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Glossary of Terms

AGES	Guatemalan Association for Sexual Education
American Convention	American Convention on Human Rights
American Declaration	American Declaration on the Rights and Duties of Man
APROFAM	Guatemalan Association for the Well Being of the Family
Beijing Conference	1995 UN Fourth World Conference on Women
Beijing Platform for Action	Beijing Declaration and Platform for Action
CEDAW	UN Committee on the Elimination of Discrimination Against Women
CHCS	Comprehensive Health Care System
Children's Convention	Convention on the Rights of the Child
Civil and Political Rights Covenant	International Covenant on Civil and Political Rights
Convention of Belém do Pará	Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women
Convention on Racial Discrimination	Convention on the Elimination of All Forms of Racial Discrimination
Economic and Social Rights Covenant	International Covenant on Economic, Social and Cultural Rights
ICPD	1994 UN International Conference on Population and Development
IGSS	Guatemalan Institute for Social Security
MINUGUA	UN Human Rights Verification Mission in Guatemala
MSPAS	Ministry of Public Health and Social Services
OAS	Organization of American States
UNFPA	United Nations Population Fund
UNICEF	UN Children's Fund
UNIFEM	UN Development Fund for Women
Universal Declaration	Universal Declaration of Human Rights
WHO	World Health Organization
Women's Convention	Convention on the Elimination of All Forms of Discrimination Against Women

Introduction

The Guatemalan government has not taken adequate steps to promote and protect its citizens' right to family planning information and services. Guatemala is among the dwindling number of countries that largely ignore national obligations under international human rights norms to ensure that all citizens have access to family planning information and services in governmental health care facilities. To date, there is no comprehensive law, government policy, or program providing access to such information and services within state-sponsored facilities for all women of reproductive age. Low-income, indigenous Guatemalan women suffer most — often with their health, sometimes with their lives — from their government's hostility toward enacting such a law, policy, or program.

The government has persistently resisted complying with the international consensus on the right of all individuals to determine whether and when to bear children. The outright hostility of the government to the right to family planning information and services is clear. For example, when the Guatemalan government gave its periodic report to the UN Committee on the Elimination of Discrimination Against Women (CEDAW) in 1994, the government's representative asserted that family planning leads to the breakdown of society and the family, that it had a negative effect on youth, and that it increased the number of women-headed households.¹ The government ignores the fact that the fundamental human right to family planning was explicitly articulated at the United Nations (UN) International Conference on Human Rights held in Teheran in 1968 and has been reinforced in numerous international human rights conventions, including the Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention), and at UN conferences dealing with many human rights and development issues since then. In 1995 at the UN Fourth World Conference on Women (Beijing Conference), governments agreed by consensus that "[t]he explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment."² The government's refusal to adopt a legislative and policy framework to enable women — particularly low-income, rural, and indigenous women — to access family planning services and information constitutes a violation of the human right to family planning. This refusal also implicitly violates other human rights norms, including the right of women and indigenous people to be free from all forms of discrimination.

The refusal of successive Guatemalan governments to integrate family planning services into the public health system has had one positive effect. It has spared Guatemalans from overly zealous efforts to restrict women's choices regarding whether to use family planning and if so, what method to use. Inadequate safeguards to ensure women's right to make choices regarding reproduction have existed in other countries where population and family planning programs have put lowering fertility rates above ensuring informed choice. However, conservative Guatemalan governments have gone to the other extreme in refusing to provide access to voluntary family planning services and to provide information to women so that they can make informed choices and avoid unwanted pregnancies. These governments have ignored the realities of women's lives: pregnancies that occur too early, too late, too frequently, and when women simply do not want to have a child can have grave consequences. Such pregnancies threaten women's lives, their health, and their ability to contribute to the economic, political, and social lives of their communities other than by bearing children.

Elections were held in Guatemala in November 1999. The new government, led by President Alfonso Portillo, should prioritize enacting an adequate legislative and policy framework to ensure its citizens' right to family planning information and services.

Objectives

This report seeks to demonstrate that the Guatemalan government has fallen woefully short in meeting its international human rights obligations related to the provision of family planning services and information. It examines in some depth the reality in Guatemala: the prevailing socio-economic indicators; how the government provides reproductive health care; the inadequacy of existing laws and policies that deal with reproductive health, yet fail to adequately integrate family planning services and information; and the existing consensus among all segments of the Guatemalan population concerning the need for such services and information. The report then establishes the government's responsibility under both international human rights law and under national law for addressing its citizens' right to family planning services and information, as well as other human rights implicated such as the right to be free from discrimination on the basis of gender and race.

This report does not endeavor to define the precise content of the legislative and policy framework needed to better address the need for family planning services and information in Guatemala. In fact, as discussed in Chapter II of this report, cabinet-level ministers undertook to define the necessary framework in 1998, but their draft policy was apparently dropped for political reasons. Indeed, there is adequate expertise in Guatemala to develop and implement such a legislative and policy framework. What is needed is political will and an understanding of how lack of action severely impacts the lives, health, and well-being of the majority of Guatemala's population and violates their fundamental human rights.

Given Guatemala's turbulent history, including its recently ended civil war, human rights advocates in Guatemala have had limited ability to focus on health issues, including reproductive health issues. Guatemalan and international women's rights and health advocates routinely lament how far behind Guatemala is in terms of reproductive health, as well as women's equality — even within the relatively conservative region of Latin America. By identifying as a violation of human rights the government's failure to adopt an appropriate legal and policy framework, and linking it to other poor social and economic indicators plaguing the majority of Guatemalan women, it is hoped that this report may serve as a catalyst for further advocacy efforts among human rights, women's rights, and health advocates. It is crucial that governments, like that of Guatemala, that blatantly disregard any facet of the inalienable human rights of their citizens be exposed for failing to make reasonable efforts, especially in the face of a clear consensus from all but the most ultra-conservative groups.

Methodology

This report is based on research undertaken in Guatemala during a 10-week period from October through December 1998. The researchers' aim was to acquire as complete a picture as possible of the Guatemalan government's efforts to date to ensure the provision of family planning information and services to Guatemalan women. The authors, particularly Ms. Jones, interviewed many individuals involved in reproductive health issues in Guatemala (see *Acknowledgements* above). In addition to these interviews, the authors conducted in-depth research on all known governmental policies, research studies, and other written sources of information on reproductive health in Guatemala.

While the authors were as thorough as possible in their research, this report does not purport to be an empirical study of the provision of family planning. Nor does it employ a traditional human rights "fact-finding" methodology by documenting particular instances of malfeasance of the government in meeting the family planning needs of particular women. Rather, it

uses the information gathered through documents and interviews as a basis for concluding that the Guatemalan government is not meeting its obligations under international human rights standards to undertake reasonable efforts to promote and protect the human rights of its citizens to family planning information and services.

All English quotations from Guatemalan government documents are the authors' own translations from the original Spanish.

**Addendum to this Report:
Recent Legislative and Policy Developments**

Since the research and initial drafts of this report were finalized, preliminary measures have been taken by Guatemala's government indicating a loosening of its past resistance to ensuring access to family planning information and services for all citizens. However, because so little time has passed, further evaluation of these measures and their implementation is needed before positive conclusions can be drawn. These steps do not encompass the magnitude of legislative and policy initiatives necessary to ensure the right to family planning information and services. For further information and a description of these measures, please see Annex I at the end of this report.

Executive Summary

A persistent problem impacting the vast majority of Guatemala's people is the government's long-standing policy position against making family planning information and services generally available within public health services. This hostility to the provision of family planning information and services disproportionately affects women living in rural areas, particularly indigenous women. As shown in numerous studies, these women are much less likely to have the knowledge, the economic means, and the ability, given the prohibitive distances and linguistic and cultural differences, to seek out non-governmental health providers to help them to control their reproductive capacity, despite their expressed desire to do so. In a low-income country such as Guatemala, where the majority of the population lives in poverty and has limited or no access to education, the government's applicable policies and programs related to family planning are significant determinants of whether individuals are able to exercise their rights to such services and information. As this report will show, the government's hostility to the provision of family planning services and information compromises the health, well-being, and reproductive autonomy of Guatemalan women and constitutes a violation of Guatemalans' human rights.

Despite limited financial resources, the government cannot abdicate responsibility for adopting laws or policies to protect the human rights of its citizens, both to family planning information and services, and to be free from discrimination on the basis of sex and race.

This report places this issue in the larger context of the government's predominant role in the provision of health care and the impact of its failure to adopt an appropriate legislative and policy framework to incorporate family planning services and information into the public health care system. The report does not seek to identify specific instances of the government's intentional deprivation of women's right to access care and information, but rather demonstrates the government's failure to establish a legal and policy framework that minimizes certain outcomes. For example, many indigenous women express a desire to space or delay births, but become pregnant anyway because: (1) they lack a basic understanding of their fertility; (2) they are unaware of both natural and modern methods of contraception; and/or (3) they have limited or no access to a range of methods. By synthesizing research clearly showing the pressing need for family planning information and services, particularly among rural, indigenous women, the report demonstrates how this failure constitutes a violation of the government's obligations under its own laws and under numerous human rights instruments. Despite limited financial resources, the government cannot abdicate responsibility for adopting laws or policies to protect the human rights of its citizens, both to family planning information and services, and to be free from discrimination on the basis of sex and race.

Finally, the report presents a number of recommendations for the Guatemalan government, international agencies and donors, and non-governmental organizations (NGOs). NGOs in particular have a crucial role to play in pressing for greater government accountability for the provision of family planning services and information.

A. The Government's Obligation to Ensure Access to Family Planning Information and Services for All Its Citizens

The right of all couples and individuals to have access to family planning services and information is well-established under international human rights law. This right consists of a composite of both the right to health, including reproductive health, and the right to reproductive self-determination. Further, the right of both women and indigenous people to be free from discrimination in all aspects of their lives, including in matters related to access to health care and other government services, is also internationally protected. These rights are explicitly articulated in human rights treaties and instruments to which Guatemala is bound, such as the Universal Declaration on Human Rights (Universal Declaration), the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant), the International Covenant on Economic, Social and Cultural Rights (Economic and Social Rights Covenant), the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention), the Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Rights of the Child (Children's Rights Covenant).

In addition, there are several major regional human rights treaties to which Guatemala is also a party. These include the American Convention on Human Rights (American Convention) and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará). Such treaties also support the right of all Guatemalans to access family planning information and services and the right of indigenous people and women to be free from discrimination in the provision of health services.

While some international human rights instruments recognize that governments may need to

Demographics

- Guatemala has a population of 12,335,580 inhabitants as of 1999.³
- Forty-three percent are below age 15.⁴
- Sixty percent of the population lives in rural areas⁵ and 87% of that group lives in communities of less than 500 inhabitants.⁶
- The annual population growth rate in 1999 was approximately 2.68%.⁷
- Seventy-five percent of Guatemalans live in poverty and 58% in extreme poverty.⁸ Poverty and extreme poverty are highest among rural and indigenous communities.⁹
- Indigenous groups in Guatemala constitute 44% of the population (*mestizos* comprise the rest).¹⁰

Health

- Life expectancy at birth is 66.5 years. Life expectancy for women is about 70 years and for men, 63.8 years.¹¹ This is one of the lowest life expectancies in Latin America, with high rates of mortality from preventable ill-

nesses, violence and accidents.

- Seventy-two percent of indigenous Guatemalan children are malnourished, as are two-thirds of pregnant or lactating women.¹²
- Almost 60% of Guatemalans - mostly indigenous women and children - do not have access to health services.¹³
- Almost one third of people using the public health systems in Guatemala live 12km, or two hours, from the nearest facility. Only 60% of the system's medical equipment fully functions - 25% does not operate reliably and 15% is inoperable. Thirty-seven percent of the facilities are in very poor condition and 28% are closed.¹⁴
- The government invested 3.2% of GDP in health care between 1990-1997.¹⁵

Reproductive Health and Family Planning

- The maternal mortality rate is 190 per 100,000 births¹⁶ and infant mortality is 45 per 1,000 births.¹⁷

phase in implementation of certain human rights obligations requiring relatively significant financial resources, such as the right to health care, it nonetheless is accepted widely that governments must take concrete steps forward and act expeditiously and effectively toward full realization of the right in question.

In the early 1990s, several major United Nations conferences, particularly the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (Beijing Conference), produced consensus agreements that reinforced governments' obligations under other human rights instruments to promote and protect the rights to family planning services and information, and detailed the actions governments should take to carry out their obligations. While Guatemala entered reservations to the final documents agreed to by consensus at these conferences, its reservations did not affect the government's obligations under its own laws and international human rights treaties to which it was already legally bound.

In terms of domestic law, the Guatemalan government has not properly implemented its obligations to its citizens under the Guatemalan Constitution and the 1996 Peace Accords that formally ended Guatemala's Civil War. The Peace Accords address the human rights of indigenous groups and require governmental reforms in the areas of health, education, social services, and women's rights. Yet the government has been slow to implement policies and programs that would have a measurable impact on the well-being of indigenous women, such as a comprehensive reproductive health policy encompassing the provision of family planning services and education in a culturally appropriate manner. Both Guatemalan law and the international human rights instruments, to which Guatemala is a party, obligate the government to take steps to fulfill the right to family planning services and information and the right to be free from discrimination on the basis of sex and race.

- Health professionals attend only 35% of births.¹⁸
- Sixty-five percent of Guatemalan women give birth at home and 34% receive prenatal care from a traditional birth attendant.¹⁹
- Fifty-four of pregnant women receive prenatal check-ups from trained staff.²⁰
- The fertility rate varies widely - from 3.8 among urban *mestizo* women to 6.8 among rural indigenous women.²¹ The overall fertility rate is 5.0.²²
- Thirty-eight percent of married or cohabiting women use some form of contraception,²³ and only 26% use a modern method.²⁴
- Although 69% of all women know of a family planning method, only 15% use one. Sixty-four percent know how to access them.²⁵ While 61.3% of women in relationships do not want to have more children, only 38.2% use contraception.²⁶
- In 1998, contraceptive use rose 3.7% for modern methods and 2.5% for traditional methods.²⁷

- Complications from abortion are the second most common cause of death among women in Guatemala.²⁸
- For every ten pregnancies there are three abortions.²⁹
- Thirty-two percent of children are born before their brother or sister reaches the age of two.³⁰

Situation of Women

- In Guatemala, gender violence has caused more deaths and disabilities among women between 15 and 44 years of age than is caused by cancer, malaria, traffic accidents, or even war.³¹
- Forty-nine percent of Guatemalan women are victims of domestic violence.³² In the majority of these cases, women suffer physical injuries such as broken or fractures bones or loss of hearing.³³
- In 1998, 63.9% of the Guatemalan population participated in the formal labor market, but only 27% of women participated.³⁴

B. Continued Government Hostility to the Provision of Family Planning Services and Information

Context

Numerous studies have found low levels of accurate knowledge in Guatemala about modern and natural family planning methods, as well as the female reproductive cycle. Rural and indigenous women have significantly less knowledge of such matters than do urban populations and *mestizos* (people of mixed Spanish and indigenous descent). Contraceptive prevalence is low, with about 30% of women of reproductive age ever having used any contraceptive method. Over 40% of *mestiza* women use some form of contraception, while less than 10% of indigenous women do. Moreover, 24.3% of women have an unmet need for family planning methods. The majority of the population desires greater access to family planning information and services and believes that the government should support that access.

On the other hand, the Catholic Church's opposition to modern family planning methods discourages many Guatemalans from using or seeking information about family planning. Related to this, and often encouraged by the Church, is the fear of some indigenous peoples that *mestizos* may promote modern family planning methods as a means to reduce or exterminate the Mayan population.

The reality of Guatemalan women's lives is characterized by pervasive discrimination in the economic, political, educational, and health spheres, as well as within the family. For example, patriarchal attitudes among males make it extremely difficult for women to access reproductive health and family planning services without their partner's approval. Gender discrimination in its many forms, including in the provision of health care, is only beginning to be recognized.

Adolescents

- Seven in ten Guatemalan children are victims of maltreatment or sexual abuse.³⁵
- Forty-two percent of Guatemalan children under the age of five suffer from malnutrition. This percentage is the highest in Latin America. In Haiti, the figure is 32%; in Bolivia and Perú, 26%.³⁶
- For every 1,000 births, 119 are to girls between 15 and 19 years of age.³⁷
- It is estimated that 5,994 children live on the streets of Guatemala City. Of these children, 95% are drug-addicted and 5% become mothers while living on the streets.³⁸

Education

- The average Guatemalan attends 3.2 years of school, and in predominantly indigenous areas, the figure is even lower.³⁹
- Only 50% of girls in rural areas have attended school at all.⁴⁰

- The illiteracy rate is 44.4% for persons over age 15 nationwide and over 60% among indigenous people. For women, the illiteracy rate is 61.2%. For men, it is 47.5%.⁴¹
- The government invests 1.7% of GDP in education, one of the lowest rates in Latin America.⁴²
- The crude matriculation rate for primary school is 88%. The crude matriculation rate for secondary school is 24.8%.⁴³

Religion

- Approximately half of all Guatemalans are Catholic.⁴⁴
- Almost 30% of Guatemalans are affiliated with Evangelical protestant religions.⁴⁵
- The remaining 20% of the population follow traditional Mayan religions or claim no religious affiliation.⁴⁶

Recently, for example, there have been some reforms of the country's Civil Code and nascent attempts to address such issues as endemic domestic violence. Neither the government nor most sectors of civil society have accepted yet that women's ability to control their fertility is basic to their well-being and empowerment.

The land that is now Guatemala has been inhabited by Mayans for thousands of years, and Mayans and other indigenous groups still comprise 44% of the population. Fifty-six percent of the country's population is made up of *mestizos*. The distribution of land, power, and social status in the country have long been extremely unbalanced, and indigenous people have generally had little or none of the three. Human rights violations against indigenous people in the civil, political, economic, social, and cultural spheres have been, and continue to be, pervasive.⁴⁷ The Peace Accords address the rights and identity of indigenous groups and affirm the emergence of Guatemala's indigenous people as a strong social and political force in the nation. The challenge in this regard is formidable: 92.6% of the indigenous population lives in poverty and of that, 81.3% lives in extreme poverty. In largely indigenous areas of the country, the rate of illiteracy is over 60%.

Current Health Care Policies and Programs of Government

Lack of access to health care is a major problem for Guatemalans living in poverty. The public health sector covers only about 40% of the population — 25% through the Ministry of Public Health and Social Services (MSPAS) and 15% through the social security system. Despite the great need of its citizens, the Guatemalan government largely has failed to provide even basic health information and services to much of the population. The government has failed to create and fund programs providing health care at local levels and has failed to involve the communities in such programs. In addition, it has not adequately leveraged the provision of health information and education as a means of both enabling the exercise of human rights and promoting good health.

The centrally administered health system is comprised of hospitals, health centers, and health posts. Reproductive health care is provided at all three levels through MSPAS's National Maternal Infant Program, the primary goal of which is to improve maternal and infant health indicators mainly through prenatal, birth, and postnatal care. At least some modern family planning methods are generally available at all three levels of services, but with a widely varying range. Long-term methods are often unavailable at health posts and centers. The current *unwritten* policy of MSPAS with respect to family planning is to provide available methods *only upon the request of the client*. There is no department-wide policy regarding the provision of family planning information, *except* in the context of post-partum care in public facilities. As a result of the lack of a department-wide policy addressing family planning for all women of reproductive age, the availability and quality of counseling in both natural and modern methods of family planning is often deficient and largely depends upon the education and attitudes of the particular providers.

MSPAS provides significantly fewer contraceptives than does the private sector. The Guatemalan Association for the Well-Being of the Family (APROFAM), Guatemala's largest non-profit family planning provider, distributes about 36% of the contraceptives used in the country. In contrast, the entire public sector, including the social security system, provides about 25%. Moreover, the public sector distributes most contraceptives from hospitals — less than 5% of contraceptives distributed by the public sector were distributed outside of hospitals. This means that the government provides very few contraceptives outside of major urban areas.

Guatemala's social security system provides only limited services to workers and, in some cases, their spouses. Among the few social security services for women are those related to pregnancy. The system recently began to offer family planning counseling and referrals for those who seek pregnancy-related care, but it does not provide contraception to clients.

In recent years, the government of Guatemala has recognized some of the pressing problems with its provision of health care — in part due to its obligations under the Peace Accords — and has attempted to formulate policies and programs addressing them. The country's new Health Code gives MSPAS greater power to ensure that the population's health needs are met through the private, non-profit, and public sectors. Several new programs aim to improve health care through increased community-based care, health education, and access to health services. However, these programs inadequately address the provision of family planning services and information. To the limited extent that MSPAS programs make family planning available, the strategies seek only to reduce maternal and infant mortality rates thus failing to promote access to family planning information and services for all women of reproductive age. Nor do these programs address women's right to make autonomous decisions concerning reproduction.

Guatemala's Lack of a Law or Policy Addressing Family Planning Access

Several attempts have been made to implement a policy addressing reproductive health needs, including the need for family planning. In 1993, the Congress passed a law to address population, reproductive health issues, and greater gender equality. Despite some significant progressive aspects, the President vetoed the law. It was deemed by many, including some women's, civil rights, and indigenous groups, as well as Catholic organizations, to be inappropriately focused on population stabilization. Under the subsequent administration of President Arzú, a lengthy process of input from all sectors of society led to a consensus favoring adoption of a national reproductive health policy. A draft was written and its adoption seemed imminent. However, in 1998, the draft, "National Policy on Safe Sex and the Formation of Responsible Family Life, 1998-2008" was suddenly shelved for political reasons, apparently due to the disproportionate influence of conservative elements. Guatemala's new government, elected in 1999, has not yet announced new legislative or policy initiatives in this area.

Thus, the government has failed to adopt a law or policy addressing comprehensive reproductive health, including family planning, needs. Moreover, its attempts to address family planning in existing MSPAS programs have also fallen short. In both cases, one problem is the government's failure to build public trust in its ability to provide family planning services and information by emphasizing the individual's freedom to make choices. By focusing exclusively on goals rather than on rights — whether on lowering maternal and infant mortality rates or stabilizing population — the government has exhibited an unwillingness to commit to meeting its citizens' demands for the provision of family planning information and access to voluntary services, and therefore to comply with recognized human rights instruments to which it is a party.

C. Recommendations: Towards Protection of the Human Right to Family Planning in Guatemala

Because of the governmental failures outlined above, Guatemala is currently violating the human and constitutional rights of its citizens. The start of a new administration is a crucial moment to seize for those within the government, national-level NGOs, and international agencies and donors concerned about lack of access to family planning services and information. Such individuals and groups should use existing mechanisms at the national, regional, and international levels to effect much-needed legislative and policy changes, and to ensure full implementation of these changes, including the allocation of appropriate resources.

Guatemalan NGOs in particular have a crucial role to play in catalyzing support for the adoption of a law or policy addressing family planning services and information. Moreover, international donors and agencies must allocate more resources to their own and to NGO efforts to foment change in this area.

However, it is first and foremost the responsibility of those in government to see that citizens' human rights are protected. The following are recommendations that Guatemalan government officials and agencies should undertake, in collaboration with national-level NGOs and international agencies and donors:⁴⁸

- Enact legislation that firmly establishes the provision of modern family planning services and information as an integral component of government-provided comprehensive reproductive health services for all Guatemalans, particularly adolescent girls and women of reproductive age at all levels.
- Develop executive branch policies and programs that fully integrate modern family planning services and information into all existing government health initiatives with the participation of local communities and women's rights organizations in the development, implementation, and assessment of such policies and programs.
- Ensure that all government programs seek not only to provide services, but to empower individuals to make decisions concerning their lives and health. Various studies demonstrate that Guatemalans want to receive family planning information and services from within their communities. Thus, implementation of a family planning law or policy should be part of increased efforts by the government to train indigenous and rural Guatemalans to provide health services and information within their own communities.

In the absence of comprehensive legislative, policy, and programmatic reforms to improve access to family planning information and services, the following government agencies and employees should undertake these steps:

- The Public Prosecutor should institute an investigation *proprio motu* pursuant to his or her power under the Human Rights Commission Law. The Public Prosecutor could issue recommendations regarding the need for the legislative and executive branches to enact appropriate laws and policies that better ensure access to family planning services and information for all Guatemalans, including indigenous people and all those living in rural areas.
- The Public Prosecutor or Attorney General should consider filing a writ of *amparo* regarding the violation of the right to family planning information and services. Alternatively, either official could consider bringing a constitutional action regarding the government's failure to protect citizens' right to family planning information and services.
- Those in government who are sympathetic to the need for better access to family planning services and information should use the discretion they have under existing policies and programs to provide unbiased information about family planning and about the right of each individual to determine the number, spacing, and timing of her or his children. Such officials can play a crucial role in increasing the popular demand for enhanced government efforts, including the adoption of a law or policy, to ensure increased access to and knowledge about family planning for all.

The mandates of regional and international human rights bodies, aided by information from national-level NGOs and international agencies, empower them to play a constructive role in addressing the lack of access to family planning information and services:

- As an international body charged with promoting peace, human rights, and non-discrimination, the UN Human Rights Verification Mission in Guatemala (MINUGUA) should play a greater role in ensuring that all Guatemalans' have access to family planning information and services and that an appropriate legislative and policy framework is in place.

- The Inter-American Human Rights Commission should obtain information on measures taken to implement Guatemalan citizens' right to family planning services and information, both from the government itself and from NGOs and international agencies. The Commission should then include recommendations on this issue to encourage Guatemala to fulfill its human rights obligations, including through the implementation of an adequate legislative and policy framework to ensure better access to family planning by all citizens.
- The Inter-American Commission should interpret the American Convention and the Convention of Belém do Pará to encompass the human rights violated by the Guatemalan government's failure to adequately ensure its citizens' access to family planning services and information.
- The UN Human Rights Commission and the Sub-Commission should consider adopting a resolution that addresses inadequate efforts to ensure the rights of women, particularly rural women and indigenous women, to access family planning information and services in Guatemala, as well as in other countries.
- The Human Rights Commission should consider appointing a Special Rapporteur to study the theme of inadequate access to comprehensive reproductive health care, including family planning information and services, and its far-reaching impact on women's social, economic, and political status in countries like Guatemala.
- The existing Special Rapporteurs should examine the human rights of women in Guatemala, including in particular their lack of access to family planning information and services and the lack of an adequate legislative and policy framework to better ensure such access. When necessary, they should request information from NGOs based in Guatemala to supplement the information received from official sources. They should underscore Guatemala's obligations under existing human rights treaties and their duty to better implement these obligations in any reports or recommendations they issue.
- The Human Rights Committee, the Committee on Economic, Social and Cultural Rights (Economic and Social Rights Committee), CEDAW, the Committee on the Elimination of Racial Discrimination, and the Children's Rights Committee should use the occasion of Guatemala's periodic reports to reinforce the government's obligation to ensure access to family planning services and information to all citizens under relevant treaty provisions. The Committees should issue strong observations condemning the government's inadequate efforts and recommend that specific measures be adopted immediately to ensure that all citizens can realize their right to access family planning information and services, including the adoption of appropriate legislation, policies, and programs.

General Background On Guatemala

A. Population and Demographics

Guatemala is a small country with a surface area of 108,889 square kilometers, which is divided into 22 departments, and further subdivided into 330 municipalities.⁴⁹ It has a population of approximately 12.3 million people,⁵⁰ and a population growth rate of 2.68% per year.⁵¹

Guatemala's people come from a diverse variety of ethnic groups. The land that is now Guatemala has been inhabited by Mayans for thousands of years, and Mayans and other indigenous groups still comprise 44% of the population.⁵² There are approximately 21 distinct indigenous groups, classified according to the language spoken in their communities, the largest being the K'iche' and Kaqchikel. Approximately 32% of the indigenous population can speak only a Mayan language.⁵³ Spaniards colonized Guatemala in 1524, and today 56% of the country's population is made up of people of mixed Spanish and Indian descent who are known as *mestizos* (sometimes referred to as *ladinos*).⁵⁴ Two other small ethnic groups also presently occupy Guatemala: the indigenous Xinca and the Garifuna. The latter are descendants of African slaves who intermarried with Indians of St. Vincent, indigenous people of Guatemala, and people from other races, and who developed their own language and culture along the coasts of Guatemala and Belize.

The population of Guatemala is very young, with 43% under the age of 15 and only 3% over the age of 65.⁵⁵ Approximately 60% of the population lives throughout the rural areas of the country,⁵⁶ and of that group, 87% lives in communities of fewer than 500 inhabitants.⁵⁷ The rest of the population lives in the metropolitan area of Guatemala City.

B. Recent History and the Peace Accords

Guatemala's history is largely one of exploitation, conflict, and repression. The distribution of land, power, and social status in the country has long been extremely unbalanced. Indigenous people have generally had little or none of the three, owing in large part to racist attitudes and other colonial legacies.⁵⁸ Although there were brief governmental efforts to reform some of these inequities in the 1940s and 1950s, they were thwarted by large landowners, including the United Fruit Company. In 1956, President Jacobo Arbenz, a democratically-elected president, was overthrown in a military coup supported by the United States.⁵⁹

After the overthrow of Arbenz, Guatemala was governed by a string of military leaders, who made political violence and military repression commonplace and who disenfranchised the majority of the population by requiring that voters be literate. In the face of these events, the poor of Guatemala formed guerrilla groups to fight for their interests, and the country's 36-year civil war began.⁶⁰

As a result of the violence of the government, right-wing paramilitary forces, and the reform-minded guerilla groups, it is estimated that over 200,000 Guatemalans were killed or "disappeared," the vast majority of which were Mayan. The military repression of the anti-governmental groups was at its worst point in the early 1980s, when the government's "scorched earth" policies resulted in the displacement of 500,000 to 1.5 million persons. More than half the massacres occurred at this time.⁶¹ In 1985, a new constitution was written and the first free elections in 30 years took place.

In March 1994, after a long negotiation process, the Comprehensive Agreement on Human Rights was signed between *La Unidad Revolucionaria Nacional Guatemalteca* (URNG), comprised of four guerilla organizations, and the government of Guatemala. This was followed by the establishment of a UN-sponsored human rights verification mission in Guatemala (MIN-UGUA) to verify the compliance and implementation of the agreement.⁶²

In late 1996, the URNG and the government of Guatemala finally signed a series of comprehensive agreements (the Peace Accords) that put an end to Guatemala's civil war. In addition to formally ending armed hostilities, the Peace Accords call for accountability for the human rights violations committed during the war; address the rights and identity of indigenous groups; and require reforms in the areas of health, education, social services, and women's rights.⁶³ Of particular note in the Peace Accords is the extent to which they affirm the emergence of Guatemala's indigenous people as a strong social and political force in the nation.⁶⁴

C. Health Conditions and Indicators

Guatemala's health indicators are relatively poor in comparison to other Latin American countries.⁶⁵ The life expectancy of Guatemalans at birth is 66.5 years, while 11 Latin American countries have life expectancies of 70 or more years.⁶⁶ Due to the extremely poor living conditions of much of the population,⁶⁷ and lack of access to health services, much of Guatemala's mortalities are caused by infectious, preventable illnesses such as malaria, dengue, cholera, and respiratory infections.⁶⁸

Poor health among Guatemalans is also caused by high rates of malnutrition, which is particularly severe in children and pregnant women. Government reports indicate that 58% of all Guatemalan children between three months and three years of age are malnourished; among indigenous children, the rate is 72%.⁶⁹ Similarly, two thirds of pregnant or lactating women suffer from malnutrition.⁷⁰

Guatemala's maternal and infant mortality rates are also relatively high, with the maternal mortality rate at 190 per 100,000 births,⁷¹ and the infant mortality rate at 45 per 1,000 live births.⁷² Moreover, the government acknowledges that 70% of the infant and maternal morbidity and mortality in the country could be prevented with the appropriate resources.⁷³ Many women receive whatever medical care they get in relation to pregnancy and birth from outside of the public health system. Thus, 34% of pregnant women get their prenatal care from a traditional birth attendant (TBA) and 59% of women give birth at home with the assistance of a TBA, friend, or relative.⁷⁴ Abortion is criminalized in virtually all circumstances in Guatemala,⁷⁵ therefore large numbers of women resort to unsafe abortion, which causes significant injuries and deaths every year.⁷⁶

The fertility rate among all Guatemalan women averages 4.7 children,⁷⁷ but vacillates greatly in different ethnic groups and areas of the country. For example, among *mestizo* women the fertility rate is 4.6 and in urban areas it drops to 4.1,⁷⁸ while among rural women and indigenous women, the rate rises to 5.8 and 6.2, respectively.⁷⁹

D. Poverty and Economic Distribution

Although Guatemala is a country with many natural resources and a rich cultural history, its persistently unequal distribution of wealth has left the great majority of its people in poverty.⁸⁰ According to 1989 figures, the wealthiest fifth of Guatemala's population holds approximately 60% of the country's wealth, while the bottom fifth holds only 3%.⁸¹ As a result of this unequal

distribution, almost 75% of the population lives in poverty, with 58% living in extreme poverty.⁸² Alarming, these rates rise to 92.6% and 81.3%, respectively, in the indigenous population of the country.⁸³ Guatemala's wealth is also inequitably distributed geographically, with 78% of the extremely poor living in rural areas and only 22% in urban areas.⁸⁴

The causes of Guatemala's high levels of poverty are multifold and include:

The great inequity in the distribution of resources, low salary levels and the slow and insufficient increases in salaries, the high rates of underemployment and unemployment, particularly the former, the low levels of education and training of workers, the concentration of land ownership, the high levels of inflation during certain periods, the low levels of capital investment, and the reduction in real terms of the government allocations of resources to the social sectors.⁸⁵

The result of such high poverty is that many Guatemalans spend much or all of their energy trying to survive and ensure the survival of their families. Consequently, the individual's sense of control over his or her life and the individual's opportunities for human social development are both extremely low.⁸⁶

E. The Current Unmet Need for Family Planning Information and Services

Much of the Guatemalan population lacks an accurate understanding of and access to contraceptive methods, both modern and traditional. In recent surveys, many Guatemalans indicate a desire to limit or space births. In short, the need for family planning information and services in the country is unmet.

Numerous studies have found low levels of accurate knowledge in Guatemala about modern and natural family planning methods, as well as the female reproductive cycle.⁸⁷ In addition, the knowledge of family planning that does exist correlates with demographic factors. Rural and indigenous populations have markedly less knowledge of such matters than do urban populations and *mestizos*.⁸⁸

Contraceptive prevalence in Guatemala is low, with only about 38% of women of reproductive age ever having used a contraceptive method, and only 34% ever having used a modern method.⁸⁹ Approximately 26.6% of women currently use some method of contraception, with 21.7% using modern methods of contraception and approximately 4.8% using natural methods.⁹⁰ These figures differ significantly between ethnic groups: over 49% of *mestizo* women use some form of contraception, while only 12.9% of indigenous women do.⁹¹

Modern contraceptive methods are largely obtained from non-governmental sources, and only about 25.2% are obtained from the public sector.⁹² The largest provider of modern methods is the private NGO APROFAM, which distributes over 36.5% of contraceptives in the country, including a significant portion of each of the methods commonly available — the pill, IUDs, injectables, condoms, female sterilization, and male sterilization.⁹³ Public health facilities vary greatly in the variety of methods they offer, and often several methods are unavailable.⁹⁴ In 1998, for example, public hospitals distributed 0.8% of all injectable contraceptives used and 0.3% of condoms, health posts offered 0.7% of the IUDs and no condoms, and public hospitals and the Guatemalan Institute for Social Security (IGSS) distributed a total of 3.1% of the contraceptive pills used in the country.⁹⁵ In addition, 91% of the women who did not use contraceptives had neither been visited by a family planning worker, nor had they visited a health facility to discuss family planning methods.⁹⁶

Despite the population's lack of knowledge and use of contraceptives, numerous studies conclusively show a significant desire for more information about, and access to, contraceptive methods.⁹⁷ These studies contradict popularly held beliefs, that Guatemalan women are opposed to the use of contraception. In fact, surveys conducted by the Guatemalan National Bureau of Statistics indicate that among the 26.2% of all women who are not using contraception and who do not intend to in the future, it is absence of knowledge of a method, or no means to obtain one, which accounts for their lack of contraceptive use.⁹⁸ This figure is more than triple the 7.4% of women who said that they did not use a method because they opposed family planning.⁹⁹ Moreover, almost 74.9% of women approved of the use of family planning methods, including almost 69.7% of rural women and 56.5% of indigenous women.¹⁰⁰ These figures drop somewhat, although not dramatically, for the women who approve such use and also believe that their partner approves such use — about 61.3% generally, 54.2% for rural women, and 39% for indigenous women.¹⁰¹

Although there is a significant need for family planning methods in Guatemala, approximately 23% of that need was unmet in 1998 and 1999. This figure is calculated by taking the percentage of cohabiting women who do not use contraception, who are *not* pregnant or lactating, and who either do not desire more children at all or do not desire more children within the next two years,¹⁰² and combining that figure with the percentage

Despite the population's lack of knowledge and use of contraceptives, numerous studies conclusively show a significant desire for more information about, and access to, contraceptive methods.

of women in union who do not use contraception and *are* pregnant or lactating, but whose last pregnancy was either unwanted or was desired but at a later time.¹⁰³ Using this formula, the level of unsatisfied need for family planning methods rises to approximately 30% for both rural women and indigenous women.¹⁰⁴

Cultural barriers pose a significant obstacle to information and services for women who may wish to limit or space births, thus contributing to unmet need. The government's failure to adopt laws, policies, and programs to ensure access to services and information serves to reinforce cultural barriers that discriminate against women — especially indigenous women.

First, Guatemala is a highly patriarchal society, and women to a large extent are considered to be the property of the men with whom they are in relationships. As a result, they have a difficult time seeking and using family planning information and services if their partner opposes it.¹⁰⁵ Male opposition has various causes: it may arise from fears that if a man does not have many children, he is not virile; it may arise from a man's attempt to ensure the fidelity of his partner by preventing her from controlling her fertility; or it may arise from a religious or other belief about family planning methods.¹⁰⁶

A second barrier to women's ability to limit family size is the Catholic Church's opposition to modern family planning methods, which influences the decisions of many Guatemalans regarding whether to seek information about, and to use, such methods.¹⁰⁷

Another barrier is that Mayan women are generally very private with their bodies, and both they and their husbands may dislike the idea of a male provider examining the woman.¹⁰⁸ In such an examination, there is the potential for both feelings of shame on the part of the woman and of distrust and jealousy on the part of her husband.¹⁰⁹ Unfortunately, the government's health care facilities have not responded well to these concerns, and often have failed to provide adequate privacy for clients during examinations and consultations.¹¹⁰

Moreover, some Mayan women believe strongly in the relationship of trust that they have with a TBA, and believe that such trust does not exist with doctors in government facilities.¹¹¹ In addition, because Mayan women traditionally have used TBAs for prenatal and birth assistance, young women are sometimes discouraged by their mothers or mothers-in-law from going outside the community to use the government's health services.¹¹² Finally, some Mayans fear that *mestizos* promote modern family planning methods in their communities as part of an effort to reduce or exterminate the Mayan people.¹¹³ All of the above cultural factors may result in women's desire for a means to limit or space births going unmet.

F. Legal and Social Status of Women

In general, Guatemalan women have little room to make decisions, pursue opportunities for personal development, or exercise their individual autonomy in their families or society.¹¹⁴ *Mestizo* culture historically has been patriarchal and "machista,"¹¹⁵ and "many of [its] most negative elements have been superimposed on the Mayan cultures."¹¹⁶ These cultural norms, and the marginalization they produce, continue today,¹¹⁷ and Guatemalan women face prevalent discrimination in the economic, political, educational, and health aspects of their lives.¹¹⁸ For indigenous women, who are subject to the double burden of discrimination as women and as indigenous people, unequal status results in heightened vulnerability and exploitation.¹¹⁹

In addition to this discrimination outside the home, many Guatemalan women face additional burdens within their families. Men are traditionally taught and enabled to play the dominant role in the family, while women are expected to be submissive and obedient.¹²⁰ Closely related to this is the fact that domestic violence is a significant and widespread problem in the country,¹²¹ and one for which the legal system has only recently begun to offer recourse.¹²² Further, women's responsibilities within the family are heavy, and frequently amount to a double or triple workday, involving childcare and education, housecleaning and cooking, and care for ill or elderly family members — as well as participation in income generation or food production.¹²³

Until very recently, discrimination against women also pervaded the legal system. For example, until 1996, the Penal Code contained discriminatory provisions penalizing women more severely than men for adultery. That year, the Constitutional Court of Guatemala ruled these provisions unconstitutional as a result of a lawsuit brought by women's organizations.¹²⁴ In addition, the country's Civil Code, dating from 1963, was, until recently, riddled with discrepancies regarding the legal status of men and women.¹²⁵ Many of these provisions designate the woman's role in the home and in childbearing, restrict her ability to represent the couple in financial and other matters, and delegate decision-making about joint property to the husband.¹²⁶ The Constitutional Court upheld these provisions in a 1993 decision challenging the repeated unequal and demeaning treatment of women in the Civil Code. The Court held that legalizing differential treatment and different roles for men and women did not violate the constitutional principle of equal rights.¹²⁷ Nonetheless, in November, 1998, Guatemala's Congress reformed the Civil Code, including many of its discriminatory sections.¹²⁸

G. Education, including Sexual Education

The level of education in Guatemala is extremely low, with an average length of schooling among the general population being 3.2 years, and in predominantly indigenous areas only 1.3 years.¹²⁹ In 1998, only about 70% of children aged six through 15 attended school.¹³⁰ Of girls who live in rural areas, 64.2% have attended school.¹³¹ Attendance rates in largely indigenous areas are generally lower than the national average.¹³²

Guatemala's illiteracy rate is the second highest in Latin America and the Caribbean, second only to Haiti's.¹³³ In the country as a whole, 44.4% of persons over 15 years old are illiterate.¹³⁴ Of those, 61% of women and 47.5% of men are illiterate.¹³⁵ In largely indigenous areas of the country, the rate of illiteracy is over 60%.¹³⁶

Guatemala's education system is fraught with problems that include low quality teaching, inadequately trained employees, poor infrastructure and materials, inefficient administration, and few bilingual educators.¹³⁷ In addition, the curriculum generally has little or no relationship to the characteristics and needs of the communities.¹³⁸

Despite the enormity of these challenges, the country has not managed to invest even as much money in education as its neighbors. To the contrary, Guatemala is one of the four Latin American countries that invests the lowest percentage of its GNP in education.¹³⁹ Unlike other Latin American and Caribbean countries (such as Colombia, Honduras, Jamaica, Costa Rica, Venezuela, Panama, Bolivia, Mexico, and Cuba) that invest 4% or more of their GNP in education, Guatemala's investment has remained around 2% or less.¹⁴⁰

Sex education in schools is governed by the Ministry of Education and is not currently included in the programs of the Ministry of Health. To the extent that sex education is offered in schools, it is offered in the late primary grades and high school. As discussed above, however, very few children go to school long enough to reach those grades. In addition, the sex education offered in public schools is rudimentary and does not include discussion of family planning.¹⁴¹ Aside from limited educational efforts in connection with some of its specific health goals,¹⁴² the MSPAS does not currently have any plans to provide sex education for the general public.¹⁴³ To the extent that sex education programs for the public are available, they are provided to a small minority of the population through the efforts of NGOs such as APROFAM and the Guatemalan Association for Sexual Education (AGES).

H. The Role of the Catholic Church and Religion

As in many other Latin American countries, the Catholic tradition is deeply rooted in the culture of Guatemala. In addition, the Catholic Church has had an important role in Guatemala's search for peace and continues to have a significant influence on the general population of Guatemala. The Church played an active role during the civil war years by supporting and protecting the poor, rural, and indigenous people, recognizing their right to have access to education, health services, and land, and to be free from discrimination.¹⁴⁴ However, this strong influence has been detrimental in the area of reproductive rights, where the Catholic Church continues to hold a conservative position opposing modern methods of family planning and promoting the "childbearing" role of women.¹⁴⁵ It continues to use its considerable political influence to ensure that its views prevail in the legislative and policy-making processes.

Although Roman Catholicism is still the predominant religion in Guatemala,¹⁴⁶ fundamentalist Evangelical religions are gaining prominence throughout the country.¹⁴⁷ Nearly 30% of Guatemalans are affiliated with an Evangelical church. Protestant missionaries have worked in Guatemala since the mid-1800s; however, they gained few converts until the 1960s, when Pentecostal Evangelical sects, in particular, began to grow rapidly.¹⁴⁸

I. Failed Attempts to Implement a Law or Policy on Family Planning

The Guatemalan government has not adopted an official policy or law with respect to promoting reproductive autonomy nor providing family planning services and information.¹⁴⁹ Nonetheless, during the last decade there has been a great deal of social discourse about reproductive health and population, including unsuccessful efforts to enact policies addressing those issues.¹⁵⁰ An examination of the country's experiences with those proposed policies provides valuable insight into why the Guatemalan government has not yet successfully integrated family planning services and information into its health programs.

In 1993, a proposed law on population and development explicitly incorporated family planning information and services. It was passed by the Guatemalan congress in 1993, but was subsequently vetoed.¹⁵¹ This law would have created a National Population and Development Council charged and empowered with planning and undertaking actions related to the size, distribution, and structure of the country's population.¹⁵² Thus, the law would have given the government explicit authority to develop population-related goals and policies. In addition to this focus on population stabilization, the proposed law also included a number of measures aimed at ensuring the free exercise of reproductive rights, as well as greater overall gender equity. Specifically, the proposed law charged the Council with the following: (1) promoting the free

An examination of the country's experiences with ... proposed policies provides valuable insight into why the Guatemalan government has not yet successfully integrated family planning services and information into its health programs.

decisions of all persons and couples with respect to the number and spacing of their children, and ensuring the distribution of education and services necessary for such decisions; (2) requiring the MSPAS to provide the facilities necessary to attend to the reproductive health of the population; and (3) promoting women's equal participation, responsibilities, and opportunities in the educational, economic and social spheres of the country.¹⁵³ In addition, the law defined reproductive health care services as "the set of services that seeks to protect, promote, and ensure the health of men and women during their reproductive years through prenatal, child-birth, birth spacing, and gynecological services, as well as through treatments for infertility and the diagnosis and treatment of sexually transmissible infections."¹⁵⁴ Despite these progressive aspects of the law, some women's and civil rights groups ultimately joined the Mayan, Catholic, and other organizations that opposed the law because of its focus on population stabilization.¹⁵⁵ The proposed law conflicted with many Guatemalans' notions of liberty regarding birth spacing decisions and religious beliefs. Supported by this strong public pressure, then-President Serrano vetoed the law in 1993.¹⁵⁶

The Guatemalan government's next significant involvement with the theme of reproductive health took place the following year, in connection with the 1994 International Conference on Population and Development in Cairo, Egypt (ICPD). Preparations for this conference came on the heels of the failed 1993 population law and the related public debate about issues related to population. Conservative religious groups carried that debate into discussions about ICPD by promoting the view that reproductive health policies were equivalent to population-control policies and abortion rights.¹⁵⁷ The conservative government of Ramiro de León Carpio was in

power, and it sent a conservative delegation that included at least one representative from Acción Católica to ICPD.¹⁵⁸ The León Carpio government was heavily influenced by pressures from fundamentalist religious groups with respect to the issues negotiated and the principles agreed to at ICPD. The government ultimately entered reservations to essentially all aspects of the consensus reached at ICPD related to reproductive health and rights.¹⁵⁹

The scenario was much the same the following year, at the Fourth World Conference on Women (Beijing Conference). The Guatemalan government's delegation was extremely conservative on all issues related to reproductive health and rights and entered reservations to the Beijing Platform for Action similar to those entered at ICPD.¹⁶⁰

Political activity in the area of reproductive health and population issues did not reach another significant milestone until the recent presidency of Alvaro Arzú. At the beginning of Arzú's term, there appeared to be great potential for the adoption of a reproductive health policy. Arzú's vice-president, Luis Flores Asturias, took a strong interest in the topic and, in 1996, he directed the Social Cabinet (which directs the MSPAS, the Ministry of Education, and related ministries) to undertake a two-step project in collaboration with the United Nations Population Fund.¹⁶¹ The first phase of the project was a full-scale inquiry into competing social opinions on reproductive health, with the aim of seeking consensus amongst those views.¹⁶² The second stage of the project was the drafting of a reproductive health policy based on the consensus.¹⁶³

To explore the range of views on reproductive health in Guatemala, the Social Cabinet undertook an inquiry involving nearly 1,000 people reflecting the diversity of Guatemala's population, and including both *mestizos* and indigenous people, men and women, religious groups, health care providers, and young people.¹⁶⁴ This representative cross-section participated in workshop discussions that explored the meaning of reproductive health and the elements that a reproductive health policy should include.¹⁶⁵ The perspectives of the participants were then summarized, and the points of both consensus and disagreement recorded in a report of the Social Cabinet.¹⁶⁶ The overall consensus reached was that, to achieve reproductive health, "it is necessary for the population to have knowledge and adequate and reliable information on the issue and access to the necessary means and services."¹⁶⁷ This call for access to information and services pertained to all aspects of reproductive health, including family planning.¹⁶⁸

In 1998, the Social Cabinet, in conjunction with the United Nations Population Fund, completed the second phase of the Vice President's mandate by preparing a draft policy, entitled "National Policy on Safe Sex and the Formation of Responsible Family Life, 1998-2008," and presented it to the Vice President.¹⁶⁹ Shortly thereafter, the effort stalled completely and the draft policy was never released, published, or formally adopted or rejected by the government.¹⁷⁰ On the contrary, after receiving both the report on the societal consensus and the draft policy, the Vice President simply discontinued the project.¹⁷¹

There are a number of theories about why the project was shelved. First, there is a small but powerful contingent of fundamentalist religious groups - including one identified with former President Arzú's sister, Mercedes Arzú Wilson - that oppose wider dissemination of, and education about, modern contraceptive methods.¹⁷² According to a number of people working in Guatemala at the time of the draft policy's completion, there were wide-spread rumors that these fundamentalist groups had pressured the executive branch to drop the reproductive health project.¹⁷³

Furthermore, some reproductive health activists have questioned whether the Government ever truly intended to adopt a reproductive health policy or whether it simply undertook the project to pacify groups that were demanding action in that area.¹⁷⁴

Finally, other political factors at the time may have discouraged the executive from pursuing the proposed policy. When it was delivered to the Vice President, there were controversies swirling over other topics, including a proposed property tax and a proposed law on the rights of children.¹⁷⁵ Regardless of the reason, this proposed policy ultimately went the way of previous efforts to explicitly address reproductive health and rights, including family planning in Guatemala — it was never enacted.

Government Provision of Health Care, Including Reproductive Health Services

A. Delivery of Public Health Services

General Health Care System

The Guatemalan government delivers health services through the MSPAS and the IGSS.¹⁷⁶ The MSPAS provides the majority of care under the public health system, but it reaches only about 25% of the population.¹⁷⁷ The Social Security system, accessible only to those with formal employment, covers about 28% of the economically active population, along with their spouses and young children,¹⁷⁸ and reaches only about 15% of the population as a whole.¹⁷⁹ This section briefly describes the two systems, as well as the services they offer with respect to reproductive health and family planning.

The MSPAS has traditionally provided health care through a three-tiered system of health services governed by a central administration. The three levels of services are comprised of health posts, health centers, and hospitals. Health posts, of which there are approximately 860, are located in villages and small settlements.¹⁸⁰ These posts are usually run by auxiliary nurses or rural health technicians, who are able to offer patients some medicines, evaluation and diagnosis of certain basic conditions, and referrals to higher levels of care.¹⁸¹ Each health post is intended to meet the health needs of approximately 2,000 neighboring residents.¹⁸² The second level of services consists of approximately 350 health centers that are located in the *cabaceras*, or heads of municipalities.¹⁸³ When health posts and health centers are considered together, they are dispersed at a concentration of approximately one facility per 10,000 people.¹⁸⁴ Health centers are usually supervised by licensed nurses or doctors, who are able to offer a greater range of medicines and treatments than do health posts.¹⁸⁵ The third level of attention is provided through 60 hospitals, which are generally located in the *cabaceras* of departments.¹⁸⁶

Reproductive Health Care

Reproductive health care is currently encompassed within MSPAS's National Maternal Infant Program (MI Program), whose goal is to improve maternal and infant health indicators.¹⁸⁷ In previous years, however, MSPAS utilized other programs to address the health needs of women and the particular issues of reproductive risks and birth spacing. Thus, in 1989, MSPAS created a Women, Health, and Development Program that was charged with addressing health problems of women, incorporating a gender perspective into MSPAS's health programs, and training MSPAS personnel with respect to the new gender perspective.¹⁸⁸ Among other activities, this program studied the impact of domestic violence on women's health and the problem of gender discrimination within the health sector.¹⁸⁹ After President Arzú came to power in 1996, MSPAS reorganized its programs and abolished the Women, Health, and Development Program.¹⁹⁰ MSPAS also previously housed a Reproductive Health Unit, which was responsible for coordinating reproductive health services within the public health sector.¹⁹¹ This Unit was short-lived and focused almost exclusively on promoting modern family planning methods, including female sterilization.¹⁹² The Unit's promotion of family planning in isolation from a comprehensive program of maternal and reproductive health put it in disfavor with the general population,¹⁹³ and particularly with fundamentalist religious groups.¹⁹⁴ The Unit was abolished in 1997,¹⁹⁵ when the MI Program was instituted to oversee reproductive health care within MSPAS.

The reproductive health services offered by MSPAS at the three traditional levels of care are quite limited, except with respect to prenatal, birth, and postnatal care. For example, Papanichulou tests for the detection of cervical and uterine cancer are now generally unavailable outside of hospitals.¹⁹⁶ Similarly, tests for the detection of sexually transmissible infections are not available in health posts, but only in health centers and hospitals.¹⁹⁷ Health posts and centers do not provide any testing and treatment with respect to breast cancer.¹⁹⁸

Family Planning Services

At least some modern family planning methods can be obtained at health posts, health centers, and hospitals, but the range of methods varies at different facilities.¹⁹⁹ Thus, for example, many of the long-term methods are often unavailable at health posts and centers,²⁰⁰ while many of the short-term methods are often unavailable at hospitals.²⁰¹ The current, though unwritten, policy of the MSPAS with respect to family planning is simply to provide available family planning methods at each of the three kinds of facilities upon the request of the patient.²⁰² There exists no department-wide policy regarding the initiation of family planning counseling with clients nor the provision of information, except in the context of postpartum care in public facilities, at which time orientation in family planning methods is supposed to be provided.²⁰³

[A]bsent a general policy addressing family planning, the availability and quality of counseling in both natural and modern methods of family planning vary ... and depend greatly upon the education and attitudes of the particular provider.

As might be expected, absent a general policy addressing family planning, the availability and quality of counseling in both natural and modern methods of family planning vary within all three levels of care, and depend greatly upon the education and attitudes of the particular provider. For example, some MSPAS providers have been found to be hesitant to offer women long-term, and in some cases even short-term, family planning methods before they have had one, or sometimes more, children.²⁰⁴ By contrast, in a few areas of the country, personnel in health posts and centers have been trained by the U.S.-based Population Council and MSPAS on the use of a methodology for offering patients services and information related to maternal and infant care, including family planning.

Overall, MSPAS provides significantly fewer contraceptives than does the private sector. While the largest private non-profit family planning group, APROFAM, distributes about 36.5% of the contraceptives used in the country, the entire public sector, including the Social Security system, provides about 25.2%.²⁰⁵ Because the vast majority of the population, particularly in rural areas, receives its primary health care from public facilities, the ability of APROFAM to bridge the vast gulf in unmet need for family planning is limited. It is from hospitals that the public sector distributes the vast majority of the contraceptive methods it does provide, and therefore very few methods are made available by the government outside of major urban areas. In 1998, less than 5% of contraceptives used in the country were distributed through public health centers, posts, and promoters.²⁰⁶

Social Security System

Guatemala's social security system aims to protect the working population of the country through the IGSS.²⁰⁷ The Social Security system is not a comprehensive health maintenance pro-

gram, but rather an outlet for particular types of health services, such as emergency, rehabilitation, and maternal health services. Moreover, not all of these services are available to the spouses of the covered worker.²⁰⁸ In addition, IGSS-administered services are concentrated in Guatemala City, thus limiting the system's ability to serve all those who are entitled to coverage.²⁰⁹

The IGSS primarily provides health services to women in connection with pregnancy.²¹⁰ Within this context, the IGSS has developed a system of offering family planning counseling and referrals to women who come in for prenatal care.²¹¹ However, coverage under this system is limited to counseling and referrals, and the IGSS does not generally provide contraceptive methods to patients.

B. Inadequate Investment in and Quality of Government Health Care Services

The government's provision of health care historically has been deficient in a number of respects. First, the government has not invested adequate funds in the provision of health care, despite its recognition of the need to do so.²¹² The government's investment in health (including investments for water, sanitation, and environment) usually has hovered below only 1.5% of the GNP in recent years,²¹³ and has never exceeded 2.2% of the GNP.²¹⁴ In 1999, the Congress appropriated only 10% of total government expenditures to health.²¹⁵ This trend has had a number of negative effects on the quality and coverage of services.

Modern medical care has failed to reach the majority of Guatemalans, covering only about 40% of the population.²¹⁶ This figure is the lowest coverage rate in Latin America.²¹⁷ Other government sources acknowledge that approximately 46% of the nation's population live in an area where no public or other modern health services even exist.²¹⁸

This lack of health services is most prominent in areas largely occupied by indigenous people.²¹⁹ Although some indigenous people have access to traditional indigenous practitioners,²²⁰ poor health indicators among such groups confirm that traditional practitioners are not meeting all of their health needs, particularly in the area of reproductive health.²²¹ In addition, public health administration and services have been inefficiently and inequitably centralized in the Guatemala City metropolitan area.²²² The capital city is the location of approximately 80% of doctors' practices and almost half the country's hospital beds, yet is home to only about 20% of the population.²²³ As a result, the southeast, northeast, and northern parts of the country, areas which are largely rural and indigenous, receive less than 19% of the MSPAS budget and about 12% of the IGSS budget, even though the population of those areas represents two thirds of the country's population.²²⁴

Even when a public health facility exists in the area surrounding a community, the time and travel distance required to get there often hinder or prevent access.²²⁵ Health posts generally are located only in areas with more than 1,000 inhabitants, yet over 20% of the population live in communities with fewer than 500 inhabitants.²²⁶

According to the Pan-American Health Organization, "[a] study undertaken in seven health districts revealed that more than one third of clients of services provided by the Ministry of Health in rural areas have to travel an average of 12 kilometers or walk at least two hours to reach the nearest health facility."²²⁷

Poverty or a lack of available financial resources further impairs the effects of such distances on access to health services. Although services in public health centers are provided free or at low cost, the costs of transportation and lost work time to reach such facilities can impose a significant financial burden on potential patients.²²⁸

Another result of inadequate investment in health is that public health services have gener-

ally been of sub-standard quality.²²⁹ Endemic problems include low quality medical attention from poorly trained medical personnel, lack of basic medicines, equipment, and supplies, and poor or nonfunctional infrastructure.²³⁰

The government's health facilities are affected by the prejudicial attitudes about women and indigenous people that are prevalent in Guatemalan society at large. These attitudes are sometimes held by health providers, who manifest them as insensitive and condescending treatment of patients.²³¹ Further, the government's health care programs for the most part have failed to integrate their services with the Mayans' cultural attitude towards health, thus hindering the acceptability of those services for much of the population.²³² Another cultural obstacle in health service provision is the diversity of languages spoken in the country. While in the indigenous population approximately one third of the people speak only a Mayan language, few health care providers speak those same languages.²³³

Inadequate investment over time has resulted in the government's health services and training programs focusing resources on curative measures to the detriment of preventative ones.²³⁴ By the government's own admission, this emphasis has meant that health services that *are* available to woman focus almost exclusively on their childbearing capacity, consisting essentially of services related to pregnancy and childbirth, but with almost no attention to prevention of unwanted pregnancies.²³⁵

C. Recent Health Legislation, Policies, and Programs Impacting Reproductive Health Care Provision

The Guatemalan government has recognized the need to respond to deficiencies in the provision of health care, and has agreed in the Peace Accords to undertake certain measures and achieve certain goals in the area of public health. Accordingly, the government's policies for the years 1996-2000 called for a significant reformation of the country's health system, in order to provide broader coverage, greater decentralization of health services and administration, involvement of communities in promoting their own health, and coordination of MSPAS with private entities and NGOs to fulfill its responsibilities.²³⁶

In accordance with these policies, in 1997 the Guatemalan legislature enacted a new health code (the "Health Code"), which made a number of fundamental changes in the structure of health services in the country.²³⁷ First, it defines an entity called the "health sector," which is made up of all public and private organizations and institutions whose competency or objective is the delivery of health care.²³⁸ Second, it gives MSPAS the responsibility and function of guiding this health sector, through the regulation, coordination, and evaluation of the sector's actions and through formulating and executing policies, programs, and plans to deliver health services.²³⁹ Third, it directs private organizations, community groups, and cooperating agencies to participate in resolving the country's health problems in coordination with other parts of the health sector and in accordance with the policies, norms, and regulations established by MSPAS.²⁴⁰ Fourth, the Health Code empowers the MSPAS to execute agreements with other entities in the health sector to bolster its efforts to coordinate and provide health services as mandated.²⁴¹ Finally, the code directs MSPAS to work with the private, non-profit, and community health care sectors to develop comprehensive standards of care, which emphasize illness prevention and health promotion.²⁴²

Pursuant to these new governmental policies and the 1997 Health Code, the MSPAS has begun to implement several new programs, and also has adopted standards of care provision applicable to all of its programs.²⁴³ Discussed in this chapter are the Comprehensive Health Care

System (CHCS), the program-wide Standards of Care, and the Plan to Reduce Maternal and Infant Mortality (the MI Plan). As a general matter, all of these new developments aim to improve health care through increased community-based care, health education, and access to health services. Nonetheless, they consistently fail to employ those strategies in the case of family planning information and services. To the contrary, to the limited extent that MSPAS currently makes family planning available, it does so through a model aimed at risk reduction and improved rates of maternal and infant mortality. This model does not attempt to create more decentralized and improved access to family planning information and services, nor to promote individuals' — particularly women's — autonomy to make decisions concerning reproduction.

1. The Comprehensive Health Care System

In response to calls for health care reform, and empowered by changes enacted in the 1997 Health Code, MSPAS recently created the CHCS program.²⁴⁴ This program, which MSPAS has begun to implement over the last two years, seeks to provide a package of basic health services to a far greater segment of the population than is now covered by the public health sector.²⁴⁵ The essential strategy for expanding coverage of primary health care services is multisectoral participation and cooperation among MSPAS, other public institutions, NGOs, and communities.²⁴⁶ The new Health Code facilitates this collaborative approach in two ways.

First, the CHCS incorporates community health providers and promoters into MSPAS's organizational structure and relies on them to provide some information and services; they, in turn, must meet MSPAS's Standards of Care.²⁴⁷ In this manner, MSPAS has essentially created a fourth level of health services, which it coordinates, but which it does not fund or provide itself. This level will be referred to herein as the ground level of services (since MSPAS has traditionally referred to health posts as the first level).

Second, under CHCS, MSPAS has entered into contractual agreements with public institutions, NGOs, and community groups, pursuant to which those groups provide and coordinate basic health care at the first (health post or community health center) and ground (community) levels of services to a particular population in exchange for financial and other resources from MSPAS.²⁴⁸

The basic health services encompassed within the current CHCS program are: services for women, services for infants and preschool aged children, emergency services, and environmental health issues, including sanitation.²⁴⁹

The CHCS program aims to greatly increase MSPAS coverage, but it is still in its early stages of implementation, and has not yet come close to its goals. In terms of *potential* coverage, the MSPAS had, as of the end of 1998, executed 100 agreements with organizations for the provision of basic health care services to a population of over two million people.²⁵⁰ Although MSPAS had believed that many of these parties would be able to quickly and independently begin full-scale service provision, the reality has been that most groups have needed significantly more time, as well as considerable support from MSPAS.²⁵¹ Consequently, as of November 1998, less than 5% of Guatemala's population was receiving basic health services through the CHCS program.

The CHCS relies heavily on the provision of health services and information by TBAs and community organization members, who are neither employees of MSPAS nor parties to the agreements with MSPAS, and who are not paid by the government for their services.²⁵²

The primary health team in each of the "jurisdictions" — made up of approximately 3,200 households — consists of members of a community organization, health guardians, TBAs, and

a community facilitator.²⁵³ All of these members of the health team act essentially as volunteers within the CHCS program, although they are reimbursed for expenses they incur to attend monthly training sessions; community facilitators receive a nominal reimbursement for their time, as they are expected to work approximately four hours per day on their duties.²⁵⁴ TBAs traditionally charge pregnant women for the services they provide, and the CHCS program does not alter this system.²⁵⁵ The responsibilities of the members of this basic health team are considerable, particularly given their volunteer status.

For example, guardians conduct the following activities with the approximately 20 or so families in their sector: watch for incidences of contagious diseases and report them as necessary; prepare and maintain a map and census of the sector; visit each household in the sector every two months to conduct health promotion activities; provide medical attention for common illnesses and emergencies pursuant to MSPAS's standards of care; and support projects to improve the environment.²⁵⁶ Similarly, TBAs continue with their usual activities of assisting with births, and also perform prenatal checks and distribute vitamins to pregnant women and newborns.²⁵⁷ They are further responsible for referring women to health centers for vaccinations, first and last prenatal checks, and pregnancy complications, and they must attend monthly training sessions in which their cases are reviewed and risk factors are discussed.²⁵⁸

The CHCS program purports to involve communities in the provision of health services. However, it involves them in a way that has little potential for empowering them to ultimately take a greater role in the health sector. For example, the program provides training and supervision for delivering the ground, or community, level of services, but it does not train community members to provide more sophisticated levels of services such as rural health technicians, auxiliary nurses, or doctors. In addition, while the CHCS program relies heavily on community members to provide the ground level of services, it does not allocate resources for salaries to make this work a sustainable activity for community members who participate.

Despite these limitations, the CHCS program nonetheless has the potential to greatly increase community access to family planning information and services. Because the CHCS program trains and oversees community members who undertake health promotion and education activities and offer basic health services, the program could create a network of personnel trained and able to offer family planning education, referrals, and some methods within their own communities. Studies undertaken in Guatemala indicate that the relationship of the health promoters and TBAs to the families within their sector would be highly suitable ones in which to provide family planning orientations.²⁵⁹ Moreover, community groups could maintain some contraceptive methods as part of their supplies of basic medicines.

Yet, despite this potential, the CHCS program does little, if anything, to expand the availability of family planning information and services. To the contrary, it utilizes the MSPAS's Standards of Care as the guide for the provision of services at all four levels, as well as for the training materials for those providers.²⁶⁰ But the Standards of Care only address access to family planning by requiring that auxiliary nurses in health posts or community health centers provide post-partum patients with family planning orientation (as discussed below).²⁶¹ Thus, CHCS does not make family planning information available to all potential users; nor does it make it available from the providers who regularly live and work within the community. In this respect, the Standards of Care conflict with the priorities of CHCS, which include birth spacing as an element of basic health care, and which instruct TBAs and ambulatory physicians to offer family planning orientations to their patients.²⁶²

Moreover, family planning information may be even more limited in certain CHCS jurisdictions than it is now in areas with health posts. This is due to the fact that many of the groups

that have been awarded contracts in the CHCS program are affiliated with Catholic or Evangelist churches, which to varying degrees oppose modern family planning methods.²⁶³ Because the program contains only the general requirement that providers offer information on birth spacing, some groups have prepared materials and orientations addressing only natural family planning methods.²⁶⁴ Finally, CHCS requires only the provision of family planning *orientations*; it does not require access to family planning *methods* or *health services* at either the community level or health post/community health center level of attention.²⁶⁵

2. Standards of Care

Pursuant to the new Health Code, MSPAS issued and distributed Standards of Care applicable to all private and public entities that provide health care within MSPAS programs in 1998.²⁶⁶ The Standards of Care are of critical importance for two reasons: they define the minimum levels of care provided within MSPAS programs, and they set out how providers are expected to address particular health problems within MSPAS programs.

The Standards of Care correspond to the four levels of attention encompassed within MSPAS's health care delivery system under the Health Code: what this report has referred to as ground level, which is provided in the community by the family, community leaders, and TBAs, and in the CHCS program by health guardians and community facilitators; level one, which is provided in health posts or community health centers by auxiliary nurses, and in the CHCS program by institutional facilitators and ambulatory physicians; level two, which is pro-

Governmental programs and policies related to health have tended to conceive of it as a social condition to be measured by health indicators, and not as an issue of enabling individuals to exercise their right to health.

vided in health centers by doctors, professional nurses, and auxiliary nurses; and level three, which is provided in hospitals by doctors, professional nurses, and auxiliary nurses.²⁶⁷

The Standards of Care address the following elements of basic health care: prenatal care; attention during birth and for the newborn; post-partum care; acute respiratory infections; diarrheal illness and cholera; auto-immune diseases; dengue; malaria; tuberculosis; rabies; and sexually transmissible infections including AIDS.²⁶⁸

The Standards of Care as published in 1998 contain almost no information related to meeting family planning needs. They refer to family planning information and services only in connection with post-partum care. In that respect, the Standards of Care instruct auxiliary nurses in health posts and community health facilities to provide family planning orientation to post-partum women,²⁶⁹ and direct auxiliary nurses in health centers and hospitals to supply the family planning methods prescribed to such patients by doctors.²⁷⁰ Consequently, the Standards of Care fail to implement the parts of the CHCS program and MI Plan which recognize access to family planning as a basic health priority.²⁷¹

Not surprisingly, the recent distribution of the Standards of Care elicited a critical response from some women's groups, physicians, and population and development experts, who noted the

failure to address family planning needs.²⁷² In response to these criticisms, the MSPAS has denied that standards of care regarding family planning have been excluded, and it stated that additional standards on sexual and reproductive health are still to be published.²⁷³ Despite this contention, the published standards and their introductory materials give no indication that they are not complete, or that they are to be supplemented by further materials.²⁷⁴ Consequently, some women's rights activists are skeptical about whether MSPAS truly intends to publish standards for family planning.²⁷⁵ As of July 1999, no such standards had been published.

3. National Plan to Reduce Maternal and Perinatal Mortality

In response to the country's high maternal, infant, and prenatal death rates, as well as its obligations regarding those issues under the Peace Accords, the MSPAS created a National Maternal Infant Program (MI Program) and a corresponding plan (MI Plan) to reduce maternal and infant mortalities.²⁷⁶ The plan's overarching goals are to reduce the maternal mortality rate to 100 per 100,000 live births and the infant mortality rate (including neonatal deaths) to 26 per 1,000 live births by the year 2000.²⁷⁷ Although the plan addresses issues such as family planning and sexually transmissible infections, it does so only in terms of their role in directly reducing maternal and infant mortality and morbidity.²⁷⁸

To achieve the MI Program's overarching goals, the MI Plan calls for improvements in the medical attention provided to three different population groups: pregnant women, men and women of reproductive age, and newborns.²⁷⁹ For pregnant women, the MI Plan's stated objectives are to provide them with more and better-quality medical services during the prenatal, birth, and post-partum stages.²⁸⁰ For men and women of childbearing age, the MI Plan seeks to increase the use of family planning methods and prevent sexually transmissible infections.²⁸¹ To reduce infant deaths, the MI Plan sets the goals of promoting and providing basic medical attention to newborns.²⁸²

The MI Plan involves essentially three primary strategies for achieving its goals: (1) training and supervising TBAs and institutional health care providers regarding prevention and detection of maternal and infant health risks; (2) providing MSPAS facilities with adequate equipment and training for responding to maternal and infant health needs; and (3) creating a network of community health promoters, TBAs, and NGOs who can communicate with and provide information and referrals to institutional health care providers, as well as helping facilitate transportation to health care facilities.²⁸³ These strategies seek to increase and improve the early recognition and referral of risks during pregnancy and in newborns so that when complications exist, they can be promptly treated in the appropriate MSPAS facility.

The MI Plan does not employ these same strategies with respect to the promotion of family planning use. Instead, it suggests three more limited, specific steps toward that goal: (1) the provision of family planning counseling to post-abortion and post-birth patients in MSPAS facilities; (2) an increase in the use of family planning methods to 40% by the year 2000; and (3) a public education campaign regarding the prevention of teen pregnancy.²⁸⁴

To date, the MI Plan has been implemented largely through its incorporation into the department-wide Standards of Care (as discussed above) that are applicable to both institutional health providers and all other participants in MSPAS programs. These standards will, if fully implemented,²⁸⁵ create the networks of information, referrals, and transportation upon which the MI Plan relies for responding to complications that often lead to maternal and infant mortality.²⁸⁶ Nonetheless, the Standards of Care do little to promote the MSPAS's objectives with respect to family planning, except requiring that health posts (or their equivalent) provide post-partum patients with family planning orientation.²⁸⁷

In addition to publication of the Standards of Care, MSPAS has also developed training programs aimed at achieving the goals of the MI Plan. First, MSPAS has worked with NGOs, including Mothercare, to train TBAs to provide better prenatal care and birth assistance.²⁸⁸ Second, it has developed a training program for personnel at all three levels of institutional services to handle obstetrical emergencies.²⁸⁹ Finally, MSPAS has worked with the Population Council to train personnel in some health centers and posts to offer and provide maternal and infant care, including family planning counseling, to all patients with a potential need for such information or services.²⁹⁰ These training sessions utilize an algorithm that permits the provider to quickly determine the potential need for services of all female patients.²⁹¹ This algorithm directs the provider to offer family planning counseling to all female patients of childbearing age who are at risk of becoming pregnant and who are not using a family planning method or who use a method that they do not find satisfactory.²⁹² The training and algorithm have been highly successful in increasing access to family planning information and services for users of health posts and centers.²⁹³ Unfortunately, they have not been adopted by MSPAS as a nationwide program, nor incorporated into MSPAS' Standards of Care at either the health-facility or community level. As a result, their potential for more broadly improving family planning information and services provision has been limited.

D. Inadequate Integration of a Rights-Based Approach to Reproductive Health Policies and Programs

The Guatemalan government's refusal to establish a legislative and policy framework that incorporates family planning services and information is reflected in its failure to adopt a rights-based approach to the provision of reproductive health services. Governmental programs and policies related to health have tended to conceive of it as a social condition to be measured by health indicators, and not as an issue of enabling individuals to exercise their right to health. This focus is reflected in the types of quantitative health indicators the government tends to set — those aimed at achieving particular benchmarks for morbidity, mortality, incidence of disease, and other categories.²⁹⁴ It also fails to incorporate the government's duty to ensure individuals' ability to exercise their rights by increasing access to health information and services.

For example, the 1997 MI Plan aims at increasing contraceptive prevalence to 40% by 2000, yet the plan has no goal or strategy for increasing knowledge of or access to contraceptive methods.²⁹⁵ It does not include programs or strategies for ensuring that a certain percentage of women can identify several methods of family planning nor that a certain percentage has reliable access to at least four family planning methods within a one-hour walk. Similarly, the 1996-1997 Plan to Prevent HIV/AIDS contains indicators to lower the rates of HIV infection and AIDS cases, and on the inclusion of HIV-prevention education in government programs.²⁹⁶ But it includes no goals or indicators related to public knowledge about HIV/AIDS or their prevention, nor to the level of access to HIV/AIDS information, testing, and services.²⁹⁷ In short, it is devoid of the vital steps that might allow it actually to meet its own goals: culturally sensitive techniques for enabling citizens to practice sound health in their own lives. Thus, rather than ensuring that individuals have the ability to exercise their human right to health, these quantitative benchmarks assume that individuals are mere numbers who can be statistically altered to meet the government's health objectives without the crucial step of individual empowerment.

More recently, MSPAS has demonstrated its potential ability to move away from the failed practice of simply setting health indicators, and towards a model of making health information and services available to individuals who have the power to make decisions concerning their own health. It has demonstrated this potential in two new health plans, which are still in the

early stages of implementation. The first is a plan to prevent and control cervical and uterine cancer.²⁹⁸ This plan stands out from the MSPAS's other reproductive health efforts because it includes goals for public education and awareness. Thus, instead of setting targets solely in relation to cancer incidence or mortality rates, it sets the indispensable intermediary goals of ensuring that after a number of years, specific percentages of the population will be informed about the prevention and control of cervical and uterine cancer.²⁹⁹ This plan may indicate MSPAS's recognition that educating people about their health is a necessary element of their efforts.

The second new plan, called the National Plan of Comprehensive Services for Adolescents, relates to adolescent reproductive health.³⁰⁰ The plan contains a number of very promising features. First, it explicitly recognizes the many legal instruments that establish health as a human right and the government's responsibility for enabling the exercise of that right.³⁰¹ Second, it focuses on a model of empowerment that involves training adolescents to participate in their own health care.³⁰² Third, the plan includes the specific objective of guaranteeing access to adolescent health services.³⁰³ Finally, it explicitly encompasses reproductive and sexual health, which consist of numerous elements, including education, counseling, and orientation about sexuality and reproduction.³⁰⁴ If the plan is implemented in accordance with these goals, it will represent a significant step forward in the MSPAS's conceptualization of health programs.

The Guatemalan government has not yet addressed family planning within this framework of enabling the exercise of rights in relation to health. Much of the controversy that emerged when the 1993 law on population and development was proposed — such as opposition to setting fertility reduction goals and rejection of the government's promotion of methods opposed by the Catholic Church and other religions — may play out very differently in the context of an “enabling” policy aimed at providing access to information and services and ensuring the freedom to make independent decisions. Moreover, the results of the Social Cabinet's investigation in 1997 suggest that the public would accept and, indeed, is demanding, such a policy. To date, however, fear of earlier controversies and the disproportionate influence of conservative views regarding family planning have prevented Guatemala's current administration from using the lessons of the past to enact a progressive, rights-based policy on reproductive health information and services.

Violations of Human Rights Resulting from the Government's Refusal to Provide Family Planning

A. Domestic and International Human Rights Implicated

The Guatemalan government's refusal to promote and protect its citizens' access to family planning services and information implicates a number of human rights. These rights are found in various domestic and international legal instruments to which the Guatemalan government is legally bound under its domestic law and under international law. This chapter describes the domestic and international instruments and their relevant provisions containing these rights. It also links these provisions to the lack of a policy or law ensuring access to family planning information and services in Guatemala. Establishing Guatemalans' lack of access to family planning information and services as an infringement of human rights is the first step in demonstrating the government's accountability under instruments to which it is legally bound.

Lack of access to family planning services and information in Guatemala constitutes an infringement on citizens' human rights.

This chapter then discusses the scope of Guatemala's responsibility to take steps to ensure the enjoyment of guaranteed human rights. The Guatemalan government is obligated to respect, to protect, and to fulfill its citizens' human rights. The lack of a comprehensive law or policy to establish citizens' access to family planning services and information constitutes a violation of a number of their rights under applicable domestic and international instruments.

Lack of access to family planning services and information in Guatemala constitutes an infringement on citizens' human rights. The most important categories of human rights implicated, each of which is protected in several of the instruments discussed below, are (1) the right to health, including reproductive health;³⁰⁵ (2) the right freely and responsibly to determine the number and spacing of one's children³⁰⁶ or the right to reproductive self-determination;³⁰⁷ (3) the right to be free from gender discrimination in all spheres of life;³⁰⁸ and (4) the rights of indigenous peoples.³⁰⁹ A low-income indigenous woman who lacks access to family planning services and information is effectively prevented from exercising her right to delay or avoid pregnancy at a given moment in her life.

Childbearing can be a health- and life-threatening proposition, particularly in resource-poor settings and where women's socio-economic status is low. Women's health and lives can be jeopardized when they have little hope of preventing pregnancy at too young an age, too advanced an age, at too frequent intervals, or when they suffer from other health problems. Although women may choose to become pregnant despite the risk, they should have access to the means to prevent pregnancy. Thus, lack of access to family planning services and information — particularly when it is systematic and widespread as in Guatemala — violates women's right to health.

The failure to provide family planning services and information is also evidence of discrimination against women, since only women can become pregnant and it is they who must endure the health and social impact of frequent pregnancies.³¹⁰ By failing to provide these services and information, a government perpetuates a discriminatory social order in which women's social and economic status and related gender-prescribed roles are unlikely to change.

Finally, when indigenous couples are affected disproportionately by the government's failure to address the unmet need for family planning information and services, as in Guatemala, then it is an infringement on the rights of indigenous people. The Guatemalan government should ensure that family planning services and information are accessible to indigenous people so that they are able to decide when and whether to use such services and information. While the right of indigenous people to be free from government policies aimed at curbing fertility among their members must be ensured, their right to be provided the means to make an informed choice to limit their family size or space births also must be guaranteed.

As this section will highlight, Guatemala has largely abrogated its obligations as contained in both domestic and international sources of law, by failing to undertake appropriate measures to ensure that all citizens, particularly low-income or indigenous women, are able to exercise their rights.

B. International Sources of Law

Under Guatemala's Constitution, international human rights treaties ratified by the Guatemalan government prevail over domestic law.³¹¹ Although various interpretations exist as to the hierarchy of sources of laws in Guatemala, the Constitutional Court has held that international human rights treaties prevail over all sources of law, except for the Constitution.³¹² Under international law, a country that ratifies a treaty, including a human rights treaty, binds itself to abide by such a treaty.³¹³ Thus, the Guatemalan government is obligated under both international and domestic law to fully implement the human rights instruments which it has ratified.

1. International Human Rights Instruments

(i) The United Nations Charter

The UN Charter lays the conceptual foundation for the development of international human rights law. Articles 55 and 56 of the Charter establish the basic obligations to which UN member states have agreed, including the promotion and "universal respect for, and observance of ... human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion."³¹⁴ By adhering to this multilateral treaty, the Guatemalan government has the obligation to take action in cooperation with the United Nations to promote "solutions of international economic, social, health and related problems"³¹⁵

(ii) Universal Declaration of Human Rights

The Universal Declaration of Human Rights (Universal Declaration),³¹⁶ which just celebrated its fiftieth anniversary, is regarded as the primary human rights instrument from which later human rights treaties are derived, and it is binding on all nations.³¹⁷ The Universal Declaration recognizes the right of each individual to health, as well as women's right to special protection and care in connection with their roles as mothers.³¹⁸ In addition, it contains several other provisions that are implicated when access to family planning services and information is lacking. The Universal Declaration's provisions on the individual's right to privacy,³¹⁹ to marry and to found a family on a basis of equality,³²⁰ and on freedom from discrimination on the basis of sex,³²¹ all underpin later conceptualizations of reproductive rights.³²²

The Universal Declaration contains a non-discrimination provision which provides that “[e]veryone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”³²³ Thus, the Universal Declaration establishes for women and indigenous people the same rights to health, to found a family, and to privacy in making decisions concerning their lives free of government intrusion as enjoyed by men and other citizens.

(iii) The International Human Rights Covenants

The two UN human rights treaties adopted in 1966 further secured the rights articulated in the Universal Declaration, developing the link between the right to family planning services and information on the one hand and the right to health on the other; it also developed the link between the former and the right to liberty, autonomy, and privacy.³²⁴ In addition, both covenants recognize the right to be free from discrimination on the basis of sex and race.³²⁵ The International Covenant on Economic, Social and Cultural Rights (the Economic and Social Rights Covenant) entered into force for Guatemala on August 19, 1988, and the International Covenant on Civil and Political Rights (the Civil and Political Covenant) entered into force for Guatemala on August 5, 1992.³²⁶

The Economic and Social Rights Covenant. In the Economic and Social Rights Covenant, states recognize the right of all people to the enjoyment of the highest attainable standard of physical and mental health.³²⁷ The same article also specifically states that in working for the achievement of the right to health, states must take steps to “reduc[e] ... the stillbirth-rate and of infant mortality and for the healthy development of the child.”³²⁸ In addition, the Economic and Social Rights Covenant commits states parties to “undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race ... and sex.”³²⁹ Thus, the covenant’s provisions clearly encompass the right of women, including indigenous women, to health services and information so as to prevent unwanted pregnancy that may jeopardize their physical or psychological well-being.

The Economic and Social Rights Covenant qualifies the obligation of states parties to take steps “to the maximum of ... available resources, with a view to achieving progressively the full realization of the rights recognized.”³³⁰ For example, this provision recognizes that states’ obligation under Article 12 to “[create] conditions which would assure to all medical service[s] and medical attention in the event of sickness” for all citizens³³¹ is not immediately achievable in all contexts. However, the provision has been interpreted not to permit conscious abrogation of the duty to adopt appropriate laws and policies and to require states “to begin immediately to take steps to fulfill their obligations under the Covenant.”³³² In 1997, the Maastricht Guidelines on the Economic and Social Rights Covenant reiterated (Maastricht Guidelines) that the nature of states’ legal obligation was unaltered and required “certain steps to be taken immediately and others as soon as possible.”³³³ Moreover, the Maastricht Guidelines established that each state party has the burden of demonstrating that it is making “measurable progress toward the full realization of the rights in question.”³³⁴

The Committee on Economic, Social and Cultural Rights (Economic and Social Rights Committee) also has stated that the failure of a State to ensure the satisfaction of at least a “minimum essential level of each of the rights” is a prima facie failure to discharge its obligations under the Covenant.³³⁵ States must use “all appropriate means, including particularly the adoption of legislative measures”³³⁶ to meet their obligations under the Covenant.³³⁷ With respect to health, the Committee has stated that states have a minimum core obligation not to deprive “any significant number of individuals ‘essential primary health care.’”³³⁸

In response to Guatemala’s initial report to the Economic and Social Rights Committee in 1995, the Committee expressed its concern about the inadequacy of access to health care that deprived

the most vulnerable citizens of the full enjoyment of their rights.³³⁹ It recommended that the Guatemalan government maintain the focus of its health and education policy on promoting access to health care and services and on educating the most disadvantaged groups in society.³⁴⁰ Finally, it noted that the monitoring role of MINUGUA should include economic, social, and cultural rights.³⁴¹ This last recommendation is particularly noteworthy since in the past MINUGUA seems to have been almost exclusively concerned with monitoring civil and political human rights.³⁴²

The Civil and Political Covenant. The Civil and Political Covenant protects the rights to individual liberty,³⁴³ privacy,³⁴⁴ and the right to marry and to found a family,³⁴⁵ as well as the right to life.³⁴⁶ It also provides that all of the rights recognized in the covenant are to be accorded without distinction on the basis of race, sex, social origin, or other status.³⁴⁷ The individual's right to reproductive self-determination has been explicitly linked to the Civil and Political Covenant's enumeration of these rights.³⁴⁸ The meaningful exercise of reproductive self-determination requires states to refrain from interfering with this right (for example, through either coercive pro-natalist or anti-natalist policies) and to ensure against others' interference with it. In the case of a person who lacks the information and economic means to exercise this right, the government's refusal to enable his or her ability to do so by enacting a legislative and policy framework to facilitate access to information and services also constitutes a governmental violation of this right.

The meaningful exercise of reproductive self-determination requires states to refrain from interfering with this right (for example, through either coercive pro-natalist or anti-natalist policies) and to ensure against others' interference with it.

(iv) The Convention on the Elimination of All Forms of Discrimination Against Women

The Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention) entered into force for Guatemala on August 12, 1982, after Guatemala ratified it without reservation.³⁴⁹ This Convention obligates states parties to ensure equality of rights of women and men, to eliminate discrimination against women and to "take ... all appropriate measures ... to ensure the full development and advancement of women."³⁵⁰

Many of the affirmative obligations agreed to by the Guatemalan government under the Women's Convention clearly obligate it to take steps to ensure that as many women as possible have access to information and services on family planning. Article 12 provides that states must eliminate discrimination in the field of health care to ensure equal access to health care services, including those related to family planning. In Article 10, devoted to equality in the area of education, the Women's Convention obligates states parties to ensure, on the basis of equality of men and women: "[a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."³⁵¹ The Women's Convention clearly recognizes the threat that unintended pregnancies pose to women's health and lives, as well as to their equal status in other spheres of life.

Of particular relevance to Guatemala's large rural and indigenous population is Article 14, which provides that states parties are obligated to take appropriate measures to eliminate discrimination against women in rural areas, and to ensure their "access to adequate health care facilities, including information, counseling and services in family planning."³⁵² The Women's

Convention recognizes that pervasive cultural and religious norms often deny women's equality within marriage and in family relations and subject women to severe pressure to produce large numbers of children, often preferably male children. It addresses many aspects of inequality in marriage and family relations. With respect to family planning in particular, the Convention provides that states parties must accord women the same rights as men "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."³⁵³

Since the adoption of the Women's Convention in 1979, the Committee on the Elimination of Discrimination Against Women (CEDAW) has issued a number of general recommendations setting out its view on measures states should take to fulfill their obligation to fully implement the Women's Convention. In 1994, CEDAW issued its General Recommendation No. 21 on Equality in Marriage and Family Relations.³⁵⁴ The recommendation provides the following guidance regarding states parties' obligations under Article 16(1)(e), which pertains to decision-making about the number and spacing of children:

Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government. In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services³⁵⁵

In 1999, CEDAW adopted its General Recommendation No. 24 on Women and Health.³⁵⁶ This recommendation focuses on women's "access to health services, throughout the life cycle, particularly in the areas of family planning [and] pregnancy" and it discusses governments' obligations under the Women's Convention to fulfill rights by taking "appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources" related to women's rights to health.³⁵⁷ It emphasizes that "[s]tudies such as those which emphasize ... the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care."³⁵⁸

In Guatemala's report to CEDAW in 1994, the Committee criticized the fact that the report gave no information about family planning laws or policies, nor about steps taken to improve the health of women and children.³⁵⁹ Guatemala's representative asserted that family planning had negative effects on the population since indigenous women were not given information about the effects of contraceptives on their bodies, and also because the donation of food was sometimes linked to the use of contraceptives. The representative also asserted that contraception led to the breakdown of the society and the family, had a negative effect on youth, and that it increased the number of households headed by single women.³⁶⁰ When a member of the Committee commented that in Guatemala sexist notions promote procreation as the "natural" role of women, and encourage women's role in the family rather than in social and economic fields, the government's representative stated that the notions of the role of women in the family should not be changed and that encouraging the concept of the complementary nature of men's and women's roles was more important than encouraging a misunderstanding of equality.³⁶¹

Clearly, the Guatemalan government's failure to adopt an adequate legal and policy framework to ensure that women have access to family planning information and services violates several provisions of the Women's Convention. In its recent Recommendation on Women's Health, CEDAW clearly directed its comments to countries like Guatemala that have failed to incorporate access to family planning into their health programs.

(v) Convention on the Rights of the Child

The Convention on the Rights of the Child (Children's Convention) entered into force for Guatemala on September 2, 1990. It obliges states parties to respect and ensure the human rights of children and adolescents under age 18.³⁶² The Children's Convention also states that its provisions are to be applied without discrimination on the basis of sex, race, social origin, or any other reason.³⁶³ Many Guatemalan women become sexually active and/or begin childbearing prior to age 18. On average, indigenous and rural women are much more likely to begin childbearing while still in adolescence than their *mestiza* and urban counterparts. When couples lack access to services and information that could enable them to prevent early or unwanted pregnancies, the result may be loss of life or severe health consequences for the woman, the child, or the couple's other children. This is because such a lack of access can severely strain couples' ability to provide adequately for their children, and because early or unwanted pregnancies increase the risk of women dying or suffering health consequences. Recognizing this reality, the Children's Convention provides that states parties shall take appropriate measures "to develop preventive health care, guidance for parents, and family planning education and services."³⁶⁴

The Children's Convention also obligates States parties to "recognize the right of the child to the enjoyment of the highest attainable standard of health ..." and that they "shall strive to ensure that no child is deprived of his or her right of access to ... health care services."³⁶⁵ Thus, adolescent girls have a right to access family planning services, as such services are part of comprehensive reproductive health care. Without family planning, adolescent girls who are sexually active — whether within or outside marriage — are at risk for early pregnancy. In addition, the Children's Convention provides that "[n]o child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honor and reputation."³⁶⁶ The right to privacy has been linked to decisions concerning whether or not to bear children.³⁶⁷ When a girl under 18 is at risk for pregnancy, the Children's Convention provision on privacy should protect her right to access confidential family planning services and information.³⁶⁸

In 1996, the Committee on the Rights of the Child raised concern about the "many problems" that continue to affect the reproductive health of women in Guatemala, including the high maternal, infant, and under-five mortality rates.³⁶⁹ The Committee recommended that the "State party consider requesting international cooperation from relevant international organizations to address issues relating to the reproductive health of women."³⁷⁰ High infant mortality rates have been linked to untimely pregnancies, low birth weight, unsafe delivery, and high fertility rates.³⁷¹ They could be reduced if women — including indigenous women — had access to preventive care, appropriate family planning services and information, and adequate maternal health services.

(vi) Convention on the Elimination of All Forms of Racial Discrimination

The Convention on the Elimination of Racial Discrimination (Convention on Racial Discrimination) entered into force in Guatemala in 1983,³⁷² and protects the right of each person to enjoy and exercise, "on equal footing, ... [the] human rights and fundamental freedoms in the political, economic, social, cultural or any field of public life."³⁷³ States parties undertake to guarantee to everyone "[t]he right to public health, medical care, social security and social services,"³⁷⁴ without any discrimination on the basis of race, color, or ethnic origin. Moreover, states parties "shall ... take, in the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups"³⁷⁵ Thus the Convention on Racial Discrimination guarantees the rights of indigenous women to equal access to health services including family planning services, and requires the Guatemalan government to take affirmative steps to ensure that the services that are available and accessible to them are of equivalent accessibility and quality as those to non-indigenous Guatemalans.

There are other binding treaties that reinforce the Guatemalan government's obligations under the Convention on Racial Discrimination to address the health and other rights of indigenous people. The International Labor Organization's Convention No. 169 for Indigenous and Tribal Peoples, ratified by Guatemala, obligates governments, under its social security and health provisions, to provide appropriate health services and resources to the indigenous population.³⁷⁶ Similarly, the Guatemalan Peace Accords establish the government's duty to include previously marginalized indigenous communities in the planning and implementation of health care services.³⁷⁷

2. Regional Human Rights Instruments

Like the United Nations human rights system, the Inter-American system protects various human rights that are implicated when access to family planning services and information is compromised.

(i) American Declaration on the Rights and Duties of Man

The American Declaration on the Rights and Duties of Man (American Declaration), which was adopted at the Bogotá Conference on May 2, 1948, along with the Charter of the Organization of American States (OAS Charter), proclaims 27 human rights and ten duties of the citizen.³⁷⁸ Among the rights protected are the right to life, privacy, special protection of the mother, health, education, and liberty.³⁷⁹ Each of these rights is implicated by the Guatemalan government's failure to address lack of access to family planning information and services.

The American Declaration is a binding instrument that sets forth the obligations for member states of the OAS and is deemed to be "a source of international obligations related to the Charter of the Organization."³⁸⁰ Guatemala's signature to the OAS Charter requires it to abide by the American Declaration. The Guatemalan government's failure to ensure access to family planning services and information constitutes a violation of a number of the rights protected by the American Declaration.

(ii) American Convention on Human Rights

The American Convention on Human Rights (American Convention), which focuses primarily on civil and political rights issues, provides that all persons are entitled "without discrimination, to equal protection of the law."³⁸¹ The Guatemalan government's failure to provide the means for all its citizens, regardless of socio-economic status, race, and gender, to protect their health and enhance their well-being by limiting or spacing their children if they so desire is a violation of this provision. Furthermore, Guatemala's failure to provide family planning information and services implicates women's right to life, which is also protected under the American Convention.³⁸² In countries such as Guatemala, where high rates of maternal mortality, poverty, and inadequate health care services during pregnancy are serious problems, access to family planning information and services can literally save women's lives.

The American Convention also contains an important provision that guarantees to each individual his or her right to privacy, reaffirming the language in the Universal Declaration and the Civil and Political Covenant.³⁸³ Because decisions about whether and when to bear a child are intensely personal, they clearly fall under the types of private decisions encompassed by the American Convention. Moreover, whether or not to use a particular contraceptive method is also a very personal decision, which under international human rights norms must be free of government coercion to encourage or discourage use.³⁸⁴ As long as government regulatory authorities conclude that a particular method is medically safe and effective for contraceptive purposes, the right to privacy is implicated. In its role in providing health care services, the government should make a range of safe and appropriate contraceptive methods available to all potential users, as well as unbiased

information on the risks and benefits of each method, without interfering with women's privacy in making decisions about childbearing. In addition, the government must adopt generally applicable measures to ensure greater respect for patients' privacy and confidentiality in all of its programs, particularly in those offering family planning information and services.

(iii) Protocol of San Salvador

The Protocol of San Salvador, also known as the Additional Protocol to the American Convention on Human Rights, was adopted in November 1988,³⁸⁵ and focuses mainly on economic, social, and cultural rights. Guatemala has signed the Protocol but not yet ratified it.³⁸⁶ Under international law, Guatemala's signature to the Protocol — even though it is not yet legally bound by its provisions — represents an obligation not to defeat the object and purpose of the treaty.³⁸⁷ In this respect, Guatemala must not act in any manner which contravenes the provisions set forth under the Protocol, including by violating the rights to be free from discrimination, to health, and to protection of the family, especially to mothers before and after childbirth.³⁸⁸ Its failure to address high maternal mortality rates and ensure women's ability to control their reproductive capacity through access to family planning services and information constitutes a disavowal of the explicit provisions of the Protocol of San Salvador to ensure all its citizens' health without discrimination.

(iv) The Inter-American Convention on Violence Against Women

The Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (alternately referred to as the Convention of Belém do Pará or the Inter-American Convention on Violence against Women), was ratified by Guatemala in 1995. It reiterates the rights of all women to the recognition, enjoyment, exercise, and protection of all human rights, including: their right to have their lives and physical, mental and moral integrity respected; their right to personal liberty and security; their right to the inherent dignity of their person; and their right to equal protection before the law and of the law.³⁸⁹ Guatemalan women — particularly indigenous and rural woman — frequently suffer violations of the above-mentioned rights. Furthermore, their human right to family planning is violated when access to family planning services and information is lacking. The Convention of Belém do Pará also links all of these rights with women's right to be free from violence, which the Convention defines to include "[t]he right of women to be free from all forms of discrimination; and ... [t]he right of women to be valued and educated free of stereotyped patterns of behavior and social and cultural practices based on concepts of inferiority and subordination."³⁹⁰ Under this progressive definition of violence against women, those policies or lack of policies of the Guatemalan government which deny women reproductive health information and services are in violation of the Inter-American Convention on Violence Against Women.

3. International Conferences

During the 1990s, a series of six conferences recognized or reaffirmed reproductive rights, including the right to family planning information and services, as critical both for advancing women's human rights and for promoting development.³⁹¹ These recent conferences have built on principles articulated at earlier conferences — dating back to the Teheran Conference on Human Rights in 1968³⁹² — that affirmed the right of individuals to determine the number, spacing and timing of their children. Such principles reflect women's advocates' championing of women's ability to control their fertility as a fundamental component of the expansion of women's equality and participation in society.³⁹³

The agreements reached at international conferences, while not legally binding on governments, indicate consensus on the issues covered. Participating governments pledge themselves

to translate the principles expressed in conference agreements into improvements in the lives of their citizens. The two conferences that dealt in greatest depth with the pressing need for governments to address the reproductive rights of women in particular were the 1994 International Conference on Population and Development (ICPD) held in Cairo and the 1995 Fourth World Conference on Women held in Beijing (the Beijing Conference).

A small minority of governments, including Guatemala, issued statements at the conclusion of the negotiations at these two conferences expressing reservations to the consensus reached. Despite the non-binding nature of the agreements, these governments explicitly put on record that they did not regard themselves as bound to certain aspects of the agreements. However, as discussed below, the broad and ambiguous nature of Guatemala's reservations and the fact that it is legally bound to certain human rights treaties that encompass the right to family planning information and services, as well as gender equality and the equal rights of indigenous peoples, nullify the effect of its reservations to the consensus documents emerging from the ICPD and the Beijing Conference.

[T]he broad and ambiguous nature of Guatemala's reservations and the fact that it is legally bound to certain human rights treaties that encompass the right to family planning information and services ... nullify the effect of its reservations to the consensus documents emerging from the ICPD and the Beijing Conference.

(i) The International Conference on Population and Development

At the ICPD, held in Cairo in 1994, 179 governments adopted by consensus a landmark agreement that acknowledged reproductive rights as integral to human rights. The ICPD Programme of Action (referred to herein as the Cairo Programme) provides that reproductive rights “rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so”³⁹⁴ The Cairo Programme further articulated governments' obligation to respect rights by ensuring that individuals have the right to make decisions concerning reproduction “free of ... discrimination,” both in government and private health facilities.³⁹⁵

The Cairo Programme took the important step of acknowledging that to ensure individuals' overall reproductive health, many important reproductive health services — not only family planning — must be included.³⁹⁶ Nonetheless, it did not alter, but rather reinforced, governments' fundamental human rights obligation to strive to make family planning counseling, information, education, communication, and services available in their primary health care systems.³⁹⁷ A key objective with respect to governments' efforts related to family planning is “[t]o make quality family-planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality.”³⁹⁸ The Programme of Action sets out specific action-oriented directives for governments to fulfill, in some cases within specific time-frames, such as:

- “All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods”³⁹⁹
- “It should be the goal of public ... family-planning organizations to remove all programme-related barriers to family-planning use by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births”⁴⁰⁰
- “Specifically, Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and access to family-planning services and methods.”⁴⁰¹
- Among the actions governments are urged to take to improve quality of care in family planning programs is to “[r]ecognize that appropriate methods for couples and individuals vary ... and ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them to exercise free and informed choice.”⁴⁰²

The actions laid out in the Cairo Programme for governments have not been addressed seriously by the Guatemalan government. The several failed attempts to adopt a reproductive health policy that includes the provision of family planning information and services are indicative of how entrenched existing barriers to access and information remain.

Guatemala’s reservations to the Cairo Programme indeed reflect and in some ways explain the government’s contemporaneous and subsequent failure to overcome conservative forces in society that seek to effectively deny most of Guatemala’s people basic information about and access to the full range of safe and effective family planning. Guatemala’s statement of reservations provides that it is “enter[ing] a reservation on the whole [of] chapter [VII] [entitled Reproductive Rights and Health], for the General Assembly’s mandate to the [Cairo Programme] does not extend to the creation or formulation of rights.”⁴⁰³ Guatemala’s statement then provides that its reservation on Chapter VII “applies to all references in the document to ‘reproductive rights’, ... ‘reproductive health’, ‘fertility regulation’, ... [and] ‘distribution of contraceptives.’” This general reservation to Chapter VII and to certain terms related to reproductive health and rights echoes the reservations of the Vatican and a few other Latin American countries that followed the Papacy’s lead.⁴⁰⁴ Interestingly, Guatemala’s reservations do not include “family planning” or similar terms. Its rationale for the inclusion of some terms and the exclusion of others, such as family planning, is not elucidated in its reservations. Guatemala also expresses its reservation “on the use of terms, stipulations and provisions which are implicitly or explicitly inconsistent with” a selected list of regional and domestic legal sources and statements.⁴⁰⁵ It does not explain precisely what in the Cairo Programme it regards as contrary to this list of sources, though one can speculate that its primary concern was with the principles of reproductive rights and health and related issues set out in the Cairo Programme.

Curiously, Guatemala’s reservation to Chapter VII ignores the explicit basis for the Cairo Programme’s inclusion of reproductive rights — that they “embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents.”⁴⁰⁶ Guatemala is a party to the major UN and regional human rights treaties that support the individual’s right to be provided the information and the services to make decisions concerning childbearing. Thus, it cannot enter a reservation to the Cairo Programme that nullifies its binding obligations under other previously ratified treaties.

(ii) The Fourth World Conference on Women

The Fourth World Conference on Women (Beijing Conference) echoes and, in some cases, builds on the ICPD's resounding affirmation of the urgent need to address women's right to reproductive and sexual health.⁴⁰⁷ In the Beijing Declaration — which was adopted at the Beijing Conference along with the Beijing Platform for Action — governments expressed their conviction that “[t]he explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.”⁴⁰⁸ The section addressing women and health in the consensus document emerging from the Conference, known as the Beijing Platform for Action, links reproductive rights to women's overall status: “In most countries, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of others rights.”⁴⁰⁹ Thus, the Beijing document recognizes women's health, including reproductive health and family planning, as one of a number of intersecting and complementary human rights that determine whether women's equality, equity, and empowerment exist in a given society. The Beijing Platform for Action also directs governments to enable women to make decisions concerning their health and lives, thus encouraging less paternalistic and patriarchal models for providing health care.

As in the case of the Cairo Programme, Guatemala issued reservations to the Beijing Platform for Action. The Guatemalan government reserved the right to implement the recommendations contained in the Beijing Platform for Action in accordance with its national laws, even though its reservation also endorses and guarantees the social, economic, and juridical protection of the family on the legal basis of “responsible parenthood, the right of persons to decide freely the number and spacing of their children, and the dignity of motherhood.”⁴¹⁰ Thus, the government's continued refusal to adopt an appropriate legislative and policy framework to better ensure its citizens' ability to decide the number and spacing of their children through access to services and information violates its own limited undertaking to implement the Beijing Platform for Action.

C. Guatemala's Duty to Implement Human Rights

International human rights instruments to which Guatemala is a party create obligations to *protect* and *fulfill* the rights set out in those instruments.⁴¹¹ When states become bound to international human rights treaties, they are obliged to fulfill rights by undertaking appropriate measures to ensure that all socio-economic groups, including especially those suffering greater societal discrimination, such as indigenous people, are able to realize their rights. Similarly, the duty to protect requires states to take measures to improve the capacity of groups and individuals to achieve and maintain their rights, by such measures as providing access to education, to information, and to other enabling conditions — such as ensuring de facto equality for women and indigenous people.⁴¹²

Thus, under international human rights law, governments are bound not only to refrain from affirmative acts that violate rights (the duty to respect rights) and to protect individuals from third parties who violate rights (the duty to protect rights), but to ensure that rights are universally enjoyed. At a minimum, states are obligated to adopt appropriate laws and policies and other measures to better ensure realization of these rights.⁴¹³ For example, in the case of the right to access family planning information and services, which is directly related to the right to health, particularly reproductive health, the state has an affirmative duty to ensure that such information and services are reasonably accessible to all citizens.⁴¹⁴ Although a comprehensive discussion of what the precise content of laws, policies, programs, and actions must be to meet the Guatemalan government's obligations is beyond the scope of this report, it is the state's duty to adopt a legal

and policy framework that will enhance access for a significant number of people and decrease the likelihood that a woman will experience an unwanted pregnancy.⁴¹⁵ In a country such as Guatemala, where the vast majority of the population cannot afford private health services to control their reproductive capacity, the government's actions are highly determinative of its citizens' ability to realize their right to health, to reproductive self-determination, and to gender equality.

Another duty of the Guatemalan government under international human rights norms is to ensure a social order in which all citizens are able to enjoy their human rights. Article 28 of the Universal Declaration provides that “[e]veryone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.”⁴¹⁶ This provision suggests that governments have a duty to identify and address the social and economic factors that may prevent some sectors of society from exercising their human rights. The Guatemalan government's failure to enable women's reproductive self-determination by establishing a legal and policy framework that provides for access to family planning services and information exacerbates its related failures to enact legal and policy measures to address women's inferior status in the family and in society. The government also has failed to recognize that indigenous people, particularly those living in rural areas, are effectively prevented from exercising their rights.

Under the Economic and Social Rights Covenant, for example, the human rights set forth therein, such as the right to health, may be realized gradually in the case of governments that lack the economic resources to ensure full access to adequate health care for all citizens at all

In a country such as Guatemala ... the government's actions are highly determinative of its citizens' ability to realize their right to health, to reproductive self-determination, and to gender equality.

times.⁴¹⁷ As stated by the Economic and Social Rights Committee, the gradual realization of certain rights, however, “should not be misinterpreted as depriving the obligation of all meaningful content.”⁴¹⁸ States are obligated “to move as expeditiously and effectively as possible toward [the] goal” of “full realization of the rights in question.”⁴¹⁹ Similarly, the Women's Convention provides that states parties “agree to pursue by all appropriate means and without delay” the adoption of appropriate legislation and other measures to eliminate all forms of discrimination.⁴²⁰ CEDAW, in its General Comment on Health, has stated that the duty to fulfill rights “places an obligation on States Parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.”⁴²¹

Moreover, a government that fails to exercise “due diligence” in addressing human rights violations has not fulfilled its human rights obligations to its citizens. In 1988, the Inter-American Court of Human Rights employed a “due diligence” standard in interpreting Article 1 of the American Convention. Article 1 requires states parties to “ensure” the free and full exercise of the rights and freedoms recognized therein.⁴²² This standard has been endorsed by other human rights bodies since then, such as CEDAW, in calling upon states parties to the Women's Convention to “[e]nsure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health”⁴²³ Thus, a government's ongoing failure to institute effective laws and policies, and to allocate resources for pro-

grams to ensure that its citizens have the ability to exercise specific human rights is a clear violation of its duty under international human rights instruments. In the case of Guatemala, its unsuccessful attempts to enact a law or policy encompassing comprehensive access to family planning information and services is an example of such an abrogation of this duty. This violation has had a disproportionate impact on women and indigenous people, who tend to suffer the greatest consequences to health and reproductive self-determination as a result of such failure.

D. Domestic Sources of Law

Guatemalan domestic law contains provisions that require the government to promote and protect the right to family planning information and services and related rights such as the right to reproductive self-determination, women's right to equality, and the rights of Guatemala's indigenous peoples. Thus, Guatemalan law protects the rights contained in international human rights instruments, thereby providing additional domestic legal sources for the government's obligation to secure its citizens' rights. Guatemala's Constitution acknowledges citizens' rights to health, equality, and to decide the number and spacing of children, and it establishes the government's obligation to protect the health of its citizens. Moreover, the recent Peace Accords obligate the government to take steps to ensure the right to health, including maternal health, of Guatemala's indigenous people.

1. Guatemalan Constitution

Guatemala's 1985 Constitution⁴²⁴ provides a strong basis for the government's obligation to act affirmatively to ensure access to family planning information and services.

Right To Health

The Constitution declares the enjoyment of health to be a fundamental human right for all citizens without discrimination,⁴²⁵ and recognizes the obligation of the State to guarantee the life, liberty, security, and integral development of all the country's inhabitants.⁴²⁶ The Constitution also sets forth a duty of the state to protect the health of the country's inhabitants and to ensure the most complete physical, mental and social well-being possible by developing programs both of prevention and promotion as well as treatment and rehabilitation.⁴²⁷ It recognizes health to be a public good which all persons and institutions are obligated to protect.⁴²⁸

In addition, it bestows on the state the responsibility for controlling the quality of food, pharmaceutical, chemical, and other types of products that can effect the health and well-being of the country's inhabitants; it also charges the state with improving the basic sanitary conditions of the least protected communities.⁴²⁹ In the context of a case involving government regulation of medicines, the Constitutional Court of Guatemala interpreted several articles of the Constitution to mean that the right to health implies "the ability to have access to services that will permit the maintenance or the restitution of physical, mental or social well-being."⁴³⁰ Moreover, the court stated that the protection of health should be realized by means of "direct and decisive intervention by the State" and that the state's obligation to protect health by both prevention and promotion is fundamental and cannot be delegated.⁴³¹

Women's Right To Equality

The Constitution provides that men and women are equal and have the same rights and responsibilities regardless of their marital status.⁴³² The government's failure to enable access to family planning services and information constitutes a violation of women's right to equality since women are disproportionately impacted by this failure. Thus, the government is not fulfilling its constitutional duties with respect to women of reproductive age, particularly rural, indigenous

women. Without adequate family planning methods, women cannot protect themselves from unwanted pregnancies or from sexually transmitted diseases. They may become subject to malnutrition and illness caused by too-closely-spaced pregnancies, and their risk of maternal mortality and morbidity may be increased.⁴³³ The Constitution's protection of women's right to equality should encompass their ability to control their fertility. Clearly, by failing to provide adequate family planning information and services the government is not fulfilling its duty to provide access to health services that protect women's health and ensure their autonomy.

The Right To Decide Number and Spacing of Children

Guatemala's Constitution acknowledges the right of people to decide freely the number and spacing of their children.⁴³⁴ Yet this right is meaningless to the hundreds of thousands of Guatemalans who lack basic accurate information concerning their reproductive capacity as well as the services which would allow them to control it. The government's failed attempts to enact policies and programs that incorporate family planning into comprehensive reproductive health care suggest that many in the Guatemalan government probably do recognize that more should be done to guarantee this right. These attempts apparently failed due to the disproportionate impact of conservative forces on government policy makers.⁴³⁵ Similarly, the government's nascent efforts to address maternal mortality through various programs demonstrate its acknowledgement that greater efforts are needed to protect women's health. Yet the govern-

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ment's policies to date fail to recognize that health as well as individual autonomy are impacted when family planning services and information are not accessible. In short, the government must ensure that the right to make decisions concerning childbearing, as articulated in the Constitution, is realized.

Right To Community Participation In Public Health Programs

Finally, Guatemala's Constitution explicitly recognizes the right and duty of all communities to participate actively in the planning, execution, and evaluation of public health programs.⁴³⁶ The inclusion of this right is particularly critical in a country emerging from civil war and where close to a majority of the population is indigenous and has been disenfranchised from government processes due to their status as indigenous, rural, and poor people. Improved implementation of this provision would help to reverse ongoing mistrust of the government's role in providing family planning as a result of the civil war and the alienation resulting from the government's failure to deliver health care services in a culturally appropriate manner.⁴³⁷

2. Peace Accords

The Peace Accords are a set of 11 agreements, 10 of which entered into effect on December

29, 1996, upon the signing of the eleventh agreement, the Agreement on a Firm and Lasting Peace.⁴³⁸ In drafting the Peace Accords, the parties used negotiations aimed at ending three decades of armed conflict as an opportunity to renovate the institutions necessary to guarantee the rights of Guatemala's people, particularly indigenous people.⁴³⁹ Thus, the agreement constitutes a sort of bill of rights for Guatemala's indigenous people and seeks to change profoundly not only the nation's political landscape, but its social fabric as well.

In the 1994 Comprehensive Agreement on Human Rights, both parties reaffirmed that all the Peace Accords must be accompanied by appropriate national and international verification⁴⁴⁰ and agreed to request the Secretary-General of the United Nations to organize a mission for the verification of human rights and the parties' compliance with the commitments of the Agreement.⁴⁴¹ The parties agreed that the UN mission should receive, consider, and investigate complaints regarding possible human rights violations⁴⁴² and ensure that the appropriate national institutions are carrying out the necessary investigations autonomously and effectively.⁴⁴³ A permanent mission, the UN Human Rights Verification Mission in Guatemala (MINUGUA), was established in November 1994, consisting of 13 offices throughout Guatemala staffed by 220 foreign human rights observers and 70 police and military liaison officers.⁴⁴⁴

The Peace Accords contain various provisions on eliminating gender-based discrimination. For example, one of the agreements commits the government to "eliminate any form of de facto or de jure discrimination against women with regard to access to land, housing, credits and participation in development projects. The gender-based approach shall be incorporated into the policies, programmes and activities of the comprehensive development strategy."⁴⁴⁵

In the Agreement on Social and Economic Aspects and the Agrarian Situation, the government undertook to implement nationwide comprehensive health programs for women that would include providing them access to appropriate information, prevention, and health care services.⁴⁴⁶ The government pledged to take the specific economic and social situation of women into account in its development strategies, plans, and programs, and to train civil servants to perform analysis and planning with women's special situations in mind.⁴⁴⁷ Throughout the agreement, the government confirms its obligation to ensure the effective enjoyment of the right to health, recognizing better health as a pillar of sustainable development.⁴⁴⁸ It pledges to increase social investment significantly, especially for health,⁴⁴⁹ to provide full access to basic services,⁴⁵⁰ to decentralize government resources,⁴⁵¹ and to give priority to the neediest sectors of society and the most disadvantaged areas of the country.⁴⁵² The government also outlines its goals with respect to reforming the national-health sector in a way that is based on a concept of health that integrates prevention, promotion, recovery, and rehabilitation.⁴⁵³ In particular, it gives priority to preventive health care and primary health care, especially maternal and child care; it undertakes to allocate at least 50% of public health expenditures to preventive care and to cut the 1995 infant and maternal mortality rates in half by 2000.⁴⁵⁴ Also by 2000, the government proposes to increase public spending on health as a proportion of gross domestic product by at least 50% over its 1995 level.⁴⁵⁵

The Peace Accords provide that the government must integrate indigenous people into the setting of priorities related to their health,⁴⁵⁶ and must ensure that health reform promotes the maximum ability of indigenous and low-income individuals to access services and to exercise their right to health.⁴⁵⁷ The government is obligated to inform indigenous communities of their rights in their own language.⁴⁵⁸ Finally, the government commits to encourage the participation of municipalities, communities, and social organizations in the planning, execution, and monitoring of the administration of health services.⁴⁵⁹ Although better access to family planning could have a significant impact on women's health and overall well-being, recent efforts to reform the health system — such as through the Comprehensive Health Care System — nonetheless continue to marginalize the provision of family planning services and information aimed at minimizing unwanted pregnancies.⁴⁶⁰

3. Guatemalan Health Code

Guatemala's Health Code affords every citizen the right to adequate health without discrimination.⁴⁶¹ The Code also establishes the government's obligation to undertake efforts aimed at the "promotion, prevention, treatment and rehabilitation of health," through its centralized, decentralized, and autonomous public health institutions, as well as private entities, to achieve the most comprehensive physical, mental, and social well-being for its citizens.⁴⁶²

The right to health information also is protected under the Health Code, which provides that in the area of health, every person has the right to dignity and respect, to medical privacy, and to be informed about health risks, diseases, and the services to which they are entitled by law.⁴⁶³ Thus, by failing to incorporate appropriate family planning services and information programs into its various public health institutions, the Guatemalan government is failing to comply with its own regulations. Article 42 of the Health Code, which refers specifically to family health, attributes to the "Ministry of Health and other institutions," the obligation to develop programs to promote the health of women and children in the area of prevention and services, including those aspects which relate to reproductive health.⁴⁶⁴

E. Conclusion: Guatemala's Failure to Provide Access to Family Planning Information and Services Violates its Citizens' Rights

Under both domestic and international law, the Guatemalan government's failure to address the urgent need for access to family planning information and services constitutes a violation of its citizens' rights. The government has acknowledged its obligation to reduce maternal and infant mortality and morbidity,⁴⁶⁵ yet it continually has failed to adopt the legal and policy framework necessary to provide family planning services and information in a systematic and conscientious way in its health facilities and programs. The international community has agreed that family planning information and services are a basic part of comprehensive reproductive health care.⁴⁶⁶

The provision of the information and the services to enable women to limit their childbearing should they choose to do so is one of the most obvious means by which to ensure these women's rights to life and health, and, by extension, to gender equality. The failure to do so also violates the rights to liberty and privacy, and the right to decide the number and spacing of children — which constitutes each individual's ultimate right to reproductive self-determination. In the case of the majority of Guatemalans — many of them indigenous, living in poverty, and possessing limited formal education — the absence of information about and lack of access to family planning services effectively precludes their exercise of the right to make decisions concerning childbearing.

International human rights obligations extend beyond merely refraining from affirmative acts that prohibit or compel the use of contraceptives; they explicitly require governments to take action to ensure equal ability to exercise and enjoy these rights. A government's total abdication of its responsibility to enable women to avoid unwanted pregnancy through the provision of family planning information and services violates this duty to fulfill its citizens' rights.

Recommendations: Towards Protection of the Human Right to Family Planning in Guatemala

Attempts to implement an appropriate legislative or policy framework to ensure Guatemalans' human right to access family planning services and information have been completely unsuccessful. Guatemala's new government must overcome this legacy of failure. The enactment of legislation on reproductive health that encompasses the provision of family planning services and information is a great political challenge.⁴⁶⁷ Clearly, binding legislation would be preferable to enactment of a policy, because of the risk that a subsequent executive easily could scrap a policy. Moreover, the political challenge of lobbying for a new policy may be nearly as difficult as lobbying for legislation, although the new President and his cabinet may prove to be more progressive than their predecessors.

The start of a new administration is a crucial moment to seize for those within the government, national-level NGOs, and international agencies and donors concerned about lack of access to family planning services and information. Those individuals and groups should consider using existing mechanisms at the national, regional, and international levels to bring about needed legislative and policy changes and to ensure full implementation of these changes, including the allocation of appropriate resources. Guatemalan NGOs in particular have a crucial role to play in catalyzing support for the adoption of a law or policy addressing family planning services and information. Moreover, international donors and agencies must increase the resources devoted to their own and to NGO efforts to foment change in this area. In particular, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and the United Nations Development Fund for Women (UNIFEM) are major UN agencies whose mandates encompass women's and girls' human rights, including their reproductive rights and their right to access family planning information and services.

Although the precise content of a law or policy that would encompass government provision of family planning services and information is beyond the scope of this report, there are some excellent starting points.⁴⁶⁸ The MSPAS algorithm currently being used at the community level in the CHCS could serve as a model should the CHCS prove to be successful in implementing it.⁴⁶⁹

A. Recommendations Regarding National-Level Actions

1. Advocating for a Family Planning Law or Policy

The most important way to address Guatemala's lack of family planning information and services is by promoting a legislative and policy framework that clearly establishes access to such services and information in government-provided facilities for all individuals of reproductive age.

Government:

- Enact legislation that firmly establishes the provision of modern family planning services and information as an integral component of government-provided comprehensive repro-

ductive health services for all Guatemalans, particularly adolescent girls and women of reproductive age, at all levels of services.

- Develop executive-branch policies and programs that fully integrate modern family planning services and information into all existing government health initiatives with the participation of local communities and women's rights organizations in the development, implementation, and assessment of such policies and programs.
- Ensure that all government programs not only seek to provide services, but also to empower individuals to make decisions concerning their lives and health. Various studies previously discussed demonstrate that Guatemalans want to receive family planning information and services from within their own communities. Thus, implementation of a family planning law or policy should be part of increased efforts by the government to train indigenous and rural Guatemalans to provide health services and information within their communities.⁴⁷⁰
- The members of the National Health Council — recently created under the new Health Code — should use their position to pressure the government to adopt appropriate legislation, policies and programs on family planning as part of its mandate to ensure the health and well-being of Guatemalans.⁴⁷¹

International Agencies and Donors:

- Donor organizations and international agencies should use their position to engage in dialogue with high-level policymakers in both the executive and legislative branches regarding the need to address the human rights of Guatemalans who are affected by the lack of an appropriate legislative and policy framework related to family planning services and information.
- MINUGUA, with its mandate to verify the Peace Accords, including provisions in the Accords on citizens' right to health, should exert pressure on the government. In particular, through its reports of the government's compliance with the Peace Accords, MINUGUA could publicize the state's failure to undertake comprehensive efforts to improve the reproductive health of Guatemalans by providing access to family planning services and information.

NGOs:

- Women's rights and human rights NGOs that have not already done so should consider systematically incorporating reproductive health issues, including access to family planning services and information, into their advocacy efforts. In short, women's rights and human rights NGOs need to build support among themselves and each other for systematic and ongoing advocacy on reproductive rights issues as a first step.
- NGOs should consider developing legislative proposals that encompass the provision of family planning services and information, including, for example, proposals on women's rights issues that include specific provisions on incorporating family planning services and information as one means of addressing women's low social status.⁴⁷² NGOs' advocacy should emphasize that the needed legislative or policy framework that includes family planning should reflect the progressive, rights-oriented approach to the provision of family planning that was adopted at the ICPD in 1994. Advocates should press the government to follow the progressive approach of other states that have either adopted comprehensive reproductive health policies or reoriented existing policies to ensure that such policies are client-centered and focused on the rights of the individual, rather than on demographic concerns.⁴⁷³
- In order to press the government to take action, NGOs should use the research of the Social Cabinet, among others, which confirms that the vast majority of the Guatemalan people

want the government to address reproductive health issues, including family planning.⁴⁷⁴ Moreover, NGOs should emphasize that the people want the government to do so in a comprehensive health policy that focuses on providing education, information, and services.⁴⁷⁵

- NGOs should cultivate alliances with members of Congress and with those in the executive branch who work directly on issues related to health (particularly women’s health and reproductive health), women’s social and economic status, the rights of indigenous people, development, and environmental and agricultural issues to obtain their support in putting a legislative, policy, and programmatic framework in place that encompasses family planning as well as other reproductive health issues.

2. Filing Administrative Complaints for Human Rights Violations

Guatemala’s Congressional Human Rights Commission (the Commission)⁴⁷⁶ could be an important national-level mechanism for the redress of human rights violations. The Commission is charged with investigating “any type” of human rights violation complaint made to it, as well as “promot[ing] the adequate operation ... of the government’s administrative processes and procedures” in the area of human rights.⁴⁷⁷ The human right to family planning services and information is no less fundamental to the long-term health and well-being of Guatemalans — in particular that of women and indigenous people — than is the right to be free of political violence.

Women’s rights and human rights NGOs that have not already done so should consider systematically incorporating reproductive health issues, including access to family planning services and information, into their advocacy efforts.

Thus, the Commission should be leveraged to aid in the struggle to ensure this aspect of Guatemalans’ human rights. The Commission has previously identified violations of the human right to health.⁴⁷⁸ However, the Commission never has taken up violations of reproductive rights and has taken up other women’s rights issues only rarely.⁴⁷⁹

Under the Commission’s procedures, any person or organization can file a complaint.⁴⁸⁰ In addition, although rarely undertaken, the Public Prosecutor for the Defense of Human Rights (Public Prosecutor) can initiate the investigation⁴⁸¹ or encourage judicial or administrative action or remedies in situations where there is precedent for such remedies.⁴⁸² Complaints also may be filed anonymously.⁴⁸³ The representative of a group of people whose rights have allegedly been violated may file a complaint on the group’s behalf.⁴⁸⁴ Complaints may be brought to the main office in Guatemala City or filed at auxiliary offices of the Commission in any of Guatemala’s 22 departments. In addition, the complaint can be written or oral and there are no formal requirements as to its content.⁴⁸⁵

The remedy for a violation of human rights is public censure and recommendations to end the violation and ensure compliance with the aggrieved individual’s or group’s rights.⁴⁸⁶ The Commission has little enforcement power outside of its moral authority. Moreover, though independent of the executive, the Commission is still an arm of government, and therefore is not immune from political pressure nor from fiscal threats from the Congress.⁴⁸⁷ Still, it is an important mechanism for redressing human rights violations and has proven effective in many cases.

Government:

- The Public Prosecutor should institute an investigation *proprio motu* pursuant to his or her power under the Human Rights Commission Law. The Public Prosecutor could issue recommendations regarding the need for the legislative and executive branches to enact appropriate laws and policies that better ensure access to family planning services and information for all Guatemalans, including indigenous people and all those living in rural areas.

International Agencies and Donors:

- International agencies and organizations (particularly MINUGUA), as well as donor organizations, should use their own good offices to publicize the filing of a complaint on this issue. In addition, they should bring pressure on the government to act on any censure or recommendations that the Commission issues.

NGOs:

- NGOs should take advantage of the moral stature of the Commission by filing a complaint and seeking recommendations from it on the government's obligation to take steps to ensure its citizens' right to family planning services and information.

3. Instituting a Judicial Action

A third means of responding to the government's failures in the area of family planning could be the initiation of a legal action in the Guatemalan courts.⁴⁸⁸ Such an action could be brought as either a petition for *amparo* or a case claiming the unconstitutionality of a government law, policy, or action.

A petition for *amparo* can be used whenever there is a risk, threat, restriction, or rights violation under Guatemala's constitution and/or laws,⁴⁸⁹ provided ordinary remedies are exhausted first.⁴⁹⁰ It also can be used to maintain or restore the enjoyment of rights or guarantees established by the Constitution or any other law.⁴⁹¹ If the court⁴⁹² grants *amparo* it results in the suspension of the law or action with respect to the complainant.⁴⁹³ The court also may decide to award damages.⁴⁹⁴

If the court finds the case to be frivolous or without merit, it can sanction the lawyer who brought it.⁴⁹⁵ A writ of *amparo* must be filed within 30 days of notice of the prejudicial act. This requirement does not apply to cases where *amparo* is brought to prevent the future application of an unconstitutional law, or where there is a threat of acts violating the rights of the complainant.⁴⁹⁶ Both the Attorney General of the Ministerio Publico and the Public Prosecutor can bring a writ of *amparo* related to the public interests they protect.⁴⁹⁷ Further research would be necessary to determine the likelihood of successfully using *amparo* to challenge the failure of existing laws and policies that encompass the right to family planning services and information.

A petition also may be brought directly to the Constitutional Court,⁴⁹⁸ seeking a declaration that a particular law, regulation, or other legal provision is unconstitutional.⁴⁹⁹ Such an action may be brought by the Attorney General of the Ministerio Publico, the Public Prosecutor, or any individual who is assisted by three attorneys.⁵⁰⁰ If the Court does not find that the legal provision at issue was unconstitutional, then the complainant's lawyers will be sanctioned.⁵⁰¹ There are several reasons why an action seeking a declaration that a legal provision is unconstitutional may be less likely to succeed in the case of family planning. First, it may be more difficult to find a law, regulation, or other provision to attack. One could challenge the weakness of existing provisions, such as MSPAS's recently-promulgated standards of care, but further research would be needed to evaluate whether such a petition would be likely to succeed. In addition, unless the Attorney General or the Public Prosecutor were willing to take up this issue, the fil-

ing of such an action would carry the risk of sanction for the three attorneys supporting the petition. On the other hand, an action for *amparo* can be sought for any government action — and arguably for government inaction as well — and thus would have a greater likelihood of success.

Government:

- Although the Public Prosecutor and Attorney General have not taken up reproductive rights issues to date, they should consider filing a writ of *amparo* regarding the violation of the right to family planning information and services. Alternatively, either official could consider bringing a constitutional action regarding the government's failure to protect citizens' right to family planning information and services.

International Agencies and Donors:

- International agencies and donors, particularly MINUGUA, should use their good offices to publicize the filing of a writ of *amparo*, a constitutionally-based complaint, on this issue.

NGOs:

- NGOs should investigate the possibility of filing a writ of *amparo* to challenge the government's violation of Guatemalans' rights under the Constitution and other laws due to the lack of access to family planning information and services, particularly for such socio-economic groups as indigenous, impoverished, and/or rural Guatemalans.
- Alternatively, NGOs should consider whether there are advantages to filing a complaint challenging the constitutionality of an existing policy that fails to effectively incorporate access to family planning information and services.
- NGOs should consider the strategy of lobbying the relevant government officials, such as the Congressional Human Rights Commission and the Ministerio Público, in order to encourage them to pursue one of these actions. NGOs then may want to publicize their efforts to encourage such an action as an added way to pressure the government to redress the underlying violation.
- Similarly, NGOs may want to publicize their own intention to bring such an action in order to draw attention to the underlying principle such an action would be seeking to vindicate. Such publicity also would be a way to pressure the relevant arms of the government to institute appropriate laws and policies.

4. Providing Public Education About the Right to Reproductive Health Care

An additional suggested strategy for responding to the lack of family planning access and information in Guatemala is through public education. While unmet demand for family planning information and services has been clearly documented, many citizens have an underdeveloped knowledge of their rights, particularly those related to health and reproductive health issues.

Government:

- Those in government who are sympathetic to the need for better access to family planning services and information should use the discretion they have under existing policies and programs to provide unbiased information about family planning and about the right of each individual to determine the number, spacing, and timing of his or her children. Such officials can play a crucial role in increasing the popular demand for enhanced governmental efforts, including the adoption of a law or policy, to ensure increased access to and knowledge about family planning for all.

International Agencies and Donors:

- International agencies and donors should support public-education campaigns in Guatemala using a human rights framework to discuss family planning issues.

NGOs

- NGOs have a crucial role to play in public education related to reproductive and sexual rights, including family planning. They should institute public-education campaigns to reach both the general public and particular sectors, such as local community leaders, women's organizations, and other civil society groups, particularly among indigenous people and in rural areas. NGO efforts in this regard would need to be linguistically and culturally appropriate and should focus on family planning as an aspect of the rights to health and personal autonomy, and of human rights generally.

5. Seeking MINUGUA's Support to Ensure Government Action on Family Planning

As an international body charged with promoting peace, human rights, and non-discrimination, MINUGUA should play a greater role in ensuring that all Guatemalans have access to family planning information and services and that an appropriate legislative and policy framework is in place. As discussed in previous chapters, the Peace Accords contain numerous provisions that bind the government to eliminate gender-based discrimination, to increase investment in the health sector, and to give priority to both preventive and primary health care, including maternal health care.⁵⁰² MINUGUA's human rights mandate includes the ability to receive, consider, and follow up on complaints of human rights violations which are brought to its attention. The Economic and Social Rights Committee has recommended that MINUGUA verify the government's compliance with the Peace Accords' provisions on health.⁵⁰³

International Agencies and Donors:

- International agencies should provide their own information to MINUGUA regarding this issue for its annual report. While such agencies have a limited ability to be overtly critical, they can provide MINUGUA with useful background and statistical data.

NGOs:

- Women's organizations and health advocates should provide information to MINUGUA staff to be included in their annual reports under the Peace Accords regarding the government's failure to abide by its obligations to enact programs to ensure all citizens' health, including their reproductive health.
- NGOs should consider whether to file complaints for MINUGUA's consideration regarding specific violations. A complaint potentially could be founded on either the general lack of an adequate legislative, policy, and programmatic framework addressing family planning, or on violations in particular cases, such as when a woman who had wanted to avoid pregnancy but lacked realistic access to family planning died or suffered illness due to the pregnancy.

B. Recommendations regarding the Inter-American Human Rights System

The Inter-American human rights system has some potential to contribute to the fulfillment of the right to family planning information and services and related rights. As this report details,

lack of access to family planning information and services implicates numerous rights explicitly covered in the American Convention, as well as the Convention of Belém do Pará.⁵⁰⁴

Guatemala has ratified the American Convention, which empowers the Inter-American Commission on Human Rights with “promot[ing] respect for and defense of human rights” in the Americas.⁵⁰⁵ While there is no periodic reporting requirement under the American Convention, the Commission may request governments to supply it with information on measures adopted by them in matters of human rights.⁵⁰⁶ It also may issue recommendations to governments to further the observance of human rights in a particular country.⁵⁰⁷

Under Article 26 of the Convention, the Commission safeguards economic, social, and cultural rights⁵⁰⁸ by making recommendations regarding these rights in a particular country. The Commission is to base its recommendations on information received from the governments,⁵⁰⁹ and publish these findings in the Annual Report to the General Assembly or in a Special Report.⁵¹⁰ To this end, “[a]ny person, or group of persons, or organization may present reports, studies or other information ... on the situation of such rights in ‘all or any of the member states.’”⁵¹¹ If the Commission lacks sufficient information from these sources, it may send questionnaires to the states or may periodically entrust its own experts to conduct studies on the situation.⁵¹²

In addition, the American Convention and the Convention of Belém do Pará also provide that “[a]ny person or group of persons, or any non-governmental entity ... may lodge petitions with the Commission containing denunciations or complaints of violation of this Convention by a State Party.”⁵¹³

MINUGUA should play a greater role in ensuring that all Guatemalans have access to family planning information and services and that an appropriate legislative and policy framework is in place.

There are few precedents in the Inter-American system for bringing complaints on an issue such as the right to family planning information and services — which has traditionally been regarded as more closely linked with social and economic rights, such as the right to health. Thus, further research would be necessary to determine the best way to approach bringing a complaint on this issue. In particular, the American Convention and the Convention of Belém do Pará also require that “remedies under domestic law [be] pursued and exhausted” in order for the complaint to be admissible.⁵¹⁴ Further research would be required to determine how this requirement would affect a complaint alleging the government’s violation of its citizens’ right to family planning information and services.

The Inter-American Commission on Human Rights

- The Commission should obtain information on measures taken to implement Guatemalan citizens’ right to family planning services and information, both from the government itself and from NGOs and international agencies. The Commission then should include recommendations on this issue to encourage Guatemala to fulfill its human rights obligations, including through the implementation of an adequate legislative and policy framework to ensure better access to family planning by all citizens.

- The Commission should interpret the American Convention and the Convention of Belém do Pará to encompass the human rights violated by the Guatemalan government's failure to adequately ensure its citizens' access to family planning services and information.

International Agencies and Donors

- International agencies and organizations should provide their own information to the Commission regarding the situation in Guatemala for the Commission's use in its Annual Report or a Special Report.

NGOs

- NGOs should explore bringing a complaint to the Commission alleging violations of various human rights protected under the provisions of the American Convention on Human Rights, as well as the Convention of Belém do Pará, as a result of the government's failure to adequately protect and ensure its citizens' access to family planning information and services. As discussed above, further research would be necessary to determine whether an NGO should invest time and resources to file a complaint with the Commission. The NGO's decision on whether to file may or may not depend on the likelihood that the petition ultimately would be admitted and adjudicated in favor of the complainant(s). Although the outcome of the case would be uncertain for many reasons, filing a complaint against the government with the Commission could be part of a larger strategy to encourage the government to take seriously its international obligations related to the provision of family planning information and services.
- NGOs should consider supplying information and documentation to the Commission regarding the government's failure to meet its human rights obligations to provide access to family planning information and services.

C. Recommendations regarding the International Human Rights System

The international (or universal) human rights system that has developed under the auspices of the United Nations consists of a number of bodies and mechanisms that should be marshaled to redress the human rights violations encompassed by the lack of adequate access to family planning information and services in Guatemala. Although the UN human rights system has weak enforcement power, it is nonetheless important to use the opportunities afforded by the mandates of various UN bodies that are in a position to monitor governments' implementation of international human rights obligations and encourage their compliance with international norms in this area.

1. UN Human Rights Treaty Monitoring Committees

Committees created pursuant to several international human rights conventions regularly evaluate states parties' compliance with the norms enumerated in the particular convention. The Economic and Social Rights Covenant, the Civil and Political Rights Covenant, the Women's Convention, the Children's Convention, and the Convention on Racial Discrimination contain provisions relevant to the issue of access to family planning services and information; thus, the independent committees established under those conventions have authority to examine Guatemala's compliance with such provisions. The Guatemalan government submits a report to each of these committees periodically — usually every four or five years — as required by those instruments or the committees. The committees then examine those reports and issue Concluding Comments and Recommendations, identifying shortfalls in governments' implementation of the treaty and suggesting measures to be undertaken to comply with their obligations. The committees have no other enforcement power.⁵¹⁵

All of the committees encourage NGOs to provide them with independent factual information on any or all human rights issues covered by the relevant treaty. In this way, NGOs can seek to provide the committees with sufficient information to enable them to adopt Concluding Comments and Recommendations critical of government efforts to meet their obligations on particular issues. These NGO reports are known as “shadow reports,” or alternative reports. Because all four of these committees hear the Guatemalan government’s reports on implementation at different times, there are ample opportunities for these committees to reinforce Guatemala’s obligation to meet its citizens’ right to family planning information and services.

Human Rights Treaty Monitoring Committees:

- The Human Rights Committee, the Economic and Social Rights Committee, CEDAW, the Committee on the Elimination of Racial Discrimination, and the Children’s Rights Committee all should use the occasion of Guatemala’s periodic reports to reinforce the government’s obligation to ensure access to family planning services and information to all citizens under relevant treaty provisions.⁵¹⁶ The committees should issue strong observations condemning the government’s inadequate efforts and recommend that specific measures be adopted immediately to ensure that all citizens can realize their right to access family planning information and services. These measures should include the adoption of appropriate legislation, policies, and programs by the Guatemalan government.

International Agencies and Donors:

- International agencies working in Guatemala, such as UNICEF, WHO, the Pan American Health Organization (PAHO), UNDP, UNFPA, and UNIFEM also are able to provide information to the committees in the context of periodic country reports. These agencies should provide information to the committees on the lack of adequate access to family planning services and information, high rates of unintended pregnancy, maternal mortality and morbidity, unmet need for contraception, and other pertinent information.
- International organizations and donors should support NGOs that want to do shadow reports and follow-up on past commentary and recommendations.

NGOs:

- NGOs should provide information to the human rights treaty monitoring committees whenever they receive a report on Guatemala regarding the lack of an adequate legislative, policy, and programmatic framework to ensure access to family planning services and information.
- NGOs should review the observations and recommendations provided to date by the Economic and Social Rights Committee and CEDAW.⁵¹⁷ Then they should use such commentaries from UN bodies to pressure the government to adopt reforms. Since the committees themselves have no greater enforcement possibilities against Guatemala, NGOs are a better means to enhance compliance.

2. UN Human Rights Commission and Rapporteurs

There are several commissions, such as the Human Rights Commission, and extra-conventional mechanisms, such as special rapporteurs, experts, and working groups outside of the treaty framework, which also review state compliance with international human rights norms. These bodies do not ordinarily examine country reports, but rather they examine information provided to them from various sources on serious countrywide human rights violations. All countries are subject to their jurisdiction by virtue of their UN membership, and there is no requirement that a country has ratified a particular instrument.

The Commission on Human Rights, which consists of 53 UN member countries, and its subsidiary body, the Sub-Commission on the Prevention of Discrimination and Protection of Minorities (the Sub-Commission), meet annually to consider information received from individuals and NGOs and to adopt public resolutions on human rights issues. The Commission on Human Rights also may authorize a mechanism or body to study country conditions or themes in greater depth, such as the Special Rapporteur on Violence Against Women, and the Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia, Related Intolerance. These special rapporteurs file annual reports with the Human Rights Commission containing recommendations for national and international actions. They also are empowered to examine individual complaints in the context of countrywide abuses.

Some of these bodies already have explicitly recognized reproductive rights as part of their mandate. For example, as stated recently in a report of the UN Special Rapporteur on Violence Against Women, “[i]nadequate levels of knowledge about human sexuality and inappropriate or inadequate reproductive health information and services, ... and limits on women’s control over their own sexual and reproductive lives all contribute to violations of women’s reproductive health.”⁵¹⁸ The Special Rapporteur on Violence Against Women also is empowered to hear individual complaints. Recently, the Special Rapporteur on the Implementation of the Human Rights of Women and Traditional Practices Affecting the Health of Women and Girl Child, submitted a report that included an analysis of data submitted by the Guatemalan government, which was inaccurate and incomplete with respect to women’s reproductive health.⁵¹⁹

The Commission on Human Rights and the Sub-Commission:

- The Commission and the Sub-Commission should consider adopting a resolution that addresses inadequate efforts to ensure the rights of women, particularly rural women and indigenous women, to access family planning information and services in Guatemala as well as in other countries.
- The Human Rights Commission should consider appointing a special rapporteur to study the theme of inadequate access to comprehensive reproductive health care, including family planning information and services, and its far-reaching impact on women’s social, economic, and political status in countries like Guatemala.

Special Rapporteurs:

- The existing special rapporteurs should examine the human rights of women in Guatemala, including, in particular, their lack of access to family planning information and services and the lack of an adequate legislative and policy framework to better ensure such access. When necessary, they should request information from NGOs based in Guatemala to supplement the information received from official sources. They should underscore the Guatemalan government’s obligations under existing human rights treaties and its duty to better implement these obligations in any reports or recommendations the special rapporteurs issue.

International Agencies and Donors:

- International agencies and organizations should provide information in their areas of expertise to the Human Rights Commission, the Sub-commission, and special rapporteurs to supplement the information they receive from the government and NGOs.

NGOs:

- NGOs could submit information to the Human Rights Commission, the Sub-Commission, the Commission on the Status of Women, and the special rapporteurs regarding the issue of violations of human rights caused by lack of access to family planning services and information in Guatemala. This may help to ensure that future reports give a full and accurate description of the situation.
- NGOs should consider filing a complaint regarding an individual or individuals in respect of violations suffered by them as a result of inadequate efforts by the government to ensure these rights with one of the special rapporteurs, in particular the Special Rapporteur on Violence against Women.

Conclusion

Every woman has the right to control the number, spacing, and timing of her children. Yet without the possibility to access family planning information and services, this right is meaningless. The Guatemalan government's failure to enable its citizens to exercise their right to a full range of reproductive health services, including family planning services and information, has tragic repercussions for women's health and lives. Their ability to participate fully in the economic, political, and social lives of their country is severely constrained when they have no means to control their fertility and must cope with an unwanted pregnancy. Guatemala's high rates of extreme poverty and disturbing levels of maternal mortality and morbidity, including from unsafe illegal abortion, are just two of the many factors that should have motivated the government to adopt a legislative and policy framework encompassing voluntary family planning services on a larger scale long ago. The conservative views of some political leaders and segments of society do not excuse Guatemala's blatant violation of its citizens' rights to family planning information and services. Their concerns could be more appropriately channeled into ensuring that there are adequate safeguards in place to ensure that women's choices regarding whether to use family planning and, if so, whether to use a particular method, are voluntary, without trying to impose their views and to undermine women's choices regarding their reproductive lives.

This report has sought to document and analyze the situation in Guatemala related to the government's provision of family planning services and information. It has attempted to demonstrate how international human rights instruments and mechanisms potentially can be used to foment legal and policy changes in this area. Finally, the report has tried to provide information to bolster the advocacy efforts of NGOs in Guatemala that wish to take action. With Guatemala's civil war finally behind it, the government must work to ensure that all citizens, including women, indigenous people, and those living in rural areas, can enjoy their human rights to voluntary family planning services and information.

Summary of Recent Legislative and Policy Developments

Law for the Dignity and Integral Promotion of Women

A new law was enacted in Guatemala in 1999⁵²⁰ with the express purpose of promoting the full development and participation of women at all levels of economic, political, and social life.⁵²¹ The law recognizes that women's equality, freedom, dignity, and rights have not been realized, due to the conditions women face in the spheres of health, education, housing, and work, among others.⁵²² It purports to advance women's fundamental human rights, as articulated in the Guatemalan Constitution and under international human rights instruments.⁵²³ It is a law of general application that purports to reestablish the fundamental mechanisms through which the State is to guarantee the comprehensive development of women. The law directs the state to undertake the measures necessary to achieve its goals, including designing and implementing policies and strategies to eliminate gender inequities.⁵²⁴

Articles 8 and 15, in particular, address women's reproductive rights. Article 8, entitled, "Mechanisms in the private sphere," provides in part as follows:

With the purpose of promoting a stable environment that ensures the eradication of discrimination and violence against women, the State will promote the revaluing of marriage and motherhood.

The following minimal mechanisms of protection shall be established:

- a. To eliminate discrimination against women on the basis of marriage and/or motherhood, revaluing the latter.
- b. To guarantee the true exercise of equitable rights for women with respect to:
 1. The right to freely elect one's spouse, to enter into marriage and to dissolve marriage, to procreate, to sexual and reproductive education, and to decide on an equal basis with one's spouse the number and spacing of children.
- c. All appropriate measures of family life education which shall include an adequate comprehension of motherhood as a social function, recognizing the common responsibility of men and women in the redistribution, equity and execution of labor related to the domestic sphere, including the care and raising of children.

Article 15, entitled "Actions and mechanisms in the health sphere," provides as follows:

The government of Guatemala, through its competent health and social security organs, whether governmental or mixed, shall develop programs to train personnel on the minimal knowledge necessary to understand the situation of women and the problems of their lives, and shall establish specific mechanisms with the participation of women as active contributors to the development of policies in this sector to ensure such women's access to services at all stages and environments of their lives to:

- a. Comprehensive health, understood as not only the absence of disease, but as complete physical and mental well-being, and the exercise of reproductive and sexual rights.
- b. Psycho-sexual and reproductive information and health care, family planning and mental health, enabling access to them, ensuring complete liberty and without coercion of any kind.

- c. Protection of health and social security in the workplace, including safeguarding of reproductive functions.
- d. Pre- and post-natal services to decrease maternal mortality.

Although this law purports to promote women's equality, provide women with greater access to reproductive health care, and more freedom in their reproductive choices, it is not yet clear whether it will engender substantial changes in women's political, social, economic, and cultural status. In particular, it is unclear who within the government has the responsibility of establishing and implementing the actions and mechanisms set out in the law. Furthermore, the law is extremely broad and vague in certain respects. For example, while it mentions sexual and reproductive rights, it does not define these terms nor does it concretely specify the measures that should be carried out by the government to ensure their realization. This puts the principles enshrined in the law on precarious legal footing. A current or future government could ignore or marginalize certain aspects of the law. It is clear that women's organizations will have to carefully monitor implementation of the law and the effectiveness of programs undertaken to make the impressive objectives set out in the law a reality for Guatemala's women.

Standards of Care on Family Planning

In September 1999, MSPAS published an addendum to its Reference Manual on the Application of the Standards of Care entitled "Reproductive and Sexual Health" that encompasses, among other reproductive health issues, family planning (the Reproductive Health Standards) applicable through the Comprehensive Health Care System to all public and private health entities under the Health Code.⁵²⁵ The Reproductive Health Standards contain a chapter devoted to family planning.

In its introduction, the chapter posits family planning as necessary to ensuring that procreation takes place "at the moment most favorable to the condition of the mother and the family, with the birth spacing necessary (two years minimum) and the appropriate number in relation to the situation of the parents and the needs of other children."⁵²⁶ The introduction then discusses the need for family planning in order to avoid unwanted pregnancies in adolescence, when high rates of maternal mortality and morbidity occur. It also emphasizes that health care personnel have a key role to play in ensuring that the public understands the personal and social benefits of family planning.⁵²⁷ While emphasizing the reduction of high-risk pregnancies at the outset, the family planning chapter also mentions "the human right to family planning" and emphasizes that family planning services "must also be accessible, offer a range of safe and effective methods, as well as counseling and follow-up services offering trustworthy information, clarify individuals' doubts, and facilitate the free election of a method or a switch to another one when a particular method is not satisfactory to the user."⁵²⁸ The section of the chapter dealing with objectives emphasizes the provision of adequate family planning information to individuals, couples, and the community. The chapter then describes seven family planning methods, including abstinence or natural family planning, oral contraceptive pills, injectables, IUDs, condoms, tubal ligation, and vasectomy — providing a very brief description of each method, its characteristics, effectiveness, and a brief list of issues for orienting users and for follow-up.⁵²⁹ It also includes the process health care workers must follow prior to performing male or female sterilization, including the consent form the client must execute.

According to a source in Guatemala, absent a broader governmental policy favoring the provision of family planning information and services, the impact of the Reproductive Health Standards on the delivery of services in most contexts between their adoption in September 1999 and March 2000 has been limited.⁵³⁰ The fact that Guatemala had a new President and Health Minister take office in January 2000 may have contributed to slow initial implementation.

In March 2000, the Ministry of Health announced a new public campaign to disseminate information on family planning methods.⁵³¹ Through the Comprehensive Health Care System, all health care personnel under the Ministry's direct supervision, as well as in the non-governmental health sector, will provide sexual education and methods of family planning.⁵³² Predictably, the Catholic Church opposed the measure, stating that, whichever government is in power, the Catholic Church will always oppose all forms of contraception save for natural methods as "contrary to life."⁵³³

Several experts have expressed reservations regarding the new government's initiative. Thelma de Duarte, director of APROFAM, expressed her view that only through concrete reproductive health policies supported by the government would Guatemalan women improve their quality of life and that "through the years, there have only been a very small number of us NGOs that have been willing to confront this controversial issue in a *machista*, discriminatory country that lacks comprehensive population policies."⁵³⁴ Jorge Roberto Escobedo of the Latin American Center for Health and Women also pointed to the fact that no government had enacted the long-term policies needed to ensure women's comprehensive development. "Governments have shown themselves to be interested in short-term projects and have not invested in providing information on family planning methods because the results of such projects are seen only in the long run."⁵³⁵ Thus, it should remain a priority for the government to enact comprehensive legislation on reproductive health, or, at the very least, a comprehensive policy. NGOs and international agencies and donors should continue to monitor MSPAS's implementation of the Reproductive Health Standards, as well as the development of their newly announced public health campaign.

- 1 Committee on the Elimination of Discrimination Against Women (CEDAW), Concluding Observations on Guatemala, ¶ 64, Doc. A/49/38, (Dec. 4, 1994) (visited March 15, 2000) <<http://www.unhcr.ch/tbs/doc.nsf>> [hereinafter CEDAW Concluding Observations on Guatemala].
- 2 Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, China, 4-15 September 1995, ¶ 17, 1 U.N. Doc. DPI/1766/Wom (1996) [hereinafter Beijing Platform for Action].
- 3 CENTRAL INTELLIGENCE AGENCY (CIA), THE WORLD FACTBOOK 1999, (visited March 23, 2000) <<http://www.odci.gov/cia/publications/factbook/gt.html#people>> [hereinafter WORLD FACTBOOK].
- 4 *See id.*
- 5 USAID, THE CENTER FOR INTERNATIONAL HEALTH INFORMATION, GUATEMALA HEALTH STATISTICS REPORT, (visited March 23, 2000) <<http://www.info.usaid.gov/countries/gt/gt.txt>> [hereinafter GUATEMALA HEALTH STATISTICS REPORT].
- 6 *See* ORGANIZACION PANAMERICANA DE LA SALUD, ORGANIZACION MUNDIAL DE LA SALUD, REPRESENTACION EN GUATEMALA, EL PROCESO DE TRANSFORMACION DE LA SALUD EN GUATEMALA [TRANSFORMATION OF HEALTH IN GUATEMALA] 22 (1996) [hereinafter TRANSFORMATION OF HEALTH].
- 7 *See* WORLD FACTBOOK, *supra* note 3.
- 8 ORGANIZACION MUNDIAL DE LA SALUD, ORGANIZACION PANAMERICANA DE LA SALUD, LA SALUD EN LAS AMERICAS [HEALTH IN THE AMERICAS], vol. II, 289 (1998) [hereinafter HEALTH IN THE AMERICAS].
- 9 *See id.*
- 10 *See* WORLD FACTBOOK, *supra* note 3.
- 11 *See id.*
- 12 *See* SECRETARIA GENERAL DE PLANIFICACION, PROGRAMA DE GOBIERNO 1996 - 2000 [GOVERNMENT PROGRAM] 67 (1996) [hereinafter GOVERNMENT PROGRAM].
- 13 Women's Environmental and Development Organization (WEDO), Guatemala: Activism Flares in Culture of Silence in RISKS, RIGHTS AND REFORMS 210 (1999) [hereinafter WEDO], citing SECRETARIAT OF SOCIAL WORK OF THE FIRST LADY AND NATIONAL WOMEN'S BOARD, SUMMARY OF THE GUATEMALAN WOMEN'S CONDITION (1997).
- 14 *See id.*, citing LATIN AMERICAN AND THE CARIBBEAN HEALTH SECTOR REFORM INITIATIVE, GUATEMALA COUNTRY REPORT, (1998) (visited March 20, 2000) <<http://www.americas.health-sector-reform.org/english/gut.htm>>.
- 15 *See* THE WORLD BANK, WORLD DEVELOPMENT INDICATORS 1999, at 90 (1999) [hereinafter DEVELOPMENT INDICATORS].
- 16 UNITED NATIONS POPULATION FUND (UNFPA), THE STATE OF THE WORLD POPULATION 1999, at 69 (1999) [hereinafter WORLD POPULATION].
- 17 *See* INSTITUTO NACIONAL DE ESTADISTICA, ENCUESTA NACIONAL DE SALUD MATERNO INFANTIL [NATIONAL SURVEY OF MATERNAL AND INFANT HEALTH], at xxiv, 86 (July 1999) [hereinafter MATERNAL AND INFANT HEALTH].
- 18 *See* WEDO, *supra* note 13, at 211.
- 19 *See id.*
- 20 *See id.*
- 21 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 29.
- 22 *See id.* at xxiv.
- 23 *See id.* at 29.
- 24 *See* WORLD POPULATION, *supra* note 16, at 69.
- 25 *Id.*
- 26 MATERNAL AND INFANT HEALTH, *supra* note 17, at 42.
- 27 *Id.*
- 28 TERTULIA, No. 10, March 19, 2000 <<http://www.cuidese.net/tertulia>> [hereinafter TERTULIA], citing ASOCIACION PRO BIENESTAR DE LA FAMILIA GUATEMALTECA (APROFAM).
- 29 *Id.*
- 30 MATERNAL AND INFANT HEALTH, *supra* note 17, at 32.
- 31 TERTULIA, *supra* note 28, Dec. 21, 1998, citing LA RED DE SALUD DE LAS MUJERES LATINOAMERICANAS Y DE CARIBE (RSMLAC) (visited March 23, 2000).
- 32 *See* International Planned Parenthood Federation (last updated Nov. 1998) <<http://www.ippf.org/resource/gbv/ma98/index.htm>>, citing NEFT and LEVINE, WHERE WOMEN STAND: AN INTERNATIONAL REPORT ON THE STATUS OF WOMEN IN 140 COUNTRIES (1997).

- 33** See DIALOGO INTERAMERICANO, PROGRAMA DE CENTROAMERICANA, LA SITUACION DE LA MUJERES EN CENTROAMERICA: UNA EVALUACION EN EL UMBRAL DEL SIGLO XXI [THE SITUATION OF WOMEN IN CENTRAL AMERICA: AN EVALUATION ON THE THRESHOLD OF THE TWENTY-FIRST CENTURY] 159 (Ana Isabel Garcia Q. ed., 1999).
- 34** UNITED NATIONS DEVELOPMENT PROGRAM, HUMAN DEVELOPMENT REPORT 1998, at 164 (1998) [hereinafter HUMAN DEVELOPMENT REPORT].
- 35** See TERTULIA, *supra* note 28, Aug. 14, 1999 (according to a representative of the Central American and Mexican Campaign Against Child Abuse (CONACMI)).
- 36** See MATERNAL AND INFANT HEALTH, *supra* note 17, at 124.
- 37** See WORLD POPULATION, *supra* note 16, at 69.
- 38** See TERTULIA, *supra* note 28, May 8, 1999 (according to the FORO for the Protection of Street Children).
- 39** See BANCO INTERAMERICANO DE DESARROLLO [INTERAMERICAN DEVELOPMENT BANK], DATOS BASICOS SOCIOECONOMICOS-GUATEMALA [BASIC SOCIOECONOMIC DATA] (visited March 23, 2000) <<http://www.iadb.org/int/sta/SPANISH/brptnet/english/gtmbprpt.htm>> [hereinafter INTERAMERICAN DEVELOPMENT BANK].
- 40** See MATERNAL AND INFANT HEALTH, *supra* note 17, at 15, 16.
- 41** See WORLD FACTBOOK, *supra* note 3.
- 42** DEVELOPMENT INDICATORS, *supra* note 15, at 74.
- 43** See INTERAMERICAN DEVELOPMENT BANK, *supra* note 39.
- 44** See MATERNAL AND INFANT HEALTH, *supra* note 17, at 14.
- 45** See *id.*
- 46** See *id.*
- 47** See Sixth Report of the Director of MINUGUA, ¶ 134 (Dec. 29, 1996), (visited Jan. 3, 2000) <<http://www.un.org/depts/minugua/sixth.htm>>; see also Supplement to the Sixth Report, ¶ 110 (Feb. 1997) (discusses a case of discrimination against an indigenous woman).
- 48** See *infra* Chapter V which sets out a more comprehensive set of recommendations to various actors with the ability to aid in improving access to family planning information and services.
- 49** See TRANSFORMATION OF HEALTH, *supra* note 6, at 21.
- 50** See WORLD FACTBOOK, *supra* note 3.
- 51** See *id.*
- 52** See *id.*
- 53** See TRANSFORMATION OF HEALTH, *supra* note 6, at 22.
- 54** See WORLD FACTBOOK, *supra* note 3.
- 55** See *id.*
- 56** See GUATEMALA HEALTH STATISTICS REPORT, *supra* note 5.
- 57** See TRANSFORMATION OF HEALTH, *supra* note 6, at 22.
- 58** See generally SISTEMA DE LAS NACIONES UNIDAS DE GUATEMALA, GUATEMALA LOS CONTRASTES DEL DESARROLLO HUMANO (1998) [hereinafter CONTRASTS OF HUMAN DEVELOPMENT] at 132-140.
- 59** See generally STEPHEN C. SCHLESINGER AND STEPHEN KINZER, BITTER FRUIT: THE STORY OF THE AMERICAN COUP IN GUATEMALA ed.
- 60** See *id.*
- 61** See GUATEMALA MEMORY OF SILENCE: REPORT OF THE COMMISSION FOR HISTORICAL CLARIFICATION AND RECOMMENDATIONS, (1999) (visited July 12, 2000) <<http://hrdata.aaas.org/ceh>>.
- 62** See U.N. GA Mission for the Verification of Human Rights and of Compliance with the Commitments of the Comprehensive Agreements on Human Rights in Guatemala (Sept. 28, 1994) (visited March 18, 2000) <<http://www.un.org/depts/minugua/mandato.htm>>.
- 63** For a more comprehensive analysis of the relevant provisions of the Peace Accords, see *infra* Chapter IV.C.2.
- 64** See CONTRASTS OF HUMAN DEVELOPMENT *supra* note 58, at 136-138.
- 65** See *id.* at 45.
- 66** See *id.*
- 67** For example, in 1994, only 68% of homes were connected to a water source; this rate is worse in rural areas, where 46% of homes do not have direct access to water. See *id.* at 50.
- 68** See TRANSFORMATION OF HEALTH, *supra* note 6, at 67.
- 69** See GOVERNMENT PROGRAM, *supra* note 12, at 67.
- 70** See *id.*
- 71** See PROGRAMA NACIONAL MATERNO INFANTIL, MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL, PLAN NACIONAL PARA LA REDUCCION DE

LA MORTALIDAD MATERNA Y PRENATAL [NATIONAL PLAN FOR THE REDUCTION OF MATERNAL AND PRENATAL MORTALITY] 4 (1997) [hereinafter REDUCTION OF MATERNAL MORTALITY].

72 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 86.

73 *See* REDUCTION OF MATERNAL MORTALITY, *supra* note 71, at 2.

74 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 101.

75 Guatemala's Penal Code lists abortion among the crimes "against the life and integrity of the person." Penal Code, Decree No. 17-73, 1999, art. 133. However, art. 137 provides for "therapeutic abortion" when needed to save the woman's life. The right to life is protected from the moment of conception. *See* Constitución Política de la República de Guatemala [Constitution of the Republic of Guatemala] (decreed by the National Constituent Assembly, May 31, 1985, as amended by popular vote; Legislative Agreement 18-93), art. 3 [hereinafter GUAT. CONST.].

76 In 1996, PAHO found that abortion is the leading cause of maternal mortality in Guatemala. *See* The Center for Reproductive Law and Policy (CRLP), REFLEXIONES SOBRE EL ABORTO [REFLECTIONS ON ABORTION] (1999).

77 *See* WORLD FACTBOOK, *supra* note 3.

78 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 29.

79 *See id.*

80 *See* TRANSFORMATION OF HEALTH, *supra* note 6, at 1.

81 *See id.* at 10.

82 *See* HEALTH IN THE AMERICAS, *supra* note 8, at 289.

83 *See* TRANSFORMATION OF HEALTH, *supra* note 6, at 12.

84 *See id.* at 10.

85 *Id.*

86 *See* generally CONTRASTS OF HUMAN DEVELOPMENT, *supra* note 58, at 13-23.

87 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 37, 38; *see also* POPULATION COUNCIL, FINDINGS AND LESSONS LEARNED IN DELIVERY OF REPRODUCTIVE HEALTH CARE TO THE RURAL MAYAN POPULATION OF GUATEMALA AND DIAGNOSTIC STUDIES 1994-1997, at 3, 16-17, 18, 19, 29 (1997) [hereinafter OPERATIONS RESEARCH]; POPULATION COUNCIL, TESTING REPRODUCTIVE

HEALTH SERVICE DELIVERY STRATEGIES IN TWO INDIGENOUS COMMUNITIES ON LAKE ATITLAN (PART I), (1995) [hereinafter LAKE ATITLAN REPORT]; POPULATION COUNCIL, RESULTS FROM DIAGNOSTIC STUDY OF FAMILY PLANNING SERVICES AND USERS/NON USERS IN THE MAYAN HIGHLANDS OF QUETZALTENANGO, (1995) (draft on file with CRLP) [hereinafter QUETZALTENANGO REPORT]; POPULATION COUNCIL & APROFAM, BASELINE STUDY OF REPRODUCTIVE HEALTH BELIEFS AND ATTITUDES OF MALES IN FOUR HEALTH DISTRICTS IN THE DEPARTMENT OF EL QUICHÉ, 1994-1995 (1995); POPULATION COUNCIL & UNIVERSIDAD DEL VALLE, STUDY OF COGNITION AND SPEECH PATTERNS OF URBAN AND RURAL INDIGENOUS RESIDENTS ABOUT REPRODUCTIVE HEALTH IN THE DEPARTMENT OF QUETZALTENANGO (1995) [hereinafter SPEECH PATTERNS]; POPULATION COUNCIL, DESIGNING AND TESTING APPROPRIATE HEALTH EDUCATION STRATEGIES FOR MEN IN FOUR HEALTH DISTRICTS IN THE DEPARTMENT OF EL QUICHÉ, AUG. 1995-FEB. 1997 (1997) [hereinafter STRATEGIES FOR MEN].

88 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 38, 42.

89 *See id.* at 40.

90 *See id.* at 42.

91 *See id.* at 44.

92 *See id.* at 49.

93 *See id.*

94 *See* Focus Group Discussion with 10 TBAs, in San Juan Comalapa, Guatemala (October 29, 1998) (tapes on file with CRLP) [hereinafter Focus Group].

95 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 49.

96 *See id.* at 56.

97 SECRETARIA TÉCNICA DEL GABINETE SOCIAL, BÚSQUEDA DE CONSENSOS EN SALUD REPRODUCTIVA, INFORME FASE I [FINDINGS FROM REPRODUCTIVE HEALTH CENSUS, PHASE I], at v, 1-2 (1997) [hereinafter REPRODUCTIVE HEALTH CENSUS]; *see also* OPERATIONS RESEARCH, *supra* note 87, at 4, 16-17, 18, 19, 30; *see generally* LAKE ATITLAN REPORT, *supra* note 87; QUETZALTENANGO REPORT, *supra* note 87; EL QUICHÉ REPORT, *supra* note 87; SPEECH PATTERNS, *supra* note 87; STRATEGIES FOR MEN, *supra* note 87.

98 *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 53; *see also* MSPAS, REPRODUCTIVE HEALTH UNIT, ANALISIS SITUACIONAL, PROGRAMA DE PLANIFICACIÓN FAMILIAR [SITUATIONAL ANALYSIS,

FAMILY PLANNING PROGRAMS], at 11, 14 (1993) (finding in separate study that 26% of women who were not using contraceptives were not doing so because of a lack of knowledge).

99 See MATERNAL AND INFANT HEALTH, *supra* note 17, at 53.

100 See *id.* at 59.

101 See *id.*

102 When asked about their desire to have children, 37% of non-sterilized women in unions stated that they did not desire to have any more children and over 20% stated that they wanted more children, but wished to wait at least two years to do so. See *id.* at 76, 82.

103 See *id.* at 81, 82; see also INTERNATIONAL CENTER FOR RESEARCH ON WOMEN, DEMANDA INSATISFECHA DE PLANIFICACIÓN FAMILIAR EN UNA COMUNIDAD PERIURBANA DE LA CIUDAD DE GUATEMALA [UNSATISFIED FAMILY PLANNING DEMAND IN A SEMI-URBAN COMMUNITY IN GUATEMALA CITY] 65-72 (1998).

104 See MATERNAL AND INFANT HEALTH, *supra* note 17, at 77, 78.

105 See REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at 27-30; see also Interview with representative of MSPAS, Programa Nacional Materno Infantil [National Maternal Infant Program], in Guatemala (Nov. 4, 1998) (notes on file with CRLP) [hereinafter MSPAS Interview].

106 See REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at 27-30.

107 See, e.g., *id.* at 3, 32.

108 See Focus Group, *supra* note 94.

109 See *Id.*

110 See MSPAS Interview, *supra* note 105.

111 See Focus Group, *supra* note 94.

112 See *id.*

113 See REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at 27-28.

114 See PROCURADOR DE LOS DERECHOS HUMANOS, INFORME ANUAL CIRCUMSTANCIADO AL CONGRESO DE LA REPUBLICA DE LAS ACTIVIDADES Y DE LA SITUACIÓN DE LOS DERECHOS HUMANOS EN GUATEMALA DURANTE EL AÑO 1997 [DETAILED ANNUAL REPORT TO CONGRESS ON THE ACTIVITIES AND HUMAN RIGHTS SITUATION IN GUATEMALA DURING 1997], at 151 (1998) [hereinafter DETAILED ANNUAL REPORT].

115 PROCURADOR DE LOS DERECHOS HUMANOS, IV CONFERENCIA MUNDIAL DE LA MUJER, BEIJING CHINA 1995, INFORME NACIONAL DE LAS ORGANIZACIONES NO GUBERNAMENTALES DE GUATEMALA [FOURTH WORLD CONFERENCE ON WOMEN, NATIONAL REPORT OF THE GUATEMALAN NON GOVERNMENTAL ORGANIZATIONS (NGO)], 7 (1994) [hereinafter NGO REPORT].

116 LAKE ATITLAN REPORT, *supra* note 87, at 3.

117 See DETAILED ANNUAL REPORT, *supra* note 114, at 27-28.

118 See HUMAN DEVELOPMENT REPORT, *supra* note 34, at 18; see also SECRETARÍA GENERAL DE PLANIFICACIÓN ECONÓMICA, PLAN DE ACCIÓN DE DESARROLLO SOCIAL 1996-2000 (PLADES) [SOCIAL DEVELOPMENT PLAN OF ACTION] 38 (1996) [hereinafter SOCIAL DEVELOPMENT PLAN]; see also NGO REPORT, *supra* note 115, at 7-8, 15.

119 See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 38; see also NGO REPORT, *supra* note 115, at 8, 15.

120 See EL QUICHÉ REPORT, *supra* note 87, at 1-2.

121 See REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at 46; see also EL QUICHÉ REPORT, *supra* note 87, at 2. For example, a 1990 study of 1,000 women in the town of Sacatepequez found that 49% of these women were abused and 74% of these were abused by an intimate male partner. See INTER-AMERICAN DEVELOPMENT BANK, TOO CLOSE TO HOME: DOMESTIC VIOLENCE IN THE AMERICAS 5 (Andrew R. Morrison & María Loreto Biehl eds.) (1999).

122 Ley para Prevenir, Sancionar y Erradicar la Violencia Intrafamiliar [Law to Prevent, Sanction and Eradicate Domestic Violence], promulgated by Decree No. 97-96, Oct 24, 1996; see also DETAILED ANNUAL REPORT, *supra* note 114, at 155-57.

123 See, e.g., NGO REPORT, *supra* note 115, at 16.

124 CRLP AND DEMUS, WOMEN OF THE WORLD (WOW): LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES 117 (1997) (citing Case No. 936-95, Constitutional Court of Guatemala, March 5, 1996) [hereinafter CRLP AND DEMUS, WOW LATIN AMERICA].

125 CIVIL CODE, approved by Decree Law No. 106, Sept. 14, 1963.

126 See, e.g., *id.* at arts. 109-115, 131-32.

127 CORTE DE CONSTITUCIONALIDAD, [CONST. COURT], EXPEDIENTE NO. 84-92, (June 24, 1993), Gaceta de la Corte de Constitucionalidad, at 29.

- 128** CIVIL CODE, reformed in Congressional Decree No. 80-98 (promulgated 19 Nov. 1998), articles pertaining to the family; *see also* Julieta Sandoval, Un Avance Mas Hacia la Igualdad [Another Step Toward Equality], LA PRENSA LIBRE, Nov. 10, 1998, at 6.
- 129** *See* HUMAN DEVELOPMENT REPORT, *supra* note 34, at 24.
- 130** *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 11.
- 131** *See id.* at 11.
- 132** *See* HUMAN DEVELOPMENT REPORT, *supra* note 34, at 31.
- 133** *See id.* at 38.
- 134** *See* WORLD FACTBOOK, *supra* note 3.
- 135** *See id.*
- 136** *See* HUMAN DEVELOPMENT REPORT, *supra* note 34, at 38.
- 137** *See id.* at 24, 26-27, 32, 34
- 138** *See id.* at 31.
- 139** *See id.* at 25.
- 140** *See id.*
- 141** Interview with Gloria Cospin de Hernandez, Asociacion Guatemalteca de Educacion Sexual (AGES), Nov. 10, 1998 [hereinafter Hernandez Interview].
- 142** *See e.g.*, MSPAS, PLAN NACIONAL DE PREVENCIÓN Y CONTROL DEL CÁNCER CERVICO UTERINO 1998 - 2005 [NATIONAL PLAN ON THE PREVENTION AND CONTROL OF CERVICAL UTERINE CANCER] (1998) [hereinafter CANCER PREVENTION PLAN].
- 143** *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 151.
- 144** This movement, known as Liberation Theology, started in the 1960's and is a particular strain of Catholicism that influenced Latin America, highlighting the importance of social justice for the poor. *See* AMNESTY INTERNATIONAL, Working for Human Rights in Guatemala (visited March 15, 2000) <<http://www.west.net/~tmiller/gh.html>>.
- 145** *See* *infra* Chapter IV.B.1(iii) (discussing comments made by the Guatemalan delegation to the UN Committee on Economic, Social and Cultural Rights).
- 146** MATERNAL AND INFANT HEALTH, *supra* note 17, at 14.
- 147** For example, the Church of Jesus Christ of Latter-Day Saints, the Salesian Mission, and the Pentecostal Church all have missions throughout Guatemala, and are particularly concentrated in remote rural areas. *See* Missions and Religion in Guatemala, Religious Topics in Guatemala (last updated Jan. 1, 2000) <<http://mars.cropsoil.uga.edu/trop-ag/mission.htm>>; Guatemala, Religious Affiliations (visited May 5, 2000) <<http://www.editie.nl/wj95/factsh/guatemala.htm>>.
- 148** Encarta Encyclopedia, Guatemala: Religion (visited May 5, 2000) <<http://encarta.msn.com/find/concise.asp?mod=1&ti=01229000&page=2>>.
- 149** *See* MATERNAL AND INFANT HEALTH, *supra* note 17, at 6.
- 150** *See, e.g., id.*
- 151** Law of Population and Development, Decree 3-93 (vetoed by the President in Acuerdo Gubernativo 89-93) (1993) [hereinafter Law on Population and Development].
- 152** *See id.* at arts. 2, 5, ¶¶ I, II.
- 153** *See id.* at art. 5, ¶¶ III, V; arts. 10, 14.
- 154** *Id.* at art. 11.
- 155** Interview with long-time activist for sexual and reproductive rights and education and representative of various women's groups (Dec. 4, 1998) (notes on file with CRLP) [hereinafter Interview with reproductive rights activist].
- 156** Law on Population and Development, *supra* note 151.
- 157** *See* Interview with reproductive rights activist, *supra* note 155.
- 158** *See id.*
- 159** Carlos Morales, Condenados a la Sobrepoblación [Condemnations of Overpopulation], LA CRONICA, Nov. 20, 1998, at 17 [hereinafter Carlos Morales]; *see also* *infra* Chapter V.C.3.i (regarding the ICPD).
- 160** *See* *infra* § IV (regarding international conferences).
- 161** *See* REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at v.
- 162** *See id.*; *see also* Laura E. Asturias, Jugando con la Salud Pública [Playing with Public Health], SIGLO VEINTIUNO, May 23, 1998, at 6 [hereinafter Asturias]; *see also* Interview with representative of UNFPA, in Guatemala, (Oct. 30, 1998) (notes on file with CRLP) [hereinafter UNFPA Interview].
- 163** *See* UNFPA Interview, *supra* note 162; *see also*, Interview with reproductive rights activist, *supra* note 155.
- 164** *See* REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at v, 1-6.

- 165** See *id.*
- 166** See *id.* at v, 1-7.
- 167** See *id.* at v, 1-2.
- 168** See *id.* at 27-33, 45-47.
- 169** Asturias, *supra* note 162.
- 170** See *id.*; see also UNFPA Interview, *supra* note 162; see also Interview with reproductive rights activist, *supra* note 155.
- 171** Asturias, *supra* note 162; see also UNFPA Interview, *supra* note 162; see also Interview with reproductive rights activist, *supra* note 155.
- 172** See, e.g., Mary Ann Budnik, Pro-Family Forces Stave Off Culture of Death, THE WANDERER, March 23, 1995; see also CATHOLICS FOR A FREE CHOICE (CFFC), MERCEDES ARZU WILSON (1999) (on file with CRLP); see also Mercedes Arzú Wilson, The Morning After Kill, THE WANDERER, October 15, 1999.
- 173** Interview with reproductive rights activist, *supra* note 155; see also Interview with medical researcher on reproductive health in Guatemala (notes on file with CRLP); see also UNFPA Interview, *supra* note 162.
- 174** Interview with reproductive rights activist, *supra* note 155.
- 175** See UNFPA Interview, *supra* note 162.
- 176** See HEALTH IN THE AMERICAS, *supra* note 8, at 294. According to this study, the other government institution that provides services is the Military Health Service.
- 177** See TRANSFORMATION OF HEALTH, *supra* note 6, at 34.
- 178** See MATERNAL AND INFANT HEALTH, *supra* note 17, at 6.
- 179** See TRANSFORMATION OF HEALTH, *supra* note 6, at 34.
- 180** See GOVERNMENT PROGRAM, *supra* note 12, at 67.
- 181** See generally, TRANSFORMATION OF HEALTH, *supra* note 6, at 36 - 37.
- 182** See MSPAS, AVANCES EXTENSIÓN DE COBERTURA EN EL PRIMER NIVEL DE ATENCIÓN [ADVANCES ON THE EXTENSION OF COVERAGE AT THE FIRST LEVEL OF CARE] 4 (1998).
- 183** See GOVERNMENT PROGRAM, *supra* note 12, at 67.
- 184** See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 21.
- 185** See TRANSFORMATION OF HEALTH, *supra* note 6, at 39.
- 186** See GOVERNMENT PROGRAM, *supra* note 12, at 67.
- 187** See MSPAS Interview, *supra* note 105.
- 188** CRLP AND DEMUS, WOW LATIN AMERICA, *supra* note 124, at 114 (1997).
- 189** *Id.*
- 190** Hernandez Interview, *supra* note 141.
- 191** See MSPAS, REPRODUCTIVE HEALTH UNIT, OPERATIVE PLAN 1996, at 2 (1996) [hereinafter OPERATIVE PLAN].
- 192** See *id.* at 2-6; see also MSPAS Interview, *supra* note 105.
- 193** See MSPAS Interview, *supra* note 105.
- 194** See, e.g., REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at 34-35.
- 195** See WEDO, *supra* note 13, at 211.
- 196** See Interview with representative of APRO-FAM, in Guatemala (notes on file with CRLP); see also CANCER PREVENTION PLAN, *supra* note 142, at 3.
- 197** See MSPAS Interview, *supra* note 105.
- 198** See *id.*
- 199** See *id.*
- 200** MSPAS, REPRODUCTIVE HEALTH UNIT, AN ASSESSMENT OF MEDICAL BARRIERS TO FAMILY PLANNING PROGRAMS IN GUATEMALA, at 16-20 (1992) (finding that only 66% of nurses and 34% of auxiliary nurses insert IUDs, and that only 68% of nurses and 50% of auxiliary nurses provide injectable contraceptives) [hereinafter ASSESSMENT OF MEDICAL BARRIERS].
- 201** See MATERNAL AND INFANT HEALTH, *supra* note 17, at 49.
- 202** See MSPAS Interview, *supra* note 105. By contrast, MSPAS had a reproductive health unit, which included within its plans the development of information, communication and education programs in reproductive health, including family planning. See OPERATIVE PLAN, *supra* note 191, at 11-12.
- 203** See MSPAS Interview, *supra* note 105; see also MSPAS, SALUD REPRODUCTIVA Y SEXUAL MANUAL DE REFERENCIA PARA LA APLICACIÓN DE LAS NORMAS DE ATENCIÓN [REPRODUCTIVE AND SEXUAL HEALTH REFERENCE GUIDELINES FOR THE IMPLEMENTATION OF THE STANDARDS OF CARE] (1998) [hereinafter STANDARDS OF CARE].
- 204** See ASSESSMENT OF MEDICAL BARRIERS, *supra* note 200, at 16-20.

- 205** See MATERNAL AND INFANT HEALTH, *supra* note 17, at 49.
- 206** See *id.*
- 207** See *id.* at 6. The IGGs is an autonomous institution (although the Director is named by the President) with its own legal functions. See also OPS, DIVISION OF HEALTH SYSTEMS AND SERVICES, GUATEMALA: PROFILE OF HEALTH SERVICE SYSTEM 4 (revised 1999).
- 208** See Interview with Representative of U.S. Agency for International Development, Population Programs, in Guatemala, (Dec. 3, 1998) (notes on file with CRLP) [hereinafter USAID Interview].
- 209** See CONTRASTS OF HUMAN DEVELOPMENT, *supra* note 58, at 54.
- 210** See USAID Interview, *supra* note 208.
- 211** See *id.*
- 212** See TRANSFORMATION OF HEALTH, *supra* note 6, at 2; see also GOBIERNO DE GUATEMALA, POLÍTICA ECONÓMICA Y SOCIAL PERÍODO [ECONOMIC AND SOCIAL POLITICAL PERIOD] 1991-1996, 51 (1991).
- 213** See GOBIERNO DE LA REPUBLICA DE GUATEMALA, MINISTERIO DE FINANZAS PÚBLICAS, PROYECTO DE PRESUPUESTO GENERAL DE INGRESO Y EGRESOS DEL ESTADO 1999, 28 (1998 and 1999 data) [hereinafter 1999 BUDGET]; see also GOBIERNO DE LA REPÚBLICA DE GUATEMALA, MINISTERIO DE FINANZAS PÚBLICAS, PROYECTO DE PRESUPUESTO GENERAL DE INGRESO Y EGRESOS DEL ESTADO 1997, 29 (1996 and 1997 data); see also CENTRO DE INVESTIGACIONES ECONÓMICAS NACIONALES (CIEN), SALUD PARA LA PAZ [HEALTH FOR PEACE], 8 (1998) (1995 data).
- 214** See GOVERNMENT PROGRAM, *supra* note 12, at 68; see also CONTRASTS OF HUMAN DEVELOPMENT, *supra* note 58, at 53.
- 215** See 1999 BUDGET, *supra* note 213, at 28.
- 216** See GOVERNMENT PROGRAM, *supra* note 12, at 68; see also NGO REPORT, *supra* note 115, at 15.
- 217** See TRANSFORMATION OF HEALTH, *supra* note 6, at 2, 34.
- 218** See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 20.
- 219** See *id.* at 22; see also GOVERNMENT PROGRAM, *supra* note 12, at 67.
- 220** See Interview with indigenous, female politician who is a former trainer of TBAs, conducted in Guatemala (Nov. 24, 1998) (notes on file with CRLP).
- 221** See generally *supra* § II.E.
- 222** See GOVERNMENT PROGRAM, *supra* note 12, at 69; see also NGO REPORT, *supra* note 115, at 20; see also TRANSFORMATION OF HEALTH, *supra* note 6, at 2; see also CONTRASTS OF HUMAN DEVELOPMENT, *supra* note 58, at 52.
- 223** See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 21.
- 224** See TRANSFORMATION OF HEALTH, *supra* note 6, at 39.
- 225** See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 21; see also TRANSFORMATION OF HEALTH, *supra* note 6, at 35; See also Focus Group, *supra* note 94; see also MSPAS Interview, *supra* note 105.
- 226** See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 21.
- 227** TRANSFORMATION OF HEALTH, *supra* note 6, at 35.
- 228** See Focus Group, *supra* note 94; See also MSPAS Interview, *supra* note 105.
- 229** See GOVERNMENT PROGRAM, *supra* note 12, at 68; see also SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 21.
- 230** See TRANSFORMATION OF HEALTH, *supra* note 6, at 35; see also CONTRASTS OF HUMAN DEVELOPMENT, *supra* note 58, at 53; see also MSPAS Interview, *supra* note 105.
- 231** See MSPAS Interview, *supra* note 105.
- 232** See *id.*
- 233** See TRANSFORMATION OF HEALTH, *supra* note 6, at 36.
- 234** See GOVERNMENT PROGRAM, *supra* note 12, at 68; see also NGO REPORT, *supra* note 115, at 20; see also TRANSFORMATION OF HEALTH, *supra* note 6, at 2.
- 235** See SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 38.
- 236** GOVERNMENT PROGRAM, *supra* note 12, at 69-71; see also SOCIAL DEVELOPMENT PLAN, *supra* note 118, at 22-23.
- 237** In addition to the changes discussed below, the 1997 Health Code defines the obligation of the State, in part, as guaranteed free health services to people whose income does not permit them to pay for those services in whole or in part. Health Code, Decree No. 90-97, 1998, art. 4 [hereinafter Health Code]. The Constitution defines the State's obligation in the following terms: "The State will ensure the health of and social assistance to all inhabitants." GUAT. CONST., *supra* note 75, art. 94. Because the new health code ostensibly permits the government to charge for health services, a number

of members of Congress voted against its passage on the grounds that it is unconstitutional. Interview with congressperson from the Frente Nuevo Democrático de Guatemala, in Guatemala (Nov. 24, 1998) (notes on file with CRLP).

238 Health Code, *supra* note 237, art. 8.

239 *Id.* at art. 9 (a).

240 *Id.* at art. 9 (e).

241 *Id.* at arts. 10 (b), 24.

242 *Id.* at art. 18.

243 One of MSPAS's new programs, which may be of great importance to the nation's health, but which is not discussed in detail herein, is a system for purchasing medicines. This buying program aims at reducing the cost of basic medicines distributed from a variety of public and private facilities. *See* CONTRASTS OF HUMAN DEVELOPMENT, *supra* note 58, at 53.

244 *See* MSPAS, SISTEMA INTEGRAL DE ATENCIÓN EN SALUD [COMPREHENSIVE HEALTH CARE SYSTEM (CHCS)], LINEAMIENTOS PARA EL NIVEL PRIMARIO DE ATENCIÓN [PRIMARY CARE GUIDELINES] 1-2 (1997) [hereinafter CHCS].

245 *See id.* at 3.

246 *See id.*

247 *See id.* generally at 20-23; *see also* MSPAS, GUIA PARA LA FORMULACIÓN DE PROPUESTAS PARA LA PRESTACIÓN Y ADMINISTRACIÓN DE SERVICIOS BÁSICOS DE SALUD [GUIDE ON THE MAKING OF PROPOSALS FOR THE PROVISION AND ADMINISTRATION OF BASIC HEALTH SERVICES], at 2 (1998) [hereinafter BASIC HEALTH SERVICES GUIDE].

248 *See* generally CHCS, *supra* note 244, at 20-23; *see also* BASIC HEALTH SERVICES GUIDE, *supra* note 247, at 2.

249 *See* generally MSPAS, SISTEMA INTEGRAL DE ATENCIÓN EN SALUD, SERVICIOS BÁSICOS DE SALUD EN PRIMER NIVEL DE ATENCIÓN [BASIC HEALTH SERVICES AT THE PRIMARY LEVEL OF CARE] (1998) [hereinafter PRIMARY LEVEL OF CARE].

250 *See* MSPAS, AVANCES EXTENSIÓN DE COBERTURA EN EL PRIMER NIVEL DE ATENCIÓN [ADVANCES IN THE EXTENSION OF PRIMARY HEALTHCARE COVERAGE] 5 (1998) (draft document on file with CRLP) [hereinafter HEALTHCARE COVERAGE]; MSPAS, CONTROL DE PROPUESTAS Y CONVENIOS [CONTROL OF PROPOSALS AND AGREEMENTS] (1998) (on file with CRLP).

251 *See* MSPAS Interview, *supra* note 105; *see also*

Interview with Representative of MSPAS, CHCS Program, in Guatemala (Nov. 2, 1998) (notes on file with CRLP) [hereinafter CHCS Interview].

252 *See* CHCS Interview, *supra* note 251.

253 *See* PRIMARY LEVEL OF CARE, *supra* note 249, at 2.

254 *See* CHCS Interview, *supra* note 251; *see also* BASIC HEALTH SERVICES GUIDE, *supra* note 247, at 9; *see also* HEALTHCARE COVERAGE, *supra* note 250.

255 *See* CHCS Interview, *supra* note 251.

256 *See* PRIMARY LEVEL OF CARE, *supra* note 249, at 4; *see also* CHCS, *supra* note 244, at 14.

257 *See* PRIMARY LEVEL OF CARE, *supra* note 249, at 4.

258 *See id.*

259 *See* OPERATIONS RESEARCH, *supra* note 87.

260 *See* CHCS Interview, *supra* note 251.

261 *See* STANDARDS OF CARE, *supra* note 203, at chs. 1-3.

262 *See* PRIMARY LEVEL OF CARE, *supra* note 249, at 1, 4; *see also* Carlos Morales, *supra* note 159, at 17.

263 *See* CHCS Interview, *supra* note 251.

264 *See id.*

265 *See id.*; *see also* PRIMARY LEVEL OF CARE, *supra* note 249, at 3-8.

266 *See* STANDARDS OF CARE, *supra* note 203, at unnumbered introduction.

267 *See* generally *id.*

268 *See* generally *id.*

269 *See id.* at ch. 3, p. 4.

270 *See id.* at ch. 3, pp. 8, 10.

271 *See* PRIMARY LEVEL OF CARE, *supra* note 249, at 1, 4; *see also* Carlos Morales, *supra* note 159, at 17; *See also* REDUCTION OF MATERNAL MORTALITY, *supra* note 71, at 7.

272 *See* generally, Carlos Morales, *supra* note 159, at 17-19.

273 *See id.* at 17-18; *see also* CHCS Interview, *supra* note 251.

274 *See* generally STANDARDS OF CARE, *supra* note 203.

275 Interview with reproductive rights activist, *supra* note 155; Interview with representative of women's rights group, in (Dec. 16, 1998) (notes on file with CRLP).

276 *See* REDUCTION OF MATERNAL MORTALITY, *supra* note 71.

277 *See id.* at 6-7.

278 *See, e.g., id.* at 12 (discussing public education campaign).

279 *See id.* at 5.

280 *See id.* at 6-7.

281 *See id.* at 7.

282 *See id.*

283 *See id.* at 10-16.

284 *See id.* at 9-10, 12. The MI Plan also states that with the objective of preventing obstetrical emergencies, the plan's educational campaigns should include information about family planning.

285 At this stage, these norms are quite new and their effectiveness and level of implementation have not yet been evaluated.

286 *See* STANDARDS OF CARE, *supra* note 203, chs. 1-3.

287 *See id.*

288 Interview with representative of MSPAS, Programa de Materno Infantil [Mother and Child Program], in Guatemala (Nov. 9, 1998) (notes on file with CRLP).

289 *Id.*

290 *See id.*

291 *See* OPERATIONS RESEARCH, *supra* note 87, at 10.

292 *See id.* at 27.

293 *See id.* at 10 - 11.

294 *See, e.g.,* GOVERNMENT PROGRAM, *supra* note 12, at 71. One notable exception to this with respect to information is the MSPAS plan for preventing and addressing cervical cancer, which sets specific goals for public awareness about preventing and controlling cervical cancer. *See* CANCER PREVENTION PLAN, *supra* note 142, at 11.

295 *See* REDUCTION OF MATERNAL MORTALITY, *supra* note 71, at 9.

296 PROGRAMA NACIONAL DE PREVENCIÓN Y CONTROL DEL SIDA, PLAN NACIONAL DE ACCIÓN PARA LA PREVENCIÓN DEL SIDA [NATIONAL PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF AIDS], at 2 (1996).

297 *See id.*

298 *See* CANCER PREVENTION PLAN, *supra* note 142.

299 *See id.* at 11.

300 MSPAS, PROGRAMA NACIONAL MATERNO INFANTIL, PLAN NACIONAL DE ATENCIÓN INTE-

GRAL A LOS Y LAS ADOLESCENTES [NATIONAL PROGRAM OF COMPREHENSIVE ADOLESCENT CARE], (1998).

301 *See id.* at 17-26, 30.

302 *See id.* at 26-29.

303 *See id.* at 31.

304 *See id.* at 33.

305 The Universal Declaration of Human Rights provides that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care and necessary social services" *See* Universal Declaration of Human Rights, adopted Dec. 10, 1948, G.A. Res. 217A (III), U.N. Doc. A/810, art. 25 (1948) [hereinafter Universal Declaration]. The Economic and Social Covenant expands upon this to provide that "the States Parties ... recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." *See* International Covenant on Economic, Social and Cultural Rights, opened for signature Dec. 16, 1966, 993 U.N.T.S. 3, art. 12 (entry into force Jan. 3, 1976). *See also* Article 12 of the Women's Convention, which specifically refers to access to family planning and services related to pregnancy, confinement and the postnatal period and Article 24 of the Children's Convention. Convention on the Elimination of all Forms of Discrimination Against Women, opened for signature March 1, 1980, 1249 U.N.T.S. 13 (entry into force Sept. 3, 1981) [hereinafter Women's Convention]; Convention on the Rights of the Child, opened for signature Nov. 20, 1989, art. 24(3), G.A. Res. 44/25, 44 U.N.GAOR Supp. (No. 49), U.N. Doc. A/Res/44/49, 30 I.L.M. 1448 (1989) (entry into force Sept. 2, 1990) [hereinafter Children's Convention].

306 This right was first articulated at the Teheran Conference in 1968. International Conference on Human Rights, Teheran, Iran 12 May 1968, Res. IX, U.N. Doc. A/CONF.32/41 (1968). The Women's Convention provides in Article 16 that women have "[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." This right implicitly includes the rights to education and information so as to be able to decide responsibly and freely. *See* Sandra Coliver, *The Right to Information Necessary for Reproductive Health and Choice Under International Law*, 44 Am. UNIV. L. REV. 1279, 1280 (1995).

307 *See* Rebecca J. Cook, *Human Rights and Reproductive Self-Determination*, 44 Am. UNIV. L. REV. 101, 123, 134-35 (1995).

- 308** This principle is reflected in an entire convention — the Women’s Convention — whose preamble provides that “discrimination against women violates the principles of equality of rights and respect for human dignity.” Women’s Convention, *supra* note 305, seventh clause.
- 309** The right of indigenous people to be free from discrimination is derived from the right to non-discrimination on the basis of “race, colour ... national or social origin, property, birth or other status ...” set forth in article 2 of the Universal Declaration, *supra* note 305.
- 310** See Cook, *supra* note 307, at 130.
- 311** GUAT. CONST., *supra* note 75, art. 46; Ley de Amparo [Law of Protection], Exhibición Personal y Constitucionalidad, Decreto. No. 1-86 ANC, art. 114 [hereinafter Law of Protection].
- 312** See Law of Protection, *supra* note 311, at art. 114.
- 313** Vienna Convention on the Law of Treaties, art. 14, U.N. Doc. A/Conf. 39/27 (1969), 8 I.L.M. 679 (1969).
- 314** Charter of the United Nations, 59 Stat. 1031 (U.S.); 3 Bevans 1153 (1945), art. 55(c).
- 315** *Id.* at art. 55(b). Art. 56 of the Charter states: “All Members pledge themselves to take joint and separate action in cooperation with the Organization for the achievement of the purposes set forth in Article 55.”
- 316** Universal Declaration, *supra* note 305.
- 317** THOMAS BUERGENTHAL, INTERNATIONAL HUMAN RIGHTS IN A NUTSHELL 29-30 (1988). Although not a binding treaty, some see the UDHR as having given content to the UN Charter provisions on human rights to which all states are bound, therefore conferring on the UDHR a binding character under international law. Others see the Charter and the Declaration as contributing to the development of a customary law of human rights, which is also binding on all states. See LOUIS HENKIN, THE AGE OF RIGHTS 19 (1990).
- 318** Universal Declaration, *supra* note 305, art. 25.
- 319** Article 12 provides that “[n]o one shall be subjected to arbitrary interference with his privacy, family, home or correspondence” *Id.* Numerous commentators have connected the right to privacy with the individual’s right to control his or her reproductive capacity. See e.g., Reed Boland, *Civil and Political Rights and the Right to Non-discrimination*, 44 AM. UNIV. L. REV. 1257, 1260-61 (1995).
- 320** Universal Declaration, *supra* note 305, art. 16.1.
- 321** *Id.* at art. 2.
- 322** See CRLP, REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS 21, 33 (1999).
- 323** Universal Declaration, *supra* note 305, art. 2.
- 324** Rebecca J. Cook, *International Protection of Women’s Reproductive Rights*, 24 INT’L L. & POLITICS 645, 653-54 (1992).
- 325** Economic and Social Rights Covenant, *supra* note 305, art. 2(2); see also International Covenant on Civil and Political Rights, opened for signature Dec. 16, 1966, 999 U.N.T.S. 171, 6 I.L.M. 368, art. 2(1) (entry into force March 23, 1976) [hereinafter Civil and Political Rights Covenant].
- 326** United Nations High Commissioner for Human Rights, Treaty Bodies Database (visited March 15, 2000) <<http://www.unhchr.ch/tbs/doc.nsf/>>.
- 327** Economic and Social Rights Covenant, *supra* note 305, art. 12(1).
- 328** *Id.* at art. 12(2)(a).
- 329** *Id.* at art. 2(2).
- 330** *Id.* at art. 2(1).
- 331** *Id.* at art. 12(2)(d).
- 332** The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, adopted 8 Jan. 1987, U.N. ESCOR, Commission on Human Rights, 43rd Sess., ¶ 21, UN Doc. E/CN.4/1987/17/Annex (1987). The Limburg Principles were approved by a group of experts on human rights at Maastricht in 1986. They also recognized that states must ensure a minimum essential level of each right “regardless of the level of economic development.” *Id.* at ¶ 25.
- 333** The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, ¶ 8, January 22-26, 1997, Netherlands Institute of Human Rights, Utrecht University (visited Oct. 7, 1999) <http://www.law.uu.nl/english/sim/instr/maastr.asp>. The Maastricht Guidelines were adopted by another group of human rights experts that met to further clarify the Limburg Principles adopted ten years’ prior.
- 334** *Id.* For a helpful discussion of the Maastricht Guidelines’ delineation of states’ “obligations of conduct” and “obligations of results” as applied to the reduction of maternal mortality — an issue singled out by the participants who developed the guidelines — see Alicia Ely Yamin and Deborah P. Maine, *Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations*, HUMAN RIGHTS QUARTERLY, vol. 21.3, at 588-591 (1999).

335 CESCR General Comment 3, The Nature of States Parties' Obligations (Art. 2, para.1), at ¶ 10 (visited Oct. 1, 1999) <<http://www.unhchr.ch/tbs/doc.nsf/>> [hereinafter CESCR General Comment 3].

336 Economic and Social Rights Covenant, *supra* note 304, art. 2(1).

337 In this respect, the Committee "recognizes that in many instances legislation is highly desirable and in some cases may even be indispensable; for example ... [i]n fields such as health, the protection of children and mothers" In addition to legislation, other measures which may be considered "include, but are not limited to administrative, financial, educational and social measures." CESCR General Comment 3, *supra* note 335, at ¶ 3.

338 *Id.* at ¶ 10.

339 Concluding Observations of the Committee on Economic, Social and Cultural Rights: Guatemala, ¶ 21, 5 May 1996, U.N. Doc. E/C.12/1/Add.3.

340 *Id.* at ¶ 32.

341 *Id.* at ¶ 26.

342 The first six reports of MINUGUA, which cover up until December 1996, can be viewed at <<http://www.un.org/Depts/minugua/informe.htm>> (visited March 15, 2000).

343 Civil and Political Rights Covenant, *supra* note 325, art. 9(1).

344 *Id.* at art. 17(1).

345 *Id.* at art. 23(2).

346 *Id.* at art. 6(1). Other rights that have been linked to reproductive rights include the right to be free from torture and inhuman or degrading treatment and from medical or scientific experimentation without consent (art. 7) which can result in damage to health due to uninformed use of unsafe contraception. See Reed Boland, *Civil and Political Rights and the Right to Nondiscrimination: Population Policies, Human Rights and Legal Change*, 44 AM. U. L. REV. 1257 (1995).

347 See Civil and Political Rights Covenant, *supra* note 325, art. 2.

348 See Cook, *supra* note 324, at 645.

349 United Nations High Commissioner for Human Rights, Treaty Bodies Database (visited March 15, 2000) <<http://unhchr.ch/tbs/doc.nsf/>>. This means that the government has obligated itself to be bound by the treaty without any limitation as a result of any conflict under its own law. See also CEDAW Concluding Observations on Guatemala, *supra* note 1, at ¶ 40.

350 Women's Convention, *supra* note 305, art. 3.

351 *Id.* at art. 10(h).

352 *Id.* at art. 14 (2)(b).

353 *Id.* at art. 16(1)(e).

354 CEDAW General Recommendation No. 21, Equality in Marriage and Family Relations, 13th Sess., ¶ 22 (visited March 15, 2000) <<http://www.unhchr.ch/tbs/doc.nsf/>>.

355 *Id.* at ¶ 22.

356 CEDAW General Recommendation on article 12: Women and Health, 20th Sess., 2 February 1999, U.N. Doc. C/1999/1/WG.II/WP.2/Rev.1 (visited March 15, 2000) <<http://www.unhchr.ch/tbs/doc.nsf/>> [hereinafter CEDAW General Recommendation on Health].

357 *Id.* at ¶¶ 2, 17.

358 *Id.* at ¶ 17.

359 CEDAW Concluding Observations on Guatemala, *supra* note 1, ¶ 45.

360 *Id.* at ¶ 64. When asked about Guatemala's family planning programs, Guatemala's representative inaccurately asserted not only that Guatemala had a family planning policy, but that the policy was given wide publicity, was open to anybody, and that every small community had family planning services.

361 *Id.* at ¶ 68.

362 Child's Rights Convention, *supra* note 305, arts. 1, 2. Article 1 defines "child" as every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier. *Id.* at art. 1.

363 *Id.* at art. 2 (1).

364 *Id.* at art. 24(2)(f).

365 *Id.* at art. 24(1).

366 *Id.* at art. 16(1).

367 Sonia Correa and Rosalind Petchesky, *Reproductive and Sexual Rights: A Feminist Perspective in POPULATION POLICIES RECONSIDERED* 107-123 (Gita Sen, Adrienne Germaine, and Lincoln Chen, eds. 1994).

368 CRLP, IMPLEMENTING ADOLESCENT REPRODUCTIVE RIGHTS THROUGH THE CONVENTION ON THE RIGHTS OF THE CHILD 3 (1999).

369 Concluding Observations of the Committee on the Rights of the Child: Guatemala, ¶ 22, 7 June 1996, U.N. Doc. CRC/C/15/Add. 58.

370 *Id.* at ¶ 35.

371 UN High Commissioner for Human Rights,

The World Summit for Children, Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s, ¶ 16, 29-30 Sept. 1990, New York, (visited May 1, 2000) <http://www.unhchr.ch/html/menu5/child90.htm>.

372 The International Convention on the Elimination of All Forms of Racial Discrimination (CERD) opened for signature Mar. 7, 1966, S.Treaty Doc. 95-2, 660 U.N.T.S. 195, 5 I.L.M. 352 (entry into force Jan. 4, 1969) [hereinafter CERD].

373 *Id.* at art. 1 (1).

374 *Id.* at art. 5(e)(iv). The Committee has also clarified that states should ensure that indigenous peoples have equal participation in public life, and that “no decisions directly relating to their rights and interests [should be] taken without their informed consent.” CERD General Recommendation 23 concerning Indigenous Peoples, 51st Sess., 18 Aug. 1997, ¶ 4(d), U.N.Doc. CERD/C/51/Misc.13/ Rev.4 [hereinafter CERD General Recommendation 23].

375 CERD, *supra* note 372, art. 2 (2). The Committee on the Elimination of Racial Discrimination “has consistently affirmed that discrimination against indigenous peoples falls under the scope of the Convention and that all appropriate means must be taken to combat and eliminate such discrimination.” *See* CERD General Recommendation 23, *supra* note 374.

376 The Indigenous and Tribal Peoples Convention, art. 25, I.L.O. C.169, ratified by Guatemala 5 May 1996, (entry into force 9 May 1991), provides: “Governments shall ensure that adequate health services are made available to the peoples concerned ... so that they may enjoy the highest attainable standard of physical and mental health.”

377 Agreement of Identity and Rights of Indigenous Peoples, The Situation in Central America, Procedures for the Establishment of a Firm and Lasting Peace and Progress in Fashioning a Region of Peace, Freedom, Democracy and Development, signed 31 March 1995 <<http://www.un.org/depts/minugua/pa.27.htm>>. *See supra* chapter II.B.

378 American Declaration on the Rights and Duties of Man, adopted May 2, 1948, reprinted in OAS, BASIC DOCUMENTS TO HUMAN RIGHTS IN THE INTERAMERICAN SYSTEMS, O.A.S. Rec. OEA/SER.L/V/II.71 (1988).

379 *Id.* at arts. 1, 5, 7, 11,12, 25.

380 Advisory Opinion OC-10/89, Inter-American Court of Human Rights, Series A: Judgments and Opinions, No. 10, ¶ 45 (1989).

381 American Convention on Human Rights, art. 24, opened for signature Nov. 22, 1969, 9 I.L.M. 673, O.A.S. Treaty Ser. No. 36, O.A.S. Rec. OEA/SER.A/16 (1969) [hereinafter American Convention on Human Rights].

382 *Id.* at art. 4.

383 *Id.* at art. 11; *See also* Richard B. Lillich, GLOBAL PROTECTION OF HUMAN RIGHTS IN INTERNATIONAL LAW: LEGAL AND POLICY ISSUES 120-124, 149 (Theodor Meron ed. 1983).

384 *See e.g.*, Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 5-13 Sept. 1994, U.N. Doc. A/CONF.171/13/Rev.I, Principle 8 [hereinafter ICPD Programme of Action].

385 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, “Protocol of San Salvador,” adopted on November 17, 1988, OAS Treaty Series, No. 69, *entry into force* Nov. 1999 [hereinafter Protocol of San Salvador].

386 Guatemala signed the Protocol of San Salvador on November 17, 1988.

387 Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, Austria, 14-25 June 1993, art. 18, U.N. Doc. A/CONF.157/23 (1993).

388 Protocol of San Salvador, *supra* note 385, arts. 3, 10, and 15.

389 Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, “Convention of Belém do Pará,” Brazil, art. 4(a), (b), (c), (e) and (f), G.A. OAS, 24th Sess., adopted on June 9, 1994 (entry into force March 5, 1995) [hereinafter Convention of Belém do Pará].

390 *Id.* at art. 6(a), (b).

391 *See* CRLP, PROMOTING REPRODUCTIVE RIGHTS: A GLOBAL MANDATE (1996).

392 Proclamation of Teheran, Final Act of the International Conference on Human Rights, Teheran, 22 April to 13 May 1968, U.N. Doc. A/CONF. 32/41, at 3 (1968). Paragraph 16 of the document states: “Parents have a basic human right to determine freely and responsibly the number and spacing of their children.”

393 Lynn P. Freeman and Stephen Isaccs, *Human Rights and Reproductive Choice* in 24 STUDIES IN FAMILY PLANNING 18 (1993).

394 ICPD Programme of Action, *supra* note 384, at ¶ 7.3.

395 *Id.* at principle 8, ¶ 7.3.

396 *Id.* at ¶ 7.6.

397 *Id.*

398 *Id.* at ¶ 7.14(c).

399 *Id.* at ¶ 7.16.

400 *Id.* at ¶ 7.19.

401 *Id.* at ¶ 7.20.

402 *Id.* at ¶ 7.23(a).

403 Written Statement of Guatemala reprinted after the ICPD Programme of Action, *supra* note 384 (Part Two, Statements and Reservations on the Programme of Action).

404 The Latin American Countries that entered reservations to the ICPD Programme of Action are: Argentina, Dom. Republic, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, and Peru. *See* ICPD Programme of Action, *supra* note 384, Part two.

405 The list is: the American Declaration of the Rights and Duties of Man; the American Convention on Human Rights; the guidelines adopted at the fifteenth summit meeting of Central American Presidents; the Constitution of the Republic of Guatemala; Civil, criminal and human rights legislation; the Multisectoral Agreement on Population Education issued by the Ministry of Education of Guatemala; and the message to the ICPD from the President of the Republic.

406 ICPD Programme of Action, *supra* note 384, at ¶ 7.3.

407 Beijing Platform for Action, *supra* note 2, at ¶¶ 94 - 97, 106-110, 223.

408 *Id.*, Beijing Declaration, at ¶ 17.

409 *Id.* at ¶ 97.

410 Report of The Fourth World Conference on Women, Beijing, China, 4-15 Sept. 1995, ch. V, ¶ 10, U.N. Doc. A/CONF.177/20. In addition, the Guatemalan government reserved the right to interpret the recommendations of the Platform in accordance with "its unconditional respect for the right to life from the moment of conception."

411 *See* Rebecca J. Cook, *State Accountability for Women's Health*, 49 INT'L DIGEST OF HEALTH LEGIS. 265, 267 (1998); *see also* Donna J. Sullivan, *The Nature and Scope of Human Rights Obligations Concerning Women's Right to Health*, 4 HEALTH AND HUM RTS 369, 377, citing A. Eide, *Economic, Social and Cultural Rights as Human Rights in ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A TEXTBOOK*, (eds. A. Eide et al.), 37-8 (1995); and A. EIDE, *THE RIGHT TO ADE-*

QUATE FOOD AS A HUMAN RIGHT, U.N. Sales No. E.89.XIV.2, at 38 (1989).

412 *See* Cook, *supra* note 411, at 377.

413 *See* Sullivan, *supra* note 411, at 270; *see also* Women's Convention, *supra* note 305, arts. 2(f), 5; *see also* Economic and Social Rights Covenant, *supra* note 305, art. 2. The Inter-American Court of Human Rights discussed the duties of states parties under the American Convention on Human Rights to "ensure" the free and full exercise of the rights in the Convention, which includes a state's "lack of due diligence to prevent the violation or to respond" to violations of rights. Inter-American Court of Human Rights, Ser. C., No. 4, 9 HUM. RTS. L. J. 212 (1988).

414 This governmental duty is most directly established in the Women's Convention which guarantees "access to specific educational information to help ensure the health and well-being of families ..." and which prohibits discrimination "in the field of health care ..." and ensures equal "access to health services, including those related to family planning." Women's Convention, *supra* note 305, arts. 10(h), 12. The Economic and Social Rights Covenant (art. 12(2)) and the Child's Rights Convention (art. 24(1)) also establish governments' obligation to guarantee access to all necessary health services. *See generally*, Sullivan, *supra* note 411, at 377.

415 For a discussion of the applicable norms giving rise to this standard and its consideration in the context of maternal mortality, *see* Yamin and Maine, *supra* note 334, at 583-86.

416 Universal Declaration, *supra* note 305, art. 28; *see also* Economic and Social Rights Covenant, *supra* note 305, preamble; *see also* Civil and Political Rights Covenant, *supra* note 325, preamble.

417 The Economic and Social Rights Covenant requires states "to take steps ... to the maximum of [their] available resources." Some of the various rights implicated by the government's failure to provide family planning information and services are regarded as having "immediate effect," such as the right to life, to privacy, and to liberty and security of person. Because these rights constitute civil and political rights, they are not regarded as being dependent on economic resources. Indeed, the Guatemalan government's failure to integrate the right to family planning information and resources into its policies can be regarded as a failure of political will to ensure realization of these rights. Economic and Social Rights Covenant, *supra* note 305, art. 2(1).

- 418** CESCR, General Comment 3, *supra* note 335, art. 2(1), ¶ 9.
- 419** *Id.*
- 420** Women's Convention, *supra* note 305, art. 2.
- 421** CEDAW General Recommendation on Health, *supra* note 356, ¶ 17.
- 422** Velasquez Rodriguez Case, Judgment of July 29, 1988, Inter-Am. Ct. H.R. (Ser. C) No. 4 (1998).
- 423** CEDAW General Recommendation on Health, *supra* note 356, ¶ 31(b).
- 424** GUAT. CONST., *supra* note 75.
- 425** *Id.* at art. 93. This provision explicitly states that the right to health is extended to all citizens without discrimination. Thus, indigenous people and women are guaranteed this right without discrimination.
- 426** *Id.* at art. 2.
- 427** *Id.* at art. 94.
- 428** *Id.* at art. 95.
- 429** *Id.* at art. 96.
- 430** Inconstitucionalidad General Expedientes Acumulados 355-92, 359-92 (1993), Gaceta de la Corte de Constitucionalidad 28, at 19.
- 431** The case interpreted articles 2, 93, 94, 95, and 96 to establish the government's duty to regulate all products, pharmaceuticals, and chemicals that can affect health, including those that are imported. It declared unconstitutional a law that would have allowed imported medicines not to be subject to the same regulation as local medicines. The case does not explicitly address the government's duty to supply health care services in a proactive manner. *Id.* at Gacetas 14, 21.
- 432** GUAT. CONST., *supra* note 75, art. 4. In protecting the family, article 47 also provides that both spouses have equal rights.
- 433** Article 52 of the Constitution provides that the State shall provide for the strict enforcement of all the rights and obligations that derive from maternity. By failing to enact a legislative and policy framework to ensure access to comprehensive reproductive health care, including family planning, the government is violating this provision as well.
- 434** GUAT. CONST., *supra* note 75, art. 47.
- 435** See *supra* § II. I.
- 436** GUAT. CONST., *supra* note 75, art. 98.
- 437** Article 66 of the Constitution protects the life and traditions of indigenous men and women. On May 17, 1999, Guatemalans voted against a Constitutional reform that was approved by Congress and that, among other provisions, would have granted additional rights to the indigenous peoples in Guatemala. See *Guatemalans Deny Changes for Indians and Army*, NY TIMES SERVICE, May 17, 1999.
- 438** The Comprehensive Agreement on Human Rights, (entry into force March 29, 1994) [hereinafter Agreement on Human Rights]. Texts of all the Accords can be found at <<http://www.mdngt.org/paz>> (visited March 15, 2000).
- 439** Agreement on a Firm and Lasting Peace, ¶ 10.
- 440** Agreement on Human Rights, ch X, ¶ 1.
- 441** *Id.* at ¶ 2.
- 442** *Id.* at ¶ 5(a).
- 443** *Id.* at ¶ 5(b).
- 444** Robert E. Lutz, *A Piece of the Peace: The Human Rights Accord and the Guatemalan Peace Process*, 2 SOUTHWESTERN JOURNAL OF LAW AND TRADE IN THE AMERICAS 183 (1995).
- 445** Agreement on Resettlement of the Population Groups Uprooted by the Armed Conflict, ch. III, ¶ 8.
- 446** Agreement on Social and Economic Aspects and Agrarian Situation, signed on June 5, 1996, ch. I, ¶ 13(d).
- 447** *Id.* at ¶ 13.
- 448** *Id.* at ch. II, ¶ 15.
- 449** *Id.* at ¶ 20(a).
- 450** *Id.* at ¶ 19(b).
- 451** *Id.* at ¶ 20(d).
- 452** *Id.* at ¶ 20(c).
- 453** *Id.* at ch. II, § B, ¶ 23(a).
- 454** *Id.* at ¶ 23(d).
- 455** *Id.* at ¶ 23(c).
- 456** *Id.* at ch. I, ¶ 10(e), ch. II, §B, ¶ 23(g).
- 457** *Id.* at ch. II, § B, ¶ 23(c).
- 458** Agreement on the Identity and Rights of Indigenous Peoples, signed on March 31, 1995, at ¶ 2(d).
- 459** Agreement on Social and Economic Aspects and Agrarian Situation, signed on May 6, 1996.
- 460** See *supra* Chapter III.C.1.
- 461** Health Code, *supra* note 237, art. 1.
- 462** *Id.* at art. 4. This article also guarantees that the Ministry of Health shall provide free health services to those who cannot afford to pay.

463 *Id.* at art. 6.

464 *Id.* at art. 44. This article refers to a comprehensive approach to health, including improvements in the physical and social aspects of health.

465 This has been demonstrated through its Plan to Reduce Maternal and Prenatal Mortality, cervical and uterine Cancer, <<http://www.safemotherhood.org>> and adolescent reproductive health programs. See Chapter III. C. 3.

466 See, e.g., Safe Motherhood Initiative Fact Sheets, Inter-Agency Group, <<http://www.safemotherhood.org>> (visited March 15, 2000), which affirms that family planning programs should be available before and after pregnancy, “as part of a comprehensive programme that addresses other sexual and reproductive health needs”; See also ICPD Programme of Action, *supra* note 384, ch. VII, ¶¶ 7.12, 7.13 and Beijing Platform for Action, *supra* note 2, ¶¶ 94, 95.

467 Both the past President and the Congress were extremely conservative. It was difficult to pass any legislation related to gender issues. Passage of legislation on reproductive health was even more controversial for conservatives. See Interview with Congressperson from the Frente Nuevo Democrático de Guatemala, conducted in Guatemala (Nov. 24, 1998) (notes on file with CRLP).

468 See, e.g., ANITA HARDON, ANN MUTUA, SANDRA KABIR & ELLY ENGLELKE, MONITORING FAMILY PLANNING AND REPRODUCTIVE RIGHTS: A MANUAL FOR EMPOWERMENT (1997) (containing useful indices of the the content evaluating aspects of reproductive health programs).

469 See *supra* Chapter III.C (discussing recent health legislation and programs).

470 See *supra* Chapter II.E (discussing the current unmet need in Guatemala for family planning information and services).

471 See Health Code, *supra* note 237, ch. III, arts. 12-15.

472 See WHO, CONSIDERATIONS FOR FORMULATING REPRODUCTIVE HEALTH LAWS, (written by Rebecca J. Cook and Bernard M. Dickens), WHO/FRH/WOM/98.1 (Geneva, 1998).

473 For example, the Colombian government enacted “Participation and Equality Policy for Women,” a policy initiative designed to comprehensively address women’s health, through programs that respond to their specific needs. CRLP AND DEMUS, WOW LATINAMERICA, *supra* note 124, at 75.

474 REPRODUCTIVE HEALTH CENSUS, *supra* note 97, at 46-47.

475 *Id.*

476 The procedures for the Congressional Human Rights Commission [Comisión de los Derechos Humanos del Congreso de la República] are set forth in the Law for the Congressional Human Rights Commission and the Public Prosecutor for the Defense of Human Rights [Ley de la Comisión de Derechos Humanos del Congreso de la República y del Procurador de los Derechos Humanos], tit. I, ch. I, tit. II, ch. V [hereinafter Human Rights Commission Law].

477 See GUAT. CONST., *supra* note 75, ch. 5, art. 275 (a), (c) (CRLP translation). As discussed in *supra* Chapter IV, the government’s refusal to promote and protect access to family planning services and information constitutes a violation of numerous rights instruments, as well as Guatemala’s domestic law.

478 See e.g., Expediente EIO. GUA. 71-97/DS, in DETAILED ANNUAL REPORT, *supra* note 114, at 57-58; see also *id.* at 43-44.

479 For example, the Commission was a key player in the adoption of the Civil Code related to women’s status in marriage only because women’s advocates filed a discrimination case before the Inter-American Commission. See OAS Annual Report 1997, 98th Sess., Report No. 28/98, Case 11.625, María Eugenia Morales de Sierra Guatemala, March 6, 1998, (visited May 1, 2000) <<http://www.cidh.oas.org/annualrep/97eng/97ench3Lan.htm>>.

480 GUAT. CONST., *supra* note 75, ch. 5, art 275 (c).

481 See Human Rights Commission Law, *supra* note 476, tit. II, ch. II, art.14(g).

482 *Id.* at art 13(f); see also GUAT. CONST., *supra* note 75, ch. 5, art. 275.

483 See, e.g., Actuación 673-97/Gua, Aug. 21, 1997 (anonymous complainants), in DETAILED ANNUAL REPORT, *supra* note 114, at 11.

484 See e.g., Expediente EIO. GUA. 64-96/DS (made by community), in DETAILED ANNUAL REPORT, *supra* note 114, at 46-47; see also Human Rights Commission Law, *supra* note 476, arts. 26, 14(f).

485 See Human Rights Commission Law, *supra* note 476, art 26.

486 *Id.* at art 13(e); see also, GUAT. CONST., *supra* note 75, ch. 5, art. 275 (d), (e).

487 El Pan la Emprende Contra Arango, LA CRONICA, 8 (Nov. 27, 1998).

488 An action may ultimately be taken before the Inter-American system but domestic remedies first must be exhausted. American Convention on Human Rights, *supra* note 381, art. 46(a).

489 Law of Protection, *supra* note 311, art. 8; *see also* GUAT. CONST., *supra* note 75, tit. VI, ch. 2, art. 265, which establishes *amparo* to protect all persons against threats to the violation of their human rights or to reinstate these rights when the violation has occurred. All areas are covered by *amparo*, and it proceeds whenever acts, resolutions, dispositions, or laws by a government authority contain an implicit threat, restriction, or violation to the rights guaranteed by the Constitution and laws.

490 Law of Protection, *supra* note 311, art. 19. However, some scholars argue that in Guatemala the requirement that ordinary remedies be exhausted first, effectively nullifies the utility of filing an *amparo* petition since such petitions normally take six to eight years to resolve. *See* Roldofo Piza, Comentarios a la ponencia de Viviana Kristicevic in CLADEM Y IIDH, PROTECCIÓN INTERNACIONAL DE LOS DERECHOS HUMANOS DE LAS MUJERES, I curso taller, at 221 (1997).

491 Law of Protection, *supra* note 311, art. 10(a); *see also* GUAT. CONST., *supra* note 75, tit. 6, ch. 2, art. 265.

492 Different Courts hear the *amparo* petitions, depending on whom the action is against. For example, the Constitutional Court hears *amparo* petitions against the Supreme Court of Justice. *See* GUAT. CONST., *supra* note 75, tit. VI, ch. IV, art. 272; *see also* Law of Protection, *supra* note 311, art. 11.

493 Law of Protection, *supra* note 311, art. 49(a).

494 *Id.* at art. 59.

495 *Id.* at art. 46

496 *Id.* at art. 20.

497 *Id.* at art. 25.

498 *See* GUAT. CONST., *supra* note 75, tit. 6, ch. 3, art. 267 This article refers to laws or regulations that are “general”; Law of Protection, *supra* note 311, art. 133.

499 Such an action may be brought pursuant to chapter 3, article 266 of Guatemala’s Constitution.

500 Law of Protection, *supra* note 311, art. 134.

501 *Id.* at art. 148. This article provides three exceptions if the case was brought by the Attorney General, the Public Prosecutor for the Defense of Human Rights or the President of the Bar Association. *Id.* at art. 134.

502 *See* Agreement on Social and Economic Aspects and the Agrarian Situation, section I, Participation of Women in Economic and Social Development (visited March 15, 2000) <<http://www.un.org/depts.minugua/par.8.htm>>.

503 *See supra* discussion of the recommendations to Guatemala of the Committee on Economic, Social and Cultural Rights.

504 American Convention on Human Rights, *supra* note 381, at arts. 4, 11, 24; Convention of Belém do Pará, *supra* note 389, art. 12.

505 American Convention on Human Rights, *supra* note 381, art. 41.

506 *Id.* at art. 41(d).

507 *Id.* at art. 41(b).

508 This article contains a general provision which states: “The States Parties undertake to adopt measures ... with a view to achieving progressively by legislation or other means, the full realization of the rights implicit in the economic, social, educational, scientific and cultural standards set forth in the Charter of the Organization of American States ...” The OAS Charter provides standards that promote and protect these rights and that obligate member States. For the human rights principles, *see* article 45 of the OAS Charter; *see also* H. STEINER AND P. ALSTON, INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS 643 (1996).

509 Regulations of the Inter-American Commission on Human Rights, OAS General Secretariat, Basic Documents Pertaining to Human Rights in the Inter-American System, art. 64 (1) (1996). Pursuant to article 42 of the American Convention, the Commission “may watch over the promotion” of economic, social and cultural rights, by receiving a copy of the reports and studies that states parties are required to submit to the Inter-American Economic and Social Council and the Inter-American Council for Education, Science and Culture, both organs of the OAS entrusted with the promotion of these rights.

510 *Id.* at art. 64 (6).

511 *Id.* at art. 64 (3).

512 *Id.* at art. 64 (4), (5).

513 American Convention on Human Rights, *supra* note 381, art. 44; *see also* Convention of Belém do Pará, *supra* note 389, art. 12.

514 American Convention on Human Rights, *supra* note 381, art. 46(1)(a); *see also* Convention of Belém do Pará, *supra* note 389, at art. 12.

515 Under some conventions, optional protocols have been adopted which permit individual complaints to be filed. *See*, e.g., Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. A/54/4 (Oct. 6, 1999); *see also* Optional Protocol to the International Covenant on Civil and Political Rights, opened for signature 16 December 1966, entry into force 23 March 1976, G.A. Res. 2299A (XXI). However, signature and ratification are optional and Guatemala has not ratified these protocols.

516 For examples of recent Committee reports on Guatemala, *see*, e.g., Concluding Observations of the Committee on the Rights of the Child: Guatemala, ¶ 22, 7 June 1996, U.N. Doc. CRC/C/15/Add.58; Concluding Observations of the Committee on Economic, Social and Cultural Rights: Guatemala, ¶¶ 21, 28, 28 May 1996, U.N. Doc. E/C.12/1/Add.3; Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Guatemala, ¶¶ 45, 63-66, 12 April 1994, U.N. Doc. A/49/38.

517 *See supra* note 516 regarding the Committees' concluding observations.

518 Radhika Coomaraswamy, Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences to the Commission on Human Rights (1999) E/CN.4/1999/68/Add.4.

519 The Implementation of the Human Rights of Women, Traditional Practices Affecting the Health of Women and the Girl Child, 26 June 1998, 49th Sess., U.N. Doc. E/CN.4/Sub.2/1998/11. For example, paragraph 25 states that contraception is

made available to women without indicating if the government or NGOs are providing it.

520 Law for the Dignity and Integral Promotion of Women, Decree No. 7-99 of March 8, 1999, in DIARIO DE CENTROAMERICA, Vol. 241, No. 29 (April 9, 1999).

521 *Id.* at art. 2(a).

522 *Id.* at Preamble.

523 *Id.* at Preamble, art. 2(b).

524 *Id.* at art. 5.

525 MSPAS, REPRODUCTIVE AND SEXUAL HEALTH, REFERENCE MANUAL ON THE APPLICATION OF THE STANDARDS OF CARE, 6-13 (1999); *see also supra* Chapter III.C.2.

526 *Id.* at 6.

527 *Id.*

528 *Id.* at 7.

529 *Id.* at 8-13.

530 Communication with former UNFPA representative (now with UNDP in Guatemala following gender and health), April 5, 2000 (on file with CRLP).

531 *See* TERTULIA, *supra* note 28, Vol. III, No. 10-18, March 2000 (Laura E. Asturias, ed.), citing Luisa Fernanda Rodríguez, Birth Control Campaign Causes Debate, PRENSA LIBRE (March 19, 2000).

532 *Id.*

533 *Id.*

534 *Id.*

535 *Id.*