

## Chapter Three

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# MEXICO & GUATEMALA

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## Why are the Refugees There?

With a population of close to 10 million people, Guatemala is Central America's most populous country. The society is composed of four main ethnic groups: Mayans, Xincas, Garifunas and Ladinos. Most of the population belongs to one of the 22 Mayan ethnic groups. The Ladinos, the country's second largest ethnic group, have ruled Guatemala throughout nearly all of the country's history. There is a fusion of indigenous and European cultures.

After the CIA-supported overthrow of democratically-elected Jacobo Arbenz in 1954, Guatemala suffered more than thirty years of war. The subsequent guerrilla uprising in 1960 was a revolt against the United States' monopoly over the country's resources, the corrupt and oppressive leadership of Ydigoras Fuentes, and the unequal distribution of land and resources. In the following years, the guerrilla movement segmented into various factions, each following a distinct ideology. In 1982, the various guerrilla groups unified to create the Guatemalan National Revolutionary Unity (URNG).

By 1982, increased violence and massacres of entire villages prompted tens of thousands of indigenous people to seek refuge in Mexico. Hundreds of thousands more became internally displaced within

Guatemala. By December 29, 1996, five major Peace Accords had been signed and a cease-fire went into effect.

## MEXICO

Mexico now hosts some 32,500 Guatemalan refugees located primarily in the states of Campeche, Chiapas, and Quintana Roo. The highest concentration of Guatemalan refugees lives in Chiapas, close to the Guatemalan border. Chiapas is one of the poorest and most neglected states in Mexico; but the refugees remain there because of its proximity to Guatemala.

Of the 16,000 refugees now living in camps in Chiapas only 30 percent are returning. Some 35,000 have already returned; and half of that population had children born in Mexico. Only those refugees registered as part of return blocks (groups of at least 50 families) as of December 1997 will return with the official support of the Guatemalan government. The government had hoped to end all returns by January 1998, but it has extended the date indefinitely.

Many of the refugees in Mexico are afraid that living conditions will be worse for them in Guatemala, and that there will not be enough NGOs to make up for the lack of government support. Yet in spite of their fears, the refugees overwhelmingly *do* want to return.

## Which Relief Agencies are Assisting the Refugees?

The refugees are very dependent on NGO support since their access to social services, jobs and subsistence activities is greatly restricted. The Mexican Commission to Help Refugees (COMAR) was formed by the Mexican government to help provide services to the refugees. But COMAR has often become entangled in bureaucracy and politics adding to the importance of local NGOs. One midwife commented, "Each year we have been getting less and less help from NGOs. We don't know if this year we'll get any support at all." Organizations working in the camps should, therefore, gear their assistance efforts toward sustainable skills whenever possible.

Among those NGOs working with the refugees are: *Mama Maquin (MMQ)*, which has been particularly active in educating women regarding their land rights; *Promotion of Community Services (Proseco)*, which provides direct RH and general health services to Guatemalan refugees in Mexico (many of its staff of health promoters and midwives are refugees themselves who live in the camps where they work); and *United Nations High Commissioner for Refugees (UNHCR)-Comitan*. The gender focal point for UNHCR in Latin America is based in Mexico City and is responsible for supervising the UNHCR offices of Latin America as they integrate gender concerns into their programs. The Comitan office agrees that RH programs should be launched immediately in refugee camps and among returnee populations and is providing financial and skills-building support to local NGOs working with the refugees in this and other areas. It would be useful if the UNHCR offices in Mexico and Guatemala had more communication regarding refugee and returnee communities.



Rachel Jones

*Refugee girls in Chiapas, Mexico— thousands of children will grow up and enter their reproductive cycle in refugee camps.*

## General and Reproductive Health for Refugees

The camps have an abundant water supply, but it is not potable and so causes chronic health problems, such as dysentery. Anyone in need of serious medical attention must travel to the nearest hospital in Comitán which is at least one hour away by car on rough roads. Refugees say they are treated well at the Mexican hospitals and seem to receive the same quality of services as Mexicans. Visits to health clinics and hospitals are reimbursed by COMAR.

Each community has health promoters who attend to the basic needs of the community. When the refugees first arrived, all of the health promoters were men. However, because few women felt comfortable expressing their health needs to the men, women's organizations, UNHCR and local NGOs helped train women health care promoters and midwives to

respond to women's health needs and set up women's clinics in the refugee communities.

In Guatemala, the indigenous community traditionally used natural remedies to cure illnesses. Grandmothers cared for people in the community and passed on their medical knowledge to their daughters. When refugees return to Guatemala they may have no choice but to return to the use of traditional remedies as modern medicines will likely be inaccessible. Many refugees, however, have lost this knowledge.<sup>1</sup> MMQ and Proseco both plan to run workshops with refugee women on beneficial traditional medicines.

The number of NGOs and individuals working in the field of reproductive health with the refugees is greater than those working with the Mexican population. With funding from UNHCR and a Dutch NGO, Proseco provides family planning, HIV/AIDS testing, pap smears, and pre- and post-natal care. The organization claims to reach 49 percent of a refugee population of 7,000. Nearly one-quarter of Proseco's funding goes to reproductive health. Its staff consists of one male and one female doctor, 17 health promoters, and 46 trained midwives.

But RH services for the refugees are far from adequate. Midwives are the primary RH providers in the camps but they lack training and supplies. In Guatemala, these midwives had no support for their work. But in Mexico they have been able to improve their skills. Midwives working with and trained by

Proseco say that at first they just assisted with deliveries. Now, they do home visits, family planning, prenatal care, pap smears, sexual violence prevention, hygiene and general health education for women and their children. Increasingly, younger women are becoming midwives, attracted by the challenging work and social respect granted to their older colleagues. While many midwives have received medical training from, for example, Proseco, they all expressed the need for more training and, especially, supplies.

### Safe Motherhood/Emergency Obstetrics

In El Porvenir camp, deliveries usually occur in homes with a midwife present. Prenatal care is given in the clinic and sometimes in people's homes. Each month, the midwives organize consultation groups with pregnant women to be sure they are in good health and free of complications. The general good health of mothers and children is confirmed by UNHCR-Comitan. The El Porvenir midwives report that when this community was in Guatemala, women were having anywhere from 10 to 15 children spaced closely together. In El Por-

**“One of the biggest mistakes made was the medicalization of this community. Traditional medicine is something we are trying to recuperate.”**

*Dr. Luis Aquino of Proseco*

venir, however, they say that women are spacing their children and using family planning methods (which weren't available to them in Guatemala) to decrease family size. Pre- and post-natal care is provided by the midwives. Breastfeeding is a common practice, so much so that some women will not use the oral contraceptives available in the camps because they interfere with breastfeeding.<sup>2</sup>

<sup>1</sup> The refugees' indigenous languages and customs, such as women's weaving and marriage ceremonies, are also diminishing as the refugees assimilate into Mexican society.

<sup>2</sup> Progestin only pills are not available.

Because delivery and midwife kits are not available, assistance before, during and after births is not as comprehensive as it should be. Midwives are in dire need of even the most basic supplies such as gauze, towels, scissors, thermometers, and scales to weigh mothers and babies. They also need vitamins, iron supplements for women and children, and folic acid for pregnant women. Seven of the 13 midwives in El Porvenir have some supplies but these cannot realistically be shared. All of the seven midwives with any supplies are scheduled to return to Guatemala in the near future, and so their skills and equipment will leave with them.

Some 15 percent of all deliveries will have unpredictable complications that could lead to maternal death. Camp clinics and health workers are not equipped to provide emergency obstetric care. Women in need of emergency obstetrics must find transport and then travel at least an hour on a rough road to the nearest hospital in Comitán. The hospital, equipped to handle most delivery complications, will not refuse services to those refugees who can make the journey.

### Abortion

Midwives report no abortions in their camp; but this assertion is refuted by other health workers and NGOs working with the refugees. They say women frequently seek medical attention after unsafe abortions. Proseco, for example, reports that the most common reasons for clients to approach their health workers involve unwanted pregnancies or complications resulting from unsafe abortions. Abortion is illegal in Mexico. NGOs cannot, therefore, provide

abortions; but some health providers will tell women in strict confidence where to go to obtain one.

UNHCR is aware that women are seeking abortions. The agency knows of at least one woman who has died as a result of an unsafe abortion. UNHCR has found that abortion is more common than the use of contraceptives in the camps.<sup>3</sup> This can be attributed to the lack of modern methods of contraceptives available to refugees and indicates a significant unmet need for family planning within this community.

### Family Planning

Overall, family planning remains a complex issue in refugee communities. The desire to replace lost family members, the fear of having more children in war situations, and the emotional traumas from continued violence represent challenges to organizations attempting to introduce family planning into refugee communities.<sup>4</sup>

In El Porvenir, oral contraceptives, Depo Provera, IUDs, condoms, and the calendar rhythm method are used as methods of contraception. Contraceptive supplies are kept in the camp clinic and are provided by local NGOs, but it has been confirmed that these supplies are inadequate. For example, IUD and the rhythm method are the most commonly used methods of contraception because the supplies of other methods are not reliable. Also, the only pills available are not recommended for breastfeeding. Many women choose sterilization at the Comitán hospital once they have had as many children as they want. Vasectomies are never mentioned as a contraceptive option.

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<sup>3</sup> Sayavedra H., Gloria. *Lessons Learned: Reproductive Health for the Refugee Population*. UNHCR-Comitán, Mexico, September 1997.

<sup>4</sup> Lozano, Itziar. *Lessons Learned in Working with Refugee Women: The Case of Chiapas*, UNHCR-Comitán, Mexico, 1996.



Rachel Jones

A midwife who provides services to returnees in Quetzal, Guatemala.

Midwives and health promoters say that refugee couples often go to the clinic together to decide what family planning method they will use and how many children they want to have. These health workers also say that family planning workshops provided in El Porvenir target both men and women. Although this was not observed or confirmed on a recent visit, if true, it is a very positive sign of male involvement in family planning.

#### HIV/STD Prevention

Midwives say they are aware of AIDS and described it as “a sickness; it is death, no cure, no medicine.” They say that AIDS has not arrived within their own community but that it has in other camps. Sexually-transmitted diseases (STDs), such as gonorrhea, are prevalent in the camp. Prevention of HIV and STDs is

extremely difficult because there is no reliable supply of condoms in the camps. Proseco provides HIV tests, but there is no treatment or counseling for those who test positive. This raises serious ethical issues as to whether testing should be done at all. No one has yet tested positive for HIV, but health workers have heard of cases existing within the refugee community at large.

#### Sexual and Gender Violence

Low self-esteem among refugee women has been observed by UNHCR and MMQ. The two organizations have provided workshops for refugee women which involve exercises intended to enlighten women to unfair gender disparities (for example, women’s greater work load yet lesser authority) while teaching them skills with which to improve the quality of their lives. These workshops also include exercises in which women draw their bodies on paper and discuss each part of their anatomy and how to enhance their sexual fulfillment. Also, women are taught about their human rights. MMQ workers consider these workshops a success given the increase they have observed in women’s participation in community decision-making, as well as in the greater number of women who are now willing to report abuse to community leaders and/or state authorities.

Domestic violence is a recognized problem within this community. MMQ says that violence against women has not necessarily increased since the community’s displacement, but women now recognize and label it as abuse. A group of about 10 midwives and other women in the camp was formed to address this issue. They attended domestic violence workshops run by MMQ. The workshop participants then educated authorities and camp leaders about vio-

lence against women and how to resolve disputes through non-violent means such as discussion and peer pressure. Women thus can seek the assistance of other workshop participants if they are confronted with domestic violence.

UNHCR-Mexico considers domestic violence a health problem and so includes domestic violence education in its RH program. The UNHCR-Comitan office hopes to expand this education initiative in the coming months.

The Guatemalan constitution says that women and men are equal; but they are not treated so in legal or social practice. Marriage may improve women's social status but it usually weakens their legal rights since laws protecting women from physical abuse are often not respected in domestic disputes. Instead, women are commonly accused of bringing the violence upon themselves. This keeps many women from reporting abuse. Throughout Latin America, November 25th has been established as an international day of awareness of violence against women. Refugee women observed this day in the camps by disseminating educational materials about violence against women.

During the war in Guatemala, rape was used by the military as a counterinsurgency weapon. Women who have been raped are seen as damaged. They are, therefore, very reluctant to discuss the violence they survived because it puts them at risk of further victimization within their communities. The stigma

surrounding rape probably stems from the cultural insistence on an unmarried woman's virginity and the notion of women as men's property. If, for example, it is discovered that a bride is not a virgin on her wedding night, her husband may reject her. She will

then have a difficult time finding another man willing to marry her.

Incest is an issue raised with alarming frequency by refugees and NGOs alike. Refugees and health workers say that when girls in their early teens become pregnant, the baby's father is likely to be a family member because most young

girls do not spend much time outside of the house. It is impossible to gauge the magnitude of incest within the refugee community; but because incest was mentioned so frequently, it warrants further investigation.

### The Next Step

RH services in the camps should include counseling. That would help ensure the efficacy of any prescribed treatments. Testing for HIV should cease pending the availability of, at the least, psychological counseling and a reliable means of prevention. Refugee camps should be well stocked with condoms provided free of charge. UNHCR, for example, should guarantee the availability of condoms to the refugees as part of its Minimum Initial Service Package (MISP) for both emergency and stable refugee settings.<sup>6</sup> Mental health services should also be integrated with RH programs. UNHCR and Proseco should participate in

**"There's no medicine you can give people to cure violence. You need support and this should be done in secret. Women say it helps for them to take all of this stuff out from inside of them."**

*El Porvenir Camp Midwife*

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<sup>6</sup> For more information about UNHCR's MISP see: *Reproductive Health in Refugee Situations—An Inter-Agency Field Manual*, UNHCR, Geneva, 1995.

and support MMQ's sexual violence workshops while promoting the concept of sexual violence as a health issue. All assistance should focus on providing sustainable skills that refugees can take with them when they repatriate, such as basic education on hygiene and nutrition. UNHCR and the NGOs in the area must cooperate more closely to ensure the efficiency and efficacy of their programs. Returnee communities should be monitored by NGOs in Mexico to see that RH services are provided during the initial phase of repatriation.

## GUATEMALA

One of the five main Peace Accords of 1996, the Agreement for the Resettlement of Populations Uprooted by the Armed Conflict, supports the repatriation of refugees as well as their social, political, and economic reintegration within Guatemalan society. Although the Peace Accords represent hope for Guatemala's future, the remaining refugees and those who have been repatriated are skeptical that the Accords will truly be respected and fulfilled.

### **Which Relief Agencies are Assisting the Returnees?**

Among those organizations assisting the returnees are: *APROFAM*, the Latin American branch of the International Planned Parenthood Federation (there are 23 APROFAM clinics nationwide providing pre- and post-natal care, family planning, and HIV/STD prevention, counseling and testing); *COMADEP*, which has assisted the returnee communities the longest and has been providing RH services to these



*IEC campaigns can be an effective way to reinforce messages.*

communities since 1995; *CONCERN*, an international NGO that worked with the refugees in Mexico and now provides health care services and appropriate technology workshops to returned and local communities; *Guatemalan Human Rights Commission*, which supports the Integral Center for Attention of Women (CIAM) in San Marcos which works with returned communities on health care projects; *Reproductive Health Project*, part of the Guatemalan government's General Secretary of Planning, the *Project* is designing a national policy on reproductive health; *Mama Maquin-Guatemala*, a member of a consortium of 15 organizations working with the returnee communi-

ties in Guatemala; *Tierra Viva (TV)*, a women's rights organization; and *UNHCR-Guatemala*, whose work in the returnee communities focuses exclusively on human rights.

Aside from UNHCR and APROFAM, none of the above organizations has a sign outside its office. This omission attests to these organizations' fear of retribution by the government or others who may be opposed to their work. The nondescript offices also point to the considerable social and political constraints on these organizations' efforts to provide the returnees and internally displaced persons with RH, or any other, services.

### **General and Reproductive Health for the Returned Refugees**

Upon repatriation, returnees get loans and food for six months from the Guatemalan government. Médecins Sans Frontières (MSF) provides health care to the returnees for six months but it is unclear if RH services are included.

Only three to five percent of the returnee community's health workers have been trained in reproductive health, and they were all trained in Mexico. Once they have settled in Guatemala, however, the lack of support and reinforcement for this knowledge result in the deterioration of these valuable skills. Refugees are returning to extremely remote locations, so it is extremely difficult, both logistically and financially, for NGOs to provide RH and general health services. Many repatriated refugees cross the border to Mexico to obtain health care; even some Guatemalan residents seek health care in Mexico.

The Reproductive Health Project published a report in August 1997 that was the culmination of a Guatemalan government study of women's, men's and adolescents' attitudes toward reproductive health.<sup>7</sup> This study revealed that the majority of Guatemalans are very interested in reproductive health and want more information. However, the government's attitude towards the returned communities seems to be: "Let them settle down first, and then we'll introduce RH projects if they are wanted."

It is essential that women's rights organizations promote reproductive health, but few of them directly address the issue. Either they are too fearful of the political consequences of promoting reproductive health or they consider other issues more urgent. Sex education is generally not part of the government school system's curriculum largely because of the strong resistance by religious conservatives in the government. APROFAM is, however, providing sex education in some private and government schools that specifically seek out its services. Premarital sex among adolescents is not socially accepted.

### *Safe Motherhood/Emergency Obstetrics*

Midwives in Quetzal provide pre- and post-natal care and assist in deliveries. There are far fewer training opportunities and medical supplies in Quetzal than were available in the refugee camps in Mexico. Without continued, up-to-date training and supplies, the midwives' abilities are severely limited.

Reputedly the best-organized return community, which is located in Quetzal, has no emergency obstetrics services. The clinic is poorly supplied, as are the midwives, who also lack training in recogni-

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<sup>7</sup> *In Search of a Consensus in Reproductive Health: Phase I*, Guatemalan General Secretary of Planning and the Technical Secretary of the Social Cabinet, August 1997.

tion of birth complications. Births occur in people's homes in the presence of a midwife. Should complications arise, the nearest hospital is at least a four-hour drive away on rugged roads. The overall maternal mortality ratio for Guatemala in 1997 was 200 per 100,000 live births.<sup>8</sup> This number is likely to be higher in the returnee communities in which there is no emergency obstetric care for the estimated 15 percent of women who will have unforeseen complications during deliveries.

The Reproductive Health Project notes that the second most common reason for women to seek medical care in government clinics is for complications resulting from unsafe abortions; the first reason is for birth. Some NGOs reveal that, if asked, they will direct women to private abortion providers known to be safe. But the open discussion of abortion puts one at risk of professional ruin. There were no private abortion services available at one returnee community recently visited, but women use traditional and unsafe methods to induce abortion.

### Family Planning

The government promotes the only two methods of contraception that are officially sanctioned by the Catholic church: the rhythm method and the Billings/ovulation method which involves charting the texture of cervical mucus. Women in returnee or

displaced communities are highly unlikely to choose or effectively practice either of these methods.

The clinic in Quetzal has no contraceptive supplies. Some women have IUDs they received in Mexico; and Norplant has been provided in very small quantities by a local NGO. But most women's contraceptive choice is limited to the rhythm method.

The government Reproductive Health Project reported that because most Guatemalan women are given family planning without counseling, there is a low continuation rate. This assertion was confirmed by APROFAM which claims to be changing its practices to include counseling with RH services. Depo Provera is very appealing to most women

because it can be used without a husband or partner's knowledge, and because injections are seen as effective health care. Improving access to family planning would help significantly to decrease the apparently high number of women having unwanted pregnancies.

### STD/HIV

There are no services available in Quetzal for HIV/STD testing, counseling, or treatment. It is impossible to determine how many people are or even might be affected by HIV/STDs in this community. Community midwives say that vaginal infections are common among the women they consult but

**“Even though the Peace Accords are signed and the war is over, not all our problems are solved. Now we need to solve the same problems that started the war: poverty, discrimination...It's important that the eyes of the international community are on Guatemala. We shouldn't forget.”**

*Indigenous Refugee Woman  
in El Porvenir Camp*

<sup>8</sup> Population Reference Bureau, Washington, D.C., April 1997.

they are never certain of the cause and have no medicine to treat infections. Condoms are unavailable, so abstinence is the only accessible preventive measure against transmission of HIV and other STDs.

### Sexual Violence

Representatives of NGOs and Quetzal health workers all express concern about the allegedly high rates of domestic violence and incest occurring in the returnee communities. As in the refugee camps in Mexico, it is difficult to determine the prevalence or causes. But, again, the frequency with which these issues were raised begs further investigation. Tierra Viva may be the only organization that is directly addressing domestic violence. It does so via information and education campaigns, including poster dissemination and prevention training.

### **The Next Step**

It is essential to support those NGOs providing RH services in Guatemala and to help them expand their services to include the returnees' communities. Mid-

wives and health workers in the returnee communities need support and training, especially in the areas of early recognition of pregnancy complications. It would be helpful if each training participant received

**“When we left Guatemala in 1982, we had never heard about women’s rights. The Guatemalan Government signed laws protecting women’s rights but never told anyone. It’s now time not just to say ‘I know my rights! I know my rights! but to put those rights into practice.”**

*Maria Guadalupe Garcia Hernandez,  
Mama Maquin-Comitan General  
Coordinator*

a supply kit upon “graduation.” Mental health services should be integrated within RH programs. More needs to be learned about contraceptive use, incest, unsafe abortion and sexual violence in the returnee communities. COMADEP and CONCERN, both of whom have earned great trust and respect within these communities, would be well-positioned to conduct studies on these issues. Support should be

given to women’s rights organizations that educate women on their rights to RH services. And finally, collaboration and communication should be improved between UNHCR’s office in Mexico and UNHCR staff in Guatemala.

*Catherine Feingold, Women’s Commission for  
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*Rachel Jones, Women’s Commission for Refugee  
Women and Children*