

Freedom of Choice

*A Study of Women's Capabilities and Constraints in
Accessing Contraceptive Services in Guatemala*

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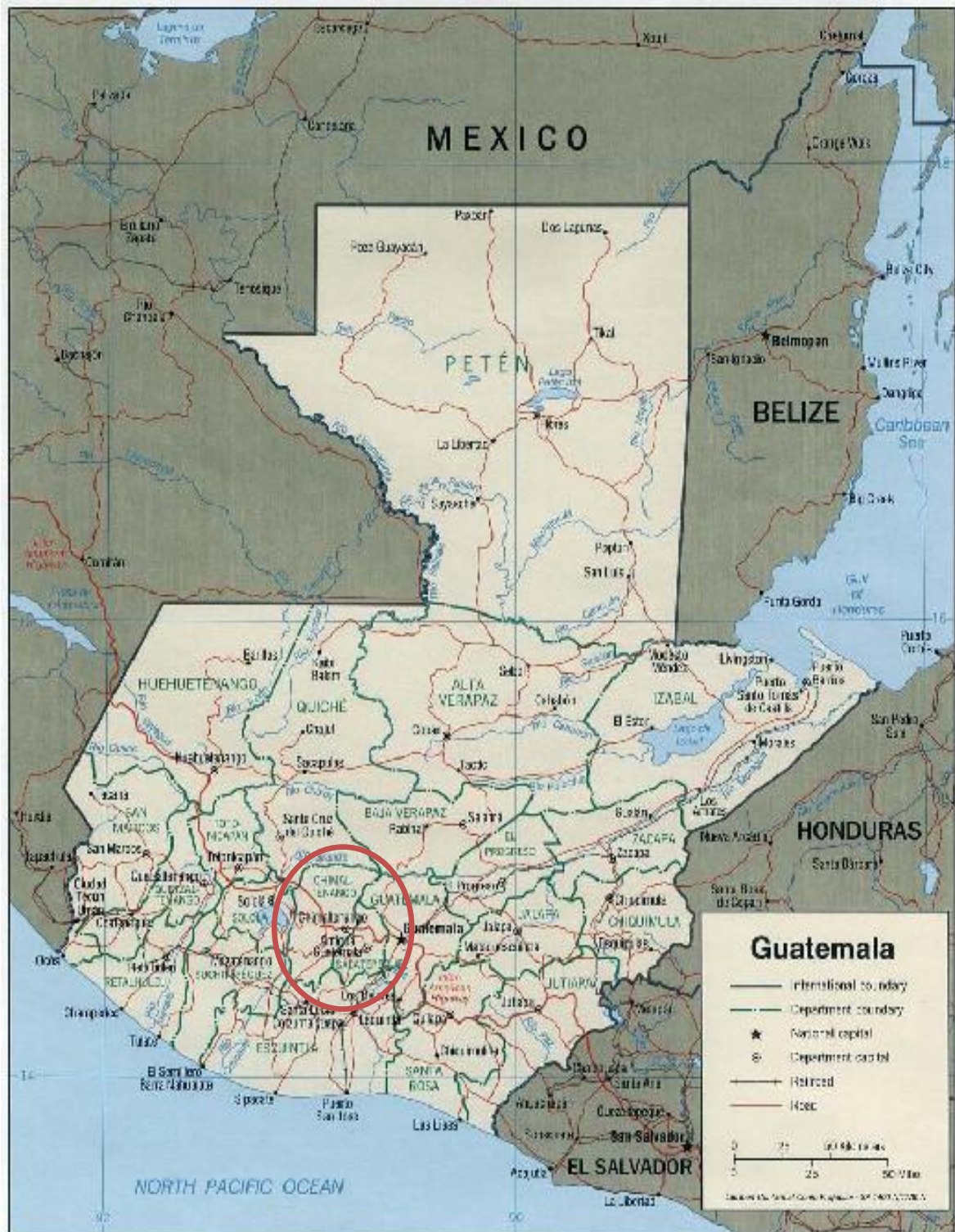
Oslo, June 2009

Abbreviations and Glossary

| | |
|---------------------|--|
| APROFAM | A non profit private organization working with reproductive health in Guatemala |
| Ciclofem | Monthly injectable |
| Depo Provera | Injection that lasts for three months |
| IGSS | Instituto Guatemalteco de Seguridad Social Guatemalan Social Security Institute |
| IMR | Infant mortality rate |
| IUD | The Intrauterine Device (IUD) is a small device placed into the uterine cavity, either copper or hormones. Long term, but immediately reversible |
| Jadelle | Type of implant that is effective for five years |
| Kaqchikel | One of the Mayan languages |
| Machismo | Attitudes and behaviors which oppress women in relation to men |
| MGD's | Millennium Development Goals |
| MMR | Maternal mortality rate |
| MSPAS | Ministerio de salud Pública y Asistencia Social Ministry of Public Health and Social Assistance |
| NGO | Non Governmental Organization |
| PAHO | Pan American Health Organization |
| Q | Quetzales (Q), Guatemalan currency, \$ 1 ≈ Q 8 |
| SIAS | Sistema Integral de Atención en Salud Integrated Health Care System |

| | |
|-----------------------|--|
| The pill | Oral contraceptive |
| Tubal ligation | Life-long, permanent protection against pregnancy. Reversal is usually not possible. Also referred to as sterilization and “the operation” |
| UNFPA | United Nation Population Fund |
| USAID | The U.S. Agency for International Development |
| Vasectomy | Male sterilization. Life-long, permanent protection against pregnancy. Reversal is usually not possible |
| WINGS | A small non profit private organization working with reproductive health and family planning in Guatemala |

Map of Guatemala



Base R027274 (ICD113; 12-00)

Source: <http://www.lib.utexas.edu/maps/guatemala.html>

○ = Study area: Chimaltenango and Sacatepequez

1. Introduction

The approach to population and human reproduction has changed considerably during the last decades. There has been a shift in focus from population control to a reproductive rights perspective. Along with the Millennium Development Goals (MDG's), with three health related goals (4, 5 and 6), reproductive health is also recognized as crucial for poverty reduction. The MDG's can be seen as the next generation of the "Health for all" goals introduced by the Alma-Ata Declaration in 1978 now being revitalised, bringing back the focus on primary health care along with the right to health (Walley et al. 2008). In contemporary global health debates, there is a focus on the right to reproductive self-determination. It is about people's freedom to choose.

Guatemala is one of the poorest countries in Latin America and has one of the highest maternal and infant mortality rates in the region. Access to reproductive health services is rather poor, especially in rural areas. This thesis is concerned with women's capabilities and constraints in pursuing their aim of securing well-being for their families. Access to contraceptives, the ability to control their own fertility is central in this regard. The analytical approach to well-being chosen in this thesis is the approach pioneered by Amartya Sen (1993, 1996, 1999, 2002, 2005). The core characteristic of the capability approach is its focus on what people are effectively able to be and to do. Sen argues that capability is a kind of freedom and emphasises the importance of the ability to live the life they want and desire (Sen 1999:75,85). The lack of choices and opportunities are indeed indicators of poverty Sen argues. Freedom of choice thus, is central to the well-being of individuals and families.

This thesis discusses women's opportunities to freely choose whether they want to use contraceptives or not. It explores women's agency (c.f. Ortner 2006) in choice and decision making and how women pursue their aims and aspirations. This thesis gives descriptions of how women seek reproductive services in order

to control their own fertility. Family planning is, by the women informants in this thesis, understood as one way to escape poverty and enhance their ability to provide for their children. Pregnancy might result in a child they cannot afford to feed. Female agency is in this thesis understood as projects i.e. a set of choices made in pursuing particular goals, aims and aspirations.

Moreover, it is a human right to choose freely when, how many and with whom they want children. It is not just about being able to make decisions it is also about being able to implement these decisions. Access to and information about contraceptive services is important in this regard. Equally important however is that the capability of using contraceptive services is embedded in different social conditions, norms and values.

The thesis base these discussions on the functioning role of public and private providers in giving contraceptive services on the local level in two of Guatemala's provinces; Chimaltenango and Sacatepequez. Some constraints associated with the public providers are understood to concern access, availability of methods, resistance to talk about the subject and lack of confidentiality. These elements have a direct effect on women's capability to make free choices. Private providers are therefore important to many women. Where the public providers fail to provide contraceptives, the private providers work to give access to women that are searching for family planning options. Many women, youths, poor and indigenous people are still being excluded in the process of providing reproductive health services. Women's opportunities to access contraceptives are also influenced by women's relation to men, religious beliefs and knowledge systems. In addition, the ethnic composition, and the geographical and linguistic situation in Guatemala add to the constraints concerning access and information.

Since the Peace Accord in 1996 the Guatemalan government has made strategies to improve the health in general and reproductive health in particular. *The Integrated Health Care System (SIAS)* introduced in 1997 was the first strategy to improve basic health care services. It had the aim of establishing

services closer to the communities and encouraged different members of the community to participate in the organization of the program. In 2001 the *Social Development Law* was passed and laid the foundation for the 2005 *Family Planning Law* that passed after months of heated debate. The latter law requires that the government provides temporary contraceptive methods in the country's public health facilities free of charge. The recognition of the need for reproductive health care and family planning however still remains a difficult task. The position of the Catholic Church in Guatemala has had great influence on the government and has affected policy and implementation regarding family planning for decades. In coalition with the Catholic Church the state has hampered the provision of contraceptives, which has influenced people's freedom to choose. The Guatemalan government has in this process been pulled in different directions. On the one hand the opposition and critique of the Church, on the other hand new civil organizations fighting for the rights of the people. Moreover, the government also faces the pressure from global development agencies that place family planning within their poverty reduction schemes and see access to reproductive services as reproductive rights.

1.1 Objectives and sub-objectives

This thesis aims to address the issue of reproductive health and family planning from the perspectives of local women seeking these services, why it is important to them and how providers in the local community in which they are living are promoting and providing reproductive health and contraceptives. Further, it aims to address how the state operates in providing access and information, and how the ideology of reproductive rights influences a woman's freedom to choose. In exploring reproductive health on all these levels this thesis aims at getting a better understanding of the capabilities and constraints women face in seeking contraceptive services. The main objective of this thesis may thus be framed as:

Explore the capability approach in relation to reproductive choice in order to contextualize women's capabilities and constraints in accessing contraceptive services in Guatemala. This is achieved by three sub- objectives:

- 1. Give a detailed description of the capabilities of women seeking reproductive and contraceptive services.*
- 2. Understand women's capabilities in relation to the constraints they face in making these choices on a local and state level.*
- 3. Apply the capability approach to explore the ideology of reproductive rights and what rights might imply for women's reproductive choice.*

1.2 Guatemala

Guatemala is among the worst performers in terms of health outcomes in Latin America. The country has a population of approximately 13 million people, and has had a population growth rate of 2.6 over the past few years (World Bank 2003, Centro Nacional de Epidemiología 2007). The life expectancy at birth for the total population was 68.9 years (65.5 for men and 72.5 for women) for the five year period 2000-2005 (PAHO 2007:378). In contrast to many other countries in Latin America, Guatemala is only at the beginning of the demographic and epidemiological transition (World Bank 2003). Guatemala has an extremely young population with 43 percent of the population under the age of 15, who are entering their reproductive years (PAHO 2007:377).

1.2.1 Reproductive health

The Infant Mortality Rate (IMR) is regarded as one of the most sensitive measures of a population's health as it is a key indicator of the mortality risk from infectious, communicable diseases and other diseases associated with poor

sanitary conditions and malnourishment (World Bank 2003:14). The IMR for Guatemala in 2002 was 39 *per 1000 live births*, and had fallen from 48 in 1997. The IMR is higher in rural areas (48), than in urban areas (35), and even higher for the indigenous population (49), compared to the non indigenous population (40). In the central region (where Chimaltenango and Sacatepequez are located), it is estimated to be 55, closely related to rural living, poverty and ethnicity (PAHO 2007:378-379).

The Maternal Mortality Rate (MMR), in 2000, was set to be 153 per *100 000 live births*¹, with an under registration rate for maternal deaths of 44 percent nationwide (PAHO 2007:380). Furthermore, the MMR for the indigenous women was three times higher that of non indigenous women; 211 versus 70 respectively (PAHO 2007:381). Over 50 percent of all babies are delivered in the mother's own home. Of the indigenous, rural and poor women, 70 percent deliver their babies at home, and over 86 percent of the extremely poor do so (World Bank 2003:52). Overall, traditional midwives attend almost half of all births and doctors attend 40 percent. Among poor women, 71 percent are assisted by midwives. The poorest women, on the other hand, 15 percent are helped by people with no medical training at all (World Bank 2003:51).

The total fertility rate² is 4.4 on a national level and is among the highest in Latin America (Jaramillo and Valladares 2006). It is higher with Mayan women, where it is constituted to be 6.1 children per woman (PAHO 2007:378). Furthermore, according to Centro Nacional de Epidemiología (2007), it is typical to be over 8 among the rural population. Hence, the country has not kept pace with other Latin American countries where the average has decreased from 6 per women in the 1960's to 2.7 in 2002 (Santiso-Galvez and Bertrand 2004). In addition, the average age for first time mothers in Guatemala is 20.3 years (World

¹ The MMR was also set to be 153 in a recent paper from MSPAS (MSPAS 2008).

² Lifetime births per women.

Bank 2003:11). Plus, 15 percent of 15 - 19 year old girls were already mothers, and among women under 29 years of age, 28.2 percent had less than 24 months between each pregnancy (PAHO 2007:379).

Family planning

In comparison to other Latin American countries, the contraceptive prevalence in Guatemala is considered low. In 2000, only 55 percent of women knew of at least one method of contraceptive. Knowledge of contraceptives is more limited in rural areas and among the poor, estimated to be 44 percent and 40 percent respectively. The estimated number of women who are aware of family planning is higher in urban areas (80 percent) and among the non-poor (70 percent) (World Bank 2003: 9)³. The contraceptive prevalence of women in unions in fertile age is 43.3 percent, however, 23.8 percent for indigenous women and 52.8 percent of non indigenous women. Of those 34.4 percent used a modern method, 8.8 percent used traditional methods (PAHO 2007:380). The figure is even lower with only 28.3 percent of women in reproductive age in total, 14-49 years, use contraceptives, and of those 22.8 percent use a modern method. Among women who are not in union, the prevalence is 17.6 percent (Centro Nacional de Epidemiología 2007).

The unmet need for family planning is high with 28 percent of married women in reproductive age wanting to space or limit birth, but they are currently not using any type of method (Singh et al. 2006). Among the users of contraceptives (the 34.4 percent of women in union) the most popular are female sterilization (17.8 percent), injectables (9 percent), oral contraceptives (3.4

³ These are the latest accurate numbers I could find, but it is likely (according to my informants) that the percentage of those who know of family planning have increased the last years.

percent), condoms (2.3 percent) and the *IUD* (1.9 percent) (Montufar et al. 2005:1). The prevalence of vasectomy is very low in Guatemala, considered to be 0.99 percent (Jaramillo 2004:19). On average, (2002 numbers) the family size was 4.4, but the desired size was 3.7 and 28 percent of all birth were unplanned (Singh et al. 2006). Smaller studies say that the number of children a family wants is between 2 or 3, but the number they have on average are 4 or 5⁴.

1.2.2 Poverty and inequality

According to the World Bank (2003:5) and PAHO (2007:375), 56 percent of Guatemalan families live below poverty line, 16 percent live in extreme poverty. For the indigenous population it is even worse, and it is estimated that 76 percent live in poverty, 27 percent in extreme poverty (World Bank 2003:5). Over 60 percent of Guatemalan households have a monthly income that is too low to cover the costs of a basic food basket, which might tell us why malnutrition is a vast problem in Guatemala (PAHO 2007). According to data on nutrition status, 23 percent of the population is undernourished. 49.3 percent of children between 3 and 59 months of age suffer from chronic malnutrition (2002 numbers). This is a more serious problem with indigenous children than non indigenous, 69.5 percent and 35.7 percent respectively (PAHO 2007:384). Education has not had the highest priority in Guatemala, and the adult literacy rate (in 2002) was 69.1 percent. The indigenous females having the lowest literacy rate with 41.7 percent and non indigenous males the highest with 82.8 percent. Two third of all illiterates are females. In 2002 it was estimated that youths between the ages of 15 and 24 years only spend 5.4 years in schooling. For the indigenous population this number is estimated to be just 3.8 and 6.5 for the rest of the population (PAHO 2007:376).

⁴ This estimate is according to WINGS and studies they have done.

The majority of the population lives in rural areas. In recent years, the proportion of people living in urban areas increased from 35 percent to 46 percent between 1994 and 2002 (PAHO 2007:378). Still, it is the least urbanized country in Central America (World Bank 2003). The incident of poverty is worse in rural areas than urban areas, where most of the Mayan population live. 68.3 percent of the Mayan population lives in rural areas, compared to 44.3 percent of the non indigenous population (PAHO 2007:378). People in rural areas, especially the indigenous population has been, and still are, excluded socially, economically and politically and lack educational and economical opportunities (World Bank 2003:5).

The indicators above reveal large inequalities, also in health performance across geographic areas and socio-economic groups. The poorest people use health facilities the least, regardless of what type of facility is being considered. There is a general tendency among the Guatemalan people to use private rather than the public facilities if they can afford it. The poorest people who live in rural areas and the indigenous population use public health facilities more often than private facilities. This results in underutilization of public health facilities (World Bank 2003). According to the World Bank (2003:2) the poor indicators and underutilization of the public facilities imply that the type and quality of the services offered by the government is not good enough to better the health indicators and meet the demand of the Guatemalan people.

1.2.3 The civil unrest paralyzed social programs

Health infrastructure was severely damaged during 30 years of civil war, a war which ended in 1996. The entire country suffered by acts of sabotage against roadways, bridges, electric energy plants, telephones, water sources and transportation systems (Santiso-Galvez and Bertrand 2004:61). Social services like education, health, housing and employment were heavily affected, and it was

difficult for the government and the private sector to implement development programs in an efficient way under these conditions (Santiso-Galvez and Bertrand 2004). All construction of health units were called off and the few that existed became worse because of lack of investment. The continuing attacks against civilians travelling on the highways and the theft of equipment and supplies from medical facilities made training and keeping of clinical personnel very difficult. People did not want to travel to the areas of the armed conflict. The lack of nurses and doctors in these areas exacerbated the situation, especially in the rural and Mayan communities (Santiso-Galvez and Bertrand 2004).

The affect of the armed conflict were even more noticeable for family planning than for health services in general. Family planning was, however, not a strong priority of the MSPAS (Ministry of Health) in the first place, and worsened during this period. Many international development agencies halted their development projects in the highlands due to security. Other NGO's continued to work in these regions, but was regularly in the site of threats and experienced disappearances of personnel (Santiso-Galvez and Bertrand 2004).

By the 1990's the peril of violence decreased and the Peace Accords were signed in 1996. The Peace Accords laid basis for several social reforms with the goal of improving the situation concerning social and economical differences in the country. However, there is doubt that the goals of this agreement have been met⁵. Improving health was one goal that was being prioritized within the Accords. The Integrated Health Care System (SIAS) (*Sistema Integral de Atención en Salud*) was introduced in 1997 with the aim of improving basic health services, in particular for the rural and indigenous population. Reproductive health and family planning were also integrated into the services, but the promotion and delivery rather failed to materialize under President Arzu's administration (Santiso-Galvez and Bertrand 2004).

⁵ With good reason when seeing the indicators outlined.

1.2.4 Population, ethnicity and representation

Guatemala has a rich cultural, ethnic and linguistic heritage. The indigenous population is Mayan, Xinca and Garifuna. Of the indigenous population Mayan account for 95.7 percent (PAHO 2007:381). When speaking about the indigenous population, it is usually the Mayan population it is referred to. The Mayan population constitute some 40 – 60 percent of the total population, depending on how being “Mayan” is defined⁶. Usually the number used is 43 percent.

Furthermore, there exist 21 different Mayan groups in Guatemala, many of which are mutually unintelligible (Santiso-Galvez and Bertrand 2004, PAHO 2007).

Guatemala is basically composed of two main groups; Mayans and ladinos. Since these two groups constitute 99 percent of the total population, it is usually these two groups that are being referred to when you discuss ethnicity (Thomassen 2004:7). The term ladino refers to "a person no longer identified culturally as Indian and, in Guatemala, includes many individuals genetically Indian as well as those representing various degrees of European-Indian racial mixtures who are Mestizos in the customary sense" (Scrimshaw and Tejada 1970 in World Bank 2003:12). In everyday language, the word ladino just means “non-Indian”, and composes of those that have Spanish as their mother tongue.

Ladinos have been in positions of power since colonial times, and the lack of policies that favor the indigenous population and development programs that do not consider indigenous traditions and practices contribute to the social marginalization of indigenous people (World Bank 2003, Santiso-Galvez and Bertrand 2004). This is shown through the fact that the indigenous population has the worst outcomes on almost any social, economical and demographical indicator (Santiso-Galvez and Bertrand 2004).

⁶ It often depends on whether they are Mayan “by blood”, if they speak a Mayan language or wear the Mayan costume (*traje*) (Interview: Dr. Camey de Astorga, Elsy. APROFAM Board of Directors. Guatemala City: September 7, 2008).

In this thesis I use the term indigenous in the meaning of Mayan, even though Xinca and Garifuna also belong to the indigenous population in Guatemala. Since all the indigenous women interviewed were Mayan, I chose to use these two terms alternately meaning only Mayan.

1.3 Methodology

This is a case study of women's capabilities and constraints in accessing contraceptive services, and how this relates to poverty reduction in the central region of Guatemala. Yin defines a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin 2003:13). You would use a case study when you want to cover contextual conditions, which has been particularly important in this study. I could not have studied women's capabilities and constraints in accessing contraceptive methods without understanding the contextual condition and the complexity within which they live. To be able to understand what influence their situation, the choice of family planning needs to be placed firmly in context. Local providers (public and private), the government's role and global initiatives, as well as socio-cultural conditions have a direct affect on women's freedom to choose.

Yin (2003) emphasizes that a case study relies on multiple sources of evidence. This, in particular, is a case study's strength; "its ability to deal with a full variety of evidence" (Yin 2003:8). According to Creswell (1998) a case study involves the widest range of data collection as the researcher try to build an in-depth picture of the case. Validity and reliability is crucial for the study result to be scientifically meaningful. The goal of reliability is to minimize the errors and biases in the study (Yin 2003: 37). How the interviews are conducted and to be aware of potential biases are important to uphold the reliability of the study. According to Yin (2003:99) one way to strengthen the validity in a case study is

to triangulate the data being used, because this provides multiple measures of the same phenomenon. Stake points out that “the qualitative researcher is interested in diversity of perceptions, even the multiple realities within which people live. Triangulation helps to identify different realities” (Stake 2005:454). In this study I have used a qualitative approach with semi-structured interviews with women and providers as primary source. I have focused on women who were able to get to the health clinics to search for family planning options. Further I have focused on their motivation and capabilities for going there. These primary sources are supplied with secondary sources such as articles, books, reports and statistics. In addition to these sources I have used direct and participant observation. All these three data collection methods as multiple sources of evidence have been crucial for me to build up an in-depth knowledge of the case studied. I speak Spanish which has been important for all three data collection methods. The majority of the interviews, most of the secondary sources gathered in Guatemala and certainly the field visits, were all done in Spanish. Without this language knowledge it would have been difficult to conduct my fieldwork and apply multiple sources of evidence.

1.3.1 The case study area

Before conducting fieldwork in Guatemala I was in contact with WINGS, an NGO that are working with reproductive health and family planning in Guatemala. Reproductive health and family planning is still a sensitive topic, and getting access to women who are searching for family planning options and being able to interview these women is not an easy task. Therefore, to be able to go to clinics to interview women I needed to go through an organization, both in terms of access and in terms of earning the trust from the women. WINGS works primarily in three provinces of Guatemala; Chimaltenango, Sacatepequez and Esquintla. When arriving in Guatemala, I had a meeting with WINGS on how I

could best approach the women and which field visit I could attend with WINGS's staff. Since I needed to go with WINGS to the clinics these were the provinces I could focus on. My main interest, among the three provinces, was Chimaltenango because this province has the largest rural and indigenous population. As my fieldwork started I chose to focus on Chimaltenango *and* Sacatepequez, both in the central region of the country. I also found it interesting to see how these two provinces differ. There are differences in terms of population and ethnicity, poverty and rural living which might affect their opportunity to access contraceptives. However, I grew to learn that many capabilities and constraints facing women are fairly similar across the districts as well.

Chimaltenango

Chimaltenango is one of Guatemala's 22 provinces and is located in the central region of the country. The province has an area of 1979 km² with 16 municipalities, and a population density of 261 per km² (Centro Nacional de Epidemiología 2007). The population is approximately 546 000. The majority, 79 percent, of the population is Mayan, 58.5 percent is rural (Centro Nacional de Epidemiología 2007). Besides Spanish, the Mayan language spoken is Kaqchikel. Kaqchikel is one of Guatemala's largest Mayan groups, which account 21 percent of the Mayan population (World Bank 2004:56). The "capital" of the province is (the city of) Chimaltenango, with approximately 45 000 inhabitants. According to Centro Nacional de Epidemiología (2007) 27.3 percent live in poverty, 4.3 percent in extreme poverty. 22 percent of children under the age of 15 are illiterate. For women the illiteracy rate is 26 percent, while for men it is understood to be 18 percent (Centro Nacional de Epidemiología 2007). According to national numbers, the indigenous population in general has lower levels of education and higher levels of poverty and malnourishment. The rural

population is larger in Chimaltenango and access to health care services is worse than in Sacatepequez.

Sacatepequez

Sacatepequez is the neighbouring province of Chimaltenango and is also a part of the central region of the country. Sacatepequez has an area of 465 km², with 16 municipalities and a population density of 597 per km² (Centro Nacional de Epidemiología 2007). There are approximately 290 000 inhabitants, 42 percent is considered Mayan and 30 percent live in rural areas (Centro Nacional de Epidemiología 2007). Besides Spanish, the Mayan language spoken is Kaqchikel, the same as in Chimaltenango. The “capital” of Sacatepequez is Antigua Guatemala, which is an urban and tourist oriented city with approximately 35 000 inhabitants. According to Centro Nacional de Epidemiología (2007) 21.9 percent live in poverty, 3.5 percent in extreme poverty. 15 percent of children under the age of 15 are thought to be illiterate. 20 percent of women and 10 percent of men are understood to be illiterate. The majority of the population in Sacatepequez lives in more urban areas and has better access to health care services in terms of location of the health facilities.

1.3.2 Fieldwork in Guatemala

My fieldwork in Guatemala took place from the beginning of September to the end of October 2008. WINGS is located in Sacatepequez and it was natural for me to start my fieldwork here. In the beginning I conducted interviews with WINGS’ staff and APROFAM (another non profit private provider of reproductive health services) about the situation in Guatemala, their work and the challenges they face. By understanding the how the health system works concerning reproductive health, formed the basis for whom (providers) I wanted to interview and visit during my fieldwork. All my interviews took place in

Sacatepequez, Chimaltenango and Guatemala City. During my fieldwork I conducted interviews with women who wanted and where able to get to the clinics for contraceptives. I conducted interviews with private and public providers, the MSPAS (Ministry of Health), more specifically with a representative from the Nacional Reproductive Health Program, and I talked with a variety of people I met during my stay. In addition, I did several field visits where I both interviewed and observed.

I went on four fieldtrips with APROFAM's Mobile Medical Units, two in Sacatepequez and two in Chimaltenango. These field visits were also attended by a representative from WINGS who served as my contact during the trips. On every four trips the same APROFAM crew was present. They were very helpful in giving me information and explaining the "context" behind every community visited. They informed the women present who I was and why I was there, which was very helpful to get in contact with women, as it sometimes a difficult task to approach women regarding contraceptive issues.

In addition to the trips with the mobile units I also went on field trips with only WINGS' staff. I visited one private hospital in Chimaltenango where WINGS did cervical cancer screening and offered contraceptives at a low costs. I went to a health posts in Chimaltenango to attend a *charla* (educational talk) hosted by WINGS. They provided information about family planning and I was able to talk to women interested in planning their families. I also visited one of WINGS' promoters in Chimaltenango to understand how this system works and go on home visits to women wanting and using contraceptives. To be able to fully understand the situation regarding contraceptives I also went to observe and listen to *charlas* with youths, both boys and girls, however in separate groups. This gave me valuable information about what they know and how they act when talking about this subject. I also visited schools to ask whether they included reproductive health in their curriculum. I visited APROFAM's permanent clinics

in both Sacatepequez and Chimaltenango and the health center in Sacatepequez to observe and conduct interviews with staff.

1.3.3 Primary sources

According to Yin (2003), one of the most important sources in a case study is the interview. The most common case study interview is of an open ended nature, where you can ask informants about fact as well as their opinions about events and situations (Yin 2003:90). The interviews I conducted gave me in-depth information which was crucial for the result of the study.

During my fieldwork I conducted 14 in-depth interviews with public and private providers, in addition to more informal talks with APROFAM and WINGS's staff (educators) in the field. Eight of the interviews were with WINGS to understand their work completely. I interviewed the founder, the director, the development manager, the program directors and coordinators, both foreigners and Guatemalan staff. The remaining six interviews were conducted with APROFAM, MSPAS (the Nacional Reproductive Health Program) and public providers. With all these informants I used semi structured interviews. The open questions were largely the same, but each interview was also adapted to suit the particular informant. This was done to obtain as much information as possible about the case, as the different informants also held different information and views. The interviews were conducted in English (the WINGS staff who spoke English) and Spanish, and all were recorded and transcribed to maintain accuracy. None of the providers interviewed had preferences of anonymity, so they are referred to by name.

Further I conducted 37 in-depth interviews with women seeking family planning options, 19 in Chimaltenango and 18 in Sacatepequez. All the women received the same questions, but the semi structured approach gave them the freedom to elaborate on issues and themes important for each of them. All the

women spoke Spanish, and an interpreter of a Mayan language was not needed. Since reproductive health and contraceptive use is a sensitive topic, I chose not to record these interviews. I feared that asking to record the interviews would make the women even more timid and reduce the possibility to speak freely. The women interviewed are not referred to by name. I chose to not ask their names, because the information they provided me with is not opinions related to an organization or the government where this can be important to outline. “Ana” as used as a case study throughout this thesis is a cover name.

Challenges with interviewing

There are several aspects that need to be considered to ensure reliability with interviews, such as biases due to poorly constructed questions and that the informant give responses that are exactly what the interviewer wants to hear (Yin 2003:86). Both the public and private providers interviewed were very open when talking about the subject and had a lot of thoughts and experiences to convey. However, it is important to consider that individuals often answer according to their interests and how they view the situation. An NGO fighting for women’s rights might give a worse picture than what actually is the case. The same goes for the MSPAS, who might try to give a better picture than it actually is.

One way to test reliability is to give the informant the same questions twice but at a different time (Hellevik 2002). I did not have time to do this, but I did ask questions during the same interview that was similar, enabling me to compare answers. According to Rubin and Rubin (2005) it is important that you investigate thoroughly and check apparent contradiction and inconsistencies. Further, you interview people that have knowledge about the case studied and in combination will present a balanced perspective (Rubin and Rubin 2005:64). By interviewing both public and private providers I was able to gain a more balanced view of the situation. Furthermore, retaining thorough records of interviews and observations and documenting the process of analysis in detail

may help the reliability issue (Mays and Pope 1995). Since these interviews were recorded I was able to ensure accuracy. However, it would have been in my interest to interview more personnel at the public health posts, as the majority of my informants were private providers.

Interviewing the women in comparison to the providers was a greater challenge. As mentioned, to get access and trust of the women I needed to go through an organization. The personnel present at the clinics were all Guatemalan, so when I came as a foreigner the women had different attitudes about talking to me. Some women did not want to talk to me, while others were very open. The setting of the interview is important to consider concerning how openly an informant can speak. Almost all of the interviews I conducted were done at the clinics⁷ while they were waiting for their turn to see the doctor or other health professional. Since the majority of the women present at the clinics were there for the same reason, those I got to talk to had no problems telling me why they wanted contraceptives, about their family and “life situation” in general. Their husbands were almost never present which also gave them a better opportunity to speak more freely. On the other hand, it is important to consider that my role as a foreigner and coming with the providers may have affected how open they answered my questions. Moreover, as mentioned, all interviews with the women were conducted in Spanish and without recording. Even though I speak Spanish well, took notes and asked again if I got uncertain about something, there might have been some points that got lost in translation. Because I did not have the interviews recorded I did endeavour to transcribe the interviews immediately after field visits. Overall, the answers the women gave, both in Chimaltenango and Sacatepequez, about why they wanted contraceptives were virtually the same, whereas some of the capabilities and constraints they faced were different.

⁷ The APROFAM Mobile Unit clinics. Where I interviewed women at other places or clinics, this was done more discretely.

As mentioned, almost all of the women interviewed were women present at the clinics searching for family planning methods. I was interested in looking at those who were able to overcome the obstacles and come to the clinics. It would also have been interesting to speak to women who perhaps want, but are not able to get to the clinic to learn about the reasons why they find it difficult. Because of time and the difficulty of access to these women, I had to limit my fieldwork to those attending clinics. I also attended home visits in a community in Chimaltenango with a WINGS educator, but these women were also able to get the opportunity to use a family planning method through WINGS promoters program. Scheyvens et al. (2003) discuss the issue of researching women. They stress that it may be very difficult to gain access to women. Partly because they are often extremely busy, or that it can be inappropriate to visit them in their own home or the husband does not approve it. By interviewing the women at the clinics (or those who got to use the services from WINGS) I was able to get by these obstacles, even though it only gave me the possibility to talk to women who were able to access family planning options.

1.3.4 Observation

By making field visits you are creating the opportunity for direct observation (Yin 2003). These field visits has been particularly important in this study both because of the ability of interviewing and for observation that these field visits provide. It helped me better understand how the system works and to understand the importance of contextualizing events. My field visits also gave me the opportunity for participation. On tour with the Mobile Units I was able to take active part in all ongoing events. I usually spent between 4 – 6 hours at each clinic, and observing the women, the personnel and the procedures gave me valuable insights and information. However, it is important to be aware that people might act differently when observed. According to Yin (2003:93), to

increase the reliability of evidence from observation, a widespread procedure is to have more than one observer making an observation. This was not possible for me, as I was the only one doing the study. There are surely certain events during the visits I have noticed and paid more attention to. This might result in elements that have been ignored during the field visits. It would have been in my interests to do more field visits as well. Because of time and access to the field it was difficult.

1.3.5 Secondary sources

Yin (2003:85) claims that documentary information is most usually relevant to every case study topic. Secondary sources were gathered both in Norway and Guatemala and include books, articles, reports, research papers and statistics. A lot of the documents I gathered in Guatemala were not available in Norway. These include reports, statistics and newspaper articles I got from WINGS, APROFAM and libraries. Most of the documentary information gathered was to gain a better understanding of the situation concerning reproductive health and family planning in Guatemala. It is important to be wary of such sources as well, as it is not always the most reliable sources. As Yin (2003:87) points out, for case studies the most important use of documents is to corroborate and supplement with other sources. Documents, in addition to interviews and observation might help building an in-depth picture of the case studied. Dealing with an issue of such controversy as reproductive health and family planning, it is important to get information from different sources and ensure representation from various points of view. The governments, the NGO's and journalists of newspapers are likely to have different opinions of the situation and what they want to communicate. Gathering statistics and documents about reproductive health and family planning in Guatemala was, however, not an easy task. A critical eye on the validity of documents was needed.

In this case study, secondary sources about the ideology behind reproductive health on a global level was also gathered, which has been an easier task. This has been about global development agencies approaches to the subject during the last decades, in addition to various researchers view on the importance of reproductive health and family planning.

1.3.6 Reflection on fieldwork

Conducting fieldwork in another country, especially in a developing country, can be a challenge. As Scheyvens et al. (2003) points out, it can represent difficult practical, ethical and personal challenges. I have lived in Guatemala, so the immediate culture differences one might experience did not represent a problem for me. On the other hand I have not done research in Guatemala before, so this type of fieldwork was new to me. I found it valuable in the beginning of the fieldwork to be familiar with the transportation system, social norms and values and at least be aware of some “do’s and do not’s”.

On the majority of fieldstrips I went with or had a contact person who was Guatemalan, either ladino or Mayan, depending on where we were going. This I found to be very helpful. In some of the communities we were visiting it would have been difficult to ask women about contraceptive use, because of the sensitive topic it is. Also, in some Mayan communities people are still skeptical of foreigners, especially regarding population issues. The providers (when ladinos) also found it sometimes difficult to go to Mayan communities, because of the long history of discrimination of the indigenous population. Despite this, I did not experience being a foreign white woman as a problem travelling to various communities. Sometimes the opposite was indeed the case. In some of the clinics I visited the doctor or the health personnel prioritized to talk to me and let the patients wait. This to me represented an ethical dilemma. There I was using their time and let them wait when access to health care indeed was part of my

study. When I said I could come back another time, the doctors insisted that I stayed. I quickly realized that there is huge class distinction, and that people in general look at doctors as “gods”. My impression is that this gave the doctors the freedom to prioritize as they found fit and they did not mind making people wait.

During my fieldwork I talked to a variety of people; women, men, youth, rich(er) as well as poor. Sexual and reproductive health and family planning are topics that most people can relate to at some point. Where people were reluctant to talk to me about reproductive health (the women at the clinics in particular), it helped me understand that the topic is still very sensitive. It gave me a better understanding of social norms and values, rites and regularities surrounding the topic. I will therefore claim that all my experiences, for good or bad, provided me with information and enriched my knowledge about family planning and reproductive health in Guatemala.

1.4 Structure of the thesis

My point of departure in this thesis is an exploration of local women’s capabilities and constraints in searching for contraceptive services (Chapter two). I do this within the conceptual framework provided by Amartya Sen; the capability approach. The aim of this chapter is thus twofold. I am concerned with explicating Sen’s analytical approach of how poverty can be seen as capability deprivation and the importance of individual freedom to choose. Importantly however, I do this by focusing upon local women’s aims and aspirations and their agency in pursuing their goals. Throughout the chapter I use one woman, Ana, as the main example to explore the usefulness of concepts such as agency, capability and choice in relation to reproductive health. The story of Ana also raises several issues concerned with access, information, socio-cultural conditions and rights, issues that will be further explored throughout the thesis.

The main aim of Chapter three is to discuss constraints of particular relevance to the health system at the local level. I describe parts of the health system that women relate to in their search for contraceptive services. A comparison between women searching for contraceptives in the two provinces studied are presented and discussed in order to provide insights into the importance of access to services, availability of contraceptive methods information and confidentiality in women's choice making. This chapter highlights the constraints that the public providers often represent by being "to local". The private providers represent a way of escaping these constraints by improving access, improved information and availability and importantly also by not being local. Public providers situated as they are in local communities and recruiting health workers also from local communities become by this very fact part of the constraints that they are set out to solve.

The importance of socio-cultural constraints is further explored in Chapter four. This chapter thus concerned with the complexity of accessing contraceptive services, and aims to understand how women's capabilities and freedom to choose these services are embedded in different social forces and conditions. These forces and conditions do not only shape capabilities of women seeking these services. It indeed also shapes the capability of the health workers in providing them. The public providers are however also constrained by the Guatemalan state's inability to suitable equip its health facilities at the local level, thus paving the way for private providers.

In order to fully understand the role and responsibility of the state I am concerned, in Chapter five, with the state's role in providing access and information regarding reproductive health and contraceptives. This discussion is also guided by the capability approach and the concept of agency. Strategies and laws passed to improve reproductive health and rights are presented. Whereas the laws passed at one level enhance the capabilities of the individual local women, the state itself also represents the constraints. I am here particularly concerned

with how the capability of the state itself is constrained by the strong position of the Catholic Church in the country. These issues are discussed by questioning what influences state decisions and policy regarding reproductive health and contraceptives services.

In my last main chapter, Chapters six, I attempt to bring all threads laid out in the previous chapters together by exploring the global ideology of reproductive health and what a rights perspective might imply for the individual woman's freedom to choose. The chapter also addresses the concept of power to understand how different actors might influence an individual's reproductive rights. In addition, the chapter discusses the argued benefits of reproductive health and family planning, and how these achievements need to be seen in relation to the freedom to choose.

2. The local women – a small, but better future?

My aim in this chapter is to provide information on capabilities and constraints local women in Guatemala face in searching for a way to plan the future of their family. This chapter emphasizes the importance expressed by the women themselves to have access to contraceptive services in order to be able to take care of their families and cope with the poverty. The first part of the chapter describes a local woman's situation and how poverty can be seen as capability deprivation. The core characteristic of the capability approach, pioneered by Amartya Sen, is its focus on people's capabilities. Sen argues that capabilities are kinds of freedom, and emphasises the importance for people to live the kind of life they want according to their desires (Sen 1999:75). Quality of life should be measured in terms of a life of real choice and not a life where the person is forced into a certain life (Sen 1996:59). It is about *freedom of choice*, and in this sense the women's freedom to choose to control their own fertility. The chapter also discusses women's agency in pursuing their aims and aspirations. Agency as understood by Ortner (2006) refers to having "projects". Projects are aspirations and goals and what women do to achieve them. The local women who are informants in this thesis have projects in the sense of taking measures to not conceive in order to be able to take care of the children they already have. They show agency in their effort to access contraceptive services despite the many constraints they might face as depicted in the story of Ana. The chapter also discusses how capability deprivation can be understood as a state of suffering.

2.1 Poverty as capability deprivation

There exist many ways to define what is poverty and who "classify" to be considered poor. The multidimensional concept of poverty has often been linked

to low income as the major indicator. Low income, however, is only one way to define the concept. The lives of the poor are characterized by deprivation such as lack of entitlements to food, health, education, security and political influence (Banik 2006:11). According to these characteristics hundreds of millions of people in the world are living in some kind of deprivation. Poverty expressed as some kind of deprivation can illustrate the reality for many women living in Guatemala. People are struggling every day to survive and do what is in their power to make their lives as good as possible. Sadly, powerlessness and struggle is what characterize everyday life for many; “the poor are those whose greatest task is to try to survive” (Sobrino 1988 in Farmer 2005:6). This is what characterizes the women I met in Guatemala who with great effort made the most of their situation to prevent their family from descending into greater misery. They experience the suffering and hardship of not being able to feed their children or providing their children the chance of a better future.

Poverty as capability deprivation can be one way to evaluate the women’s situation. To explore deprivation in relation to people’s capabilities allows us to understand *absolute* poverty as lack of capabilities to realize basic needs. It *also* allows us to consider poverty and deprivation in *relative*⁸ terms as well, *and* it goes beyond “income poverty” and takes into account people’s daily suffering and hardship. As Sen points out; “it is also important to recognize that the capability approach is not confined to basic capabilities only” (Sen 1993:41). The capability perspective enhance the understanding that people are different and have different views on what is a good life, and considers people’s freedom to achieve their goals and what they value as a “good life” (Sen 1999). I therefore find the capability approach fruitful in this study, as the “deprivation” of the women informants in this thesis is more complex than poverty simply in terms of low income. I will in the next section introduce Ana as a woman seeking contraceptive services in order to improve her family’s well-being. Further I will

⁸ Defines poverty in social terms, often linked to inequality and social exclusion (Banik 2006:12).

use Ana to explore the usefulness of concepts such as agency, capability and choice in relation to reproductive health and the projects of the women informants in this thesis.

2.1.1 The story of Ana

Ana is representative for the women I met in Guatemala seeking reproductive services. She is a woman that despite capability constraints has been able to pursue her goals. Ana is a Mayan woman. She lives just outside Chimaltenango, the biggest city and “the capital” of the province of Chimaltenango with her husband and children. Ana is 37 years old and got married when she was 21. As most girls in the area get married when they are between 15 and 19 years old her marrying age is some years above the average. Ana, like most of the women I met, got her first child soon after marriage and has given birth to five children during a period of nine years. Her husband is the only one in the household who has regular paid work. Ana takes care of the house and the children, which is a full time job with no washing machine or modern stove. Ana went to school for three years and her husband for six years. She knows how important education is to be able to get a job and a better future. Education as a way to increase job opportunities is becoming increasingly important because prices are higher and everything has become more expensive though general salaries have not increased at the same pace. Ana’s youngest daughter is five years old and Ana has been careful and tried not to conceive, but she is constantly worried about getting pregnant again. She has never used any method of birth control.

Ana is fighting to be able to give her children a better future. Because she has not had another child in five years, she has had the opportunity to work a little bit in addition to being a housewife and a mother. She does not have a regular job, but does small jobs such as cleaning, selling things at the market, picking tomatoes in the field from day to day as people ask her to. She does this

to be able to send her children to school. Four of her children already go to school and the youngest daughter is starting next year. Her oldest son goes to *Colegio* (high school), and her oldest daughter will attend *Colegio* next year. Ana is proud of this and works hard for her children's education. Sending children to school is costly as parents have to cover material such as school uniforms, books, pencils in addition to school and tuition fees. *Colegio* is even more expensive, nevertheless Ana is determined on doing this. Lately the economic situation has become worse due to higher prices, and Ana is now even more worried than ever of getting pregnant again. First of all, she would not have time to work to be able to send her children to school. Secondly the cost of having another baby would mean school for all of the children would be impossible. Because of this Ana has decided to undergo *tubal ligation*⁹. She determined to not have more children permanently. To be able to access a family planning method at a price that she can afford is crucial for Ana, in order to be able to continue her fight to give her children a better future.

The reason why her choice has fallen on the *tubal ligation* is because it is a one-time procedure and cost where she does not have to come back again for another *injection* or *pill*, and it is (almost always) 100 percent certain. Moreover, according to my informants, the local understanding of the harm that contraceptives might cause, gives many women a preference for the operation. In fact, *tubal ligation* is the most commonly used family planning method among women in union in Guatemala. The demand for the tubal ligation is high, but it is difficult for many women to undergo this operation as it can only be done in the hospitals (among the public facilities), usually only after giving birth there. The possibility of having the operation in hospital is thus rather small, since the majority of women give birth at home. Having the operation at a private clinic is very expensive, even at APROFAM¹⁰ it is too expensive for many women. In

⁹ Also known as sterilization or the "operation". A life long permanent protection against pregnancy.

¹⁰ Non profit private provider (also mobile) of reproductive health services. See chapter 3.4.1 for presentation.

specific areas WINGS¹¹ subsidizes *tubal ligation*, the *Jadelle* (implant) and the *IUD*¹² provided by APROFAM, to give the women a more affordable price. Ana would not have the possibility to undergo the operation without the subsidies from WINGS which give her a price of Q¹³ 25 (\$ 3, the original price at APROFAM's permanent clinic is Q 300, \$ 37. At APROFAM's Mobile Medical Units the original price is Q 120, \$ 15)¹⁴.

Ana's husband supports her decision to have a *tubal ligation*. Health workers are convinced that there are plenty of women wanting the same as Ana, but who are unable to do so because their husbands or the community will stop them or openly disapprove. Social norms and values and belief systems make the decision process in family planning challenging for women, if at all possible. There is a nexus of values, norms and regularities that influences Ana's situation and opportunity to make her own choices concerning her effort to improve and sustain her family's state of well-being. Despite these constraints Ana had the opportunity to choose, which is an important element of the capability approach I will now turn to.

2.1.2 The capability approach

One approach that is concerned with a person's well-being as an indicator of poverty and deprivation is the one of *human capabilities*. The core characteristic of the capability approach is its focus on what people are effectively able to be and to do; also labelled people's capabilities (Sen 1993:30). However, as Robeyns (2005) stresses, this is not a theory to explain poverty, inequality or well-being, but a theory to facilitate conceptualization and evaluation of these phenomena. Evaluations and policies should concentrate on what people are able

¹¹ Non profit private provider of reproductive health services. See chapter 3.4.2 for presentation.

¹² Intrauterine Device – long term, but immediately reversible.

¹³ The Guatemalan currency is Quetzales (Q), Q 8 ≈ \$ 1.

¹⁴ The average salary is Q 7.3 per hour, and even lower in agriculture, Q 3.3 per hour (World Bank 2004:84).

to do and to be and on their quality of life. It is about removing obstacles in people's lives and enlarging their choices in order to enable them to live their lives according to their needs and interests (Robeyns 2005:94-95). The capability of a person corresponds to the freedom a person has to lead this kind of life (Nussbaum and Sen 1993:3). Sen sees poverty as lack of basic capabilities¹⁵ to live a tolerable life, and denial of choices and opportunities. He stresses that poverty is not only about economic deprivation, but about quality of life, well-being, agency, rights and freedom (Sen 1999). For Ana and the other women, it is not about whether they use family planning methods or not, but about their capabilities, to be able to do so if they want to. It is not about whether she actually gets fewer children, but about the opportunity to choose and control the number and timing of her children. It is about removing obstacles such as information, access and social conditions and giving her the freedom to choose. By means of these constraints, she is living in a state of capability deprivation.

Sen claims that the capability perspective draws the primary attention away from means (such as income) to ends¹⁶ that people have reason to pursue and the freedom to be able to satisfy these ends (Sen 1999:90). Robeyns emphasizes that according to the capability approach, "the ends of well-being, justice and development should be conceptualised in terms of people's capabilities to function; that is, their effective opportunities to undertake actions and activities that they want to engage in, and be whom they want to be" (Robeyns 2005:95). The valuable life a person can lead can be seen as a combination of various "beings and doings", which Sen calls functionings (Nussbaum and Sen 1993:3). For Ana to "undertake actions and activities *she* wants to engage in", she needs access in terms of location at a price she can

¹⁵ Definition of "basic capabilities" has been one of the critiques of the approach, however, as Robeyns points out; "they refer to the freedom to do some basic things that are necessary to avoid or escape poverty" (2005:101). Often considered to involve aspects of nutrition, health, education etc.

¹⁶ Only the ends have intrinsic value, while means are instrumental to reach the goals of increased well-being, justice and development. These distinctions can often be unclear, since some ends are also often means to other ends. E.g. good health is an end in itself, but also a means to the capability to work (Robeyns 2005:95).

afford without being discriminated as a woman, indigenous or as poor. In many situations not only the physical differential access to health care is the issue, but the processes of health care itself (DeJong 2006).

Sen thus differentiate between realized/achieved *functionings*, which are what a person is actually able to do and achieve, from the *capabilities*, which are the real opportunities to achieve (Sen 1999:75). Or how Robeyns (2005:95) terms it; between achievements on one side and freedoms or options from which one can choose on the other. What matters in the end are freedom and opportunities; providing capabilities to lead the kind of life that you want to lead. When individuals have these opportunities they can choose the options that they value the most (Robeyns 2005). In some cases it is better to focus on achieved functionings instead of capabilities, because achieved functionings can also say a lot about capabilities. Robeyns provides a good example of this in relation to domestic violence: “If a persons achieved functionings of achieved bodily integrity are harmed by domestic violence, then it is an unequivocal sign that the victim did not have the capability of being safe from bodily harm in the first place” (Robeyns 2005:101). By evaluating the abused person’s well-being in terms of achieved functioning, we can see that his or her capabilities are being violated.

However, two persons with the same capability set¹⁷ will most likely end up with different achieved functioning because they choose differently (Robeyns 2005:101). The capability approach show deference to people’s different views on what is a good life, and that is why (primarily) capabilities rather than functionings is the appropriate political goal (Nussbaum 1999:237, Robeyns 2005:101). We cannot claim that Ana is living in poverty and deprivation just because she has many children. But if she does not have the capability of choosing and controlling her own reproduction and because of that cannot provide for her children, then we can talk about deprivation and lack of freedom.

¹⁷ All the possible achievements an individual may have (Sen 1999).

The central questions asked by the capability approach are “what is she actually able to do and to be?” (Nussbaum 1999:233). It asks whether people are well nourished, and whether the conditions for this capability are being met, such as access to health care and basic knowledge on health issues. “The core idea is that of the human being as a dignified free being who shapes his or her own life, rather than being passively shaped” (Nussbaum 1999:234). Again, it is about the women’s capabilities which reflects her *freedom to choose*, and the elimination of, what Sen (1999) terms it; unfreedoms.

According to Robeyns an important distinction in the capability approach is the distinction between the means, such as goods and services, and the functionings and capabilities. A good has certain characteristics that makes it interesting to a person, which further enable a functioning (Robeyns 2005:98). A family planning method may in this case be seen as a good. We do not value oral contraceptives, for instance *the pill*, just because it is a pill. We value it because it enable us to control our fertility, which is the functioning *the pill* enable us.

The possibility to use a good to enable a functioning is influenced by three groups of conversion factors, outlined by Robeyns (2005:99). The first one being *personal conversion factors*, which influence how a person can translate the characteristic of the commodity into a functioning. If Ana (or a woman) has never been given the information about family planning and does not know what it can do for her, then access to these kinds of services does not serve any point. Second you have *social conversion factors*, such as gender roles, social norms and discriminating practices. For instance, women can have physical access to family planning services, but husbands will prevent them from using it. In many cases in Guatemala women are still often valued primarily as mothers and bearers of children in line with patriarchal family norms and structures¹⁸. Third you have *environmental conversion factors*, if there are no services offered it makes it difficult for a woman to use the good to enable the functioning: If a woman does

¹⁸ Emphasized by informants in this thesis.

not have access to a family planning method, then the fact that this exists does not facilitate her in achieving her goal of controlling her fertility. There are many material and non material circumstances that influence a person's capability set and the choices people make from his or her capability set (Robeyns 2005:99). Social norms and traditions can in many cases form a woman's preferences and choices. There is a great difference between a life where a person is fully free to make life choices and a life constrained by different social norms, traditions and lack of access to health care services. This is influenced by the three *conversion factors* discussed above.

Nussbaum (1999:237) focuses on what she calls *combined capabilities* which may be defined as internal capabilities (states of a person that enable her to exercise a specific function) combined with appropriate external conditions that effectively enable the person to exercise the function. Hence, the necessity of an appropriate political, economic and social environment is needed to give her an actual choice. "Capability is thus a demanding notion; it does not put people into functioning: once the stage is fully set, the choice is theirs" (Nussbaum 1999:238). The notion of *freedom to choose* is central in this thesis, and this perspective of the capability approach will follow throughout the thesis, when the women's capabilities and constraints in relation to various levels and issues in society are discussed.

2.2 Agency and fighting for a better future

The capability approach is thus about well-being and agency, the latter which Sen terms the "capabilities of each person" (Sen cited by Farmer 2005:43). Further within Sen's approach there is a distinction between well-being and agency goals. The distinction between achievements and freedom to achieve can be applied to, and is important, for both well-being and agency (Sen 1993:35). This can be clarified with an example. Many women in Guatemala run the risk of

using family planning methods behind their husbands back¹⁹. The women have physical access to contraceptives, but social conversion factors like the *machismo* (male domination) culture, which is related to patriarchal family and community systems, might give her husband's prerogative in family decision making. This, in some situations, makes her capability of using a method smaller. If a husband discovers that his wife is using contraceptives without his knowledge and approval her effort to achieve agency and goals can mean sacrificing her own well-being. This distinction is important in the sense of evaluating what is relevant; achieved well-being or agency freedom. However, agency freedom can lead to well-being, but it is important to make the distinction because in many situations there is a difference. Agency is about choices and controlling your own life and the choices you make to empower yourself is not always related to well-being (Sen 1993:35-36, Sen 1999:190).

Ortner (2006) argues that one modality of agency is closely related to ideas of power, encompassing both domination and resistance. Another modality is closely related to ideas of intention, to people's (culturally constituted) projects and their ability to pursue and perform them (Ortner 2006:143). Further Ortner claims that agency is never merely one or the other, they blend into one another. To elaborate further, Ortner defines agency as projects. There is a strong role of intentionality in agency that distinguishes agency from routine practices. Agency is also culturally and historically constructed. All people have the capacity for agency, but the exact form it takes will vary in different times, places and situations (Ortner 2006:136). As for the factor of power, agency can be said to be the forms of power people have, which involve their ability to act according to own interests, influence other people and situations and uphold some kind of control in their own lives. Agency is thus relevant for both domination and resistance. People in positions of power have often "a lot of agency", but the

¹⁹ According to informants in this thesis.

dominated too also have certain abilities to exercise some degree of influence over the ways situations evolve (Ortner 2006:143-144).

Although Ortner claims that these two modalities of agency are not two different “things”, the agency of power may be contrasted with the agency of intentions formulated in terms of culturally established projects. The latter is often considered the most fundamental dimension of the idea of agency; cultural projects as individual goals and actions undertaken to achieve them. This can be individual intentions and desires, or it can be full blown “serious games”²⁰, which involve pursuing cultural goals within a matrix of local inequalities and power disparities (Ortner 2006:144). Although Ana was able to pursue her aims and aspirations, she operates within social norms and traditions in the community and relations to people in that community. Norms, traditions and relations will form how Ana and the other women pursue their projects. With a *machismo* culture, it might make it harder for women to make decisions and implement them. The discrimination they experiences from being poor and being women, and for many in Guatemala, also from being indigenous, and a government that does not implement their rights, makes their goal harder to achieve. Because they are acting within a context of unequal power relations, their agency also becomes the agency of power-as-resistance; protecting projects or the right to have projects. Women are not supposed to have projects in this sense, but they strongly resist this conception by mobilizing agency and maintaining some control over their own life.

Ana and the women use their agency to do what is in their power to try to better their own and their families’ situation. They seek these services to be able to control their own fertility and to be able to take care of the children they already have. They have projects. As several of the women stated;

²⁰ A concept developed by Ortner which involve more complex forms of social relations, power relations and more complex dimensions of the subjectivity of social actors (Ortner 2006:129).

I cannot afford feeding another child, I do not know what I would have done without this opportunity.

This shows that when they have the *capability* to do something, they often will. To have this capability acquires an appropriate political, economic and social environment. The women need combined capabilities to be able to actually access the services; information and knowledge about reproductive health, physical access and a changing environment concerning the fact that a woman cannot in many cases decide this herself. Social norms and belief systems sometimes hinder her in exercising her “agency” or her “project”. The functioning (the outcome) is not the most important factor; it is about her freedom to choose. For Ana and most of the women the opportunity of access was important to be able to provide for their family, as they cannot afford feeding or sending another child to school. Ana also stressed that having another child would spoil the other children’s opportunity to continue their education. Having another child does not mean provide more bread, it means dividing the existing bread into smaller pieces. This constituted the women’s biggest worries. By having access to these services and the possibility to use them Ana can choose and do what she feels is best for herself and her family; in her situation the achieved functioning of a smaller family. She strengthens her agency and the ability to decide over own life.

2.3 Rights to reproductive health care – access and social conditions

One of the central points in Paul Farmer’s book “Pathologies of Power” (2005) is that public health and access to medical care are social and economic rights. The right to health is the right to life, and making social and economic rights a reality is the most important goal for health and human rights. Farmer further highlights that social inequalities based on race or ethnicity, gender, religion and social class are the motor force behind most human rights violations (Farmer 2005:219).

Farmer calls these inegalitarian social structures for *structural violence*, and points out “that we need to remediate inequalities of access to services that can help all humans to lead free and healthy lives” (Farmer 2005:239).

2.3.1 Understanding suffering

Ana and many other women in Guatemala live in these inegalitarian social structures called *structural violence*, part of which the lack of access to reproductive health services that the government has a legal obligation to provide, is only one aspect. The government is required to provide information and temporary family planning services (free of charge), which plays an elementary role in ensuring that people can make and implement meaningful choices about their reproductive and sexual lives. Women have the right to control the number and spacing of their children, and such control over reproduction and sexuality is a vital element of human dignity and fundamental freedom (Freedman 1999:149). Hence, a focus on women’s decision making in reproductive health, which includes the capability of making decisions and implementing them, is of great importance. The latter is extremely important as the right to make decisions is worthless if the circumstances needed to carry them out do not exist (Freedman 1999:149). The right to implement decisions is directly tied to the struggle for social justice, to the fight against inequality, which is, according to Farmer (2005), one of the biggest challenges we are facing today. Inequality, imbalances in power and access to resources, puts the control of women’s reproduction easily into the hands of more powerful groups of men, governments and social groups (Freedman 1999:150). Inadequate access to health services and poor health is often a result of inequality based on gender, race and class.

Farmer (2005) emphasizes the importance of gender in understanding human suffering, often seen simultaneously with ethnicity and poverty. He

recognizes that in most societies studied, men have the dominating privilege and that this power differential has meant that women's rights are violated in innumerable ways. Gender inequality is often maintained through patriarchal family and community systems where women are viewed primarily as wives and sexual partners to men and producers of children (Freedman 1999:150). Control over women's reproduction and sexuality is often justified and maintained by cultural and religious systems, which consider this as "normal". This can have serious health consequences as she does not have control over her own body; it is she who bears the major burden of reproduction (Freedman 1999:150).

Ana and many women typically live in a society as just described. Their life situation is based on they being poor (and for many also for being indigenous) women in a society biased towards them. When considering their choices and their ability to pursue and implement decisions, these constraints need to be considered. It is not enough to have rights on paper. A human rights perspective calls for a view of health that seriously considers its relationship to social conditions such as poverty and discriminations (Freedman 1999:151). Farmer discusses the notion of extreme suffering and poverty. He argues that "it is one thing to make sense of extreme suffering and quite another to explain it" (Farmer 2005:41). Local understandings, the historical system of the country/community and the social and economic forces that dictate life choices must be embedded in understanding the suffering of individuals. Further, as Sen points out, to understand social inequality on health; "we have to go well beyond the delivery and distribution of health care to get an adequate understanding of health achievement and capability" (Sen 2002:660).

In order to state the suffering amongst women in Guatemala, several factors need to be considered. What influences Ana's freedom of choice? First and foremost she needs information about her opportunities and rights, and she needs physical access to the services. This is elementary to be able to make a choice and implement it. As access and information are important, so are social

and economical conditions. If women cannot afford the services and if social norms and values (e.g. male decision-making) or belief systems hinder them from using the services, then physical access as well as information are of no use.

Sen further stresses that the processes of health care too are important; that inequalities even in health care itself is relevant in understanding health equity (Sen 2002:661). Hence the quality of care is important too. According to my informants many young and indigenous people in Guatemala experience discrimination and refusal of services and contraceptive methods when visiting a public health facility. Ana however, is able to pursue her project of having the operation and to continue to fight for her children's education. Her husband also supports her decision to undergo the operation despite the many social and religious constraints that might have influenced their choices. My informants stressed that many women are still "victims"²¹ of the lack of access and information, and constrained by socio-economic conditions.

2.3.2 The right to control one's own fertility

There is plenty of evidence that high fertility has negative health consequences for women and children. Children's health has been given most attention. A birth spacing of minimum three years between each pregnancy has proved significant for child survival (Freedman 1999:152). Women's age when giving birth the first time (and the last time) has also been seen as significant (Allen 2007). Women's health as well has received more attention in recent years. According to Freedman (1999:152), women are obviously concerned about the effect of contraception, pregnancy and childbirth on their own health. Ana's concern was not about her health at all; her only focus was on the economic situation and the future of her children. She claimed that she did not have time to think about her

²¹ I do not like to use the word "victim" to characterize the women as I see them as strong women able to fight for their goals. I use the word only to state the government's responsibility to improve the infrastructure of providing access to reproductive health care to its people.

health. Whatever her choice, a human rights perspective necessitates that the health system respects her decision, and “that it support and facilitate her right and ability to make and implement it” (Freedman 1999:155).

Freedman (1999:155) claims that contraception can give a woman control over her own fertility and subsequently, control over many aspects of her life. This will only be the case if she has control over the decision to use contraceptives. In Guatemala, many women using contraceptives do it in agreement with their husbands. She is usually the first one to recognize the need, and then often needs his support before starting. On the other hand, as mentioned, there are many women who use contraceptives without their husband’s knowledge and approval because they know he will prevent them. Consequently they live under constant fear that their husband will find out. Some of my informants claimed that violence against women is not a rare procedure. Although these women by doing this control their own fertility, he is still the final decision maker. The need for women to go behind their husbands’ backs indicates that there still remain many aspects of her life to gain control over. Controlling fertility might be one step in influencing decision making as it can open doors for working and earning money herself. Ana was able to work and earn some money because she did not have more children. She was able to pursue her project of having the operation and continue her work to be able to pay for her children’s education.

Ana has the right to have access to these services and to be able to control her own body and reproduction. But to demand access, they need to know that this is in fact their right. For many women, it is not about their reproductive *rights*, it is about *survival*. For them it is about the opportunity to avoid pregnancy and take care of the children they already have. Most of the women did not know that this was a human right, nor that the country had just passed a law that gave them the right to receive free contraceptives in the country’s health facilities. How can you claim something that you do not know exists? To inform

people about their rights is the first step to start claiming, and a focus on rights can make the government feel more pressured to act. Still, power inequalities are present, and many factors influence how a woman can exercise her agency.

Farmer (2005) uses the term “outcome gap” in explaining that there are growing differentials between rich and poor in access to effective technologies and health services, which is closely related to discrimination of being poor. In Guatemala, the poor, rural and indigenous population is often discriminated by not having access to health services. With no access to information or health services the “outcome gap” will be even larger. The rich part of the population will have increased access to services, the poorest part of the population still remains excluded. According to Freedman (1999:146) this does not seem as horrifying as human rights violation such as torture and the like. Still, censorship of information and lack of access to reproductive health services is a violation of rights, because it is in itself a human right. Women have a fundamental right to maintain control over their own body and their lives, and the information to be able to exercise that right. Further Freedman stresses that withholding contraceptives and information regarding this denies women reproductive freedom, but the opposite, making it available does not necessarily ensure freedom. The state needs to provide reproductive health information in a way that supports rights, health and the well-being of women in the society (Freedman 1999:164). They need to promote the decision making of the individual woman. Ana and the women live in these growing differentials between rich and poor, however, on the poor “side”. She lives in a place where there is physical access to amenities such as health facilities, but many social and economical factors influence her capability to make free choices. This is what it is all about; having a choice and the opportunity to be the decision maker, which also is the fundament of the capability approach with its focus on human choice and freedoms. It is also about understanding that these choices are embedded in, and constrained by, different social forces and conditions.

2.4 Summary

The story of Ana has been an attempt to describe and discuss a woman's capabilities and constraints in accessing contraceptive services in Guatemala. The purpose has been to discuss her everyday struggles being a poor woman fighting for the betterment of her family. For Ana, and the other women, the motivation behind their goal was simply due to the fact that they could not afford to provide for another child. Their main focus was on the ability to give their children a chance of a better future, and the ability to send them to school. The capability approach focuses on what people are able to be and to do; that is, on their capabilities, and the importance to make free choices. It is about removing obstacles which might affect her freedom to choose. Ana was able to pursue her project of not having more children despite the many constraints that may have affected her capability of making choices and implementing them. Moreover, Ana and the other women in Guatemala have a right to reproductive health care and contraceptives, but these rights are often violated because of social inequalities. To understand suffering it is necessary to take into account local understandings, and the social and economical forces that influence the ability to make choices. The women's capabilities of making free choices are somewhat constrained by lack of access, information and different social conditions.

Health system constraints are often argued to be the main obstacle in enhancing women's capabilities. In the next chapter I will be concerned with health system constraints on the local level and its link to capabilities and deprivation. The local level will be concerned with the two provinces of Chimaltenango and Sacatepequez in particular. Further I will discuss the role of private providers and how the women relate to both private and public providers in their search for contraceptive services.

3. Health system constraints on the local level

In this chapter I will discuss the health system in Guatemala and the possible constraints it represents on the local level concerning contraceptive services. I will start by giving an introduction to the organization of the health system in Guatemala. This system is what people have to relate to, also in the search for family planning options. Further, the women searching for contraceptives in Chimaltenango and Sacatepequez (the two provinces studied) will be presented, and the differences between the women in the provinces will be reflected. The constraints the public providers might represent will be discussed and the role of private providers in giving the women the ability to access contraceptive services and the freedom to choose according to their desires. Finally the interface between the women and the providers in terms of capabilities and constraints will be discussed.

3.1 The organization of the health system in Guatemala

The main actors in Guatemala's health sector are the Ministry of Public Health and Social Assistance (MSPAS), the Guatemalan Social Security Institute (IGSS), the private-for-profit sector, and private voluntary organizations. MSPAS is the largest actor and has the responsibility for providing curative and preventive care for the whole population. The services are practically free of charge to the users. The MSPAS is broken down into 27 Health Areas with one central administrative level, and provides health care through three levels (World Bank 2003:26):

1. The first level being community centers (*centro comunitario de salud*), and health posts (*puestos de salud*)²². The community centers are staffed by voluntary community members who are trained by the MSPAS and make up the simplest public health facilities. They are visited by doctors and health technicians on a regular basis, more or less once a month. The health posts provide preventive and primary health care and some curative services (World Bank 2003:26). There are, according to MSPAS and the Centro Nacional de Epidemiología (2005) 974 health posts in the country. They are usually staffed by an auxiliary nurse and, at times, by a rural health technician (World Bank 2003:26). Both these health facilities are located in smaller communities and villages.

2. The second level comprises health centers (*centros de salud*), mainly of either type A (with some beds, primarily for maternal care) or type B (without beds, ambulatory care only)²³ (World Bank 2003). There are 292 health centers in the country, almost all of them type B (Centro Nacional de Epidemiología 2005, PAHO 2007). The health centers are usually staffed by a doctor, a nurse, an auxiliary nurse, a rural health technician and administrative personnel. Sometimes a laboratory technician and a dentist are present (World Bank 2003:26).

3. The third level is general and specialized hospitals, which provide curative care. There are 44 hospitals in the country, where the Metropolitan region of Guatemala (Guatemala City and around) has the best access, with seven of the hospitals located in the region (Centro Nacional de Epidemiología 2005).

The Guatemalan Social Security Institute (IGSS) provides health services to workers and their families in the formal sector who are covered, which are separate from MSPAS's services. Members of the IGSS can use MSPAS facilities, but only affiliated members can use IGSS facilities (World Bank 2003). The IGSS covers approximately 18 percent of the population, and has about 145

²² This thesis will be concerned with health posts as the first level of care. This distinction was of no concern for my informants as they only referred to health posts when discussing services on a local level.

²³ According to MSPAS there are other types of health centers as well, but most of them are type B or A (http://portal.mspas.gob.gt/segundo_nivel_de_atencion.html and PAHO 2007:389).

health facilities, with 50 percent of its services concentrated in 6 provinces (PAHO 2007:387, 389).

The remaining health services in Guatemala are provided by the Armed Forces and Police health network, by NGOs and by the private for-profit sector²⁴ (World Bank 2003:27). There are both international NGO's and national NGO's that vary in size and have different specialization and areas of focus.

3.2 The local women searching for family planning in Chimaltenango and Sacatepequez

The health system just described is what people have to relate to, also in search of family planning options. Even though this “system” (at least MSPAS) is supposed to be present in every province in Guatemala, access to health facilities is different within the provinces. The further discussion is based on the women as my informants. It is included to give the reader an overview of the situation in the two provinces studied, and to be able to get to know them better. It is a description of numbers of children, age differences in terms of marriage, first pregnancy and when the women first search for contraceptives to plan their families, education levels and information and knowledge of family planning. Within these two provinces, however closely located²⁵, there exist various differences. Many of the constraints the women face seem to derive from the same source, but there are differences that will be discussed.

Numbers of children

The average number of children per women among my informants was higher in Chimaltenango than in Sacatepequez when they decided to use a family planning method. The majority of the women in Chimaltenango were indigenous and/or

²⁴ Which also include traditional medicine.

²⁵ They are both located in the central region of Guatemala.

rural in contrast to Sacatepequez, where the majority were ladinos and living closer to urban areas. In Chimaltenango the women had 5 children on average, in comparison to 2.2 in Sacatepequez. The highest number of children a woman had was 9 in Chimaltenango and 4 in Sacatepequez. In Chimaltenango no women had less than 3 children before wanting a long term family planning method, in contrast to Sacatepequez where women with one child also were searching for the *Jadelle* or the *tubal ligation*. These numbers represent living children, which also adds to the differences between the two provinces. About half of the women in Chimaltenango had suffered the loss of at least one child, in contrast to one woman in Sacatepequez. However, the women had no problem talking about this, and said that it was a very common tragedy in the rural areas where they come from.

Age

The average age of my informants when wanting a contraceptive method was much higher in Chimaltenango than in Sacatepequez; 32.4, and 25 respectively. Most of the women in both provinces wanted a *tubal ligation*, they were sure they did not want another child, and felt like the operation was the best alternative. Among my respondents in Chimaltenango the youngest women wanting the operation were both 25 years old with 3 and 4 children. In Sacatepequez she was 19 with 2 children. The average age of getting married was also different in the two provinces, with an average of 17.2 in Chimaltenango and 18.6 in Sacatepequez. Ana was a bit older than the average in Chimaltenango when she married at 21, but represented the age group where the majority came from in this province when searching for family planning options.

Education

Education and schooling levels were low among my informants. Ana had three years of schooling, which is a little bit above the average in Chimaltenango,

which was 2.4 years. However, one woman from the city of Chimaltenango had twelve years of schooling. Excluding her from the numbers give the rest of the women an average of 1.8 years. In contrast, the average in Sacatepequez was 5.5 years. A lot of the women in Chimaltenango could not read or write, which might add to the problem of obtaining information. If you are not able to read, the process of learning may be harder, and your only source of information is primarily through other people telling you. Very few schools have sexual and reproductive health education²⁶. As a result, this makes access to information from the public and private providers even more important, since they do not get information in school, either from lack of sex education or from not attending.

Information and knowledge

In general, knowledge about contraceptive methods was lower in Chimaltenango than Sacatepequez. Most of the women interviewed in Chimaltenango had less information about contraceptives and only a few of them had used any type of contraceptive before. This stands in contrast to Sacatepequez where the majority of the women did use another reversible method before deciding to have the *Jadelle* (however reversible, but long term) or the operation. Having the operation was also the first time Ana was introduced to a family planning method. For Ana and many of the other women in Chimaltenango, she felt that it was difficult talking about this to neighbours and friends. The only persons she did talk to about this were other women in the family and her husband. Ana found out about the operation through a sister who lived in the village where APROFAM's Mobile Unit²⁷ was visiting on that particular day. Some of the women were provided with information from APROFAM and WINGS²⁸ promoters or posters some weeks before the Mobile Unit came. Others were informed by female family members who either had had the operation

²⁶ Even though there is a law that says that it is supposed to be on the curriculum. See chapter 5.2.1.

²⁷ APROFAM is a private provider, which has Mobil Medical Units travelling around. See below for presentation.

²⁸ WINGS is a NGO working with family planning. See below for presentation.

themselves, seen posters or listened to *charlas* (informative talks) provided by either one of the NGO's. The women in Sacatepequez had little more knowledge regarding contraceptive methods. Because of this they seemed more comfortable (though not *comfortable*) talking about the subject.

Why is there a difference?

Among my informants, the women in Chimaltenango got married earlier, were older with more children when searching for a family planning method and had a lower education than its neighbouring province Sacatepequez. According to the national numbers concerning poverty, fertility rates, IMR, MMR and education levels outlined in chapter one, the indigenous and rural population have higher numbers among all the indicators. The rural and indigenous population is much larger in Chimaltenango than in Sacatepequez, and access to hospital and clinics in the rural areas is worse. In Sacatepequez the majority of the population has at least physical access within a reasonable distance. Many of the women living in rural areas have to travel to get to a health clinic which represents constraints in terms of money and time. Access is one constraint, among others, that might tell us why the indicators are worse in Chimaltenango.

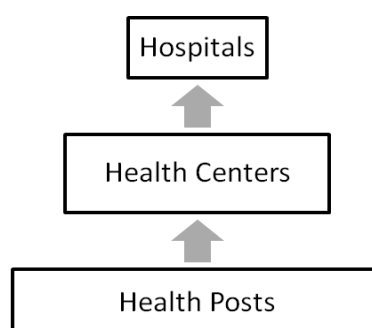
The women in Chimaltenango had also lower levels of information about contraceptives and the possibilities of planning their families. This indicates that the information flow in rural areas is less than in the urban areas. Contraceptive methods is still a taboo topic, and it seems as though the government is not giving appropriate information since the majority of the women obtained the information from private providers. Moreover, when people do not talk to each other either, the knowledge level remains low. Surely, this affects their capability to lead the life they value and the freedom to choose and decide over their own reproduction, as many do not know their options (and rights).

However, my group of women who attended was able to get the information they needed to make a choice. They knew they did not want another

pregnancy and this became their project. They created their own agency, made choices and controlled their own reproduction. Although my informants were able to pursue their project, the road to getting there is somehow filled with constraints. Access and information are important, but not the sole reason for why it is difficult for many women to actually be able to use contraceptives. My group of women, in both Chimaltenango and Sacatepequez, chose to use the services of private providers due to the many constraints associated with the public providers.

3.3 Public providers of contraceptive services

As earlier mentioned there are different actors providing health care in Guatemala. In the provinces of Chimaltenango and Sacatepequez there are both public and private providers of reproductive health and contraceptive services. This discussion concerned with public providers relates to the MSPAS's health facilities in the respective provinces. The MSPAS is the largest actor and these services are for many people the only contact they have with health care services. There are, as emphasized by the private providers, some constraints concerning contraceptive services provided by the public health facilities.



Levels in the public health supplies discussed in this thesis

3.3.1 Access

In the province of Chimaltenango there are one public hospital, 14 health centers (*centros de salud*) and 56 health posts (*puestos de salud*). In Sacatepequez there are two public hospitals, four health centers and 19 health posts (Centro Nacional de Epidemiología 2005). Looking at the difference between the two provinces in numbers, Chimaltenango is about four times bigger than Sacatepequez and has almost twice as many people. The population density in Chimaltenango is half the density of Sacatepequez. Some of the health posts serve several communities and people have to travel to get there.

The health posts are supposed to distribute oral contraceptives, injections and condoms. At the health centers, which are a little bigger than the health posts, you should find all these methods, in addition to the *IUD*. At some centers they are also introducing the *Jadelle*. According to Dr. Morales from MSPAS and the National Reproductive Health Program (*Programa Nacional de Salud Reproductiva*), you will find all these methods in the hospitals, including the operation for both men and women. Nevertheless, a provider at the APROFAM clinic in Chimaltenango claimed that at the hospitals they usually only do the operation if a woman has given birth there, and decides to have the operation shortly after giving birth. Their possibility to have the operation at the hospitals is rather small, since the majority of Guatemalan women give birth at home with a midwife attending. This holds true for the rural and indigenous population which constitute the majority in Chimaltenango. Ana gave birth to all her children at home, and did not know that she could have had the operation at the hospital if she had given birth there. Furthermore, the hospital is located in the city of Chimaltenango, and for many people living in the province of Chimaltenango, a trip to the city is still out of reach due to the costs of travelling and the time it demands. Thus, there is a *limitation of access*. The limitation of access is worse in Chimaltenango than in Sacatepequez, where a bigger share of the population live in remote, rural areas.

3.3.2 Availability

For most people living in the rural areas of the provinces, the health posts (or health centers) are the only contact they have with public health services and the only (supposedly) access to contraceptive services. According to Danessa, the former coordinator of the WINGS advocacy program, and Meira, former director of WINGS, the problem is that the distribution and *availability* of contraceptives in these health posts or health centers does not seem to function as it is supposed to. Often they do not have the contraceptives available when a woman needs them. To use oral contraceptives or injections demands that you are on time. If the health posts or health centers do not have the methods available, there is no point in using these types of reversible methods. This certainly affects her capabilities as the real opportunities to be or do what she wants; with limited access and availability of treatment her freedom to choose is rather restrictive.

3.3.3 Knowledge and resistance

Availability is one constraint with the health posts and health centers. Another is understood to be lack of *knowledge* and *resistance* to talking about reproductive health and family planning among the health personnel working there. According to Meira, the former director of WINGS, the providers have their own prejudices against family planning and will not distribute contraceptives. Meira told a story about a woman who went to a health posts to ask for a family planning method. They asked her how many children she had, and she said two. They replied by telling her to come back when she had three. This woman's experience adds to the observation that there is a resistance to provide contraceptives. According to Meira, they do not believe in it, and they impose their beliefs on other people. Danessa pointed out that in many cases the personnel will not tell a woman about her opportunities and rights, even if you come and ask the information is not good enough. Furthermore, there is lack of knowledge concerning contraceptives,

and the women do not get enough information at the health posts²⁹. The personnel do not always have the information they need about the different types of contraceptives and side effects that the patient needs to know about. Lack of knowledge and resistance to talk about it among the personnel might contribute to the way her life is being constrained by different social norms and values. This also influences the *personal conversion factors*³⁰ stressed by Robeyns (2005). These factors have to do with how a person can convert the characteristics of the commodity into a functioning. If she does not know about her possibilities and does not have the information it makes it difficult for her to use the goods to enable the functioning: If she does not have the information about contraceptives, it is difficult for her to make the choice of using one. In this situation physical access is of no value.

3.3.4 Confidentiality

Another constraint with the health posts is understood to be lack of *confidentiality*. Meira (at WINGS) stressed that at many health posts you are in a waiting room with a lot of people and they ask you in front of everybody why you are there. In a small village, the chance that you will know somebody or somebody that knows your sister is definitely present. Sexual and reproductive health is still a sensitive topic, and this practice may scare people away.

Discrimination of indigenous people and youths is also understood to be a problem related to the health posts and health centers (and in addition, also the hospitals). How they are treated in the clinics and denied information and services often influence whether they will go or not. Emma³¹, one of the program directors at WINGS told a story that provides a good example:

²⁹ It is referred mainly to the health posts concerning lack of knowledge, since the health centers have more medical personnel present.

³⁰ See chapter 2.1.2 for discussion.

³¹ White American woman.

I went to a health center with a young Mayan woman. She was pregnant and was going to have a scan, but the receptionist did not even look at her. She ignored her and looked at me instead, she did not even ask her name, nothing. I do not know if it was because she was Mayan or young, but either one, in a public health clinic everybody should be treated equally.

Guatemalan youths start very early having sexual relations, 14 percent of the adolescents under 14 years of age are having sexual relations and 70 percent of the adolescents under the age of 19³². They start having children at a very early age, and this is, according to several providers, because of problems related to obtaining contraceptives. This will lead to the mother dropping out of school, and in many cases the father too, because he has to start working to support his family. Sadly, according to Meira, the discrimination of youths and the practices that often follow in the health posts and health centers scare the youths away. When they are being asked in front of everybody and have to sign their name on the patient list to get condoms, they will not come because they are frightened that their parents or other family members will find out. The fact that the use of contraceptive methods to delay the first child is basically non present³³ (except with middle and upper class Guatemalan youths), reflects this very well. On the other hand, this is also related to the local understanding that family planning methods are going to make them infertile before they have at least one or two children. These local understandings are further elaborated in chapter 4.3.

The practice of non confidentiality adds to the obstacles of being able to access a contraceptive method. Many women are somehow restrained by lack of access, information, availability and confidentiality which affect their freedom of choice. It becomes what Sen terms “deprivation of freedom” (Sen 1999:15). It is harder for them to make an appropriate choice about how they want to “function in life” when the constraints (either one or all) discussed are present.

³² Interview: Dr. Camey de Astorga, Elsy. APROFAM Board of Directors. Guatemala City: September 7, 2008.

³³ Interview: Delphine. Program Director WINGS. Antigua Guatemala, Sacatepequez: September 25, 2008.

3.4 Non profit private providers of contraceptive services

The private providers discussed below are two non profit private organizations focusing on reproductive health and family planning services in Guatemala.

These two organizations are the private providers included in this study. Both organizations work in various provinces in Guatemala, including Chimaltenango and Sacatepequez.

3.4.1 APROFAM

APROFAM, *Asociacion ProBienestar de la familia* (The Association of Family Well-being) was organized as an affiliate of the International Planned Parenthood Federation in 1964 (Santiso-Galvez and Bertrand 2004). APROFAM is a non profit private organization. The first clinic opened in Guatemala City in 1965 with a focus on giving sexual and reproductive health services based on quality assurance and gender equality. APROFAM took charge of family planning at a time when it was politically controversial and to express its acceptability to the civic. APROFAM has been the main institution in providing family planning methods in Guatemala for over 30 years, in contrast to many other countries where the government soon went in front in providing contraceptive services (Santiso-Galvez and Bertrand 2004).

APROFAM focus on providing services to lower income families in Guatemala, and have financed the services with financial assistance from national and international donors and funds generated by the patient in payment for the service received. USAID have been a main donor of APROFAM and is now cutting support as APROFAM is more established as an institution and needs to be sustainable³⁴. This has resulted in an increase in the prices of the services offered. According to a provider at the APROFAM clinic in Chimaltenango, it

³⁴ Interview: Secretary. APROFAM Chimaltenango. Chimaltenango: October 14, 2008.

will be the Mobil Medical Units (see below) that will have to be reduced, as most of the funding from USAID has been for this purpose. Most permanent clinics now run by themselves. The costs of having the *tubal ligation* in a permanent clinic are Q 300 (\$ 37) and the *Jadelle*, Q 232 (\$ 29).

APROFAM has 29 permanent clinics located in urban areas in different provinces and municipalities throughout the country. In addition, they have a Rural Development Program which has five Mobile Medical Units and 58 educators and 3200 volunteers³⁵. The Rural Development Program has the objective of giving access, geographically and economically, to family planning services for the rural and marginal poor, Mayan and ladino population, which respect the culture in the communities. The educators of the program carry out educational and informative talks in the communities and also do home visits to directly give information to the users. The Mobile Medical Units travel around offering (long term) contraceptive services, usually the *Jadelle*, the *tubal ligation*, the *vasectomy* and sometimes the *IUD*.

The units consist of a team of qualified professionals, one gynaecology-obstetric doctor, one general practitioner, two auxiliary nurses and one driver³⁶. They carry with them medical and surgical equipment and the necessary medicine to be able to provide the services. Promotional activities are being done in the community 14 – 30 days ahead of the arrival of the Mobile Unit in order to assure that most people are aware of the services offered and the presence of as many as possible. Before deciding to have the surgery or any other family planning method, women are informed about how it works from the doctor of the team, and they have to sign an informed consent. At the Mobile Units the costs of the operation is Q 120 (\$ 15) and the *Jadelle* is the same as in the permanent clinics. Some will argue that APROFAM has lost some of its social orientation, because they now target people that are able to pay (Santiso-Galvez and Bertrand 2004).

³⁵ Interview: Dr. Camey de Astorga, Elsy. APROFAM Board of Directors. Guatemala City: September 7, 2008.

³⁶ http://www.aprofam.org.gt/rural_development_program_.html.

The prices at APROFAM are lower than in other private clinics, but still too expensive for many poor, rural or marginalized people. However, the *tubal ligation*, the *vasectomy*, *Jadelle* and the *IUD* offered by APROFAM are in many provinces subsidized by other organizations to make it affordable for women (or men) in need of these services.

3.4.2 WINGS

WINGS (*ALAS*) is a US- registered non – profit organization that is located in Antigua Guatemala, Sacatepequez. WINGS was formed in 1999 and has a core mission of providing information, financial resources and access to reproductive health services to low income, rural and indigenous Guatemalans. The organization has three main programs; the Cervical Cancer detection and treatment program, WINGS Youth and the Family Planning Program. The latter being the strongest and the most important one. They also have programs directed towards men and religious leaders to be able to meet and work with some of the barriers (they identified) to family planning in Guatemala. WINGS is a small NGO with 19 employees, working mainly in the provinces of Chimaltenango, Sacatepequez and Escuintla. All three provinces are located in the central and south central region of Guatemala. They also partner with health care providers nationwide and share material so that their programs can be replicated elsewhere. In addition they provide training for other organizations concerning family planning. WINGS' base its economic financing mainly on private donors and foundations. They are also supported by USAID. Some of the donors earmark their donations especially for the family planning program.

WINGS' family planning program

The Family Planning program has one coordinator (who also works as an educator), three educators, and one educator for the “WINGS for men” program³⁷, in addition to the Program Director. The program consists of three components, one of them being general family planning education. WINGS only use Guatemalan staff to go into the field, staff that also speaks the Mayan language in the community where it is needed. They go out to the communities to give talks to any group of women (or men) who wants to hear about family planning and give them the information they need to make an informed choice. These talks are called *charlas*. *Charlas* is a very important part of the family planning program as WINGS is mainly information based and about reproductive health and family planning promotion. This is in contrast to APROFAM which is more service oriented. WINGS do not have their own clinics, but work through other organizations, giving information and financial resources for poor people to be able to access the services at an affordable price.

The second component is the family planning promoters in different communities in Chimaltenango, Sacatepequez and Escuintla, to which they provide temporary contraceptive methods. These include condoms, *the pill*, *Depo Provera* and *Ciclofem*. Some of these promoters are organizations and some are just women in the communities that work for WINGS in promoting these methods at a much lower costs. They charge Q 5 (\$ 0.6) for the *Depo Provera* every third month and Q 1 (\$ 0.12) for one month of using *the pill*. The idea behind the program is to bridge the gap; they are trying to target first time users or women who have not used a contraceptive method in a long time. Furthermore, many women do not like to go to the health posts in their community asking for this for different reasons. A lot has to do with stigma, or they cannot trust the health post or they are afraid that people are going to see them ask for contraception (related to the confidentiality issue discussed above).

³⁷ See chapter 4.1.1 for more information regarding “WINGS for men”.

Moreover, many women cannot afford to go to APROFAM or other private clinics. WINGS' promoters provide the women with contraceptives in a secretive and confidential way at a cost they can afford.

The third components do promotion of the APROFAM Mobile Medical Units. The staff of WINGS promotes APROFAM's units by going to the community about two weeks before the visit is scheduled to give talks and information. They coordinate with the health posts and health centers and other groups of women who gather to promote the Mobil Unit and the services they provide. Furthermore, one important part of the cooperation between APROFAM and WINGS is their subsidies of the *Jadelle*, the *tubal ligation*, the *vasectomy* and the *IUD* in the Mobile Units in 13 provinces of Guatemala, including both Chimaltenango and Sacatepequez. They also subsidize these services in the permanent APROFAM clinics in Antigua (Sacatepequez), Chimaltenango, Escuintla, Mazatenango (Suchitepéquez) and Barberena (Santa Rosa). In Antigua they also subsidize the *Depo Provera* due to the high demand in the area. At the Mobile Units where WINGS subsidize, the price the patient pays is Q 25 (\$ 3), for the *Jadelle*, the *tubal ligation* or the *vasectomy*. To access these services to the heavily subsidized price in the permanent APROFAM clinics, they need to get a reference from one of WINGS educators. This is done so that the initiative reaches those who needs it the most.

3.5 The interface between the women and the providers

The public and private providers discussed so far are what many women relate to in their search for family planning options. As mentioned my group of women chose to use the private providers in their search for family planning options. The further discussion is concerned with the interface between the women and the health providers and what might give them the possibility of accessing a family planning method and give them the freedom to choose.

3.5.1 Demand and capability to achieve access

The demand for family planning methods was high in APROFAM's permanent clinics in Chimaltenango and Sacatepequez. Even though they are offering other reproductive health services, family planning methods got the highest demand in both clinics³⁸. Furthermore, *Depo Provera* got the highest demand in both clinics. At the health posts and health centers the *Depo Provera* and the other reversible methods mentioned above are supposed to be given free of cost. Both these APROFAM clinics are located in urban areas of the respective province, and are located closely to public health centers and health posts. Still, many choose to go to the APROFAM clinic, even though they have to pay. This supports the observation discussed in chapter 3.3.2 that the distribution and availability in the health centers and health posts is not good enough.

Even though APROFAM try to reach those affected by lack of access and availability, the two APROFAM permanent clinics are located in urban areas in the provinces. For many it is not possible to come to these clinics due to the time it takes and the transportation costs to get from the rural areas and into the city. The Mobile Units that go to the local villages do not offer short term reversible methods. WINGS is trying to overcome these obstacles by offering the promoters program in different communities, where the women can be certain to access the methods when they want one and on time. These obstacles (time and cost) also reflect why some of the women chose to have the operation when they had the chance with APROFAM's Mobile Unit. It is one time, one cost and the clinic came to them, which were three elements my group of women stressed was important. Because of the costs and time of travelling, many of the women claimed that they could not have done it if the clinic did not come to the village (this has also to do with confidentiality). The capability approach focuses on removing obstacles in people's lives so that they have more freedom to live the

³⁸ Interview: Secretary. APROFAM Chimaltenango. Chimaltenango: October 14, 2008. Interview: Dr. Roberto. APROFAM Antigua Guatemala. Sacatepequez: October 3, 2008.

kind of life that they want according to their needs and interests. The Mobile Units gave them the opportunity to access a method by coming to the village and trying to overcome the obstacles of access and costs. Nor could they have done it without the subsidies from WINGS. Most of the women informants in this thesis claimed that they could not afford to pay more for the services.

The Mobil Units serve as the only option for many women living in rural areas, when the public health system fails to provide access in many cases. The way APROFAM and WINGS meet in giving access to services and overcome the constraints of time, cost and location creates agency and gives them the possibility to pursue their project in offering family planning services to the poor and rural population. Where the public health facilities fail to provide access and availability, they provide a direct link to the women. Moreover, the way APROFAM and WINGS meet, give the women an ability to pursue their goal.

3.5.2 Information and capability to choose

Information is also an element of why many women choose to go to the APROFAM clinics. According to Danessa at WINGS, they do not get enough information at the health posts. Therefore they search for a clinic that can give them the right information, as both little information and resistance to giving information frequently characterized the personnel at the health posts. To get information about reproductive health and family planning is a human right and also a right according to Guatemalan law. The lack of information and education about the subject affect the women's capability of being able to choose to use a method and be able to plan their families. It affects the *personal conversion factors* discussed above. Information is crucial, and is often a constraint for the women, as many do not know anything about their possibilities and rights. By not implementing the law and providing information in schools etc. they are acting out a kind of censorship regarding family planning. For some, the information

provided by APROFAM and WINGS serves as the only source of information available. Ana could not express her gratitude enough by having this opportunity, using the words “*Gracias a Dios!*” (Thank god) to describe how she felt. This constitutes the importance of giving women an opportunity to learn about reproductive health and family planning and with this enhance the possibility to choose. However, this puts the emphasis on the providers’ responsibility to give information if someone wants it, as opposed to women’s “lack of information”. By this I argue that it is not always about women’s “unawareness”, they might just make different choices based on their local understanding. The understanding they have is based on their experiences, and they make choices on the grounds of these understandings. One cannot say that these choices are “wrong choices”. People make choices based on the information they have. This is the reason why I argue that it is the providers’ responsibility to give appropriate information, and not the women’s “irresponsibility” for not knowing.

Using contraceptives also demands information regarding side effects and the fact that not all women can use all types of contraceptives. Providers at the APROFAM clinic in Chimaltenango claimed that many women came to the APROFAM clinic scared because they had side effects from using contraceptives they were not properly informed about at the health posts or health centers. Knowledge concerning reproductive health and family planning was much lower in Chimaltenango as mentioned. Some women I talked to did not have any knowledge about methods of contraception before meeting with the Mobile Medical Units. This situation led these women to have the operation instead of considering or choosing other forms of contraception because this was what was offered at the Mobile Unit on that particular visit. This too adds to the assumption of the importance of information and education regarding reproductive health and family planning.

Concerning the issue of information, social norms and religious beliefs increase the complexity of the issue at the health posts or health centers and

affect their ability to promote contraceptives. Dr. Morales from MSPAS and the National Reproductive Health Program, stressed that the government cannot promote family planning as APROFAM does, on the one hand due to the costs of promoting. On the other hand, they have to be more careful in promoting this than APROFAM because it still is a sensitive topic. Dr. Morales said that the government cannot always act like an NGO fighting for a case, as it will often have to show respect and consideration for different opinions, i.e. the Catholic Church's opinion³⁹. However, according to Dr. Morales the health posts and health centers are slowly gaining space in providing services, but still have a long way to go in terms of access, availability and confidentiality.

3.5.3 Confidentiality and trust – public health posts become too local

It seems as though many women have distrust in the public services offered because of the lack of availability and confidentiality within MSPAS's health system. The lack of availability of contraceptives and the failure of earning trust from people will limit women's freedom to make their choices and pursue their aims. Many women are reluctant to go to the health posts or health centers due to these constraints. Moreover, the trust issue is also related to discrimination at the health clinics. The services of WINGS and APROFAM are free of discrimination of women, indigenous people and youths, and everybody is able to access these services⁴⁰. This in contrast to the health posts and health centers in many areas. My group of women seemed comfortable with the services offered by APROFAM and trusted that they were getting the service in a proper manner. APROFAM also uphold the problem of confidentiality related to the health posts.

³⁹ This will be elaborated more on in chapter 5.3 and 5.4.

⁴⁰ The only restriction they have in access is that they do not carry out the sterilization on people under the age of 18, which I would say is not about discrimination, rather responsibility.

The providers are not local and do not represent a threat in terms of telling family and neighbours in the local community.

Many women choose to go to the private providers due to lack of confidentiality by the public providers. It seems that in many cases the local health posts⁴¹ become *too local*. They are afraid that they will be seen in the health posts asking for contraceptives. In a local community, the chance that the provider or someone else present at the clinic will know you or someone in your family is great. The fact that the Mobile Unit comes and goes gives her an opportunity to escape this constraint. Even though they have access to a public health clinic they choose to go to the private provider. The fact that APROFAM only offers long term contraceptives also makes it easier for women. With the operation they do not have to keep going back and forth. Since reproductive health and family planning is a sensitive topic, many women are afraid that people in the community will know that they are using contraceptives. APROFAM's Mobile Units might represent one way of overcoming this obstacle. WINGS promoters program is also one way to getting past the obstacle of the health posts as being "too local". They are there to give the women access to contraceptives in a confidential manner. The question we then have to ask is *why* it becomes "too local". It is not always just about giving her access, information and availability. Local norms and values may affect her possibilities of accessing these services and having agency to maintain some control over own life.

3.6 Summary

In this chapter I have discussed the constraints related to the public health facilities in providing contraceptives. One of the constraints discussed is limitation of access. Many women have to travel to get to a local health facility

⁴¹ I refer mainly to health posts because these clinics are the ones that are located in small, local communities.

and this represents obstacles in terms of time and cost of travelling. Moreover, there is understood to be lack of availability of contraceptives in the public health post and health centers. Often they do not have the contraceptives available when a woman needs them, and ask her to come back next week. By this time it might be too late. Knowledge and resistance to talking about reproductive health and family planning among the personnel also represent a constraint concerning the women's freedom to choose when they do not get enough information. The last issue discussed is the lack of confidentiality. The chance that some of the providers or somebody else present at the local health posts know you or someone in your family is too high and might scare women away. They are afraid they will be seen in the health post asking for contraceptives. Even though there is access, it seems that in many cases the local health posts become *too local*. Because of these constraints (either one or all), many women choose to go to private providers, in this case, APROFAM and WINGS. They offer access and availability, and provide the right information many women are searching for. Moreover, the Mobile Units, by coming and going and offering long term family planning methods, represent a way of escaping the obstacle of being "too local".

Health system constraints hamper women's freedom to choose. However, it is not just about giving access, availability and information. Access is useless if women are "not allowed" to use contraceptives because of socio-cultural conditions, which also affect the health posts as "too local". This adds complexity to the actual capabilities of the women and the freedom to choose according to their desires. This is the topic of the next chapter I will now turn to.

4. Socio-cultural constraints

Guatemala is a diverse country and the constraints and capabilities of women seeking contraceptive services are comprehensive and complex. Some of these constraints affect the women's capability of being able to choose and implement these choices. In some cases these constraints make the local health posts "too local", in terms of fear of being seen asking for contraceptives. There are various norms and values that influence this situation. Traditional relationships between men and women represent one element that might affect her freedom to make choices about what she wants to be or to do, as the husband in most cases is the decision maker in the family. Religion is also seen as a challenge, as the Catholic Church prevalent in Guatemala typically is in opposition to the use of modern contraceptives. In this chapter I will discuss belief systems on a personal and community level and how this can be understood as a constraint to family planning. I will also describe the system of knowledge and local understanding of contraceptives, also known as "misconceptions" among reproductive health providers, and how this influences constraints concerning contraceptive use. A discussion of ethnic composition, the geographical and linguistic situation and how these affect women's freedom to choose, in terms of access and information will be provided in the latter part of this chapter.

4.1 Norms and values

The women are situated in a nexus of different norms and values that make an impact upon their opportunity to choose freely the number and timing of their children and methods to control this. There exist different "views" about how one are supposed to relate to reproductive health and contraception use. The acceptance of family planning methods and the openness around talking about

this topic have still a long way to go. It is still a taboo topic. According to Luis, the family planning coordinator at WINGS, communication between spouses about this subject is rather rare and many women find this very difficult. Many women are scared of their husbands' reaction towards using a family planning method. They have a *cultura del silencio* (culture of silence). Luis claimed that this is closely related to whether people are used to hearing about the subject, which makes it easier to work with and introduce contraceptives in urban areas rather than remote, rural areas where the information flow is smaller. Sue, the founder of WINGS and WINGS chairperson, stressed that people in general are very timid and shy when it comes to talking about reproductive health and family planning issues. It is a family, or a women's concern. In some communities there exist so many taboos around the subject that the women using contraceptives must keep it to themselves. Because if other knew, there would be criticism about its use and speculation as to why she is using it. This is one reason why public health posts become "too local" in many cases.

4.1.1 Women in relation to men - decision making and communication

The *machismo*⁴² culture is dominant in Guatemala. There are still very traditional gender roles, and most often the man is the decision maker. In many cases a women cannot make the decision about using a family planning method without her husband's approval. This certainly affects women's freedom to choose and implement the use of contraceptives according to their interests.

Ana, as with most of the women I met, was allowed to use a family planning method by her husband. She had discussed the subject with him, and he supported her decision of having the operation. These women were able to get beyond the obstacle of male decision making and were able to access the

⁴² Attitudes and behaviors which oppress women in relation to men.

services. A focus on a person's capabilities is related to their quality of life and removing obstacles in their lives, which gives them more freedom to live the kind of life they want and be whom they want to be (Robeyns 2005). Many women in Guatemala lack that kind of freedom. One obstacle that might be understood as a constraint is the decision making patterns that allows the man to decide over her reproduction. Many providers are convinced that there are many women who suffer from these decision making patterns, which affect her freedom to make choices and to achieve her preferred goals. Hence it affects her agency. Nonetheless, legally the situation has changed. The women have the *right* to freely choose if they want to use a family planning method. However, according to providers, it takes more than a piece of paper to let this practice be implemented. They argue that the norms and values are often found to be stronger than the claims of women.

According to Sue, the founder of WINGS, many men have the opinion that “the more children you have the more of a man you are” and women are supposed to get the number of children they can have. Further she stresses that where this view is present, it might influence his decision of not letting her use contraceptives. If this “non- acceptance” of family planning is present, it might also contribute to making the local health posts “too local”. Even though Ana’s husband will accept it, other people in the community might not. This might put her in an uncomfortable situation if people found out. In a situation like this, going to a private provider that comes and goes and offers confidentiality would seem to be an easier solution.

Husbands are often accused of not being accepting of contraceptives. Also there is understood to be a lack of conversation about the subject. According to Delphine, one of the program directors of WINGS, this is influenced by lack of information. She stresses that men are often excluded from getting information, because it is regarded as a women’s issue. Delphine emphasized that without knowledge about the subject it is hard for him to make a decision based on the

well-being of his wife. He will base his decisions on being the head of the family and do what is “expected” of him as a man in the society in relation to his wife and family. Many health providers hold the view that when there is no discussion of the subject and the acceptance of family planning is low, it makes it harder for women to be able to use a family planning method. Where this perhaps constitutes a constraint, going to the public health posts and asking for contraceptives may be too risky - they become somewhat “too local”.

However, men also feel the pressure of providing for many children. Luis, family planning coordinator at WINGS, claimed that many men are interested in planning their families, but they are often afraid to ask or feel ashamed to ask. Because they are not the ones who are pregnant and go to health facilities for care, they are often excluded in getting information. Moreover, according to Delphine, men typically are not getting proper counselling on sexual health issues. If he meets up for other health reasons than reproductive health, the providers do not usually take the initiative of talking about his sexual or reproductive health, nor his wife’s health. Many providers are convinced that since men are the decision makers, their level of knowledge influences women’s capabilities; their ability to do what they desire and their freedom to choose. Delphine stressed that if the man in the family can take the initiative of bringing up the topic of family planning, the woman will often be more than happy to talk about it. She is usually the first one to think about it, as she bears the burden of reproduction. The providers emphasized that when he has the necessary information, it can make all the difference in her access to contraceptives and to allowing her take part in the decision making. As mentioned, Ana talked to her husband and they made the decision of using a family planning method. She took part in the decision making process and this enabled her to pursue her project of not having more children. By communicating with her husband, she achieved agency and the freedom to choose. For Ana this became a strategy she used to be able to reach her goal.

Moreover, according to Delphine, many women suspect that their husbands do not want anything to do with family planning. She stressed that often this also has a lot to do with the men lacking information. Providers emphasized that as a result of not communicating properly and men's thoughts about contraceptives, many women use family planning methods without their husbands consent. They assume that if they tell their husband, then this will lead to them becoming resistant. By not telling them, they create their own strategy to strengthen their agency, and it becomes a part of their project of not having more children. According to a provider at the APROFAM clinic in Chimaltenango many women using contraceptives without telling their husbands use the services provided by APROFAM and WINGS. Perhaps because going to the local health posts with a chance that they would be seen is too much of a risk. Some providers claimed that some women are scared of their husband's reaction when confronting him with family planning options. In my group of women, many knew somebody that had been exposed to domestic violence. However, the assumption that men are reluctant might add to the observation that the health posts are "too local".

"WINGS for men" – an example of including men in family planning

WINGS address the issue of gender in family planning and have therefore a program called "WINGS for men". As discussed above they have identified men as being a barrier to providing reproductive health and family planning services. To overcome these barriers they needed to address family planning in relation to men. They provide workshops about reproductive health to groups of men talking about responsible parenthood, communication with their partner, STI's⁴³ and family planning methods. Their aim is to make them acknowledge the work of women. They have also launched a media campaign and are planning to have peer educators in the nine communities in Chimaltenango and Escuintla where

⁴³ Sexually transmitted infections.

they are currently working. Although this is a pilot project, they have experienced a demand for the services they provide. A lot of men want to learn about the subject, even including the police and military groups which are often considered to be the most *machistas* (male chauvinists) of all. Yet there have been difficulties as well. There is still a huge stigma related to the subject and they feel uncomfortable talking about it. They would not let a woman be present during the workshops, but the fact that they are interested only shows the demand for information amongst men as well. After all, pregnancy, children and sexual health are issues concerning women *and* men. There exists a communication gap, and there is a need to emphasize that this is a couple's issue.

Delphine told a story of a woman that had contacted a "WINGS for men" educator saying that she did not want her husband to participate in the workshop. Whatever the reason, but the educator thought she was afraid he would be unfaithful by learning how to protect himself. Her husband participated anyway. After he had finished the workshops she contacted the educator again, thanking him for the information they had given him and that she had noticed such a difference. He had been aggressive to her previously, and she felt that after the workshops he had been less violent with her. This story is an example of how this affects women in relationships who without doubt have the most to gain when it comes to information and communication about this subject.

4.2 Belief system

Guatemala is a Catholic country and over half, 53 percent, of the population state to be Catholic, even though for many this is more cultural than doctrinaire. There has been a major conversion to Evangelicalism among large parts of the population, but Catholicism still remains as the dominant religion (Santiso-

Galvez and Bertrand 2004:61). The Church's⁴⁴ influence on people's lives differs in various communities, depending on how strong the local church is, also in giving information. Ward et al. (1992:61), in their study of socio-cultural barriers to family planning among Mayans in Guatemala, argue that in this culture religion is particularly influential, since Mayan youths are given almost no information from their families about family planning and sexuality. Further, they claim that in their study religion was the first topic to come up when talking about family planning. Both Catholics and Evangelists were distrustful of family planning because of religious beliefs, saying that their leaders (assistant mayors, catechists and pastors) claim that it is sinful and harmful (Ward et al. 1992). Furthermore, modern Mayan culture is more of a combination of traditional beliefs and Western attitudes. Ward et al. point out that a traditional belief that is held is that "a woman is born with all the children she will have within her" (Ward et al. 1992:61). This belief is conceptualized as a necklace in which each child is a separate bead. The Mayans combine these beliefs with Catholicism; "family planning is a sin because the Virgin Mary has put a necklace on each of us and we have to fulfil this obligation" (Ward et al. 1992:61). Family planning is sometimes seen as equivalent to murder (Ward et al 1992, Terborgh et al. 1995).

In some communities the Church is very strong and influences how people will relate to family planning. It becomes a constraint because they are "trickling down" their attitude against family planning and the people feel they have to follow what the local priest says. It becomes a barrier on a personal level. According to Luis, family planning coordinator at WINGS, the well-known phrase "*Tener todos los hijos que Dios mande*" (to have all the children God wants) is a widespread belief, and talking about family planning issues with people that are very religious is difficult. Luis claimed that they think the promoters are saying that they should not have children and that it is bad to have children. This saying about having the children God wants might affect a

⁴⁴ Both Catholic and Evangelic.

woman's opportunity to control her own reproduction. Moreover, it also makes it harder for her to go to the local health post asking for contraceptives. If she uses contraceptives, she is interfering with what God "wants". Being seen in a public health posts asking for this, might have consequences for her in terms of social disapproval in the community. Where this view is present the health posts might become "too local". Searching for private providers that offer long term, one time contraceptives might serve as a way of escaping this obstacle. It gives her a possibility to pursue her project of not having more children, if that is what she wants.

WINGS did a barrier analysis, and came to the conclusion that religion was one barrier to using a family planning method. Furthermore, it seems that men are more formed by the Church's opinion about family planning than women, as it was his principal reason for not using a contraceptive method in their study (WINGS 2006). Men are understood to be decision makers, and this might influence the women's capability to make effective choices and to achieve their preferred goals concerning family planning. Even though it is not her main reason for not using a method (for her it was health issues related to usage⁴⁵), it will still affect her freedom to choose because of the influence the Church has on the men and the men on the women. Religion and men may create agency (of power) to oppose the use of contraceptives.

Among my group of women in both Chimaltenango and Sacatepequez, all were members of a church, either Catholic or Evangelic, except only a few that said they did not belong to a church. Still, none of them said anything about religion being an issue for them regarding their search for a family planning method, nor that it had been an issue when discussing this with their husbands. It seems that in many situations people, on a *personal* level, do not have strict rules for themselves regarding family planning because of religion. As discussed, a larger issue seems to be community churches and how they handle the subject;

⁴⁵ According to WINGS barrier analysis. See chapter 4.3 for further discussion on health and usage.

their influence on people and how they feel they have to follow the Church's rules. Furthermore, another issue is the Catholic Church's power to influence the government's decisions regarding family planning strategies on a national level. This has had (and still has) an effect on the information given regarding family planning and the availability of methods in the country's health posts and health centers. The relation between the state and the Catholic Church will be elaborated in more detail in the next chapter, as this part has tried to focus on the aspect of religion on a personal and community level. Even though the relation between the state and the Catholic Church certainly affects the communities, and again have an impact on a personal level, I find it useful to distinguish between these levels. A person's own thoughts about religion and family planning often differ from what the Church articulates.

4.3 Knowledge system and local understandings of contraceptives

There are, according to the health providers, some local understandings of contraceptives that add to the constraints the women meet in searching for family planning options. Among them are "misconceptions" about family planning and the issue of linking infidelity to contraceptive use.

"Misconceptions"

According to health providers at both WINGS and APROFAM there are a lot of "misconceptions" about family planning methods which contribute to the scepticism of using one. They claimed that there are a lot of rumours and myths out there that form people's beliefs concerning family planning. People have a lot of fears, and in many cases choose not to use a method due to local understandings. People's understanding of contraceptives are often based on

experiences they have had themselves or been told, which is a quite “normal” way to create an opinion.

One of the beliefs that were strongly held was that the use of contraceptives causes cancer and illness and that it might kill you. However, the use of contraceptives is of course not free of side effects, and there are certain methods that involve some risk. Not all women can use all types of contraceptives, and each individual needs to be considered for the appropriate use of each method. As discussed in chapter three, many women did not get this information (at the public health posts or centers) before using a method and got scared when they had side effects they did not understand. If then a person gets ill, and even might have died as we have seen with *the pill* in Western countries as well, this will of course scare people. Correct usage for the right person together with correct information is crucial for her health and for rumours and myths not to spread and scare people.

Ana had heard about the illness a contraceptive could cause, but for her it was not an issue since she was having the operation, which is not a hormonal method. She was not scared, only glad she had the opportunity. She had never considered any other family planning method than the operation and therefore had not been thinking about it in a manner that had worried her. However, some of the women I met did believe that *the pill* and *the injection* may cause cancer. One woman told a story about a woman she knew that had cervical cancer due to *the pill* and about a neighbour that had used *the injection* for 12 years and now was very ill. However, the latter was an extreme situation, since it is not recommended to use *the injection* for more than 2-3 years⁴⁶. Furthermore, concerning the *IUD*, rumours said that if you got pregnant using this, the baby would be born with the *IUD* sticking out of its head⁴⁷. Rumours or not, you can get pregnant while using the *IUD* and the baby can actually be born with it. Many

⁴⁶ Because of loss of bone density (WHO/RHR and CCP 2007:80).

⁴⁷ Interview: Meira. Former Director of WINGS. Antigua Guatemala, Sacatepequez: September 9, 2008.

of the women wanted a *tubal ligation*, and did not consider another method due to the fears just mentioned. The government's "censorship" regarding family planning adds to the "misconceptions". It is a health provider's responsibility to give correct information and make sure the person receiving contraceptives is capable of using the particular method.

The capability approach is concerned about a person's well-being and expanding people's choices. Sen argues that capability is a kind of freedom, and emphasise the importance for people to live the kind of life they want according to their desires (Sen 1999:75). Several of the health providers at WINGS and APROFAM stressed that these "misconceptions" were due to lack of information and that they do not have the knowledge, thus the freedom, to make informed choices. Information will in most cases not harm you (if you get the right information), but there needs to be a reminder that it is about the freedom to choose. Even though she gets information, she might choose differently. If she believes contraceptives to be harmful, and *chooses not* to use one, according to the capability approach she is not living in a state of deprivation (concerning this particular issue). Or is she, because her beliefs are understood by providers as being "misconceptions" and lack of information? Another issue which reflects this is that the usage of contraceptives to delay the first pregnancy is rather a rare procedure. This is related to the local understanding that family planning methods will make them infertile. Because of this they choose not to use one, but they still make choices about how they want to "function in life". Is it then a capability deprivation based on "information deprivation"? However, information often serves as the first step of being able to make a choice. This influences the *personal conversion factors*⁴⁸ stressed by Robyens (2005), which focus on how a person can convert the characteristic of the commodity into a functioning. To be able to make the choice of using contraceptives, information and knowledge are elementary.

⁴⁸ See chapter 2.1.2 for further discussion.

Infidelity

Another obstacle to contraceptive use is understood to be the belief about the reason for wanting to use contraceptives. Health providers claim that there exists a widespread belief that the reason why a woman wants to use a family planning method is to protect herself from pregnancies when being unfaithful and in this way gain the chance of hiding her infidelity. Therefore the husband is rejective of letting her use a family planning method. This infidelity belief was also a concern for the women. The rate of men having *vasectomies* instead of the women using contraceptives is very low. Nevertheless, as some of the women claimed:

It is better that I have the operation than him. If he does it, it is easier for him to cheat on me.

They wanted to do it instead of their husbands. No matter the reason, in the end it is usually his decision in making the choice of who should do it anyway. This belief about infidelity also adds to the problem of the health posts as being “too local”. If people think you ask for this because you want to hide your infidelity, surely this will affect the choice of going to the health posts.

Despite the fact that a *vasectomy* is a much easier operation than the *tubal ligation*, only four men at the clinics visited wanted a *vasectomy*, in contrast to about 80 women who wanted a *tubal ligation*. All four men lived in Sacatepequez, non in Chimaltenango. Emma, one of the program directors of WINGS, claimed that men are in general more reluctant to having the *vasectomy* because of the common belief that if he cannot reproduce, “he is no longer a man”. Several providers claimed that there exist a lot of myths regarding the *vasectomy*. According to Luis, the family planning coordinator at WINGS, many are afraid and think that a *vasectomy* is like castrating a bull; that they will cut off the testicles. Meira, former Director of WINGS, claimed that some even believe that a *vasectomy* will make you gay. However, these understandings (if present), in combination with the *machismo* culture makes this issue a complex one. For

the men as well, with these beliefs, he will not be seen in a health facility asking for a *vasectomy*. What if people think “he is no longer a man”?

For Ana it was not an option that her husband should have a *vasectomy* instead of her having an operation, they had not even talked about it. She did not consider it either since it was her that wanted this the most. In my group of women, the majority laughed at the thought of him having a *vasectomy* instead of her. It seemed that it was not an option; they had not even discussed it with their husbands. However, either it is him or her, this does not constitute the biggest obstacle here, as she gets the opportunity to choose whether she wants it or not. Nevertheless, if he makes the decision of not letting her use a family planning method because he is afraid she will cheat on him (true or not), this will affect her freedom to choose. According to Emma, providing information regarding family planning, that is not just an issue of the use of contraceptives and getting fewer children, but also about the health of the mother and child may help keep the right purpose in focus.

4.4 Ethnic composition, geographical and linguistic constraints

Guatemala has a rich cultural, ethnic and linguistic heritage. As mentioned in chapter one, about half of the Guatemalan population is considered Mayan. A lot of Mayans have adopted the Christian religion, but still many practice the Mayan *cosmovision* (or combine the two as mentioned above). According to Santiso-Galvez and Bertrand this *cosmovision* further mitigates against family planning, as they believe that “God has created a world in which man is meant to live in harmony with his natural environment” (Santiso-Galvez and Bertrand 2004:60). Thus, often the use of modern contraceptives opposes the basic philosophy of letting nature lead the way. This may make it harder for Mayans wanting to use a family planning method given the high levels of social disapproval, and many do

not want to be seen in a clinic for the purpose of family planning (Santiso-Galvez and Bertrand 2004). Furthermore, after centuries of marginalization and oppression, many Mayan groups have become sceptical of things foreign to their own culture. They are, with good reason, more distrustful and suspicious of outsiders, as the message “having fewer children” has been understood as a strategy to reduce or eliminate the indigenous population (Terborgh et al. 1995:144). Interestingly, WINGS claimed that they had looked into the Mayan cosmology with indigenous staff members concerning family planning. They said that there is nothing in Mayan cosmology that would prevent it (or promote it) and that it is not a huge issue, rather a neutral one⁴⁹. They stressed that the fact that Mayan communities in general are less accepting of family planning methods is not because of their cosmology, but because of discrimination through decades and that service providers typically do not speak their languages.

There are large differences between the Mayan populations, how they practice their cosmology and whether they live in remote rural areas or closer to more urbanized areas. However, the majority of Mayans live in rural areas, many without access to proper health services, education or electricity (Santiso-Galvez and Bertrand 2004). Geographically Guatemala is a difficult country to travel through and many people live in areas that are geographically isolated which adds to the problems of access⁵⁰. Many do not have the economy to use a bus (if there is one, in many areas there are not) to go to a health facility. A provider at the APROFAM clinic in Chimaltenango stressed that one challenge was to reach people, since there are so many small villages which are still difficult to reach⁵¹.

These geographic barriers have first and foremost to do with physical access to services, as a crucial part of the *combined capabilities* or the *conversion factors* needed for the woman to choose freely to use a contraceptive. These combined capabilities stressed by Nussbaum (1999:237), also focus on the

⁴⁹ Interview: Meira. Former Director of WINGS. Antigua Guatemala, Sacatepequez: September 9, 2008.

⁵⁰ Interview: Delphine. Program Director at WINGS. Antigua Guatemala, Sacatepequez: September 25, 2008.

⁵¹ Geographical isolation is not synonymous with being Mayan. Ladinos also live in remote, rural areas.

suitable external conditions that effectively enable the person to exercise the function e.g. physical access. Robeyns (2005) stresses that three conversion factors influence the possibility to use a good to enable a functioning (an achievement). One of those three, *environmental conversion factors*, include the importance of geographical location. If there is no access, it is difficult for a woman to achieve her preferred goal. The conversion factors influence her capabilities and the choices she can make (Robeyns 2005). APROFAM's mobile clinics are trying to overcome these obstacles, but concerning the issue of becoming "too local", there is a chance that they might face the same problem as the health posts. Not in relation to confidentiality among the providers, but of being seen entering the clinic. The clinic is visible, and thus the reason why they are coming is clear. My group of women were able to overcome this obstacle, but it might hinder other women in going. WINGS promoters program might serve as a way for the women affected by this as there is no clinic involved, only a person providing it in an even more secretive manner.

43.4 percent of the Mayan population is monolingual, only able to speak one of the 21 Mayan languages which often do not understand each other either (PAHO 2007:378). Furthermore, women are more likely to be the ones that only speak their native language. Delphine, one of the program directors of WINGS, stressed that this represents a barrier in terms of giving information. Many Mayan groups do not receive information in their native language and this may be a root to misinformation and misunderstandings. This is typically a problem Guatemala is facing, in contrast to the neighbouring countries El Salvador and Honduras for instance, which do not have over 20 different languages. Many health workers do not speak the Mayan languages and communication is difficult. The language barrier is also clear in the production of information, education and communication material; either there is no material in indigenous languages or it is a poor translation (Terborgh et al. 1995). There is a lack of bilingual personnel to explain the services. This is especially important since it is often the women

who do not speak Spanish. Furthermore, sometimes the man will not let his wife go to the clinic in fear of her being fooled into using a contraceptive because she is unable to communicate with the health provider (Terborgh et al. 1995).

Ana and the other women, all spoke Spanish, so the language barrier did not constitute an issue for them. They were also able to overcome the geographical challenges, however, also due to the fact that APROFAM's mobile unit came to them. Ana live just outside the city of Chimaltenango, so for her geographical isolation is not an issue either. These differences represent the variation between the Mayan groups as well. Furthermore, the ethnic composition, the geographical and linguistic situation in Guatemala is complex, and neither one of them or all three of them might hinder a woman's access to contraceptive services. However, these barriers are typically the government and providers responsibility. By not creating the infrastructure to overcome geographical and linguistic barriers, they are the ones who limit a woman's opportunity of accessing contraceptives and information.

4.5 Summary

In this chapter I have discussed some of the socio-cultural constraints women might face when searching for contraceptive services. There are different norms and values that impose upon their capabilities; their opportunity to choose freely the number and timing of their children and methods to control this. Even though there are health posts in their community, these clinics may be *too local* for them to be actually able to go there for family planning services. In general, men are the decision makers and where there is low acceptance of family planning this might represent an obstacle for her in the freedom to choose. Where religion opposes family planning, this also is seen as a constraint. This affects her ability to go to the local health posts because of the fear of being seen. Even though her husband accepts it, other people in the community might not, and she will be a

“victim” of speculations as to why she is using it or that she is opposing God’s will. The local understanding of contraceptives as harmful and that they serve as a way to hide infidelity adds to the speculations. Especially the latter adds to the observation of the health posts as “too local”, as they do not want people to think they ask for contraceptives to be able to cheat on their partner. The private providers (APROFAM and WINGS) serve in many cases as a way of escaping some of these obstacles, since they come and go and can offer confidentiality. They are still strangers. In particular this applies to women using contraceptives behind their husband’s back. The private providers also serve as a way to overcome the issue of access and language differences where this is an issue. Many indigenous women only speak their native language and many people still live in geographical isolated areas with poor access to health services. On the other hand, by coming as a family planning mobile clinic, they run the risk of reducing their benefit of being “strangers”. There is no doubt what kind of services they are offering, and being seen entering the clinic might scare some women away. These constraints need to be considered when seeking to understand women’s opportunity to choose and control their own reproduction.

Socio-cultural constraints add complexity to the women’s freedom to choose. As argued in chapter three, there are also certain constraints regarding the health system on the local level in terms of access and availability of contraceptives. In the next chapter I will be concerned with constraints on a state level regarding access, information and availability in particular. People have a right to access, and the state have a responsibility to uphold these rights and ensure freedoms. This is the topic I will now turn to.

5. The state and reproductive health – capabilities and constraints

In this chapter I will briefly describe the strategies the Guatemalan government has made since the Peace Accords in 1996 in trying to improve the quality of the health system and access to basic health services. I will look closer at what they have done to improve reproductive health care services and access to contraceptives, by passing laws that require them to provide access, information and availability. Further I discuss the role of the Catholic Church and its relation to the state, and how the Church's agency has affected family planning services in Guatemala. Moreover, I discuss peoples' right to reproductive health and contraceptives and the governments accountability to uphold these rights and secure capabilities and freedoms. I will focus on the state "project" regarding access to contraceptives and how this affects women's capabilities and constraints. Towards the end I will discuss the state in relation to global initiatives in reducing poverty in Guatemala.

5.1 Health strategies

The Peace Agreement was signed in 1996 and aimed to solve the armed conflict, but also to reformulate Guatemala's economic and social development agenda, in which health was a part. The main concern regarding health at that time was the lack of coverage by the national health system (World Bank 2003). In 1996, it was estimated that 46 percent of the population had no access to any health care service. MSPAS's (Ministry of Health) primary health activity was concentrated in 860 health posts, each one covered around 2,000 individuals and 318 health centers, where each center covered about 10,000 people. These facilities provided primary and secondary-level health care (World Bank 2003:30).

As a response to the Peace Accord the Integrated Health Care System, SIAS, (*Sistema Integral de Atención en Salud*) was introduced in 1997, financed by the Inter-American Development Bank (IDB) Health Reform Loan. It had the aim of improving coverage of basic health services to the poor, rural and indigenous population (World Bank 2003). The SIAS system is responsible for the organization and administration of basic services and resources of the health sector with the aim of: 1. extending coverage to the parts of the population that traditionally have limited access and 2. improving the quality of health services according to principles of equity, solidarity and universality, in an efficient and sustainable way (World Bank 2003:30).

There exist various measures on the percentage of the population that lack access to basic health services. World Bank (2003) showed in a paper that the percentage of the population without access declined from 46 percent in 1996 to 9 percent in 1999. According to MSPAS 18.8 percent lack access (Centro Nacional de Epidemiología 2007). Still Guatemala has one of the worst indicators of health in Latin America. The problem can be related to the fact that many people do not use the services for various reasons. One reason might be that they have to walk two-four hours to get to the clinic (Thomassen 2004:82). *Adequate* access to health facilities is defined by the World Health Organization (WHO) as living no more than one hour of travelling time to a health care facility (World Bank 2003:59). With this measurement, the picture changes considerably. According to World Bank (2003:61) only 10.7 percent have *adequate* access to health facilities based on WHO's definition⁵².

The SIAS program had the goal of establishing services closer to most communities and of encouraging different members of the community to participate in organization of the program (World Bank 2003). This is a strategy to get closer to the communities and increase the usage of primary health care. Community participation and making primary health care more local has not been

⁵² This is based on numbers from 2000. According to my informants access to health posts has improved.

a project just in Guatemala, but has been on the international agenda since the Alma-Ata Declaration in 1978⁵³. Even though this might work with many primary health care services, it seems as though in Guatemala it sometimes becomes a difficulty concerning contraceptive use. As discussed in chapter three and four, these health posts might become “too local” due to the sensitive topic it is. Reproductive health services and family planning were also integrated into the SIAS system, but to a large degree failed to materialize under President Alvaro Arzu’s administration in the late 90’s when the system was introduced (Santiso-Galvez and Bertrand 2004). This is, however, not about the health posts being “too local”, but how the strategies have been (or *not* have been) put into operation due to political, religious and cultural constraints.

5.2 Reproductive health strategies and laws

President Alfonso Portillo (2000-2004) came to power in January 2000 and his government supported family planning in the context of reproductive health (Santiso-Galvez and Bertrand 2004). During the first months of this administration, the MSPAS announced its aim to make a reproductive health program in a “technically sound, systematic and culturally appropriate manner” (Santiso-Galvez and Bertrand 2004:64). MSPAS then made its first Reproductive Health Program to provide a normative framework for reproductive health services in public hospitals and health centers (Brambila et al. 2007). The program focuses on reducing maternal and infant mortality, family planning, responsible parenthood, cervical cancer, prostate cancer, adolescents, infertility and other components that are part of reproductive health⁵⁴. However, they had a

⁵³ The Alma-Ata Declaration is presented in chapter 6.1.

⁵⁴ Interview: Dr. Morales. MSPAS. The National Reproductive Health Program. Guatemala City: October 8, 2008.

program at that time, but no support from a legal body. At this time there was a need for a social development law.

In 2001, the Portillo administration brought together members of various civic organizations to design the Social Development Law (*Ley de Desarrollo Social*). Representatives from the Guatemalan Association of Obstetrics and Gynaecology, The Guatemalan Associations of Journalists and the Office on Human Rights and the Defence of Women, three universities, private enterprises, workers groups, feminist organizations *and* the Evangelic and the Catholic Church participated in making the law (Santiso-Galvez and Bertrand 2004:64). The Law, Decreto #42 – 2001 is clear in certain articles that it is a right to make informed and free decisions regarding the number and spacing of your children (Article 15). They will strengthen reproductive health services, including family planning which will be given with correct and objective information that is easy to understand and accessible for all in MSPAS's and IGSS's health clinics (Article 25 and 26)⁵⁵.

Toward the end of the process however conservative sectors of the Catholic Church appealed to the government to veto the law because it did not guarantee the protection of life from the moment of conception and it recognized households led by women as families (Santiso-Galvez and Bertrand 2004). This appeal was denied as the National Congress approved the law in September 2001 and the president signed it in October 2001. In April 2002 the government issued its Policy on Population and Development, which provided a strategy for implementing the law. It takes time to improve the service of distribution of contraceptives, but the law represented a better climate for reproductive health (Santiso-Galvez and Bertrand 2004).

⁵⁵ Portal del Migrante. [online].- URL: http://www.unidosporguate.gob.gt/index.php?option=com_content&task=view&id=41&Itemid=24. Retrieved 28 January 2009.

The MSPAS, under President Berger (2004 -2008) and current President Colom, have made a strategy to reduce the MMR and IMR, a plan for 2008 - 2012⁵⁶. The first plan to reduce these rates came in 2002, but they are currently working on implementing the new strategy. It is supported by the World Bank, and is based on multiple strategies. They will strengthen the system and the qualifications of the personnel on a community level at the health posts and health centers. Furthermore, they will qualify 15 000 midwives in hope of reaching the huge part of the population that uses midwives instead of going to hospitals when giving birth⁵⁷. They cannot expect to change people's perceptions and reasons for not going to hospitals overnight. Location of the hospitals, travelling time and cost make it difficult for most people to go to the hospital for giving birth. In addition, discrimination due to indigenous ethnicity and or inability to speak Spanish are also reasons why many choose not to go to hospitals (World Bank 2003). This strategy is designed to meet them in their local environment. They hope to reduce the MMR to 140 the first year and to 100 in 2012, which demands a lot of action. Access to contraceptives is on the agenda as well. As Dr. Morales from the MSPAS and the National Reproductive Health Program (*Programa Nacional de Salud Reproductiva*) noted:

We cannot fight the MMR with only focusing on family planning, but on the other hand, we cannot fight it without offering family planning.

The Social Development Law and other health improvement strategies are focusing on the importance of access and availability of contraceptives, in addition to other health concerns. The strategy to reduce the MMR focuses on strengthening the personnel on a community level, as was also a part of the SIAS system in making the health posts more local. This strategy might work with various health related issues, but it may face a challenge concerning contraceptives and the health posts being “too local” as discussed above. The

⁵⁶ Interview: Dr. Morales. MSPAS. The National Reproductive Health Program. Guatemala City: October 8, 2008.

⁵⁷ Interview: Dr. Morales. MSPAS. The National Reproductive Health Program. Guatemala City: October 8, 2008.

Social Development Law gives a person a *right* to reproductive health and family planning, but still access and availability of contraceptives remained low.

5.2.1 The Family Planning Law

The law on universal access to family planning was accepted by the congress November 16th 2005 (Hurtado 2005). The law is an amplification of the Social Development Law's articles 15, 25 and 26 which is about reproductive health and family planning. The acceptance by congress was only the beginning of months of debating between those fighting for the law and the conservative parties opposing it. The president vetoed the law with pressure from the Catholic Church, who claimed that it violated the constitutional right to life. Cardinal Rodolfo Quezada Toruño said that the law would open the door to abortive practices (Alvarado 2005). To make his point he held up a box of birth control pills in one hand and a bullet in the other, stating that both were killers⁵⁸. Senior Catholic leaders claimed that modern contraceptives created a “culture of death” (Roberts 2006:1228). At the same time women's right groups and the medical body in Guatemala were fighting for the law to be passed, focusing on the right to reproductive health and family planning services. The President vetoed the law too late, and in the end the law was passed in April 2006⁵⁹.

The Law on Universal and Equitable Access to Family Planning Services (*La Ley de Acceso Universal y Equitativo de Servicios de Planificación Familiar*), Decreto #87 – 2005, obliges the government to make temporary family planning methods available free of charge at all Guatemalan government health units. Furthermore, the law specifically says that the government is required to have funds to finance the services. In addition, for the first time in Guatemalan

⁵⁸ Replogle (2006), Interview: Sue. Founder of WINGS and WINGS Chairperson. Antigua Guatemala, Sacatepequez: September 14, 2008.

⁵⁹ Interview: Meira. Former Director of WINGS. Antigua Guatemala, Sacatepequez: September 9, 2008.
Interview: Sue. Founder of WINGS and WINGS Chairperson. Antigua Guatemala, Sacatepequez: September 14, 2008.

history, schools are now required to include reproductive health in their curriculum. To finance the implementation of the law, 15 percent of the taxes on alcohol is (supposed) to be used for this purpose⁶⁰. The Law of Taxes on Alcoholic Beverages earmarks funds for reproductive health. The law was included for the first time in 2004 as a response to the Social Development Law, but it was first with the introduction of the Family Planning Law that civil society demanded an assurance that the earmarked funds were to be used for reproductive health and the purchase of contraceptives (Santiso-Galvez and Bertrand 2007:140).

The law is passed, but still there is a lot to be done at the level of implementation. Some health providers claim that President Berger still blocked the implementation after the law was passed. As Dr. Morales from the MSPAS and the National Reproductive Health Program emphasized; there exists a right on paper, but when there is no penalization for not providing the services or the information, it is harder to carry out the intention of the law. If a law has penalization, more pressure exists for implementing it. A lot of people still lack information, access and availability. Furthermore, the constraints described in chapter three and four also need to be considered when a woman's opportunity of using a contraceptive is evaluated. Even though there is a law that guarantees availability, the postulation that the health posts sometimes become "too local" is still present. Nonetheless, the implementation and availability of contraceptives at the health facilities has a lot to do with political will and power relations which surround the subject.

⁶⁰ Interview: Dr. Morales. MSPAS. The National Reproductive Health Program. Guatemala City: October 8, 2008.

5.3 The Catholic Church and its relation to the state

The majority of the Guatemalan population is Catholic, which is also the dominant religion among the politically powerful. Furthermore, the Church has taken the role of society's moral authority, which has resulted in limiting the provision of contraceptives (Santiso-Galvez and Bertrand 2004). Catholicism in itself does not necessarily constitute an obstacle to family planning. In some Latin American countries the Catholic Church has had limited influence on the personal decisions concerning use of contraceptives, where the contraceptive prevalence is comparable to the United States. Catholicism can play a powerful role in hampering family planning when church and state unite to hinder the implementation of contraceptive services (Santiso-Galvez and Bertrand 2004:61).

When APROFAM opened its first clinic in 1965 with family planning methods available, the Catholic Church was in the process of reconsidering its position in response to the appearance of *the pill* as a family planning method. There was optimism internationally regarding the possibility that the Vatican could be tolerant of modern contraceptives, but Pope Paul VI declared his opposition in *Humanae Vitae* in 1968. This represented a major hinder for family planning in many parts of the world (McLaughlin 1982 in Santiso-Galvez and Bertrand 2004:61). This position profoundly influenced decision making regarding family planning in Guatemala. Many eminent politicians in the Guatemalan government were members of religious orders who held the same view as the Vatican. The Church has tried to influence every Guatemalan government for four decades to resist the acceptance and promotion of family planning methods (Santiso-Galvez and Bertrand 2007:149).

Various incidents demonstrate the powerful connection between the Guatemalan government and the Catholic Church during the 1970's-1990's. In 1978 under the government of General Romeo Lucas, the Catholic Church claimed that the *IUD* was an abortifacient. The MSPAS gave in to pressure from the Church and proclaimed that all women who had received an *IUD* from a

government facility should come back to have it removed (Santiso-Galvez and Bertrand 2004). They also limited the access to contraceptives in its health facilities. In 1984-1985, a constitutional meeting formed to draft a new constitution. Article 47 required that the government would promote responsible parenthood and that people have a right to freely decide the number and spacing of their children (Santiso-Galvez and Bertrand 2004:62). At the same time representatives from the Catholic Church incorporated Article 3, which stated that “life shall be protected from the earliest moment of conception” (Santiso-Galvez and Bertrand 2004:62). This article led to efforts to forbid the distribution of contraceptives because they were considered as abortifacients.

How the government and the Catholic Church unite to hamper family planning became very clear with the 1994 International Conference on Population and Development in Cairo. Administrators from the MSPAS and APROFAM attended the introduction meetings before the Conference. But President Ramiro de Leon (1993-1996) appointed more conservative representatives to attend the Cairo Conference, and instructed them to oppose all references to reproductive and sexual rights, sexual education, and services for adolescents, abortions, contraceptive services and safe motherhood (Santiso-Galvez and Bertrand 2004:62). Guatemala supported the Plan of Action, but announced its reservation of the whole chapter concerning reproductive rights.

As mentioned above, in the late 1990’s, during the administration of Alvaro Arzu, reproductive health and family planning were integrated in the SIAS program. The program was supposed to make reproductive health services more accessible, but failed to materialize. Since 2000 there have been attempts to acknowledge the importance of reproductive health, starting with President Alfonso Portillo, who during his presidency introduced the Social Development Law, which the Catholic Church actually did help formulate. This should tell us that the Church is being more acceptable of *reproductive health and rights*, but still there is less acceptance of *contraceptives*. This is shown with the Church’s

opposition to the family planning law discussed above, which President Berger vetoed with pressure from the Church.

The current President Colom came to power in 2008 and there seem to be different perceptions among people that work with reproductive health and family planning about his approach to the subject. Danessa, former coordinator of WINGS' Advocacy program claims that they have not noticed any difference from former presidents. On the other hand, Dr. Elsy Camey de Astorga, from the Board of Directors at APROFAM and Dr. Morales from MSPAS and the National Reproductive Health Program, claim that they think he is fighting a little bit harder and that his focus on health is stronger. According to Dr. Morales, one year into Colom's presidency, the strategy of reducing the MMR and IMR is coming into operation and the family planning law is there to be implemented. Further he claims that the governmental health facilities are gaining ground in distributing contraceptives, but have to take one step at a time, as there are many challenges to be faced. How the situation regarding contraceptive services under Colom will proceed, remains to be seen.

The Catholic Church has obviously had great influence on the situation regarding family planning in Guatemala. Even though it may not be understood as a hinder on a personal level, it becomes a problem when it affects the availability of contraceptives in health facilities nationwide. When the state in coalition with the Church impedes the provision of contraceptives, it affects people's freedom to choose. Furthermore, it will have greatest influence over the poorest part of the population that cannot afford to go to a private clinic. Even APROFAM's services are too expensive for a large segment of the population. The Family Planning Law obliges the government to provide temporary contraceptives free of charge in the government's health units. However important it is to consider socio-cultural constraints to contraceptive use; access and availability are fundamental in the discussion. With access and availability we can discuss further constraints as to why it is not being used, but without

access and availability there is no point discussing socio-cultural constraints. The relation between the state and the Church concerning family planning has a vast influence on the women who are “victims” of the lack of access and availability, which by law is supposed to be present.

5.4 Accountability of the state and rights to reproductive health - whose project?

The capability approach focuses on the individuals’ possibilities to lead a life according to their desires. Sen differentiates between a person’s functionings, which is the actual achievements from the capabilities which is the freedom to achieve (Sen 1999:75). The emphasis is not only on how a person actually functions, but on they having the capability, a practical choice, to function according to their interests. It is about freedom of choice. How successful people are in living a life of their own choice is determined by their capabilities to make choices and to achieve their desired goals (Andreassen 2006).

To achieve desired goals can be seen as a person’s “projects” which Ortner (2006) defines agency to be. Ortner (2006) distinguishes between agency as a form of power (domination or resistance) and agency as a form of intention and desires, as the pursuit of goals and the performance of projects. Furthermore, according to Ortner, “both domination and resistance are always in the service of projects, of being allowed or empowered to pursue culturally meaningful goals and ends, whether for good or for ill” (Ortner 2006:153). The capability to make choices and a person’s success in pursuing his or her project are in many cases influenced by various factors. This we have seen to be the situation for many women in Guatemala searching or wanting family planning options. The access and availability to contraceptives is influenced by the relation between the Church and the state, which too have their own projects in terms of pursuing something they want to accomplish. The powerful influence the Catholic Church

has had in the Guatemalan government, and how they in coalition have hindered the acceptance of family planning in Guatemala, creates agency which influence the women's capabilities to make choices. Whether in terms of agency as power (domination) or as a form of intention and desire, however, it is still a "project".

The agency of the state and the Catholic Church also affect the women's *conversion factors*. I outlined in chapter 2.1.2 three types of conversion factors; personal, social and environmental, stressed by Robyens (2005). These factors influence how a person can use a good to enable a functioning. The relation between the state and the Church directly influences *the social and environmental conversion factors*: The Church's project has been to reduce or deny access to modern contraceptives and by so doing try to control women's reproduction, which has influenced the government's policies on family planning in terms of access and availability of contraceptives.

However successful the Church has been during the last decades in doing so, the government has also had certain strategies and projects considering basic health services and reproductive health. As discussed, the different presidents have during their tenures made strategies to improve the health infrastructure following the Peace Accords, with greater or less success; the SIAS program, the passing of the Social Development Law, strategies to reduce the MMR and even in the end the passing of the Family Planning Law. Both these laws have been pushed through mainly from various women's organizations, the medical body in Guatemala and universities. The Family Planning Law in particular being attributable to women's organizations. They have also had their projects and used their agency to push these laws through. However strategies and laws on paper, the Catholic Church has used their agency of power to influence the government and by this reduce people's freedom of choice. The Church's ability to influence decisions regarding family planning directly influences people's capabilities of being able to achieve access to contraceptives and information. This is what

Ortner (2006) terms “serious games”⁶¹, which involve pursuing goals within a matrix of local inequalities and power differentials.

Nonetheless, especially concerning the Family Planning Law, women, men and youths have *rights*. Not only according to human rights, but a right according to Guatemalan law, to reproductive health services and access to contraceptives and information. This means that people have the possibility to claim their rights.

The ability to articulate their claims and voice them is influenced by various factors. Gloppen (2005) focuses on how people can voice their claims in the legal system. First and foremost the claimants must be aware of their rights and have access to resources enabling them to articulate their claim. Further she claims that numerous barriers impede access to the justice system for poor and marginalized groups. These barriers include fear and distrust of the court due to cultural and social distance or negative experiences in the past and perceptions of poor performance and corruption (Gloppen 2005:5). Practical barriers such as costs, geographical distance, language barriers and lack of information also affect the possibility of voicing their claims together with the status of legislation of social rights. For poor groups it can be very important whether an organization or individual can litigate on the behalf of others. For the social rights litigation to succeed is further influenced by the responsiveness of the court, the capability of the judges to handle social rights issues and the compliance and implementation of political authorities (Gloppen 2005:3-4).

These factors will not be elaborated further, but are included briefly only to state that when people have rights, there needs to be a “system” that will give the claimant a possibility to voice their claim. There needs to be accountability of the state to uphold the rights and secure capabilities and freedoms (Andreassen 2006). This is influenced by different factors and various groups’ “projects”, e.g. the Catholic Church. State accountability can be expressed as the responsibility of the state to respect, protect and fulfil these rights (Andreassen 2006:318).

⁶¹ See chapter 2.2 for definition of “serious games”.

Moreover, as Dr. Morales from the MSPAS and the National Reproductive Health Program claimed, there needs to be a penalization as a “(reverse) incentive” to carry out the law and people’s rights.

It is not an easy “job” to be the government in a poor, developing country either. They face a lot of challenges and claims from local environments to global agencies as to what they need to fulfil. Their capability to act and pursue their projects is often formed by lack of resources in terms of financial capital and human capital. They often face dilemmas concerning what their focus should be in terms of where the capital flow should go. According to Thomas and Allen (2000), to choose one developing program often means not choosing another. Plans and strategies also relate to interests and values which often are influenced by other agents and groups. The state has several parties with different interests it needs to consider. As the controversial issue family planning has been, and still is, it may be easier to focus on projects which do not lead to such a conflict. Even though the laws are passed, this does not necessarily mean that they will be implemented, especially in the case of Guatemala where the Catholic Church’s opposition and role have been so strong. Their agency is so strong that it still has the power to influence the state’s action. The state is pushed from different groups, but in many cases the development scheme serves the interest of those who are already dominant (Thomas and Allen 2000), which may explain why the Church’s agency is so strong.

An analogy of political agency has been seen as “trying to ride a tiger in a particular direction, the tiger being more or less obedient masses who must be coaxed along and who may, if goaded too hard, turn on the ruler and make big trouble” (Thomas and Allen 2000:194). The Guatemalan people and organizations are fighting for their rights and using their agency to pursue their project, which the state has to consider. On the other hand, the Church is pursuing their project. The “tiger” the government is riding is running in different directions.

5.4.1 The Advocacy Program in Chimaltenango – local vs national projects

As noted above, it is particularly important for poor groups as to whether an organization or individual can litigate on the behalf of others (Gloppen 2005). However, if not litigate, at least be the voice of the marginalized in trying to influence the government in fulfilling their rights. WINGS work with the MSPAS (Ministry of Health) and the Ministry of Education to develop strategies for implementation of the Family Planning Law. As we have seen the law is supposed to ensure access to family planning through the national health system and requires sex education to be taught in all public schools. WINGS in this case act as an agent in giving the poor and marginalized a voice in the process of implementing the law. This is a pilot project in the province of Chimaltenango, focusing mainly on youths who are often denied access and to make them aware of their rights.

The program is divided into two parts. On the local level WINGS work with decision makers in Chimaltenango who work with health and education, and who coordinate the programs and local political projects to implement the law. They give training and qualification to health providers about reproductive health and family planning, about the law and the obligation they have to support this in the communities. Furthermore, they give training and qualification to teachers about the subject and how they can present it to the pupils.

On the central level they work with public policy in correspondence with congressmen and legislators who implement laws on a national level. WINGS is working in strategic alliances with other organizations and pressuring the legislators to implement the law. The program is divided into two parts because of the differences on a local and central level. On the local level people still do not know the content of the law and their rights as opposed to the central level where they know the law and the procedures, which is the reason why they have

to start with different advocacy. Further, the social norms and values regarding the acceptance of contraceptives need to be handled differently on a local level.

According to Danessa, the former coordinator of the program at WINGS, the government has done little in trying to implement the law. This is also due to the strong role of the Catholic Church in making decisions in the government. She stressed that there is a lack of political will in the sense that they have the resources to implement the law, but *choose* not to. On one hand the Catholic Church act out their agency of power in trying to deny access and availability, on the other hand WINGS and the other organizations together with people in Chimaltenango have agency as well, and pursue their project of access and information regarding family planning. The government is caught in between with pressure from both sides. However, the lack of political will to carry out the law directly affects people's capabilities to make effective choices and to achieve their preferred goals.

5.5 The state in relation to global initiatives in reducing poverty

Guatemala is one of the poorest countries and has among the worst health outcomes in all of Latin America. To decrease poverty rates in the country, health is one indicator that is seen as important. Particularly regarding the high levels of inequality, where the poor part of the population suffers from the worst health outcomes.

As previously discussed, the country has developed strategies to improve the health care quality, however, with varying success. The strategies focus on access to health care, including reproductive health and access to contraceptives. Furthermore, they have made strategies with assistance from the World Bank in reducing the MMR and IMR which are closely related to the Millennium Development Goals (MDG's). UNFPA and the MSPAS are also cooperating in

promoting reproductive rights and providing access to contraceptives (UNFPA 2004, UNFPA/Oifarnes 2008)⁶². Despite the Catholic Church's influence on reproductive health and family planning in Guatemala, the government has in cooperation with global agencies made strategies to improve the situation.

Improving health conditions among disadvantaged population groups has become an increasingly important development objective for many development agencies, including the World Bank. Reproductive health is recognized as important for the MDG's since it affects mortality rates, nutrition status and population conditions. The Guatemalan government's strategies to improve the situation regarding reproductive health are attached to global initiatives and the commitment they made with the MDG's. The government in collaboration with international development agencies have their project in reducing these rates and providing access to health care services for all parts of the population. The initiatives on the state level focuses on the bigger pillars of development. As Dr. Morales from the MSPAS and the National Reproductive Health Program stressed; the components that have to be present for a country to develop are health, education and security. He claimed that these three pillars are indicators of development. If these pillars are present, development will start to increase automatically, which further affects nutrition and population conditions. All these elements overlap. According to Dr. Morales, a focus on reproductive health is crucial in improving these indicators as it affects all of them in a positive manner. Furthermore, he claims that access to contraceptives is a significant part of improving reproductive health.

The global initiatives in collaboration with governments in poor countries are stressing the overall indicators of poverty and aiming at reducing poverty on a national and global level. However, by doing so, this might strengthen people's agency in terms of pursuing their own project of improving well-being. At the same time, it is easy to forget the individual's freedom to lead the kind of life she

⁶² <http://guatemala.unfpa.org/proyectos/insumos.htm>.

or he desires. Reproductive health is also about having as many children as you like; the freedom to choose and go safely through a pregnancy. Human reproduction has been a concern for many governments, often more than many other health issues just because of the impact it has on demography and resources available in a country. A woman's reasons for wanting reproductive health services and contraceptives may be quite different from the reason the government see as important.

As noted above, the Guatemalan government faces a lot of challenges in giving the population access to health care services, especially access to family planning. The government recognizes the rapid population growth and the challenges they face with infrastructure and resources to provide for the population and the challenges concerned with alleviation of poverty. With the recognition of these challenges, it can be seen as a paradox that they do not give their population proper access to contraceptives. This paradox shows how the state is pulled in different directions between "own" interests, the Church, global agencies and the people of the country. However, population as an issue has changed from population control to a rights perspective on the global arena. What the main interests of the Guatemalan government might be, control or rights (or even both), they still have a long way in improving the situation regarding reproductive health and poverty reduction.

5.6 Summary

In this chapter I have described the Guatemalan government's strategies to improve the health situation in the country since the Peace Accord in 1996. I have discussed the reproductive health strategies and laws passed, which have had the goal of improving access and information to reproductive health and family planning. The SIAS system was the first strategy to improve access to basic health care and focused on establishing services closer to communities. It

included reproductive health and family planning, but the implementation of these services rather failed to materialize. Moreover, this strategy of being local may, as previously discussed, make the health posts “too local” in relation to contraceptive services.

The 2001 Social Development Law laid the foundation for the 2005 Family Planning Law. This law obliges the government to make temporary family planning methods available free of charge at all Guatemalan public health facilities. However, this process has not been free of problems, mainly because of the Catholic Church’s role in opposing modern contraceptives. The Catholic Church’s role is strong and they have used their agency of power in influencing the government’s decision which in many cases has affected the policy regarding family planning directly. As a result, the state in coalition with the Church has hampered the provision of contraceptives, which affects people’s freedom to choose. However, people have *rights*, which the state was pressured to recognize and in the end led to the passing of the laws. The state seems to be in a position of conflict between the power of the church and the rights of its people. Moreover, they are also in the spotlight of global development agencies that have their project concerning poverty reduction and individual rights. Reproductive health is recognized as important for improving living conditions in Guatemala, which is a part of reaching the ultimate goal of poverty reduction.

In the next chapter I will be concerned with the global ideologies of reproductive health. In particular, I will be concerned with reproductive rights and what this approach might imply for the individual. Reproductive health and family planning are argued to be important for development and poverty reduction, but to be able to achieve these positive outcomes, people need the opportunity to access these services and the freedom to choose them.

6. The global ideologies and shifting agendas

In the previous chapter I discussed the challenging position of the Guatemalan state in taking responsibility and upholding the reproductive rights perspective. I discussed how this conflict between the state and the Church has hampered the distribution of reproductive services. Moreover, the state is not only pressured by the Catholic Church, it is also subjected to the global agenda in which reproductive health is considered an important part of human freedoms and rights. In this chapter I will briefly point to how the global approach to human reproduction has changed. There is a shift in the global agenda that is of importance to me; the shift to the *reproductive rights* perspective. My concern is what a rights approach might imply for the individual person. The “project” of the global agencies is concerned with ensuring the rights of the individual and giving them freedom to choose. As discussed in the previous chapters, even though people have a right, there will always be certain power relations which influence how “rights” are maintained. Further I am concerned with the proposed link between reproductive health, family planning and poverty reduction. Women participating in my research emphasized that access to contraceptive services was crucial for them to be able to decide how many children they wanted and when, and giving them a chance to a better future. To realize these positive outcomes, people need the freedom to choose and the ability to utilise the services chosen.

6.1 Reproductive rights – introduction and affirmation

The world has witnessed during the last decades different approaches to human reproduction and development. The freedom to choose and control your own reproduction has been influenced by these different approaches. Neo-Malthusian arguments emerged in the 1950-60’s with the view that population growth is the

cause of the world's problems. People, especially the poor, should be persuaded (or even forced) to reduce the number of children they have. This argument was challenged in the 1970's, in particular at the Bucharest World Conference on population in 1974 (Hewitt and Smyth 2000). During this time the language of (reproductive) rights was introduced⁶³, and challenged the Neo-Malthusian view by affirming the right to reproductive decision making (Freedman and Isaac 1993).

In 1978 the Alma-Ata Declaration was adopted and expressed the need for urgent action to protect and promote "Health for all" (by the year 2000), motivated by the call for social justice. This gave rise to primary health care as the most important base for development. Communities and families controlling their own health, hence putting the "public" into public health was emphasized. Health care should be provided close where people lived and worked, and care should be given by community workers (Lawn et al. 2008:919). According to Walley et al. (2008:1002), all levels, including individual, family, community, facility, district, provincial, national and global, have a role and responsibility if the goal "Health for all" was to be achieved. The emphasis on social justice brought the focus closer to the individual's needs and to people's right to health. This in turn created a better environment for an individual's right to choose and by implication also the freedom to choose.

During the 1990's the language of rights had a firmer grip on the global agenda. There was an emphasis on the respect for *individual human rights* and the possibility for the public to participate not only in development, but also in political issues (CMI 2006). Governmental spending on public health had been weakened by the neo-liberal macroeconomic policies which dominated during the 1980's. But during the 1990's there was a shift in focus back to the link between

⁶³ For the first time at the international human rights conference in Teheran in 1968 and reaffirmed at the Bucharest conference in 1974 (Freedman and Isaacs 1993).

health and development and to the encouragement of increased government spending in public health (Lawn et al. 2008).

The International Conference on Population and Development (ICPD) held in Cairo in 1994 led to what became an almost complete reformulation of global population policies and strategies. Even though “reproductive rights” had been introduced a couple of decades earlier, population growth was for many governments still a concern (Freedman and Isaacs 1993). The ICPD called for dropping demographic targets in favour of a broader policy agenda that focused on women’s reproductive health needs, including family planning, and that focused on empowering women and strengthening their rights (Sinding 2007:10).

Reproductive rights are supported by several internationally recognized human rights, which were the guiding principles underpinning the ICPD’s Program of Action on Population and Development (Glasier et al. 2006). Reproductive rights encompass the broad principles of rights to reproductive health care, the right to reproductive self-determination, the right to information, education, decision making and non-discrimination (Cook et al. 2003). A definition of reproductive health was developed at the conference:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the *right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility* which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (Cook et. al 2003:12).

Hence, at the Cairo Conference the concept of reproductive health and rights was defined, and the link between reproductive health and development issues such as poverty reduction was affirmed (Burke and Shields 2005). Besides the Cairo conference, the 1993 International World Conference on Human Rights in Vienna and the 1995 Fourth Conference on Women in Beijing also addressed

women's reproductive choice as a human development issue (Hellum and Knudsen 2006). The well-being and rights of the individual, especially women who bear the major burden of reproduction became a significant part of the development agenda. This approach to reproductive health engages the concept of *freedom to choose* and the ability to control their own reproduction.

Furthermore, reproductive health became an important part of the Millennium Development Goals (MDG's), adopted in 2000. According to the UNFPA universal access to education and reproductive health care are vital for individuals to break out of cycles of poverty. Moreover, UNFPA argued that reproductive rights were essential to women's empowerment, which was understood as crucial to achieve healthier and more productive families, communities and countries⁶⁴. Hence, women's capabilities and their rights to equality are defined as elementary to achieving the MDG's (Hellum and Knudsen 2006). The MDG's can be seen as the next generation of the "health for all" goals with three explicit health related goals⁶⁵. According to Walley et al. "primary health care is an approach to achieve both the MDG's and the wider goal of universal access to health through acceptable, accessible, appropriate and affordable health care" (Walley et al. 2008:1001). Perhaps a revitalisation of the Alma-Ata declaration is back on the agenda. The focus on primary health care and making health care more local is argued to have vast benefits in improving health and development in many countries (Lawn et al. 2008, Walley et al. 2008). There is then a global consensus that reproductive health and family planning are needs that should be addressed according to the rights approach.

⁶⁴ UNFPA: <http://www.unfpa.org/icpd/mdgs.cfm>.

⁶⁵ Goals 4-6: 4. Reduce child mortality 5. Improve maternal health 6. Combat HIV/AIDS, malaria and other diseases. Goal 3 also reflects reproductive rights: Promote gender equality and empower women (Singh et al. 2003:6).

6.2 The global “project” of (reproductive) rights

As mentioned above, reproductive health is now recognized as a human right and important for development and poverty reduction. Family planning is recognized as important for ensuring the rights of the individual to control and choose the number and timing of their children, thus improving reproductive health.

The shift from population control to a rights perspective has led to a change of focus. The state’s responsibility for population control is reduced, and a focus on individual rights is promoted. The “project” of the global agencies is concerned with ensuring the rights of the individual as a key to development and improvement of living conditions. Sen argues that, “development can be seen as a process of expanding the real freedoms that people enjoy” (Sen 1999:3).

Freedoms enhance people’s capabilities to make choices according to their desires. Hence, the capability approach sees the right to reproductive *choice* as an important part of human development. Hellum and Knudsen state that several scholars, including Sen and Nussbaum, stress that “reproductive autonomy is a fundamental freedom particularly important to women’s empowerment, individual development and status in the society” (Hellum and Knudsen 2006:58).

Sen (2005:152) points out that human rights can be seen as rights to certain specific freedoms. Since capabilities can be seen as kinds of freedoms, a relation between rights and capabilities is established. There has been a massive discussion in the literature concerning capabilities and rights and the possibility to combine these two concepts, especially by Sen and Nussbaum themselves. Sen claims that there are several human rights for which the capability perspective has much to offer. It is important, however, that we do not subsume either entirely within the other (Sen 2005:163). Nussbaum points out that in some areas the best way of seeing rights is to see them as capabilities. Further she claims that “to secure a right to a citizen is to put them in a position of capability to function in that area” (Nussbaum 1999:240). I will argue that since the right to reproductive

health incorporates the right to reproductive self-determination, the capability perspective has much to offer since it concerns people's freedom of reproductive choice. To uphold a rights perspective may in this sense be seen in accordance with giving people the freedom to choose.

This shift to a rights perspective of the global agencies creates a direct link to the individual, where the state should play a role, or have an obligation to fulfil these rights and eliminate discrimination. Regardless of the "rights consensus", there are still many different approaches as to why reproductive health is important and what it can achieve on a global/national or family/individual level. What the global agencies see as important may for the individual be less important. (The same issue raised in chapter 5.5 where the *government's* goal may be different from the individual's). By trying different approaches to reach the goal of development and poverty reduction, an individual is just one "invisible part" of this process. Even though the rights approach focuses on the individual, there are certain characteristics of what "development" in a country should look like. At the individual level, it may not be about rights at all, but about basic strategies for survival. Moreover, concerning the debated subject of human reproduction; population growth is still a concern and reducing growth remains as a goal for many countries and global agencies. The focal point outlined is the right to reproductive choice and the rights to control the number and timing of one's children, which also refers to the rights to have as many children as you like (also mentioned in chapter 5.5). Nevertheless for poor families, poverty reduction is still often seen in accordance with reducing the number of children. According to the capability approach it is about people's capabilities and the freedom to choose, and if they have that capability, and choose *not to*, does it oppose the poverty reduction goal?

As outlined in chapter five, Guatemala has formed strategies to reduce the MMR and IMR in collaboration with the World Bank, which is directly influenced by the MDG's in reducing poverty. Moreover, the Family Planning

Law ensures the individual's rights to contraceptives and information. Not only a human right at the international arena, but a right according to Guatemalan law as well. The "rights project" of the global agencies is aimed at the individual directly. In the case of Guatemala this rights project has made national organizations and individuals stand up and fight for their rights, with the passing of the law as a result. Still the global "rights project" is complex and as we have seen through the previous chapters, several elements influence implementation in Guatemala. The rights of women to reproductive choice are often found to be a contested position between international human rights law and social, cultural and religious norms (Hellum and Knudsen 2006). Moreover, the right to choose is also influenced by power relations in the respective country as well as the international stage.

6.2.1 Understanding power and the Catholic Church's influence on a global level

Hydén (2006) discusses the role of power in policy analysis and the importance of understanding power relations. A focus on power would give a better understanding of why situations evolve as they do and how factors in the "grey zone" between economics and culture are forming the results of policies. It provides a more informed perspective on threats and opportunities, strengths and weaknesses concerning the policy process in a country (Hydén 2006:221). Hydén claims that understanding how power influences policy, whether it is good or bad, is the new challenge in development collaboration (Hydén 2006:227). Hydén defines power as "the capacity to exercise control and influence over others through the use of means, soft or hard, which, within the way power is constituted and distributed in the first place, cause outcomes that are empirically verifiable through the presence or absence of conflict" (Hydén 2006: 228). Moreover, the effect of power on the lives and rights of citizens is crucial to determine. How power influences the making and implementing of policy have

an impact, positive or negative, on people directly or indirectly affected (Hydén 2006:229).

In the case of Guatemala, to be able to understand the making and implementing of policy in the country, it is important to understand the power relations that exist. Recognizing who prevails in decision-making and finding out which groups have more power than others might reveal which direction a country is heading in the development process. As we have seen, the Catholic Church has been resistant to the right to contraceptives in particular, and there is no doubt that their power has been and still is significant. On the other hand, the democratic processes of listening to its people are also in force, as the rights to contraceptives became incorporated in Guatemalan law. Yet the Church obviously still has power in terms of the implementation of these rights, which are not yet implemented properly. As mentioned in chapter five, the World Bank and UNFPA in collaboration with the Guatemalan government work to improve the reproductive health situation in the country. By identifying the power relation between the Catholic Church and the state, the global agencies may use their power as donors (their agency), in terms of being agenda setters. In this way they might have the capability to influence these power relations, which hamper the individual's rights to reproductive choice.

The Catholic Church's influence at the global level

The Catholic Church has influenced policy on reproductive health and family planning, not only in Guatemala, but on the global arena as well. Hellum and Knudsen (2006:66) state that monotheistic religions such as Catholicism often view gender, sexuality, reproduction and family in a manner that might conflict with principles of freedom and equality associated with the human rights approach. In the reservations by the Catholic Church to UN declarations and conventions it appears as though the Church is opposed to women's reproductive rights. At the Cairo and Beijing Conferences, 1994 and 1995 respectively, the

Vatican pioneered a resistance to paragraphs with reference to a woman's right to control sexuality (Hellum and Knudsen 2006). Guatemala was one of the countries following the resistance. Furthermore, President George W. Bush reinstated the "Mexico City policy"⁶⁶ (which had been rescinded by Clinton in 1993) early in his first term and made dramatic changes in international reproductive health policy. During his tenure, the US responded to the international HIV/AIDS pandemic by operating the bilateral President's Emergency Plan for AIDS Relief (PEPFAR) (McFarlane 2006). PEPFAR has stressed abstinence and limiting funds for condoms, and requires one third of prevention funds be spent on "abstinence-until-marriage programs" (McFarlane 2006:415). This, undoubtedly, was warmly welcomed by the Catholic Church. Furthermore, the US, under Bush's presidency, stopped funding to the UNFPA and the International Planned Parenthood Federation (IPPF) which had devastating effect on international reproductive health work (Hellum and Knudsen 2006, McFarlane 2006). This resulted in decreased contraceptive capacity, which affected several countries and thus people's access to contraceptives (McFarlane 2006). Despite efforts by the Bush administration, highly influenced by the Catholic Church's principles one might say, reproductive health and contraceptives are recognized as a *right* and important for development and poverty reduction.

Although there are forces of power (i.e. the Catholic Church) which have agency at a global level, I would like to suggest that reproductive rights can create demand for the fulfilment of individual rights among local women. In Guatemala this was precisely the case. People were fighting for the Family Planning Law to be passed, hence putting pressure on the Guatemalan state. When people acknowledge their rights, they also address who has the duty to

⁶⁶ At the 1984 International Population Conference in Mexico City President Reagan announced what became known as the "Mexico City Policy". This policy prohibited all American NGO's from using funds from the USAID to assist any foreign NGO that perform and promote abortions as a method of family planning (Freedman and Isaacs 1993).

provide them (Nussbaum 1999:239). When somebody has a duty, for instance when the Guatemalan state is recognized as a duty bearer, people demand their rights to be fulfilled. To combine rights and capabilities Nussbaum points out; “to secure a right to a citizen is to put them in a position of capability to function in that area” (Nussbaum 1999:240). Demand in this sense may create capabilities and thus the freedom to choose.

6.3 Reproductive health and poverty reduction

According to the capability approach, poverty can be seen as capability deprivation. The main focus is on the capabilities a person has, which is the real freedoms she enjoys to lead the kind of life she has reason to value (Sen 1999:87). It is about the freedom to choose. Absence of reproductive choice can thus be seen as capability deprivation. This conceptualisation principally focuses on capabilities rather than achieved functionings. Sen differentiates between a person’s functionings, which is the actual achievements, from the capabilities, which is the freedom to achieve (Sen 1999:75). Concerning reproductive health and poverty reduction there are certain outcomes (achieved functionings) of having the opportunity to access reproductive services that are argued to be substantial. As Sen points out, “health achievement tends to be a good guide to the underlying capabilities, since we tend to give priority to good health when we have the real opportunity to choose” (Sen 2002:660). Health achievements might say something about a person’s capabilities, but it is the *capabilities* that first and foremost need to be in place to be able to achieve. My group of women in Guatemala are good examples of Sen’s statement; when they had the *real opportunity to choose*, they chose to use the reproductive health services available.

Reproductive health aims to support pregnancy and childbirth, and to reduce unfavourable outcomes of reproduction. It also aims to give all individuals

the ability to practice safe and satisfying sexual relationships by dealing with obstacles such as inequalities in accessing health services, restrictive laws and gender discrimination (Glasier et al. 2006:1596). Reproductive health is as much a development and a human right issue, as it is a health issue (Cook et al. 2003).

Reproductive health problems, though almost entirely preventable, are still extensive in much of the developing world. WHO identified reproductive health problems to be the principal cause of women's ill health and death worldwide (WHO cited in Singh et al. 2003 and UNFPA 2005). UNFPA (2005:33) claim that these figures mask immense inequalities, both within and between countries, since reproductive health status depends on income and gender. According to WHO (2004) poverty is generally linked to unbalanced access to health services, particularly maternal health services. UNFPA emphasize that "addressing the issue becomes a matter of social justice, ethics and equity" (UNFPA 2005:33). In this sense it also becomes an issue of people's opportunity to access these services, which often depends on socio-economic conditions. As Sen emphasizes; "we have to go well beyond the delivery and distribution of health care to get an adequate understanding of health achievement and capability" (Sen 2002:660). The women in Guatemala as reflected in this case study highlight Sen's point very well. They live within a nexus of social norms and values, rites and regularities, which influence their freedom to choose. To understand women's capabilities and constraints concerning contraceptive use "we had to move beyond the delivery and distribution of health care".

I have also throughout this thesis shown that strengthening the health system concerning access, information and availability is of importance. This is exactly what UNFPA (2005) stress when claiming that many problems concerning reproductive health could be averted by strengthening health systems, first of all within the context of primary health care. The poorest and the most disadvantaged women and men are often those who are most dependent on public health care (Singh et al. 2003). UNFPA also argue (in line with Sen) that

reproductive health concerns are affected by many social and economic aspects and the health sector cannot resolve this alone. Increasing access to reproductive health services must also consider social, cultural, economic and gender factors. Strengthening health systems also requires building trust among individuals and the communities they provide (UNFPA 2005:33). This discussion reflects what I argue in this thesis; health systems *and* the consideration of socio-cultural conditions are of importance in understanding women's (individual) opportunities to access reproductive services. As this study observed, primary health care provided close to where people live made contraceptive services "too local". The reason for this was due to lack of confidentiality at the health facilities and social and cultural conditions surrounding the issue.

The benefits (achieved functionings) of reproductive health are often measured in medical terms, which are of course important and substantial (Singh et al. 2003). The benefits of reproductive health are also argued to expand beyond medical terms, and may be economic or social and a contribution to wider development goals. Singh et al. (2003:24) argue that improving reproductive health "increases productivity in the home and labour force, resulting in personal, household and societal economic benefits". They stress that protecting parents' health keep their families from falling into poverty, as better health may lead to new economic opportunities and allow more possibilities for productive investment, in particular for poor women (Singh et al. 2003:25). As Bloom and Canning argue; health improvements fortify the economy and alleviate poverty since economic growth is an "exceedingly powerful way to reduce poverty" (Bloom and Canning 2000:1207).

Furthermore, Singh et al. (2003:15) argue that reproductive health is essential to a person's identity and fulfilment, and to family and social relationships. One of the issues they point out is that reproductive health services contribute to improving women's social position by preventing or correcting various stigmatising conditions that can influence their status in the family and in

the community (Singh et al. 2003:23). As argued here, reproductive health services can improve women's situation in Guatemala when they are exposed to, for instance, patriarchal community systems which oppress them in various ways. According to UNFPA (2005:34) reproductive health, gender equality and poverty reduction are closely linked. To be able to achieve these positive "achieved functionings" as the argued outcome of reproductive health, people need the opportunity to access and choose the reproductive health services.

6.3.1 The role of family planning in poverty reduction

The emergence of modern contraceptive methods led to a noteworthy increase in contraceptive use in many countries. Less than 10 percent of married women used contraceptives in the 1960's, to 60 percent in 2003 (Glasier et al. 2006:1601). However, this increase of usage was also due to forced family planning in some cases, and an emphasis on reducing population growth, rather than the individual's health and rights. Family planning has therefore during the last decades been a subject of discussion about where the focus should be. According to the reproductive rights approach, family planning is about an individual's choice to decide if and when to have children. It is about the freedom to choose to control your own fertility, and not about the number of children you actually have. However, concerning family planning and poverty reduction there are certain outcomes (achieved functionings) of having the opportunity to access contraceptives (and use them) that are argued to be extensive.

According to Singh et al. (2003:16) contraceptive services are often underestimated in evaluation of benefits because unintended pregnancy is not a disease. They argue that there are many social and economic benefits that result from improving people's ability to control the timing and number of their children, which health based measurement does not capture. With about 200 million women having an "unmet need" for contraceptives, according to Singh et

al. (2003:18), this demonstrates the importance of access to reproductive health services and contraceptives. UNFPA (2005) stress the link between family planning and poverty reduction and emphasize that limited access to contraceptives constrains women's and their families' opportunities to escape poverty. This opportunity was what my women as informants in Guatemala stressed was important for them. They were searching these services to be able to cope with their poverty and give their children a chance of a better future.

The medical benefits of contraceptive services are argued to be quite clear. Pregnancies become high risk when women are too young or too old, have too many children or have children too close together (Allen 2007). According to Allen (2007) and WHO (2004), to give women a possibility to space their children and have fewer pregnancies reduces the risk of maternal death and disability, with respect to both mother and child.

There are also argued to be many non-medical benefits of contraceptive services. According to Sing et al. (2003) women of all ages report that using contraceptives to control their fertility and avoid unintended pregnancies has a positive affect on their personal well-being and status in the household. Women also point out that delayed pregnancies and smaller families gave them educational and economic opportunities (Sing et al. 2003:23). This point is exactly what my group of women stressed was important, however, for them the focus was on their *children's* education and economic opportunities. Further Singh et al. (2003) and Allen (2007) emphasize that control over own fertility may give women more confidence and improve participation in decision-making within the household. Furthermore, it gives them the opportunity to contribute economically to the household. Ana had the opportunity to work a little besides being a housewife and a mother because she had not had more children during the lasts five years. This gave her the ability to provide education for her children which was the reason why she chose to undergo the operation.

Along with UNFPA (2005), Cleland et al. (2006) also argue that effective family planning programs may make a powerful contribution to poverty reduction. They also emphasize that there exists no contradiction between respect for reproductive rights and family planning promotion. They claim further that high fertility among the poor is not simply about reproductive choice, but from the absence of such an option for the poor. They do not have the *freedom of choice*. However powerful a contribution to poverty reduction effective family planning programs are, people, women in particular, need first and foremost the opportunity to access these services and the freedom to make their choice and implement it.

6.4 Summary

The global “rights project” is complex and is also influenced by different power relations. The Catholic Church has been in opposition to modern contraceptives and has pioneered resistance to women’s right to control their own fertility. This resistance has had implications for various Catholic countries, among them, Guatemala. Despite the power of the Catholic Church, reproductive health is recognized as a right and important for development and poverty reduction. Further, the reproductive rights approach of the global agencies creates a direct link to the individual where the state has a responsibility to fulfil these rights. Even though this perspective focuses on the individual’s rights, there still remains a perception of what development in a country should look like. For poor people in particular, poverty reduction is often still seen as a result of reducing the number of children they have. I have argued that to uphold a rights perspective is to give the people freedom to choose, as it focuses on reproductive self determination. In this sense people also have the right to have as many children as they like.

I have also argued that the rights perspective creates some sort of demand despite the many obstacles in fulfilling these rights. This was the case in Guatemala when people were fighting for the Family Planning Law to be passed. They knew they had the right and the right created the demand. Demand in this sense may create capabilities and freedom to choose, hence the freedom to choose good health. Sen points out: “We tend to give priority to good health when we have the real opportunity to choose” (Sen 2002:660). When my group of women had the real opportunity to choose, they chose to use the contraceptive services offered. According to the women this opportunity gave them and their children in particular, a chance to a better future.

7. Conclusion

Population, reproductive health and family planning have been areas of discussion for decades. There is now more of a consensus among global agencies and initiatives that reproductive health is a human right and people have a right to freely decide the number and timing of their children. Moreover, reproductive health is also recognized as important for development and poverty reduction. Sen argues that “development can be seen as a process of expanding the real freedoms that people enjoy” (Sen 1993:3). Freedoms enhance people’s capabilities to make choices in life according to their desires. I have argued that to uphold a rights perspective may be seen in relation to giving people the freedom to choose. This shift to a rights perspective of the global agencies creates a direct link to the individual, where the state should play a role and have a responsibility in fulfilling these rights and eliminate discrimination. I have also argued that reproductive rights can create demand for the fulfilment of people’s rights. This link between the global initiatives and the individual person would appear to correspond as they focus on the individual person’s rights and freedom to choose. The problem of upholding these rights and giving people (the women in particular) the freedom to choose stems from relations *in between and within* the levels; the state and local level, community and family.

The State, the Catholic Church and Rights of the people

Reproductive health and family planning has been a topic of controversy in Guatemala. The inclusion of reproductive health and the provision of contraceptives in the country’s public health facilities have not had the strongest priority. Yet laws have been passed concerning reproductive rights. The 2001 *Social Development Law* laid the foundation for the 2005 *Family Planning Law*, which requires the government to provide temporary family planning methods free of charge at all Guatemalan public health facilities. The process of passing

and implementing the law has not been free of problems, mainly because of the Church's role in opposing modern contraceptives. The Church's agency and power in opposing contraceptives has influenced the government's decisions and affected the national policy regarding family planning directly. As a result, the state in coalition with the Church has impeded the provision of contraceptives, which affects people's freedom to choose. However, people have *rights*, which I have argued to create demand for the fulfilment of these rights. The state has had to recognize these rights which led to the passing of the laws mentioned. Yet the state seems to be caught in the middle between the power of the church and the rights of its people, also in terms of implementing the law. This further affects people's rights concerning access to contraceptive services.

Access, availability and information

An important part of the state's responsibility is to provide access. Many women have to travel to get to a health facility and this represents obstacles in terms of time and cost of travelling. Access is fundamental to the capabilities to freely choose the usage of contraceptives and control of your own fertility. It is the state's responsibility to overcome geographical barriers and provide access to its people. Moreover, there is understood to be a lack of availability of contraceptives in the public health posts and health centers. In many cases they do not have the contraceptives available when a woman needs them, and ask her to come back the later. This made some women having distrust in the public health facilities. Knowledge and resistance to talking about reproductive health and family planning among the personnel at the public health facilities also represents a constraint concerning the women's freedom to choose. Providing access, availability and information is elementary in enhancing women's capabilities to be able to use a family planning method. This is the state's responsibility. Yet the state has not been able to provide these components in a proper manner. Private providers have therefore played a significant role

concerning contraceptive services. They are there to provide access, information and availability where the public facilities fail to do so.

Confidentiality and the health posts as “too local”

Access, availability and information are important, but I have also stressed other constraints that add complexity to the women’s freedom to choose. One of these constraints is discussed to be the lack of confidentiality at the public health facilities. In a local community, where there are health posts, the chance that the provider or someone else present at the clinic will know you or someone in your family is too high. They are afraid they will be seen in the health post asking for contraceptives. The SIAS system, introduced in 1997, aimed to improve access to basic health care and make the health posts more local. I have argued that the endeavour to make the health posts more local might represent a profound barrier to access. The health posts become *too local* regarding contraceptive services. Many women therefore choose private providers, in this case, APROFAM and WINGS. The Mobile Units that come and perform their task and leave again is then argued to represent a way of escaping this obstacle.

Further, social norms and values, belief and knowledge systems influence the women’s real opportunity to choose. These socio-cultural constraints are part of the reason why the health posts become “too local”. In general, men are the decision makers and where there is low acceptance of family planning this might represent a barrier to choice. The husbands’ “non acceptance”, has also led many women to use contraceptives behind their husbands’ back. Moreover, when religious beliefs on a personal and community level oppose family planning, this also might represent a constraint. This affects women’s opportunity to go to the local health posts in terms of the fear of being seen. Even though her husband accepts it, other people in the community might not. This might result in speculations as to why she is using contraceptives or that she is opposing God’s will. The local understanding of contraceptives as harmful and that they serve as

a way to hide infidelity adds to these speculations. Especially the issue of infidelity might also add to make the health posts “too local” as they do not want people to think that they ask for contraceptives to be able to be unfaithful to their partner.

The private providers (APROFAM and WINGS) serve in some situations as a way of escaping some of these constraints and as a way of providing capabilities, since they come and go and can offer confidentiality. On the other hand, a family planning mobile clinic is visible, and it is easy to understand why they are there. As a result, they may lose their advantage of being “strangers”. As it is quite apparent what kind of services they are offering, the fear of being seen entering the clinic might scare some women away. These constraints need to be embedded in the understanding of women’s capabilities to choose and control their own reproduction. Exploring the capability approach in relation to reproductive choice in order to contextualize women’s capabilities and constraints has also offered to contextualize each individual woman, as it has been shown that the constraints the women face may not be the same.

The local women’s capabilities

The capability approach thus focuses on what people are able to be and to do; that is, on their capabilities, and the importance to make free choices. It is about removing obstacles which might affect her freedom to choose. Sen stresses that poverty is not only about economic deprivation, but should also be evaluated in terms of quality of life, well-being, agency, rights and *freedom* (Sen 1999). It is not about whether the women use family planning methods or not, but about having access and the opportunity to do so if they want to. It is not about whether they actually get fewer children, but about the *freedom to choose* and decide the number and timing of their children according to their own desires.

For Ana and the other women in Guatemala, the opportunity to choose and control their own fertility is filled with constraints. Yet they have agency and are

able to pursue their aims and aspirations. They were able to pursue their project of not having more children despite the many constraints that may affect their capabilities, their real opportunities, to make choices and implement them. The motivation behind the women's goal was the simple fact that they could not afford to provide for another child. Their main focus was on the ability to give their children a chance to a better future, and the ability to send them to school. The current focus on health and women's individual rights may enhance the women's freedom to choose and with this obtain a chance to control their own fertility. Most important to the women is the opportunity to access family planning methods which are crucial for them, first and foremost in relation to family well-being and survival. They emphasize that this opportunity gave them and especially their children a chance to a better future.

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