Women Hold Up Half the Sky

WIPHN News

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"As a woman I have no country. As a woman my country is the whole world."

–Virginia Wolfe

"A healthy city is also a gender-aware city where all efforts are made to remove the discrimination that women face in access to housing, services and jobs."

–Her Highness Princess Basma Bint Talal Jordan

INSIDE

NICARAGUAN WOMEN'S HEALTH: AN EXPERIENCE

In September 1995, I traveled to a rural Nicaraguan "resettlement" community on the Atlantic coastal plain to work as a volunteer registered nurse in a women's clinic. I went to Nicaragua.

Nicaragua continues to be devastated economically and socially following the overthrow of the Somoza dictatorship in 1979 and a US-sponsored war against the Sandinistas that lasted for nearly a decade. The Sandinistas inherited a nation deeply in debt and without governmental infrastructure, for when the Somoza regime fled, it took not only the nation's capital, but its bureaucracy as well. Although the Sandinista government implemented widespread social changes (i.e., the literacy campaign and health brigades) that would benefit the heretofore ignored and underserved poor, these programs were interrupted with the onset of the Contra War only three years after the Sandinistas took power. The war sapped the financial resources available.

After six years of democratic rule by the Chamorro government, the health care system barely exists. The Ministry of Health has no funding and depends on outside financial assistance to meet health emergencies brought on by the extreme poverty that exists throughout Nicaragua, which leads to a myriad of health-related problems. Nicaragua is an area of endemic malaria and parasitical infestations, with the accompanying anemia; recurrent diarrheal and respiratory infections; and high birth rates. Add to this scenario primitive living conditions and malnutrition and a cycle of poor health and shortened lifespan.

Much of Nicaragua is mountainous and isolated. The community in which I lived is located in the foothills, and typically one-third to one-half of the clients seen at the clinic had traveled long hours, even days, to receive med-

ical care. Many rural Nicaraguan communities have state-run health posts, some of which have now been abandoned because of a lack of funding. The majority of those that continue to operate are staffed by unsupervised health promoters and auxiliary nurses. Rarely are these health posts fortunate enough to be staffed with physicians, and when available, they are newly graduated and are fulfilling their required two years of social service prior to licensure. Even when operational, these health posts have no medicines or medical supplies. Our

community's rural health post had a physician for a total of six weeks during the six months that I was there.

This women's clinic, which began some six years ago as a cooperative effort to serve women's health needs, has increasingly found itself absorbing the overwhelming health needs of the entire community, although the staff struggle to give priority to the needs of women.

The majority of the women seen in this clinic have never before had an internal examination, nor have they received a Pap test. The clinic provides these services routinely for women patients. Much effort is directed to ensure that the women return on a regular basis for treatment or yearly exams. Gynecological problems have the highest priority, but the women typically suffer from other conditions which must also be attended to improve overall health.

The community in which I lived and worked is deeply affected by profound poverty and the violence. Organized gangs of bandits as well as individuals target *campesinos* (small farmers) whom they rob and at times kidnap and hold for ransom. Typically this ransom is raised by selling off whatever livestock the family owns. This violence is increasingly forcing the *campesinos* to flee their small plots of land to seek the security of nearby communities, straining already limited resources and further reducing the availability of agricultural products nationwide.

Nicaragua has a high percentage of single-mother households, and the burden on these women, the majority of whom are illiterate and lack the skills to earn money outside of the home, is great. The women are usually limited to selling *tortillas* and *nacatamales* or running small *tiendas* (shops) from their homes.

Infant mortality is extremely high in the rural areas. Although the majority of the women who live in the mountains breastfeed, increasing numbers of young women, exposed to the more "modern" world of the larger towns and cities, bottlefeed. While not encouraged by those in the Nicaraguan healthcare field, women influenced by advertisements in the larger towns and cities feel that bottlefeeding is more "modern" and therefore "better". Unfortunately, the majority of rural families cannot afford to purchase breastmilk substitutes and offer bottles of *atole,* a packaged rice and sugar drink mixed with water that offers no nutritional value. Children commonly suffer ear infections, chronic parasitical infestations, and recurrent malaria, which leads to anemia and infections. Malnutrition and recurrent diarrheal and respiratory diseases are the norm and are the leading causes of death in children under five.

With the advent of aggressive pharmaceutical treatments, drug resistance is highly prevalent, especially in children. At the clinic it was not uncommon to see children under the age of one who had already developed resistance to the readily-available sulfa and penicillin medications. Antibiotics are much in demand and are considered the "magic cure." There is a single-minded focus on acute care and lack of attention to wellness. The resources of the clinic could be used to work in the *barrios* (neighborhoods) to reduce parasitical and diarrheal disease and malnutrition as well as to address family planning and expand the use of traditional plant remedies. To concentrate only on the treatment of acute medical problems and not address the causative factors leads to a revolving door syndrome and dependency on pharmaceuticals whose continued availability is uncertain.

Acute treatment is more effective and long term when it is used in conjunction with community education in the home to alleviate many of the preventable causes of illness. Antibiotics do not address nor eliminate malnutrition and anemia, nor do they address the causative factors of diarrhea.

This project had been in an excellent position to meet the health care needs of the women of this community and, at the same time, train community health workers who would be able to go into the *barrios* and work with the community members, individually and in groups. This is a project that went into a community that had been without health care for some time. It is also a community in an area where traditional plant remedies have not been forgotten but have been ignored in lieu of "Western" pharmaceuticals. It was an opportunity missed that will have a negative effect on the community as a whole when this project leader is forced, by age, to withdraw, as no future planning has been done to ensure continued funding. Nor have efforts been made to further the education or the empowerment of the existing staff.

Funded projects can also take care that they do not become overlarge and over-extended. To do so may lead to the loss of original focus and thus diminish the quality of care provided.

Just prior to my departure, the co-founder of the women's cooperative shared with me concerns that she has about the change in the direction that the clinic has taken and about the feasibility of survival. Sadly stated, "... after six years of aggressive medical treatment, the health of the community is worse." It seems that this is a lesson that can well be utilized by other projects.

Marianne Birenbaum
Tucson, AZ

JOBS

The Institute for Policy Research is looking for candidates to fill two positions:

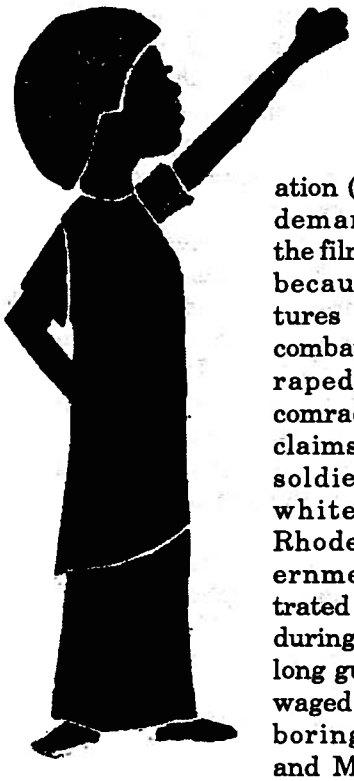
1. Director of Research and Policy Analysis. Senior policy researcher to lead and manage research department. Projects include domestic violence, health care.

2. Study Director - coordinating nationwide research efforts on welfare reform.

If interested contact WIPHN or Jody Burns, Institute for Policy Research, 1400 20th Street, NW Suite 104, Washington DC 20036.

WOMEN'S WAR STORY FILM CAUSES A STIR

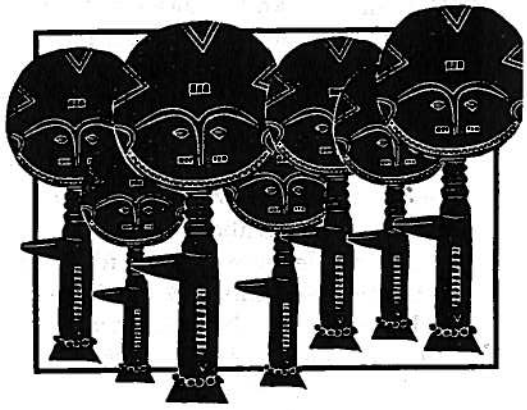
Ingrid Sinclair's film "Flame", is based on 7 years research with women ex-combatants in Zimbabwe. It shows the abuse suffered by women guerrillas in Zimbabwe's war of independence and has male veterans up in arms. Fifteen years after Zimbabwe's independence, this film depicting both the courage and the personal abuse suffered by women freedom fighters has roused a bitter controversy. The Zimbabwe War Veterans Association (ZWVA) has demanded that the film be banned because it features women ex-combatants being raped by their comrades. ZWVA claims that only soldiers of the white-minority Rhodesian government perpetrated such crimes during the decade-long guerrilla war waged from neighboring Zambia and Mozambique.



However, according to Freedom Nyamubaya, a female ex-combatant: "I, Freedom, was raped and that is the truth. A society which denies the truth cannot develop or move forward. And for me to say I was raped is a kind of therapy. We must accept the truth and show what happened."

None of the women she interviewed was prepared to say what they had told her in front of a camera. They thought that it would be dangerous to their jobs and well-being. The fear is still evident, even after Sinclair agreed to make a fictional film grounded in fact. A woman ex-freedom fighter, who asked not be named, said husbands of women ex-fighters might be prompted by the film to seek divorce "because they will start to think that they were all raped."

The film shows how two young village girls, Florence and Nyasha, stow away and join the war, where they adopt the pseudonyms Flame and Liberty. The film revisits the struggle for black majority rule, an era that is now almost history to the younger generation of Zimbabweans. Some 250,000 young Zimbabweans left the country to join the forces of the Zimbabwe African National Union and Zimbabwe African Peoples Union waging a guerilla war from neighboring Zambia and Mozambique. Roughly 10 percent of them were women.



The film flashes from the war of high ideals, made bitter by the personal trials the two women suffered, to 1992, when the two women meet again. They find that they are still fighting for the same thing: their freedom. Sinclair says she "used the struggle for the independence of Zimbabwe as a metaphor paralleling the struggle for the personal independence of women." She stresses that in a film of 120 scenes, only "one of them deals with rape, and four others put a context around the situation of rape. That leaves 115 scenes that are about entirely different issues." The ZWVA's Chirongwe says: "If this film is not stopped, it will give a wrong picture to the people."

"We want to portray a correct picture," adds the woman ex-combatant who asked not be named. "Women went to the war to fight... If the war was about rape, we would have not have fought or even won."

URGENT APPEAL — HAITI

For most women in Haiti, health care is not readily available nor affordable. The few existing health facilities have to concentrate on acute care of the moment, which certainly doesn't include Pap smears or breast exams.

But women in Haiti need what all women need — respectful, holistic, preventive care. Especially since so many women were affected by violence during the coup — rape, torture, mutilation, murder of family members and friends — the care must include mental and emotional support as well as gynecological and medical care and health education.

The Haitian Women's Solidarity Organization (SOFA) began over a year ago to work with its members and other community women in Martissant, a poor neighborhood of Port au Prince, to develop a women's clinic. With strong community participation and a close collaboration with MADRE, a women's project support group in New York, a clinic opened on February 22, 1996.

One of the first women to come for care was a young woman at the end of her pregnancy who had developed very serious pre-eclampsia. She was immediately taken to the general hospital where labor was induced. She delivered before serious complications set in. The young woman came to the inauguration of the clinic two weeks later on March 8, International Women's Day, and introduced her beautiful new daughter, Sofia, whom she had named after the group that had brought healthcare to her neighborhood.

Weeks before the clinic opened, ten Martissant women formed a group to learn to be health motivators in the community. Four nurses worked with them, including two from the US. Besides this on-going course, there is a weekly free blood-pressure clinic and community education sessions. In April, a US nurse who is a specialist in working with survivors of rape and other violence will conduct a two-week intensive workshop in group therapy techniques for a combined group of professional nurses, social workers, and lay community women. Graduates of the course will then start group therapy sessions in the clinic.

Another goal of the clinic is to provide women's human rights education and advocacy, which SOFA has been doing since the coup with many victims in the zone.

The clinic is happy to receive donations of medications, supplies, equipment and education materials in Kreyol or French, suggestions, good wishes — whatever! You can contact us in the US through Ellen Israel, 617-522-4383, or MADRE, 212-627-0444, and in Haiti at SOFA, 011-509-45-84-77.

LETS WRITE THE NAME BY LOVE AND EMBROIDERY
A Call for Action From Bosnia

After conversations with women, we are starting a movement:

"LET'S WRITE THE NAME BY LOVE AND EMBROIDERY." It is well known to all that many people — too many — have "disappeared" in Bosnia. There are reports of "disappeared" persons and their families are looking for them, without facts about them. Soon it will be one year since Srebrenica and four years since our people began to "disappear." Time is passing. *And our dearest are not here, let's write their names again, write by love:*

And that is why we are starting an action "by love and embroidery let's write the name..." For our dearest who have disappeared, for each of them, one by one, we will make a little pillow on which we will embroider their first and last name, year of birth, and place from which they come.

The number of disappeared persons is large. The number of pillows will also be large. We need your help — that is why we are inviting you to participate in this action. Donations of material and thread and/or embroidery of the names will strengthen the action. We are inviting women and women's associations to take part in the action.

For more information contact BOSFAM Tuzla at telephone +387 75 33 559 or write BOSFAM — Bosnian Family, Women of Srebrenica, Amica, Association of Women in Tuzla or email M.STRUYK@ZAMIR-TZ. ZTN. APC.ORG

M. Struyk, Tuzla, Bosnia

ROLLER BALL ELECTROSURGICAL EXCISION PROCEDURE IN TAIWAN

Roller Ball Electrosurgical Excision Procedure (RBEEP) continues to be used in Taiwan despite attempts to control indiscriminate use of this procedure.

A hearing on RBEEP was held recently in Taiwan at the insistence of women's groups. RBEEP is being promoted as a "great invention" to control "menstruation quantity" and to replace "hysterectomy" by burning away the endometrial layer of the uterus.

In Taiwan, after one son is born, a high percentage of births are followed by hysterectomy. The Taipei Association for Promotion of Women's Rights thought it was unethical to promote RBEEP to control menstruation (by partial excision of endometrium) without proper studies (as only 21 women have been studied), and there is not enough supporting literature. Unfortunately the hearing was not successful as the Health Department lacks regulations to enforce the control of modified technology.

The Taipei Association for Promotion of Women's Right (TAPWR) is a grassroots organization which promotes women's health rights, education, anti-family violence in the community. We are the only women's group that is taking the effort to record women's history by launching the "Women Write Women" movement, hoping to construct a Taiwanese women's history. Recently, we were awarded a contract by Taipei Municipal Government to found a Women's Center.

Sue Huang, Chairperson of the Women's Association for Promotion of Women's Rights

Editor's Note: There have been no clinical trials on RBEEP. The July 18,1996 issue of *The New England Journal of Medicine* includes the results of a study on endometrial resection (of which RBEEP is one method) as an alternative to hysterectomy ("Endometrial Resection for the Treatment of Menorrhagia," N Engl J Med 1996 335:151-156). The authors of this study of 525 consecutive women from August 1988 through July 1993 concluded that "endometrial resection is an effective alternative to hysterectomy in women with menorrhagia." The study does not report separate results by the type of method used for endometrial ablation.

An editorial in the same issue cites other evidence that "endometrial ablation results in amenorrhea in about 50 percent of women treated and in decreased flow in another 35 percent" ("Alternatives to Hysterectomy for Menorrhagia," N Engl J Med 1996 335:198-199). The editorial goes on to caution that "the long-term effectiveness of endometrial ablation has been uncertain, however." Hysterectomy eliminates the possibility of future uterine cancer and obviates the need for a progestin, therefore simplifying estrogen-replacement therapy to prevent osteoporosis and cardiovascular disease and treatment of menopausal symptoms.

Also, little is known about the risk of endometrial hyperplasia or cancer associated with hormone-replacement therapy in menopausal women who have undergone endometrial ablation. The costs of endometrial ablation can be a fraction of the costs of hysterectomy. The authors of the editorial conclude that "many women with menorrhagia might seek such minimally invasive types of ablation. *Careful studies of outcomes related to health, cost, and quality of life should be performed before such treatment becomes standard.*"

If you have any information or comments about endometrial ablation and the use of RBEEP, please send it to WIPHN and we'll forward it or print it in the WIPHN News.

Pablo Picasso 1932

HIV IN MALAWI

The HIV/AIDS pandemic has left an indelible mark on the Malawian population. According to a recent press brief at the National Conference on AIDS Crisis in Malawi held in Blantyre, there are three female cases for every male case in the 15-19 age group. One of the primary explanations for such a high incidence among adolescent girls is financial. These girls engage in unprotected sex with older men for money to support themselves and their families. In addition, older Malawian men feel that young girls are pure and "free" of AIDS. This has resulted in increased sexual proclivity in this age group. The AIDS epidemic has exacerbated Malawian women's extreme poverty and gender imbalance.

VISITING A MINILAP CAMP IN NEPAL: Another View

Response to Michelle Leslie's article Visiting a Minilap in Nepal, WIPHN Newsletter Vol 18, Summer 1995

It is my experience (both in my three years as Senior District Public Health Nurse in Nepal, and my year in remote Burmese refugee camps) that supply and distribution of temporary contraceptive methods is a major obstacle to women's access to contraceptive options. Accepting the statistics referred to by Michelle, about 2/3 of women are aware of "pills" and of "injections." For these women, lack of awareness is not the obstacle; nor is lack of formal education the most immediate factor. A combination of "medical barriers", politics at all levels including the Ministry of Health, local authorities and donors, and geographical obstacles combine to obstruct reliable and safe delivery of Family Planning options and services.

One of the women who took our village midwife training (TBA) and who lives about one day by bus plus one day of walking from Kathmandu, asked me to palpate her abdomen to see if she was pregnant. I asked her, "Bisnu, did you not use family planning as you had intended?" She answered, "I used the injection but the next time there was none. Then I used pills, but then there were no pills (at the health post)." She was now pregnant with her fourth child.

Research-based recommendations aimed at reducing/removing medical barriers have recently been developed and are beginning to receive recognition and promotion (see references below). This may improve access to temporary methods from the standpoint of there being more service providers trained in provision of more methods, locally available; however, my present experience suggests that the safety and quality of the services they are capable of producing are questionable. This is related to the politics of teaching/training service providers: who receives training, who decides who receives training, what training program is used, what quality assurance tools are in place, etc. As well, the issue of reliability of supplies, and, of course, referral system when needed, remain problematic.

Many women have asked me to help them have access to a means of contraception, even among those whom the literature suggests would not "want to or be able to" for any of the many socio-economic, political or

cultural reasons. The primary problem in these contexts was a reliable supply, and following that, a safe provider.

Maureen Minden MSc, BScN, RM
Nepal

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Technical Guidance Working Group (TGWG). Nov. 1994, Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting. K.M. Curtis and P.L. Bright, Eds. INTRAH and the Dept. of Epidemiology, University of North Carolina at Chapel Hill.

JHPIEGO. Complete Course in Family Planning (COPF). JHPIEGO Corporation, Baltimore.

CROATIA SEEKS SUPPORT FOR WOMEN'S ACCESS TO SAFE AND LEGAL ABORTION

Since 1978 abortion has been legal in Croatia; however, in 1996 a law was introduced to restrict women's access to abortion so as to increase the national birth rate. Under this law, women would have to consult either a priest, a doctor, or a social worker before they could have an abortion. In this conservative pronatalist state, abortion has become both expensive and restrictive. One hospital already rejects women coming for abortions on the basis of "conscientious objection," even though there is no such clause in the present law.

The women's human rights group "Be active, Be emancipated" (B.a.B.e.), in cooperation with the Young Women in Democracy Program from A SEED-Europe, asks you to write letters of protest to Mr. Franjo Tudjman, the President of Croatia, to members of the Parliament of Croatia, and to the Human Rights Committee of the Croatian Parliament. Please send letters to B.a.B.e., Petreticev trg 3, 10000 Zagreb, Croatia or a fax to 385-1 41 93 02.

PATIENTS FIGHT UNNECESSARY OPERATIONS

The Alliance of Fujimi Ob/Gyn Hospital Victims was organized and is made up of women who suffered from medical injuries at Fujimi Gynecology and Obstetrics Hospital in Tokorozawa-city, Japan.

In the autumn of 1980, Sanae Kitano, the chairman of the Board of Trustees of the hospital, was arrested and charged with practicing medicine without any qualifications. He had diagnosed women with ultrasonic tomography and recommended operations. This event triggered the discovery of numerous problems at the hospital.

Sister Namibia, July & August 1995

After news of Kitano's arrest spread, city hall and the health center were flooded with phone calls from worried patients. Many of these patients were women whom Kitano had advised to have operations for uterine myoma and ovarian cystoma. Other hospitals told these women that there was no need for such an operation. Many women underwent surgery for removal of the uterus and ovaries, and 1,138 cases were reported of women who had a part of their ovaries removed or were admitted to the hospital for a long-term stay after having an operation to prevent miscarriage. Most of these patients had believed the chairman was a qualified doctor. Some had pictures of their extracted uterus and ovaries and brought them to specialists for examination. These specialists found no myomas or cystoma on the removed organs.

The most shocking point about this case was that those unnecessary operations brought no controversy over seven years. Some of the patients had questions about their own operations, but they had no way to obtain the truth about the conditions of their disease and the operation, information held only by the hospital. Some went to the health center, police station, and city hall, but the authorities rejected their complaints, saying that such a big hospital would never make medical mistakes.

The operations were performed by qualified doctors following the chairman's policy. Unnecessary operations are not medical treatment but injury. The Alliance sued the chairman and doctors for bodily injury. However, the trial was never held. The Prosecutor's Office decided that it was up to the medical practitioner's discretion to operate on a patient if he judged it necessary! It was established that Kitano had made big political donations to members of the municipal and prefectural assemblies, Diet members and the mayor. Tens of millions of yen were donated to the Minister of Health and Welfare, the chairman of the Public Safety Commission, and the Minister of Home Affairs. It was rumored that the chairman and doctors were not prosecuted because the donations worked in their favor, although this could not be proven.

One of the reasons that women could not argue the hospital's medical injustice was their lack of information and prejudice against women's bodies. Now some doctors have voluntarily begun to give patients duplicate copies of their medical records, to help patients understand their condition and help them to seek second opinions. The ideas that doctors should supply thorough explanations and obtain a patient's consent before operating are beginning to gain acceptance. The terms "patient's rights" and "informed consent" are being used more often. The medical system has not changed, but the consciousness of patients has widely changed in the wake of this event.

Atsuko Konishi, Alliance of Fujimi Ob/Gyn Hospital Victims
Source: Women and Health in Japan, Spring 1996

CALL FOR PROPOSALS

Private Grants for Field Research in International Health

The Center for Field Research (CFR) at EARTHWATCH has field grant awards that offer volunteers qualified non-specialists, recruited and screened according to your needs. Proposals are accepted and reviewed year round.

Contact person: Acting Program Officer Abby Armstrong, Center for Field Research, 680 Mt. Auburn Street, Watertown, MA 02172, US, or call: 617-926-8200; fax: 617-926-8532; internet: aarmstrong@earthwatch. org; World Wide Web: http://gaia.earthwatch.org/www.html.

VIOLENCE AGAINST WOMEN: CURRENT LEGAL RECOURSES IN JAPAN

Domestic violence against women has been ignored and sayings such as "even the dog ignores family quarrels" are used to explain it away. All lawyers who handle divorces acknowledge that domestic violence is almost always committed by husbands but they continue to ignore it. "Domestic violence" or "mental cruelty" always ranks high among reasons given by women for seeking divorce. One third of the women who have used women's shelters in each prefecture of Japan are those fleeing the violence of their husbands. These official statistics represent only the tip of the iceberg.

Most women have been forced to keep silent. We organized "The Domestic Violence Action and Research Group" and conducted our first national survey in 1992 to ascertain the actual incidence of domestic violence and the effects of that violence on women, to collect information for social structures that could help prevent domestic violence, and to provide a forum for women to talk about their own experiences. We received nearly 800 responses from women throughout Japan with an average age of 43.5; 60% were legally married and relatively highly educated, but the survey was fairly representative by both employment and class.

The incidence of injury by domestic violence is far wider spread and more serious than we could have imagined — 80% of the respondents said they have been injured, and more than 40% have suffered various forms of violence: physical, mental, or sexual. Some were strangulated, threatened or cut with a knife, beaten with a baseball bat or golf club, and various other types of injuries. Life-threatening incidents are a daily occurrence.

Just as with physical violence, other forms of violence were recorded: insult or threat by words or manner, humiliation and fear of neglect or indifference, mental violence such as restrictions on freedom of speech and action, economic restrictions such as refusing to turn over money for household expenses, and sexual violence such as forced sex. The assailants are ordinary men, commonly called "good husbands" or "hard workers." Not all violence was caused by drinking; 10% of the reported cases happened without the women being able to understand why they were being beaten.

Although we prepared ample space for writing answers to this survey, we received some in which the space was insufficient and the answers were continued on second sheets. We couldn't read them without feeling anger. Not all respondents were resolved to live passively without self-assertion, caught up in a feeling of helplessness

or self-hate. Some decided on separation or divorce. However, more than half of all respondents continue to live with their violent husbands.

Why don't they separate if they are abused? In this investigation, we paid attention to this point, but there seems to be no easy answer. We might be able to explain this phenomenon as individual pathogenesis such as codependence or proclivity, but such explanations would put the blame on the women, saying, "you women too must be part of the problem."

The biggest problem, however, is the social fact that it is extremely difficult for women to support themselves in Japan. Moreover, when she makes up her mind to divorce, the husband often refuses (in Japan, the husband must agree before a divorce can take place). Threats may be pointed at the children or the wife's family. Many wives just give up, saying "the only way is to be patient." But even if a wife runs away from her husband, terrible violence may be waiting for her after she is taken back home. Husbands often murder their wives after separation or after the wives have run away.

"It's not an offence for a man to beat his wife or children." This myth is a common belief in Japan. Everyone knows it's a crime to strike another person in public. However, once we step into our house, we're in a place of extraterritoriality. Police policy is "the law doesn't reach into the home." The duty of the police is the "protection of individual life, body and property" (article 2 of the Police Code). If they detect violence, they should treat it as a crime according to the law and do their duty to protect the victims. There are many judges who think that "a little violence" by husbands is unavoidable. They question women closely, asking questions like: "What did you do to make your husband angry?" They search for provocation or rebellion on the part of the wives, but they don't pay any attention to the injury women suffer from violence at the hands of their husbands.

Tamie Kainoh, Japan
Excerpts from Women and Health in Japan, Spring 1996

WOMEN AND CHILDREN ABUSED BY WAR

"Women are often forced to provide sex in exchange for food and shelter in zones of armed conflict," said Dr. Debararti Guha Sapir, Center for Research on the Epidemiology of Disasters, Belgium. In 1995, there were 30 major civil conflicts ongoing in the world, giving rise to over 15 million refugees and 26.5 million internally displaced citizens. Sapir said women and children are most adversely affected by war as "they suffer as a direct result of the event, being the last to leave their beleaguered villages, or because of social inequities in access to food and other services."

A major difficulty facing these vulnerable groups is the diversion of emergency food supplies by the military. In parts of war-torn Africa, it is estimated that only 12% of the food aid reached the civilian victims for whom it was destined. To make matters worse, scores of feeding centers in Liberia, Rwanda, Angola and Sudan are frequently bombed or attacked.

Moreover, in cultures where women play a secondary role, registering for food or actively obtaining medical care or relief supplies are traditionally men's duties, thus denying women access to emergency services. Violence against women has developed into a major crisis, and often women are driven into offering sexual favors in exchange for food supplies, usurped by army warlords. This has had widespread implications for sexually transmitted diseases and unwanted pregnancies. Sexual violence and family welfare issues affecting refugees still remain beyond the pale of relief programs.

"Since the conditions that protect women in a village no longer function in a displaced camp, careful design of shelter, water and sanitation become critical in order to avoid creating further opportunities for sexual or physical aggression," Sapir said.

Siddhartha Prakash
Earth Times News Service

WOMEN'S HEATH ACTION: WHAT YOU CAN DO

- Advocate the development of a national women's rights agenda to include full educational, health and social services
- Advocate a remaking of all laws that continue to oppress women and/or young girls.
- Run campaigns calling for an end to all practices that cause women and girls to suffer.
- Encourage equal love, devotion and care of all children.
- Encourage equal education for all children, boys or girls, rich or poor.
- Actively oppose all customs and laws which mutilate women, whether physically or psychologically.
- Encourage sex education, whether in the home or in the education system.
- Join with other women and on other political platforms, in order to extend women's rights on all fronts.
- As soon as you form a group, make use of all means of struggle: give talks; organize fora, poster campaigns, public meetings; spread leaflets; hold press conferences; use whatever means you think appropriate to spread this message on women's rights.
- You can inform the Women's Global Network for Reproductive Rights of all your actions (no matter how apparently small) at the address: Women Global Network for Reproductive Rights, 1012 RZ Amstersdam, The Netherlands. Tel. 31-20 620 96 72 Fax 31-20 622 24 50

WOMEN'S HEALTH AND PERINATAL DEATHS

Perinatal deaths are inextricably linked to women's status and nutrition and result from inadequate care of pregnant women and newborns. Perinatal deaths can only be reduced when women receive better care, especially skilled attention during delivery, and when the needs of the newborn are better met — hygienic conditions of delivery, warmth, immediate breastfeeding, resuscitation when necessary, and treatment of infections. The number of infants born dead or who die during the first week of life has remained virtually unchanged.

Ninety-eight percent of perinatal deaths occur in developing countries. The rate of perinatal death in developing countries for mothers who are not taking oral contraceptives is from eight to five times that of developed countries, where the rate is estimated to be 11 deaths per 1,000 births. The highest rates are found in Africa (80/1,000 births) and south-central Asia (66/1,000 births). Currently, four out of every 10 babies who die in the first year of life die in the first week. Almost 4.3 million die before or during birth, and another 3.4 million newborns die within the first week of life.

Source: WHO/1996 WHO Home Page: http://www.who.ch

TIME TO STOP THE ABUSE!

As an American raised in Montana, I had not learned the assumptions and survival tactics many women learn as they grow up in a macho-led culture, such as Mexico has accepted for centuries. I had married a Mexican, and my daughter Marita was born in Mexico City.I was shocked and unprepared when I experienced abuse and I did not know where to get help, especially in Mexico. Even after we moved to the United States for a fresh start and marriage counseling, our dysfunctional relationship deteriorated to the point that my husband abducted my daughter and fled with her to Mexico.

I wrote the book, *Marita: Missing in Mexico*, to describe the issues and events that eventually enabled me to bring her back to the USA fourteen months later when she was four years old. I wrote this book hoping it may save someone else the pain I endured for far too long.

Codependent relationships destroy lives. Women often endure abuse because they lack financial support if they leave with their children, or they are reluctant to leave for religious reasons. Yet there comes a time to STOP the negative cycle of abuse. Some situations have such an insidious gradual worsening that those involved may not notice what danger they are in. Children in at-risk homes may think what they endure is normal, when they indeed are being abused.

Any kind of abuse is serious and should be stopped or reported. If you know of abuse, please do report it. You may be that child's or that woman's only hope. The report should include a description of the victim's demeanor, photos if possible, and their own words. You may be in a position to help a woman write a history of the abuse. This will help her and others notice the increase in frequency and severity of the kinds of abuse and threats. Many women want to leave a dangerous relationship, but the threats the abuser holds over them are real: "I will kill you if you leave!", "I will kidnap the children!", or "I will not pay the child support!". When the threats reach this level, it is time to get the victim competent help. Do not let the victims slip through the cracks.

The abused woman needs effective safety planning and may need help to plan her escape to safety. There are so many obstacles to her leaving: the shelters are full, the man has all the money, she has no place to go that he cannot stalk her and find her again, he is holding a gun to her head, many homeless shelters will not take women with children, nobody will listen to her or believe her, she cannot get on welfare because she has no address, or she has no family who will help. Many women are still in denial, are still in love with the abuser, will not recognize the danger, or feel powerless to do

anything about it. As a professional, you may be in a position to open her eyes, suggest some effective options of where she can go or what she can do, and guide her or the police to a needed change.

Following are some useful sources of help for prevention of domestic violence and for handling a crisis:

1. In the USA, call the National Domestic Abuse Hotline: 1-800-799-SAFE.

2. Call 911, local family violence centers, child protection centers, counseling centers, the local health department, or the police.

3. Call the National Center for Missing and Exploited Children: 1-800-843-5678 or 1-800-THE-LOST. In 1988, 354,100 children were abducted by family members in the USA, and 500-600 are taken out of the USA to live. Rarely are the children recovered. This Center sends out excellent free information packets in English and in Spanish, telling what to do if a child has been abducted as well as how to prevent abduction.

4. Call Child Find of America: 1-800-A-WAY-OUT and 1-800-I-AM-LOST. The first number is help for parents, the second is for lost children and those who identify them.

5. Get a personal protection order at the Circuit Court. A woman can get the form and go before the judge the same day for protection. Then she does not have to wait to be harmed before she calls the police. Just calling and saying, "He is outside on the porch now" is enough for them to make the arrest.

Outside the USA, there are international and national organizations. Mothers in Guatemala City whose children have been abducted and held for ransom for drug money, or operated on to sell their body parts, have formed a coalition called "Las Madres Angustias" or the Anguished Mothers. Mothers in Argentina have been politically active for many years for their children who have disappeared. If you look, you can find help in most countries. Too many men get away with domestic violence, and this is the generation to stop it. Too many children are growing up in violent homes. They learn what they live. They act out the violence. When they become parents later on, the cycle of abuse will repeat itself unless more people intervene, hold the abusers accountable for their actions, educate the family, and open doors to better options.

Mari Vawn Tinney
Michegan, US

For an autographed copy of "Marita: Missing in Mexico," send $14.95 plus postage (about $3.50) to the author, Mari Vawn Tinney, P.O. Box 87356 in Canton, MI 48187-0356. To order directly from the publisher, call 1-888-467-4446.

THE SUN ROSE MORE THAN TWICE ON AMINA

UNICEF/Maggie Murray-Lee

Amina was just 17 and expecting her first baby. She had married at 15 but her husband left soon after Amina found she was pregnant. When Amina went into labor but made no progress, her family took her to the nearest rural dispensary, first by cart, then by dugout canoe. She stayed there for the best part of two days — pain, high temperature and low blood pressure and no progress. She was referred to a health post, but money was short so they went home first to their village to try to find more funds. Selling, borrowing and seeking gifts took two more days. Amina was now in extreme distress and barely conscious. They put her on a cart and set off again. The health post they decided on was too far, so they went to another rural dispensary. Fortunately, a nurse was visiting from the district medical center. He was shocked by Amina's condition. He wasn't sure he could help her, but he knew she would die if he didn't, so he decided he might as well try, although he was short of even the most basic drugs and equipment.

Amina was semicomatose. Her temperature was over 40$C, her blood pressure was dangerously low, the head of the fetus was fast stuck in her vulva, and there was a fetid smell that indicated an advanced state of infection. The fetal heart was not beating. The only choice was to perform an episiotomy as quickly as possible and remove the fetus.

The nurse hesitated, only for a moment. He had worked in a city hospital and knew what to do. There were no scissors so the nurse made do with a scalpel, removing a dead male fetus that had already begun to decompose. A perineal suture was followed by a massive dose of antibiotics, the only treatment possible in view of lack of medicines.

There was nothing more he could do. The next task was to get Amina to a district medical center as soon as possible. Amazingly in this area where you go sometimes for days without seeing a vehicle, a car came by and the driver was willing to take Amina to the medical center though it meant a 60 Km trip back to the way he had come.

Several hours later, he resumed his original journey and passed the rural dispensary again. The dispensary staff were delighted to hear that Amina had survived the journey to the medical center. The nurse returned to the district dispensary a few days later to find Amina alive but exhausted. She had survived, but her urine would not stop running. Amina had a vesico-vaginal fistula, a complication of obstructed labor. The urine now flows straight from the bladder to the vagina.

What lies ahead for Amina? At the age of 17, incontinent, smelling of urine, she is likely to end up a social outcast. There is a saying in Niger that "a woman in labor should not see the sun rise twice." Amina saw it rise far more than that, a victim of neglect, delay, poverty, lack of medical resources and poor communications. Sadly, there are many more girls in amina's situation.

Mme Maiga Amsou Amadou,
President of Niger Committee Against Traditional Birth Practices
Adapted and reprinted from Safe Motherhood, *18:11, 1995.*

EDITORIAL:

Dear WIPHN members:

The Safe Motherhood campaign has been rhetoric and more rhetoric.

New estimates indicate that Maternal Mortality is higher than previously thought. Almost 600,000 women die each year in pregnancy and childbirth. And for every woman who dies, approximately 30 more incur injuries, infections and disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong. The issue of maternal mortality and morbidity is the most neglected tragedy of our times. The case report of Amina illustrates some of the problems.

The state of women's health will continue to deteriorate until adequate emergency care for obstetrical emergencies is made available, legal abortion is permitted and the quality of maternity services upgraded. Trained personnel must be made available to supervise deliveries under hygienic conditions.

Unfortunately health care providers are being trained to provide superficial antenatal care by palpation of the abdomen for fundal height and maybe checking fetal heart rate and occasionally measuring blood pressure with no attention to correcting anemia and ensuring rapid transfer for referral and emergency and first aid procedures. Most pregnancies are normal and do not need ten antenatal visits.

Motherhood is not safe. It carries a risk. Motherhood must be made safer. Instead of agencies spending millions of dollars on conferences and meet-

UNICEF/Illas

For women like this one in rural India, health care may be too far, too late, or too expensive.

ings, the money could have been used to help women get to health centers and hospitals. Just helping people recognize obstetrical danger signs and paying for hospital transport could have more impact. The large number of women left with vesica-vaginal fistulae after childbirth must end. It is unconscionable and is yet another indicator of societies' indifference to women.

We are still getting requests for blood pressure measuring devices, speculums and urine dip sticks. This shows how primitive services are. Surely mothers of the nation deserve better. Please send your comments and ideas. WIPHN members can make a difference. Please add your weight to the struggle to make motherhood safer.

WIPHN continues to grow and serve a need. We have members in 89 countries involving a wide range of health care providers.

PLEASE SEND YOUR COMMENTS AND ARTICLES AND ADVISE US OF YOUR ACTIVITIES AND PUBLICATIONS. FOR WIPHN TO BE EFFECTIVE, WE NEED YOUR SUPPORT. LET US HEAR FROM YOU.

Naomi Baumslag MD
President, WIPHN

From: Vitality, Winter 1991/92.

MICROENTERPRISE DEVELOPMENT FOR BETTER HEALTH

Expert Meeting Highlights

The Society for International Development Health and Development Workgroup, in collaboration with the George Washington University Center for International Health and the National Council for International Health, held an expert meeting on Microenterprise Development for Better Health Outcomes.

Participants agreed that women in particular can be empowered by improved economic opportunities and, if combined with education, improved investments in family health. A representative from FINCA pointed out that their village banking programs focus exclusively on providing credit and saving services. However, in their programs in Uganda, FINCA staff had to deal with the issue of AIDS education, if only to enhance the chances of survival for bank members. Save the Children representatives found that it was natural to add credit activities to health education activities in many of their programs.

Although many organizations have experimented with combining income-generating activities such as microenterprise support with health education and/or services, little has been done to document which strategies are most effective in terms of improved health, financial and institutional sustainability, and cultural appropriateness. It is important to determine the appropriate public/private mix when entering into a microenterprise/heath program. Market forces need to be utilized to assure the financial viability of savings and credit programs, and borrowers should be free to invest their loans in whatever enterprise they feel will be most productive. At the same time, health promotion activities may need to be subsidized through government or other sources, although borrowers' increased income may allow them to purchase more health services and may therefore contribute to local health systems' development. Possible negative effects of microenterprise support programs on family health include the risk of micro-entrepreneurs' (mostly women) time being devoted to expanding their business, thereby limiting the amount of time they can spend with their families. Other concerns included addressing how increased responsibilities, such as adding credit programs to health programs, affect the financial and institutional health of the implementing organization.

James Macinko

PUBLICATIONS

Arrows for Change, Women's Gender Perspectives in Health Policies and Programmes, September 1995, Vol.1, No.2, Comments: The Editor, Arrows for Change, Asian-Pacific Resource & Research Centre for Women (ARROW), 2nd Floor, Block F, Anjung Felda, 54000 Kuala Lumpur, Malaysia. Phone: 603-292-9913, fax: 603-292-9958, e-mail: arrow@po.jaring.my.

Bohler, Erik, Impact of Mother's Subsequent Pregnancy on the Previous Child's Health, University of Oslo, Department of International Health, Department of Pediatrics, Ullevaal Hospital, P.O. Box 1130 Blindern, 0317 Oslo, Norway, phone: (+)47 22 85 06 23, fax: (+) 47 22 85 06 72. This is a fascinating report of a study in Bhutan on how growth and morbidity are influenced by birth interval, prolonged breastfeeding, seasonal variations and primary health in Bhutan with a review of the relevant literature.

Breastfeeding Abstracts, November 1995, Vol. 15, No. 2, published quarterly by La Leche League International, P.O. Box 4079, Schaumburg, IL 60168-4079, US.

Breastfeeding Paper of the Month, April 1996, Improving Cost-Effectiveness of Breastfeeding Promotion in Maternity Services, Sanghvi, T., UNICEF New York, Nutrition Section.

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Carter, C.S., Altemus, M., Integrative Functions of Lactational Hormones in Social Behavior and Stress Management, Department of Zoology, Univ. of Maryland, College Park 20742, Laboratory of Clinical Science, NIH, Bethesda, MD 20892, US.

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Child Health Dialogue, newsletter on child health and disease prevention incorporating ARI News and Dialogue on Diarrhea, Issue 1, 4th quarter 1995. AHRTAG, 29-35 Farrington Road, London EC1M 3JB, England. Phone: +44 171 242 0606, fax: +44 171 242 0041, e-mail: ahrtag@gn.apc.org and ahrtag@geo2.poptel.org.uk.

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NU Editorial Office, ICH, University Hospital, S-751 85 Uppsala, Sweden.

Commitments to Sexual and Reproductive Health and Rights for All, Framework for Action, based on relevant international agreements and conventions, including the Beijing, Copenhagen, Cairo, and Vienna conferences, published by Family Care International, 588 Broadway, Suite 503, New York, NY 10012, US. Phone: (212)941-5300, fax: (212)941-5563, e-mail: fci@chelsea.ios.com.

Dialogo sobre la Diarrea, September - December 1995, No. 53, newsletter in Spanish published by AHRTAG, Grupo CID, P.O. Box 39256, Washington, DC 20016, US.

ETHICS, newsletter of the International Network of Feminists Interested in Reproductive Health, Vol. 4, Issues 2 & 3, 1436 U Street, NW, Suite 301, Washington, DC 20009-3916, US. Phone: (202)986-6093, fax: (202)332-7995.

Hesperian Foundation News, Winter 1995, 2796 Middlefield Road, Palo Alto, CA 94306, US. Phone: (415)325-9017, e-mail: hesperianfdn@igc.apc.org.

Journal of the National Cancer Institute, September 1995, Volume 87, No. 17, NCI Information Associates Program, 9030 Old Georgetown Road, Bethesda, MD 20814-1519, US. Phone: 1(800)624-7890 or (301)496-7600; fax: (301)231-6941.

Notes from a Midwife, Robin Lim, Yayasan Anak Bahagia, Happy Child Foundation, P.O. Box 62, Ubud 80571, Bali, Indonesia. Phone: 62-361-974075, fax: 62-361-974739.

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conference summary, July 1995, U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Executive Office Center, Suite 501, 2101 East Jefferson Street, Rockville, MD 20852, US.

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Update, PMM Network, August 1-December 31, 1995, No. 12, Center for Population and Family Health, Columbia University School of Public Health, 60 Haven Avenue B-3, New York, NY 10032, US.

Violence Against Women: A Comprehensive Background Paper, prepared for The Commonwealth Fund, Commission on Women's Health, November 1995, Columbia

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University, College of Physicians & Surgeons, 630 West 168th Street, P&S 2-463, New York, NY 10032, US. Phone: (212)305-8118, fax: (202)305-4063.

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Women's Global Network for Reproductive Rights, Newsletter 51/52, July-December 1995, NZ Voorburgwal 32, 1012 RZ Amsterdam, The Netherlands. Phone: (31-20)620-96 72, fax: (31-20) 622 24 50, e-mail: wgnrr@antenna.nl.

Women's Health Journal, 3-4/1995, Latin American and Caribbean Women's Health Network, Casilla 50610, Santiago 1, Santiago, Chile. Phones: (562)634-9826 and (562)634-9827, fax: (562)634-7101.

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Women's Health Today, premiere issue, a publication from the Society for the Advancement of Women's Health Research, 1920 L Street, NW, Suite 510, Washington, DC 20036, US. Phone: (202)223-8224, fax: (202)833-3472.

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MEETINGS AND SEMINARS

INTERNATIONAL SYMPOSIUM ON PROBLEM-BASED LEARNING, September 21-25, 1996, Durban, South Africa. Network secretariat, University of Limburg, Faculty of Medicine, PO Box 616,6200 MD Mastrict, The Netherlands. E-mail: secretariat@network.rulimburg.nl

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2ND INTERNATIONAL CONFERENCE ON HEALTH AND HUMAN RIGHTS, October 3-5, 1996, c/o Fracois-Xavier Bagnoud, Center for Health and Human Rights, Harvard University, 8 Story Street, Cambridge, MA 02138, US. This conference will bring together people working at the forefront of health and human rights, from grassroots organizations, academic centers, non-governmental organizations, to governmental and international agencies.

8TH INTERNATIONAL WOMEN AND HEALTH MEETING, November 1996, Sao Paulo, Brazil. For more information: the 8th Meetings Commission, Rua Bartolomeu Zunega, 44, 05426-020 Sao Paulo, SP Brazil

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CHILDREN'S HEALTH, CHILDREN'S RIGHTS, ACTION FOR THE 21ST CENTURY. WABA Global Forum, 2-6 December, 1996, Thailand. It will formulate strategies to improve young child health and nutrition in the 21st Century, respecting the rights of women and children. It will be held at a University Campus in the outskirts of Bangkok. Meeting rooms, catering and accommodations at a moderate price. For more information please contact: Susan Siew, WABA Global Forum Coordinator, P.O. Box 1200, 10850 Penang, Malaysia. Phone: 60-4-658 4816, fax: 60-4-657 2655, e-mail: secr@waba.po.my.

16TH INTERNATIONAL CONGRESS OF NUTRITION July 27th-August 1st 1997, Montreal Canada contact person; Dr. Stephanie Atkinson Department of Pediatrics, Room 3V42. McMaster University Faculty of health S Sciences 1200 Main street West, Hamilton, ON. Canada L8N3Z5

NEW WIPHN ORGANIZATIONS

THE WORLD ALLIANCE FOR BREASTFEEDING ACTION

The World Alliance for Breastfeeding Action developed a Global Participatory Action Research Project (GLOPAR) as part of an effort to promote, protect, and support breastfeeding around the world. UNICEF has provided some start-up funding.

The aim of GLOPAR is to stimulate action as much as it is possible to collect information. People and groups, especially those involved with breastfeeding, will work together to ask questions designed both to effect change and to gather information about the status of breastfeeding in their country. This should empower national groups, stimulate networking, identify key obstacles to breastfeeding, help planners and policy makers identify effective national strategies, and develop ways to measure implementation of the goals of the Innocenti Declaration.

GLOPAR is using social research as its vehicle. Social research means that anyone can participate, and that the information gathered will be alive and immediately useful, instead of sitting in some journal somewhere. The central idea of GLOPAR is to see if "simply asking a few questions" will start "a process of change for the better."

What excites me personally about GLOPAR is the feeling of connection with every person in the world who cares about breastfeeding, the thrill of stirring up change in a country (US)

whose state of breastfeeding is the lowest of any industrialized nation, and the sense that an individual can do something to make a difference.

To join GLOPAR, contact WABA, P.O. Box 1200, 10850 Penang, Malaysia. For information about US GLOPAR, contact the National Alliance for Breastfeeding Advocacy (NABA), 254 Conant Road, Weston, MA 02193-1756, US. Phone: (617) 893-3553 or Fax: (617) 893-8608.

Nikki Lee
Pennsylvania, US

THE INTERNATIONAL WOMEN'S DEMOCRACY CENTER

The International Women's Democracy Center was established to provide training, education, research, and networking in all facets of democracy to women worldwide in order to ensure their full participation in the political process within their own countries. IWDC is unique not only in its commitment to train women worldwide in how to run a campaign and how to use computers, but also in its efforts to use the skills of returned Peace Corps volunteers who have served communities around the world. Contact person: Barbara Ferris, President, International Women's Democracy Center, P.O. Box 32243, Washington, DC 20007, US. Phone: 202-965-3124 and fax: 202-965-0432.

TICIME

TICIME organizes meetings between traditionally and formally trained midwives during which they share experiences. They feel a sense of identity in their needs and also by listening and learning from each other. Their aim is to be able to develop training programs and materials which take into consideration mutual views and ideas of rural and indigenous midwives. They give lectures and have developed a network with sister organizations in Mexico and abroad. They want to bring support to grassroots programs in their community. TICIME has a small documentation center and a newsletter, "Conversando entre Parteras" (Conversing Among Midwives). It offers informative talks and classes for expecting and new mothers and parents. Write TICIME, Cda. Flor de Agua 11, 01030 Mexico, D.F., Mexico. Phone: (525)524-1412 and 524-1423.

CALL FOR ARTICLES

The next issue of WIPHN News will deal with issues of women in sex trade and the abuse of women in the workplace, in their homes, etc. Please send your articles to WIPHN News #21, 7100 Oak Forest Lane, Bethesda, MD 20817, USA.

VIDEO

WOMEN'S LIVES AND CHOICES

3 x 28 minutes Color rental $90 Order # 96234

A series which deals with women's health and social and cultural factors underlying reproductive choices. Ventre Livre (Ana Luiza Azevedo) paints a grim picture of life for women in Brazil where sterilization and abortion are often the only forms of birth control available. Rishto (Manjira datta) explores the practice of male sex preference in India and its ramifications for women. The Desired Number uses the Ibu Eze ceremony in Nigeria to highlight how family planning issues often conflict with traditional family values.

Ventre Livre (96089); Rishte (96098); the Desired number (96072). Each program rents for $50. There are copies that can be requested for review.

Contact: Maya Stowe at women make movies 462 Broadway, 5th floor New York, NY 10013. phone: 212 925 0606.

WOMEN'S INTERNATIONAL PUBLIC HEALTH NETWORK (WIPHN)
7100 Oak Forest Lane, Bethesda, MD 20817, USA

MEMBERSHIP FORM

To join, please fill in this form (print clearly) and include your membership fee: $25 for individuals, $50 for organizations.
Organizations or individuals in developing countries who cannot afford the fee, please send cloth or artwork of the same value as the fee.

Name_____

Title/Degree _____

Address _____

_____

Telephone number_____ Fax_____ Telex_____

Current Employer _____

Special Interests _____

Drawn by Jan Pana.

PLEASE REMEMBER TO RENEW YOUR MEMBERSHIP.

WIPHN NEEDS YOUR SUPPORT!

Please send us notices of your publications, news about your projects, and articles for our Let's Change column.

Remember to buy your autographed copies of "Milk, Money, and Madness: The Culture and Politics of Breastfeeding" from WIPHN and support the network.

The Women's International Public Health Network

The Women's International Public Health Network was formed as a grassroots movement at the World Federation of Public Health Association Meeting in Mexico City, March 1987, to provide all women in the field of public health with an opportunity to work together to improve women's health worldwide.

Who Is It For?

Any woman working in public health.

What Are The Objectives?

To serve as a resource network and umbrella organization for women's groups throughout the world in health or health related areas. Through this educational support and communication network, women in public health will be able to maximize their resources and work together more effectively to promote better health for all women.

What Do We Do?

- Provide support to colleagues in the field of public health. Groups in each country share information, experiences, ideas and resources. Colleagues visiting from other countries will find a network of friends.
- Promote women in international public health and identify women's issues such as: safe motherhood and health rights.
- Network with other women's organizations.
- Publish a newsletter that addresses international women's health issues, programs and opportunities.
- Participate in policy development related to women's health and publish position papers on specific issues.
- Serve as an exchange forum.
- Maintain a speakers bureau and sponsor programs, panels, and meetings at conferences.
- Provide technical assistance.
- Offer information on existing training, resources and materials for identified needs.
- Act as a resource for funding information and opportunities for members.
- Research neglected women's health areas.
- Provide employment information through a job bank.

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