Организация Объединенных Наций A/HRC/17/25/Add.2

Генеральная Ассамблея

Distr.: General
16 March 2011
Russian
Original: English

Совет по правам человека
Семнадцатая сессия
Пункт 3 повестки дня
Поощрение и защита всех прав человека, гражданских, политических, экономических, социальных и культурных прав, включая право на развитие

Доклад Специального докладчика по вопросу о праве каждого человека на наивысший достижимый уровень физического и психического здоровья Ананда Гровера

Добавление

Миссия в Гватемалу*

Резюме

Специальный докладчик по вопросу о праве каждого человека на наивысший достижимый уровень физического и психического здоровья посетил Гватемалу 12−18 мая 2010 года. Специальный докладчик провел встречи с представителями правительства, организациями гражданского общества, специалистами в области здравоохранения и представителями коренных общин в городе Гватемале, Малакантасито, Уэуэтенанго и Истауакане.

Во время миссии Специальный докладчик отметил, что сектор здравоохранения в Гватемале серьезно недополучает ресурсы и сосредоточивается в городских районах. Кроме того, прослеживается существенное неравенство в осуществлении права на здоровье коренными общинами и женщинами, в частности в областях сексуального и репродуктивного здоровья. Он также выразил обеспокоенность по поводу правительственной политики, ограничивающей доступ к лекарственным препаратам.

* Резюме настоящего доклада распространяется на всех официальных языках. Сам доклад, содержащийся в приложении к резюме, распространяется только на том языке, на котором он был представлен, и на испанском языке.

Доклад состоит из шести разделов. В разделе I Специальный докладчик представляет вводную информацию по докладу. В разделе II подытоживается исторический контекст давнего неравенства и дискриминации в гватемальском обществе и излагается международная и национальная нормативная база права на здоровье. В разделе III Специальный докладчик анализирует вопросы охраны здоровья коренных общин, включая исторические условия, обусловившие те проблемы, с которыми в настоящее время сталкиваются эти общины. Указанные проблемы в значительной степени связаны с глубоко укоренившимся неравенством и дискриминацией, которые оказывают пагубное воздействие на основные факторы здравоохранения, а также доступ к медико-санитарной помощи. В дополнение к отсутствию всеобъемлющей политики или национального плана, касающегося оказания медико-санитарной помощи коренным народам, в качестве ключевых барьеров для доступа коренных народов к медико-санитарной помощи были отмечены сосредоточение услуг здравоохранения в городских районах, недостаточное финансирование и существенные языковые барьеры. В разделе IV он обсуждает право женщин на здоровье, в частности сексуальное и репродуктивное здоровье. Он отмечает, что проживающие в сельских районах женщины, принадлежащие к коренным народам, остаются маргинализованной группой и что существуют серьезные различия в плане показателей использования контрацептивов и доступа к акушерской помощи. Он также выражает обеспокоенность по поводу статуса законов об абортах в Гватемале и вызванного этим широкого распространения практики небезопасных абортов, а также увеличивающихся масштабов насилия в отношении женщин.

В разделе V обсуждается доступ к лекарственным препаратам, в частности правительственная политика государственных закупок лекарственных средств и положения об интеллектуальной собственности, содержащиеся в Центральноамериканском соглашении о свободной торговле, которые ограничивают доступ к лекарственным препаратам. В разделе VI Специальный докладчик высказывает некоторые рекомендации по каждому из вопросов, рассматривавшихся в ходе миссии.

Annexe

Contents

I. Introduction

1. At the invitation of the Government, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health visited Guatemala from 12 to 18 May 2010. The purpose of the mission was to understand, in a spirit of co-operation and dialogue, how Guatemala endeavours to implement the right to health, the measures taken for its successful realization and the obstacles encountered both at the national and international level.

2. The focus of the mission was on the right to health of indigenous peoples; the right to health of women, specifically considering sexual and reproductive health; and access to medicines. Additionally, the mission generally examined the impact of poverty, discrimination and inequalities on the enjoyment of the right to health. During the mission, the Special Rapporteur travelled to Guatemala City, Malacantacito, Huehuetenango and Ixtahuacán, and had the opportunity to visit indigenous communities and meet with their representatives.

3. Throughout the mission, all levels of Government and other relevant actors were open and constructive. The Special Rapporteur had the pleasure of meeting the Vice-President, Rafael Espada; the Minister of Finance, Juan Alberto Fuentes; the Minister of Health, Ludwig Ovalle; the First Vice-President of Congress, Gabriel Heredia; the President of the Health Commission, Víctor Manuel Gutiérrez Longo; as well as a number of other senior Government officials.

4. During the mission, the Special Rapporteur also held meetings with the Human Rights Ombudsman (Procurador de los derechos humanos) and his staff; with magistrates of the Constitutional Court, including its President; and with members of the Congress, including its President. The Special Rapporteur also had exchanges with representatives of the Presidential Commission on Discrimination and Racism against Indigenous Peoples in Guatemala and the Office for the Defence of Indigenous Women. In addition, the Special Rapporteur met with members of the international community in Guatemala.

5. The Special Rapporteur had the opportunity to meet with representatives of civil society organizations and communities, academics and health professionals, and would like to thank all those who have given their time and extended co-operation to him.

II. Background and legal framework

6. Guatemalan society is marked by long-standing inequalities and discrimination that can be traced back to the dispossession and social exclusion of its original inhabitants resulting from the Spanish conquest and colonization of Central America. The country recently experienced a brutal, 36-year-long civil war, which ended only 14 years ago. The 1996 Peace Accord, along with the 1985 Constitution, set the groundwork for the contemporary Guatemalan State.

7. Today, Guatemala is classified as a middle-income country with a strong exports sector, particularly related to agriculture. This income level, however, has not adequately translated into equal, sustainable development; the country ranked 116 of 169 countries in the Human Development Index in 2010.[1] The colonial impact continues to profoundly affect the majority indigenous peoples, the Maya, Xinca and Garifuna, of whom nearly

[1] United Nations Development Programme (UNDP), Human Development Report 2010: The Real Wealth of Nations: Pathways to Human Development (New York, 2010).

75 per cent live in poverty.[2] The most apparent manifestation of the colonial legacy in Guatemala is the extremely unequal distribution of both land and wealth between persons of European ancestry (criollos) and the indigenous peoples. Fifty-four per cent of all farms occupy only four per cent of the total area of agricultural land, while 2.6 per cent of larger farms account for nearly two thirds of total arable land.[3] The wealthiest 20 per cent of the population consumes 57.8 per cent of the gross domestic product (GDP).[4]

8. The 2010 per capita gross national income converted into purchasing power parity is $4,694, and yet approximately 51 per cent of the population live below the national poverty line.[5] By an internationally accepted measure of inequality (the Gini coefficient) Guatemala ranks as one of the most internally unequal countries in Central America and, indeed, the world.[6] Although this situation resulted from particular historic events and policies, the inability of the State to generate revenue is now primarily a result of its inability to levy sufficient taxes. The tax rate, at 11.3 per cent of GDP in 2008, is one of the lowest in the world.[7] This has limited State resources, and allowed capital to remain largely in the hands of a few, generally landed, criollos.

A. The right to health in Guatemala: an overview

9. The Ministry of Public Health and Social Assistance (Ministerio de Salud Pública y Asistencia Social de Guatemala, or MSPAS) is the primary health-care services and goods provider in Guatemala, constituting around 70 per cent of all health-care provision. This, however, does not mean that all receive the same kind or level of services; the majority of this percentage only receive a basic package of services through subcontracted non-governmental organizations that visit communities once a month. Permanent services are absent in most rural areas.

10. It is complemented by the social security system (Instituto Guatemalteco de Seguridad Social or IGSS), which covers approximately 10 per cent of the population through work-based health-care insurance. Finally, the Ministry of Defence provides health-care services to the armed forces. These three institutions comprise the bulk of the public health system.

11. Public, private and social security expenditures on health comprise approximately 7.3 per cent of GDP, on a par with other parts of Latin America.[8] Yet, in comparison, health indicators in Guatemala are amongst the lowest in the region. Total health expenditure is the primary difference between Guatemala and other countries in the region; public expenditure comprises a much smaller proportion of the aggregate percentage in Guatemala.[9] The experience of other similarly situated countries suggests that even the

[2] Instituto Nacional de Estadística (INE), *National Survey of Living Conditions 2006* (ENCOVI 2006), (Guatemala, 2006), p. 1. Available at www.ine.gob.gt.

[3] La Comisión para el Esclarecimiento Histórico (CEH), "Guatemala: Memoria Del Silencio" (February 2009), para. 2. Available from http://shr.aaas.org/guatemala/ceh/report/spanish/.

[4] World Bank, "Income Share Held by Highest 20%", *World Development Indicators database* (2006). Available from http://data.worldbank.org/.

[5] UNDP, *Human Development Report 2010* (New York, 2010), pp. 145, 162.

[6] World Bank, "GINI Index", *World Development Indicators database* (2006). Available from http://data.worldbank.org/.

[7] World Bank, "Tax revenue (% GDP)", *World Development Indicators database* (2008). Available from http://data.worldbank.org/.

[8] World Bank, "Health expenditure, total (% GDP)", *World Development Indicators database* (2008). Available from http://data.worldbank.org/.

[9] World Health Organization (WHO), *National Health Account database* (2008). Available from http://www.who.int/nha/country/gtm/en/.

limited resources available for health in Guatemala can be allocated more efficiently to improve the overall health outcomes of its citizens.

12. Unfortunately, the recent trend in Guatemala has not been to increase investment in health or promote more efficient allocation of resources. Public investment in health has declined over the last two decades, and the little investment made is largely at the tertiary level. For the most vulnerable communities – rural indigenous peoples and women – the greatest area of need is in primary care, as will be discussed. Various attempts to address this deficiency are being made, but much more will need to be done.

13. The health sector is severely under-resourced and concentrated in urban areas, despite a reported increase in budget allocation to the Ministry of Health for the period 2007-2010. For the first time in nearly 20 years, health-care spending significantly decreased in absolute terms in the 2010 budget; previously, there were at least nominal increases intended to cover for the cost of inflation. Policies promoting increased privatization of health services, along with a lack of public expenditure, have resulted in a fragmented health-care system in which private primary and secondary level care is frequently unavailable in rural areas, and the public system is unable to fill the gap. These rural communities require access to comprehensive primary health services, goods and facilities but often cannot afford to pay the high prices of private health care. Private expenditure on health is estimated to total 72 per cent of the total health expenditure.[10]

14. Moreover, the trauma of the civil war has added to the burden of mental illness and disability in the population, particularly in rural indigenous communities that were disproportionately affected by violence during the war. This issue is not being adequately addressed by the Government; only one per cent of the current health budget is allocated to mental health care, and community mental health services do not exist. The only mental health institution in Guatemala is overcrowded and under-resourced. Much of its resources are utilized to detain unsentenced prisoners and persons with mental disabilities – groups that should be housed separately. Although the scope of the problem was not further assessed throughout the mission, the Special Rapporteur believes this to be a critical area requiring significant improvements.

15. In addition to increased resource allocation to rural health-care services, concerted efforts are needed to comprehensively incorporate rural health training into the curricula of medical professionals. Many doctors and other health workers are not trained to address the particular problems faced in rural communities, one reason among several for their reluctance to work in remote areas. Moreover, those that receive rural health training must be supported adequately in meeting the challenges of serving such communities.

16. Like many other countries in Latin America, Guatemala has initiated a conditional cash transfer programme. The Mi Familia Progresa programme was started by the Government of Alvaro Colom and operates under the umbrella of the Consejo de Cohesión Social, a set of social welfare programmes. The programme services over 30 municipalities, and links cash transfers to educational and health/nutritional requirements. The programme, however, must be re-evaluated to ensure implementation within a right to health perspective and in a non-discriminatory manner, as will be discussed further.

17. To their credit, some senior Government leaders attach priority to human rights, including the right to health, and recognize the issues faced by the country. There is a constitutional right to health guaranteed to the citizens of Guatemala, but it is not being realized.

[10] Ibid.

B. International, regional and national legal framework

18. Guatemala has ratified numerous international treaties that explicitly provide for the right to health: the International Covenant on Economic, Social and Cultural Rights, and its Optional Protocol (signed, but not yet ratified); the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child, the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Rights of Persons with Disabilities; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families; and Convention No. 169 of the International Labour Organization.

19. In Guatemala international treaties take immediate domestic effect upon ratification. Moreover, the Guatemalan Constitution gives pre-eminence to human rights treaties ratified by the Government over juridical order and domestic law.[11] Consequently, all international treaties that include the right to health – or any other human rights norm – take priority status in Guatemala over domestic law.

20. Guatemala has affirmed the right of indigenous peoples to access all social and health services without discrimination through the endorsement of the United Nations Declaration on the Rights of Indigenous Peoples. Having the third largest indigenous population in Latin America,[12] Guatemala is committed to improving the economic and social conditions of indigenous peoples, including the rights to education, work, housing and health.

21. Guatemala also has regional human rights obligations that include the right to health. As a member of the Organization of American States, Guatemala is a party to the American Convention on Human Rights, which calls for the progressive realization of all rights implicit in the economic, social, educational, scientific and cultural standards set forth in the Charter of the Organization. Furthermore, it has ratified and acceded to the Additional Protocol to the American Convention on Human Rights on economic, social and cultural rights, known as the Protocol of San Salvador, in which the right to health is set out in article 10.

22. The Guatemalan Constitution explicitly recognizes the right to health in articles 93 to 96 in a section that establishes various economic, social and cultural rights. Moreover, as stated earlier, priority is given to international human rights instruments over domestic law through article 46 of the Constitution.

C. The right to health framework

23. The analysis in this report is grounded in article 12 of the International Covenant on Economic, Social and Cultural Rights, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This implies ensuring that health facilities, goods and services are available, accessible and acceptable to everyone and are of good quality.

24. Availability requires a functioning public health system and health-care facilities, goods and service in sufficient quantity within a State. Accessibility has four overlapping dimensions: (a) non-discrimination, requiring that health facilities, goods and services be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any prohibited grounds; (b) physical

[11] Constitution of Guatemala, art. 46, 1985.

[12] Raul A. Montenegro and Carolyn Stevens, "Indigenous health in Latin America and the Caribbean", *Lancet,* vol. 367, no. 9525 (June 2006), p. 1860.

accessibility, requiring that health facilities, goods and services are within safe physical reach for all sections of the population, including women, children, indigenous peoples, older persons or persons with disabilities; (c) economic accessibility, requiring that health facilities, goods and services are affordable for all; and (d) information accessibility, which includes the right to seek, receive and impart information and ideas concerning health issues. Acceptability requires that health facilities, goods and services are medically and culturally acceptable. Finally, as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

25. The right to health is an inclusive right, extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, safe food and adequate nutrition, adequate housing, and healthy occupational and environmental conditions, inter alia. The underlying determinants of health extend beyond just material rights, and include social determinants such as inequality.

D. The right to health and its underlying determinants

26. Access to basic health facilities, goods and services is highly inequitable for the most vulnerable and marginalized, and this has consequences for an individual's health, often placing a tremendous burden on the health-care system. The combination of limited primary care facilities, difficulties in physical accessibility to health care for rural populations, and diminished access to underlying determinants of health, including food, water and sanitation, has created an environment in which people are at increased risk of morbidity and mortality resulting from readily preventable or treatable illnesses.

27. Some of the most acute deprivations concern access to an adequate supply of nutritious food, and general food insecurity. The prevalence of chronic malnutrition in Guatemala places it fourth in the world, and first in Latin America, at 43.4 per cent.[13] Disaggregated data reveals the severity of the situation, especially concerning indigenous peoples and children. Some estimates indicate that 58.6 per cent of indigenous children under five are malnourished.[14] Even though indigenous peoples comprise the majority of the population, most policy decisions are taken without any input from the indigenous community, especially when many of these relate to land development.[15]

28. Deficiencies with respect to access to safe drinking water and adequate sanitation also demonstrate profound geographic and ethnic disparities. In 2006, although 78.6 per cent of all households had access to a water supply, 91.2 per cent of urban households compared to 64.2 per cent of rural households had access.[16] Similar disparities exist with respect to sanitation: only 17 per cent of rural households have access to adequate sanitation facilities. The Special Rapporteur, however, notes with commendation that a 2009 World Bank report shows a significant improvement in access to sanitation for the period 2000-2006, one of the greatest in the last 25 years.[17]

29. Lack of access to both health care and other basic services in these areas reveals the disparities in treatment between the urban/rural and criollo/indigenous communities, of which the latter two are often unable to access the most basic material necessities of life. It

[13] Samuel Loewenberg, "Guatemala's nutrition crisis", *Lancet*, vol. 374, No. 9685 (July 2009), p. 187.

[14] INE, *Encuesta Nacional de Salud Materno-Infantil 2008-2009* (Guatemala, 2009), p. 46. Available from www.ine.gob.gt/.

[15] A/HRC/13/33/Add.4.

[16] WHO/UNICEF, "Estimates for the use of Improved Drinking-Water Sources", (Guatemala, March 2010), p. 6. Available from: http://www.wssinfo.org/fileadmin/user_upload/resources/GTM_wat.pdf.

[17] World Bank, *Guatemala Poverty Assessment: Good Performance at Low Levels* (2009), p. 31.

should be noted that "rural" is often a proxy descriptor for indigenous communities, as the rural population is about three-quarters indigenous. On a deeper level, it is an expression of discriminatory practices, and an affront to the dignity of the rural and indigenous populations. Such practices have manifested in otherwise preventable health conditions, and this disease burden will persist in the coming years should the Government not take adequate steps to address deficiencies in access to basic services.

III. Right to health of indigenous peoples

30. Due to a confluence of factors, including historical repression and prejudice, and the civil war, indigenous peoples have faced significant barriers in realizing the right to health. Indigenous peoples have the right to specific measures to improve their access to health-care facilities, goods and services that are culturally appropriate. The Committee on Economic, Social and Cultural Rights has noted that States should provide resources for indigenous peoples to design, deliver and control such services.[18] Unfortunately, the indigenous peoples in Guatemala have been systematically excluded from health-related decision-making, which has contributed to major gaps between indigenous and non-indigenous health outcomes.

31. The Committee also notes that, in indigenous communities, individual health is often linked to the health of the society as a whole, and has a collective or community dimension.[19] As mentioned previously, a number of underlying determinants of health directly contribute to whether a community progressively realizes the right to health (see para. 25). In many communities basic services are absent, resulting in widespread deprivation and poor health. The basic needs, including the provision of health-care services, of indigenous peoples must be met to effectively realize the right to health of this group.

A. Historical background

32. The indigenous peoples of Guatemala include the Maya, Xinca and Garifuna; in total, there are 25 socio-linguistic groups, 23 of which are of Mayan descent.[20] Guatemala is the only republic in Central America in which indigenous people comprise a majority; currently, 51 per cent of the population is estimated to be Mayan.[21] Although outside the scope of this report, the historical circumstances leading to the persistent repression of indigenous peoples elucidate the disadvantage and health-related barriers experienced by these people today.

33. Events from the Spanish Invasion in 1524, to the division of the population into indigenous and criollo groups in 1880, to subsequent forcible acquisition of indigenous peoples' lands by the elite,[22] all contributed to the social and economic dispossession experienced by the indigenous peoples of Guatemala. Although this eased during the Government reforms of 1944-1954, the 1954 coup and subsequent internal conflict had a

[18] E/C.12/2000/4, para. 27.
[19] Ibid.
[20] SEGEPLAN, Objetivos de Desarrollo del Milenio: Informe de Avances 2010 (Guatemala, 2010), p. 10.
[21] Minority Rights Group International, World Directory of Minorities and Indigenous Peoples - Guatemala: Maya, July 2008. Available at: http://www.unhcr.org/refworld/docid/49749d163c.html.
[22] INE, Marco conceptual para enfocar estadísticas de pueblos indígenas, (Guatemala, 2009), pp. 9-10.

devastating effect on the indigenous population.[23] The Truth Commission of Guatemala determined that significant political mobilization occurred among indigenous people during the civil war, particularly in the early 1980s, but it was widely suppressed by the State to maintain social control.

34. Despite the continuation of the armed conflict until 1996, indigenous identity became increasingly acknowledged by law during this time. Article 66 of the Constitution provides for protection of indigenous communities, acknowledging that Guatemala is made up of diverse ethnic groups – including indigenous groups of Mayan descent – and that the State recognizes, respects and promotes their ways of life, customs, traditions, forms of social organization, and use of traditional dress, languages and dialects. Articles 67 to 69 outline specific areas in which protection is required: protection of land and indigenous agricultural cooperatives, and of the health and safety of migrant workers within the State.

35. Since 1982 Guatemala has ratified several international declarations and treaties concerning the rights of indigenous peoples. For instance, in 1996 Guatemala ratified the Indigenous and Tribal Peoples Convention of the International Labour Organization (ILO), which was subsequently deemed compatible with domestic law by the Constitutional Court.[24] The provisions of ILO Convention 169, along with various constitutional provisions, have since been applied in various cases. These include, inter alia, petitions allowing indigenous prison inmates to wear traditional dress,[25] and the application of customary Mayan law to movement of protected objects for use in Mayan rituals.[26] Guatemala has also ratified the International Convention on the Elimination of All Forms of Racial Discrimination.

36. Despite this recent progress and the constitutional protection of indigenous groups, there has been a clear and consistent failure to adequately address the situation of indigenous peoples within Guatemala. In the March 1995 Agreement on the identity and rights of indigenous peoples, concluded as part of the Peace Accords, it was acknowledged that the indigenous peoples had been subject to discrimination, exploitation and injustice, and had endured unequal and unjust treatment and conditions on account of their economic and social status. It further acknowledged that this "historical reality" continues to affect these peoples profoundly, denying them the full exercise of their rights and political participation. It is encouraging to see that some steps have been taken to enshrine and protect the rights of the indigenous peoples of Guatemala, but more practical steps must be taken to secure equality in respect of health outcomes.

B. Health status of indigenous populations

37. The continuing reverberations of the civil war, together with marked structural and de facto discrimination and inequality have led to a stark contrast in health outcomes between the indigenous and criollo communities. Where disaggregated data is available, clear gaps between these communities are seen. For instance, 68 per cent of indigenous children under the age of five suffer from chronic malnutrition, compared to 49 per cent of children in the general population.[27] Between 1987 and 2002 negligible gains were made in

[23] E. Higonnet (ed.), Quiet Genocide: Guatemala 1981-1983 (2009, Transaction Publishers, New Brunswick), pp. 3-4.

[24] Case 199-95, advisory opinion on Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (ILO), May 18, 1995.

[25] Legal protection No. 46-2003, case 1, judgement of October 30, 2003.

[26] File No. 517-2003, case I, judgement of November 18, 2003.

[27] WHO, *Guatemala: Country Cooperation Strategy at a Glance* (May 2007, Geneva), p. 1. Available at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_gtm_en.pdf.

redressing malnutrition in the indigenous population generally: it was reduced from 71.7 per cent to 69.5 per cent, in comparison with an 8 per cent reduction in the general population.[28] Similar figures are seen when indicators of the underlying determinants of health are examined. For instance, approximately 29 per cent of the indigenous people live in extreme poverty, in contrast to 15 per cent of non-indigenous people.[29,30]

38. Although there have been encouraging increases in reproductive health-related indicators at the national level – 41 per cent of births are attended by skilled health personnel and contraceptive prevalence is recorded at 43.3 per cent[31] – these changes do not appear to have a substantial effect within indigenous communities. Of the births attended by skilled personnel, 70 per cent of those were deliveries of non-indigenous pregnant women, whilst only 30 per cent were of indigenous women. Similarly, only 40 per cent of those who utilized contraceptives were of indigenous descent.[32]

39. Development-related activities that displace indigenous peoples from their traditional lands have been noted to negatively affect health outcomes.[33] The consequences from this cultural disconnection notwithstanding, removing indigenous peoples from their land also contributes to poverty and food insecurity and alienation from mainstream society. Land ownership remains highly inequitable in Guatemala. The holdings of the largely indigenous poor are noted to be small, untitled, isolated and of poor quality; indeed, the main reason identified for welfare disparity between indigenous and non-indigenous households is low asset holdings.[34]

40. Educational attainment is also significantly lower among indigenous peoples due to the many barriers indigenous children face in entering and completing schooling. Although educational coverage has increased significantly, with net primary school enrolment rates rising from around 50 per cent in the 1970s to approximately 80 per cent by 2000, approximately one-third of indigenous girls are not enrolled.[35] Illiteracy poses a major problem throughout Guatemala, and is most marked among indigenous peoples: 38 per cent of indigenous women are illiterate.[36] This directly affects health outcomes, as use of planned methods of contraception is significantly lower in illiterate populations.

41. The above factors combined paint a bleak picture of indigenous living standards. There are difficult, systemic challenges for the Government, but this does not excuse it from taking steps that could immediately improve health outcomes and equality. Prompt implementation and enforcement of policies prohibiting discrimination – a core component of the right to health – is readily achievable, and adoption of this approach would do a great deal to address the plight of indigenous peoples immediately.

[28] SEGEPLAN, *Objetivos de Desarrollo del Milenio: Informe de Avances 2010* (Guatemala, 2010), p. 13.

[29] Ibid., p. 11.

[30] See also para. 27 of the present report.

[31] WHO, *World Health Statistics 2010* (Geneva, 2010), pp. 27-28.

[32] K Slowing Amana, "Gender Equality and Empowerment of Women in the Context of the Implementation of the Millennium Development Goals", presentation to 2010 High-level Segment, Economic and Social Council New York, 28 June – 2 July, p. 8.

[33] E/C.12/2000/4, para. 27.

[34] World Bank, *Poverty in Guatemala* (Washington DC, 2004), pp. 6, 52.

[35] Ibid., p. 96.

[36] INE, *ENCOVI 2006, Resultados Nacionales* (Guatemala, 2006), p. 13. Available at www.ine.gob.gt.

C. Barriers to improving indigenous health outcomes

42. A major omission identified by the Special Rapporteur during the mission was the lack of a comprehensive policy or plan as related to the health care of indigenous peoples, particularly in rural and remote areas. A core obligation of the right to health is the adoption and implementation of a national public health strategy and plan of action that "shall give particular attention to all vulnerable or marginalized groups".[37] There has also been little or no attempt to recognize and protect traditional medicine within indigenous communities – for instance, Guatemala has no specific legislation to protect or recognize indigenous medicines.[38]

43. It is promising that an Indigenous Peoples Unit in the Ministry of Health (Unidad de Atención de la Salud de los Pueblos Indígenas e Interculturalidad) has recently been established in an attempt to redress the inequality inherent in the health system vis-à-vis indigenous peoples. Discrimination against persons of indigenous origin is a nationwide, multifaceted problem that clearly extends to the health system. The formulation of this Unit is a welcome initiative but, irrespective of this, until Government health programmes are completely restructured with cultural diversity at the forefront, there is unlikely to be a significant change in the health status of indigenous peoples.

44. There is a clear need to actively recruit persons of indigenous descent into national medical training courses, to redress the cultural imbalance in staffing of health centres in Guatemala. Targeted training of indigenous doctors and nurses would improve quality and acceptability of care for indigenous patients, and potentially redress staffing shortages in rural and remote areas throughout the country. There is also a major paucity in respect of cultural training for medical professionals, as health-care workers are not required to undergo any formal cultural training component as part of their tertiary education.

45. Mainstream doctors also do not speak the local native languages. At the health-care centres visited on the mission no interpretation service was available. Instead, patients relied on ad hoc and informal interpretation performed by bilingual nursing staff. This situation is clearly unacceptable in light of the proportion of the population who do not speak Spanish. In consultations with indigenous community members, the Special Rapporteur was informed of instances where people were turned away from medical facilities because they could not adequately explain their symptoms to the Spanish-speaking medical professional. One indigenous family was denied access to treatment for their child, who later died en route to the nearest public hospital; the family could not convey the length or severity of the child's febrile illness to the doctor in question, and no translator was available.

46. A stronger impetus is needed for medical professionals to become familiar with the dominant indigenous dialect in their operational catchment. Emphasis on language skills in recruitment of medical professionals may promote cultural change in the profession, whereby it is no longer acceptable to work within a community without having the ability to communicate with its indigenous members. In the interim period, this gap could be cheaply and quickly redressed through implementation of a central telephone interpreter service.

[37] E/C.12/2000/4, para. 43(f).

[38] R. Montenegro and C. Stephens, "Indigenous Health in Latin America and the Caribbean", *Lancet*, vol. 367, p. 1866.

D. Health-care services delivery to indigenous communities

47. During his visit, the Special Rapporteur observed significant disparities between urban and rural health-care service delivery, which disproportionately affects indigenous people. Currently, 53 per cent of the workforce of the Ministry of Health is based in the department of Guatemala, and 80 per cent of the staff of the Instituto Guatemalteco de Seguridad Social is based in the metropolitan region,[39] which indicates how centralized health-care service delivery is in Guatemala.

48. There are significant barriers to overcome in improving access to quality health-care services for indigenous people, in addition to the discrimination and language barriers addressed previously. Part of the difficulty encountered is the topography of Guatemala, and the remote location of certain communities. Over 70 per cent of households in the lowest two quintiles of the *Encuesta Nacional de Condiciones de Vida*, the national survey of living conditions, lacked access to a surfaced road, and 13 per cent of households could not access any motorable road at all.[40] This directly affects health-care service delivery: lack of paved roads puts health-care services out of reach according to the WHO definition of access, which is less than 60 minutes.

49. Such obstacles, however, are not insurmountable, and it has largely been a result of a lack of political will and insufficient funding which has resulted in substandard delivery of health-care services in these locations. For instance, the Special Rapporteur visited Ixtahuacan, and was informed that a health centre in the locality had not been functioning for months. In many remote areas, non-government organizations have largely assumed control over health-care service provision. Although such efforts are admirable, this is not a sustainable substitute for State action.

50. The Mi Familia Progresa programme has had an observable impact, delivering funds to some of the most impoverished indigenous communities. This is commendable, but this conditional cash transfer programme simply cannot address fundamental issues concerning equitable access to health care. An indigenous woman noted that the 300 Quetzales (approximately $37) required to purchase medication for her child consumed almost the entire cash grant she received under the scheme. Routine use of these funds for various out-of-pocket expenditures further demonstrates the urgent need for the development of health infrastructure that ensures universal access to basic services. Moreover, the proportion of the grants being spent on health-related items is uncertain, and further monitoring and evaluation is necessary.

51. The development and implementation of a comprehensive national policy and plan addressing the health status of all Guatemalans, including indigenous people, in a participatory, transparent and inclusive process, will not only satisfy a core obligation of the right to health, but is also the first step to redress the long-standing inequalities. This, along with targeted assistance programmes and capacity building in the most disadvantaged areas of the nation, preferably driven by the Indigenous Peoples Unit within the Ministry of Health, will hopefully affect the changes necessary to achieve this goal.

[39] WHO/PAHO, Health System Profile: Guatemala, p. 41.

[40] World Bank, Poverty in Guatemala (Washington DC, 2004), p. 146.

IV. Right to health of women: right to sexual and reproductive health

52. As previously mentioned, accessibility is a core component of the right to health. General comment No. 14 of the Committee on Economic, Social and Cultural Rights notes that, in order to eliminate discrimination against women, a comprehensive national strategy for promoting women's right to health throughout their lives is necessary. Major goals associated with such a plan should include strategies to reduce maternal mortality and protect women from domestic violence.[41] States are also obliged to refrain from imposing discriminatory practices relating to women's health status and needs, and to take measures to protect all vulnerable or marginalized groups – in particular women.[42] As such, it is clear that the Government is under an immediate obligation to address these issues more fully.

53. The status of women's health in Guatemala has lagged behind other countries in the region – and worldwide – for many decades. The prevalence of contraceptive use remains at 43 per cent, with an adolescent fertility rate of 92 per 1,000 girls aged 15-19.[43] Some progress has been achieved, albeit slowly; only 41 per cent of births are attended by skilled health personnel, but around 84 per cent of women now receive at least one antenatal episode of care, although this remains below the regional average.[44]

54. Insufficient family planning services accessible to all poses a significant challenge. Currently, 27.6 per cent of fertile, sexually active women are not using any form of contraception, despite expressing a desire to delay or prevent subsequent births. Furthermore, certain health conditions are increasingly and disproportionately affecting women. The cases of HIV/AIDS in the 15-24 age group were approximately equal for men and women in 2002 (at approximately 8 cases per 100,000 people), yet by 2008 around 19.5 per 100,000 females were infected compared to 14.9 per 100,000 men.[45] There is also a significant problem concerning violence against women, which remains to be adequately addressed by the Government.

A. The right to sexual and reproductive health for women

55. Maternal mortality rates dropped to 136 deaths per 100,000 live births in 2010, from a previous rate of 153 deaths per 100,000 live births in 2000. Nevertheless, the rate is not decreasing quickly enough to achieve the Millennium Development Goal of 55 deaths per 100,000 births set for 2015.[46] Moreover, these gains disguise the failure to make progress in certain populations. In 2006, eight departments in Guatemala had rates higher than the national average; in each of these departments, the majority of the population was of indigenous descent and recorded low levels of educational attainment. Indeed, maternal mortality has been recorded as up to three times higher amongst indigenous than amongst non-indigenous women.[47] The Government informed the Special Rapporteur of its efforts to strengthen local service networks in order to reduce maternal mortality in heavily affected

[41] E/C.12/2000/4, para. 21.
[42] Ibid., para. 34-35.
[43] WHO, *World Health Statistics 2010* (Geneva, 2010), pp. 28-29.
[44] Ibid., pp. 27, 30.
[45] K. Slowing Amana, "Gender Equality and Empowerment of Women in the Context of the Implementation of the Millennium Development Goals", presentation to 2010 High-level Segment, Economic and Social Council New York, 28 June – 2 July, p. 5.
[46] Ministry of Health, *Planes Departamentales de Reducción de la Mortalidad Materna* (Guatemala, 2007), pp. 18-19.
[47] Ibid., p. 20.

areas. In that context, the Multisectoral Committee for Safe Motherhood (Comisión Multisectorial para la Maternidad Saludable) was created on 7 December with a view to monitoring and evaluating a strategy to reduce maternal mortality.

56. Rural, indigenous women are among the most marginalized members of Guatemalan society. This is reflected in many indicators relating to reproductive health, such as contraceptive uptake and access to skilled birth attendants, as previously discussed. Throughout the mission, indigenous women informed the Special Rapporteur that they perceived judgment from non-indigenous medical professionals for having too many children, or for their preference for "natural" birth control methods or "vertical" delivery of children. There is also a clear tension between modern medical treatment and traditional healing methods, including utilization of traditional midwives, whose role is highly valued by many indigenous communities.

57. The Special Rapporteur was informed that previous attempts to integrate traditional midwives into a Western-style medical structure had largely failed, and that midwives had, on occasion, been made to undertake menial tasks when working in hospitals or health-care centres. Simply attempting to employ traditional midwives is not acceptable to either midwives or indigenous women, and alternative steps can be taken to address this.[48] Education of medical professionals regarding service delivery which is acceptable to indigenous women is essential, particularly vis-à-vis obstetric care.

Obstetric care

58. Ethnicity is a strong predictor of use of medical care during pregnancy. It has been suggested that lower rates of uptake of medical care result from traditional cultural beliefs, alongside past negative experiences within the health-care system in Guatemala.[49] It has also been demonstrated that men in Guatemala are more likely to be considered primary decision-makers in emergency situations relating to pregnancy and birth, often because of higher economic costs.[50]

59. The difficulties associated with delivering services that are culturally acceptable, particularly in remote locations, to expectant indigenous women should not be dismissed as insurmountable. In rural Nepal, for instance, interventions from women's groups addressing perinatal problems with local facilitators within villages was shown to reduce neonatal mortality by 30 per cent.[51] As such, outcomes can be improved in remote areas even without skilled birth attendants, and participation is powerful in resolving seemingly intractable problems. Similar interventions could readily be adapted to the most remote villages in Guatemala, and utilize traditional midwives in their implementation.

60. The role of traditional midwives in modern Guatemalan society has become uncertain. There appears to have been, at best, a lack of understanding of the importance of their role in certain communities, and, at worst, a lack of respect and rejection of their practices altogether by mainstream health-care providers. Legitimate concerns, however, were also expressed regarding the inconsistency in skills and training between traditional midwives.

[48] See e.g. A/HRC/14/20/Add.2.

[49] Glei, D. A. et al., "Utilization of care during pregnancy in rural Guatemala: Does obstetrical need matter?", *Social Science & Medicine*, vol. 57, No. 12 (2003), pp. 2459-2460.

[50] S. Becker et al, "Husbands' and wives' reports of women's decision-making power in Western Guatemala and their effects on preventive health behaviors", *Social Science & Medicine*, vol. 62, No. 9 (2006), p. 2324.

[51] D. Manandhar et al., "Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial", *Lancet*, vol. 364, No. 9438 (2004), p. 976.

61. Traditional midwives could be more appropriately utilized to facilitate interaction between indigenous communities and Government health services. This does not necessarily have to occur through integration into existing hospitals; rather capacity-building should be undertaken with these professionals, and formal opportunities for information exchange between midwives and other health professionals be facilitated by the Government. A model that only involves provision of information to midwives, and not vice-versa, is not appropriate: cooperation and respect must be fostered, rather than simply attempting to train traditional midwives in Western methods of health-care delivery.

62. As accommodation around hospitals is often prohibitively expensive for families, women often delay attending facilities until they are actually in labour, which creates enormous health risks for both mother and child. As such, the Special Rapporteur was pleased to see the introduction of facilities such as Casa Materna in Huehuetanango, created to provide accommodation for residents of remote areas prior to delivery of their children. Establishment of facilities such as these in every department would be a welcome development. It is, however, very important that such facilities take care to respect indigenous traditions and to consult with indigenous people in this regard. Additionally, many women interviewed on the mission noted that they simply could not afford to attend centralized health-care services, even if they considered them culturally acceptable.

Family planning

63. The fertility rate remains high in Guatemala – 3.6 children per woman – and represents an independent risk factor for women's health.[52] The low rate of contraceptive uptake, particularly amongst indigenous women, is an important determinant of the fertility rate and, in turn, increases risk of maternal and infant mortality. The Special Rapporteur was pleased to note the passage of the Universal and Equitable Access to Family Planning Services Law, and the Government's efforts to provide for free universal family planning services through other agencies.

64. Historically, it has been noted that it is difficult to implement a "Western" model of birth control in rural Guatemala, as such a model ignores beliefs of indigenous Mayans; namely, preference for a larger family size and childbirth being a God-given attribute, as well as suspicion of Western contraceptive methods.[53] More culturally acceptable options for these communities include promotion of birth spacing, and postpartum abstinence. "Responsible parenthood" could also form a key aspect of education programmes: having fewer children in order to provide better for them.

65. It is clear that contraceptive use in Guatemala correlates with socio-economic status and ethnicity, but socio-economic status does not appear to serve as the barrier to contraceptive use among criollo women that it does for indigenous women.[54] Low socio-economic status, however, has proved a less definitive predictor of contraceptive use over time: this suggests that an ideational shift in indigenous communities may be occurring.[55] Contraceptive use and intent has increased for indigenous women despite no corresponding increase in adoption of Spanish, which suggests that economic and educational changes – rather than language – are responsible for any ideational change.[56]

[52] INE, *Encuesta Nacional de Salud Materno-Infantil 2008-2009* (Guatemala, 2009).

[53] R. Reddy, "Culture and Access Issues in Sexual Health Care in Mayan Guatemala" TuftScope vol. 9, No. 1 (2009), p. 27.

[54] K. Grace, "A comparative analysis of contraceptive use and intent in Guatemala", MPIDR Working Paper WP 2009-036 (Rostock, 2009), p. 21.

[55] Ibid., pp. 21-22.

[56] Ibid., pp. 22-23.

66. Ethnicity, however, remains a strong predictor of low contraceptive use and intent, and as such programmes which specifically target indigenous women and families are necessary in any global family planning strategy for the country, they must include culturally appropriate birth control options alongside more novel methods. In any event, any initiative that promotes family planning in indigenous communities must necessarily utilize community and religious leaders to ensure adequate engagement of communities. The Special Rapporteur also recommends the increasing inclusion of men in family planning decisions, although care must be taken to ensure that gender equality and empowerment of women is at the forefront of any initiative.

Access to abortion

67. The illegality of abortion in Guatemala, except in very limited medical circumstances, raises concerns. Currently, abortion is only permitted in cases where the life of a pregnant woman is endangered,[57] known as "therapeutic abortion". Abortion remains illegal even in instances of rape or sexual violence, unless it is considered medically necessary. Additionally, there are no guidelines concerning the interpretation of the penal code provisions that permit therapeutic abortion. As such, inconsistent interpretations by different institutions create uncertainty for a woman who seeks an abortion, as the outcome is entirely dependent on the discretion of those from whom treatment is sought.

68. The Special Rapporteur is concerned about the high rate of unsafe abortions throughout the country, generally resulting from these restrictive laws. Although the data in this area is lacking, unsafe abortions have been cited as a critical factor in maternal morbidity and mortality, and represent an area of significant and disproportionate health expenditure. On average, it is estimated that one woman is hospitalized for every three who obtain induced abortions,[58] and abortion is variously cited as the third or fourth most important cause of maternal deaths.[59]

69. In this regard, the Special Rapporteur notes that the Programme of Action of the International Conference on Population and Development urges Governments and relevant intergovernmental and non-governmental organizations to strengthen their commitment to women's health and to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. The Programme of Action also specifies that reproductive health care in the context of primary health care should, inter alia, include: family planning counselling, information, education, communication and services; abortion as specified in the Programme of Action, including prevention of abortion and the management of the consequences of abortion; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, inter alia, should always be available, as required. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions. In light of the Programme of Action, the Beijing +5 Outcome Document encourages States to consider reviewing laws containing punitive measures against women who have undergone illegal abortions.

[57] Guatemala Penal Code Decree No. 17-73, arts. 133 and 137, 1999.

[58] S. Singh et al., "Induced Abortion and Unintended Pregnancy in Guatemala", *International Family Planning Perspectives*, vol. 32, No. 3 (2006), pp. 137, 141.

[59] MSPAS, *Informe Final: Línea Basal de Mortalidad Materna para el Año 2000* (Ministry of Health, Final Report on Maternal Mortality Data for 2000), (Guatemala City, Guatemala, 2003).

B. Violence against women

70. The Special Rapporteur was alarmed to discover the extremely high incidence of femicide and violence against women throughout Guatemala. This problem appears endemic, and difficult to combat in a society where violence seems to be accepted as a norm. From 2001-2009, 4,602 violent deaths were recorded, and it has been estimated that, throughout Guatemala, 45 per cent of women have been victims of some type of violence.[60]

71. In her 2005 visit to Guatemala, the Special Rapporteur on violence against women concluded that violence against women would only be eradicated by acting on fundamental issues including ending impunity, systematically eradicating extreme inequality, and engaging in "serious reform" to rebuild the State.[61] Unfortunately, insufficient progress has been made in the interim period, and no noticeable decrease in violence against women has resulted.

72. Some steps, however, have been taken to combat this problem. In 2000, the Coordinadora Nacional para la Prevención de la Violencia Intrafamiliar y contra las Mujeres (CONAPREVI) was established to prevent, punish and eradicate violence against women. Its mandate is based on the Inter-American "Convention of Belém do Pará", and article 17 of the Act against Femicide and other Forms of Violence against Women. There is also a National Plan for the Prevention of Domestic Violence and Violence against Women (PLANOVI) 2004-2014, which clearly indicates that the Guatemalan Government has recognized that these issues need to be addressed as a matter of urgency.

73. These initiatives, however, have not resulted in a reversal of femicide rates. On 17 September 2010, the head of the office of the Human Rights Ombudsman announced that a formal case would be brought against the Government of Guatemala at the Inter-American Commission on Human Rights for lack of attention to femicides,[62] noting that femicide has increased 79 per cent in the last six years.[63] When the Special Rapporteur visited San Juan de Dios Hospital, he was informed that a clinic had been established by Médecins Sans Frontières in 2007 to treat victims of sexual violence. This is a welcome development, and one which is clearly necessary in light of the high prevalence of such incidents, but more training for medical professionals is clearly required in this area.

V. Access to medicines

74. The Government has made numerous efforts to ensure a continuous and adequate supply of affordable medicines to its people through its national procurement procedure and the provision of medications at Government hospitals. These efforts are admirable. Nevertheless, two major Government policies, drug procurement and the intellectual property provisions of the Central America-Dominican Republic-United States Free Trade Agreement, have had the effect of severely curtailing access to medicines.

75. The Ministry of Public Health and Social Assistance of Guatemala is responsible for the provision of medicines and other health services to the population. Due to budget constraints, however, the Ministry often does not have adequate resources to meet its mandate and guarantee access. Consequently, families often contribute out of pocket for

[60] INE, *Encuesta Nacional de Salud Materno-Infantil 2008-2009* (Guatemala, 2009).

[61] E/CN.4/2005/72/Add.3, para. 68.

[62] Procurador de los Derechos Humanos, "PDH presenta en la CIDH denuncia por femicidos" (17 September, 2010). Available at: www.pdh.org.gt.

[63] M. Hernández, "PDH se queja por femicidios" (Guatemala, 20 July 2010). Available at: http://www.sigloxxi.com/nacional.php?id=15447.

goods and services. Furthermore, poor procurement policies and price-inflating intellectual property protections unnecessarily drain an already limited health budget for the Government, families and individuals.

76. Access to essential medicines is a core obligation of the right to health.[64] States parties to the International Covenant on Economic, Social and Cultural Rights have an obligation to provide safe, efficacious and affordable medicines and, in particular, to ensure access for marginalized populations, such as the rural poor. The right to health requires that health goods and services must be accessible, available, acceptable, and of good quality. Furthermore, the State is responsible to respect, protect and fulfil the right to health, which includes policy, legislative and regulatory changes that may take near immediate effect.

A. Government procurement policies and their implications on access to medicines

77. The Ministry of Public Health and Social Assistance of Guatemala coordinates the public drug procurement policy of the Government through an open-contract system. The basis for the system was created in October 2004 under article 46 of the Law of State Procurement, and was expanded to include the open-contract system in 2005, under a number of resolutions.[65] In this system, the Ministry of Public Health and Social Assistance selects quantities and varieties of drugs to be procured for the next year and then asks suppliers to submit bids. Formerly, there was a direct purchase system in place in which, as the name implies, drugs were directly purchased from the suppliers.

78. The procurement process is opaque, with regulations and administrative procedures that work against the selection of bids from generic drug companies. The existing bases for contracts under the open bidding system severely limit the free collection of offers.[66] Other requirements result in the exclusion of generic drugs that have to obtain special commercial registration conforming to the enacted legislation. These requirements and hurdles constitute barriers to equal access to the market and free competition to the benefit of branded drug companies and against generic drugs.

79. Procurement prices in the open-bidding system are subject to legal challenge. Often these challenges have intentionally been used by multinational pharmaceutical manufacturers to delay Government procurement, thereby limiting the supply of essential medicines. Furthermore, these points were brought to the attention of the Government, and changes were made, but multinational pharmaceutical companies actively lobbied against the changing of regulations to ensure free competition and brought actions known as *amparos* against relevant ministries for attempt to change the contract criteria.[67] At present, the guidelines procedures remain as they were prior to any changes, with considerable detriment to free competition and access to drugs.

[64] E/CN.4/2004/49, para. 28.

[65] Guatemala, DNCAE, resolutions nos. 03-2004, 04-2004, 05-2004 and 06-2004, (2004).

[66] Procurador de los derechos humanos, “Investigación, EXP.EIO.GUA 442-2004/DESC” (Guatemala, 2005).

[67] Ibid.

B. Central America-Dominican Republic-United States Free Trade Agreement and its impact on drug prices

80. The Central America-Dominican Republic-United States Free Trade Agreement (CAFTA/DR) is an agreement expanding trade relations between the United States and Guatemala, Costa Rica, El Salvador, Honduras, Nicaragua and the Dominican Republic.[68] Within its remit are a number of areas: trade in goods, services, intellectual property and others. The object of this agreement, as with similar agreements, is the reduction of trade barriers, in the hope of ultimately eliminating them entirely, to drive development and economic growth between the parties. Trade agreements affect nearly all parts of an economy and have ramifications well beyond trade.

81. Often these agreements are negotiated without public consultation and transparency, the result being that key stakeholders are left out of the process. Claims such as these were made about CAFTA/DR.[69] The standing of the United States as the largest and primary trading partner of nearly all the countries in the region resulted in a significant imbalance in the negotiations for the agreement. Moreover, many countries in the region did not possess the same legal expertise on intellectual property matters to address concerns adequately. In the case of access to medicines, this meant erosion of critical safeguards included in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights to protect public health and the public good.[70] These and many other access-restricting implications are discussed in greater detail in an earlier report of the Special Rapporteur.[71]

82. The net negative effect of the United States, European Union and other free trade agreements on access to medicines and their intellectual property expanding provisions is well documented.[72] Recent iterations of such agreements have almost always included provisions that raise the floor set by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS-plus) so as to require greater intellectual property protections as the new minimum. They have also often restricted flexibilities found in TRIPS and reaffirmed by the Doha Declaration. These effects are not limited to medicines, but also extend to access to food, work, etc.

83. The accession of Guatemala to the Central America-Dominican Republic-United States Free Trade Agreement has required it to put in place intellectual property polices that curtail access to medicines. Increased intellectual property protections, such as data

[68] United States Trade Representative, Central America-Dominican Republic-United States Free Trade Agreement Final Text (CAFTA/DR), (June 16, 2009), Available at: http://www.ustr.gov/tradeagreements/free-trade-agreements/cafta-dr-dominican-republic-central-america-fta/final-text.

[69] Georgetown Human Rights Action/Human Rights Institute Fact-Finding Mission, "Prescription for Failure: Health and Intellectual Property in the Dominican Republic", (2010), pp. 23-25 Available at: http://www.law.georgetown.edu/news/releases/documents/FinalDRReport.pdf.

[70] Numerous examples of this analysis can be found. See e.g., Carlos Correa, "Implications of bilateral free trade agreements on access to medicines", *Bulletin of the World Health Organization*, vol. 84, No. 5 (May 2006), p. 399; Report of the Commission on Intellectual Property Rights, Innovation and Public Health (2006), preface.

[71] A/HRC/11/12.

[72] A/HRC/11/12; See Oxfam, "All costs, no benefits: How TRIPS-plus intellectual property rules in the US-Jordan FTA affect access to medicines", briefing paper (March 22, 2007) Available from: http://www.oxfam.org/en/policy/bp102_jordan_us_fta; Georgetown Human Rights Action/Human Rights Institute Fact-Finding Mission, "Prescription for Failure: Health and Intellectual Property in the Dominican Republic", (2010), pp. 23-25.
Available at: http://www.law.georgetown.edu/news/releases/documents/FinalDRReport.pdf.

exclusivity, that prevent generic drugs from reaching the public market as quickly as possible, allow branded drug companies to retain monopolies on drugs. This results in much higher prices for medicines as has been seen elsewhere. In a country where 60 per cent of all medical expenditures are out of pocket and the majority of people live in poverty, this is a worrying outcome.

84. In many instances, there have been documented generic drug price increases as a result of provisions in the Agreement. In some cases, drugs have been prevented from entering the market entirely. For example, many generic versions of branded drugs used for major causes of mortality and morbidity cannot enter the market because they effectively cannot receive marketing approval. Many drugs have even been denied market entry because of data exclusivity requirements of up to 15 years in accordance with articles 15.10.1(a) and 15.10.1(b). In a country like Guatemala, which has a moderately sized domestic generics industry, this not only reduces access but also directly harms the local economy.

85. Along with data exclusivity requirements of five years, the Agreement also obliges States parties to grant mandatory patent term extensions in article 15.9.6(b) and link marketing approval of drugs to their patent status in article 15.10.2(a). In aggregate, these extensions result in market monopoly by branded drug manufacturers for periods well beyond the patent term. Consequently, prices for certain drugs will remain artificially inflated due to a lack of participation and market pressure. This unfortunately dovetails with a drug procurement process that favours procurement of branded medicines over generics, even where generic drugs cost less. In the final calculation this results in a compound dysfunction, leaving drugs in short supply and priced far above market value.

86. In negotiating free trade agreements, States bear responsibility for ensuring compliance with pre-existing legal obligations, such as their international human rights treaty commitments. Guatemala, as a party to the agreement and numerous international instruments that ensure the right to health, must take all the necessary steps to ensure that the right is respected, protected and fulfilled.

87. The Government has an obligation under the right to health to investigate its policies affecting access to medicines, especially the two discussed here. Although there are aspects of the right to health that may be "progressively realized," there are many more immediately actionable changes that can be made to address pressing right to health problems. In any event there can be no retrogression. Adequate safeguards must be kept in place and/or created to ensure equal access to quality medicines, many of which can be immediately implemented.

VI. Recommendations

88. **The Special Rapporteur urges Guatemala to consider the following recommendations in the area of the health of indigenous peoples:**

(a) Adopt a comprehensive health strategy for the promotion of rights of indigenous people, focused on non-discrimination, and increase investments from the national budget to improve accessibility to health-care facilities, goods and services in rural communities and increased quality of services and information.

(b) Incorporate and ensure the consultation and participation of indigenous community members in the development of policies and programmes related to the delivery of health services and goods into indigenous communities.

(c) Increase the number of rural primary care facilities and health professionals and accessibility of these facilities. In cases where such facilities cannot

be immediately provided by the Government, extension of services provided by non-governmental actors should be facilitated.

(d) Ensure that all health service institutions have adequate language support for indigenous community members. Ensure that over a period of time medical staff deployed to rural areas learn indigenous languages. Immediately develop a system of interpretation via telephone or an alternative method, if on-site interpreters are not available in all health-care facilities.

(e) Analyze the effectiveness of conditional cash transfers in improving health and other social indicators. If appropriate, expand and refine conditional cash transfer programmes in order to cover more municipalities and create greater incentives for impoverished indigenous households to spend their money on the health and education of their children.

(f) Introduce a voucher system for the purpose of transport to health services, in order to improve health outcomes for rural indigenous people, especially women.

89. **The Special Rapporteur urges Guatemala to consider the following recommendations in the area of women's health, with a focus on sexual and reproductive health rights:**

(a) Build the capacity of traditional midwives along with health-care professionals through human rights and other relevant training, and provide formal opportunities for information exchange between midwives and other health professionals, which can be facilitated by the Government. Allow traditional midwives to practise without undue interference or discrimination.

(b) Provide sensitivity training for health-care workers to enable them to recognize the importance of midwives in Mayan culture, as part of a larger programme to develop the sensitivity of health-care workers to indigenous peoples and their traditions more generally.

(c) Develop training and sensitivity programmes for health-care workers to assist them in recognizing and appropriately treating victims of domestic violence. Complement such programmes with targeted, culturally appropriate community awareness and education programmes to combat domestic violence.

(d) Improve information and counselling on contraception within the public health-care system, including promotion of all forms of family planning and modern methods of contraception, and ensuring cultural appropriateness. Improve accessibility and affordability of all forms of contraception by providing contraceptives to underserved groups.

(e) Guarantee women's effective exercise of their right to the highest attainable standard of health, including access to safe, acceptable and affordable abortion services (at least in cases of medical emergency or sexual assault) and review the laws containing punitive measures against women who have undergone illegal abortions.

(f) Ensure that access to justice is available to women who have been subject to violence through law, administrative and other measures.

90. **The Special Rapporteur urges Guatemala to consider the following recommendations in the area of access to medicines and drug procurement:**

(a) Simplify the drug procurement system and eliminate regulatory barriers that discriminate against the purchasing of generic drugs. Increase transparency and

independence of actors in the drug procurement process. A modified open-bidding system, in which all bidders were given equal credence, would be ideal.

(b) Increase drug procurement from regional drug purchasing programmes, such as those provided by PAHO, in order to increase access to low cost, high quality mechanisms.

(c) Make use of the available TRIPS flexibilities, such as compulsory licensing and others, in order to increase competition and thereby reduce drug prices.

(d) Resist entering into additional free trade or economic partnership agreements that require a TRIPS-plus level of intellectual property protections.