Thematic working paper

Health Accountability for indigenous populations in a period of civic leadership criminalization: the case of Guatemala

DRAFT REPORT

1. Introduction to the Guatemalan context

Guatemala is an ethnically and culturally diverse country located in Latin America. Of its almost 16 million inhabitants, about 45% belong to one of the 22 indigenous groups. The remaining 55% of the population identifies as non-indigenous, and is mostly of mixed Amerindian and European ascent. The official language is Spanish, but it is reported that up to 40% of the population use it only as a second language and are native speakers of one of several indigenous languages in the country (1).

Although the country's economy is the largest in Central America, and Guatemala is one of the biggest exporters of coffee and sugar in the world (2), this wealth is not evenly distributed. The World Bank has ranked it as one of the most unequal countries in the world in terms of income concentration and distribution (3). This is evident in the national poverty rate, which is estimated at 59.3%. When broken down by ethnicity we see that 79% of the indigenous population is poor, compared to the 35% rate for non-indigenous Guatemalans (4, 5). Despite the country having made significant improvements in primary school education during the last 25 years, only 62% of indigenous children complete primary education, with a wide gender disparity: indigenous boys are 7% more likely than girls to finish (6, 7). Literacy rates for non-indigenous people men reach 91%, but only 35% of indigenous women can read. Only about 23% of the population attends secondary school, and only 10% finish this level (6). Poverty and the financial sacrifices that families must make for children to attend school, combined with low coverage and poor quality of the schools represent the main barriers to education in the country.

Guatemala has a regressive tax structure, and indirect taxes on goods and services represent 40% of the total tax revenue, and place a higher tax burden on the poor (8). Social spending for health, education, housing, sanitation and other services represented 7.6% of the GDP in 2013, while the regional average is 19.1% (9). Generous tax exemptions, fiscal incentives for businesses, and low rates of collection of existing taxes have contributed to deficient tax revenue. Currently, revenue comes to about 13% of the country's GDP, while in Latin America the average is 21.3% and in OECD countries it is 34.1%. As a result of insufficient tax revenue and

low social spending, combined with the marginalization of indigenous people in the country, the most vulnerable population receives the least benefits and their most urgent needs cannot be readily addressed (7).

The stark inequalities that are present in every sphere of Guatemalan life are informed by ethnicity, and indigenous peoples carry a higher burden of disease than their non-indigenous counterparts. Currently, the country has one of the highest rates of chronic malnutrition in the world, with a rate of about 54% for children under five. This condition does not affect all population groups equally, and chronic malnutrition among indigenous children is twice as high than in non-indigenous ones (70% vs. 35%)(7). This leads to high rates of stunted growth (75% of adults present this condition), cognitive damage and to a higher risk of death due to a compromised immune system (10). Around half of all infant deaths occur during the neonatal period, and would be easily preventable if families had access to skilled birth attendants.

In addition, the country also has one of the highest rates of maternal mortality in Latin America. The estimated maternal mortality rate (MMR) in 2011 was 140 per 100,000 live births. However, when broken down by ethnicity we see that indigenous women are more than twice as likely to die in childbirth (11). After adjusting for underreporting, UNICEF estimated that the actual national MMR was 290 per 100,000 live births (12). Together with the indicators for poverty, education, child malnutrition and the MMR, we see that indigenous people face a dire situation in the country: overall, indigenous people are more likely to have poorer health outcomes and die younger, up to 13 years earlier than non-indigenous Guatemalans (1, 10).

The Guatemalan health system

The Guatemalan health system is highly fragmented and unequal; which translates into low and unequally distributed numbers of human resources for health, inefficient services and high concentration of resources in the central, metropolitan area, where only about 25% of the population lives. This leads to very low access to services and high out of pocket expenditures for the poorest population, which tend to be Maya (13). The country has private, public and social security systems that subdivide and have different schemes for different populations that lead to inefficiencies and duplications of labor. There are no links of separations between systems and each one has a population to which they render differentiated services. Another important characteristic of the health system is that users seek care in all

the subsystems interchangeably depending on their need, economic capacity or on the availability of the services (13, 14).

The public health system is made up of the Ministry of Health (MoH), the Ministry of Defense, local municipalities and the social security system, and represents about half of the country's total expenditure in health. Most of the funds are channeled through the MoH (13, 14). Investment in the public health sector declined steadily from 8% to 7.3% of the national budget between 1998 and 2003, with public spending falling almost 50% in that same period (13, 15). Resource allocations for the MoH is based on historical budgets, and these do not necessarily take into account the needs or demands of the population.

For the MoH, there are three levels of care: the first is the health post, which tend to be operated to by a certified nurses' assistant (CNAs), who provide care based on demand, as well as vaccines for children. The second level of care is comprised of health centers, located one per health district and staffed with medical personnel and paramedics who can carry out minor surgeries and deliveries. The third level of care are hospitals, which have infrastructure, personnel and supplies that allow them to provide surgical care, general medicine and emergency care, maternity care, pediatrics and some specialties (16).

2. Indigenous communities and health accountability

The Network of Community Defenders for the Right to Health (REDC-Salud in Spanish) started in 2011 in Guatemala. It is an organization of about 160 indigenous leaders (60% male and 40% female) that have come together to work collectively and voluntarily to seek and establish accountability mechanisms at public health facilities. The REDC-Salud works in 30 municipalities in five regions of Guatemala (Quiche, Alta Verapaz, Huehuetenango, Solola and Totonicapan), in areas with a majority of indigenous population. Their main focus is to defend the access to health services as a fundamental human right.

Each one of the representatives from the REDC-Salud has been selected through democratic processes in their communities, which awards their leadership with a high degree of legitimacy. They accountability work within the Guatemalan health system consists of collecting information and evidence directly in public facilities through user interviews, collecting individual complaints and audiovisual documentation. Everything that is collected is part of a database that generates

information on specific indicators that allow for the monitoring of work carried out by the Guatemalan Ministry of Health (MoH).

The REDC-Salud has the institutional backing of the Center for the Study of Equity and Governance in Health Systems (CEGSS in Spanish). REDC-Salud articulates and coordinates the accompanying of patients, and put into practice the accountability work in the country.

3. Criminalization of civic leadership

The criminalization of a civic leader or a human rights defender is understood as a process in which a person is labeled as a criminal as result of exercising his/her rights. The purpose of the criminalization is to stop the work that a person or his/her organization carry and to send a message to the public about limits to exercising their own rights (17).

The criminalization of civic leadership can be expressed as:

- Libeling, stigmatizing and hate speech
- Spurious criminal charges
- Law reforms to include practices and actions (i.e. freedom of speech, consultation to ethnic minorities) that were previously allowed or protected

In some cases, the criminalization may result in violence and direct attacks against civic leaders and human rights defenders. Latin America is the region in the world in which human rights defenders face the highest risk to their lives. In the year 2017, two-thirds of all human rights defenders who were killed in the world were from Latin America (18).

Human rights defenders have always been at risk in Guatemala. However, after two decades of advances in the protection of rights and expansion of civic leadership, Guatemala is rapidly experiencing a deteriorating climate for human rights defenders, particularly those from indigenous populations. The situation is becoming so serious to the point of United Nations expressing concerns about the deteriorating situation in the country (19).

Human rights defenders under attack have usually been those ones opposing land grabbing and protecting indigenous territories from extractive industries. However, in recent months, the criminalization has also been extended to civic leaders and

human rights defenders working for health, education and cultural rights. A recent case is the criminalization of Paulina Culum, who is a female indigenous leader of the REDC-Salud. Paulina is facing an investigation by the general attorney as result of a spurious accusation by Ministry of Health authorities. Below there is a profile of Paulina Culum and then a box summarizing the criminalization case.

3. Profile of a community defender for health rights suffering criminalization

Paulina Culum Xajil is a 52-year-old Tz'utujil woman. She is a community leader, an activist and lives in the municipality of San Pablo la Laguna, in the Solola region. In her community, she is recognized because of her active participation in several civil society organizations. Her focus has been on social accountability, human rights, women's rights, peasant rights, access to education and on representation for indigenous peoples. She represents her municipality in several organizations. There is her human rights defender role in the REDC-Salud; but she is also active in women's organizations. She has been acting secretary for the regional-level development council as well. She ran for mayor of San Pablo la Laguna in 2015, where she was the candidate from Convergencia. She came in second last.

As a member of the REDC-Salud, Paulina Culum has carried out important accountability work in San Pablo la Laguna's health center. Through her work, data regarding the stocking of medicines has been obtained, and the evidence she collected has helped to improve the quality of the care that public health providers deliver. She has helped to coordinate resources and bring together the municipal government with the health center. Finally, she has implemented a continuous social accountability process that monitors the work that health authorities carry out at the regional level. She has integrated her municipality into a citizen-led accountability process based on the participation of communities through organized assemblies that demand accountability from public health providers. All of this work has been supported and recognized by the municipal government and by the development councils [1]. However, in 2018 she had criminal charges filed against her for allegedly threatening and insulting five public authorities. This is a direct result of her work with the REDC-Salud. Paulina Culum states that this is a spurious accusation because the situation described in the accusation has never occur and the intention of the health authorities is to stop her work in leading the citizen-led accountability in her municipality.

[1] https://www.no-ficcion.com/project/vigilantes-de-las-salud-publica

Box 1. Summary of legal charges against Paulina Culum, a community leader

File MP104-2018-30 of the General Prosecutor's Office Auxiliary office in Santiago Atitlan, Solola	
District attorney	Eduardo Lopez Queme
Aggrieved party	Employees of San Pablo la Laguna's health center: Rosa Celia Cox Chavajay (secretary), Rosalia Bizarro Yojcom (head of stocking), Gladys Aracely Ordoñez Tzurec (data input), Juana Karina Hernandez Chavajay (data input)
Syndicated	Under investigation / no individual responsibility assigned
Crime	Coercion
Summary	In early January 2018, Mayron Martínez, Celia Cox, Gladys Ordoñez, Rosalia Bizarro and Karina Hernández, all MoH employees, filed a criminal complaint with the police, the ombudsman's office and the prosecutor's office because of a series of insults and death threats receive through social media, mainly Facebook. As part of this criminal complaint, suspicion was raised regarding the active participation of Paulina Culum and the REDC-Salud and they were pointed as indirect parties that carried out the death threats and insults against the aggrieved parties. The MoH employees argue that this was caused by the community assemblies and public meetings that REDC-Salud have organized in San Pablo la Laguna as part of a citizen-led social accountability process that is carried out in the health center of this municipality. In these accountability processes, carried out with the support of San Pablo la Laguna's municipal government, and organized by the REDC-Salud, evidence has been collected on the abuse and mistreatment that patients are subject to when they go to the health center. They have also documented the lack of medication and the general discontent over the hiring of staff that is not from the town. As a result, the prosecutor's office in Santiago Atitlan began an investigation, typifying the complaint as a crime of coercion. The main suspect is Paulina Culum, from the REDC-Salud because the aggrieved parties argue that she is the one that has stirred the insults and death threats they have received from the population of the town through social media.

	The investigation has already begun against Paulina Culum and the REDC-Salud and is still ongoing.

The case of Paulina Culum was presented during the regional consultation of indigenous population rights and accountability (March 2018). It was presented as an example of the increased risks and criminalization faced by civic leaders demanding accountability, a demand that is widely protected by the existing legal framework in Guatemala. The case of Paulina Culum generated the sharing of experiences by the rest of participation in the consultation event. The opinions and information share by participants is summarized in the next section.

4. Opinions from Indigenous leaders working in health accountability

During the regional consultation of indigenous population rights and accountability (March 2018) the issue of a growing criminalization of indigenous leaders was the central theme of the event. In the second day of the event, 48 delegates representing 5 different geographical regions of Guatemala and the province of Puno in Perú, participated discussing different barriers and local conditions that they perceived as associated with two problems: a) a growing situation of criminalization towards them as indigenous leaders and b) a growing number of state officials (including health sector) that are opposition practices of transparency, accountability and citizen participation. A summary of the opinions conveyed by participants is presented below.

4.1 There is still fear to report abuse and discrimination:

Participants expressed that many community members who use public services are afraid to report mistreatment, abuse or discrimination because they fear a backlash. The general view is that health services violate human rights and that, without the support of Community Defenders, there would be higher levels of corruption and more human rights violations. Many participants perceive this mistreatment and abuse as racism, with non-indigenous providers being rude or violent towards indigenous patients. Although Community Defenders stand up to these providers, they are often intimidated, harassed or threatened. As one defender from Nebaj put it:

> *'I was there accompanying a patient. I'm a traditional birth attendant (TBA) and when the nurse saw I was coming in they blocked me from entering. I was stubborn and I said they had to care for the patient. The nurse, he saw me and had me thrown out and would not let me care for*

> *my patient. In the end, they did a C-section on her even though she was almost ready to deliver normally. The patient only needed help, but nurses don't want to help. I kept asking why they didn't want to care for her and the nurse told me 'go away already or I will have you locked up in a room'. I stayed but I was quiet. I got a stomachache from how angry I was, and a few days after that I got sick and had to take medicine. I got sick because the nurse would not let me go into the facility but would not take care of my patient'.* TBA Nebaj.

This was not an isolated case and Community Defenders from all the regions where they are active reported some type of harassment or threat. These went from being told to leave or that they would be locked in a room to being yelled at. On one occasion, a provider took the notebook where the defenders keep their notes and ripped it apart, threw it to the ground and then stomp on it. In that case, when the defenders spoke to the physician in charge of the facility, it was made clear that those were actions carried out by a nurse without the knowledge of their superiors. Afterwards, the behavior changed and improved as the Community Defender worked with the physicians more.

4.2 Filing complaints about abuses by service providers:

In rural communities, it is not uncommon for providers to not show up for work, or to not keep clinic hours even if they are there. There are also routine illegal charges, like those for using ambulance services, denial of care and sometimes, physicians carry out different actions to humiliate and denigrate indigenous population who use the healthcare services. To this, we must also ad the many instances in which patients are turned away because no one in the health facility speaks the local language. Participants expressed that some patients refuse to file formal complaints when they face abuse such as the ones described above, because the word 'complain', which in Spanish is the same word as the one that is used for calling out a crime, carries a lot of baggage. This hinders communication and leads to a breakdown of the relationships between communities and authorities:

> *'The obstacle we find here is that the word complaint* [denuncia] *is very strong. I can't say I'm going to give information on the complaint because to them it is like going to jail. When the providers hear us say complaint they think we will take them to jail and I believe that is because our people don't really use that word. That word doesn't exist in my town at all so then no one wants to file complaints even if they are mistreated'* Participant in Group 1.

4.3 Despite challenges, there is a need to stand-up against abuse and discrimination:
The consensus among participants was that without accountability actions and demands by communities and users of services, the quality of the services would be lowered because no one would be there to stand up for patients. Because of this, many more leaders acting as "Community Defenders" is needed. Training more Community Defenders should include support to reflect and understand more about citizenship and human rights. It is important to think about the future so that, when a defender cannot continue with their job, another one can take their place.

4.4 Strategies of legal empowerment should be expanded:
Participants also agreed that expanding training and handing out support material around the legal framework is crucial. They specially identified training on laws that promote citizen participation and freedom of information act. These are all valuable tools for civil society.

4.5 Learning from other country experiences:
When it comes to the work they do at the national level, participants agreed that it is important to learn from international experiences like in Peru, where monitoring services has led to less women dying as a result of childbirth. The work on monitoring there also includes work on infectious diseases like tuberculosis.
The two participants from Peru spoke about the context where they work, in Quechua-speaking communities. There, the right to health has been promoted through the media, but also through capacity building in local languages. To deal with the issue that there is no word for 'rights' in that language, they contextualized the meaning and explained to the communities that a right is a benefit that belongs to all and that cannot be taken away. The use of other tools like putting on small plays and role-playing have also helped to promote a deeper understanding of what human rights are. The Peruvian participants expressed:

> '*To me, it is important to speak but more important to act. We need to gather experience and be trained, have our tools like our cell phones with us… we have to do radio spots and be on local cable stations, even speaking at the park if that is all that we can do to reach others. People need to feel that the right to health is real and we also need to involve young people… and when there are other institutions working near us we need to be on their agenda so they help us to spread the word to women, men and young people, to everyone, that we have a right to health'.* Peruvian participant.

4.6 Increased opposition of health officials to accountability and participation: Participants commented that some health authorities do not welcome them and treat Community Defenders with disregard or disrespect. In some places, they are made to feel like a burden by service providers. When asked who they are and why they are there collecting evidence, they say they are human rights community defenders, some physicians bans them from entering the health facility. That is because the health staff does not see community participation as something positive. If the defenders remind the staff about their responsibility, many get upset. And not everyone in the community recognizes their work. Many think they are there as paid members of an organization and are often asked what their salaries are. Participants stated that they think this is because Guatemalan is still far away of showing a culture of dialogue and participation.

> '*Once I wanted to monitor the stocking of medicines in a facility. The physician asked who I was and how much were 'they' paying me. When I said I was a volunteer, the sneakered and said 'I thought they would at least give you money', and asked for my ID. 'I don't have one' I replied. 'I don't know anything about the network you talk about'. So then Paulina stepped in and she explained why we wanted to check the supplies. The doctor said 'if you have an ID yes, if not, no'. I told him 'whether I have an ID or not, you will let me in to see because I have a right to see if there are any medicines'. He tried to call the deputy-director to get authorization so Paulina said we would go in and the physician finally admitted there was only about 5% of the medicines they should have'. He was a great obstacle to our work'* Participant from Nahuala municipality.

5. Conclusions

As in many other countries within Latin America and other regions of the world, Guatemala is going through a process of closing of civic spaces and state officials opposing transparency and accountability.

In many countries of Latin America, international and national corporations investing in extractive industries are colliding with state authorities to criminalize human rights defenders who are opposing the imposition of extractive industries in their territories. In the specific case of Guatemala, many indigenous community leaders who have been active in promoting health accountability, live in territories with large social conflicts as results of extractive industries. The increment of the

conflict and the criminalization and imprisonment of indigenous leaders is directly affecting their work as community defenders.

In the process of advancing health accountability, civil society organizations cannot ignore the difficult reality that indigenous community leaders face. Human rights are indivisible, so working for health rights also must take into account the social, economic and political rights that are under increasing threat by repressive and corrupt governments allied with private corporations.

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