different service. The cost of reproducing the material requested was also reported to be inflated to the extent that many members of the public were unable to proceed with their request, creating a further barrier from those from poor backgrounds who already felt excluded from State services and political participation.

The cost of travelling to the State body that held the information was often prohibitive to members of civil society, especially those already marginalised by living in rural areas. There was indignation from some individuals who had attempted to request information only to be told that they would have to travel to another place to get it; financial constraints meant this was rarely an option for the requester, especially when they sensed that the answer was an unhelpful excuse and that they were likely to encounter further obstacles in the other public body.

Reliability of information

Many concerns were voiced about the extent to which information held in public institutions is reliable. The sanctioning of officials for not reaching performance targets relating to numbers of patients seen, specific kinds of treatment delivered and vaccinations carried out had in the past led to the wilful distortion of information as it was entered into systems. According to some campaigners, these targets were not sophisticated enough to incorporate variables such as changes in population numbers or the time it took staff to reach certain remote rural areas to carry out visits and as a result

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the levels of productivity on which staff were judged (albeit informally) were seen as entirely unfair. For example, migration during the period of internal violence meant that rural communities had sometimes lost a large proportion of their population, while targets still reflected numbers according to their previous size, rendering them impossible to meet. It is widely suspected that staff members who realised they were failing to reach targets embellished their figures so as to avoid dismissal.

There was unease at the processes employed to arrive at figures based on quality control and patient satisfaction surveys. The figure cited by the Ministry of Health to show how many patients were satisfied with its services was based on the simplistic calculation of the number of complaints reached (approximately 480) divided by the number of consultations (approximately 50 million). Civil society organisations were adamant that this was an entirely misleading indicator as such a small minority of unsatisfied patients would actually be motivated to, or even know how to make a complaint. Even the methodology of external surveys were questioned; in one example cited, the Ombudsman's Office had interviewed users on their levels of satisfaction *after* they had been seen by a health practitioner; as a result the figures were suspected to be far more positive than they would have been if the user had been approached during the often lengthy wait prior to any appointment.

Complaints made about the accuracy of information and the fact that what was eventually accessed was seriously out-of-date highlighted problems in the systems used to process information. While many of the inaccuracies present were reportedly a result of human error at the moment of data entry (for example, in statistics published on the Ministry's website¹⁷³ we found the surprising figure that in 2004, twenty men had been seen under the category "pregnancy, labour and post-natal care"), it was the nature of systems themselves that made it impossible for civil society groups to obtain reliable and recent statistics on local services or problems. The unreliability and inaccuracy of information available meant that many civil society representatives challenged the very idea of making information requests; why, they asked, should they waste their time chasing

¹⁷³ See the "Consulta Dinamica HIS" found at http://www.minsa.gob.pe/oei/servicios/index_mapas.htm
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information that they knew would be misleading, incorrect, or so out-of-date that it was of no practical use to them at all?

Non-existent information and poor dissemination

Although the access to information law does not oblige government authorities to generate information, civil society groups noted that many categories of information that they consider to be most important for their work do not exist. One criticism made was that statistics were only produced on illnesses that are either fatal or “create a storm” due to their public health implications. Information relating to non-infectious or apparently prosaic diseases was seen by health activists as equally important to their work due to the significant impact they have on the social conditions of the local population.

The absence of formal channels to disseminate information was cited as the reason why information on policy changes often does not reach civil society representatives directly from State officials, and organisations complained that they were forced to rely on informal methods to obtain such information through personal contacts, civil society networks and other NGOs. Upon obtaining background documents, one NGO said that it could prove that the information eventually reaching health centres was often biased as a result of its passage through several levels of interpretation imposed by officials throughout the hierarchical structure.

Underreporting

Underreporting of reproductive and sexual health issues is prevalent, and according to community activists arises from the reluctance of individuals to visit health services for problems seen as highly personal or embarrassing. The absence of formal mechanisms to channel information from non-Health Ministry and private health service providers is also a significant factor in the problem of underreporting and will be explored in the following section.

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In some - mainly rural - areas of Peru, traditional medicine is far more common than conventional medicine, and one doctor in a popular clinic in Tarapoto estimated that 70-80% of births in her region were attended by traditional midwives. She claimed that few of these births are integrated into official statistics, in spite of some new State-led initiatives designed to encourage reporting through trained community agents. Ministry of Health officials admitted that in some areas nearly 50% of births go unreported. Similarly, many cases of sexually transmitted infections are never formally reported, and local organisations complained of not knowing how serious the transmission rates were in their areas because of the reluctance of individuals and even health professionals to register cases. Although health professionals have a legal obligation to report on cases of HIV/AIDS, one Ministry of Health official confided in us that his medical counterparts working in the armed forces, police and prison authorities were extremely protective about the cases they saw, and although they might mention them in an informal conversation, they would avoid reporting them through official channels at all costs.

According to civil society campaigners, complications in pregnancy resulting in maternal mortality are often unreported because of the difficulty in accessing official State health services, and the high incidence of unsafe illegal abortion. Approximately 35,000 miscarriages and abortions¹⁷⁴ are registered each year in Peru by the Ministry of Health, but this number is considered to be a very conservative estimate, due to the fact that this is an issue enveloped in social stigma and surrounded by complex legal implications. The coordinator of the new reproductive and sexual health policy for the Ministry of Health estimated the real figure to be approximately 500,000 per year and independent studies carried out by civil society groups and researchers reach a similar total.

Supervision of alternative health services

It is almost impossible to calculate how many people rely on non-Ministry of Health services, whether these are traditional healers, individual doctors' surgeries, private

¹⁷⁴ The translation of the Spanish term *aborto* is difficult as it can either refer to an induced act ("abortion" in English) or be the result of natural causes ("miscarriage" in English).

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clinics, EsSalud services or even those provided by the armed forces and prison authorities. Apparently there are no official procedures in place to incorporate information from any of these establishments into Ministry information systems (except in a few examples relating to specific programmes or epidemiological reporting) and so a large number of cases are never reflected in official statistics. Although some large non-State hospitals and clinics do operate their own highly sophisticated information systems, civil society groups were critical of the fact that the information they collected was never shared externally or even with patients, only being used internally to improve the services run by a private business.

Apart from the consequent underreporting in State figures, the absence of processes gathering information relating to services offered by non-State health clinics and practitioners means that there is no official information available on the standards of their services. The Health of the People Directorate (DGSP) is responsible for monitoring private health services, but as we were unable to interview any member of staff in charge¹⁷⁵ we have not been able to explore the allegation made by officials in regional authorities and civil society groups that no monitoring is carried out in practice.

¹⁷⁵ We made repeated attempts to speak to an official from the central DGSP office but were never conceded an interview.

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Individuals' Access to Information and Interaction with the State**Why is access to information important to the reproductive and sexual health of individual women?**

As has been explained in section three of this report, there have been periods in Peru's recent history in which reproductive and sexual health rights have been severely curtailed. Even today, in the context of a new window of opportunity for progressive reform under the present Health Minister, women remain deeply disadvantaged by their place in society. From a human rights perspective, all women should enjoy the freedom necessary to make and implement meaningful choices with respect to their reproductive and sexual health. In order to achieve this, women have the right to clear, unbiased and accurate information that will enable them to inform their personal decision-making. The withholding or censorship of such information has a direct affect on society as a whole as women are prevented from breaking out of individual and collective circumstances – at a family, community and national level - that stop them from attaining genuine inequality in Peru.

If women are able to exercise their full range of rights, they will be less vulnerable to external intrusion into their reproductive and sexual health lives in the form of population control policies and anti-choice initiatives. Women's health has often been an arena in which different political and religious agendas have collided in Peru and individual women find themselves at the weaker end of a power dynamic that causes at best inconvenience and at worst, extreme suffering. This was most starkly underscored in the mid- 1990s when thousands of indigenous women living in rural areas in Peru underwent sterilisations performed by medical personnel working in State establishments who failed to observe principles of informed consent. As this section will discuss, it is vital that the government as well as civil society address this information deficit by working together to better understand the social conditions which impact upon the ability of women to exercise control over their reproductive and sexual health and to disseminate information that speaks directly to them.

Cultural and linguistic issues

Reproductive and sexual health issues are often difficult for many women to discuss. One Citizen Watch Committee in Cusco had experienced widespread reticence among the local community in referring to matters of sexual health, and was forced to find new ways of approaching the issue. They valued direct contact as the only reliable way to communicate with their community and so held activities such as free haircut campaigns to reach as large an audience as possible whilst still being able to talk with them on a one-to-one basis. The need for privacy during treatment and sensitivity to situations in which women find it difficult to talk freely about such personal matters must be considered in all aspects of health care and civil society work on these issues.

In many rural areas where a *machista* culture is still dominant, many women are subject to pressure within their own families, particularly from their partners. In Tarapoto, local organizations were extremely concerned about the complicity of older female family members in encouraging younger women into prostitution. In all areas the repercussions of sterilizations performed on women without their full consent in the past were being understood to be not merely physical, but also cause for tensions in many families. According to the interviewees, jealous husbands blamed their wives for subjecting themselves to sterilizations, and others accused their wives of undergoing the procedure because they had been unfaithful.

The lack of information offered to the individual woman about sterilisation, and the limited involvement of their husbands in the decision-making process due to a lack of information that satisfies their needs can lead to clashes within families that the interviewees believed may in part explain the occurrence of domestic violence against women. If information were made freely available to women and their partners about the procedures themselves, the choices available for couples who no longer wish to have children and the implications of these methods, there would be a greater opportunity for

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informed discussion within the household. This would allow women to make and act upon informed decisions over their own reproductive and sexual health lives.

According to the last census¹⁷⁶, nearly 3.8 million people (nearly 6% of the total population) speak a native language as their mother tongue, with almost 3.2 million of these being Quechua speakers. In rural areas the distribution of non-Spanish speakers is much higher, and linguistic diversity inevitably goes hand in hand with high levels of illiteracy among women whose access to education has been limited (official figures suggest that in 2001 the national rate of illiteracy among the population aged 15 and over was 12.1%¹⁷⁷). As a result there is a crucial need for basic State services to take into account the individual needs of women living in rural areas who are already at a disadvantage compared to their counterparts elsewhere. This may require health centres to adopt a more imaginative approach to disseminating information that is relevant to these communities, through personal meetings and oral campaigns rather than written materials.

Although in some rural health centres staff members are able to communicate in local languages, there appear to be no institutionalised procedures for appointing individuals with particular linguistic abilities relevant to the areas in which they work. Materials produced in languages other than Spanish are not seen as a priority, and only appear to be published when financed by external agencies. In any case, a predominantly oral culture and disproportionately high illiteracy among the non-Spanish speaking population means that written materials in native languages are not the most effective communication tool. Community ombudsmen and citizen watch committees stress that direct communication with non-Spanish speakers or the illiterate is fundamental, and they envisage their role as acting as culturally and linguistically sensitive intermediaries who can provide information orally and respond to concerns directly. Other civil society organisations may also be able to plug this gap by disseminating important reproductive and sexual health

¹⁷⁶ IX Censo de Población y IV de Vivienda (CPV), held on 11 July 1993. See: www.inei.gob.pe

¹⁷⁷ Encuesta Nacional de Hogares IV Trimestre, 1997-2000. See www.inei.gob.pe

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information to indigenous communities as part of their own public awareness raising drives.

Sensitivity to cultural and linguistic diversity must not compromise equality in treatment and care. One hospital manager in an area with a large indigenous population suggested that by providing an indigenous patient with information he would cause them “trauma, because they don’t understand things”. His concern that the information be given to his patients “on their cultural level” showed a paternalistic attitude: “why would I give a copy of a clinical history to a patient who doesn’t even know how to read?”. His willingness to be flexible and address the language problems faced by his patients appeared limited, and his only solution was to rely on the few Quechua-speaking staff at the hospital to talk to patients in person. While this might address the immediate need of the particular patient, there appeared to be no formal system in place to ensure the different information needs of the significant local indigenous population more broadly were met and instead, there existed a resigned attitude to the “obstacle” posed by their presence.

There is a need to ensure that all materials produced for public consumption are appropriate for each distinct target community to ensure their maximum impact. One regional directorate official was indignant that materials produced by the Ministry of Health in Lima were often culturally unsuitable for use in his region. He referred to a leaflet about tuberculosis that depicted the image of a child with a “TB” imprint on his forehead that he had refused to use: according to the official this would only serve to further stigmatise an illness that is often ignored precisely because of the disgrace attached to it in local communities.

Visiting the Health Centre*Access to services*

In a culture where few feel entitled to receive free treatment, the first interaction of an individual with State health services requires prior knowledge of the fact that free treatment and services are indeed available to them. One key example has been the implementation of the new Integral Health Insurance (SIS) system; many feel that it has been abused by those who should not have access to it while the people for whom it was in fact conceived (the extremely poor) remain widely unaware of its existence. In the words of one official, “generally the people who make use of the SIS are the people who know about the issue”. A long history of marginalisation has rendered the extremely poor both materially and culturally unaware of their rights. Without information from health authorities explaining that services are on offer to them, individuals will not know to use them or demand them when they are denied.

The advisory role of health professionals

The approach of the individual health professional is fundamental to the guarantee of the right to informed choice. Policy and treatment protocols dictated from above will influence the services they offer and the information patients receive, but the personal manner of each staff member is, in the eyes of many service users, equally important. The experiences and future actions of many women who are not accustomed to receiving institutional treatment for their own health, especially those who have traditionally relied on alternative forms of medicine, will be dictated by their first contact with these services, and the health professional with whom they establish a direct relationship will often be the greatest factor influencing their response.

Many health professionals referred to the limitations of the former system that had encouraged them to focus their guidance on reproductive health to women at a fertile age, causing them in the process to overlook other vulnerable age groups, particularly adolescents. Many civil society groups confirmed these same concerns. All public

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officials were convinced that the implementation of the new policy that mainstreams issues across “Life Cycles” would enable them to provide their patients with necessary information on issues that transcend different age and gender groups.

A worrying factor influencing the relationship between service users and health professionals is derived from the system that is seen to award pregnant women for attending prenatal health services (some are given food and other supplies) and, according to one Ombudsman’s Office official, punish those who do not attend prenatal services by fining them when they seek healthcare later. The effect is that many women who already fear institutional treatment become even more reluctant to demand health care and information. It is hard to imagine that a system that does not respect the individual’s freedom to seek or not seek treatment will be able to ensure the existence of fair and free information allowing the individual to make decisions and exercise their rights more effectively.

The individual as an active member of a community

Participation

Community groups frequently expressed the conviction that there would inevitably be a large majority in any population who remain uninterested in wider public participation and have no desire to be organised. Some health officials suggested that the educational level of their patients had a direct impact on their level of interest in wider issues that would prompt them to demand more information and that as such, in a community with a low educational standard, the teachers would be the only ones interested enough to ask for information. On a more optimistic note, some groups had noted that events they had held had a cumulative effect and that through a first meeting they often aroused sufficient curiosity in the local population to ensure their continued participation in events. A particular example of this was in a CLAS that invited participation in public assemblies to discuss administrative and managerial matters, and which as a result felt that its relationship with its users was much more fluid and trusting.

Women's reluctance to report abuses and seek information

The research revealed that individual women are less likely to request information, question services or complain about shortcomings within the health system than men. Furthermore, women are fearful that making a complaint is something too personal and as such will jeopardise their future treatment in the health service concerned. The experience of the Truth and Reconciliation Commission showed that although more women than men made statements relating to human rights violations (56%), a large number of them did not consider themselves as victims and instead went to report the violations suffered by their husbands, sons and male relatives. It is thought that as a result, the representation of violations against women in the Commission's report is likely to be underestimated. Although women were considered particularly unlikely to complain about how reproductive health services affect them personally it was suggested that they had become more willing to criticise the lack of contraceptive methods available. It is interesting to note, in a similar vein, that the Ombudsman's Office never receives individual complaints about deficiencies in reproductive and sexual health services from the users themselves, only some relating to stock shortages.

While there is no doubt that the matters surrounding reproductive and sexual health are likely to be extremely sensitive to individual women, one Commissioner from the Ombudsman's Office noted that the reluctance of women to complain was not confined to this particular issue, and that of the cases they receive, the large majority are reported by men. Furthermore, the fact that complaints about other health services (in particular the SIS) are indeed made to the Ministry of Health and other entities such as the Ombudsman's Office suggests that there is a strong psychological and cultural influence at play in the willingness of women in particular to complain about reproductive and sexual health services in particular. Furthermore there was a feeling that the size of provincial cities and towns made it hard for individuals to monitor or protest without the rest of their community becoming immediately aware of their actions. They feared a backlash within small local professional or community circles if they challenged the

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authorities, which would be particularly damaging if they had friends or family members working within the State structure.

Those members of the public who have State health insurance are generally from backgrounds with higher educational levels and so are more familiar with their rights; officials suggested that this made them more concerned with taking care of their own health and therefore they held higher expectations of treatment in EsSalud. The act of contributing to a healthcare scheme also fomented a sense of entitlement among insurance-holders who were more disposed to stake their claim for quality services in exchange for their monthly payments, as opposed to uninsured individuals who often considered that any services they received were given as a favour. As one health campaigner suggested “a person who is not informed of how things work, what rights he/she has, how to cure him/herself or when to go and be treated is obviously going to be at a great disadvantage compared to others”.

Individuals are not taken seriously

Many individuals are reluctant to make official complaints, and in particular to accuse health professionals of negligence, because, in the words of one community ombudsman, “it is the word of a humble, peasant, illiterate woman against the word of a knowledgeable professional doctor”. In such an unequal power relationship the individual has limited influence and sanctions are rarely imposed on the health professional, unless the individual is supported or defended in their claims by an organisation with considerable social standing. The uncompromising solidarity of health professionals and the institutional united front that is often put across by the State in response to complaints or accusations of negligence means that the individual faces a daunting task of criticising an extremely unified professional and institutional body.

Access to information

Information is not a priority need

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The research findings suggested that for an individual living in poverty, the need to monitor State services or ask for information would be the least of their priorities: “the population does not see monitoring as a necessity, or rather, the real necessity is to survive, to see how I will manage to feed my children today or tomorrow”. Although most people interviewed could see the potential use of information, it was often relegated to a secondary level of importance, and not seen as instrumental to achieve their primary needs, such as access to basic services or the active respect for their rights. However, most individuals, and particularly those from poor communities, are generally unaware of the existence of the access to information law, and those who do know about it often feel daunted by the formality of the procedures. For this reason, local organisations play a vital role in providing a bridge between individuals and the government by promoting the use of the law to broaden participation in processes involving the State.

Individual interest in information

It was argued that unless information was presented in a suitable format, it would not attract public attention and worse still, could even ultimately discourage active interest in its content. It was suggested that this was as relevant to State information as to NGO-produced materials, including those based on projects that seek to raise awareness of transparency and accountability issues. Financial information presented in complicated databases which requires a high degree of technical expertise to comprehend was often seen as a particular stumbling block, even for civil society groups specialising in this area. The information published on the Economy and Finance Ministry web-page was particularly criticised for the complex format in which it appeared.

For what purpose is information useful?

Individual interest in different kinds of information is often based on personal motivations, and so it is important for individuals to grasp how information can be used as a tool in the personal, professional and social aspects of their lives. In a brief *vox pop*

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of patients waiting to be seen in one CLAS, we observed an almost universal lack of interest expressed in the noticeboards that had been created for their benefit. Patients either had not seen the noticeboard, or had seen it but were not inspired to read it. All appeared concerned that they receive quality care in their health centre, but when asked if they were interested in how the centre was run they replied that they were not. Only one woman said that she was interested in knowing what was going on, and expressed particular interest in finding out about preventative health campaigns.

Although it is likely that our way of approaching individuals did not create the most amenable situation in which to invite a measured and trusting response, their answers were still revealing for many reasons. Over the past few years, this particular CLAS had, according to a member of its management committee and other local health experts, alienated what had been a highly participative and committed local community through its management style. The community had initially made considerable effort to build the centre, but felt they had since lost “ownership”, even in spite of the CLAS structure. The result was a distancing effect and thus a growing level of resignation at not being consulted, which manifested itself as lack of interest and even suspicion among local service users. It is possible that passive reactions we received to the information available are likely to be not only in reaction to the disorganised way it was presented, but also because the alienated local community could not see the point of having a greater insight into the mechanics of the institution.

All officials questioned said they understood why access to information was important, and some identified key areas in which it would be of constructive use to individuals. According to one, if the shocking statistics relating to the incidence of HIV/AIDS in his district were published, the public might be encouraged to take measures necessary to protect themselves from infection.

Are individuals able to access information?

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In all of our discussions about experiences of accessing information, local activists stated that it was much harder for individual citizens to gain access to official information in a personal capacity than it was if they presented themselves as part of an organisation. Often the official behind the desk for receiving documents acted as a “gatekeeper”, and their frosty manner discouraged many individuals from approaching them on future occasions, whether to present formal documents or request information. When viewed alongside the fact that many individuals lack the means or ability to demand their rights and entitlements, we can see the challenge ahead for convincing individuals to proactively use the access to information law.

Conclusion

Our interviews with public officials and civil society representatives in Peru enabled us to identify the needs of individuals, local initiatives, health professionals and wider social movements and to evaluate the extent to which these are already being met by the access to information legislation. We have been able to draw conclusions about the wider impact of these issues on the ability of individual women to exercise their reproductive and sexual health rights in the present day as well as to anticipate the future implications, demands and opportunities presented by the new legislation.

Achieving fuller implementation of the access to information legislation through institutional policy making

At present, few authorities in public bodies appear to be aware of how the access to information law is being implemented within their institutions. Officials are often not knowledgeable of institutional policies on how to manage information requests, have not received guidance on the processes to which they should adhere and, in some cases have even been misled by the continued publication of an obsolete administrative document¹⁷⁸. Overall, they themselves find the procedure cumbersome and confusing.

As a result, the act of providing information to the public can be unpredictable and arbitrary. We identified a clear distinction between officials who are reluctant to commit to greater institutional openness and so try to remain in control of information and officials committed to increased transparency who often make mistakes simply due to the absence of clear procedures. Safe in the knowledge that there is no concrete policy in place to monitor implementation of the law, the first category of official feels vindicated in his or her secretive approach and therefore perpetuates past practices against which the more committed official must continue to struggle. Whilst there were positive initiatives

¹⁷⁸ The “TUPA”, or Texto Único de Procedimientos Administrativos, published on the Ministry of Health’s own webpage pre-dates the implementation of the access to information law. See: <http://www.minsa.gob.pe/portaldetransparencia/institucional/tupa/TupaFinal.pdf>

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underway in some health bodies that were having a significant impact within their communities, the officials responsible for them felt too disempowered to lever broader changes. Instead, they felt that their initiative went against the grain, and therefore passed either unnoticed or unappreciated.

In order to realise the widespread culture change associated with greater access to information, support is required from the highest levels within the health authorities. Policy change can act as a catalyst to culture change, and vice versa, but neither can be truly successful alone. The end result will depend on the extent to which policies reflect the priorities and needs of civil society at the same time as how they address any systemic limitations that may at present be hindering the ability of the public body to provide information. The scant policy that has been drawn up within the Ministry of Health was produced without adequate public or even internal consultation and consequently, the procedures it entails often fail to reflect a proper understanding of the information needs of the public or the limitations encountered by public officials. A fully consultative process would ensure that the procedures designed to facilitate access to public documents were realistic, and would also encourage a sense of shared responsibility for the task of implementing new transparent practices.

Moving towards transparency – taking on new tasks and responsibilities

The State

Movement towards a more transparent culture requires not only a firm base in policy, but an acceptance of the new tasks and responsibilities this policy will incur. Concerns have been expressed regarding the cost and timeframes associated with the implementation of the access to information law since its conception, and these issues continue to be used as an excuse by public officials for neglecting their responsibilities. The propensity of officials to cite their institution's few apparently positive measures (such as the participatory budget schemes so frequently lauded by regional governments) shows a genuine wish to be able to prove improved practice, but at the same time draws attention

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to the fact that such initiatives are isolated and even tokenistic at times. What is still lacking is a concerted effort to involve the population in all aspects to public affairs.

In many institutions, particularly the CLAS, we found that the presence of staff members who were reluctant to move towards greater openness greatly damaged the potential for increasing information access, despite there being progressive institutional initiatives in place. Public officials often felt that it was easier to maintain past standards and attitudes towards public participation than to make the changes necessary to improve upon the current system; furthermore many shied away from taking on new individual responsibilities or passed the buck to colleagues or other institutions. Although most officials were keen to be seen to subscribe to new standards, a remarkably small number were able to explain how they implemented these standards in practice.

In the absence of an overarching State policy on access to information or fora in which different sectors could share their experiences of implementing the law, the Ombudsman's Office was the only government entity adopting a cross-cutting approach to the issue. The Ombudsman's Office uses its autonomy to pressure institutions to comply with the law, to address cases of denied information requests, and to provide training to State and civil society organisations. The Office has taken on a significant role in promoting access to information and alongside its work supervising State services, and more recently the right to health, it has great potential to facilitate implementation in the health sector.

Civil society

Civil society groups promoting political reforms and structural changes in many State sectors are paying increasing attention to the access to information law as a tool to further their aims. Organised groups are in a strong position to represent marginalised sectors of society, as well as to increase public interest in participation by driving forward an inclusive social agenda. Acting as a bridge between these marginalised sectors and State bodies, grassroots groups are well placed to assist individuals in overcoming the

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psychological and practical barriers that hinder their ability to participate in public life. By making information requests on behalf of individuals, and by helping them make requests for themselves directly, NGOs are able to ensure that the access to information law becomes a mechanism to empower citizens.

The discretionary implementation of formal access to information procedures has in many cases been matched by the arbitrary and informal way that some organisations and individuals have employed the law. Although their reliance on personal contacts to obtain information is clearly aimed at expediting the process, it in fact exacerbates the informality with which the act of accessing information is approached from both sides. Furthermore, their tactics often seem to make officials increasingly uneasy about a process that they were already having some difficulty knowing how to implement. NGOs must assist public officials to understand that access to information a formal procedure.

Advocacy strategies are most easily carried forward by NGOs that are committed to working in cooperation with each other to further a common agenda. Hierarchies within the NGO community where some organisations enjoy closer relationships with the State, and therefore more privileged access to documents than others, must be overridden in order for cohesive networks to form and be used to promote the right to information effectively. These networks will be kept alive by civil society groups pooling the information they acquire through use of the law and acting together on issues of priority concern in the field of reproductive and sexual health. Knowledge sharing between more established organisations and younger community groups is working well and it is important to replicate this commitment on a regional and international level.

Few local civil society organisations understand the importance of creating their own information, registering cases they receive and processing data that can be used as a basis for their advocacy strategies. Although the information they create does not fall under the jurisdiction of the access to information law, their understanding of the importance of information created by the State must be counterbalanced with an appreciation of the value of their own information, much of which may be based on the official documents

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they obtain. It would be beneficial for the sector as a whole if greater thought was given to the ways in which the raw data gathered from State entities could be pooled or shared more effectively within the civil society sector. This would ensure that the full multiplier effect of the information is fully realised.

The media

The key potential of the media in promoting information relating to reproductive and sexual health as well as a spirit of participation in social initiatives has been identified by both State officials and civil society representatives. Journalists can play an important part in encouraging the full and fair implementation of the access to information law and publicising both newsworthy stories and personal features that are spawned by the advocacy carried out by civil society groups. Likewise, proactive publication of categories of information relating to public health matters and State affairs in the media could in fact diminish the number of requests made by the public, as well as allay the sense of scandal around issues that appear to be dealt with in a secretive or sensationalist fashion.

Opening up access to information requires promoting the use of and interest in information itself

Public bodies often shy away from actively drawing attention to the right to information, believing that this responsibility falls within the domain of NGOs. They do not see the act of publicising access to information procedures as a means also to explain them to the public in such a way that could prevent misunderstandings and save time for all those involved in the process. Instead, we found public officials united in the fear that drawing any publicity to the procedures would inevitably open the flood-gates to a quantity of requests they would not be able to deal with subsequently.

The promotion of information access and use is part of a wider need to encourage citizen participation in public life. The access to information law is one mechanism available to

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the public to scrutinise the workings of the State. Civil society initiatives monitoring local government have proved that by actively inviting participation in their activities, individuals become increasingly interested in matters of local importance. In contrast, by not promoting participation, local authorities will encourage a sense of alienation to take root among the community, and the perceived gap between the workings of the State and the needs of the public will be widened; this proves even more harmful in situations where the community has historically played an instrumental role in setting up and supporting local services. The creation of spaces for effective stakeholder participation and concrete mechanisms to enable the free flow of information within them, are fundamental to establishing a constructive working relationship between public officials and the community.

The positive value of information

Often the government's guarded approach to reproductive and sexual health issues has led to the inadequate promotion of rights and entitlements attached to this issue. This has predictably proved as counterproductive as any form of secrecy: information is invested with a political value by the State itself and thus is viewed as provocative or dangerous. As some government officials have recognised, proactively publishing information can make even the most worrying statistics less alarming and have a positive effect by spurring members of the public to take responsible measures to protect their own health.

Furthermore, the act of charging for the right to make a request, or for the information itself, results in a commodification of information that is having a negative repercussion on its use in Peru. This practice encourages a reluctance to share information and fuels the harmful misconception that those in possession of information have every right to view it as some kind of earned capital, to use it exclusively, or even to employ it as a means to pull rank over their peers. The perception that information is "owned" by the public official, something to be traded, shared only under certain conditions and, above all, paid for, stimulates an unjustified sense of power and only serves to breed further distrust of public institutions.

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Sharing information based on the treatment given to individuals in non-State health establishments would be one way of safeguarding the standard of care and measuring the extent to which national standards are upheld; it would also discourage the practice of illegal activities (for example, some smaller clinics are suspected of offering illegal and unsafe abortion services). Although the autonomy of these small health centres has been important in ensuring a wide range of services are offered during periods in which resources are scarce within the Ministry of Health, patients who have been directed to them by State bodies often have no idea that the services they are recommended are in fact unregulated.

The value of information in promoting consensus and empowering the public should give human rights NGOs and those working specifically with women, adolescents and people living with HIV and AIDS pause. Initiatives to improve reproductive and sexual health depend upon a free flow of information to enable different sectors to work towards a common goal, to pave the way for civil society to take a constructive role in improving shared agendas around public health. Reliable information is not only useful to counteract misconceptions and prejudices, but, as one official suggested, it has an unequivocal role in building strong working relationships: “I think that the more we inform the community, the more awareness we raise, the more success we are going to be able to have in keeping problems under control...perhaps we aren’t using a bridge for communication, that is the meaning of information”.

What is understood by “information” and “transparency”

With the promotion of such a new concept as access to information in Peru, the first step to be taken is to deconstruct the very idea of information. Statistics are perhaps the easiest to imagine as being covered by this law (and this is shown by the predominance of requests made for statistical information), but a full exploration of categories of information that exist and should exist could help both officials and civil society groups understand the scope of this right. It was noticeable that those who had no experience of

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working in the State have a limited grasp of what kind of information is generated within public bodies and thus were often unaware that the law could help them access information other than statistics and registers. This warrants a fuller discussion of the ambit of the legislation and a greater degree of openness on behalf of State bodies with regard to the information they create.

Even when there is considerable reticence around politically sensitive reproductive health issues in Peru there is no doubt that the term “transparency” is loaded with positive connotations. Officials are keen to be seen to subscribe to principles of open government, and new civil society initiatives monitoring public administration have played a significant role in ensuring that such words do not remain as empty terms merely employed as part of a drive towards improving public image.

The findings did, however, reveal some discrepancies amongst public officials in their understanding of what transparency and access to information actually mean in the day-to-day running of public bodies. One of the negative connotations assigned to such concepts was the idea that they were necessarily part of a bargain; as the State’s movement towards transparency involved undue effort it could only be achieved in exchange for an equal sacrifice from civil society. Some officials felt that being forced to open up to public scrutiny was too controlling, and as such was only a fair demand if it came in exchange for increased controls on the work of NGOs. This tit-for-tat mentality confuses the inherent responsibilities of State towards its citizens and the right of non-governmental bodies to take an active role in scrutinising public affairs.

Transparency is often most readily understood in relation to economic matters, probably as a result of the perception that its principle function is to combat corruption. In EsSalud, for example, transparency was only associated with public procurements as these had formed part of the institution’s operations that had been most keenly questioned by civil society groups and the media. Furthermore, in almost all public institutions, the will to comply with access to information provisions appeared to be conditional upon how immediate the impact would be on their public image. The positive impact of increasing

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transparency on public perceptions was universally understood by public officials, and as a result, the motivation to adopt new measures all too often arose from superficial designs rather than a genuine commitment to the value such measures could have in the public sphere. Interestingly, the need to generate and use information is often best understood by the most professional private health care providers; their operation as a business requires them to provide a level of care and services to their clients that can only be achieved through permanently monitoring and evaluating their own performance and the satisfaction of their patients, and they know this to be impossible without securing a free flow of information.

The positive examples of both public officials and civil society groups using the access to information law underscored the potential of this new legislation. There is no doubt that its impact to date has been limited and that there is still a regrettable lack of public awareness around the legislation, but the emergence of success stories is an important catalyst in achieving its full potential. For this law to provoke change and make transparency the rule rather than the exception, its potential must be further examined by both State bodies and civil society groups. For it to be of real use in the exercise of reproductive and sexual health rights, open access to information and the employment of the legislation must be considered an essential part of all initiatives, whether this be in campaigning for necessary reforms, implementing services, disseminating important public health messages, or drawing attention to shortcomings and unfulfilled rights. The law's implementation and its use in the long run thus plays a constructive role in the improvement of access to healthcare and the ability to exercise fundamental rights, and the individual act of invoking the law must cease to be seen as a threat.

Our research has proved that there is extensive interest across the health sector in improving on past practices, and shows that in many instances the structural framework for achieving this does indeed exist. The opportunity presented by the decentralisation process is unique, offering a chance to build transparent practices and wider participation into the very structure of government from the bottom upwards. Meanwhile the progressive trends set within the Health Ministry by the current Minister provide an

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opportunity to propel the cultural change that will counteract past tendencies towards secrecy, and provide an opportunity for a new approach to reproductive and sexual health that de-politicises the issues and invites serious debate around the problems faced by many women in disadvantaged areas. Once in place, these initiatives will ensure that the new institutional structure and customs can never be compromised, setting a standard for future work that becomes a norm for good practice.

What does this mean for women living in poor areas in Peru?

Governments are under an obligation to ensure that all individuals are able to access the information they need to protect their reproductive and sexual health. In some cases, the particular behaviour of public officials has undermined this right as employees in State health establishments have failed to provide information on treatment or services that are against their own personal beliefs or due to lack of familiarity with best-practice related to disclose. The access to information law provides a vital recourse for civil society groups working to ensure that a full range of reproductive and sexual health rights is protected. It provides an institutional mechanism to help guarantee that individuals are informed about government policies and therefore, about their entitlements and options. The right to health requires governments to ensure that the most vulnerable sectors of society, such as women living in rural areas, have access to a range of information, counselling and services.

Efforts must be made to provide information to all who want or need it. Failure to request information is not necessarily an indication of a lack of interest because people lack sufficient information even to appreciate the full meaning of their right to information. It is crucial that the Peruvian government sustains its commitment to raising public awareness of this right and enhancing the public's understanding of how it can be exercised. As we have noted above, the media can act as an important ally in this strategy, by publicising the legislation, highlighting public interest stories and encouraging individuals to seek the information they need. Furthermore, in order to

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service an increased demand for information, the government must devote sufficient resources to training public officials charged with managing public information.

Literacy has been shown to be among the most significant factors relevant to the ability of women to protect their reproductive health and to make and implement informed choices about their reproductive and sexual health lives. Women with at least some secondary education tend to be better informed about family planning possibilities, and more likely to discuss and decide with their partners whether to have more children and if so, when and how many. Those with a higher education level are also more likely to benefit from information detailing methods to prevent the transmission of sexually transmitted infections. Improving women's literacy is an important step in improving the effectiveness of reproductive and sexual health programmes. The obligation to promote women's literacy is most pressing where the disparity between women's and men's literacy is greatest. Poor literacy levels tend to occur in areas of greatest poverty and it is vital to properly address the higher risks faced by women of the conditions that endanger their health and their lives¹⁷⁹.

Numerous studies show that most people need substantial information about HIV/AIDS if they are to take effective measures to protect themselves. At the beginning of this report, we referred to some of the myths that continue to surround the transmission of HIV and AIDS. It is not sufficient for only policy-makers to be well informed; instead there must be a trickle-down of information to the public that is accurate and easy to understand. Governments have a duty to take proactive measures to publicise this information so that individuals can make their own decisions. Special attention must be paid to the needs of women because despite the serious risks posed to them, they are often less informed than men due to their lower literacy levels and their more limited access to newspapers and radios.

As we explained at the outset, this report has focused on a very clearly defined aspect of the right to access information. We have paid exclusive attention to the value of access to

¹⁷⁹ This argument was first made in ARTICLE 19's publication *The Right to Know*.

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information legislation as a means for governments to achieve greater public participation in policy- and decision-making processes, and for civil society groups to obtain State-held information in order to carry forward advocacy strategies on behalf of individual men and women whose reproductive and sexual health rights are unrealised or actively threatened. This movement towards greater transparency within the health sector will assist the broader reform process necessary to reduce poverty. There is still considerable work to be done in order to ensure that all individuals can access a full spectrum of information that is free from political agendas, religious influence and commercial interests but in the meantime, it is hoped that the report will generate debate and encourage a new platform for change in Peru.

Appendix 1

International treaties ratified by Peru that guarantee the right to health, right to information or both

International Covenant on Economic Social and Cultural Rights, ratified by Peru 28 July 1978; Articles 12 (right to health), 2 and 3 (non-discrimination)

International Covenant on Civil and Political Rights, ratified by Peru 28 July 1978; Articles 19 (right to information), 26 (non-discrimination and equality before the law)

International Convention on the Elimination of All Forms of Discrimination against Women, ratified by Peru 13 October 1982; Article 12

International Convention on the Rights of the Child, ratified by Peru 4 October 1990; Articles 3 (right to health), 13 (right to information), 17 (right to information) and 24 (right to health)

American Convention on Human Rights, ratified by Peru 12 July 1978, Article 13 (right to information)

Protocol of San Salvador, ratified by Peru 4 June 1995, Article 10 (right to health)

Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Convention of Belém Do Pará), ratified by Peru 4 June 1996, Articles 7 (freedom from violence), 8 (duty to provide education and information regarding all forms of violence against women)

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Other instruments

Universal Declaration of Human Rights, Articles 19 (right to information) and 25 (right to health)

Appendix 2

About the Study

Public bodies in Peru were given a 150 day period to put into place the necessary procedures to implement the access to information law, which should now be part of the regular functioning of every State body. The purpose of this study was to examine how this process has advanced since the law was first approved in August 2002, and how it is being employed by organisations and individuals working on reproductive and sexual health.

The study examined the implementation and use of the law at different levels of the State structure by conducting interviews in the capital city and three regions of Peru, thereby gathering first-hand experiences of those actively involved. By conducting fieldwork in regions separated by marked geographical and cultural differences¹⁸⁰ as well as in the capital city, Lima, we have been able to assess the impact of the law in distinct settings as well as the variations in the way in which it has been implemented.

In each location, interviews were conducted with a broad range of local civil society representatives and NGOs, as well as public officials in government institutions relevant to reproductive and sexual health¹⁸¹. Site visits were made to urban and rural areas, and included both new grassroots groups as well as better-established NGOs¹⁸². Interviews with government officials included Ministry of Health bodies, regional governments, the

¹⁸⁰ The regions in this study are: Cusco, the capital city of a region in the heights of the Andes mountains; Piura, a region on the northern border with Ecuador; and San Martín and its capital city Tarapoto, found in Peru's central jungle region.

¹⁸¹ Local coordination of all the interviews conducted in this study was facilitated by Katya Zamalloa (Cusco), Lloy Meri Ríos and PRODEMU (Tarapoto) and María García (Piura).

¹⁸² See Appendix 7 for a list of organisations involved in this study

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Ombudsman's Offices, the social security health provider EsSalud, and some other government dependencies¹⁸³.

While the implementation of access to information procedures is still relatively recent, the institutional structures into which it fits are in many cases not. This study considered the impact of these well-established structures as well as newer political and social changes, such as decentralisation, on the implementation of the legislation. Likewise, it examined assorted civil society initiatives working on reproductive and sexual health in order to do justice to the complexity of the issues associated with promoting access to information in the health sector.

The research conducted for the empirical study was based on 80 qualitative interviews with public officials, civil society organisations and activists in Cusco, San Martín, Piura and Lima between July and November 2004. Focus group sessions with civil society representatives were held in Cusco, Tarapoto and Piura during the same period. The interviews for this research were conducted using a semi-structured guide.

¹⁸³ See Appendix 6 for a list of bodies included in this study

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Appendix 3

Overview of the State Structure

Institutional Framework

The Ministry of Health

The Health Ministry's responsibility for protecting and promoting the right to health is met partly through the formulation of policy at a national level, which must then be implemented across both public and private sectors. The Ministry recognises the significant role it must play in ensuring the socio-economic development of the population and it is currently under its fourth minister since President Toledo took office.

ARTICLE 19 has focussed the research on three main departments within the Health Ministry (see Appendix 4 for organigram): the General Office for Statistics and Information Technology, the General Directorate for People's Health (DGSP) and the General Epidemiological Office (OGE). The health infrastructure is divided nationwide into 25 Regional Directorates, each of which is staffed by representatives of the different central offices who report directly to their superiors in Lima. Below these regional directorates, the Ministry's structure breaks down into a hierarchy made up of local networks, which in turn administer health centres and in more remote areas, health posts¹⁸⁴. Health networks are largely administrative in their functions, while centres and posts are usually small service-oriented entities.

An important model that forms a part of this structure is that of the Local Committees for Health Administration¹⁸⁵ (CLAS). These are health centres run in co-management with

¹⁸⁴ In order to explore how the hierarchical structure of the Ministry of Health affects access to information, we performed interviews at three different levels of the regional structure (regional directorate, network and centres) as well as the ministry headquarters.

¹⁸⁵ Set up under the Shared Administration Programme, passed under Supreme Decree 01-94-SA in 1994
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local communities, and in many cases have grown out of grassroots initiatives to improve and participate in local services¹⁸⁶. They aim to ensure that the local community acts as a stakeholder in the centres' administration and allocation of resources and finances. Through implementing Local Health Plans (PSL) they strive to address local health needs directly. The CLAS model has been cited as a successful example across the Latin American region for promoting the right to health at a community level. Although in theory the CLAS offer an excellent opportunity for direct participation and accountability, and some centres do indeed have a strong record of holding public assemblies and surveying their users, the reality is not always so promising and some centres have been criticised for attempting to act as private health facilities. For these reasons we have considered it important to take into account the CLAS model as these centres not only not only fulfil an important function in local reproductive and sexual health care, but also provide a mechanism conducive to the promotion of greater access to information.

EsSalud

EsSalud is a social security body which provides health care to 7 million insurance-holders (around 26% of the national population). It is a State entity that was historically financed by three income sources (the public treasury, employers and employees) whose equal contributions ensured its solvency. It was granted financial, economic and budgetary autonomy by law in June 2003¹⁸⁷ and the supervision of its budget and expenditure now falls under the sole responsibility of its own Management Council. In the past, the Finance Fund for State Business Activity (FONAFE) shared the role not only of supervising its budget and expenditure, but also of identifying and complying with management targets. With an income of 2,982 million soles (\$852 million) in 2003 (an amount greater than the total budget managed by the Ministry of Health during the same

¹⁸⁶ There are many interesting studies of the experiences of the CLAS in Peru, including: Laura C. Altobelli "Participación Comunitaria en la Salud: La experiencia peruana en los CLAS", in Juan Arroyo (ed.) *La salud peruana en el siglo XXI: Retos y propuestas de política* (Lima: CIES, Proyecto Policy, DFID, July 2002) pp.303-354

¹⁸⁷ Law No. 28006

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year) the economic power wielded by EsSalud over Peru's economy is considerable¹⁸⁸. In some cases EsSalud provides services to the un-insured, usually where local agreements have been established in areas where Ministry of Health facilities are absent or limited; it is also the case that in many areas where EsSalud services do not exist, insurance-holders receive treatment in Ministry of Health establishments. EsSalud falls under the authority of the Ministry of Health insofar as the policy guidelines it must follow, but it is free to define the services it offers, in part due to its financial independence. Since amendments to the Access to Information Law were made in February 2003, EsSalud, like all bodies forming part of the public administration¹⁸⁹ (including autonomous and private entities offering State services), is now covered by the legislation.

Decentralisation

Regional Governments

The decentralisation process in Peru began formally with the modification of Chapter XIV of the Constitution in 2001-2002, allowing for the election of regional authorities, and the subsequent approval of the Law for the Basis of Decentralisation¹⁹⁰ in 2002. The installation of 26 regional governments was started on 1 January 2003, under the supervision of the National Council for Decentralisation (CND). This long-standing initiative, given political support and formalised under the Toledo administration, aims to transfer the responsibility for certain components of the public administration to the local or regional level and to promote economic activity in areas where growth has been limited. In this way, the government aims to reach traditionally disenfranchised sectors of Peruvian society and engage with them in a manner that encourages more equitable development.

¹⁸⁸ Ciudadanos Al Día “*EsSalud: ¿Mas autonomía con menos información? Hacia un sistema de vigilancia ciudadana en EsSalud*” (Lima: February 2004).

¹⁸⁹ Understood in accordance with the definition provided in the first article of the 2001 Law of Administrative Procedures, N°27444.

¹⁹⁰ The *Ley de Bases de la Descentralización*, N°27783, approved on 17 July 2002 and subsequently modified by Law N°27902, *Modificatoria de la Ley Orgánica de Gobiernos Regionales*, approved on 30 December 2002, defines the competencies of the different levels of government to be established through the decentralization process.

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Initial debate around the issue of decentralisation revealed a concern among legislators and the public that the election of local authorities in a fragile transitional democracy could lead to the weakening of political authority, rather than a consolidation of a new, more inclusive structure. It is now clear that the decentralisation process is not only extremely laborious, but also that the establishment of a more localised structure does not necessarily mean an increased trust in government in the regions. The operation of the CND in overseeing the process has been widely criticised for failing to build consensus and implement the processes necessary to transfer political and budgetary functions to the regions. Few regionally elected presidents enjoy much local credibility, with strong party allegiances often leading to divisions, and many corruption scandals further tainting the public's perception of regional government institutions: many consider that increased regional autonomy has merely opened the way for a new kind of corruption to take root. State spending in certain sectors is to be decentralised in an attempt to make investment reach areas of need more effectively, but the transferral of budgetary autonomy has proved one of the most problematic aspects of the process to date and is currently behind schedule. New initiatives to form macro-regions illustrate the desire of individual regional governments to consolidate power through direct coordination with their neighbours, rather than having to rely on central coordination from the CND.

The establishment of regional governments has created a new framework for formal public participation. In each region, a Regional Coordination Council (CCR) is elected, made up of 40% civil society representatives and 60% local mayors, which acts to independently monitor the regional government (although they only have consultative powers) and a to channel civil society participation in the government. Although in many regions their formation has been the cause for concern rather than a means to instil public confidence, they engender a new mechanism with the potential to perform an important function in opening up local governance to a more inclusive platform of stakeholders.

The participatory budget schemes that regional governments are obliged to establish offer another opportunity for civil society involvement in public life, but experiences to date

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have revealed many teething problems. The legal and political framework established by the decentralisation process undoubtedly marks a significant step towards achieving a new style of governance, but there are in fact few concrete examples of new governments showing genuine eagerness to work in close coordination with civil society in practice.

The health sector

The exact functions of regional governments relating to health are set out in the Organic Law for Regional Government¹⁹¹, and the formalisation of their ability to draft a regional health policy (as a shared responsibility with central government) is likely to prove to be one of the most significant advances of the decentralisation process in this sector. The establishment of the National Coordinated and Decentralised System for Health (SNCDS) in August 2002¹⁹² attempts to prevent fragmentation within the health sector, considered to have been one of its particular weaknesses in the past. The SNCDS acts as a coordinator between the Ministry of Health, EsSalud, other public health service providers, universities and civil society organisations, and is to operate through a three-tiered structure of National, Regional and Provincial Health Councils¹⁹³. The National Health Council is already operational, acts as a consultative body to the Ministry of Health, and coordinates widely with other health sector actors¹⁹⁴.

The installation of the Regional Health Councils is underway, in coordination with the Social Development Management of each regional government. In many cases there have been problems with the selection processes of Regional Health Council Managers (and thus the consequent personnel changes in local regional health authority management structures), slowing the process and leading to concerns over the autonomy of local managers. Citizen participation has in many cases been minimal, calculated by the National Health Council to average 40%, but in some areas it reaches as little as 14%. The delays in establishing the regional councils have meant that the subsequent stage,

¹⁹¹ Article 49, *Ley Orgánica de Gobiernos Regionales y su Modificatoria*

¹⁹² Law N°27813, 13 August 2002

¹⁹³ See Appendix 5 for a diagram showing the structure of decentralisation in the health sector.

¹⁹⁴ See Appendix 5 for the makeup of this Council

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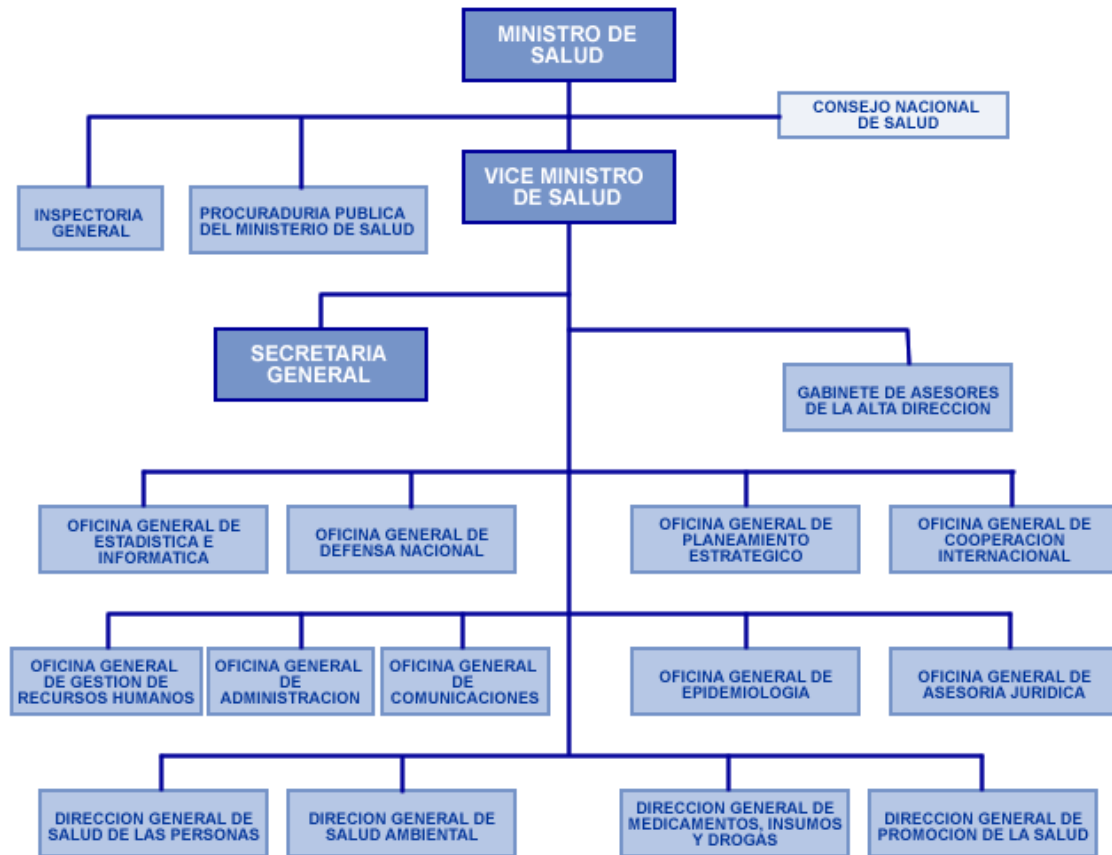
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setting up the provincial councils, has yet to begin. The three-tiered structure should eventually ensure the implementation of coordinated strategies across the sector, invite wider public participation and put new local health plans into place, but at such an early stage in their operation few have yet to prove their success in so doing.

Appendix 4

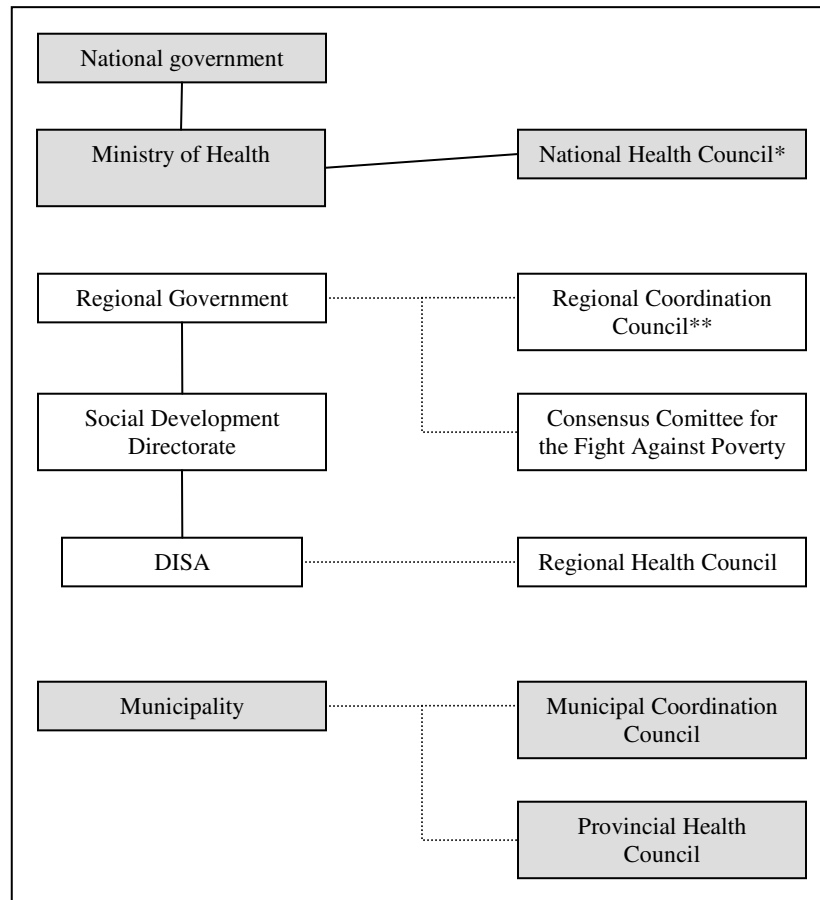
Structure of the Ministry of Health¹⁹⁵



¹⁹⁵ Copied from the Ministry of Health webpage: www.minsa.gob.pe
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Appendix 5

Structure of State Health Sector¹⁹⁶



*The National Health Council is made up of the following:

- The Minister of Health (President of the National Health Council)

And a title-holder and alternate member from the following:

- Representatives of Ministry of Health services
- Representatives of the Vice-Ministry for Health
- Representatives of EsSalud

¹⁹⁶ Diagram reproduced thanks to PHRplus Perú, taken from Ugarte U., Oscar and Zavala L., Verónica, *Marco Legal de la Descentralización en Salud* (Lima: PHRplus, 2004). The footnotes are our own.

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- Representatives of the Peruvian Association of Municipalities
- Representatives of Armed Forces health services
- Representatives of National Police health services
- Representatives of private sector health services
- Representatives of the National Assembly of Rectors
- Representatives of the Peruvian Medical College
- Representatives of health sector workers
- Representatives of community social organisations

** The Regional Coordination Council is made up of 40% civil society representatives and 60% local mayors.

Appendix 6

Public bodies in the Study

We interviewed staff from the following public bodies:

Cusco:

Ministry of Health

Regional Health Directorate (DISA)

South Health Network

Ttio Health Centre (CLAS)

Others

Ombudsman's Office

Regional Government, Social Development Directorate

Lima:

Ministry of Health

Department for Reproductive and Sexual Health Strategy

Executive Office for Statistics

Executive Office for Transparency and Health Ombudsman

Others

Ombudsman's Office, Department for Constitutional Affairs

Ombudsman's Office, Department for State Administration

Ombudsman's Office, Department for Women's Rights

EsSalud

Piura:

Ministry of Health

Regional Health Directorate (DISA)

Morropón-Chulucanas Health Network

Pachitea Health Centre (CLAS)

Others

Ombudsman's Office

EsSalud

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Tarapoto:

Ministry of Health

San Martín Health Network
San Martín Regional Directorate
Punta del Este Health Centre (CLAS)
Lamas Rural Hospital

Others

Ombudsman's Office
Beneficencia Pública
Women's Emergency Centre (CEM), Ministry for Women and Social Development (MIMDES)
Regional Government, Tarapoto Zone Office

Appendix 7

Civil society in the study

We interviewed the following civil society representatives:

CUSCO

- Luzmila Flores, *Defensorías Comunitarias*
- Rosa Jeri, *Mujer Sana*
- Enrique Loayza, *Mujer Sana*
- Mery Luque Guerra, *Comité de Vigilancia de los Derechos Sexuales y Reproductivos*
- Hayde Obando, *PRODIFAM*
- Shirley Palomino Olivera, *Asociación Kallpa*
- Katya Zamalloa Echegaray, *Sayariy Warmi*

LIMA

- Rosa María Alfaro, *Veeduría Ciudadana*
- Epifanio Baca, *DESCO, Propuesta Ciudadana*
- Mari Burneo, *DESCO, Propuesta Ciudadana*
- Juan Carlos Cortés, *Ciudadanos al Día*
- Pedro Francke, *Foro Salud*
- Mario Ríos, Head of Economic, Social and Cultural Rights Area, *APRODEH* and *Coalition for Human Rights in Health*
- Jorge Salazar Cussiánovich, Editor, *Datos del Congreso, Transparencia*

PIURA

- María Abanto, *Foro Salud*
- Alina Anton, *CIPCA*
- María Céspedes, *INPPARES*
- Ricardo Escobedo, *Asociación del Comité de Vigías*
- María García, *Colegio de Obstetrices*
- Enrique Gómez, *Asociación Quorum*
- Lucy Harman, Regional Director, *CARE*
- Maruja Joo, *Red Nacional de Promoción de la Mujer*
- Rosa Rivero, Director, *Centro de Promoción y Desarrollo Andino (CEPRODA-MINGA)*
- Martha Rodríguez, *Asamblea de CLAS Pachitea*

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- María Semino, *Grupo Impulsor Nacional/Instituto Regional de Salud Integral y Medio Ambiente*
- Alcides Villena, *Central Peruano de Servicios, (CEPESER)*

TARAPOTO

- Elvira Ángulo Tuesta, Director, *PRODEMU*
- David Arevalo Arevalo, *Caritas*
- Tania Flores Vela, *Red de Promotoras Prevención de Violencia Familiar*
- Rosa Giove, *ForoSalud*
- Miriam Guevara Guevara, *Red de Promotoras "Mujer Rural San Martin"*
- Betty Leveau Sinti, Director, *Centro de Estudios y Promoción Comunal del Oriente, (CEPCO)*
- Rubén Ponce, *PRODEMU*
- Félix Enrique Ramírez Sánchez, *CEPRECS*
- Lloy Mery Ríos, *PRODEMU*
- Orfelina Valera Vega, *CEPRECS*

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Laura C. Altobelli et.al, *Estudio de Costo-Eficiencia de las asociaciones CLAS* (Lima: Future Generations)

J. Arroyo, E. Cáceres, S. Chávez, M. Ríos, *Vínculos entre la salud pública y los derechos humanos* (Lima: Observatorio de Derechos Humanos para la Salud y el Consorcio de Investigación Económica y Social, 2004).

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ARTICLE 19, *The Johannesburg Principles: National Security, Freedom of Expression and Access to Information* (Londres: ARTICLE 19, 1996)

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