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Sociedad Peruana de
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Country report: Peru

NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

FOR THE PERUVIAN SOCIETY OF OBSTETRICS AND GYNAECOLOGY (SPOG)

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)
CONDUCTED BY THE KIT-ROYAL TROPICAL INSTITUTE – DEPARTMENT OF HEALTH

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Executive Summary

This needs assessment had the objective to identify and analyse the capacities and needs of the Peruvian Society of Obstetrics and Gynaecology (SPOG) when it comes to the advocacy² of safe abortion. This study forms part of a multi-country needs assessment of safe abortion advocacy, involving ten countries, and has been realized at the request of the International Federation of Gynaecology and Obstetrics (FIGO).

The assessment is based on a review of the literature about abortion in Peru, an online survey which was completed by 155 members and not-members of SPOG, and 15 in-depth interviews of SPOG members, scientific organizations, nongovernmental organizations, and public workers. In addition, a workshop with key actors was held to identify needs and tangible priorities for the advocacy of safe abortion in Peru, as well as to generate input for SPOG's plan of action.

The results of the literature review, the interviews and the workshop with key actors confirm that – in spite of the legality of therapeutic abortion and the decrease of insecure abortion through the growing use of medical abortion – access to safe abortion is restricted in Peru, especially for women with less resources and women who do not live in the capital. This can be explained by the disinformation concerning the legal framework and the technical norm of therapeutic abortion that is shared amongst medical staff members, potential users, and the general public. Another explanation can be found in the strong and general stigma attached to abortion. Consequently, secrecy prevails around abortion in Peru, which causes both health risks for women and a lack of visibility on the prevalence of abortion due to the absence of data and records.

The recommendations of this study are as follows:

- **To strengthen SPOG** both on the organizational level as on the level of its tangible advocacy capacities, especially the development of leadership and communication skills.
- **To promote the perspective of rights** in relation to the integral attention for abortion and sexual and reproductive health in general by providing training with awareness for the transformation of attitudes.
- **To ensure the implementation of the National Technical Guide** of therapeutic abortion and to lead the discussion on its interpretation.
- **To expand the support network for safe abortion** through the involvement of new actors, including actors from both the medical sector (e.g. general practitioners, psychiatrists) and other sectors (e.g. legal workers and social workers).
- **To promote the generation of abortion data** by using and improving existing registration systems and formats in order to better monitor and plan services and to fuel the abortion debate.

² In this report advocacy is defined as the strategic use of information and action to develop opinions, policies and practices that have an impact on people's life (IPAS, 2009) (Adapted from Hord, 2001 and Sharma 1997).

Introduction

This country report is the result of a needs assessment conducted by KIT Royal Tropical Institute with the Kenya Obstetrical and Gynaecological Society (KOGS) regarding Safe Abortion Advocacy. Kenya is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country FIGO-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and should provide a better and more in depth understanding of the capacities and needs of KOGS, to then identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case KOGS. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

- Insights on the situation of abortion in each country
- Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
- Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
- Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as abortion advocates, translated into a comprehensive proposal

Methodology

This needs assessment used a participative approach and had a formative character. Throughout the needs assessment there was constant and clear communication with SPOG in order to develop a common understanding of the objectives of the assessment. During the entire process inputs were shared by means of mutual feedback, which improved the collaboration and the quality of the joint work.

The methods used to reach the objectives of the needs assessment were the following:

Literature review

The literature review started between February and March of 2018 and was based on a common guide tool developed for the 10 countries. SPOG shared a selection of documents and articles about the context of abortion in Peru. A search of academic articles in both international and national scientific journals – like the Peruvian Journal of Obstetrics and Gynaecology (RPOG) and the Peruvian Journal of Experimental Medicine and Public Health – was conducted. Furthermore, statistical data were requested via the portal of Peru's Ministry of Health and reports of international and national key actors in reproductive health – like the United Nations Population Fund – were consulted. Additionally, grey literature was taken into account in order to complement the different areas of the theoretical framework for the needs assessment.

Online survey

A self administered online survey was sent to the 590 members of SPOG using the Survey Monkey platform. The survey was originally designed in English for all ten countries. Therefore, the inputs of SPOG were requested to make sure that both the Spanish terminology and the questions were appropriate for the Peruvian context. The distribution of the survey was realized via the Survey Monkey platform and every member received an e-mail with a personal invitation which could not be forwarded to someone else. It was also guaranteed that answers of the survey were anonymous. The invitation was sent with a message in name of the president of SPOG and the e-mail address of the SPOG was programmed to appear as the sender of the e-mail. Initially, the survey was only sent to the 491 associated members of SPOG. After the workshop it was also sent to the 99 titular members. Over time, as ten reminders were sent out, the response rate rose.

The survey was open for response for over two months – from February 26 to May 6 – with the objective to obtain additional respondents during the First and Second Scientific Session of SPOG, which took place on the 10th and 24th of April. At the Scientific Sessions SPOG promoted the survey. The survey obtained 155 responses, corresponding to a participation rate of 26%. The estimated rate of completion was of 81%.

Interviews

15 interviews were conducted, the majority of which took place on the 2nd, 3rd, and 4th of April in Lima. Some interviews were held at later dates either due to agenda limitations of previously selected key actors or due to the fact that additional key actors were identified at a later stage. The key actors that participated in the interviews were representatives of SPOG, other medical societies such as the Peruvian Society of Contraception and the Society of Obstetrics and Gynaecology of Infancy and Adolescence, private health organizations like the Institute of Public Health, the academic sector (via a representative of the National Major University of San Marcos), the sexual and reproductive health department of Peru's Ministry of Health, entities of the United Nations (UNFPA and OPS), national and international organizations of civil society (Catholics in favour of the right to choose, Manuela Ramos, Flora Tristán, Planned Parenthood Global), and the Peruvian Network for the Support of Access to Safe Abortion (see appendix 1).

The interviews were conducted in the office spaces of the different organizations and medical centres. The duration of the interviews was of approximately 45 minutes on average. All interviews were recorded with the

consent of the interviewees and during the interviews notes were made. Afterwards, these notes were edited and complemented using the audio fragments. The interview notes were thoroughly analyzed and divided into different themes which correspond to the themes presented in the outcome section of this report. Appendix 2 provides a detailed overview of the realized interviews.

Workshop with key actors

Together with SPOG a two day workshop with key actors was organized. This workshop took place at Hotel José Antonio Deluxe on the 5th and 6th of April. The purpose of the workshop was to identify necessities and priorities for the advocacy of safe abortion in Peru in order to generate inputs for SPOG's plan of action, according to the FIGO project which aims to develop a needs assessment in ten countries.

The specific objectives were as follows:

- To discuss and identify the opportunities and obstacles for doing advocacy of safe abortion in Peru based on the review of documents and the personal experience of participants.
- To explore, based on professional ethics, personal and professional values related to abortion and to identify activities to improve access to safe and legal abortion as well as post abortion attention services.
- To explore the implications of the political and legal framework related to abortion.
- To discuss the concept of advocacy and to identify challenges and obstacles of the advocacy of safe abortion in Peru.
- To identify the strengths and weaknesses of SPOG when it comes to advocacy of safe abortion.
- To provide points of action for a project of advocacy of safe abortion

On the first day of the workshop there were 30 participants, on the second day 27. Although all participants were titular members or associates of SPOG, some occupied multiple functions. Therefore, there were also representatives of the Society of Obstetrics and Gynaecology of Infancy and Adolescence, the Peruvian Society of Contraception, the National Major University of San Marcos, Pathfinder International, the Peruvian Institute of Responsible Parenthood (INPPARES), the Peruvian Network for the Support of Access to Safe Abortion (REDPAAS), the Institute of Public Health, the Health Institute of Callao, the National Perinatal Maternal Institute, and the Hospital of María Auxiliadora. During the workshop SPOG also took a facilitating role by giving a presentation about the progress of safe abortion over the past years. Appendix 2 provides a detailed overview of the workshop program.

Challenges and limitations

Two weeks before the visit to the country the – by then – president of Peru offered his resignation. For this reason, important functionaries of the Ministry of health – whose contact details were provided by SPOG – could not participate in interviews until there was clarity on the new appointments of political functions in the ministry, including those for the Minister of Health, the Vice ministers of Health and the Director of Sexual and Reproductive Health. The interviews could not be conducted a week after the visit because there was no definition on the renovation of the function of Vice Minister of Public Health and because the request to interview a director of Public Health was rejected. The rotation of representatives of the Ministry of Health (MINSa) forms a general challenge – noted by SPOG – for working in the area of reproductive health in general, including safe abortion. Another limitation arose because MINSa scheduled an event on maternal mortality on the dates of the workshop. Since this event formed part of a signed agreement, the representatives of MINSa and United Nations agencies (UNFPA, OPS) could not attend the SPOG's workshop about safe abortion.

The online survey had a lower response rate than the expected 20%. This makes the outcome not representative for the whole of SPOG. Additionally, it has to be mentioned that the majority of the participants, who provided input for the needs assessment via the online survey, the interview and/or the workshop, were in favour of safe abortion and had a rather open attitude toward abortion in general. Although this attitude may be representative for the attitude of the directive board and for part of SPOG's members, the overall attitude is not homogeneous and therefore other perspectives are not represented by the outcomes presented in this report.

Results

Review of documents and literature

The principal findings of the literature review are presented in the following subsections: demographic and socio-economic situation; sexual and reproductive health; the legal and political context; the stigma attached to abortion; provision of services; obstacles in the access to therapeutic abortion; and activities related to safe abortion.

Demographic and socio-economic situation

The National Population Censuses of Peru reveal a population growth from 7 million inhabitants in 1940 to 28.7 million inhabitants in 2007, the year in which the last census on population and housing was conducted (Instituto Nacional de Estadística, INEI). Based on projections of the National Institute of Statistics (INEI), Peru was estimated to have 32 million inhabitants in 2018 with an annual population growth rate of 1.07% in the period from 2016 to 2017 (INEI, 2009a). Divided by gender, it is estimated that men constitute 50.1% of the population and women the remaining 49.9% (INEI, 2009b). The Global Fertility Rate for the period 2012-2016 equalled 2.5 children per woman at the national level, with a higher average in rural areas than in urban areas (3.3 versus 2.3 children per woman) (INEI, 2016^a)

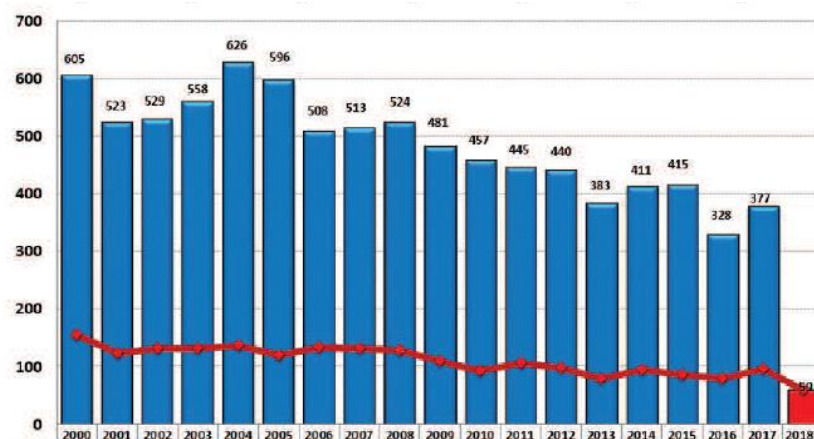
Regarding poverty, Peru has made important progress over the last years in reducing extreme poverty in both rural and urban areas. Between 2013 and 2016 the rate of extreme poverty went from 4.7% to 3.8% and the general rate of poverty decreased from 23.9% to 20.7% (INEI, 2016b).

Sexual and reproductive health

Maternal mortality

Peruvian data show a clear decrease of maternal mortality over the past decades, especially in urban areas. According to the registers of the National Centre of Epidemiology, Prevention and Control of Diseases of the Ministry of Health, the total number of maternal deaths in Peru went from 605 in 2000 to 377 in 2017³ (Figure 1⁴). Although these maternal deaths are concentrated at women between 20 and 35 years (62.9% of all maternal deaths in 2017), from 2013 onwards an increase in the percentage of maternal deaths of women younger than 19 is observed, passing from 8.9% in 2013 to 15.9% in 2017. In absolute numbers, there were 377 maternal deaths in 2017, of which 58 were women younger than 19 years old (MINSa, 2018)

Figure 1. Number of maternal deaths in Peru, 2000-2018



The Rate of Maternal Mortality (RMM) is estimated at 93 deaths for every 100,000 live births according to data of 2010 (GOBIERNO DEL PERÚ, 2017). Other projections, based on records of maternal death through epidemiological surveillance, estimate the RMM at 83.3 deaths for every 100,000 live births for the year 2014 and

³ These data refer to maternal death cases preliminary classified as direct and indirect

⁴ In the graph, the blue columns represent the total number of maternal deaths and the red line represents the maternal mortality ratio

66.1 per 100.000 live births for the year 2016 (MINSA, 2017). According to UNFPA “this decrease of the RMM has been slower over recent years than in the previous decade” (Mesa de Concertación de Lucha contra la Pobreza, MCLCP, 2014, p.6). According to the organization called ‘Counter Poverty Roundtable’ – from the Spanish ‘Mesa de Concertación de Lucha contra la Pobreza’ – the reduction of maternal mortality can be explained by different interventions, actions and strategies aimed at reducing the possibilities of unplanned parenthood, and improving the capacity of health institutions to attend and resolve complications during pregnancy, childbirth and puerperium, as is the case in the intercultural and equitable approach of institutional childbirth for the poorest populations (MCLCP, 2014).

Regarding the epidemiological classification of maternal deaths, data of 2017 indicate that 59.4% of deaths were qualified as direct maternal mortality, 31.1% of deaths were classified as indirect maternal mortality, and 9.4% of deaths were classified as incidental deaths (MINSA, 2018). In 2014, while GUZMÁN (2014) estimated that unsafe abortions caused 17.5% of deaths classified as direct maternal mortality, the Ministry of Health mentions that the principal reasons for maternal mortality are haemorrhages (36.5%), hypertensive pregnancy disorders (31.5%), sepsis (21.5%), and other causes (10.5%). To find an accurate estimate for the weight of abortion in the maternal mortality rate, one can add up all deaths with sub qualifications related to abortion. In this way one can link 9% of all maternal deaths to abortions (MINSA, 2016).

Family planning and adolescent pregnancies

The use of methods of contraception constitutes another field in which, according to the data, Peru is making progress. In 2016 53.4% of women between 15-49 years old used contraceptive methods. 38.9% of women used modern contraceptive methods and 14.5% of women used traditional methods. The most widely used modern methods were injectable methods (19%) and the condom (13.6%), 9% of women declared to have been sterilized and 8.6% declared that they use the pill (INEI, 2016a). The total demand for family planning services⁵ for the women combined was estimated at 84%; 52% to limit the size of the family and 32% to spread out childbirths. The satisfied demand for family planning services is 76.2%; 27.9% to spread out childbirths and 48.3% to limit the size of the family. The percentage of women between 15 and 49 years old who reported unsatisfied demand for family planning services in 2016 was 6%; 2.6% to spread out childbirths and 3.4% to control the size of the family. The biggest unsatisfied demand for family planning services came from adolescents between 15 and 19 years old (12.4%), women without education (8.4%), women in poverty (7.4%), and women in rural areas (6.8%) (INEI, 2016a).

Regarding reproductive intention, it was mentioned that 19.3% of childbirths that occurred over the past 5 years were undesired, a percentage that was higher under adolescents between 15 and 19 years old (INEI, 2016a). The rate of adolescent pregnancies has remained stable over the past 15 years: 13% of adolescents between 15 and 19 was pregnant or already a mother in 2000, 13.6% in the period from 2014 to 2015, and 12.7% in the period from 2015 to 2016 (INEI, 2000 and INEI, 2016a). In 2015 there were 1538 childbirths from adolescents between 11 and 14 years old and 24,049 childbirths from adolescents between 15 and 17 years old (RENIEC).

Abortion

There exist no official abortion numbers and none of the existing estimates is actual. According to estimates realized in 2006, 371,420 clandestine abortions took place. This number is calculated based on the official number of incomplete abortions in establishments of the Ministry of Health, the social security system and the private sector, and excludes spontaneous abortions (FERRANDO, 2006). A more recent approximation estimates that over a year 28,652 women ended up in a hospital and 58 died because of unsafe abortions (TAYPE and MERINO, 2016).

Regarding therapeutic abortions, the data are also incomplete. One of the explanations for the fact that it is hard to obtain reliable information about the treatment of therapeutic abortions in health institutions, is to be found

⁵ The total demand consists of both satisfied and insatisfied demand.

in the large amount of time it took for the Ministry of Health to approve a guidebook on this theme (GUEVARA, 2015). The Ministry of Health reports 265 cases in 2017 (MINSa, 2018a). This number is much lower than the estimation realized by GUEVARA (2015) in the National Maternal and Perinatal Institute for the period 2009-2013. Accordingly, there were 61 (0.23%) treatments of therapeutic interruptions of pregnancy on a total number of 26,214 abortion treatments. The reasons for therapeutic abortion were: risk of maternal health (87%) and risk of maternal death (13%).

Likewise, another estimation, covering 10 hospitals from 2010 to 2014, finds 68,777 cases of abortions, of which 257 were therapeutic cases (TÁVARA and others, 2016). Of these therapeutic abortions, 38.91% were realized because of maternal disease and 61.09% because of severe congenital malformations. The same source reveals that 65% of therapeutic abortions happened between week 13 and week 20 of pregnancy and that less than 20% were cases attended before 12 weeks of pregnancy. In the period of analysis, 98.05% of these cases was without complications, 1.17% caused a hyperthermia and 0.78% caused haemorrhage after the procedure was finished. Not a single maternal death occurred because of therapeutic abortion.

Regarding the methods used for therapeutic abortion, TAVARA and others (2016) found that of the total number of therapeutic abortions, 62.7% involved a combined procedure of misoprostol and curettage, and 28.8% a combination of manual vacuum aspiration – known as Aspiración Manual Endouterina (AMEU) in Spanish – and misoprostol, 3.1% involved misoprostol only, 2.3% involved only manual vacuum aspiration, 1.6% only curettage and 1.6% involved other methods. GUTIERREZ and GUEVARA (2015) mention that uncomplicated incomplete abortion forms one of the most frequent obstetric emergencies for health providers, leading to high treatment costs. To manage incomplete abortion, gynaecology and obstetrics institutions use both the technology of manual vacuum aspiration and medical misoprostol treatments, both treatments being equally effective and safe.

The legal and political context

In Peru, the Penal Code of 1991 (Legislative Decree N° 635) consider abortion as a crime against life, body and health, except when the life or health of the mother is in danger. “Abortion practiced by a medic with the consent of the pregnant woman or her legal representative – in case she has one – is not punishable, when it is the only way to save the life of the pregnant or to avoid a serious and permanent harm to her health” (article 119). In this sense, the Peruvian legislation stresses that all forms of abortion are to be penalized with the exception of therapeutic abortion, which has been permitted since 1924 and includes ethical/sentimental abortion and eugenic abortion.

Between 2005 and 2014, in absence of a national protocol for therapeutic abortion, 28 hospitals developed protocols for handling therapeutic abortions. In 2014 the “National Technical Guide for the standardization of the procedure of the integral attention of the pregnant in the voluntary interruption, for therapeutic reasons, of the pregnancy shorter than 22 weeks with informed consent and within the framework of the provisions of article 119 of the penal code” was developed and approved (RM N° 486-2014/MINSa). This guide includes a non exhaustive list of clinical situations of the pregnant that deserve an evaluation of the possibility of therapeutic interruption of pregnancy (this list can be found in appendix 3).

LEYVA (2016) remarks that the incorporation of the Technical Guide of therapeutic abortion in the governmental political agenda was possible thanks to a confluence of the following factors: 1) political and institutional factors on the national level, 2) the strategies of the groups in favour and the groups opposed to this regulation, 3) and the international influence. The problematic situation of therapeutic abortion in Peru was reflected by the fact that even though therapeutic abortion was decriminalized, it often could not be carried out in case the pregnant woman decided so. This had undesired effects like possible harm to the mental and physical health of the mother, and the prevalence of clandestine and unsafe abortions which could cause the mother’s death. These undesired effects created a window of opportunity for putting the regulation of therapeutic abortion on the agenda.

According to LEYVA (2016), no authority of the highest level of the ministry of health seems to have assumed the role of “political entrepreneur” in favour of the regulation.

Until this day, Peru has been convicted twice in international court rooms for the failure to attend abortions for health reasons. This failure affected the lives of two adolescents. The first conviction was sentenced by the Committee of Human Rights of the United Nations in 2005 and the second was emitted by the Committee on the Elimination of Discrimination against Women (CEDAW) in 2009. In both cases the women affected were under-aged – one was 17 and one was 13 years old – and it was determined that both suffered discrimination, since both were denied access to legal abortion, whilst being in their right to undergo legal abortion. The charge of cruel and negligent treatment was added to this conviction, for both women were exposed to unnecessary suffering (CHÁVEZ, 2013 and MEZA, 2016). In 2017, “the Commission of Consumer Protection of the National Institute of Competition and Intellectual Property Protection” (INDECOP) fined private clinic “El Golf” for not processing a request of therapeutic abortion according to the Technical Guide and for not having provided the therapeutic abortion even though the pregnant woman showed serious degradations of her mental health” (Diario de La República, 22 de agosto 2017).

It needs to be mentioned that in Peru, even though emergency contraceptive pills were included in the Technical Norm for Family Planning of 2001, there was a long process during which lawsuits were filed to prevent the Ministry of Health from distributing these contraceptives based on the false argument that they would produce abortions. During that period, emergency contraceptive pills could not be distributed by public health services. In 2016, in accordance with the provisions of the First Constitutional Court of Lima on the 22nd of August, the Ministry of Health realized the acquisition and free distribution of levonorgestrel of 0.75 mg in all health institutions.

The stigma attached to abortion

Few studies about the stigma attached to abortion in Peru have been done. ZAMBERLIN (2015) argues that the general discourse of Peruvian society condemns abortion, which is seen as an undesired event and is, linguistically, marked with negative connotations. The interruption of pregnancy goes against the expected reproductive and care-taking role of women. Therefore, women who make use of abortion are often called sinners and murderers and are attributed characteristics like promiscuity and egocentricity.

ZAMBERLIN (2015) finds a relationships between stigma and conscientious objections by health providers; and between stigma and unsafe abortion. Due to the stigma, abortion services are handled in a separate way, abortion training for health professionals in urban and rural areas is exclusive, and undergraduate professional training does not include abortion either.

This stigma is reinforced by the laws that regulate, limit, prohibit and penalize abortion and entangle the practice of abortion with secrecy. Since women do not count on the support of the community, the often abort without support. In the community the perception of the negative consequences varies from myths about the loss of one’s partner, the deterioration of family ties, or the supposed relationship with cancer, to preoccupations about health aspects like fertility. In this way, a vicious circle of mutual feedback is being created: criminalization of abortion perpetuates the stigma, which, in its turn, legitimizes the criminalization of abortion (ZAMBERLIN, 2015, 9.183).

Provision of services

There are 10.992 health establishments in Peru divided over hospitals, specialized health institutions, health centres and health posts. The highest concentration of health institutions is found in the province of Lima (INEI, 2018b). According to information provided by the Ministry of Health, there were 1.229 medics specialized in gynaecology and obstetrics at the national level in 2017 (MINSa, 2018a). Therapeutic abortion can be offered in any health institution from the second level of attention (RM N° 486-2014/MINSa) and the costs of therapeutic abortion are covered by the Integral Health Insurance (SIS). Incomplete abortion is treated in establishments of

the second and third level and in some establishments of level I-4 (health centres with a medic), provided that the medic is competent when it comes to the use of Manual Vacuum Aspiration (AMEU). The treatment of incomplete abortion is also covered by the Integral Health Insurance (JUAREZ, 2017).

The Technical National Norm explains the procedure for getting access to therapeutic abortion. The pregnant woman needs to – after a medic has concluded that her pregnancy forms a threat to her life or is causing serious and permanent harm to her health – file a written request to the department of gynaecology and obstetrics and inform the directors of the health institution. Upon receipt of the request, three doctors are summoned to a medical assembly in order to decide whether the request of therapeutic abortion can be approved. The patient is hospitalized and administered misoprostol until the product of her pregnancy is expelled, later she undergoes a Manual Vacuum Aspiration or a uterine curettage, depending on the gestational age. After the intervention, the patient needs to receive instructions on how to continue the treatment and on how to recognize alarm signs. Of course, she also needs to be given guidance and advice on reproductive and sexual health and she needs to be offered contraception to prevent a new pregnancy. A week after the intervention a consult must be organized to assure that the patient is recovering from the intervention and to reinforce the emotional support and guidance when it comes to sexual and reproductive health. The second consult is to be organized a month after the first menstruation.

It must be mentioned that, although pharmacies demand a medical prescription for the sale of misoprostol, on the internet it is possible to order abortive medicine like misoprostol and have it delivered inside the country⁶. Prices fluctuate between 24 and 60 dollar (80 and 200 soles). In Lima exists a phone line that provides information about safe abortion through the use of misoprostol, the line attends people twice a week via two different mobile phone numbers. Also, it is possible to find ‘hidden’ abortion advertisements in national newspapers of the type: “Menstrual delay?”, “Doctor Normalize Menstruation”, or “Direct and painless cleaning”⁷. Also, on public lightning poles one can find posters with the mobile phone numbers of persons who offer to bring women to health clinics and places where they practice clandestine abortion. The costs of these abortion services vary from 106 USD (305 soles) when the procedure only involves medication, to 1000 USD (3500 soles) when the procedure involves tweezers or aspiration devices.

The costs incurred by the health system as a consequence of the complications caused by incomplete abortion treatments is high. The average cost per case incurred by governments in Latin America was estimated at USD 130 (in American dollars of 2006) (VLASSOF, 2008). The costs for the treatment of uncomplicated incomplete abortions (calculated in 4 hospitals) was estimated at between 110 and 150 USD. For complicated abortions, the costs varied between 376 and 858 USD. The total treatment costs of elective abortions was similar to the treatment costs of uncomplicated abortions in hospitals (TÁVARA and otros, 2016).

Obstacles in the access to therapeutic abortion

A study realized by JUAREZ (2017) identifies the following obstacles in the access to therapeutic abortion services. They consist of:

- a) Factors related to service providers, including: ignorance about regulation RM 486-2014/MINSA; health professionals’ lack of competence to successfully abort in cases of therapeutic abortion; discrimination by the professional personnel, especially when adolescents are involved; fear of participating in Medical Conventions and of realizing the procedure to interrupt pregnancy, which stem from supposed and

⁶ Sale of abortive medicine via Facebook by Cytotec: <https://www.facebook.com/Soluci%C3%B3n-de-embarazo-no-deseado-peru-396130787435011/www.cytotecperu.net>

⁷ https://www.google.com.pe/search?q=AVISO+DE+ABORTO+EN+PERIODICOS&rlz=1C1SQJL_esPE772PE772&source=lnms&tbn=isch&sa=X&ved=0ahUKewj85dLN1vPZAhUBIJAKHfLAAjoQ_AUICigB&biw=908&bih=411

imagined legal repercussions, which, in their turn, stem from the unfamiliarity with the legal framework; conscientious objection of some health professionals; the lack of political decision taking by those in charge of the health institutions.

- b) Factors related to the services, including: the absence of information about abortion rights and the absence of flowcharts to inform patients once they enter the health establishment; the absence of material resources, equipment and supplies; restrictive patient attention schedules; unjustified delays of the attention of abortion requests (be it because of: patients handing in the request too late, doctors not being able to convene in the medical assembly, or doctors giving other procedures – like caesarean sections – priority); the long duration of the request process (women often have to wait up to 7 days before receiving a response).
- c) Factors related to the woman's environment, including: the factor of religion; disinformation about the availability of legal abortion and of the circumstances that would justify a therapeutic abortion request; the fact that under-aged women are obliged to be assisted by parents or a tutor.

Regarding the obstacles that limit the access to professional abortion services, the study further elaborates on the following three aspects: 1) the lack of knowledge about the normative frameworks that regulate abortion practices in different contexts and the lack of knowledge about technical aspects related to medical abortion, 2) cultural, subjective, ideological, and religious barriers that affect the clinical practices of doctors because of the fear of being denounced – caused by the criminalization of abortion – and the social stigma – caused by a lack of adequate education and training – attached to abortion, and 3) traditional concepts of gender related to female heteronomy, and the blaming and shaming of women for their sexual and reproductive decisions. The relationship of professionals with conscientious objections to the access to legal abortion is widely recorded. Studies provide more insight in the subjective factors implied in professional practices, like the relationship between professional and personal convictions (LOPEZ GOMEZ, 2015). Religious commitment can influence the decisions of the medical personnel, especially when it comes to abortion. MONTESINOS-SEGURA and others (2016) find that students of medicine with a higher level of religious commitment were less likely to be in favour of the legalization of abortion in case of rape, while 57.5% of the respondents to the survey are in favour of the legalization of abortion in case of rape. A favourable stance towards the legalization of abortion in case of rape was associated to the extent to which the respondent's family approved the legalization of abortion, revealing the influence of the family when it comes to shaping the moral principles of the students. More than 80% of the surveyed students was in favour of studying the legal aspects of abortion in Schools of Medicine, but only 40% found it necessary to teach the procedures to realize an abortion. Only 7.9% of the respondents turned out to be in favour of the full legalization of abortion – i.e. the request of the mother being the only prerequisite of abortion.

According to SANCHEZ-CALDERÓN (2015), the fact that doctors have a practice of reporting induced abortions to the police, causes extra complications for women who go to health institutions, and forms another barrier for the access to safe abortion services. These denouncements are frequent, are done to abide article 30 of the General Law of Health, and give doctors the certitude of not being charged for participating in a cover-up operation. However, this article is contrary to the professional secrete as consecrated in numeral 18 of article 2 of Chapter 1 (fundamental rights of the person) of the Constitution of Peru. Some interviewed doctors justified the act of reporting women to the police as a strategy to identify and punish those who are dedicated to abortive practices, others justify this act as a punishment for the woman. 43.5% of doctors reported their latest case of induced abortion to the police.

Activities related to safe abortion

Publications of the Peruvian Magazine of Obstetrics and Gynaecology give prove of SPOG's contribution to the obstetric specialty, including their role in creating visibility regarding the theme of abortion through the generation and diffusion of evidence. GUEVARA (2017) recounts that in its 70 year of existence the Magazine of the Peruvian Society of Gynaecology and Obstetrics has published 28 articles about maternal mortality and 234

articles about the four main causes of maternal mortality in Peru: haemorrhage (71), pre-eclampsia (100), infection (36), and abortion (27).

In September of 2014, a citizen initiative, initiated by the women’s movement (amongst others: Manuela Ramos, Promsex, Demus, Flora Tristán), recollected about 80.000 signatures and presented a bill to decriminalize abortion in cases of rape and congenital malformations to the Congress of the Republic. This proposal was archived by the Congressional Commission of the Constitution. In 2016, two members of congress of the party named “Frente Amplio” presented a similar proposal supported by feminist organizations and women, this proposal is expected to be debated – without the proposal having a realistic chance of being approved – in 2018 (Diario el Comercio, 2016).

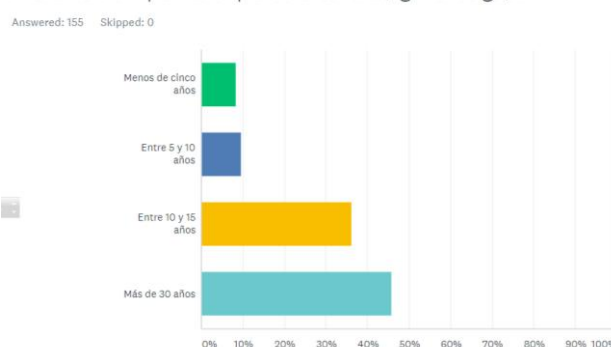
Online Survey

Although the response rate of the survey was low and the results of the survey are not representative of SPOG in its totality, the results do provide valuable information about the position of SPOG members when it comes to strengthening the organization and their attitude towards abortion. Appendix 4 provides a visualization of all answers to the questions of the survey.

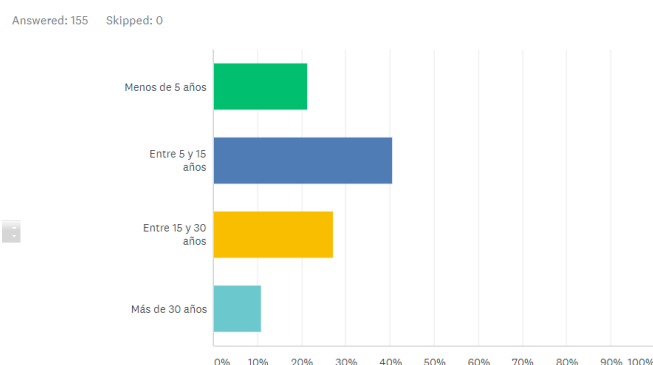
Members of SPOG

The results indicate that the majority of the respondents has been active as gynaecologist-obstetrician for over 30 years and SPOG members for 5 to 15 years. This suggests that young specialists only comprise a small part of SPOG’s membership. Additionally, 67% of the respondents reported to also be a member of other professional organizations, like FIGO and FLASOG and associations of other specialties like, amongst others, contraception, infertility, sexology, and surgery.

¿Cuánto tiempo hace que es obstetra / ginecólogo/a?



¿Cuánto tiempo hace que es miembro de la Sociedad Peruana de Obstetricia y Ginecología?



Involvement and

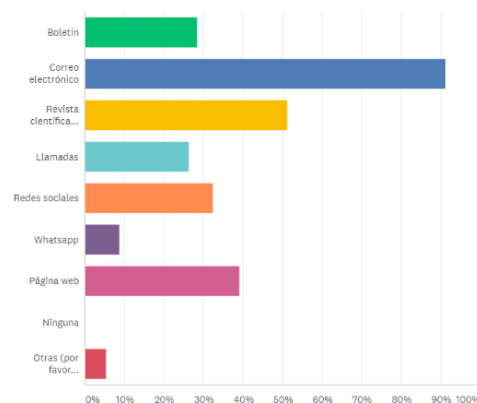
communication with SPOG

The majority of respondents reported a certain level of involvement with SPOG – with 12% reporting high involvement, 28% normal involvement, and 42% moderate involvement. The following activities constitute the

ones that are attended by most SPOG members: conferences (61%), regular meetings (59%), and thematic meetings (45%). The results show that SPOG utilizes multiple communication methods to communicate with its members, these methods include, from most widely reported to less widely reported: e-mail, the scientific journal, the webpage, social media, the bulletin, phone calls, and Whatsapp. According to the respondents, these methods of communication are generally deployed on a monthly basis (61%). The majority of respondents expressed their satisfaction with the existing way of communication, even though 53% of respondents did mention that there is room for improvement.

¿Cuáles son las rutas de comunicación existentes entre la Sociedad Peruana de Obstetricia y Ginecología y sus miembros? (puede marcar multiples respuestas)

Answered: 148 Skipped: 7

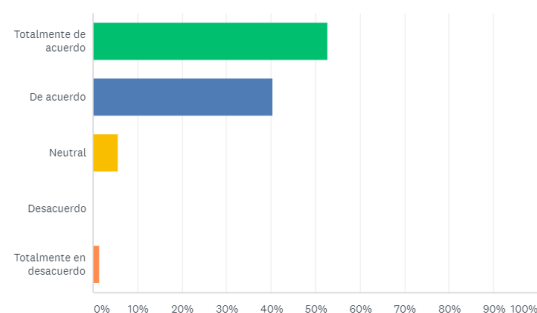


About SPOG's position regarding abortion

More than half of the respondents (53%) affirmed that SPOG has a clear position regarding safe abortion. However, 37% of respondents reported not to know what SPOG's position is. The reported descriptions of SPOG's position show variance. The majority reported that SPOG is in favour of safe abortion. Several respondents mention that it is considered a right of women and some of them even refer to cases of malformation and rape. A few respondents described SPOG's attitude towards safe abortion as the mere support of therapeutic abortion – some of them explicitly emphasizing the words “within the legal framework” – and one respondent described SPOG's stance towards abortion as: “it should not be legalized”. The majority reported to agree with SPOG's position.

¿En qué medida está usted de acuerdo o en desacuerdo con la posición de la SPOG respecto el aborto seguro?

Answered: 72 Skipped: 83



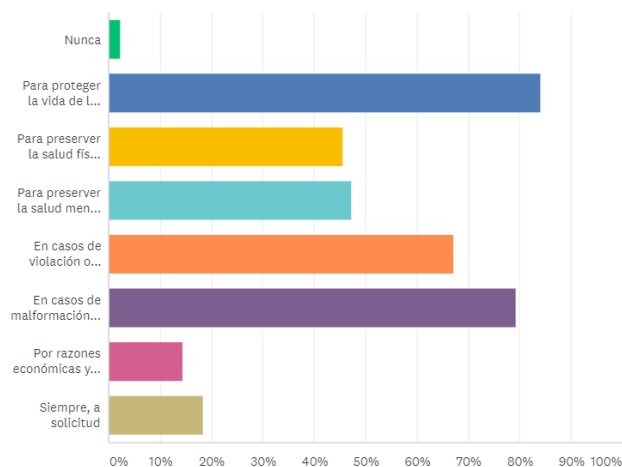
The information and position of respondents with respect to abortion

The answer to the question whether SPOG informs its members about new evidence and information about abortion was diverse; 45% replied affirmative, 29% replied in the negative, and 26% was unknowing. Nevertheless, almost all respondents (91%) reported to want to receive more information about themes related to abortion. Their specifications showed that this need covers the following fields of interest: knowledge and information about the national legal framework in Peru and other countries, clarification on the concept of safe abortion, the protocols of therapeutic abortion, data and statistical relationships about and between – amongst others – mortality, maternal morbidity, abortions involving adolescents.

The answers to the question about the circumstances under which safe abortion should legally be permitted, reveal that the general stance towards therapeutic abortion is favourable: 84% mentioned the protection of the mother's life as a valid situation under which abortion should be permitted, 46% the preservation of physical health, 47% the preservation of mental health. Also, there was high support for reasons that are currently criminalized like: malformation of the foetus (79%) and rape (67%). Also, while 18% reported that safe abortion should always be allowed, a couple of respondents (2%) responded that it should never be allowed.

¿En qué circunstancias cree que el aborto seguro debería ser permitido / legal?(puede marcar múltiples respuestas)

Answered: 125 Skipped: 30



Regarding the role of health professionals as suppliers of abortion services, the respondents reported to agree with the following affirmations (from major to minor degree of agreement):

- The post abortion treatment forms part of the medical treatment and should not be separated from the rest of the treatment.
- Health workers need to be obliged to provide post abortion treatment to all women, without distinguishing between legal and illegal cases of abortion.
- Safe abortion forms part of the medical treatment and must not be separated from the rest of the treatment.
- Health workers need to have the right, following their personal values and stance towards abortion, to decide whether to realize safe abortions or not.
- Health workers have to play a role as advocates of safe abortion.
- Health workers who are opposed to and refuse to realize safe abortion should be obliged to bring the women in contact with health workers that will realize safe abortions.
- Health workers need to inform the respective authorities of cases with indications of illegal abortion.
- Specialized health workers (gynaecologists and obstetrics) have to be obliged to realize safe abortions in cases in which the law permits to do so.

The respondents reported to disagree with the following statement:

- Safe abortions must only be realized in private clinics and not in the public health system

Finally, the majority of respondents affirmed that they would support SPOG in the advocacy of safe abortion: 56% of respondents reporting “definitely yes” to this question, 22% “probably yes”, and 9% “possibly yes”

Semi structured interviews

Based on the analysis of the 15 conducted interviews, the presentation of the outcome is structured using the following points:

- Magnitude of abortion
- Methods of abortion
- Post abortion treatment
- Barriers to access legal and safe abortion

- Positions with respect to abortion
- Challenges and opportunities for the advocacy of safe abortion
- Other pending topics

Magnitude of abortion

All interviewees indicated that it is hard to give a suggestion of the magnitude of abortion because the last estimation was realized in 2006. The secrecy around induced abortions and the poor registration of therapeutic abortions lead to a lack of reliable data about the prevalence of abortion in Peru. In the interviews different arguments for the reason for the lack of reliable data emerged, suggesting that there is no clarity on the systems and procedures of registration. Some interviewees argued that the Ministry of Health has not established registration requirements for cases of induced abortion that arrive at the hospital, nor for cases of therapeutic abortion. Others specified that information regarding these cases is requested via CIE-10, but is often not filled in adequately. The majority explained that, because of the existing fear to register therapeutic abortion, therapeutic abortions are often not registered or are reported as incomplete abortions. There are some exceptions though like the Maternal Perinatal Institute, which does adequately keep track of the number of therapeutic and incomplete abortions attended. Estimations of the number of abortions realized outside the hospital are nonexistent.

Several participants indicated that there are also no specific data on the influence of unsafe abortion on maternal mortality. The arguments regarding this issue were also heterogeneous. On the one hand, efforts were made to point the Ministry of Health at the necessity to create more detailed specifications of the causes of maternal death as to make sure that abortion does not remain an invisible sub-category of the cause “haemorrhage”. Some participants argued that for some years these data were available, while others indicated that these data still exist. On the other hand, the majority of participants argued that these data are unavailable due to the lack of reporting in officially presented data and, above all, due to the absence of the political decision to make abortion visible as the third cause for maternal mortality in Peru in 2017.

Methods of abortion

The interviewees proved to be knowledgeable about the legal framework with respect to abortion and about the Technical Norm of Therapeutic Abortion which also establishes admissible abortion methods. All interviewees argued that the most widely used method for therapeutic abortion is manual vacuum aspiration (AMEU) for being a quick, minimally invasive and uncomplicated procedure which can also be executed in the ambulance. Over the past years, there have been multiple efforts to capacitate gynaecologist-obstetricians in manual vacuum aspiration (AMEU) techniques and to provide the necessary equipment to all hospitals of the second and third level. However, various interviewees indicated that some hospitals – with a higher frequency for hospitals outside the capital – continue to use the method of curettage. Not all hospitals have the necessary overview of the situation regarding human capacities and technical equipment for manual vacuum aspiration. Also, there is no supervision, monitoring and evaluation of abortion treatment services in national and regional hospitals. Moreover, various interviewees indicate that some professionals continue to use curettage, even after having received the necessary training and equipment for manual vacuum aspiration, due to fears of double standards. In private health institutions manual vacuum aspiration is generally utilized as the method of abortion.

In addition, medical abortion with misoprostol is common in Peru. This medicine is registered in the national list of pharmacies and is sold both through pharmacies and through the black market. According to the protocols of the World Health Organization, Mifepristone has to be used together with Misoprostol in therapeutic abortions. In Peru Mifepristone is not registered. Although the commercialization of Misoprostol requires a doctor’s prescription, women can acquire the medicine at elevated prices in some pharmacies. The major part of Misoprostol is obtained via social networks. In the street and on social media the “miraculous pill” is sold. Interviewed doctors indicated that, on a regular basis, women with incomplete abortions and symptoms like

fever, pelvic pains and haemorrhages are hospitalized. Sometimes, while doing a health check, doctors can observe the pill in the vagina.

According to the perception of the interviewed persons, the situation regarding unsafe abortion has varied in the country over the past 20 years. Until about 15 years ago, abortion was done in a different manner: through the manipulation of the uterus, the introduction of traumatic instruments via the vagina (e.g. knitting sticks or clothespins), or the introduction of liquids in the uterus by means of a probe or a pump (e.g. water with soap, kerosene). These practices provoked the rupture of the uterus, septic abortions, complications and even the death of the mother. The interviewees explained that these methods are practically out of use and they consider that maternal deaths caused by induced abortions have apparently diminished by the introduction of misoprostol in the Peruvian market. However, the interviewees also remarked that the consumption of misoprostol without sound medical advice can lead to haemorrhages, bleedings, and frustrated abortions, when women take incorrect doses or take doses without regard of their own general state of health or their gestational age.

Post abortion treatment

After the treatment of therapeutic abortion or incomplete abortion, women are attended by a multidisciplinary team. This treatment is described in the Technical Norm of Therapeutic Abortion and in the treatment protocols of the hospital. Accordingly, women receive information from the doctor, advice from the nurse or obstetrician, psychological guidance and social care. This guidance is provided to make sure that women overcome the problems that brought them in their current situation and to make sure that they make an informed decision on methods of contraception. The emergency services stimulate the use of contraceptive methods of long duration like birth control injections and birth control implantations.

The National Perinatal Maternal Institute (INMP) provides abortion services for adolescents, which include a specialized post abortion service that focuses on mental health. Through its network the INMP can support the family, provide services of contraception, and offer legal support in cases of sexual violence. INMP works with a multidisciplinary teams consisting of a psychiatrist, a psychologist, a nurse, a lawyer and a doctor. The entire team attends the adolescent and supports her in her physical and mental recovery. Given that the majority of these adolescents were victims of sexual violence, the recuperation of mental health acquires great importance.

Barriers to access legal and safe abortion

The interviewed persons identified different barriers to access legal and safe abortion. The majority of these barriers have to do with medical personnel and centres of health, but some have to do with the women themselves:

- Ignorance about the norm by doctors of different specialties. For instance, pregnant women with cardiac problems or cancer are not correctly informed about abortion services and are being sent from office to office until they surpass the 22 weeks of pregnancy.
- Ignorance or preconceptions of those gynaecologists who do not take the correct decision to inform the pregnant patient about the negative health effects of their pregnancy. In this way, gynaecologists can make sure that patients surpass the maximal gestational age and that abortions do not have to be realized.

“... In Chiclayo, after a woman requested an abortion, doctors purposely delayed the process to make sure that she would surpass the 22 weeks deadline established in the protocol. They kept her hospitalized until the deadline had past, then they sent her home in spite of the fact that she had complied with all requirements of the protocol”.

- The attitudes and beliefs about abortion of health suppliers. Many doctors prefer to keep their opinion about abortion to themselves in order to not become marginalized or typecast as “abortero”, which can negatively affect their family and/or working life.

- Doubts and fears regarding the possible administrative sanctions of realizing therapeutic abortions, even though the legal framework supports the execution of such a procedure. This happens partly because doctors are unsure about what will support them if their patients' case turns out to be more complicated. The interviewees mentioned that many health establishments decide to inform the police in these situations for fear of being sanctioned themselves. After this denouncement there is no follow up research to find out whether the patient has been convicted or imprisoned. Recently, there was a case of a health establishment which placed a poster to inform everyone that incomplete abortions will be reported to the police.
- Women's ignorance about the right to request therapeutic abortions and the situations in which they are eligible to access this service. Also, their religious beliefs influence the women by infusing feelings of guilt and fear.

Positions with respect to abortion

At the SPOG level, there exists a clear position in favour of safe abortion which has come to establish itself over years within the directive board. SPOG has contributed to the generation and stimulation of the abortion debate from a technical-scientific perspective, especially through observations, training, congresses, and the publication of studies. SPOG has extensive experience with collaborative work and maintains alliances with various actors: with the Ministry of Health regarding the topic of technical advice and efforts to capacitate medical personnel, with NGOs regarding initiatives of sensitization of the medical personnel, and with the academic sector – especially the faculties of medicine – to revise curriculum contents. Nonetheless, at the same time SPOG admits that there does not exist a homogeneous position in favour of safe abortion amongst all its associated members.

At the level of the Ministry of Health, the topic of abortion is shrouded in silence and there does not exist a clear public position regarding abortion. The focus of the work that is being realized in the ministry is on the prevention of maternal mortality by postpartum haemorrhage, preeclampsia, and even sepsis. A decision to promote contraceptive methods does not exist and even less so for contraceptive methods of long duration, which can form a key strategy in the combat of maternal mortality. These positions depend on rotations of political functions of both the leadership of the Ministry of Health and the government. Amongst international organizations, the approach is to work within the legal framework and to focus on the prevention of maternal mortality and the promotion of planned parenthood. On the other hand, international nongovernmental organizations have a more head-on approach and clearly position themselves in favour of the amplification of the legal framework regarding abortion. These organizations also do work in training, education and sensitization.

Finally, feminist and women's organizations and movements focus their discourse on reproductive autonomy and women's rights. They also take the lead to initiate law proposals for the decriminalization of abortion in cases of rape and congenital malformations.

Challenges and opportunities for the advocacy of safe abortion

- Opposition groups

There are religious groups (Catholics and evangelicals) that find themselves in positions of power (the congress of the republic, some members have even managed to become Minister of Health) which realize meticulous work by opposing fundamental problems of abortion through the manipulation of sexual education and the diffusion of false messages like the so called "ideology of gender". Conservative groups against abortion were unsuccessful in their attempts to prevent the approval of the technical norm of therapeutic abortion. However, these groups do individual work with every doctor and generate feelings of guilt amongst the students of medicine. Conservative thoughts are infiltrated in various departments of the Ministry of Health, including the direction of medicine (DIGEMID).

- Opportunities

There exist various opportunities for improving the efficacy of work regarding advocacy of safe abortion in Peru: i) the use of social networks/digital media, as is currently done by institutions of civil society to promote sexual and reproductive rights in general and the decriminalization of abortion, ii) the bill presented by two members of congress for the decriminalization of abortion in cases of rape and congenital malformations, iii) alliances with medical faculties of Peruvian universities to introduce the topic of therapeutic abortion in the study programs, iv) the status of SPOG as a scientific entity to make its opinions more respected.

- Challenges

The training of young leaders and the incorporation of young members, which could improve the visibility of SPOG in the media, forms one of the challenges of SPOG. Likewise, changing the attitudes of doctors in gynaecology and obstetrics forms a challenge for doctors have a conflict between personal and professional aspects. Another challenge for SPOG is to develop its communicational capacities by creating an adequate budget for the production of media materials. Likewise, it is important for SPOG to be active on social networks and to update the web page on a regular basis.

Other pending topics

- Sexual education

This topic is pending. Opposition groups managed to eliminate several aspects of gender equality from the National School Curriculum. This has a prejudicial effect on the education of adolescents.

- Contraception services

Regarding family planning, in spite of the efforts of the state and the existence of technical norms in the Ministry of Health that promote services of differentiated attention for adolescents, in many places there is no access to contraceptive methods. When these methods are available, adolescents do not make use of them because they lack in training and knowledge or because they feel too ashamed to enter health centres to ask for contraceptive methods. Consequently, adolescents do not take care of themselves and end up pregnant or with sexually transmitted diseases. Once this moment is reached, the adolescent “falls” as they identify her and take her out of school. This must be changed.

Workshop with key actors

Below the principal findings resulting from the discussions and activities of the different sessions of the workshop are presented.

Personal positions and professional responsibilities

The participants were in favour of defending safe abortion. The two most prominent arguments were the relationship between access to safe abortion and the decrease of maternal mortality and morbidity, and the perspective of abortion as a right of women related to reproductive autonomy. In general agreement, the participants expressed that conscientious objection is not common in Peru. However, it was also pointed out that the low frequency of conscientious objection does not mean that there are no beliefs and positions contrary to abortion amongst the medical workers.

Advocacy

The principal topics, roles and levels at and for which SPOG realizes advocacy of safe abortion were the following:

a) Thematic

In general, the participants argued that the debate about safe abortion should be approached from the perspective of abortion as a problem of public health and human rights. Some of the most widely discussed and concrete topics to effectively approach the advocacy of safe abortion were:

- The diffusion of the legal status of therapeutic abortion as part of the reproductive rights of women.
- The promotion of manual vacuum aspiration (AMEU) as the prioritized method for therapeutic abortion.
- The relationship between abortion and maternal mortality and morbidity.
- The integral treatment of abortion, which includes the use of manual vacuum aspiration and personal guidance throughout the treatment process, including post abortion family planning with an emphasis on contraceptive methods of long duration.
- Sexual and reproductive rights of women, with special emphasis on reproductive autonomy.

b) Roles

SPOG's role as an educator was defined as its current predominant role and also as its role of highest priority. This role consists in the generation, use, and diffusion of technical knowledge about abortion. However, possibilities to expand SPOG's role with persuasion activities were identified, especially related to the advocating safe abortion to hospital directors and decision makers. About its role as a witness, although the wealth of information in first hand experiences of medical personnel and its potential use were recognized, it remains to be considered how to develop a potential communication strategy around this information.

c) Levels

In the discussion about the levels on which to realize advocacy, it was argued to continue the efforts on the level of professional practice and, above all, to expand these efforts to medical personnel of other specialties and to general practitioners. This approach forms a fundamental strategy for avoiding pregnancies that endanger the life and health of women and to make people aware of therapeutic abortion treatments. Furthermore, specific advocacy opportunities were identified at the level of policy makers, especially regarding technical observations and specific topic like the registration of abortion data. The level of the media was also identified as important, but it was concluded that training and external advice are necessary to operate on this level.

Social networks

During the workshop a plenary session was held⁸ to map out organizations, allied groups and people, potential allies, and opponents, and to discuss how these entities could be reached. The mapping was realized with an emphasis on the dynamic nature of alliances and their dependency – especially at the level of organizations – on the individuals that occupy administrative functions. Also, allied actors can stop being allies or at least stop being so in an active way and organizations identified as potential allies can become true allies. In Appendix 5 the mapping of actors is visually specified.

Strengths, weaknesses, opportunities and threats

The principal findings of the SWOT analysis, realized in groups, are presented in Appendix 6.

Plan of Action

Based on the discussions and the outcome of the different sessions of the workshop, it was agreed to centre the plan of action on five principal areas: i) the diffusion of legal and political frameworks and the discussion of their interpretation, ii) the promotion of the change of attitudes at multiple levels, iii) the improvement of inter-alliance collaboration and inclusion, iv) The stimulation of the use and generation of evidence about safe abortion, and v) the strengthening of SPOG as an organization.

1. Diffusion, revision and possible improvements of the existing legal and political frameworks

- More diffusion of the Technical Norm of Therapeutic Abortion to all medical professionals across the country.
- Training about the implementation of the Technical Norm of Therapeutic Abortion in the hospitals.
- To promote and to support the development of protocols about Therapeutic Abortion, based on the Technical Norm, in those hospitals that do not have protocols yet.
- To impulse a major discussion about the multiple interpretations of point 11 of the Technical Norm of Therapeutic Abortion through an integral concept of health which includes an emphasis on the impairment of mental health.
- To support – using technical recommendations – legal initiatives aimed at the decriminalization of abortion in case of rape
- To sensitize the medical personnel about the integral treatment of incomplete abortion cases as part of the gynaecology-obstetrics practice

2. The change of attitudes

- To stimulate the perspective of women's sexual and reproductive rights with emphasis on reproductive autonomy amongst health professionals and actors of other key sectors through sensitization and training.
- To position the topics reproductive and sexual health, contraceptive methods and safe abortion on the national public agenda.
- To diffuse the legal status of therapeutic abortion and the availability of integral and safe incomplete abortion treatment services amongst the general public.
- To support efforts aimed at generating women's knowledge about their sexual and reproductive rights.
- To generate debate amongst medical personnel about the double moral, the balance between personal attitudes and professional responsibilities, and the legal aspects of therapeutic abortion.

⁸ Although this activity was scheduled as a group exercise, the methodology was – at the request of the participants – changed and a plenary session was held instead.

- To work with hospital directors and department managers to tackle the fears and stigmas related to therapeutic abortion of medical professionals, including the registration of therapeutic abortion and the use of manual vacuum aspiration (AMEU) as the preferred method.
- To identify and approach the lack of equipment and training necessary for conducting AMEU in hospitals across the country.

3. Inclusion and alliances

- To include general practitioners and other health professionals like nurses, advisers, and psychologists in the training about therapeutic abortion and the creation of materials for the advocacy of access to safe abortion.
- To generate a discussion about the legal aspects of abortion in collaboration with the Lima's College of Lawyers (Colegio de Abogados de Lima – CAL).
- To increase the involvement of psychiatrists in the implementation of the Technical Norm of Therapeutic Abortion and to foster – together with the Peruvian Society of Psychiatry – the debate about the negative mental health effects of undesired pregnancies especially in cases of sexual violence.
- To strengthen the collaboration with the academic sector and ASPEFAM in order to include contents about sexual and reproductive health and women's rights in the faculties of medicine.
- To join forces with movements and groups that intend to position violence against women as a top priority on the public agenda.
- To strengthen and increase the ties with young people via the medical student association or youth groups within organizations that are active in the field of sexual and reproductive health rights – e.g. Impares.
- To maintain and strengthen collaborations – involving training, communication, and political influence – with organizations of civil society in the fields of feminism, women's rights and human rights.

4. The use and generation of knowledge

- To generate technical recommendations for the Ministry of Health about the necessity to make incomplete abortion cases visible in the registration of official data as a sub-category of haemorrhage and an indirect cause of maternal mortality.
- To tackle the lack of data and recent estimations about the prevalence of abortion in Peru.
- To promote the registration of therapeutic abortion services realized in hospitals.
- To create a mapping of the current situation in all hospitals regarding the availability of AMEU equipment and the capacity of health workers to use this equipment.
- To translate technical knowledge about abortion and experiences of health professionals in the field into 'humane and friendly' communication materials to diffuse amongst the general public.
- To exchange experiences with other countries in the region where progress in the decriminalization of abortion has been made (e.g. Uruguay).

5. Organizational strengthening of SPOG

- To increase the percentage of specialized gynaecologists affiliated to SPOG.
- To enhance the ties and the involvement of SPOG's subsidiaries in all activities.
- To strengthen the relationships with FIGO, FLASOG, and other societies through the participation in jointly-organized congresses.
- To develop – with the support of specialists – an integral and effective communication strategy for different audiences.
- To receive training in leadership skills for SPOG members.
- To increase the human and administrative resources of SPOG.

Appendix 7 makes reference to a preliminary plan of action based on the inputs of the participants of the workshop. This plan contains potential objectives and specific activities for the coming three years and will be shared in an attached Excel document. This plan will be further elaborated in tight collaboration with SPOG and FIGO.

Conclusions

The results of the literature review, the interviews and the workshop with key actors confirm that – in spite of the legalization of therapeutic abortion and the decrease of unsafe abortion due to the rise of medical abortion – access to safe abortion is restricted in Peru, especially for women with little resources and for those that live outside of the capital. This is caused by the fact that the medical personnel, users, and general public are often not informed about the legal framework and the Technical Norm of Therapeutic Abortion and that there exists a strong stigma attached to abortion in general. Consequently, secrecy prevails, exposes women to health risks, and makes the prevalence of abortion largely invisible due to the resulting absence of data and registration.

In this context, work focused at the improvement and extension of access to safe abortion is necessary, relevant and pertinent. Although there exist opportunities for SPOG to lead this work in advocacy of access to safe abortion, there also exist multiple challenges that make it difficult to make progress. The evaluation highlights the following opportunities and challenges:

Opportunities:

- **The creation of the national therapeutic abortion protocol in 2014** with the approval of the *'National Technical Guide for the standardization of the procedure of the integral attention of the pregnant in the voluntary interruption, for therapeutic reasons, of the pregnancy shorter than 22 weeks with informed consent and within the framework of the provisions of article 119 of the penal code'*. Diffusing this guide to all hospitals and providing training about its implementation, offers an opportunity to improve and expand women's access to therapeutic abortion.
- **The open character of the list of clinical conditions under which pregnant women qualify for evaluations of therapeutic interruptions of pregnancy** as defined by the National Technical Guide. According to the eleventh point of this list, *'any other maternal pathology that endangers the life of the pregnant woman or does serious and permanent harm to her health, duly substantiated by the medical board'* can justify therapeutic interruption of pregnancy. This opens up the possibility of integral interpretations of health like the one established by the World Health Organization, which includes both risks to physical and mental health. More integral interpretations of health would enable the medical board to justify and to approve therapeutic abortions in cases that are not explicitly mentioned on the list, including rape.
- **The position of SPOG** at the national level as a respected technical society closely linked to various key actors in the area of sexual and reproductive health. Also, the clear position in favour of access to safe abortion held by SPOG's current (and past) boards of directors assure the sustainability of the Society's commitment to this issue.

Challenges:

- **The general stigma attached to abortion.** This stigma results in: double morals; ignorance about the legal status of therapeutic abortion amongst the general public; public silence about abortion amongst political leaders; fear and reluctance amongst the medical personal, which make the implementation of the National Technical guide difficult.
- **Conservative and religious groups** opposed to topics related to sexual and reproductive health are well positioned, have influence on policy makers and are capable of directing social mobilization. This opposition goes beyond just abortion and is especially fierce with respect to family planning, sexual education and that what these groups call the *'ideology'* of gender.

Recommendations

To strengthen SPOG and to position it as a leading actor of the advocacy of safe abortion, while taking into account both the Peruvian context regarding abortion and SPOG's own organizational strengths and weaknesses, the following general recommendations are formulated:

- **To strengthen SPOG** both on the organizational level as on the level of its tangible advocacy capacities, especially the development of leadership and communication skills.
- **To promote the perspective of rights** in relation to the integral attention for abortion and for sexual and reproductive health in general through training with awareness for the transformation of attitudes.
- **To ensure the implementation of the National Technical Guide** on therapeutic abortion and to lead the discussion on its interpretation.
- **To expand the support network for safe abortion** through the involvement of new actors, including actors from both the medical sector (e.g. general practitioners, psychiatrists) and other sectors (e.g. legal workers and social workers).
- **To promote the generation of abortion data** by using and improving existing registration systems and formats in order to better monitor and plan services and to fuel the abortion debate.

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Appendix 1: Interviews with key actors

	Actor clave	Fecha y hora	Lugar
1	Gineco Obstetra, Sociedad Peruana de la Contracepción	02.04.2018, 09.00 h	Instituto Materno Perinatal
2	Gineco Obstetra, Instituto Materno Perinatal	02.04.2018, 10.30 h	Instituto Materno Perinatal
3	Sociedad de Obstetricia y Ginecología Infancia y Adolescencia	02.04.2018, 10.00 h	Instituto Materno Perinatal
4	Gineco Obstetra/Universidad San Marcos	02.04.2018, 11.30 h	Instituto Materno Perinatal
5	Católicas por el Derecho a Decidir (CDD)	02.04.2018, 11.30 h	Oficinas CDD
6	OPS	02.04.2018, 16.00 h	Oficinas OPS
7	MINSA- Grupo SSR	03.04.2018, 10.30 h	Oficinas MINSA
8	MINSA- Grupo SSR	03.04.2018, 11.30 h	Oficinas MINSA
9	Manuela Ramos	03.04.2018, 11.00 h	Oficinas Manuela Ramos
10	Planned Parenthood Global	03.04.2018, 13.00 h	Oficinas Foro Social de Salud
11	UNFPA	03.04.2018, 15.00 h	Oficinas UNFPA
12	Red Peruana de Apoyo al Acceso al Aborto Seguro	03.04.2018, 15.00 h	Oficinas PROMSEX
13	Instituto de Salud Popular (INSP)	04.04.2018, 09.00 h	Oficinas INSP
14	Pathfinder International	04.04.2018, 09.00 h	Oficinas Pathfinder International
15	Flora Tristán	04.04.2018, 11.00 h	Oficinas Flora Tristán

Appendix 2: Workshop invitation and program



KIT



Sociedad Peruana de
Obstetricia y Ginecología



FIGO

International Federation of
Gynecology and Obstetrics

Agenda del Taller de validación y discusión de las Barreras y oportunidades para la defensa del aborto seguro en Perú

Fecha: 5 y 6 de Abril 2018

Lugar: Hotel Jose Antonio Deluxe- Lima

Participantes: 30 personas

Objetivo general del taller.

El objetivo del taller es validar el análisis preliminar sobre el contexto del aborto seguro en Perú y proporcionar insumos sobre oportunidades y limitantes para la defensa del aborto seguro en Perú que alimenten los planes de acción a desarrollar para el futuro proyecto de la FIGO sobre fortalecimiento de capacidades para la defensa del aborto seguro.

Objetivos específicos.

Al final de los talleres, se habrá:

- Discutido e identificado oportunidades y barreras para proporcionar aborto seguro en el país a través de la validación de los resultados preliminares de la evaluación y testimonios sobre experiencias propias de los y las participantes
- Explorados posicionamientos personales y profesionales en relación al aborto seguro e identificado actividades para mejorar el acceso a servicios de aborto seguro y post-aborto desde la ética profesional
- Explorado las implicaciones de la ley nacional sobre el aborto y las políticas para el acceso al aborto seguro.
- Abordado el concepto de 'advocacy' en sus diferentes niveles e identificado los desafíos y barreras para la defensa del aborto seguro
- Identificado las fortalezas y debilidades de la SPOG para la defensa del aborto seguro
- Formulados puntos de acción para un programa de fortalecimiento de capacidades en material de defensa del aborto seguro.

Agenda preliminar:

Jueves 5 de Abril del 2018		
08.30– 9.00	Recepción	
9.00 – 9.15	Bienvenida	Presidente de la SPOG
09.15-09.30	Introducción del taller	KIT
09.30-10.30	Presentación de resultados preliminares y discusión	KIT
10.30-11.30	Implicaciones del marco legal en materia de aborto seguro (estudios de caso)	KIT
<i>Pausa</i>		
11.45-12.30	Posicionamientos personales y responsabilidades profesionales	KIT
12.30-13.30	“Advocacy”: concepto, niveles, riesgos y beneficios	KIT
<i>Almuerzo</i>		
14.30-15.30	Perspectiva de advocacy y roles	KIT
15.30-16.30	“Advocacy para el aborto seguro”	KIT
16.30-17.00	Cierre y evaluación del día	SPOG y KIT
Viernes 6 de Abril del 2018		
08.30-9.00	Recepción	
9.00-09.30	Recapitulación del día anterior	SPOG y KIT
9.30-10.30	Redes sociales y llegar a diferentes audiencias	KIT
10.30-11.30	FODA	KIT
<i>Pausa</i>		
11.45-12.30	Presentación de logros, debilidades, barreras y oportunidades para el proyecto sobre aborto seguro. FODA de SPOG	SPOG
12.30-13.30	Cómo desarrollar el plan de acción para proyecto en advocacy para aborto seguro	KIT
<i>Almuerzo</i>		
14.30-15.30	Continuación desarrollo del plan de acción	KIT
15.30-16.30	Presentación y discusión de los planes de acción en plenaria	KIT
16.30-17.00	Evaluación y cierre	SPOG y KIT

Appendix 3: Additions to the literature review

Listado de situaciones clínicas que ameritan la consideración de la interrupción del embarazo según la Guía Técnica Nacional sobre el Aborto Terapéutico

1. Embarazo ectópico tubárico, ovárico, cervical.
 2. Mola hidatiforme parcial con hemorragia de riesgo materno.
 3. Hiperemesis gravídica refractaria al tratamiento con deterioro grave hepático y/o renal.
 4. Neoplasia maligna que requiera tratamiento quirúrgico, radioterapia y/o quimioterapia.
 5. Insuficiencia cardíaca congestiva clase funcional III-IV por cardiopatía congénita o adquirida (valvulares y no valvulares) con hipertensión arterial y cardiopatía isquémica refractaria a tratamiento.
 6. Hipertensión arterial crónica severa y evidencia de daño de órgano blanco.
 7. Lesión neurológica severa que empeora con el embarazo.
 8. Lupus Eritematoso Sistémico con daño renal severo refractario a tratamiento.
 9. Diabetes Mellitus avanzada con daño de órgano blanco.
 10. Insuficiencia respiratoria severa demostrada por la existencia de una presión parcial de oxígeno < 50 mm de Hg y saturación de oxígeno en sangre < 85%.y con patología grave; y
 11. Cualquier otra patología materna que ponga en riesgo la vida de la gestante o genere en su salud un mal grave y permanente, debidamente fundamentada por la Junta Médica.
-

Listado de Hospitales que tienen aprobados protocolos sobre aborto terapéutico

1. Hospital EL CARMEN de Huancayo
2. Hospital Regional del Cusco
3. Hospital Amazónico de Yarinacocha
4. Hospital Antonio Lorena del Cusco
5. Hospital Apoyo II Sullana
6. Hospital Belén de Trujillo
7. Hospital Carlos Cornejo de Puno
8. Hospital Daniel Alcides Carrión de Pasco
9. Hospital Daniel Alcides Carrión de Huancayo
10. Hospital de Apoyo Víctor Ramos Guardia de Ancash
11. Hospital de Apoyo Virgen de las Mercedes de Ancash
12. Hospital Docente Las Mercedes de Chiclayo
13. Hospital General María Auxiliadora
14. Hospital Goyeneche de Arequipa
15. Hospital Honorio Delgado de Arequipa
16. Hospital II - 1 Tarapoto
17. Hospital La Caleta de Chimbote
18. Hospital Nacional Daniel A. Carrión del Callao
19. Hospital Nacional Docente Madre Niño San Bartolomé
20. Hospital Nacional Dos de Mayo
21. Hospital Nacional Hipólito Unanue
22. Hospital Regional de Ayacucho
23. Hospital Regional de Cajamarca
24. Hospital Regional de Pucallpa
25. Hospital Regional Docente Las Mercedes de Chiclayo
26. Hospital Regional Felipe Arriola de Iquitos
27. Hospital Santa Rosa de Piura
28. Instituto Nacional Materno Perinatal

Pasos establecidos en la Norma Técnica para el aborto terapéutico

- a) El o la médico tratante informa a la gestante que el embarazo pone en riesgo su vida o causa un mal grave y permanente en su salud, los riesgos graves del embarazo y los procedimientos terapéuticos que correspondan.
 - b) La gestante solicita al médico/a tratante que presente la solicitud escrita del caso a la Jefatura del Departamento de Gineco-Obstetricia con conocimiento de la Dirección General, del establecimiento de salud.
 - c) La Jefatura del Departamento de Gineco-Obstetricia recibe la solicitud, y en la fecha constituye y convoca una Junta Médica
 - d) El o la médico/a tratante informará a la gestante o su representante legal la decisión de la Junta Médica.
 - e) En caso que la Junta Médica apruebe la interrupción del embarazo menor de veintidós (22) semanas, la gestante o su representante legal firmará el formulario para el consentimiento informado y la autorización del procedimiento.
 - f) La Jefatura del Departamento de Gineco-Obstetricia inmediatamente designará al médico/a que llevará a cabo el procedimiento, el cual será programado dentro de las siguientes veinticuatro 24 horas, comunicando al Director General del establecimiento de salud la fecha y hora de la intervención.
 - g) El lapso desde que la gestante solicita formalmente la interrupción voluntaria por indicación terapéutica del embarazo menor de veintidós (22) semanas hasta que se inicia la intervención en forma oportuna que garantice la eficacia de la intervención, la que no debe exceder de seis días calendarios.
-

Casos y pronunciamientos en la CEDAW

UNA DEUDA PENDIENTE: CASO L.C . VS. PERÚ ANTE EL COMITÉ CEDAW

HECHOS

L. C. quedó embarazada a los 13 años de edad por los repetidos abusos sexuales de un vecino. Trató de suicidarse lanzándose al vacío con la finalidad de interrumpir su embarazo, ya que en el Perú la ley no autoriza el aborto por causa de violación o abuso sexual.

El Comité para la Eliminación de Toda Forma de Discriminación hacia las Mujeres (Cedaw) examinó si la negativa del hospital a realizar el aborto terapéutico a L.C. –previsto en el artículo 119 del Código Penal– y la programación tardía de su operación de columna –que provocó que más tarde quedara cuadraplégica– dio lugar a una violación de sus derechos.

RESOLUCIÓN

Cedaw (Comité para la Eliminación de Todas Formas de Discriminación hacia las Mujeres. Comunicación No. 22/2009. Dictamen aprobado por el Comité en su 50 período de sesiones, celebrado del 3 al 21 de octubre del 2011. Párrafo 9,2) observa que el hecho de que el Estado parte no protegiera los derechos reproductivos de la mujer ni promulgara leyes para reconocer el aborto por causa de abuso sexual o violación contribuyó a la situación en que se encuentra L.C.

Por tal motivo, determinó que el Estado Peruano debe revisar su legislación para despenalizar el aborto cuando el embarazo tenga como causa abuso sexual o violación.

El Perú –como medida de no repetición– tiene la tarea de seguir la recomendación de esta resolución.

Cabe señalar que el Comité para la Eliminación de la Discriminación contra la Mujer ha realizado las siguientes recomendaciones al Estado Peruano en relación al aborto terapéutico (NACIONES UNIDAS, 2014 pp. 11-15):

- a) “Haga extensiva la legalización del aborto a los casos de violación, incesto o malformación fetal severa;
- b) Garantice la disponibilidad de servicios de aborto y el acceso de las mujeres a atención de calidad después de un aborto, especialmente cuando se presenten complicaciones a raíz de un aborto en condiciones de riesgo;
- c) Elimine las medidas punitivas contra las mujeres que abortan, entre otras cosas adoptando las medidas necesarias para armonizar la Ley General de Salud y el Código de Procedimiento Penal con el derecho constitucional a la intimidad;
- d) Se asegure de que el ejercicio de la objeción de conciencia por los profesionales de la salud no impida el acceso efectivo de las mujeres a los servicios de salud reproductiva, incluido el aborto y la atención posterior;
- e) Garantice el acceso a servicios de planificación familiar, en particular en las zonas rurales, y adopte todas las medidas necesarias para distribuir gratuitamente anticonceptivos de emergencia en el sistema de salud pública, en particular a las mujeres y niñas víctimas de abusos sexuales;
- f) Desarrolle la capacidad del personal médico en relación con el derecho a la salud, incluida la salud sexual y reproductiva, con miras a garantizar una prestación adecuada de servicios de salud a las mujeres y niñas;
- g) Divulgue información sobre las directrices técnicas relativas al aborto terapéutico entre todo el personal de salud y vele por que al aplicar las directrices se dé una interpretación amplia al derecho a la salud física, mental y social”.

Appendix 4: Answers to the online survey

Attached PDF document: Answers to the online survey

Appendix 5: Social Networks and Alliances

SECTOR	ALLIES		POTENTIAL LEVEL ALLIES	OPONENTS	
	Organization	Contacts	Organization	How to reach these organizations	Groups and persons
Health Sector	<p>The National Perinatal Maternal Institute of Lima</p> <p>National and regional hospitals with therapeutic abortion protocols:</p> <ul style="list-style-type: none"> - H. San Bartolomé - H. Dos de Mayo - H. María Auxiliadora - H. Pucallpa - H. Piura - H. Trujillo - H. Iquitos - H. San Martín <p>The Institute of Public Health (INSAP)</p> <p>The Peruvian network of health professionals who facilitate the access to abortion</p>	<p>Dr Enrique Guevara and Dr Santiago Cabrera</p> <p>Doctors:</p> <ul style="list-style-type: none"> - Sixto Sanchez - Ysoé Ramírez - Luis Makya - Walter Leveau - Leonardo Lachira - Pedro Aldave - J.Marín y J.Vasquez - Enrique Guzmán <p>Luis Lazo and Alexander Seco</p> <p>Enrique Guevara</p>	<p>The Medical College of Peru</p> <p>Hospitals:</p> <ul style="list-style-type: none"> - H. Hipólito Unanue - H. Sergio Bernales - H. Callao - H. San Juan de Lurigancho <p>Peruvian Society of Adolescence and youth</p> <p>Jorge Bruge (Psychoanalyst)</p>	<p>Through the installation of a high-level commission.</p> <p>Through sensitization and positioning of the topic.</p>	
Organizations of Peruvian civil society	<p>Flora Tristán</p> <p>PROMSEX</p> <p>Manuela Ramos</p> <p>Foro Salud</p>	<p>Liz Meléndez</p> <p>Susana Chávez</p> <p>Victoria Villanueva</p> <p>Enrique Guevara</p>	<p>The Peruvian Institute of Responsible Parenthood (INPARES)</p> <p>The movement/campaign of</p>		<p>The group called “Don’t interfere with my children” (<i>‘con mis hijos no te metas’</i>)</p>

			'Not even one less' (<i>'Ni Una Menos'</i>)		
The national political sector			Ministry of Health		Member of Congress Julio Rosas
The legal Sector	Defensoría del Pueblo (Advocacy of the People)		Fiscalía de la Nación (The Public Prosecutor) The College of Lawyers	Samuel Abad	
Academics	National Major University of San Marcos (the Dean) Peruvian University Cayetano Heredia (the faculty of Public Health) The Peruvian Association of the Faculties of Medicine (ASPEFAM)	Antonio Luna	Universities The Association of Students of Medicine		
International organizations and multilateral agencies	Pathfinder International Planned Parenthood Global UNFPA Pan American Health Organization	Miguel Gutierrez Pilar Montalvo Elena Zúñiga Raúl Gonzalez, Erick Rousselin			
Religious groups	Catholics for the right to choose	Gladys Vía, Rosa Mavila			The Catholic and Evangelical Church Cardinal Cipriani Sodalitium of Christian Live (Luis Solari, Carbone)

Media		Journalist Patricia del Río	Journalists: <ul style="list-style-type: none"> - César Hildebrant - Jaime Chinchá - Mávila Huertas - Cecilia Valenzuela - Luis Devalleus - Mónica Delta - Milagros Leyva - Renato Cisneros - Andrea Llosa - Fernando Vivas Webpages: Ojo Público and Wayka	Through generating information and press releases, and by starting a comprehensive communication project.	Rafael Bey (communicator)
Communities			Young people	Social Networks	

Appendix 6: SWOT analysis

SWOT analysis of SPOG's advocacy of safe abortion	
<p>Strengths</p> <ul style="list-style-type: none"> • Technical capacity supported by scientific evidence • Strong and long-standing commitment with Sexual and Reproductive Rights • Technical and scientific experience of SPOG members • International and national presence and reference • Experience with the generation of scientific debates • Strong ties with the academic sector 	<p>Opportunities</p> <ul style="list-style-type: none"> • The existence of favourable legal framework for therapeutic abortion which is widely interpretable • The existence of actors of civil society committed to sexual and reproductive rights. • The change of societal thoughts and the stream of opinions favourable to therapeutic abortion, especially in cases of (sexual) violence against women. • Possibilities to sensitize and train actors regarding safe abortion and sexual and reproductive rights (e.g. general practitioners and the general public) • Possibilities to strengthen existing alliances and to generate new ones
<p>Weaknesses</p> <ul style="list-style-type: none"> • Not all members are informed and sensitized about sexual and reproductive rights and safe abortion • Little presence in the media, lack of opinion leaders and interlocutors within SPOG • Few permanent training about safe abortion in hospitals • The absence of an adequate and sustainable communication strategy • Not all gynaecologists of the country are SPOG members • Limitations in economic and human resources for administrative work. • Lack of positioning in SPOG's regional subsidiaries 	<p>Threats</p> <ul style="list-style-type: none"> • Religious influence • Political power: a conservative majority in congress • High speed of rotations in Ministry of Health • Ignorance about Sexual and Reproductive Rights amongst the general public • Well-organized conservative groups with an effective discourse about 'victims'.

Appendix 7: Draft version of the list of actions

Attached excel document: Draft version of FIGO plan of action Peru