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لجنة حقوق الإنسان
الدورة الحادية والستون
البند ١٠ من جدول الأعمال المؤقت

الحقوق الاقتصادية والاجتماعية والثقافية

حق كل فرد في التمتع بأعلى مستوى من الصحة البدنية
والعقلية يمكن بلوغه

تقرير مقدم من المقرر الخاص المعني بحق كل فرد في التمتع بأعلى مستوى
من الصحة البدنية والعقلية يمكن بلوغه، السيد بول هنت

إضافة

البعثة إلى بيرو**

* يُعمم موجز هذه الوثيقة بجميع اللغات. ويُعمم التقرير، المرفق بالموجز، باللغتين الإنكليزية والإسبانية فقط.

** قدم التقرير في وقت متأخر بغية شمول أحدث المعلومات قدر الإمكان.

موجز

قام المقرر الخاص المعني بحق كل فرد في التمتع بأعلى مستوى من الصحة البدنية والعقلية يمكن بلوغه ("الحق في الصحة") بزيارة بيرو في الفترة من ٦ إلى ١٥ حزيران/يونيه ٢٠٠٤. وزار مجموعة من المرافق الصحية على الساحل (دائرة ليما)، وفي الجبال (آياكوتشو)، وفي الغابة (إنكيتوس وضواحيها).

ومما أثار إعجاب المقرر الخاص التعاون بين وزارة الصحة، والمنظمات الدولية، والمناخين، والمجتمع المدني، فضلاً عن تنوع ودينامية المجتمع المدني في بيرو.

ويقدم الفرع الأول وصفاً للأطر القانونية الوطنية والدولية ذات الصلة، بينما يعرض الفرع الثاني المشاكل الصحية الخطيرة في بيرو، التي يتصل كثير منه اتصالاً وثيقاً بالفقر والتمييز. والتحدي الرئيسي المتعلق بالحق في الصحة هو تحديد السياسات وتنفيذ الاستراتيجيات القائمة على الإنصاف، والمساواة، وعدم التمييز، والكفيلة بتحسين الوصول إلى الرعاية الصحية، والعوامل الأساسية المحددة لصحة الذين يعيشون في ظل الفقر.

ويتناول الفرع الثالث مجموعة من السياسات الحكومية - وبعضها مرمود للغاية - التي تمس الحق في الصحة. ويوصي المقرر الخاص بأمور منها أن تضع الحكومة سياسة صحية شاملة تتسم بالإنصاف ومواتية للفقراء وتستند إلى الحق في الصحة، وإلغاء المجتمع الدولي لنسبة كبيرة من ديون بيرو، على أن يُعاد تخصيص الأموال المفرج عنها لتنفيذ هذه السياسة.

ويركز الفرع الرابع على بضع قضايا محددة للحق في الصحة ويقدم توصيات بشأنها: الاتفاق التجاري بين الولايات المتحدة وبيرو؛ والبيئة الصحية، وخاصة في بيلين (المياه والإصحاح)، وكالاو (التسمم بالرصاص)، وسان ماتيو دي هوانتشيور (أثر التعدين)؛ والصحة العقلية، وخاصة الحق في الرعاية الصحية للأشخاص من ذوي العاهات العقلية، وأثر عقدين من النزاع المسلح الداخلي؛ والصحة الجنسية والإنجابية، بما في ذلك فيروس نقص المناعة البشري/الإيدز؛ والإثنية والثقافة، وخاصة في سياق الشعوب الأصلية.

Annex

CONTENTS

| | <i>Paragraphs</i> | <i>Page</i> |
|--|-------------------|-------------|
| Introduction | 1 - 5 | 4 |
| I. THE RIGHT TO HEALTH: NORMS AND OBLIGATIONS | 6 - 12 | 5 |
| A. International legal framework | 7 - 10 | 5 |
| B. Domestic legal framework | 11 - 12 | 6 |
| II. ILL-HEALTH IN PERU AND THE CONTEXTS OF POVERTY, DISCRIMINATION AND INEQUALITY | 13 - 21 | 6 |
| III. POLICY AND INSTITUTIONAL FRAMEWORKS | 22 - 45 | 8 |
| A. A national health policy to address poverty and discrimination | 27 - 35 | 9 |
| B. Availability of resources | 36 - 38 | 10 |
| C. The international community | 39 - 41 | 11 |
| D. The Defensoria del Pueblo (Ombuds) | 42 | 11 |
| E. Civil society participation | 43 | 12 |
| F. Health professionals and health system users | 44 - 45 | 12 |
| IV. ISSUES OF PARTICULAR CONCERN | 46 - 82 | 12 |
| A. United States-Peru trade agreement | 47 - 51 | 13 |
| B. Environment and health | 52 - 60 | 13 |
| C. Mental health | 61 - 71 | 15 |
| D. Sexual and reproductive health | 72 - 78 | 17 |
| E. Ethnicity and culture | 79 - 82 | 19 |
| V. FURTHER CONCLUSIONS AND RECOMMENDATIONS | 83 | 20 |

Introduction

1. At the invitation of the Government of Peru, the Special Rapporteur visited Peru from 6 to 15 June 2004 in order to consider the implementation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“right to health”), and to assist the Government - and other actors - in their efforts to address the challenges and obstacles to its realization. The agenda for the Special Rapporteur’s visit was arranged by the Ministry of Health in close cooperation with the United Nations country offices, in particular the Office of the Resident Coordinator, the United Nations Development Programme (UNDP) and the Pan-American Health Organization of the World Health Organization (PAHO/WHO) and with civil society, in particular the National Coordinator for Human Rights and the Coalition for Human Rights in Health. The Special Rapporteur is grateful for the excellent cooperation and assistance he received at every stage and, in particular, the exemplary collaboration between Government, international organizations and civil society in the organization and conduct of the mission.

2. Over the course of the mission, the Special Rapporteur met with officials from the Ministries of Health, Finance, Justice, Foreign Affairs, Women and Social Development, and Trade, as well as with members of Congress. He met with international organizations and United Nations agencies working in Peru, including PAHO/WHO, UNDP, the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the International Labour Organization (ILO) and the World Food Programme (WFP). He also met bilateral and multilateral development partners including the European Commission, the Department for International Development of the United Kingdom (DFID), the United States Agency for International Development (USAID), and the Agencia Espanola de Cooperación Internacional. The Special Rapporteur met with officials working on follow-up to the recommendations of the Truth and Reconciliation Commission, and with representatives of the multisectoral national Round Table for the Fight Against Poverty. He visited a range of health facilities, including first-class medical facilities, such as the Maternity Hospital of Lima; facilities needing urgent updating and reform, such as the Victor Larco Herrera psychiatric hospital; and facilities serving rural communities, such as the health post in Luyanta, Ayacucho. He also visited locations that present troubling environmental health issues, such as Belen, Iquitos; the port of Callao, near Lima; and San Mateo de Huanchor, Lima Department. He met with rural communities, including indigenous peoples, in Ayacucho and Iquitos. He held meetings with associations of health professionals and with a wide range of civil society organizations, including associations of people living with HIV/AIDS and people affected by tuberculosis. Within the space of this report, it is not possible for the Special Rapporteur to list the dozens of national and local civil society organizations he met, but he particularly appreciates the coordination efforts of the National Coordinator, the Coalition for Human Rights in Health, ForoSalud, the Asociación Pro Derechos Humanos (APRODEH), CARE, the Coordinadora Nacional de Comunidades Afectadas por la Minería (CONOMACI), and the Mesa de Vigilancia Ciudadana en Derechos Sexuales y Reproductivos, as well as insights and information provided by other civil society organizations.

3. Throughout the mission, all levels of Government - central, regional and the municipalities - were open and cooperative. To its credit, the Government sought to provide a balanced, realistic and frank presentation of the right to health in Peru. The Special Rapporteur was impressed by the commitment of the Minister of Health, Dr. Pilar Mazzetti, and her officials and colleagues in the Department of Health and some other ministries to the realization of Peru’s national and international right to health obligations.

4. The Special Rapporteur was struck by the diversity and dynamism of civil society in meetings he attended in Lima, Ayacucho and Iquitos. He was impressed with many aspects of the work of civil society, such as non-governmental organizations, church groups, patient groups,

health professional associations and academics, including their familiarity with, and commitment to, the right to health.

5. The Special Rapporteur was also impressed by the cooperation between the Ministry of Health, international organizations, donors and civil society. This has created an unprecedented opportunity for the promotion and protection of the right to health in Peru. The Special Rapporteur urges the continuation and strengthening of this cooperation.

I. THE RIGHT TO HEALTH: NORMS AND OBLIGATIONS

6. The contours and content of the right to health are set out in some detail in previous reports of the Special Rapporteur.¹ For the present purposes, he underscores that the right to health is a fundamental human right recognized in a number of international and regional human rights treaties. The right to health is an inclusive right, containing freedoms, such as freedom from non-consensual medical treatment, and entitlements, such as the rights to health care and to the underlying determinants of health, including healthy natural and workplace environments, health information and education, and adequate nutrition.

A. International legal framework

7. The Government of Peru has ratified a range of international and regional human rights treaties recognizing the right to health and other health-related rights, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the American Convention on Human Rights, the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women. Peru has also ratified a range of important International Labour Organization Conventions, including ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries. The ratification of international and regional human rights treaties gives rise to obligations which are binding under international law.

8. An obligation arising from Peru's ratification of ICESCR in 1978 is that it is required to periodically submit reports to the Committee on Economic, Social and Cultural Rights (CESCR). While these periodic reports are usually required every 5 years, Peru's last report to CESCR was submitted some 15 years ago. **The Special Rapporteur understands that the Government has begun to prepare this long-overdue report and recommends that the report is finalized and submitted as a matter of urgency. The Government may wish to approach the Technical Cooperation Programme of the Office of the High Commissioner for Human Rights (OHCHR) for assistance in relation to its reporting obligations to United Nations human rights treaty bodies.**

9. Important commitments relating to the right to health have also been made at international conferences organized under the auspices of the United Nations, including the Millennium Summit of the General Assembly, the International Conference on Population and Development,² the Fourth World Conference on Women, the World Summit for Social Development, the General Assembly special session on Children, the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, the General Assembly special session on HIV/AIDS, and the World Conference on Human Rights. National law and policy should be guided by, and be consistent with, these international commitments.

10. The Special Rapporteur understands that the Government has begun to prepare a national human rights plan of action, as anticipated by the Vienna Declaration and Programme of Action in 1993. **The preparation of the plan of action - and, in due course, the implementation of the plan itself - must be provided with adequate financial support. In this regard, the Special Rapporteur recommends that the Government approach the OHCHR Technical Cooperation Programme for assistance, not only in relation to the preparation of the plan, but also its implementation.**

B. Domestic legal framework

11. The Constitution of Peru (1993) recognizes, in article 7, the right of everyone to the protection of their health. Article 9 emphasizes the responsibility of the State in relation to developing national health policy, and the responsibility of the executive branch for designing and administering its implementation, in a decentralized and pluralistic manner so as to assure equal access to health services for all. Peru's General Health Law proclaims that the State has a duty to regulate, safeguard and promote health, and that public health is primarily the responsibility of the State.³ In addition to these general provisions relating to the right to health, the Constitution and other domestic legislation offer a range of additional protections of specific right to health norms, or relating to other human rights closely linked to the right to health.

12. While these standards go some way towards promoting and protecting the right to health, the Special Rapporteur notes a number of shortcomings in the legislative framework in relation to the right to health. For example, the 1993 Constitution incorporates the right to health in a separate chapter on economic and social rights, which are considered as "Directive Principles". The chapter on fundamental rights does not include economic, social and cultural rights, in contrast to Peru's 1979 Constitution where economic, social and cultural rights were included in that chapter of Fundamental Rights. The distinction enshrined in the 1993 Constitution does not reflect the fundamental principle reaffirmed by all States at the World Conference on Human Rights (1993) that all human rights must be treated in a fair and equal manner, on the same footing and with the same emphasis.⁴

II. ILL-HEALTH IN PERU AND THE CONTEXTS OF POVERTY, DISCRIMINATION AND INEQUALITY

13. There remain significant obstacles to the enjoyment of the human right to health in Peru.

14. Over the course of his mission, the Special Rapporteur received information about a wide range of health problems and their root causes. The permitted length of this report does not allow a detailed human rights analysis of all of these problems. Instead, the Special Rapporteur focuses on a few issues of particular concern, as well as some of the promising responses by the Government and other actors. To begin with, however, he wishes to highlight the scale of the health problems confronting the Government and people of Peru.

15. Peru has the highest incidence of pulmonary tuberculosis in Latin America, with 100 cases per 100,000 population, compared with the regional average of 17 cases, and a high incidence of multi-drug-resistant tuberculosis. The incidence of HIV/AIDS in Peru is increasing, and an estimated 72,000 people are currently living with HIV/AIDS. Malaria is widespread, in particular in the jungle (*selva*) region, and Peru's population is vulnerable to other infectious diseases such as leishmaniasis. Thirty per cent of the urban population and 60 per cent of the rural population still do not have access to safe water or adequate sanitation.⁵ Environmental determinants of health, such as unsafe drinking water, inadequate sanitation, as well as air and water pollution, exert a heavy toll on the health of the population. Malnutrition affects the health of up to 25 per cent of

children under the age of 5, while obesity is also an increasing problem, especially in urban areas. Between 1980 and 2000, internal conflict led to the death or disappearance of an estimated 69,000 people, caused widespread psychosocial health problems, and contributed to a culture of violence that continues to have an impact on health in Peru today.⁶

The impact of poverty and discrimination

16. Many of the health problems in Peru are inextricably linked to problems of poverty and discrimination, which are among the causes and consequences of ill-health in the country. People living in poverty have poorer access to basic services, such as clean water, sanitation and health care. Ill-health also often impoverishes individuals and families on account of the cost of treatment or because of its impact on revenue-generating activities. Some diseases, including HIV/AIDS, have given rise to multiple forms of discrimination against those affected, which further impedes the enjoyment of the right to health and other human rights. Poverty and discrimination have perpetuated great disparities in the enjoyment of the right to health between rural and urban areas, between regions and among different population groups.⁷

17. While Peru is a middle-income country, and despite its recent robust macroeconomic performance, 49 per cent of Peru's population lives in poverty, and 18.1 per cent in extreme poverty.⁸ Moreover, there are striking inequalities between different regions: in the Andean region (*sierra*), for example, 70 per cent live in poverty and 35 per cent in extreme poverty.⁹ Health disparities between regions are also dramatic. For example, while in metropolitan Lima the infant mortality rate is 17 per 1,000 live births, this figure rises to 71 and 84 in the impoverished rural departments of Huancavelica and Cuzco, respectively.¹⁰ In 2000, the infant mortality rate was 28 per 1,000 live births in urban areas while it was 60 per 1,000 in rural areas.¹¹ While there has been progress at the national level in reducing maternal mortality, and while chronic malnutrition in children under 5 years of age has been stable in recent years, the national aggregates mask growing inequalities: the situation on both counts has worsened for the poorest quintiles in the country, and chronic malnutrition has reached around 75-80 per cent in rural areas.¹² For a middle-income country, this is an astonishing state of affairs.

18. Particular population groups are at risk in the context of specific health problems. Women and adolescents are especially vulnerable in the context of sexual and reproductive health. The maternal mortality ratio is reported to be 185 deaths per 100,000 live births in 2000, one of the highest in the Latin American region.¹³ The incidence of unsafe abortion and teenage pregnancy are also unacceptably high. Women are also particularly vulnerable to violence: an estimated 41 per cent of women have been mistreated or subjected to physical aggression by their husbands or partners.¹⁴ The great majority of people living with HIV/AIDS lack access to antiretroviral drugs. Certain groups of people, including those with mental disabilities and people living with HIV/AIDS, face various forms of discrimination which are rooted deeply in related stigmatization and prejudices. Indigenous populations have inferior access to health-care services, including on account of linguistic and cultural barriers.

19. A lack of access to health care for poor and marginalized groups has compounded many of these health problems. While the supply of primary care clinics has increased significantly in the past decade, in 2001, 25 per cent of Peru's population still lacked access even to primary health-care services.¹⁵ Services for specific health or health-related problems, including psychiatric disorders and the consequences of violence, are not widely available outside urban centres. Access to information on some health issues and for some population groups, notably information for adolescents on sexual and reproductive health, is also unduly restricted.

20. Poverty, discrimination, and a lack of adequate targeting of the health needs of particular population groups have all contributed to these health-related vulnerabilities. **In these circumstances, the main right to health challenge is to identify policies and implement**

strategies that (i) are based on equity, equality and non-discrimination; and (ii) improve access to health care, and the underlying determinants of health, of those living in poverty. This overarching challenge provides the main theme that recurs throughout this report.

21. In this context, the Special Rapporteur emphasizes that international human rights law proscribes any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement, on grounds including race, sex, disability and health status (including HIV/AIDS), which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. Under international human rights law, States also have an obligation to take special measures to remove obstacles to, and promote, the enjoyment of the right to health for vulnerable groups.

III. POLICY AND INSTITUTIONAL FRAMEWORKS

22. The realization of the right to health is a major challenge in Peru owing to a number of structural political, economic, social and cultural factors. Some of the policies pursued, and obstacles encountered, by previous administrations were detrimental to the right to health, and, in some cases, their effects are still felt today. The internal conflict in Peru contributed towards a culture of violence and to psychosocial problems. Hyperinflation during the 1980s, and economic development policies pursued in the 1990s, posed new challenges to the right to health, including reductions in budgetary allocations to the health sector. Other problems have arisen in the context of the heavily centralized State and allegations of widespread corruption. Since 2001, the Government has taken a number of important steps to address these problems. These include establishing the Truth and Reconciliation Commission in June 2001, and subsequently a commission to act upon its recommendations; pursuing policies of decentralization; and launching investigations into corruption.¹⁶

23. The Government has also developed a range of new policies and programmes of central relevance to the right to health. Here, the Special Rapporteur confines his remarks to policies which he considers of particular importance to the right to health in the overarching contexts of poverty and discrimination.

24. In 2001, national, regional and local *Mesas de Concertación para la Lucha contra la Pobreza* (Round Tables for the Fight Against Poverty) were established to provide a space for discussion between sectors on development issues and policy. Following consultation between representatives of the State sector, political parties, churches, businesses and civil society organizations, the *Acuerdo Nacional* (National Agreement) was adopted in July 2002, setting out 29 guiding State policies relating to human development and well-being, several of which are particularly relevant in the context of the right to health. One policy states that a priority of the Government is poverty reduction and the reduction of social inequalities.¹⁷ Another enshrines a commitment to universal access to health services which are free of charge, continuous, appropriate and of good quality, and states that priority in this respect should be given to impoverished areas and the most vulnerable populations.¹⁸ The *Acuerdo Nacional* also specifies a range of more specific commitments of the State towards ensuring health care and the enjoyment of the underlying determinants of health. The Ministry of Health's Sectoral Plan for 2002-2012 also includes a commitment to address inequalities in health.¹⁹

25. In addition to the general framework provided by the *Acuerdo* and the Sectoral Plan, the Government of Peru has adopted a range of new health-related policies and initiatives in recent years which impact the right to health and address the contexts of poverty and discrimination. One policy of particular importance is the *Seguro Integral de Salud* (SIS) introduced in 2001, which is a subsidy covering the cost of particular health-care interventions and which is targeted towards the poor and specific groups, such as infants, children, pregnant women and adults in emergency

situations. SIS is a key strategy for improving access to care by removing economic barriers to care.²⁰ As such, there is much to recommend it from the point of view of the right to health - it corresponds with the right to health requirement that health-care goods, services and facilities are economically accessible. Nevertheless, SIS does have some shortcomings, including inadequate coverage and funding. A significant proportion of people living in poverty and extreme poverty, including women and children under 18, are reportedly not affiliated to SIS. Also, unfortunately, SIS fails to cover some important health interventions, such as mental health care. Moreover, while SIS targets the poor, it targets the poor who have geographic access to health-care facilities in the first place, while in many rural areas, geographic inaccessibility of services remains an obstacle to accessing care.²¹ **Geographic accessibility of health-care facilities, goods and services is also a fundamental dimension of the right to health, and one which the Government needs to urgently and innovatively address.**

26. The Government, in particular the Ministries of Health and Women and Social Development, should be commended for its initiative in developing new policies and encouraged to take further action where it is needed, including through ensuring full implementation of sound policies, to ensure the realization of the right to health. **The Special Rapporteur commends the Ministries of Health and Women and Social Development for the attention they are increasingly giving to human rights in their policies and programmes.²² He urges these and other ministries to ensure consistent mainstreaming of human rights in all policies, programmes and other initiatives bearing upon the right to health.**

A. A national health policy to address poverty and discrimination

27. People living in poverty, and other marginalized groups, face the greatest challenges to the enjoyment of their right to health. A range of policies, including those described above, aim to address the health problems of the poor and other vulnerable groups. Yet there is currently no comprehensive pro-poor or equity-based health policy in Peru.

28. **The Special Rapporteur's primary recommendation is that the Government, in cooperation with all stakeholders, formulate a comprehensive health policy and strategy, underpinned by the right to health, that is specifically designed to address inequity, inequality, discrimination and the situation of those living in poverty (in short, a "pro-poor equity-based health policy"). The recommendation anticipates both a health policy and strategy, i.e. not only identification of the goals, but also the measures by which the goals are to be reached.**

29. **The policy and strategy should be informed by human rights, build upon existing initiatives and attract widespread political support. It is important that the policy has sufficiently broad-based support to survive changes of ministers and Governments. In other words, the goal should be a policy of the State rather than a Government.**

30. At least four of the eight Millennium Development Goals are health-related. At the time of the mission, Peru's Millennium Development Goals Report was in preparation. The Special Rapporteur suggests that the report will provide much of the context within which the Government should endeavour to formulate its pro-poor equity-based health policy. Other existing policy documents, in particular the Acuerdo Nacional and the Ministry of Health's *Lineamientos de Políticas Sectorial para el Periodo 2002-2012*, will also inform and enrich the process.

31. While the pro-poor equity-based health policy should have national scope - clearly establishing a national vision, direction and framework - it must also enable the regions and municipalities to define their own health priorities and approaches within this nationally agreed framework.

32. The Government of Peru will have to decide upon the best process by which such a pro-poor equity-based health policy should be prepared. In this regard, however, the Special Rapporteur makes the following suggestions. The process should be: interdepartmental, but led by the Ministry of Health; national in scope, with substantial input from the regions and municipalities; transparent and participatory, e.g. with substantial input from civil society; provided with adequate financial, research and administrative support; and provided with technical assistance from the key international agencies, in particular PAHO. Whatever process is chosen, it must allow sufficient time for the active and informed participation of all stakeholders - probably between 12-24 months from commencement of the project to finalization of the policy and strategy. Of course, implementation will take much longer.

33. Throughout the policy-making process, Peru's development partners must be fully included in the most appropriate manner. This is important for a number of reasons, not least that the partners should be invited to provide substantial funds towards this important policy-making project. If the process is to be participatory, inclusive and well researched, it will have to be supported by significant resources. **The Special Rapporteur recommends that Peru's development partners provide the necessary financial support, enabling the Government to both organize a good process and prepare a compelling policy.**

34. **Moreover, at the end of the project, when the pro-poor equity-based health policy and strategy has been devised, the development partners should be invited to contribute substantial resources for its implementation by way of a Common Fund for the health sector.** Sectoral Common Funds for the implementation of "country-owned" policies and strategies have been used in other States. They have many advantages for all parties. For example, they provide a common vision and avoid the wasteful administrative costs generated by bilateral funding for multiple individual projects.

35. While it is not possible here to explore in any detail what the content of the policy might be, a number of the following recommendations address issues that are integral to a pro-poor equity-based health policy. For example, a health policy focused on equity, human rights and poverty reduction will have to encompass environmental health, sexual and reproductive health, and issues of ethnicity and culture. Thus, the pro-poor equity-based health policy can provide cohesion to a wide range of interrelated initiatives, including some of those signalled in the following paragraphs.

B. Availability of resources

36. In addition to developing sound policies, making resources available to the health and health-related sectors is an essential ingredient for realizing many aspects of the right to health in practice. In the view of the Special Rapporteur, the Government currently devotes inadequate resources to the health sector. Public expenditure on health, which has been around 1 per cent of gross domestic product (GDP), and total expenditure on health as a percentage of GDP, around 4.5 per cent, are very low for the region.²³ While the *Acuerdo Nacional* contains a commitment to progressively increase the percentage of the budget allocated to the health sector, in practice, government support to the health sector has recently declined, from 95 nuevos soles per capita in 2001, to 78 nuevos soles in 2003.²⁴ Moreover, budget allocations for health care to richer and poorer regions have reportedly been inequitable.²⁵

37. Under international human rights law, States have an obligation to progressively realize the right to health, through making available maximum available resources, including resources available from the international community. The Committee on Economic, Social and Cultural Rights in its general comment No. 14 has emphasized:

“A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above (para. 47).”

38. The decrease in budgetary allocations to the health sector, in particular in light of Peru’s continuing poor health indicators, is inconsistent with the State’s international right to health obligations. **The Special Rapporteur strongly recommends that this decline in expenditure be reversed and that greater financial resources allocated to the health sector, in line with the commitment made in the *Acuerdo Nacional*, as well as Peru’s international human rights obligations, and that these resources be utilized on the basis of the pro-poor equity-based health policy signalled in the preceding paragraphs.**

C. The international community

39. Some of the obstacles to the enjoyment of the right to health in Peru derive from structural obstacles at the international level, including the heavy burden of debt repayments, which absorb about 24 per cent of the national budget. **In these circumstances, the Special Rapporteur recommends that a significant proportion of Peru’s debt, whether bilateral or multilateral, be cancelled on the understanding that the released funds will be reallocated for the implementation of the pro-poor equity-based health policy signalled above.**

40. Donors have played an important role in Peru, in particular through providing funding to the Government and to civil society organizations. In recent years, consistent with the United Kingdom’s human rights responsibilities of international assistance and cooperation, the Department for International Development (DFID) has developed a pioneering programme in Peru called “Improving the health of the poor: a human rights approach”. Working with the Ministry of Health, Defensoria Del Pueblo and civil society, this programme - and a series of more modest initiatives - has sought to strengthen research and dialogue about poverty, health and human rights. While on mission, the Special Rapporteur heard nothing but positive comments about the DFID health and human rights work. Therefore, it is especially regrettable that the United Kingdom announced in 2003 its closure of the DFID bilateral programme in Peru. The United Kingdom has confirmed that this closure arises from its reallocation of resources for the reconstruction of Iraq. The Special Rapporteur understands that DFID will continue to provide support for Peru via other regional and multilateral programmes. Nonetheless, at the time of writing, its commendable bilateral health and human rights programme is being terminated. **The Special Rapporteur deeply regrets that British policy towards Iraq is seriously jeopardizing such a valuable health and human rights initiative in Latin America. He urges the United Kingdom to find additional resources as a matter of urgency so that its health and human rights work in Peru may continue.**

41. To avoid repetition, the Special Rapporteur refers to paragraphs 33, 34, 39, 40, 42, 51, 71 and 78 of this report for other recommendations regarding the international community.

D. The Defensoria del Pueblo (Ombuds)

42. The Defensoria, which has a national office in Lima and 35 regional offices, and which has previously undertaken some work on health-related rights including sexual and reproductive rights, plans to give greater focus to the right to health and education in upcoming years. Unfortunately, funding committed by DFID for a five-year programme on health and human rights has been cut to

support only a significantly shorter programme (see paragraph 40). **The Special Rapporteur recommends that donors ensure that this programme is adequately funded to ensure that it runs for its full five-year execution period.**

E. Civil society participation

43. The Special Rapporteur was impressed by the scheme, implemented by the Ministry of Health, of *Comités Locales de Administración de Salud* (CLAS: Local Health Administration Committees).²⁶ CLAS are local, private, not-for-profit health associations composed of six elected community members and the health facility manager, who collaborate in the management of Government-owned health centres and health posts. Regional Health Offices provide infrastructure, personnel, goods and funds for services. While experiences have varied, CLAS have reportedly been a facilitator of enhanced community empowerment and participation in the delivery of health services and health promotion. They have often been popular providers of care where they exist, and people living in population centres with CLAS facilities reportedly seek care more often than those with non-CLAS facilities. **Generally speaking, the Special Rapporteur commends CLAS as a good practice concerning health-related community participation, which is an integral element of the right to health. He encourages the Government to take measures to improve and refine CLAS and to extend the scheme throughout the country.**

F. Health professionals and health system users

44. As providers of health care, health professionals are central to operationalizing the right to health. They have a responsibility to ensure that their work respects, protects and promotes the right to health. Human rights education for health professionals and awareness-raising about rights among health system users are important ways to ensure that health professionals, and health-care systems, deliver rights in care. A range of issues concerning the rights and responsibilities of health professionals, and the rights of patients, were raised during the mission of the Special Rapporteur. These included the poor terms and conditions of health professionals, including doctors, nurses and dentists; accountability within the health system; and the incidence of stigmatizing attitudes and discriminatory practices within the health system against people living with HIV/AIDS. **The Special Rapporteur recommends that human rights education be provided to health professionals, including in training at medical schools, and that the Government give attention to improving the terms and conditions of all health professionals.**

45. **The Special Rapporteur recommends that the law provide full recognition of the rights of health system users. The law should ensure that independent and accessible accountability mechanisms (courts, national ombuds or other) can consider complaints by health system users who allege that their human rights have been violated in care. The Special Rapporteur is concerned that a new draft law on patients' rights overemphasizes the individual responsibilities of health professionals without taking due account of institutional and structural factors that may contribute to causing harm to patients.**

IV. ISSUES OF PARTICULAR CONCERN

46. Over the course of his mission, the Special Rapporteur met with organizations and individuals working on diverse issues connected with the right to health. These consultations revealed the very wide range of health problems that afflict different population groups in Peru. Given the strictly limited length of this report, it is not possible to devote adequate attention to all of these important health problems. Instead, the following paragraphs devote attention to a few of the most pressing right to health issues in Peru.

A. United States-Peru trade agreement

47. At the time of the Special Rapporteur's mission, the Government of Peru was engaged in negotiations towards a bilateral trade agreement with the United States. While the agreement may cover a wide range of issues, for the purposes of the present report the Special Rapporteur focuses on the potential impact of the trade agreement on access to essential medicines in Peru.

48. The Special Rapporteur is concerned that the bilateral trade agreement may result in "WTO-plus" restrictions, including new patent and registration regulations that impede access to essential medicines for those living in poverty.²⁷ In the past, Peruvian legislation did not allow for pharmaceutical patents. The Special Rapporteur is concerned that the agreement might allow for the grant of a five-year patent-like monopoly for drugs that are not patented by the original manufacturer. He is also concerned that the agreement might allow companies to apply for a new 20-year patent for each "new use" of a product, and that it might propose the establishment of a national drug regulatory body to monitor the enforcement of drug patents, including by delaying or blocking generic medicines. If these provisions were introduced and implemented, they would significantly impede access to affordable essential medicines for some individuals and groups, including antiretrovirals for people living with HIV/AIDS. Such provisions would undermine the consensus reached at the WTO on the need to balance the protection of intellectual property and the protection of public health.

49. **The Special Rapporteur stresses the human rights responsibility of countries to make use of the safeguards available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health - such as compulsory licences - to protect public health and promote access to medicines. He recalls that TRIPS and the Doha Declaration allow countries to protect public health. Thus, the conclusion of bilateral trade agreements must not result in a restriction on Peru's ability to use the public health safeguards enshrined in TRIPS and the Doha Declaration (see E/CN.4/2004/49/Add.1).**

50. **The Special Rapporteur urges Peru to take its human rights obligations into account when negotiating bilateral trade agreements. He suggests that before any trade agreement is finalized assessments identify the likely impact of the agreement on the enjoyment of the right to health, including access to essential medicines and health care, especially of those living in poverty. All stages of the negotiations must be open, transparent and subject to public scrutiny.**

51. **In accordance with its human rights responsibility of international cooperation, the United States should not apply pressure on Peru to enter into commitments that either are inconsistent with Peru's constitutional and international human rights obligations, or by their nature are "WTO-plus".**²⁸

B. Environment and health

52. Environmental health problems arise from a lack of access to safe water, inadequate sanitation and contamination by extractive industries, and affect the health and livelihoods of communities across Peru. These problems disproportionately affect vulnerable groups, including people living in poverty, indigenous peoples and children. The Special Rapporteur visited several areas affected by such problems, including Belen municipality (Iquitos, Department of Loreto), Callao and San Mateo de Huanchor (Department of Lima), where he met with local authorities, non-government organizations and affected communities. He makes the following observations:

(a) *Belen*. The population of Belen has dramatically increased in the last two decades on account of rural to urban migration. The residents of Belen are among the poorest in Iquitos and live in overcrowded conditions in housing elevated above the flood plain of the river Nanay. Over half of Belen's residents lack access to safe water and adequate sanitation and the river is contaminated with mercury due to activities of companies dredging for gold upstream. The incidence of water-borne diseases and acute diarrhoea is high and particularly affects infants and children. The infant mortality rate in Belen is high - 4.9 per cent. The Special Rapporteur was impressed with the commitment of the municipal and regional authorities, and local civil society, to redress these, and other, poverty-related problems. Local authorities have developed plans to build sanitation facilities in the area, but there is as yet no budgetary allocation to support implementation;

(b) *Callao*. Callao has played an historic role in Peru's economic development: most of Peru's exports, including mineral products, leave the country through its port. Transportation of lead ore to and from, and storage in, large depots in Callao has resulted in lead poisoning. In a recent survey, over 50 per cent of local children were found to have over twice the permissible limit of blood lead concentration defined by WHO.²⁹ Most recently, these activities have been undertaken by private sector companies, following privatization of State mining enterprises during the 1990s. A representative from two of these companies informed the Special Rapporteur that storage and transportation of lead has been improved, although he noted that pilfering of ore during transportation still occurs and contributes to contamination. Others informed the Special Rapporteur that the depots, including the movement of materials in and out, were still causing local contamination. At any rate, studies suggest that the levels of lead in children's blood remain dangerously high;³⁰

(c) *San Mateo de Huanchor*. The Special Rapporteur was informed about the impact of toxic mine tailings, including arsenic, lead, mercury and cadmium, on the health of the community of San Mateo, including indigenous peoples and children. While mining activities are currently halted, contaminating waste in the tailing pit has not been removed, despite an order to this effect made by the Government to the concerned company (Wiese Sudameris). Since domestic remedies have not been forthcoming, this case was submitted as part of a broader complaint by CONOMACI to the Inter-American Commission on Human Rights, which has requested precautionary measures and decided, in November 2004, that this case is admissible and invited the parties to find a friendly settlement.³¹

53. The Special Rapporteur's investigations into problems in Callao and San Mateo afforded him the opportunity to learn about the apparent disregard of human rights, including the right to health, by the private mining sector and some government departments. The Special Rapporteur received information indicating that these are not isolated cases, but illustrative of a wider problem. He notes that the original complaint submitted by CONOMACI to the Inter-American Commission includes not only the cases of Callao and San Mateo, but another 13 cases involving, among other things, poisoning of children, environmental contamination and illegal expulsions from land, affecting local communities located near foreign and domestic mining projects. Meanwhile, while the lack of access to clean water and sanitation has a particularly acute impact on the health of the residents in Belen due to poverty, overcrowding and flooding, many communities across the country face similar problems.

54. The right to health, as well as the rights to water and adequate housing, give rise to obligations on States to ensure an adequate supply of safe and potable water and adequate sanitation. The right to health also gives rise to an obligation to prevent and reduce the population's exposure to harmful substances that impact upon health. Environmental contamination, as well as inadequate water and sanitation, can have a particularly severe impact on children, and hinder their enjoyment of the right to health. In particular, the Special Rapporteur

notes that the Government of Peru not only has an obligation to respect the right to health, but to protect this right against harm by third parties. As a State party to the Convention on the Rights of the Child, Peru has an obligation to “combat disease ... through, inter alia, the application of readily available technology and through the provision ... of clean drinking water, taking into consideration the dangers and risks of environmental pollution (art. 24 (2) (c))”. As a State party to ILO Convention No. 169, the State also has a particular obligation to protect the right to health and other related human rights of indigenous peoples.

55. Promoting health must involve effective community action in setting priorities, making decisions, and planning, implementing and evaluating strategies to achieve better health. All individuals and groups have the right to participate in decision-making processes that may affect their health or development. **The Special Rapporteur recommends that the Government give urgent attention to fulfilling this right to participation at all stages of development or mining projects, including planning, development, implementation and monitoring.**

56. **The Special Rapporteur recommends that the Government ensure that independent rights-based environmental and social impact assessments are conducted prior to the setting up of all mining or other industrial projects that may have harmful impacts on the right to health.**

57. **Any alleged victim of a violation of the right to health who has suffered harm should have access to effective judicial or other appropriate remedies at both national and international levels, as well as adequate reparation in suitable cases.**

58. **The Special Rapporteur urges the Government to appoint a high-level, wide-ranging, independent public inquiry to investigate the situation in Callao and make recommendations as a matter of urgency. The inquiry should take into account all relevant national and international law, including human rights, and consider all reasonable solutions, including the closure and removal of the facilities to a different location.**

59. **The Special Rapporteur also urges the Government to comply with the precautionary measures requested by the Inter-American Commission in the case of San Mateo.**

60. **Concerning water and sanitation, the Special Rapporteur reiterates and endorses the relevant recommendations of the Special Rapporteur on the right to adequate housing (E/CN.4/2004/48/Add.1, paras. 23-25). He also urges regional, national and international institutions to ensure that technical and financial resources are made available to support the plan to bring sanitation and safe water to Belen, and all comparable communities.**

C. Mental health

61. Over the course of his mission, the Special Rapporteur had the opportunity to learn about two important mental health issues in Peru: the right to health care of persons with mental disabilities, including persons affected by psychiatric and intellectual disabilities and psychosocial problems, and the mental health legacy of two decades of internal armed conflict.

The right to health care of persons with mental disabilities

62. The human right to health, including the right to health care, of persons with mental disabilities is protected by, among others, ICESCR, Peru’s Constitution, the General Health Law, and General Law of the Person with Disability.³² For many years, this right was marginalized in the domestic health agenda. To its significant credit, the Government of Peru has recently begun an

important process of mental health reform. Most notably, the Ministry of Health has adopted “Guidelines for Action in Mental Health” and other policies, and announced its intention to develop a national mental health plan.³³

63. There remains, however, a notable disparity between, on the one hand, the Government’s new goals and its international and domestic human rights obligations, and, on the other hand, the current reality of health care available to people with mental disabilities. Of course, the limited length of this report does not permit the Special Rapporteur to address all the important human rights problems relating to health care for persons with mental disabilities in Peru.

64. The right to health gives rise to an entitlement to health care that is geographically accessible, designed to improve the health status of those concerned, and scientifically and medically appropriate. In contrast, the provision of mental health care in Peru is largely centralized, making it inaccessible for much of Peru’s population. Where it exists, mental health care predominantly consists of large psychiatric institutions. There is an almost universal lack of rehabilitation services and community-based mental health and support services. The centralized and institutionalized model of care denies those with mental disabilities the rights to be treated and cared for in the community in which they live,³⁴ and to live and work in the community, as far as possible.³⁵

65. Of further concern to the Special Rapporteur is the vulnerability of users of psychiatric services, in particular those confined within large psychiatric hospitals, to violations of a range of their human rights within care. During his mission, the Special Rapporteur visited the Victor Larco Herrera Hospital and witnessed at first hand some of these problems. He also received information reporting practices and conditions in other institutions which appear inconsistent with the right to health and other human rights.³⁶

66. During his visit to the hospital, the Special Rapporteur was taken to all the places he requested to see. He also met with 10 representatives of staff and patients’ families who had organized a large demonstration to coincide with his visit. During his visit, the Special Rapporteur found that some wards appeared to be in an alarming state of disrepair. Conditions in some wards were insanitary. The Special Rapporteur was told that staff and patients were demoralized. The Special Rapporteur also heard about periods of inadequate supervision in the emergency ward, which, it was alleged, had been a factor in the recent killing of one patient by another patient; the inappropriate institutionalization of persons with intellectual disabilities; and the lack of rehabilitation.

67. The week following his visit to the hospital, the Director was suspended while certain serious allegations were investigated. More recently, the Special Rapporteur has been informed that a new Director has been appointed. The Special Rapporteur has also learnt that the Defensoria del Pueblo has been invited to work with the hospital towards improving its human rights record, and that a new emergency ward offering better protection for patients is planned. The Special Rapporteur warmly welcomes all initiatives that improve conditions for patients and their families, as well as staff. He will continue to monitor the situation at the hospital with close interest.

The conflict and its legacy on mental health

68. Two decades of internal armed conflict (1980-2000) gave rise to a range of human rights violations and other abuses, including extrajudicial executions; forced disappearances; and torture and violence, including sexual violence and rape perpetrated against women and girls. The conflict’s legacy includes high levels of trauma and related psychosocial problems that continue to burden many Peruvians to this day.

69. In 2001, the Government of Peru set up the Truth and Reconciliation Commission to investigate human rights violations and abuses committed by the State and armed opposition groups. The Commission recommended, in its Comprehensive Plan for Reparations, that the Government should set up free health programmes to provide treatment for mental and physical problems, including specialist mental health treatment for women.³⁷ The Government continues to develop and implement new plans to improve mental health care for affected populations.

70. During his mission, the Special Rapporteur visited the town of Ayacucho and its environs, which had been at the geographic centre of the conflict. In Ayacucho, he attended a workshop, organized by regional and municipal governmental authorities and civil society, on conflict-related mental health problems and initiatives. He received information about local frustrations concerning the lack of permanent mental health services in Ayacucho. **He strongly supports the establishment of a permanent facility for mental health in Ayacucho.** Since his mission, the Special Rapporteur has learnt of the announcement by the Ministry of Health to establish a permanent team of psychiatrists and psychologists in Ayacucho, a development which he welcomes and will monitor with interest.³⁸

71. **The Special Rapporteur recommends that:**

(a) **Civil society, in particular people with mental disabilities, and their families, be involved at all stages in the development and implementation of mental health policy, legislation, programmes and strategies;**

(b) **The Government take appropriate measures towards implementation of the new mental health policies of the Ministry of Health, including ensuring that adequate resources are made available;**

(c) **The Government take steps towards making appropriate mental health care - including care provided through general health services and in community settings, rehabilitation services, and support services for family members - available and accessible to people with mental disabilities and psychosocial problems throughout Peru, including in rural areas;**

(d) **Appropriate mental health services be made available to persons in detention;**

(e) **The human rights of persons with mental disabilities be fully respected within health-care services and facilities. Human rights training should be provided to all professionals who regularly interact with the mental health system. Independent monitoring and accountability mechanisms for mental health services, including accessible, transparent and effective complaints mechanisms for patients, must also be implemented. A review board should undertake regular inspections of mental health facilities, including patient interviews. Monitoring mechanisms should also include an independent, regular and systematic review of cases of involuntary admission and treatment, which should also be subject to strict procedural safeguards;**

(f) **Donors contribute funding and technical assistance for the implementation of the Comprehensive Plan for Reparations of the Truth and Reconciliation Commission, including in the area of mental health.**

D. Sexual and reproductive health

72. The Special Rapporteur has highlighted some of his concerns in relation to sexual and reproductive health in Peru elsewhere in this report. He is deeply concerned by the extremely high

rates of maternal mortality, the second main cause of which is unsafe abortion. **He stresses the importance of ensuring access - in particular for poor populations - to a wide range of sexual and reproductive health services, including family planning, pre- and post-natal care, emergency obstetric services and access to information. In particular, women should have access to quality services for the management of complications, whether arising from pregnancy, childbirth or abortion. Punitive legal provisions against women who undergo abortions, as well as against the relevant service providers, should be removed.**

73. The Special Rapporteur welcomes the commitment of the Government to taking all appropriate measures to promote sexual and reproductive health. In particular, he notes with approval the recent reaffirmation by the Government of its commitment to the Programme of Action of the International Conference on Population and Development.³⁹ He welcomes the position of the Minister of Health that the Government's policies, including those on sexual and reproductive health, should be based on scientific evidence and compliant with legal obligations under the Constitution of Peru, as well as regional and international human rights law. During his mission, numerous informants advised the Special Rapporteur that the Minister of Health is subject to considerable pressure from a powerful minority which propagates views that are unscientific, inconsistent with Peru's constitutional and international human rights commitments, and unrepresentative of the views of the majority of the population. Particularly in the light of these pressures, the Special Rapporteur commends the Minister for insisting that the Government's policies, including those on sexual and reproductive health, shall be based on scientific evidence and respectful of Peru's binding legal obligations.

74. **He notes, however, the urgent need for the development of a comprehensive, intersectoral policy on sexual and reproductive health which focuses on the health needs of women, in particular those that are socially and economically marginalized. In particular, sexual and reproductive health-care laws, policies and programmes should be designed to reach women living in poverty, indigenous peoples and rural populations, with full respect for their human rights. Legislation to promote non-discriminatory access to sexual and reproductive health services should be developed, promoted and implemented. Civil society and women's groups should be involved in the development of policy, legislation, programmes and strategies in relation to sexual and reproductive health.**

75. **Similarly, the Special Rapporteur recommends that a comprehensive, intersectoral policy on sexual and reproductive health should be developed for - and with the participation of - adolescents. The policy should be grounded in international human rights law and should recognize, in particular, the right of adolescents to access information, education and user-friendly sexual and reproductive health services, including on family planning and contraceptives, risks related to early pregnancy, and prevention of sexually transmitted infections such as HIV/AIDS. The right of adolescents to privacy, confidentiality and informed consent should be protected.**

76. Fulfilling the rights to sexual and reproductive health requires ensuring access to high quality and comprehensive reproductive health information and services, including access to a wide range of safe, effective, affordable and acceptable contraceptive methods. In this regard, the Special Rapporteur welcomes recent initiatives of the Ministry of Health such as the national plan on emergency contraception, and stresses the importance of the full implementation of the plan.

77. The rights to sexual and reproductive health include an obligation to ensure access to screening, counselling and treatment for sexually transmitted infections including HIV/AIDS, as well as for breast cancer and cancer of the reproductive system. **The Special Rapporteur welcomes the development of a comprehensive national policy on HIV/AIDS and urges that**

strategies for implementing the policy explicitly address gender inequalities, stigma and discrimination; provide comprehensive sexual and reproductive health information, education and services to young people; and ensure access to voluntary testing, counselling and treatment for sexually transmitted infections, including HIV/AIDS.

78. The donor community provides important funding for sexual and reproductive health care in Peru. The Special Rapporteur urges those countries providing assistance to adopt a rights-based approach to their policies and programmes.

E. Ethnicity and culture

79. The Special Rapporteur is deeply concerned about disparities in access to health services and goods for marginalized groups in Peru, including indigenous peoples and ethnic minorities. These disparities are rooted in geographic, cultural, economic and linguistic barriers. Indigenous peoples and ethnic minorities are also particularly vulnerable to other particular health problems: in some places, mineral extraction has led to environmental degradation and contamination of their water sources and food supplies; they were disproportionately affected by Peru's internal conflict; and thousands of indigenous women, primarily those living in poverty and in rural areas, are believed to have been sterilized without their consent during the family planning programme carried out during the 1990s.⁴⁰ Despite these serious issues, some of which were discussed during the Special Rapporteur's visits to Ayacucho and Iquitos, the obstacles to the enjoyment of the right to health of indigenous peoples were not extensively documented in the significant amount of material made available to the Special Rapporteur, and were seldom raised by those with whom he met in Lima.

80. Following its consideration of Peru's report in 1999, the Committee on the Elimination of Racial Discrimination (CERD) noted its concerns about the close relationship between socio-economic underdevelopment in Peru and ethnic or racial discrimination against part of the population, mainly indigenous and peasant communities (CERD/C/304/Add.69, para.12). The Special Rapporteur endorses the Committee's analysis. According to international human rights law, disadvantaged indigenous people have the right to specific measures to improve their access to health services and care, as well as the underlying determinants of health. These services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines.

81. The Special Rapporteur endorses the recommendations of CERD (ibid., sect. D), and he also encourages the Government to implement recommendations bearing on the right to health adopted by the Permanent Forum on Indigenous Issues at its third session (see E/2004/43 - E/C.19/2003/23). The Special Rapporteur urges the Government and other actors to make every effort to ensure that:

- **Research is carried out into the economic, cultural, political and linguistic obstacles to the enjoyment of the right to health faced by indigenous peoples and ethnic groups in Peru. This research should involve the active participation of representatives, including women, from Peru's indigenous and ethnic minority communities, and should serve as the basis for developing policies and programmes to address these obstacles;**
- **Whenever possible, all health data are disaggregated by ethnicity and socio-economic status;**

- **All health policies, programmes and projects specifically take into account the needs, cultures and traditions of, as well as discrimination affecting, different ethnic groups, and indigenous women;**
- **All affected ethnic groups participate actively and in an informed manner whenever health policies, programmes and projects are formulated and implemented;**
- **All health professionals are provided with training to ensure that they are aware of, and sensitive to, issues of ethnicity, culture and gender;**
- **So far as possible, the health facilities, programmes and projects that are in - or serve - a community are available in the mother tongue of most people in that community;**
- **Central and regional government, teaching institutions, health professional associations and others actively devise and implement strategies that encourage individuals from all ethnic groups to become health professionals. These strategies should include measures to increase the ethnic diversity of the student body attending existing training programmes. However, in addition, new training courses should be devised for - and by - indigenous and other non-dominant ethnic groups. These courses should include training in the medical traditions and practices of the groups concerned. In this way, these courses will serve several extremely important purposes. Not least, they will help to preserve the invaluable and increasingly threatened traditional knowledge of indigenous peoples.**

82. **The Special Rapporteur on the situation of the human rights and fundamental freedoms of indigenous people and the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance should be encouraged to visit Peru.**

V. FURTHER CONCLUSIONS AND RECOMMENDATIONS

83. **The Special Rapporteur will not repeat the numerous recommendations, addressed to various actors, that are set out in the preceding paragraphs of this report. Here, the Special Rapporteur confines himself to three brief concluding recommendations:**

(a) The Government should ensure that all legislation, policies, programmes and other initiatives are consistent with Peru's international and regional human rights obligations, domestic human rights law, commitments related to the right to health made at recent international conferences, and the recommendations adopted by the Permanent Forum on Indigenous Issues, in particular those related to their right to health;

(b) The Government should enhance intersectoral coordination between ministries in the development and implementation of policies and programmes relating to (i) health and (ii) human rights;

(c) Whenever appropriate, the offices of the United Nations and the Organization of American States, including PAHO/WHO, should be called upon to give technical assistance in relation to health and human rights legislation, policies and programmes.

Notes

¹ See the Special Rapporteur's reports E/CN.4/2003/58, E/CN.4/2004/49 and Add.1, A/58/427 and A/59/422.

² The Special Rapporteur also notes the recent World Leaders Statement supporting the International Conference on Population and Development (ICPD): Achieving Health, Rights and Development, 13 October 2004.

³ Law 26842, introduction, arts. 2 and 4.

⁴ Vienna Declaration, Part I, para 5.

⁵ Ministerio de Salud (MINSa), *Lineamientos de Política Sectorial para el Período 2002-2012 y Principios Fundamentales para el Plan Estratégico Sectorial del Quincenio Agosto 2001-Julio 2006*, p. 10.

⁶ Flora Tristán, Centro de la Mujer Peruana, *Violencia Familiar, Violencia Sexual, Aborto, Derechos Reproductivos*, 2003.

⁷ See, e.g., A. Yamin, *Vigilancia Social del Derecho a la Salud: Conjurando Inequidades*, Centro de Estudios Democráticos de América Latina (CEDAL) 2002.

⁸ UNDP, *Human Development Report 2004*.

⁹ APRODEH, *Informe sobre la Situación de los Derechos Económicos, Sociales y Culturales 2002-2003*, p. 9.

¹⁰ *Act of Constitution* of the Peruvian Coalition for Human Rights and Health.

¹¹ Instituto Nacional de Estadística e Informática, *Encuesta Demográfica y de Salud Familiar 2000* (ENDES) (2001), reproduced in A. Yamin, *Vigilancia Social del Derecho a la Salud* 2002, p. 85.

¹² MINSa, *Lineamientos*, pp. 10-11.

¹³ ENDES, 2000. Other estimates put the mortality rate as high as 410/100,000 live births, see WHO, UNFPA, UNICEF, *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA*.

¹⁴ ENDES, 2001.

¹⁵ MINSA, *Lineamientos*, p. 10.

¹⁶ See, e.g., APRODEH, *Informe*.

¹⁷ Policy 10.

¹⁸ Policy 13.

¹⁹ MINSA, *Lineamientos*, p. 29.

²⁰ *Ibid.*, p. 33.

²¹ *Ibid.*, p. 15.

²² *Principios Fundamentales para el Plan Estratégico Sectorial del Quinquenio Agosto 2001-Julio 2006*, p. 40.

²³ Statistics from the Instituto Nacional de Estadística e Informática (INEI), Banco Central de Reserva del Perú (BCRP), Marco Macroeconómico Multianual (MMM), 2003/04, Sistema Integrado de Administración Financiera del Sector Público (SIAF-SP). For example, in Chile, public expenditure on health is around 2.4 per cent of GDP, while in Costa Rica it is 5.6 per cent. Reported in APRODEH, *Informe*, p. 76.

²⁴ *Ibid.*

²⁵ APRODEH, *Informe*, p. 76.

²⁶ L. Altobelli, "Participación comunitaria en la salud: la experiencia peruana en los CLAS", J. Arroyo (ed.), *La Salud Peruana en el Siglo XXI*. Consorsio de Investigación Económica y Social (CIES) DFID/Proyecto Policy, 2002.

²⁷ In brief, "WTO-plus" refers to stricter intellectual property standards than are required by the TRIPS Agreement. See the Special Rapporteur's report on his mission to the World Trade Organization (E/CN.4/2004/49/Add.1, para. 67).

²⁸ Also see Press Release, United States-Peru Trade Negotiations, Special Rapporteur on right to health reminds parties of human rights obligations, 5 July 2004.

²⁹ MINSA, Dirección de Salud, Callao, Plan Integral de Prevención y Control de Intoxicación por Plomo en el Callao, 2002.

³⁰ MINSA, Dirección de Salud, Callao, *Poisoning by Lead in Callao*, June 2004 (information handed to the Special Rapporteur on 12 June 2004).

³¹ Information provided to the Special Rapporteur by the Center for International Environmental Law, November 2004.

³² Law 27050.

³³ MINSA, *Lineamientos para la Acción en Salud Mental*, 2004.

³⁴ Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, (General Assembly resolution 46/119 of 17 December 1991, annex), principle 7.

³⁵ *Ibid.*, principle 3.

³⁶ Mental Disability Rights International (MDRI)/APRODEH, *Human Rights and Mental Health in Peru*, 2004.

³⁷ For an NGO account, see Amnesty International, *Peru: The Truth and Reconciliation Commission - A First Step Towards a Country Without Injustice*, AI Index: AMR 46/063/2004, 26 August 2004.

³⁸ MINSA, press release, *Ayacucho contará con equipo de psiquiatras y psicólogos en forma permanente*, 12 October 2004.

³⁹ World Leaders Statement, see footnote 2 above.

⁴⁰ See A. Yamin and J. Miranda, "Reproductive health without rights in Peru", *Lancet*, vol. 363 (2004).