MADRE speaks

Winter 2001

Women's Health in a Sick World

Jonathan Snow

From the Executive Director

Vivian Stromberg

Winter 2001

Dear friends,

Here we are at the start of 2001 and half way into our seventeenth year of MADRE's work. Together we have built an organization whose services span four continents and whose membership is now 23,000. We have delivered over $16 million of medicines and supplies, helped build community women's organizations that generate powerful women's leadership and engaged the vision of women from our sister organizations in helping to create new international law. And we have not become bureaucratic or anonymous as we have grown. Our relationships with our sisters around the world are richly interactive and human, and our principles remain the rock on which MADRE stands.

We are now planning our programs for the coming period. Our new programs will build on our previous successes as well as adapt to the new challenges of the 21st century. We will look carefully at the impact of race, gender and economic policies on the most marginalized communities. And we will continue to challenge the direct and indirect impact of destructive US government and US corporate policies.

Please take a look at our new and expanded website, www.madre.org, for updated postings on programs, analyses and action alerts. Do let us know what you think. We love hearing from you, and your input helps us to guide our work.

Here's to a powerful year with enough creativity and perseverance to make great strides toward the world we imagine and the world we all deserve.

Sincerely,

[signature]

MADRE

121 West 27th Street, #301
New York, NY 10001
212/627-0444 Fax: 212/675-3704
e-mail: madre@igc.org
www.MADRE.org

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Since 1983, MADRE has worked in partnership with community-based women's organizations in conflict areas worldwide to address issues of women's health, economic development and other human rights. MADRE provides resources and training for our sister organizations and works to empower people in the US to demand changes to unjust policies. Based on the priorities of the women with whom we work, MADRE develops programs that meet immediate needs in communities threatened by US policy and supports women's long-term struggles for social justice and human rights.

Newsletter Staff
Yifat Susskind, Editor
Sarah Widmer, Assistant Editor
Amy Thesing, Design

cover photos: (right) © Jutta Meier-Wiedenbach, Impact Visuals (left three) © Jonathan Snow

Photo (this page): MADRE Executive Director, Vivian Stromberg with Rose Cunningham, an Indigenous leader and educator from Nicaragua's Atlantic Coast.

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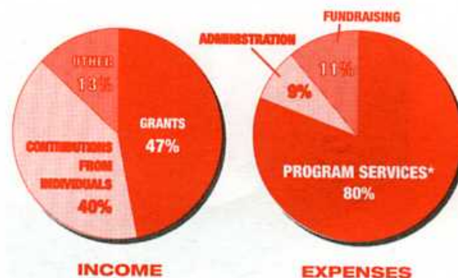
MADRE Income and Expenses Fiscal Year 1999-2000



* PROGRAM SERVICES INCLUDE: WOMEN, CHILDREN AND FAMILIES, AID, INTERNATIONAL EXCHANGE, PUBLIC EDUCATION AND DEVELOPMENT

NOTE: $3,409,378 is the value of "in-kind" medical shipments and services that MADRE sent our sister organizations during the year. This category is not considered income by the Internal Revenue Service, but to us it is an exceedingly important source of support.

WOMEN'S HEALTH in a Sick World

by Yifat Susskind

Genevieve is a 23 year-old mother in Port-au-Prince, Haiti. Five years ago, her husband went bankrupt after his local rice business failed to offer the inexpensive prices of US-imported rice. When her husband found a job as a Coca-Cola distributor, traveling around the country for weeks at a time, Genevieve had to generate an income in addition to taking care of her family. Having only been educated through primary school, she had few options. Unable to earn enough by selling fruit at a local market, Genevieve was forced to begin exchanging sex for food so she could feed her children while her husband was away. Three months later, she contracted HIV.

Three years ago, Carmelita's village on the Atlantic coast of Nicaragua became the site of a logging project. Pollutants from the project contaminated the nearby river, killing off fish. Carmelita and her family, who have always relied on fishing for their survival, lost the mainstay of their diet. Within one year, she and her children began showing signs of malnutrition.

Cristina lives in Guatemala City. Working long hours in a dirty, high-stress *maquila* (sweatshop) and living in an overcrowded slum, she contracted tuberculosis. Because of new hospital user fees and a rise in the cost of pharmaceuticals, Cristina did not have enough money to pay for medicine. She had no choice but to continue her work at the *maquila*, and her condition steadily worsened.

Maddy Miller

MADRE has always worked to promote women's health as part of the matrix of human rights. An early MADRE project provided support to the Bertha Calderón Hospital, Nicaragua's first women's hospital.

We tend to think of health mainly as a function of biology, but as the above scenarios suggest, the strongest determinants of health are actually the social, political and economic forces in our lives. Health is not only the absence of disease or infirmity but also a state of physical, mental and social well-being. How healthy we are depends enormously on our access to nutritious food, clean water and medical care, on the levels of violence and stress in our lives, on how much and under what conditions we work and on the opportunities we have for love, pleasure and fulfillment. In the US, the notion that health is mainly a measure of medical fitness and a commodity that can be purchased (whether over the counter, in the gym, or at the doctors' office) creates confusion between health (our broadly-defined well-being) and medicine (institutionalized treatment from professional practitioners).

While medical intervention can provide people with critical treatment, the above examples illustrate that our level of health is not so simply the function of the availability of medical services but more the result of deeper social, political and economic forces that shape our lives. Genevieve's poverty as a result of globalization and gender inequality, Carmelita's inability to produce adequate food as a result of deforestation, and Cristina's deterioration as a result of poor conditions and lack of medical services are all examples of these structural forces. Each woman's state of health has less to do

NICARAGUA
Indigenous Land, Culture & Health

Denslow Brown

For Nicaragua's Indigenous Peoples, the destruction of local ecosystems means the loss of traditional food sources and medicines.

- **Nicaragua's maternal mortality rate is 124 per 1,000 live births, as compared to 8/1,000 in the US.**
- **One in every three adult women suffers from anemia.**
- **Two in every three children suffer from, or are at risk for, vitamin A deficiency.**
- **Only 12% of the rural population has access to safe drinking water.**

The Nicaraguan Revolution created great strides in public health, improving immunization coverage, lowering infant mortality and increasing access to health care. But since the electoral defeat of the Sandinistas in 1990, many of these gains have been reversed. Women's reproductive health, in particular, is threatened by the resurgence of the Catholic Church as a force in policy making. And the racism and neglect that has long characterized government treatment of Nicaragua's Indigenous and Afro-descendant Peoples is ongoing. The Atlantic Coast of the country, home to most of these communities, still has the nation's worst health indicators: almost three-quarters of the population suffers from malnutrition, and maternal mortality rates are double the national average. Since the devastation of Hurricane Mitch in 1998, national development strategies have been narrowly focused on industrial reconstruction in the hopes of attracting foreign investment. Health crises in poor communities, including a sharp rise in cholera, malaria and leptospirosis, continue to be ignored by national policy makers.

Moreover, the rich tropical rain forests upon which the area's population depends are being destroyed. Nearly 400 small communities of Miskitu, Sukawala and Mayagna peoples are threatened by mining and logging companies that have recently stepped up their take-over of indigenous lands. The Nicaraguan government has already granted multi-national corporations control over 40% of the country's natural resources. Indigenous Peoples have always relied on local forests and lagoons for food and fresh water. But increasingly, when people go out to fish, hunt, haul water or cultivate lands, they are confronted with armed police protecting newly privatized property. For Indigenous Peoples, the loss of their lands means the destruction of their cultures, with grave consequences to health. For example, the ruin of local food sources, coupled with aggressive marketing of processed foods like bread and cola, is undermining traditional diets and worsening malnutrition. Cultural disintegration brings on social devastation that gives rise to health hazards like domestic violence (already the number one cause of injury to women worldwide) and drug addiction. The Awas Tingis community is combating the assault on its collective rights and resources and challenging the government's sale of its territory to the SOLCARSA lumber company. This landmark case, based on Nicaragua's 1988 Autonomy Law, which recognizes indigenous property rights over communal lands, will have ramifications for indigenous land struggles throughout the hemisphere.

Jonathan Snow

irls produce most of the world's food. Yet worldwide, over
ult women are disabled as a result of girlhood malnutrition.

CORRECTION

There was a misprint about maternal mortality rates in our reference source on the website of the Pan American Health Organization. The maternal mortality rates on pages 4, 6, 8 and 10 should read "per *100,000* live births" rather than "per *1,000* live births."

We apologize for the error.

a sharp illustration of the matrix of social inequalities that interact to claim the lives of more than half a million women each year. Pregnant and childbearing women die because their reproductive rights are violated, their asic nutrition is compromised and eir access to medical care is denied as result of gender inequality. Women e because they have been subjected colonization and racism; in atemala, maternal mortality among igenous women is 83% higher than ong non-indigenous women. And men die because public health bud in the poorest countries have been hed by US-required economic poli today, a full 99% of maternal ities occur in developing countries.

HREATENING WOMEN'S HEALTH

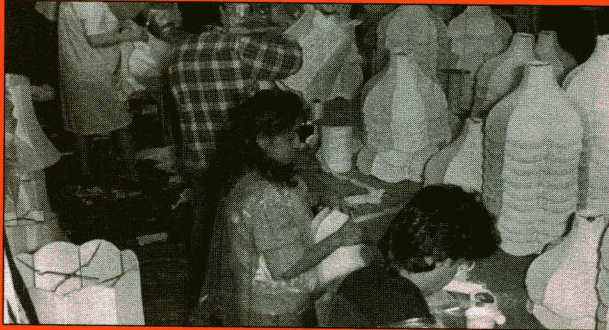
GENDER INEQUALITY

Inequality between men and women is a major threat to women's health, as evidenced by the role of reproductive rights in society. The denial of reproductive rights has long been used to control women within families and communities, with severe consequences to health. Data from the World Fertility Survey show, for example, that if women controlled their fertility, births would decrease by about 35% in Latin America, where over half of all maternal deaths result from unsafe abortions. The manipulation of women's reproductive health is also a tool of international policy. Madeleine Albright, in her first public appearance as Secretary of State in 1997, explained why "family planning is an important component of United States' foreign policy" (*New York Times*, 2/12/97). Albright emphasized the importance of "stabilizing population growth rates" in developing countries, and assured Congress that "family planning programs serve our broader interest by elevating the status of women… and reducing the flow of refugees." Her comment spans both the rhetoric and the reality of US interest in women's reproductive health. While concern about "the status of women" is often invoked by government officials and development experts, the dominant approach to women's health remains instrumental, with women's bodies serving as sites for policy objectives like regulating migrations and controlling the growth of certain labor forces.

Access to food also varies between men and women. Nutrition is probably the single biggest factor in assuring good health. Yet, most women and children are less likely to receive protein-rich foods when they are available,

GUATEMALA

Maquilas & the Military Threaten Women's Health



Maquila workers

- **The maternal mortality rate is 190/1,000 live births.**
- **91% of all indigenous (and 45% of non-indigenous) Guatemalans live in extreme poverty (i.e. survival on less than $1 a day).**
- **84% of girls under six suffer from malnutrition.**

For women in the slums around Guatemala City, health hazards emanate from both their workplace and their community. Export manufacturing sweatshops, or *maquilas*, are emblematic of Guatemala's new role in the global economy. They are also notorious for endangering workers' health. Eighty percent of *maquila* workers are young women who work longer hours than men, are paid half the wages and endure harsher conditions. Many suffer upper respiratory infections, chest pain, rashes, depression, memory loss and numbness from exposure to toxic materials. In Guatemala's numerous textile factories, many workers sustain permanent lung damage from textile dust. Others live with chronic pain from the repetitive manual work of sweatshop labor. Stress is sometimes the biggest health threat, exacerbated by poverty wages, humiliation and physical violence including sexual assaults, strip searches, violence against union organizers and the forced consumption of amphetamines to increase output.

Many of these young women are migrants who have left behind their rural communities, along with healing traditions and social networks that help maintain good health. They live nearby the *maquilas* in overcrowded slums like the three communities that have sprung up on Guatemala City's garbage dump. Like people everywhere in poor, unplanned urban areas, these families have no sewage, sanitation facilities or other municipal services that protect public health. Cholera from contaminated water; parasites and skin diseases from insect and rat infestations; and chronic bronchitis and asthma from dust-containing fecal matter and industrial pollution generate life-threatening conditions in these communities.

A climate of rising political violence and insecurity further threatens women and families in the slums. Violent crime has recently become epidemic. And in just the first half of this year, over 200 acts of political intimidation and violence were reported by Guatemalan human rights and labor organizers, journalists, community activists and public prosecutors. These are the core of people working to ensure that the social provisions of Guatemala's 1996 Peace Accords — including some basic guarantees for health care — are respected. Many now fear that President Portillo seeks to violate the Accords by using the rising crime rate as an excuse to gradually reintroduce military rule to the country. Portillo's proposal to increase the army's role in civilian law enforcement is strongly favored by President of the Congress Rios Montt, who spearheaded Guatemala's genocidal campaign against the indigenous Maya during his stint as military dictator from 1982-1983.

Rather than oppose this violation of the Peace Accords, the US continues to back Guatemala's military to the tune of over $3 million a year. Recently, President Clinton proposed to increase this funding and provide training for more Guatemalan forces at the School of the Americas (the US center for training Latin American soldiers, including those responsible for grave human rights abuses). Five years after the signing of Guatemala's Peace Accords, the deep inequalities that fueled decades of popular resistance are still in place. As in the 1980's, the US provides and supports the mechanisms of violence and intimidation that enforce structural injustices in Guatemala.

and their nutrition is the first to be sacrificed when food is scarce. As a result, most of the 840 million people in the global South (and 11.2 million in the US) who go hungry everyday are women and girls. Where women control a bigger portion of family resources, they and their children are more likely to eat well.

Women receive less medical care than men. In most of Africa, roughly equal numbers of men and women suffer from AIDS, but almost all hospital beds are filled by men. In Latin America, user fees at privatized clinics and hospitals have meant that millions of women can no longer afford treatment. While men are also affected by privatization, women's lower status means they are less likely to have access to the little care available. Furthermore, the policy creates a special burden on women. Privatization of health services, unlike that of transportation or utilities, usually means privatizing responsibility and management of the system, rather than literally selling enterprises. The unspoken assumption is that women, whose unpaid labor is deemed unlimited and cost-free, will care for those who can no longer afford medical care. In fact, women now provide 75% of health care in developing countries. Along with this silent expectation is an unasked question: who will care for the millions of women made even more vulnerable to sickness and infirmity by worsening poverty and added workloads?

Worldwide, women work twice as many hours as men. Economic policies like those that have decimated health systems in the global South have forced millions of women into dangerous and unhealthy jobs in sweatshops, factory farms, informal economies, exploitative domestic environments and the sex industry. The full-time task of caring for and maintaining their families and households adds to this already tremendous strain. The health consequences of overwork, including severe physical and psychological stress, remind us that rest, pleasure, and time for oneself, friends and family are not luxuries for anyone, but are necessary elements of health that are denied to millions of women worldwide. Wealthier women are also affected by gender discrimination in medical treatment. For example, in the US, women are subjected to over-medicating (nearly two-thirds of pharmaceutical drugs are prescribed to women); inappropriate medicating (women are twice as likely as men to receive mood-altering drugs for problems like depression and anxiety, whose causes may be social); and high rates of unnecessary surgical procedures (especially hysterectomy and Cesarean section).

MADRE-supported Klinik Fanm in Haiti provides medical care, human rights education and leadership development through programs shaped by the needs and hopes of community women.

Margaret Ratner

RACISM

Racism is a major source of stress-related illnesses and violence in the lives of targeted peoples worldwide. For millions of people, racism is also a serious obstacle to obtaining needed medical care. Throughout much of Latin America, the ongoing destruction of indigenous cultures has meant the loss of traditional healing and healthcare practices. Meanwhile, indigenous women are effectively denied access to most public services, including medical care. In fact, the medical system is often a site of disrespect, hostility and even violence towards indigenous women. Many professional health providers do not speak indigenous languages. Indigenous women rarely participate in the design of public health programs, which, consequently, often fail to address their needs. Examination by male doctors is often culturally unacceptable, but the only available option. And in numerous Latin American countries (as well as the US), poor and indigenous women seeking professional health care have been forcibly sterilized.

The history of racism has a palpable effect on the health of formerly enslaved and colonized peoples today.

Laura Flanders

Vivian Stromberg examines the wounds of a woman attacked by paramilitary forces during Haiti's coup d'etat.

HAITI
US Policy Makes People Sick

- **The maternal mortality rate is 460/1,000.**
- **Around 8% of adults in urban areas and 4% in rural areas are infected with HIV.**
- **There is an average of 0.76 physicians per 10,000 people, as compared to 26.5/10,000 in the US and 52.9/10,000 in Cuba.**
- **Tuberculosis, a disease that has been treatable for over 100 years, is the number one infection in Haiti and kills more adults than any other disease.**

As in Guatemala, poor health for many Haitians is rooted in political circumstances fostered by the US. For example, the full role of the US in fomenting and sustaining Haiti's 1991-1994 coup d'etat is still being revealed. This period of violence and unrest degraded the health of an already vulnerable population by increasing assaults, disease and trauma. Rape, torture and permanent disability can become common health hazards in times of war. But the coup also meant shortages of food and medicine and the suspension of most water protection, vaccination and health outreach programs. These conditions led to a rise in measles, tuberculosis, typhoid and complications from HIV infection that continue to plague Haiti. The spread of AIDS in Haiti, as in other poor countries, is directly related to migration and Structural Adjustment Programs (economic policies including cut-backs in government spending to enable debt repayment). By 1991, five years of Structural Adjustment Programs (SAPs) in agriculture had displaced millions of peasant farmers who migrated to Port-au-Prince in search of work. High rates of HIV infection in poor city neighborhoods spread throughout the countryside during the coup, when nearly half of all slum dwellers fled the city to escape political violence.

The few health clinics that managed to stay open during the coup reported a staggering rise in psycho-social disorders like depression, anxiety and post-traumatic stress disorder. Such problems are common in communities besieged by war and violence. In fact, mental health disorders are increasingly associated with powerlessness and oppression and quickly being recognized as a category of illness that disproportionately burdens poor and marginalized communities.

In 1994, President Clinton, motivated in part by a desire to stop the flow of Haitian refugees to Florida, dispatched 20,000 US troops to Haiti and ended the coup. Eventually, he also allowed Haiti's exiled President, Jean-Bertrand Aristide, to be reinstated. But US cooperation came at a high price: intensified SAPs that benefit US corporations were imposed. Many of President Aristide's proposed reforms, including those aiding the health sector, were nullified by US demands to further reduce public health spending for the poor. New trade regulations pressured Haiti to cut tariffs on US-grown rice (already slashed from 30% to 3% during the 1980's). Imports of cheap US rice increased 27 fold, bankrupting more farmers and causing an alarming rise in hunger and despair throughout the countryside. Today, Haiti is forced to import half of all its food — the highest percentage in the western hemisphere. And its health indicators continue to reflect the high levels of inequality and political insecurity exacerbated by US-imposed economic policies.

For example, the roots of Haiti's public health crisis can be traced directly to its history of slavery. In 1804, when Haitians finally won independence from France and ended slavery, nearly all of the European doctors who "tended" the slaves left the country. Indigenous health practices were annihilated along with the Arawak people and much African knowledge of health and healing was lost to slavery. Haiti was left with virtually no health system. Since independence, US economic blockade, invasion, occupation and devastating economic policies have undermined Haitian efforts to develop a public health system. Today, racism continues to reinforce the assumption among many in the US that Haitians are incapable of either self-government or managing public health.

Jonathan Snow

Poverty means not only material deprivation, but also the denial of social resources like health care and a lack of basic choices about one's life.

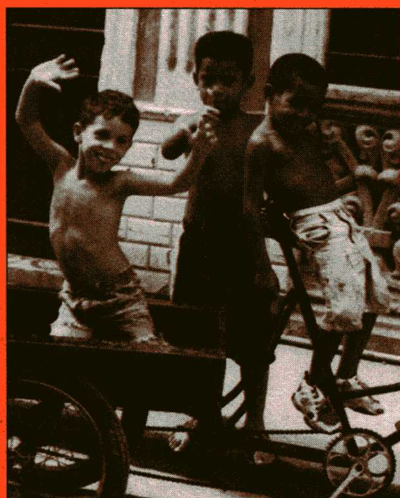
POVERTY AND THE GLOBAL ECONOMY

Wealth once amassed through slavery and colonization is today generated via economic policies imposed by the US and other Northern governments on former colonies. Today, poverty is the root cause of most people's poor health. It is the main reason that people go hungry, can't vaccinate their babies and lack clean water and sanitation. And poverty is a major contributor to serious public health problems like violence, mental illness, stress and substance abuse. Seventy percent of the world's poor are women, millions of whom suffer from intestinal parasites, skin diseases, malaria, measles, diarrhea, ulcers, hypertension, malnutrition, typhoid and tuberculosis. Diseases once thought to be nearly eradicated, like polio and Hansen's disease (leprosy), have returned to plague poor communities around the world.

The economic trend is directly related to policies that undermine public health. Debt servicing, for example, (interest payments on money owed to rich countries) eats up a larger share of many national budgets than health care. Today, thirteen million children die annually from preventable illnesses, 97% of them in heavily indebted poor countries. And while less than half the people in the world's 46 poorest countries have access to health care, US-based HMO's (health management organizations) make huge profits running the newly-privatized health systems serving those who can still afford treatment.

The frightening regression in health and health care contrasts sharply with encouraging media reports about increased life expectancy and breakthroughs in medical technology. In fact, there have been important recent advances in medicine, but the good news benefits mainly the world's elites. Countries where most poor people live now carry 90% of the disease burden, but have access to only 10% of the world's health resources. One source of the disparity is the pharmaceutical industry, which has little profit motive for developing treatments for diseases of the poor, like malaria and tuberculosis. Even drugs for diseases that mainly effect poor people, like AIDS, are often priced too high for the majority who need them.

Mirroring the growing gap between the global North and South, the health of people of color in the US compared with whites is worsening. Privatization of health care, first initiated and now most advanced in the US, has meant less access and lower quality health care for poor communities of color. This deprivation has a special impact on women, who use the US medical system twice as often as men because we are so often responsible for the care of children and the elderly. Life expectancy and infant mortality in some US communities of color are now worse than in some developing countries. The biggest risk to babies is low birthweight, which is largely preventable, but requires precisely the kind of investment in education, reproductive health services and food assistance programs that have been eroded by policies like President Clinton's 1996 "welfare reform" act. Even within the same economic class, black babies die at higher rates than white babies — a testimony to the compounded effect of poverty and racism.



Kate Clouse

CUBA

A Picture of Possibility

- The maternal mortality rate is 33/1,000.
- The life expectancy rate, 76.1, is higher than in most Latin American countries (the US life expectancy rate is 76.8).
- The daily per capita calorie supply is 135% of the daily requirement.
- Nearly 100% of all births are attended by trained personnel and 99% of infants receive basic immunizations.

Mainstream economists and policy makers claim that high rates of disease and infirmity are unavoidable in poor countries. They argue that public health can only be improved by increasing Gross National Product (GNP; the value of goods and services produced by a country in a year) through policies like free trade, downsizing government and deregulating controls on corporate conduct. And yet, even in the few countries where such policies have increased GNP, public health has generally worsened along with inequality. Conversely, the case of Cuba demonstrates that high standards of health and health care are indeed attainable in poor countries — if the government prioritizes health. Cuba's outstanding public health record derives from the government's understanding that health is the responsibility of the state. Free, comprehensive and high-quality health care is guaranteed to everyone, as are the education, food and other resources needed to maintain good health.

The biggest threat to health in Cuba, in fact, is the US embargo. In 1989, with the dismantlement of the Soviet Union, Cuba lost 85% of its foreign trade. The US exploited the economic crisis by escalating the embargo and intensifying pressure on Cuba's healthcare system. Throughout the 1990's, medicines, health supplies and equipment — ranging from pens and paper to advanced technology — became even more scarce. Incidence of certain illnesses increased markedly. For example, without replacement parts and other inputs for water treatment facilities, the percentage of Cubans with access to chlorinated water dropped from 98% to 26% between 1988-1994. As a result, rates of infectious disease and parasitic infection rose, as did death rates from tuberculosis, typhoid and diarrheal diseases.

But even during the worst years of crisis (1989-1993), the government guaranteed that vulnerable sectors of the society did not bear the brunt of the embargo. So while millions of Cubans have endured hunger as a result of food shortages, equitable food distribution policies ensured that scarcity meant weight loss for most adults, not malnutrition for children and the poor. Similarly, while the 1990's saw a rise in low birth weights, Cuba's National Low Birth Weight Program prevented increased infant mortality. Indeed, despite the embargo, overall Cuban mortality rates are low, even compared to the US. But needless sickness and death remain particularly appalling in a country with both the capacity and the political will to provide quality health care to all, but whose government is hamstrung by US policy.

THE WORLD BANK TAKES OVER HEALTH CARE

A look at the World Bank's growing role in health care gives an indication of how macro-economic policies shape public health. Twenty years ago, the World Bank had no say in health policy. Its mandate, after all, is to ensure that countries repay their foreign debt. In this capacity, however, it often "helps" governments to cut expenses by scaling down health systems. Today, the Bank outsizes even the World Health Organization (an independent agency of the United Nations) as global health policy maker. The World Bank is now the single biggest funder of health systems in many poor countries and actually designs the national health policy of many governments.

The World Bank's approach to "restructuring" health care relies heavily on non-governmental organizations like the community-based women's groups that MADRE supports. These groups are now expected to deliver the health care no longer provided by government. Indeed, around the world, women's organizations are filling the role of government in creating and running community health clinics, battered women's shelters, AIDS education programs, nutrition classes and more. These efforts are a powerful expression of women's abilities, resourcefulness and sheer hard work. But even the best local organizations are no substitute for responsible government nor should they have to be.

World Bank pressure on poor countries to cut public expenditures is immense; once governments are dependent on the Bank for new loans, they easily become captive to its policy demands. Often, governments implement cutbacks at the expense of poor and minority communities, while protecting the interests of their national elites. To challenge this injustice, local activists need to respond at the community level to provide critical services; at the national level to hold their governments accountable to meeting people's basic needs; and in the international arena to demand macro-economic policies that respect human rights, including the right to health care. That's why MADRE's International Advocacy Program provides our sister organizations with training and concrete opportunities to address local, national and global issues in an integrated fashion as they work to defend women's human rights.

Elena Arengo

Cuba's national breakfast program for the country's children demonstrates that good public health is attainable if it is a government priority.

HEALTH CARE IS A HUMAN RIGHT

An impoverished country by most standards, Cuba's excellent health indicators show that an equitable distribution of social and material resources is even more important than absolute wealth in influencing public health. But usually the policies that produce inequality (and generate riches for a small minority) are overlooked in public health outcomes. Instead, local and cultural factors are highlighted. For example, as Dr. Paul Farmer, long-time health advocate of the poor and co-founder of Partners In Health, points out, the main lesson to be learned from Haiti's exploding HIV rate in the early 1990's was that AIDS will ravage societies with high levels of poverty, instability and inequality. Today, the toll of the disease in Haiti and sub-Saharan Africa testifies to this grim reality. But in both Haiti and Africa, much of the US medical establishment sought causes in what it considered to be "exotic" sexual and ritual practices of local peoples and "genetic" factors based on race.

Similarly, many large health agencies believe that "culturally sensitive education" is the best guarantee of halting HIV transmission. While culture is always a facet of human behavior, economic necessity, not culture, is the biggest reason women enter into multiple sexual partnerships or barter sex for food and shelter. In fact, poverty and gender inequality are the primary enhancers of risk for exposure to HIV. For many women, the immediate need to guarantee survival for themselves and their children forces them to face longer-term dangers, including HIV. Conventional wisdom about the spread of AIDS tells us that women are at risk because they do not

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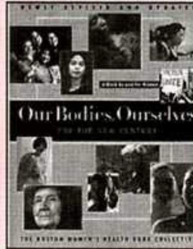
Chiapas, Mexico

use condoms. Yet without the resources to live independently of men, women lack the power to negotiate condom use (and relationships with men in general). Facile notions of "personal choice" and "free will" similarly underlie notions that poor people "have bad eating habits," or that people whose communities lack sanitation facilities are at fault for the diseases and infections that plague them.

Rather than blame marginalized people for their own sickness and infirmity, we need to target conditions that deny people the personal agency to make the best choices for their health. Having this degree of control over our lives is linked to our power in other realms, like land use, systems of production and the political and legal frameworks in which we live. Like all human rights, guaranteeing optimum health for women and families ultimately means maximizing women's opportunities and abilities to make decisions and play leadership roles in our families, communities, countries and in the international arena. ✦

From the MADRE Bookshelf

Our Bodies, Ourselves for the New Century is an updated edition of a founding text of the women's health movement by the Boston Women's Health Collective. In a plain and powerful voice, it explores personal and political issues surrounding women's health, including violence against women, sexuality, race, sexual health, body image and holistic and biomedical care. This book is both a valuable health resource for individual women and a cogent analysis of the social, political and economic factors that shape women's health worldwide. (www.SimonSays.com)



In *Dying for Growth: Global Inequality and the Health of the Poor*, editors Jim Kim, Joyce Millen, Alec Irwin and John Gershman examine the complex relationship between global economics and poor people's health. Containing vivid case studies about under-served communities and broader analyses of political and economic issues, this book profoundly illustrates the ways in which global inequality jeopardizes the health and welfare of marginalized communities. (www.commoncouragepress.com)

The World Family Cookbook, published by the Boston University Hubert H. Humphrey Fellowship Program, contains 100 delicious, international recipes from nearly as many countries. Created as a part of a global effort to raise funds and awareness for "children of war" in Africa, the book will benefit Rwandan children left as the sole caregivers of younger siblings and as adoptive parents of abandoned infants. Proceeds from the book will help establish an agricultural center, purchase necessary farm tools and provide psychological counseling for these children. (www.bu.edu/hhh/cookbook/)

UPDATE ON COLOMBIA

by Victoria Maldonado

As a Colombian living in the United States, I have experienced directly North Americans' perspective on Colombians, an attitude which reflects the mainstream media propaganda and state policy in blaming Colombia for the US's pervasive drug problem. The primary focus of US policy makers towards Colombia since the mid-1980's has been the war on drug trafficking, while the country's widespread poverty and undemocratic political structure — the roots of a decades-long internal conflict — have been neglected. The US has worked to further militarize the country in the name of the drug war, exacerbating a violent internal conflict; over the last 11 years, as Colombia has become the largest recipient of US military aid in the hemisphere, it has simultaneously developed the worst human rights record.

In 1982, the year I left Colombia, the country was already showing signs of today's deeper crisis. The MAS, or "Muerte a Secuestradores" (Death to Kidnappers), a nefarious right-wing death squad organized by drug traffickers and rich landowners, was just beginning its activities. It targeted anyone it found "guilty" of having anything to do with leftist guerrillas, including judges, human rights activists, grass roots organizers and opposition and Indigenous leaders. The use of paramilitary groups like MAS, who are not only tolerated by the government, but have deeper relations with the Colombian Armed Forces, became so widespread that in 1999 these irregular forces carried out a massacre every other day. The Colombian Commission of Jurists notes that since 1993, human rights abuses committed by the guerrillas have remained more or less constant, at about 25%. But responsibility for much of the remaining 75% of abuses has shifted from state security to paramilitary forces. Unlike government troops, the paramilitary groups are not easily held accountable for human rights violations. This shift has therefore helped the US evade criticism for funding the Colombian army.

The result of this dirty war can be seen mostly in the countryside, where entire communities have been displaced as a result of paramilitary activity or guerrilla combat. The internal refugee population today is almost two million — 1.5 million in the last five years — of whom 75% are women and children. Communities forced to relocate to refugee camps or urban shanty towns are mainly poor peasants, and many of them are Afro-Colombian or Indigenous Peoples. Like displaced persons elsewhere, they have experienced a breakdown of their families, economies

WHAT IS "El Plan Colombia?"

Last summer, in a sharp escalation of the joint US-Colombian "drug war," President Clinton signed a $1.3 billion aid package known as Plan Colombia. The Administration presented the plan as a human rights and development initiative, but in fact, 80% of the funds are dedicated to military purposes, making Plan Colombia the largest US military enterprise in all Latin America.

Funding was initially contingent on Colombia meeting certain human rights conditions: holding members of the military accountable for abuses; trying violators in civilian courts; ensuring public officials' cooperation with human rights investigations; and ending the military's links with paramilitary forces. But a loophole in the law allowed President Clinton to simply waive these stipulations, based on the notion that drug trafficking from Colombia threatens "US national security." The waiver sent a clear message to the Colombian government that human rights abuses are no obstacle to securing US funding.

In early 2001, the US President will again decide whether or not to waive human rights conditions as a prerequisite for more aid to Colombia. US corporations, including helicopter manufacturers Textron and United Technologies, Occidental Petroleum and tobacco giant Philip Morris have all lobbied for phase two of Plan Colombia. The funding will likely be released (although Colombia has still not met human rights conditions), further escalating US intervention in Colombia's counter-insurgency war.

and cultures, and the aid provided to them has been minimal.

The US-backed drug war, with its emphasis on military solutions, has failed to curtail the flow of drugs into the US. Meanwhile, Colombians are being killed at a rate of 30,000 a year. Nevertheless, the US and Colombian governments are escalating their joint drug war through the so-called "Plan Colombia" (see box, page 13).

US media's headlines about "drug violence" have obscured the fact that the US is funding a civil war and making Colombia safe for US business interests, such as oil, coal and companies profiting from the vast bio-genetic resources of the country with the largest bio-diversity in the world. Meanwhile, drug abuse remains a major public health crisis in the US, where national resources are being allotted to military intervention rathe than effective remedies. ✦

VICTORIA MALDONAD
CO-FOUNDER OF COLOMBIA MEDIA PROJEC

For more information on the situation in Colombia contact:

COLOMBIA MEDIA PROJECT
P.O. Box 1091 • New York, NY 10116
212/802-7209 • mmcompa@igc.org

MADRE Speaks Out Against Nurse's Deportation From Nicaragua

In December 2000, MADRE issued the following letter to the US State Department, protesting the Nicaraguan government's intent to deport Dorothy Granada, a nurse and long-time health advocate of poor women and families.

Visit MADRE's website, www.madre.org, for an update on the campaign to support Dorothy and her commitment to providing health care to people in rural Nicaragua.

December 22, 2000

Dear U.S. Ambassador Oliver Garza,

We at MADRE, an international women's human rights organization, are writing to express our grave concern about the pending deportation of Dorothy Granada from Nicaragua. Granada is a nurse and U.S. citizen who has lived in Nicaragua for 11 years, providing critical health care to women in a rural health clinic — the Maria Luisa Ortiz Women's Cooperative Clinic — in Mulukuku, northeast of Managua. At the end of November, she was threatened by President Arnoldo Alemán with deportation after he falsely accused her and the clinic which she founded of treating leftist rebels. The Alemán government has since revoked Granada's residency status, issued a warrant for her arrest and threatened the closure of the clinic. In fear of these terms against her, the 70-year old Granada is currently in hiding.

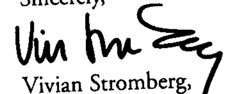
In a country where health care is so scarce and desperately needed, it seems inhumane to expel one of the few individuals who has selflessly and impartially devoted her life to helping an extremely under-served community. We have worked with rural communities in Nicaragua since 1983 and have first-hand knowledge of the critical lack of services available to rural Nicaraguans. Clinics like Granada's often carry the heavy responsibility of being the sole service-providers in their region. Closing Mulukuku's only medical facility and deporting Granada would effectively deny 30,000 Nicaraguans the basic human right to health care.

If the Nicaraguan government was concerned about violations, why not go after the lumber companies that are illegally destroying forests on Nicaragua's Atlantic Coast and dumping pollutants into the water? These companies are denying local communities access to their staple diet of fish and clean water, thereby raising rates of malnutrition and intestinal diseases. Yet the government has chosen to ignore their wrongdoings. Instead, President Alemán is targeting a 70-year old nurse who is committed to improving the health of the very communities that have been devastated by his neoliberal polices. That seems to us very cruel.

Dorothy Granada is in no way partisan to Sandinista patients in her medical practice. Various investigations have confirmed this. Five former members of the anti-Sandinista "contra" army even testified before Nicaragua's National Assembly in support of Granada, praising her and the clinic for having saved their lives. Granada is not a criminal nor a threat to Nicaragua; her sole focus over the past 11 years has been to selflessly provide health care to this impoverished rural community.

We urge you to take a stand against the Alemán government's threatened deportation of Dorothy Granada. Please express your concern to the US embassy for the inhumanity of this action. Rather than being expelled from the country, Granada's expertise should be used by the government to aid them in improving health for the country.

Sincerely,



Vivian Stromberg,
Executive Director, MADRE

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MADRE Volunteers Needed in Nicaragua & Palestine

Nurses, dental hygienists, doctors, masseuses and other health professionals are needed to help launch CADAMUC Clinic, an innovative new MADRE-supported women's clinic on the Atlantic Coast of Nicaragua.

Volunteers skilled in administration, grant writing, office management and media work are needed to help the Ibdaa Children's Center maintain its critical programs in emergency trauma counseling, human rights education and more for children in Deheishe Refugee Camp, Palestine.

Contact MADRE for more information.

Join MADRE Delegations!

NICARAGUA: an eco-tour focusing on Indigenous Peoples and Afro-Descendant communities and autonomy on the Atlantic Coast. **June 9-16, 2001.**

GUATEMALA: a study tour focusing on women's organizing in the *maquilas* to put an end to abusive labor conditions. Learn about working conditions in name-brand clothing factories from the women who work there, and see for yourself the strength of women pulling together to demand their rights. **June 23-30, 2001.**

CUBA: a study tour focusing on the impact of the embargo and life and culture in Cuba. All travel to Cuba is fully licensed. **July 20-26, 2001.**

Come see for your yourself!

MADRE

121 West 27th Street, Room 301
New York, New York 10001
Telephone 212 627-0444
Fax 212 675-3704
e-mail: madre@igc.apc.org
http://www.MADRE.org

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