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Treating the Revolution: Health Care and Solidarity in El Salvador and Nicaragua in the 1980s

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Treating the Revolution: Health Care and Solidarity in El Salvador and Nicaragua in the
1980s

A Thesis Presented

by

BRITTANY L. MCWILLIAMS

Submitted to the Graduate School of the
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1980s

A Thesis Presented
By
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ABSTRACT

TREATING THE REVOLUTION: HEALTH CARE AND SOLIDARITY IN EL SALVADOR AND NICARAGUA IN THE 1980S

MAY 2020

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Health care played an important role in the revolutions of El Salvador and Nicaragua. Both the Sandinistas and the Farabundo Martí National Liberation Front (FMLN) prioritized popular health throughout the 1980s. Clinics and hospitals served as sites of revolution that drew healthcare solidarity activists from the United States. These health internationalists worked to build community-level networks that relied upon trained medical volunteers. In both El Salvador and Nicaragua, women comprised a bulk of the community health workers. These women chose to interact with revolution by building on radical promises of universal healthcare access. Healthcare solidarity activists trained community volunteers and encouraged women to pursue their own needs within the revolutionary frameworks. Health internationalists actively undermined United States' policies toward Central America. In the 1980s, the United States implemented economic policies and supported military violence that targeted healthcare infrastructure. In training community health workers, treating civilians, sharing knowledge through international exchange, and sending funds and medical supplies, health activists mitigated some of the damage being done. This thesis posits that health care was an important site of revolution for Central Americans and internationalists alike. By choosing to mend

bodies, medical activists stood in direct opposition to the violence of the decade. They also served as fundamental to the revolution because they helped carry out the will of the people. The revolutions rested on the hope of improving the lives of every day Nicaraguans and Salvadorans. As the violence of the 1980s forced the guerillas of El Salvador and the leaders of Nicaragua to focus on war, the people continued to implement revolutionary health goals at the community level. This thesis argues that understanding how health internationalists, women, and community activists engaged revolutionary ideas of medicine is vital to the study of 1980s Central America.

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ABBREVIATIONS

AMES – Asociación de Mujeres de El Salvador (Association of Women of El Salvador)

AMNLAE – Asociación de Mujeres Nicaragüenses ‘Luisa Armanda Espinoza’

(Association of Nicaraguan Women Luisa Armanda Espinoza)

CHRICA – The Committee for Health Rights in Central America

CISAS – Centro de Información y Servicios de Asesoría en Salud (Center for

Information and Advisory Services in Health in Nicaragua)

CISPES – The Committee in Solidarity with the People of El Salvador

CODIPSA – Comisión Diocesana de la Pastoral en Salud de Chalatenango (Diocesan

Health Commission of Chalatenango Province)

FMLN – Frente Farabundo Martí para la Liberación Nacional (Farabundo Martí National

Liberation Front)

FSLN – Frente Sandinista de Liberación Nacional (Sandinista National Liberation Front)

IMF – International Monetary Fund

MCAF – Medicines for Central America Fund

MINSA – Ministerio de Salud de la República de Nicaragua (Sandinista Ministry of

Health, Nicaragua)

NCAHRN – National Central America Health Rights Network

STISSS – Sindicato de Trabajadores del Instituto Salvadoreño del Seguro Social (Union

of Salvadoran Social Security Institute Workers)

USAID – United States Agency for International Development

WP – Witness for Peace

CHAPTER 1

INTRODUCTION

“I understand health care as a window through which one can discover more concretely the multiple layers, old and new, of a society in the revolutionary-controlled zones, forming itself through numerous trials and errors.”¹ -Francisco Metzi

Italian doctor Francisco Metzi first travelled to El Salvador in 1983. After spending three years in the guerilla-controlled territories of the country, he documented his experiences in an attempt “to describe the immense difficulties and the exhilarating successes, the bitter disappointments and the real growth processes” of the Salvadoran people.² Metzi, like so many others who travelled Central America in the 1980s, stood in solidarity with the people and against the United States, by offering his medical expertise. U.S. nurse Susan Classen, too, spent time in El Salvador in the 1980s. Moved by the physical and mental trauma of El Salvador’s poor, she helped treat patients and train health workers at the community level. Others spent time in Nicaragua, where they helped train and disseminate the new health programs of the Sandinista government, and where many helped in the war zones of that country as well. Each person who dedicated their life to aiding the Nicaraguan and Salvadoran people put themselves at risk; this was especially so for those who spent time in war zones and dared to engage in medical practice.

¹ Francisco Metzi, *The People’s Remedy: The Struggle for Health Care in El Salvador’s War of Liberation*, trans. Jean Carroll (New York: Monthly Review Press, 1988 Medical Aid for El Salvador), 2-3.

² *Ibid.*, 1.

Despite the international laws regarding medical neutrality in war zones,³ the practice of targeting healthcare workers and facilities seems ubiquitous in conflict. This fact remains as true in today's conflicts as it was in the Central American conflicts of the late twentieth century.⁴ Despite the dangers, solidarity workers, alongside the incredible volunteers of Central America, worked to provide healthcare services to the civilians most deeply impacted. Both countries went through major civil conflict in the 1980s, which manifested in violence against civilian populations, displacement within the region and abroad, and the explicit targeting of healthcare workers and facilities. Much of this violence was supported and funded by the United States, and the legacy of that violence continues to impact Central America today.

This thesis argues that U.S. solidarity health workers addressed U.S. policy in Central America by healing the very people the U.S. sought to destroy. As U.S.-backed forces intentionally destroyed health systems, solidarity activists built them back up; as

³ Medical neutrality, enshrined in international laws through the Geneva Conventions, requires the protection of healthcare workers and facilities, the unhindered access to care, the humane treatment of all civilians, and non-discrimination in treatment of the injured, regardless of affiliation. For more information, see the International Committee of the Red Cross's database on international humanitarian law, particularly rules 25-29, 35, 55, and 92. See also the Physicians for Human Rights *Introduction to Medical Neutrality*, <https://phr.org/wp-content/uploads/2019/11/Introduction-to-Medical-Neutrality-Fact-Sheet-2013.pdf>.

⁴ Soumitra S. Bhuyan, Ikenna Ebuenyi, & Jay Bhatt, "Persisting trend in the breach of medical neutrality: a wake-up call to the international community," *BMJ Global Health* 1 (2016), <http://dx.doi.org/10.1136/bmjgh-2016-000109>. See this article's conversation on the attacks against healthcare workers and facilities in Afghanistan, Sudan, and Syria spanning from 2012 to 2016. For more reading on recent breaches of medical neutrality in the Middle East, see Zoë Mullan, "Medical neutrality: resetting the moral compass," *The Lancet* 4, no. 4 (2016), <http://dx.doi.org/10.1136/bmjgh-2016-000109> and Adia Benton & Sa'ed Atshan, "'Even War has Rules': On Medical Neutrality and Legitimate Non-Violence," *Culture, Medicine, and Psychiatry*, 40, no. 2 (2016), <https://doi.org/10.1007/s11013-016-9491-x>.

U.S.-backed forces aimed weapons at civilians, activists treated their wounds; as U.S.-backed forces restricted access to medicine and supplies, activists bought and shipped medications to those in need. This work focuses on the activist side of the equation, with careful consideration of where those solidarity workers fit into the revolutions in El Salvador and Nicaragua. Health care was an important site of revolution, particularly for women and the poorest communities of Central America. During the 1980s, healthcare solidarity workers saw this reality and worked in tandem with Central American activists to make the revolutions real for those to whom it mattered most.

Chapter one lays the foundation for this work by discussing background on the conflicts in El Salvador and Nicaragua, considering the existing literature on healthcare solidarity and how this thesis expands upon it, and discussing the goals and methodology of this work. Chapter two dives into the healthcare systems and statistics leading up to and then defining the 1980s. Understanding how each of the acting bodies approached healthcare is integral to the arguments that follow. Chapter three engages many voices of healthcare solidarity and seeks to understand how they understood and navigated their role within a revolutionary system. Chapter four offers a gendered perspective of health care in the revolution by arguing that women embraced leadership in developing revolutionary health systems. Chapter four further investigates ways in which solidarity bolstered women's voices within communities. Chapter five offers a look at how the popular healthcare systems of El Salvador and Nicaragua fared in the early 1990s and in the face of neoliberal policies.

A. Background on El Salvador and Nicaragua

1. El Salvador

“I came to see that the violence in El Salvador didn’t begin with the war. The revolution was like an abscess that burst from the pressure of social unrest.”⁵ –Susan

Classen

The conflict in El Salvador was rooted in the 1920s when Agustín Farabundo Martí Rodríguez, along with a growing number of radical left supporters, helped lead a peasant insurrection against an oligarchical ruling class.⁶ In January 1932, *campesinos* rose up in response to “the transformation of a radicalized union movement that became revolutionary under the pressure of frustration among peasants and rural workers with the violent abrogation of democratic rights, combined with a rapid increase in rates of exploitation and dispossession.”⁷ The massacre that came in retaliation for the uprising resulted in decades of continued repression along with “commonsense notions about the danger of reformism and foreign communist manipulation of peasants.”⁸ Martí and his Marxist-Leninist beliefs became the basis for the Frente Farabundo Martí para la Liberación Nacional (Farabundo Martí National Liberation Front, FMLN), the guerilla group embroiled in violent conflict with the Armed Forces of El Salvador throughout the 1980s. The conflict ended with the signing of the Chapultepec Peace Accords in 1992.

⁵ Susan Classen, *Vultures & Butterflies: Living the Contradictions*, 136.

⁶ Jeffrey L. Gould and Aldo A. Lauria-Santiago, *To Rise in Darkness: Revolution, Repression, and Memory in El Salvador, 1920-1932* (Durham: Duke University Press, 2008), 88.

⁷ *Ibid.*, xxiii.

⁸ *Ibid.*, xix.

The roots of the violence were nothing new in Salvadoran society. In 1982, Americas Watch Committee and the American Civil Liberties Union identified those causes as “the highly concentrated system of land tenure, the denial of basic rights to a peasant majority still prevented by law and practice from forming independent organizations, and a half century of hardline military rule by an army that has traditionally represented the interests of the landed oligarchy.”⁹

The Revolutionary Government Junta of El Salvador came to power via coup on October 15, 1979. The violence that defined the civil war began in 1972, “in the face of 60 percent inflation and 30 percent unemployment,” when a “coalition of opposition parties formed to run against the oligarchy’s official candidate,” Colonel Arturo Armando Molina.¹⁰ Despite the victory of the opposition candidate, José Napoleon Duarte, Molina was declared the winner. “Molina’s government was known for its friendliness to the interests of foreign investors, export companies, landowners, and anyone who supported his repressive rule.”¹¹ These policies exacerbated inequality, which the Salvadoran people protested. The regime violently suppressed protests and silenced prominent figures that spoke out against the military violence. For example, on February 15, 1977, some 200 peaceful protesters were killed in San Salvador; on March 24, 1980, the Archbishop of El Salvador, Óscar Romero, who had turned against the regime, was assassinated while conducting mass; on December 2, 1980, four American church women, three of whom

⁹ *Report on Human Rights in El Salvador: Compiled by Americas Watch Committee and the American Civil Liberties Union*, January 26, 1982, xix.

¹⁰ Teresa A. Meade, *A History of Modern Latin America: 1800 to the Present* (U.K., and Malden, MA: Wiley-Blackwell, 2016), 292.

¹¹ *Ibid.*, 292.

were nuns, all of whom worked with the poor of El Salvador, were raped and murdered by Salvadoran paramilitaries.¹²

The brutality displayed in the 1970s endured through the 1980s, a decade that saw the regime targeting civilian populations living in war zones and guerilla-controlled territories. By the signing of the peace accords, an estimated 75,000 Salvadorans, a majority of whom were civilians, were dead,¹³ and the US had poured over US\$6 billion (US\$4 billion via the United States Agency for International Development, USAID) into the Salvadoran government in attempt to defeat the communist threat.¹⁴ In *The Massacre at El Mozote: A Parable of the Cold War*, Mark Danner documents the United States' complicity with one of the most well-known and horrifying massacres carried out during the war. The brutal assault and murder of the people sheltered in the village of El Mozote in December 1981 was not only a crime against humanity, but it was also covered up by the Reagan administration, which helped train the troops who carried out such horrific acts.¹⁵ In fact, by 1987, under the Reagan administration, El Salvador had become "the only country since South Vietnam in which U.S. aid surpassed the government's national budget. Counterinsurgency training, U.S. military advisers, bombing campaigns, low-intensity warfare, electoral manipulation, subversion of the labor movement – the entire

¹² Ibid., 292-293.

¹³ Ibid., 295.

¹⁴ Adán Quan, "Through the looking glass: U.S. aid to El Salvador and the politics of national identity," *American Ethnologist* 32, no. 2 (2005): 280, <https://www.jstor.org/stable/3805283>.

¹⁵ Mark Danner, *The Massacre at El Mozote: A Parable of the Cold War* (New York: Vintage Books, 1993).

U.S. foreign policy arsenal [had] been used in El Salvador, and the United States [had] become a virtual parallel government in the country.”¹⁶

The low-intensity warfare conducted by the United States in Central America during the 1980s was a reincarnation of “the most repressive aspects of the covert operations and counterinsurgent doctrines of the 1950s and 1960s,”¹⁷ policies that encouraged the Salvadoran Army’s strategy of ‘draining the sea’. This policy aimed to eliminate the support base, and potential support base, of the FMLN by destroying the people and the infrastructure of the war zones. It was, according to John Waghelstein, the leader of the U.S. military’s advisory team in El Salvador, “total war at the grassroots level.”¹⁸ This total war on the ground meant the intentional targeting of health care, healthcare workers, facilities, and those found in possession of medical equipment. The low-intensity warfare of the United States deeply impacted the people of Central America in every way, but the destruction, and attempted destruction, of their health was one particular way that Nicaraguan and Salvadoran citizens suffered most during the decade of violence.

2. Nicaragua

In many ways Nicaragua was the inverse of El Salvador. While El Salvador’s revolutionary movement was being violently suppressed, Nicaragua’s had succeeded; while the Salvadoran government implemented mass violence against its civilians, Nicaragua’s government sought to build a government for the masses; while the United

¹⁶ Metzi, *The People’s Remedy*, xi.

¹⁷ Quoted in Greg Grandin, *Empire’s Workshop: Latin America, the United States, and the Rise of the New Imperialism* (New York: Holt Paperbacks, 2006), 118.

¹⁸ *Ibid.*, 91.

States funneled millions of dollars toward the support of the Salvadoran government, the United States funneled millions of dollars to destroy the Nicaraguan government. Despite the differences, the civilian populations of each endured violence and hardship at the hands of United States' policies. The low-intensity warfare used against Salvadoran peasants also defined the violence in Nicaragua.

Like the FMLN, the Frente Sandinista de Liberación Nacional (Sandinista National Liberation Front, FSLN) in Nicaragua was rooted in politics of the 1920s. Augusto César Sandino led armed opposition to U.S. occupation from 1927 to 1933.¹⁹ Despite the relationship between Sandino and Martí, and though the U.S. labeled him a communist, Sandino “was not motivated by communist ideology.”²⁰ Though the U.S. occupying force did withdraw from Nicaragua in 1933, it left a U.S.-trained National Guard and a president friendly to U.S. interests. On February 21, 1934, Sandino was executed, which set the stage for his name to be used again decades later in advocating for change in the country.

After ordering Sandino's execution, Anastasio Somoza García assumed the presidency, a position he and then then his sons, would hold for several decades. The Somoza era saw the repression of the Nicaraguan people and ultimately led to the formation of the FSLN in 1961. For nearly two decades, the FSLN battled against the Somoza regime in an attempt to install a democratic, revolutionary government. On July 19, 1979, the FSLN successfully brought down the regime of Anastasio “Tachito”

¹⁹ Matilde Zimmermann, *Sandinista: Carlos Fonseca and the Nicaraguan Revolution* (Durham: Duke University Press, 2000), 5.

²⁰ Meade, *A History of Modern Latin America*, 208.

Somoza DeBayle in a victory that reverberated in Central America and terrified the United States.²¹

Nicaragua has long been a hotspot for U.S. intervention. In the mid-nineteenth century, the U.S. was deeply interested in building a canal across Nicaragua. With few exceptions, the United States government occupied Nicaragua for twenty-two years between 1911 and 1933 in a move to give U.S. companies greater advantage in the fruit and coffee industries.²² In the 1920s, Nicaragua became “the site of a struggle over U.S. involvement in international affairs.”²³ When the U.S.-friendly Somoza dictatorship fell in 1979, the United States again intervened in the country by arming and training opposition fighters against the Sandinistas. This group, the Contras, would devastate the Nicaraguan countryside and severely limit the FSLN’s ability to enact real reform.

Not only was the violence of the U.S.-backed Contras detrimental to the FSLN, but from 1981, the United States “blocked \$163.5 million in multilateral loans to Nicaragua, which were intended to fund road and housing construction projects as well as new health facilities.”²⁴ By ending bilateral assistance, blocking multilateral loans and commercial credit, and enforcing a trade embargo against Nicaragua, the Reagan administration forced the FSLN to turn toward the USSR for assistance, and effectively curbed their support for the FMLN in El Salvador.²⁵

²¹ Zimmermann, *Sandinista*, 220.

²² Meade, *A History of Modern Latin America*, 208.

²³ Lars Schoultz, *Beneath the United States: A History of U.S. Policy Toward Latin America* (Cambridge and London: Harvard University Press, 1998), 265.

²⁴ Paula Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, *International Journal of Health Services* 17, no. 1 (1987): 175, doi: 10.2190/DB43-MWPL-2V12-WGXY.

²⁵ William M. Leogrande, “Making the economy scream: US economic sanctions against Sandinista Nicaragua,” *Third World Quarterly* 17, no. 2 (1996): 329-348.

The U.S. actions against Nicaragua in the 1980s diverted money, time, and attention away from developing the healthcare system the FSLN aimed to build. Moreover, the resources that were funneled toward health were more frequently allocated to victims of the Contra war. The low-intensity warfare that the United States waged against Nicaragua, like that in El Salvador, had very real and devastating consequences on the ground. The role of U.S. policy in Central America inspired solidarity in many citizens. These citizens engaged in solidarity at home and, in many cases, by travelling to Central America.

B. Scholarship

This thesis brings together existing scholarship on the conflicts in 1980s El Salvador and Nicaragua, health care under the FSLN, FMLN and Salvadoran government, and Central American solidarity. To date, a thorough consideration of the intersection between solidarity, health care, and U.S. intervention in Central America has not been undertaken. Though health often figures as a minor topic in the work on the Central American solidarity movement, it warrants greater focus. Not only was health care a major target in the violence that besieged Central America, but also many Americans and others from around the world travelled specifically to offer their support by providing medical care and community health planning. The actions of healthcare solidarity workers, those based in the U.S. and those who went to Central America, helped build on the popular health movements supported by revolutionaries. This thesis brings together previous scholarship along with new analysis in order to further illuminate the place of healthcare solidarity in building the revolutions of El Salvador and Nicaragua.

Memoirs comprise a large portion of the written work on Central American solidarity, and those written by healthcare workers and activists give important detailed accounts of the realities healthcare solidarity workers faced. In 1984, Charles Clements, published *Witness to War: An American Doctor in El Salvador*. In this memoir, Clements weaves together his time as a pilot for the U.S. Air Force with his later endeavor to aid the suffering population in El Salvador's war zone. Clement's memoir is both an indictment of U.S. imperialism and a narrative tale of the realities of a foreign doctor on the ground in El Salvador.²⁶ Francisco Metzi's *The People's Remedy: The Struggle for Health Care in El Salvador's War for Liberation* (1988) looks at the experiences of someone who learned the centrality of health care to revolution upon arrival. He came to understand the revolutionary struggle through the building of successful health programs.²⁷ In *Vultures and Butterflies: Living the Contradictions* (1992), Susan Classen expands on her time working as a nurse in El Salvador. She notes, in the first line, that the "book was born of contradictions,"²⁸ and in part, she refers to hope in the midst of destruction, peace and love in the midst of malice and violence, and acts of healing in the midst of so much death. These memoirs illuminate the contradictions and give insight to the lived reality for solidarity workers in Central America. They are vital sources of narrative that give life to the analysis presented here.

A portion of scholarly works focus on US-based solidarity efforts. In *Sanctuary: The New Underground Railroad* (1986), Renny Golden and Michael McConnell write

²⁶ Charles Clements, *Witness to War: An American Doctor in El Salvador* (New York: Bantam Books, 1984).

²⁷ Metzi, *The People's Remedy*.

²⁸ Susan Classen, *Vultures and Butterflies: Living the Contradictions* (Eugene, Oregon: Wipf & Stock Pub, 2005), 9.

about the church's role in keeping refugees safe on American soil.²⁹ Roger Peace's *A Call to Conscience: The Anti-Contra War Campaign* (2012) looks at the battle to end U.S. funding of the violence in Nicaragua.³⁰ Emily K. Hobson considers solidarity of the radical gay and lesbian left based in San Francisco in her 2016 book *Lavender and Red: Liberation and Solidarity in the Gay and Lesbian Left*.³¹ The US-based response remains significant to this work, though not central. Domestic actors often used health care as part of their rhetoric against U.S. policies but less frequently made health care a central concern. For these actors, healing wounds directly was hardly as possible as pressuring Reagan's administration.

Recent scholarship that emphasizes the agency of Latin American's in fostering and building solidarity serves as a significant base in this paper. Héctor Perla, Jr., argues for a transnational approach to the Central American Peace and Solidarity Movement (CAPSM). "Nicaraguan and Salvadoran revolutionaries, both in Central America and in the United States, played crucial roles in this movement's creation, growth, and success."³² Perla criticizes earlier scholarship for identifying U.S. activists as "sole protagonists" of solidarity.³³ This thesis follows Perla's transnational lens by arguing that U.S. healthcare solidarity workers played a crucial role in supporting popular health, but

²⁹ Renny Golden, and Michael McConnell, *Sanctuary: The New Underground Railroad* (Maryknoll, N.Y.: Orbis Books, 1986).

³⁰ Roger Peace, *A Call to Conscience: The Anti-Contra War Campaign* (Amherst: The University of Massachusetts Press, 2012).

³¹ Emily K. Hobson, *Lavender and Red: Liberation and Solidarity in the Gay and Lesbian Left* (Oakland: University of California Press, 2016).

³² Héctor Perla, Jr., "Si Nicaragua Venció, El Salvador Vencerá: Central American Agency in the Creation of the U.S.-Central American Peace and Solidarity Movement", *Latin American Research Review* 43, no. 2 (2008), 137, doi: 10.1353/lar.0.0011.

³³ *Ibid.*, 138.

that they were only successful in that role when putting the needs and desires of the community first. Many healthcare activists sought a lower position in the hierarchy of decision-making, though most recognized that they continued to receive privileges associated with their race and nationality.

Comrades in Health: U.S. Internationalists, Abroad and at Home, the work of Anne-Emanuelle Birn and Theodore M. Brown on healthcare internationalism acts as a basis for understanding the significance of healthcare within the broader context of solidarity. Solidarity encompasses a wide range of actions taken in support of people all over the world. This work considers that subsection of healthcare internationalists, whether they be trained health professionals, public health workers, or citizens contributing their time or money to advocating for healthcare access. Birn and Brown argue that “U.S. health activist efforts may be understood as a form of resistance.”³⁴ It may also be understood as revolutionary. The actions of health internationalists in El Salvador and Nicaragua aligned with and built upon the revolutionary goals of the people.

This thesis argues that supporting the popular health systems of Central America served not only as a revolutionary act, but also as resistance to U.S. policies and the U.S.-backed actions of the Contra and the Salvadoran government. Understanding the role of healthcare solidarity activists is important because, according to Birn and Brown, “the story of American health internationalists remains little known.”³⁵ This thesis works to

³⁴ Anne-Emmanuelle Birn and Theodore M. Brown, “Introduction,” in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home*, ed. Anne-Emmanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 6.

³⁵ *Ibid.*, 6.

rectify that obscurity by engaging the stories and experiences of health solidarity workers in El Salvador and Nicaragua in the 1980s.

Scholarship on gender and revolution plays an important role in chapter four where it is discussed more thoroughly. This thesis draws especially on the scholarship of Diana Carolina Sierra Becerra³⁶ and Sandy Smith-Nonini³⁷. Sierra Becerra and Smith-Nonini each contend that Central American women defined revolution that was feminist and broke with traditional gender roles. Smith-Nonini notes that healthcare, in particular, served as a vital stage upon which women developed their own gendered ideas of revolution.

Steve Striffler's 2019 work, *Solidarity: Latin America and the US Left in the Era of Human Rights*, offers an extensive and important consideration of American's solidarity with Latin America starting with the anti-imperialism of the nineteenth century. Striffler explores "the broader history of Latin American solidarity in order to better understand how current forms of solidarity came to be, and how past efforts have or have not shaped or diverged from more recent struggles."³⁸ He focuses on the evolution of solidarity rather than the mechanics. Striffler's synthesis serves as a base for this work not only for its timeline, but also because it contains important definitions and considerations of what solidarity means. As Striffler notes that even his work is not

³⁶ Diana Carolina Sierra Becerra, "For Our Total Emancipation: The Making of Revolutionary Feminism in Insurgent El Salvador, 1977-1987," in *Making the Revolution: Histories of the Latin American Left*, ed. Kevin Young (Cambridge: Cambridge University Press, 2019).

³⁷ Sandy Smith-Nonini, *Healing the Body Politic: El Salvador's Popular Struggle for Health Rights from Civil War to Neoliberal Peace* (New Brunswick: Rutgers University Press, 2010).

³⁸ Steve Striffler, *Solidarity*, 4.

comprehensive, neither is the consideration given here. This thesis gives neither a full picture of Central American solidarity, nor a complete analysis of healthcare solidarity in the 1980s. Instead, by building upon previous scholarship and making connections with the lived experiences of solidarity activists, this work ventures into a new aspect of Central American solidarity.

C. Thesis & Methodology

Throughout the 1980s, Central America claimed much of the U.S. government's attention. The supposed threat of the Sandinistas in Nicaragua led to the U.S. backing of Contra forces stationed on Nicaragua's borders with Honduras and Costa Rica,³⁹ and to years of violence carried out by those forces. In El Salvador, the United States backed violent regimes that favored U.S. policies and slaughtered the population in the name of eliminating communism. The healthcare systems of these two nations experienced wholly different fates in the 1980s. In Nicaragua, the FSLN pursued equitable, popular healthcare as a central policy. In El Salvador, the U.S.-backed regime targeted and destroyed significant portions of the healthcare system, while the FMLN struggled to rebuild community health networks. This thesis considers how healthcare solidarity activists responded to the violence and the attempts by Central Americans to build popular health networks. U.S. activists played an important role both in supporting these networks by travelling to Central America to provide medical care and in sending monetary aid and medical supplies. In many cases, activists risked their lives to act as a barrier between the people of Central America and the U.S.-backed armed forces.

³⁹ Martha Honey, *Hostile Acts: U.S. Policy in Costa Rica in the 1980s* (Gainesville: University Press of Florida, 1994), 202.

Understanding the many roles played by these solidarity workers is pivotal to the conversation on how popular health systems developed in Central America. The policies implemented by the Nicaraguan and Salvadoran governments will be considered here at length. By considering the motives and actions of solidarity workers and health volunteers in El Salvador and Nicaragua, this thesis will spotlight the complexities and realities of accessing health care for the majority of Salvadoran and Nicaraguans throughout the 1980s.

This thesis embraces current scholarship that uses transnational thinking as a framework for research. It follows the lead of recent works which, as Heidi Tinsman argues, “challenge the idea of a stark difference between the North American experience (primarily stories about the United States) and that of Latin America (presumably all of it).”⁴⁰ Instead, this paper will consider the particular international connections forged by a variety of actors including the U.S. government, U.S. solidarity activists, Central American governments and Central American activists. In keeping with Tinsman’s argument, the solidarity workers are not here considered to be separate from the world, but rather in constant relation with the nations under consideration.

Exploring the role of gender in El Salvador’s and Nicaragua’s healthcare systems is vital to understanding the consequences of the wars and the attempts to develop community health systems in each country. The burden of family health fell primarily on mothers in Nicaragua and El Salvador, particularly when so many men were engaged or killed in warfare. During the violence and upheaval, women as caretakers contended with

⁴⁰ Heidi Tinsman, *Buying into the Regime: Grapes and Consumption in Cold War Chile and the United States* (Durham and London: Duke University Press, 2014), 9.

a lack of access to medicine and food for their families and for themselves. They were asked to shoulder the burdens of provision and care in a time when both tasks were made increasingly difficult. Further, women's access to gynecological care and family planning played an important role not only in the developing healthcare system of Nicaragua, but also in the rhetoric of U.S. solidarity activists. Women assumed leadership of building and maintaining community health networks that benefitted their families and brought them together with other women. They stepped into roles that previously had not been available to them, and they asserted their own medical needs in a way that pivotally shaped access.⁴¹

At the heart of this thesis lays the claim that health care was revolutionary. For women, health care offered a site upon which revolutionary feminism could be built. For U.S. solidarity workers, constructing popular health networks through treatment, training, and funding epitomized the struggle against oppressive forces and in favor of the people. The people of El Salvador and Nicaragua saw in health care a way to engage with the promises of revolution. Both the FMLN and FSLN espoused healthcare access as central to their cause, but it was the people, the women, and the solidarity workers who actually built the revolutionary goal from inside their own communities. Their efforts ensured that the basis of the revolution remained central even as fighters and revolutionary leaders focused their attention on warfare.

In carrying out this research, I engage a variety of sources. U.S. newspapers provide an indication of what information was being widely circulated about the conflicts in El Salvador and Nicaragua and the U.S. role in perpetuating them. Solidarity

⁴¹ Aynn Setright, interview by author, August 2, 2019, Brattleboro, Vermont.

organization papers (including newspapers, flyers, informational pamphlets, and membership request forms) show the incredible efforts undertaken to persuade the U.S. public and policymakers that the violence in Central America needed to stop. They provide vital information, prove the commitment of U.S.-based activists, and identify the main focus held by each group. Central American government propaganda, particularly that put out by the FSLN, identifies the goals and rhetoric used in promoting their cause. Medical journals and reports published in Central America and the United States provide important statistics and insights into the realities on the ground. Rarely do the reports or journals refrain from a moral valuation of the numbers presented, so these sources also offer insight into what medical institutions and professionals believed about the actions taken by the United States, the governments of Nicaragua and El Salvador, and the FMLN. Oral histories conducted by other scholars with Central American activists help ensure that this paper considers the incredible work done by Central Americans, for Central Americans. I am fortunate to have access to interviews done by the Global Feminisms Project with activists involved in health care in Nicaragua during the 1980s. Finally, I conducted a series of oral interviews with individuals who were active in solidarity during the 1980s. These histories paint a picture of what life was like on the ground in El Salvador and Nicaragua. They also identify the motivations of at least some solidarity workers and show how so many U.S. citizens chose to act in direct opposition to their government.

CHAPTER 2

SALVADORAN AND NICARAGUAN HEALTHCARE SYSTEMS

“access to technically advanced medical care and political economy-inspired struggle against oppression and exploitation are two parts of the same agenda.”⁴² – Anne-

Emanuelle Birn and Theodore M. Brown

Instability defined the politics of 1980s El Salvador and Nicaragua. Healthcare systems, integrally linked to government policy and economic prosperity, underwent changes and challenges that impacted the peoples of Central America in drastically different ways. In Nicaragua, Sandinista policies attempted to provide universal health care through popular health networks that functioned at community and national levels. At the same time, Contra forces limited the capacity of the new health policies by targeting medical personnel and health centers.⁴³ El Salvador’s military carried out brutal campaigns against rural populations, labeled healthcare workers as subversives, and hampered the FMLN’s ability to setup health networks in guerilla controlled regions.⁴⁴

El Salvador and Nicaragua traversed different paths in the 1980s, but each was deeply impacted by nefarious U.S. policy that hampered the development of effective healthcare systems. The Sandinistas were more successful in building health networks,

⁴² Anne-Emmanuelle Birn and Theodore M. Brown, “Across the Generations: Lessons from Health Internationalism,” in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home*, ed. Anne-Emmanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 306.

⁴³ Richard Garfield and Glen Williams, *Health Care in Nicaragua: Primary Care Under Changing Regimes* (New York and Oxford: Oxford University Press, 1992), 67-68.

⁴⁴ Committee for Professional Health Workers (COPROSAL), *El Salvador, War and Health: The Consequence of the War on the Health of the Salvadoran People* (International Command of Information for the Salvadoran Revolution, 1983), 17.

whereas the FMLN had fewer resources and spent more time focused on fighting El Salvador's armed forces. Health statistics reflect this variation. This chapter navigates the history of health care in each of these countries and offers a point of comparison for two countries with revolutions that advocated for popular health systems in the face of U.S.-backed violence.

A. Nicaragua: Sandinista Healthcare Reforms

“It will provide health care free of charge to the entire population. It will set up clinics and hospitals throughout the country.”⁴⁵ -Carlos Fonseca

Alongside defense of the revolution, economic reforms, and education reforms, healthcare reforms formed a crucial cornerstone of FSLN policy.⁴⁶ The Sandinistas took major steps toward the development of universal access to healthcare by promoting a system based at the community-level. In building these community networks, the government was able to address a number of public health issues including high infant mortality rates, widespread lack of access to vaccinations, and high instance of communicable disease, all of which flourished under Somoza.⁴⁷ The Sandinistas considered health care such a vital aspect of their policy that “within three weeks [of coming to power], they inaugurated the Unified National Health System.”⁴⁸

⁴⁵ Carlos Fonseca, “The Historic Program of the FSLN,” in *New International: A Magazine of Marxist Politics and Theory: The Rise and Fall of the Nicaraguan Revolution*, 9th ed., ed. Mary-Alice Waters (Montreal: Pathfinder Press, 2018), 158.

⁴⁶ John M. Donahue, *The Nicaraguan Revolution in Health* (South Hadley, MA: Bergin & Garvey Publishers, 1986), 24.

⁴⁷ David C. Halperin, and Richard Garfield, “Developments in Health Care in Nicaragua,” *The New England Journal of Medicine* 307, no. 6 (1982): 389.

⁴⁸ Richard Garfield, and Glen Williams, *Health Care in Nicaragua: Primary Care Under Changing Regimes* (New York and Oxford: Oxford University Press, 1992), 22.

1. Somoza-Era Health Care

The rapid implementation of new health policies came in response to decades of oppression compounded by years of destruction leading up to the success of the revolution. Before the FSLN took power, years of fighting between the National Guard and the Sandinista forces resulted in the loss of over 40,000 lives and 100,000 injuries and caused major destruction of hospitals, sewage plants, and other public health facilities.⁴⁹ All this destruction was wrought on an already broken system. In the 1970s, “Nicaragua possessed some of the Western Hemisphere’s most appalling health statistics.”⁵⁰ As such, a focus on health care was imperative for the Sandinistas in building a better Nicaragua and in maintaining popular support. Moreover, the FSLN’s policies around healthcare responded to the corruption of the Somoza regime. By 1975, for example, thousands of poor Nicaraguans living in Managua made money selling their blood to a Somoza-partnered lab that produced 15% of the world’s blood plasma.⁵¹ Under Somoza, Nicaraguan’s health was something to be profited from; where profit could not be made, health was disregarded.

The Sandinistas sought to rectify the class and geographic divides that defined Somoza-era health care. Under Somoza, medical systems suffered everywhere, but the people living in poor, rural areas of the country had little, if any, access to treatment. As of 1974, three quarters of the health budget was spent in Managua, where only one quarter of the population lived.⁵² Life expectancy during the 1970s was estimated as

⁴⁹ Ibid., 23.

⁵⁰ Kristin Cheasty Anderson, “Health Care Reform in Sandinista Nicaragua, 1979-1990”, (PhD diss., UT Austin, 2014), 1.

⁵¹ Garfield & Williams, *Health Care in Nicaragua*, 4.

⁵² Donahue, *The Nicaraguan Revolution in Health*, 10.

twenty years less for Nicaraguans than for their Cuban counterparts;⁵³ maternal mortality was twice as high in rural areas as in urban centers; urban areas had better, though not great, access to potable water and sewage; vaccinations were rare with only 5.7% of the vulnerable population under four years of age receiving the diphtheria, pertussis and tetanus (DPT) vaccine in 1974.⁵⁴ The actual statistics are likely worse considering many of these estimates were made with incomplete data from rural areas.

John M. Donahue, writing in the mid-1980s, argued that Nicaragua's Ministry of Health failed to address these issues prior to 1979 because the health care "system was characterized by vertical control, fragmentation with the twenty-three autonomous institutions making up the health sector, and a mode of community organization which enhanced the control and fragmentation."⁵⁵ Moreover, according to Donahue, this was less a failure to reform than it was an intentional method used by the Somoza regime to maintain control and political patronage over the population.⁵⁶ He notes that the "presence of many competing health institutions diffused internal solidarity within the health sector and left each entity dependent on political patronage and control from above... Somoza allocated health benefits less on the criteria of need and more on the basis of strategic and political impact."⁵⁷ This system permeated the entirety of the health care system. Hospitals utilized a system which denied care to those who lacked the

⁵³ Jose Escudero, "The Politics of Health Care in Nicaragua," in *Health Care in the New Nicaragua: Medical Aid for Nicaragua*, 3.

⁵⁴ Donahue, *The Nicaraguan Revolution in Health*, 10-11.

⁵⁵ *Ibid.*, 11.

⁵⁶ *Ibid.*, 13.

⁵⁷ *Ibid.*, 13.

appropriate admission fee, gave limited care to those with some money, and personalized top-tier care to those who showed up with the most funds.⁵⁸

When the FSLN took power in 1979, it intended to deconstruct the network of political patronage and privilege put into place by the Somoza regime. The Sandinistas put an end to health care as a privilege, and instead created an equitable system of health care throughout the country. The reforms revolutionized the medical system of the country, though they were not entirely successful.

2. Outcomes of Reform

The Sandinistas faced a monumental task in implementing popular health care in a country where there was a limited prior network of facilities, professionals and materials upon which to rely. The destruction of existing hospitals and schools in addition to the flight of many trained medical professionals during the Revolution left the country even more vulnerable than it had been prior to 1979. Richard Garfield, in discussing his experience working in health care in Nicaragua, states that “the Sandinistas were haunted by the fear of a mass exodus of doctors” based on the experiences of other Latin American nations, like Cuba, where political upheaval had resulted in the flight of many health care professionals.⁵⁹ Some flight was inevitable as “many doctors were part of the political and social elite of the country” and supported the Somoza regime.⁶⁰ The substantial impact of the reforms thus merits discussion. Despite setbacks during the 1980s, the FSLN made incredible strides in improving the Nicaraguan people’s access to

⁵⁸ R. Giuseppi Slater, “Reflections on Curative Health Care in Nicaragua,” *American Journal of Public Health* 79, no. 5 (1989): 646.

⁵⁹ Garfield and Williams, *Health Care in Nicaragua*, 148.

⁶⁰ *Ibid.*, 10.

health care. Moreover, that these steps were made in a developing country immediately following years of poor economic and social leadership and a subsequent revolution speaks volumes to the commitment of the Sandinistas, the Nicaraguan people, and their allies to achieving universal health care.

Most accounts argue that the outcomes of Sandinista healthcare reform were mixed, but impressive. This interpretation comes, in part, from doctors and other health care workers who spent time working in solidarity in newly built clinics and who helped develop health programs in Nicaragua. Dr. R. Giuseppe Slater wrote in 1989 of their experience working in rural and urban areas of the country, and concluded that “Nicaragua, in the nine years since the Sandinista revolution, has developed a medical system that is physically and financially accessible, offers care that is very uneven in quality, is generally adequate for most common problems, and is suboptimally [sic] coordinated with preventive health efforts.”⁶¹ Slater’s main criticism of the system developed in the 1980s was the failure to offer consistent, high quality care throughout the country.

U.S. health worker, Sister Patricia Edmiston, discussed the difficulties faced by the regime in building a healthcare network from nothing. In one interview she alluded to a period of growing pains when she said that, “since the victory, all medicine has been free. But that is being changed now because the richer people were taking advantage of the [new] system.” She also noted that in the neighborhood where she worked, each consultation cost ten cents, though the Ministerio de Salud de la República de Nicaragua

⁶¹ Slater, “Reflections on Curative Health Care in Nicaragua,” 646.

(Nicaraguan Ministry of Health, MINSA) held no such standard.⁶² As the main goal for the FSLN was access regardless of financial means, this issue was likely isolated to the area where Sister Edmiston worked. Even so, it indicates the uneven distribution of care and accessibility, particularly for the extremely poor.

The success of the reform lay in its popular roots. MINSA promoted grassroots organizing and, starting in 1980, began organizing Jornadas Populares de Salud (Popular Health Work Days, JPS, Appendix A), to “focus the attention of governmental bodies and popular organizations on a common activity.”⁶³ These events were intended to encourage communication between local health councils and MINSA, though Donahue argues that these health days highlighted “two competing philosophies of primary health care delivery” within the Ministry, one that was based in popular health, and another predicated on institutional primary care.⁶⁴ The popular health model offered a flexible path in which Nicaraguan’s in rural and poor communities had more consistent access to health workers, though not necessarily professional medical workers or specialists.⁶⁵

Statistics indicate a system that, though it faced challenges, had a broadly positive impact on the Nicaraguan people (see Table 1). In just five years’ time, between 1978 and 1983, government expenditure on health care expanded from 200 million cordobas to 1,593 million cordobas.⁶⁶ Massive campaigns around vaccinations saw the near

⁶² Frances Moore Lappé and Joseph Collins interview with Maryknoll Missioner Patricia Edmiston in the pamphlet *Nicaragua: A Look at the Reality*, 1993, box 2 folder 4, Marge Van Cleef Collection, University of Texas, Austin.

⁶³ Donahue, *The Nicaraguan Revolution in Health*, 29.

⁶⁴ *Ibid.*, 31.

⁶⁵ *Ibid.*, 93.

⁶⁶ Richard M. Garfield and Eugenio Taboada, “Health Services Reforms in Revolutionary Nicaragua”, *American Journal of Public Health* 74, no. 10 (1984): 1140.

elimination of polio and a rapid reduction in measles.⁶⁷ Moreover, accessibility to medical care increased significantly, with the number of visits to hospitals and health clinics doubling in the decade after 1977.⁶⁸ Visits to community-based primary care facilities increased at greater rates than outpatient visits to hospitals, though this fact may be contributed in part to the near tripling in number of community-based primary care centers.⁶⁹ This access was increased mostly in areas of greatest need. The number of physicians and beds available increased in the first years after the revolution.⁷⁰ Infant mortality “decreased from 121 to 80.2 per 1,000 live births” between 1978 and 1983. In the same time period, life expectancy rose from 52 to 59 years, while malaria decreased by fifty percent. Diarrhea fell from the first to fourth cause of hospital mortality.⁷¹ A new emphasis was placed on eliminating childhood dehydration through visits to oral rehydration stations. The number of visits to such stations steadily increased throughout the 1980s, particularly for children under the age of five.⁷²

⁶⁷ Ibid., 1143. see also Donahue, *The Nicaraguan Revolution in Health*, 31-36.

⁶⁸ Donahue, *The Nicaraguan Revolution in Health*, 43.

⁶⁹ Paula Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, *International Journal of Health Services* 17, no. 1 (1987): 171.

⁷⁰ Ibid., 47-49.

⁷¹ Garfield and Taboada, “Health Services Reforms in Revolutionary Nicaragua,” 1143.

⁷² Garfield and Williams, *Health Care in Nicaragua*, 135.

Table 1: Nicaraguan Health Statistics from 1977 to 1984.

Year	Number of Vaccine Doses Provided ¹	Reported Cases of Measles ¹	Reported Cases of Whooping Cough ¹	Number of Hospital Beds ¹	Hospital, Health Center, and Health Post Visits ¹	Dental Visits ¹
1977	No Data	No Data	No Data	4,313	No Data	203,540
1980	1,790,343	3,784	2,469	4,677	4,982,623	258,742
1981	2,544,396	224	1,935	4,729	5,411,432	331,821
1982	3,859,174	220	383	4,765	6,034,445	417,078
1983	3,304,155	102	90	No Data	6,467,187	448,417
1984	No Data	153	60	5,040	No Data	No Data

That the FSLN achieved so much success while faced with very little infrastructure, a legacy of corrupt politics, and continued violence and destruction at the hands of the Contras speaks volumes to the dedication and to the positive impacts of state planning. Anderson argues that although the “Sandinistas did not accomplish what they envisioned in 1979... what they did was impressive, in light of the challenges they faced.”⁷³ In just a decade, the Sandinistas tackled many of the pressing health issues facing the nation’s poor. Despite the difficulties and setbacks, the FSLN proved that social spending worked – a fact that they mobilized against their enemies. This was a monumental task set before the Sandinista government, as were the many other reforms they undertook, but they nonetheless managed to build a lasting infrastructure of hospitals and health care staff as well as eliminate many preventable diseases that plagued Nicaragua in the years leading up to 1979.

⁷³ Anderson, “Health Care Reform in Sandinista Nicaragua,” 118.

3. Health Care and the Contras

The Contra war undermined the dramatic successes achieved by the Sandinistas in the early 1980s.⁷⁴ The U.S.-backed Contras attacked Nicaraguans to undermine the Sandinista government. Violence, in all its forms, falls under the umbrella of public health issues, and so it was every time the Contras attacked. Not only did they leave a wake of death and injury where they went, but they also destroyed important public health facilities. The destruction wrought against Nicaraguan infrastructure, including healthcare buildings and professionals, was part of a targeted effort to undermine the Sandinistas domestic policies.

FSLN officials diverted financial resources away from social spending and toward military investment. Before the Contra war, investment “in health as a percentage of the national budget increased by more than 50 percent between 1977 and 1981.”⁷⁵ Between 1982 and 1984, the Nicaraguan military budget grew from 18% of total spending to 25%, diverting money away from social spending, including the health budget.⁷⁶ Moreover, the budget that remained designated for healthcare services was funneled toward care of wounded combatants including the creation of hospitals in war zones specifically for the purpose of combatant care.⁷⁷ Destruction by Contra forces resulted in an estimated \$30 million in health system damages by 1987.⁷⁸

⁷⁴ Unitarian Universalist Service Committee, *Health as a Human Right in Nicaragua: The Impact of Low-Intensity Conflict* (Boston, 1987), 3.

⁷⁵ Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, 170.

⁷⁶ Garfield and Taboada, “Health Services Reforms in Revolutionary Nicaragua”, 1141.

⁷⁷ Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, 172.

⁷⁸ Unitarian Universalist Service Committee, *Health as a Human Right in Nicaragua*, 17.

The diversion of resources resulted in regressions of the rapid gains made during the Sandinista's first years. In 1989, writing for the American Journal of Public Health, Giuseppe Slater stated that "the impact of the contra war, including the resultant economic disruption... slowed or reversed some earlier gains."⁷⁹ Slater pointed to, for example, the initial rapid increase in the number of physicians, nurses and nurse auxiliaries, which leveled off later in the decade. In 1977, there were 52 physicians per 100,000 people; in 1983, that number had increased to 69. By 1987, though, the number had come back down to 59 per 100,000.⁸⁰ Similar trends occurred with nurses and nurse auxiliaries, a fact that Slater argued was due to Contra terror efforts. Regression also occurred in nation-wide vaccination campaigns. By 1986, regions designated as war zones saw three times as many cases of measles, though all regions of the country reported similar numbers prior to 1985.⁸¹

Healthcare professionals moved from civilian clinics to serve in hospitals created specifically for combatants. Slater noted that, "the lack of clinical teachers and attending physicians, already acute because of the exodus of well-trained doctors after the revolution, [was] worsened by the contra war, which... caused diversion of resources and manpower, including medical manpower."⁸² U.S. doctor and solidarity activist, Paula Braveman, referred to newly designated combatant facilities as "special hospitals" and argued that the movement strained an already groaning system by mobilizing over five thousand healthcare workers and their families and leaving limited staff behind "to cope

⁷⁹ Slater, "Reflections on Curative Health Care in Nicaragua", 646.

⁸⁰ Ibid., 647.

⁸¹ Unitarian Universalist Service Committee, *Health as a Human Right in Nicaragua*, 11.

⁸² Ibid., 648

with the increased patient loads.”⁸³ The reorganization extended beyond health workers and permeated the entire network of regional and centralized healthcare that defined initial Sandinista policy. The reassignment of regional facilities as emergency and trauma centers forced central hospitals in major cities including Managua to take on cases from areas outside of their jurisdiction. Moreover, the repositioning burdened urban health care and limited access for non-emergency patients.⁸⁴

Contra forces specifically targeted healthcare workers and facilities in war zones. In reporting on her 1985 and 1986 visits to Nicaragua as part of the Third and Fourth North America-Nicaragua Colloquia on Health, Paula Braveman stated:

As of October 1, 1985, 38 salaried civilian health workers had been killed by the Contras. Eleven additional health workers had been wounded and 28 others had been kidnapped. Virtually all of these attacks occurred while the health workers were assigned to medical functions. Health facilities have also been the direct target of contra attacks. Sixty-one health institutions have been completely or partially destroyed since 1981, while 37 others have been intermittently or totally closed because of contra activity. Fifty-five of the 61 destroyed facilities have been health posts, primarily in rural locations.⁸⁵

Contras aimed to instill fear in the civilian population through this destruction and violence leading to a virtually complete shutdown in parts of Nicaragua. One case study of the villages surrounding Acoyapa (in central Nicaragua) showed half of the healthcare workers had been kidnapped and five had resigned under threat of harm.⁸⁶ Moreover, the same study noted that 20% of health centers in war zones had been attacked, closed, or destroyed between 1983 and 1987.⁸⁷

⁸³ Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, 173.

⁸⁴ Ibid., 176.

⁸⁵ Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, 172.

⁸⁶ Unitarian Universalist Service Committee, *Health as a Human Right in Nicaragua*, 12.

⁸⁷ Ibid., 10.

Simply getting to a health clinic became dangerous when Contra forces began mining roads. Land mines threatened travelers and aimed to keep civilian populations isolated and afraid. Healthcare workers risked their lives transporting supplies and patients between villages, and civilians were often unable to make the treks necessary to receive vital care. Marta, a woman from the isolated war zone area of La Pavona, suffered from a severe strain of tuberculosis for which she required a monthly shot; the trek from her village to the nearest clinic was made impossible by land mines.⁸⁸ Many health workers bravely faced the danger of the roads to deliver emergency care. U.S. solidarity activist, Aynn Setright drove an ambulance for two years in conflict zones and notes that the job was the most dangerous of all healthcare responsibilities.⁸⁹

The war limited access to medicine and medical supplies, particularly in rural areas where having such supplies often marked an individual as subversive. Importing medicine from abroad, as Nicaragua had limited domestic pharmaceutical manufacturing, proved difficult under the financial strain of the war and U.S. economic sanctions.⁹⁰ The mining of the port of Corinto, remembered mainly for the 400,000 gallons of fuel lost,⁹¹ also resulted in the destruction of “660 tons of imported foodstuffs and 40 tons of UN-donated medical supplies.”⁹²

⁸⁸ Ibid., 8.

⁸⁹ Aynn Setright (U.S. solidarity activist), interview by author, August 2, 2019, Brattleboro, Vermont.

⁹⁰ Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, 173.

⁹¹ “Nicaragua Evacuates Port Raided by Rebels”, *New York Times*, October 13, 1983, url: <https://www.nytimes.com/1983/10/13/world/nicaragua-evacuates-port-raided-by-rebels.html>.

⁹² James Ciment, *Encyclopedia of Conflicts Since World War II* (Armonk, NY: Sharpe Reference, 1999), 479.

The psychological impacts of the war strained the civilian populations and created a need for more mental health workers in the country. In her 1985 and 1986 tours, Braveman noted a substantial increase “in the use of outpatient psychiatric services,” particularly for those who “lost family members in combat” and “mothers with sons and daughters fighting in the war.”⁹³ One study found that in 1987, 18% of mental health consultations were related to the war and that soldiers constituted a large number of the patients; the same study notes that civilians living within audible distance of gunfire suffered higher levels of mental health complications.⁹⁴

The Contra war devastated the lives of countless Nicaraguans, and it severely strained a burgeoning healthcare system. Violence dampened the successes that had been achieved in the early years and undermined progress in conflict zones. Facilities and professionals outside of the war zones felt the burden of the conflict as the government funneled resources toward the war effort and away from the popular structure implemented just days after the Sandinistas took power. During the same period, north of Nicaragua another battle raged on; the Salvadoran people and their healthcare system suffered, too, under the pressures of war.

⁹³ Braveman, “Nicaragua: A Health System Developing Under Conditions of War”, 174.

⁹⁴ Richarg Byng, “Primary Health Care in Nicaragua”, *Social Science and Medicine* 36, no. 5 (1993): 628-629.

B. Salvadoran Health Care: A Split System

“the FMLN... is establishing a health delivery system. The effort is heroic.”⁹⁵ –

Medical Aid for El Salvador

Salvadoran health care suffered dramatically as the country’s civil war raged. The (already poor) system deteriorated in the years leading up to the conflict, and the splitting of the country into guerilla- and government-controlled areas only furthered the withering of the system. Injuries and psychological trauma unique to war-torn areas increased the need for access to health care while also ensuring that there was virtually no way to acquire medicine, supplies, or professionals. Health care suffered in both regions and was particularly difficult to maintain in war zones and guerilla-controlled territories. Despite the massive influx of foreign aid given to the Salvadoran government, the statistics for the government-controlled areas remained dismal throughout the civil war. Money funneled into the country rarely found its way to social expenditures and instead funded the brutal violence that characterized the El Salvador of the 1980s. El Salvador’s poorest suffered the most from the unequal and difficult access to proper medical care in both the guerilla and government controlled territories. Moreover, the healthcare system became a pawn in the government’s strategy for winning the war. The government not only targeted healthcare facilities and professionals in guerilla-controlled regions, but also sought to destroy the very basis of popular health care promoted by the FMLN. This was, after all, an attempt to suppress the Salvadoran people, and regardless of where those people lived, they needed to be controlled. Nonetheless, the most desperate areas of the

⁹⁵ Medical Aid for El Salvador, *Medical Aid for El Salvador: People-to-People Aid*, (Los Angeles, CA), pamphlet, Frostburg State University.

country were in the war zones, as evidenced in pamphlets, medical journals, and first-hand accounts that documented the violence and brutality enacted against those unlucky enough to be living in the war zones.

1. Health Care Prior to the Civil War

Much like the situation in Nicaragua leading up to the 1980s, access to health care became increasingly restricted for the vast majority of Salvadorans throughout the 1970s. El Salvador had long been characterized by economic and social polarization, and the “absence of a sound health programme” in addition to “the impossibility of access to health services and medicine,” resulted in a “high level of mortality and a condemnation of the people to a life of total misery.”⁹⁶ Throughout the 1970s, health care was a particular point of struggle for poor Salvadorans, and lack of access served as a central rallying point for the urban poor, rural peasants and student movements.⁹⁷ Interestingly, though, health statistics had a general, upward trend that peaked in the late 1970s and fell apart in the wake of the 1979 coups and the subsequent war.

The health trends of the decade leading up to war may have been slightly positive, but any increases were minimal and insignificant in comparison to the massive financial gulf that divided society. Nonetheless, the trends were toward a better health system. Between 1960 and 1980, infant mortality fell from 76.3 per 1000 births to 44 per 1000; child mortality rates similarly decreased from 17.5 per 1000 to 4.8 per 1000 in 1981, a significant improvement; maternal mortality rates fell from 17.4 per 1000 in 1960 to 6.2

⁹⁶ Committee for Professional Health Workers, *El Salvador: War and Health: The consequences of the war on the health of the Salvadoran people*, 1983, 1.

⁹⁷ Victor Amaya and Maria Black, “Tradition for revolution: Traditional medicine in El Salvador”, *Community Development Journal* 28, no. 3 (1993): 229.

per 1000 in 1980.⁹⁸ There was a similarly positive trend in the number of hospitals and medical units operated by the Salvadoran Ministry of Health (see Figure 1).⁹⁹

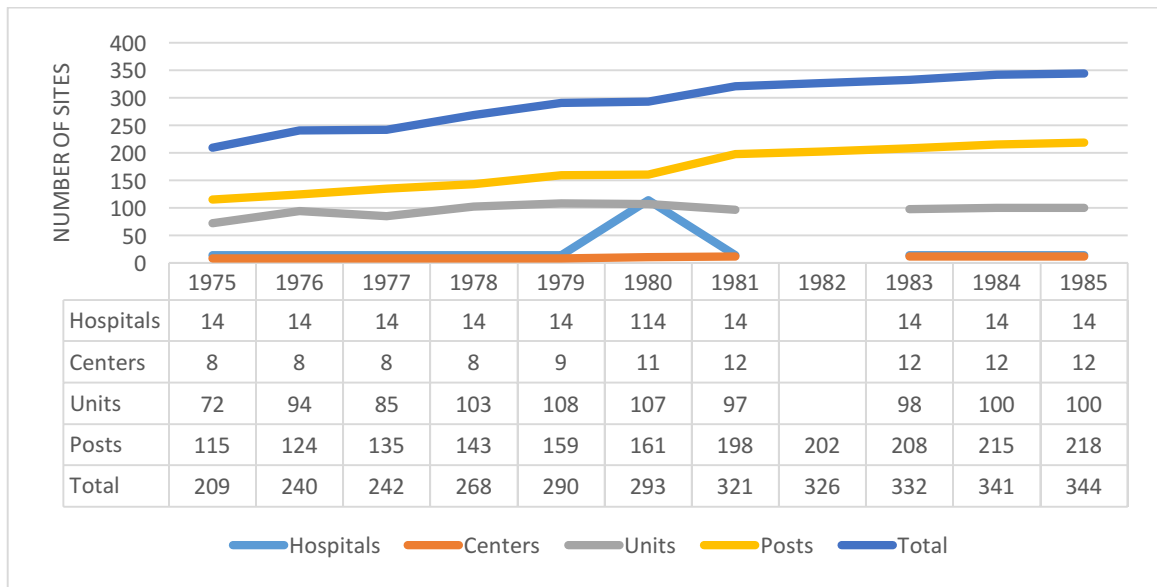


Figure 1: Evolution of El Salvador’s Health Infrastructure.

Behind the statistics lay a reality in which health care was rarely available to most Salvadorans. Throughout the 1970s, roughly 15% of the population had reliable access to health care (access to private care and the Salvadoran Social Security Institute), leaving the remaining 85% with a precarious relationship to medicine (dependent on an unreliable and underfunded public health system).¹⁰⁰ Moreover, immediately prior to the outbreak of the war, the main illnesses reported by Salvadorans were linked to issues of sanitation and malnutrition. Between 1969 and 1979, the number of children under five years of age who suffered from malnourishment increased by 50%.¹⁰¹ The war, which

⁹⁸ John L. Fiedler, “El Salvador’s Ministry of Health, 1975-1986: a provisional performance assessment,” *Health Policy* 10, no. 2 (1988): 178.

⁹⁹ Fiedler, “El Salvador’s Ministry of Health, 1975-1986,” 178. Chart and table based on Fiedler’s figures.

¹⁰⁰ Committee for Professional Health Workers, *El Salvador: War and Health*, 3.

¹⁰¹ *Ibid.*, 8.

saw an increased need for medical care alongside a shift of funds away from the Ministry of Health and toward military spending, certainly helped to destroy an already crumbling system. The system prior to the war was split, and the Ministry of Health had little effective control over the allocation of resources and the growing need for medical professionals throughout the country.¹⁰²

2. Health Care During the Civil War

The decade of civil war saw a further deterioration of an already hobbled medical system. The country was broken up into shifting territories, one of which was controlled by the government, the other by the FMLN. Each of these territories saw a piecing together of different medical systems under distinctly different interpretations of what access to health care should look like. Moreover, the violence saw a greater need in care for anyone caught, intentionally or not, in the fighting, and an increased difficulty in accessing necessary medical supplies, particularly for Salvadorans in war-torn regions of the country.

The health statistics from civil war-torn El Salvador are staggering. More than 50% of the population suffered malnutrition; the infant mortality rate in rural areas was as high as 18%, with nearly half of all newborns weighing less than five and a half pounds; life expectancy was under 45 years.¹⁰³ One New England Journal of Health article remarked that there was “virtually a complete breakdown in the health system. All hospitals have shortages... In the Maternity Hospital two or three women occupy the

¹⁰² Fiedler, “El Salvador’s Ministry of health, 1975-1986”, 179.

¹⁰³ Medical Aid for El Salvador, *Medical Care in El Salvador Condition: Critical*, Los Angeles, CA, 1984, Cornell University Library, 5.

same bed... In the rural areas virtually no medical services exist for the population.”¹⁰⁴

The lack of doctors in the country, one for 25,000 people, meant most Salvadorans had no access to healthcare at all.¹⁰⁵

3. Government-Controlled Areas

Following the coups of 1979, repression of Salvadoran health care became pronounced. In early 1980, Dr. Hector Silva, who performed routine cervical cancer testing, was told that his recognition of positive cases was causing a social problem, and, when he refused to cease the screenings, he was targeted and forced to flee.¹⁰⁶ Dr. Silva’s story was but the beginning of years of repression by the government that manipulated the healthcare sector in order to undermine the Salvadoran people. The government saw healthcare programs and efforts as subversive to their agenda as well as threatening to the elites who had held onto power in the country for decades.

What government funds had been channeled toward health care were, once the conflict began, largely subverted toward military efforts. Between 1976 and 1986, the Salvadoran Ministry of Health saw a decrease from 10.6% to 7.1% in the share of the government budget received (see Figure 2).¹⁰⁷ The decrease in budget meant that that hospitals and clinics struggled, more than they had previously, to provide even the most basic care to patients. In hospitals surrounding San Salvador, doctors and nurses often

¹⁰⁴ Letter to the Editor, “Health and Human Rights in El Salvador,” *New England Journal of Health*, (1983): 1029, doi: 10.1056/NEJM198304283081713.

¹⁰⁵ Medical Aid for El Salvador, *Medical Care in El Salvador Condition: Critical*, 5-6.

¹⁰⁶ Health PAC Bulletin, “Health and Human Rights in El Salvador”, volume 14-15, issue 6-1, 1983, Five College Library Repository Collection, 30.

¹⁰⁷ Fiedler, “El Salvador’s Ministry of Health, 1975-1986,” 182. Chart based on Fiedler’s figures.

lacked food for patients.¹⁰⁸ One bulletin reported that the death rate of sick newborns admitted to San Salvador’s Maternity Hospital approached an astounding 80%.¹⁰⁹ Pharmacies had few medications to give, if any, and, for those medications that were available, inflation of prices ensured they were out of reach for many Salvadorans.¹¹⁰

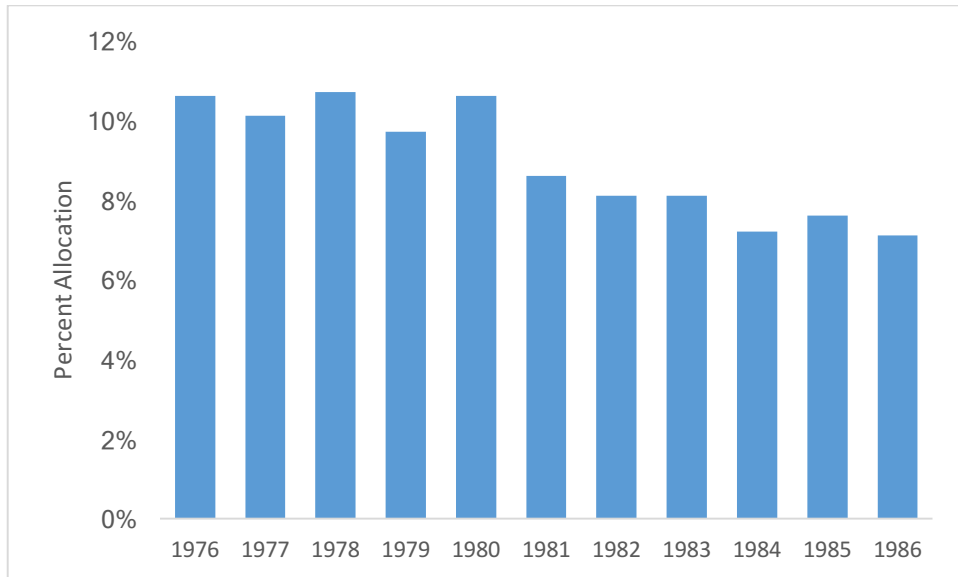


Figure 2: Share of El Salvador’s Health Budget Allocation.

4. FMLN-Controlled Areas

The FMLN saw health care as a community issue, and one that should be entirely removed from the market. Victor Amaya and Maria Black have summarized the FMLN position by noting that the organization argued, “no matter what type of medicine one practices, if health, knowledge, skills and resources are sold on the market as commodities this will necessarily limit access to health care, fragment and distort the

¹⁰⁸ Health PAC Bulletin, “Health and Human Rights in El Salvador,” 30.

¹⁰⁹ Ibid., 31.

¹¹⁰ Ibid., 31.

nature of the health process, constrain the relation between health workers and users, and undermine people's control over their health.”¹¹¹

While the FMLN touted equal access to medicine for all Salvadorans, the reality of care was far less rosy. Resources in war zones and guerilla-controlled areas were scarce, and where resources and facilities did exist, they often did not exist for long. Francisco Metzti described guerilla hospitals as similar to neighborhood cafés where people gathered to discuss the latest news.¹¹² According to Metzti, they were lively places, but also places with very few resources. In describing the treatment of one FMLN combatant, Juan, who had been shot in the leg, Metzti says:

It was a period in which we were very short on medical supplies. We didn't even have IV fluid. Under these conditions, an amputation is a delicate operation, and even more so in the presence of a ferocious germ [like gangrene, which Juan had developed]. But in spite of all this, we operated on Juan under a silk-cotton tree, cutting through the bone with the tiny sawblade of a Swiss Army knife, and using the milk from several coconuts as IV fluid.¹¹³

Metzti's story highlights one extreme of the medical reality many faced during the war years, but while scarcity was a constant, the degree of struggle varied greatly. In the latter years of the war in the department of Morazán, FMLN medical care held to a clear hierarchy with considerably more access to medicine and equipment than Metzti experienced. In Michael Terry's account of his time working as a *brigadista* in the mountains of Morazán, he describes well-developed capacities for surgeries related to

¹¹¹ Amaya and Black, “Tradition for revolution,” 228.

¹¹² Metzti, *The People's Remedy*, 10.

¹¹³ *Ibid.*, 17.

war wounds, and notes that there was access to anesthetic, IV fluids, and other equipment necessary for surgeries; he boasts that all of the surgery patients he saw survived.¹¹⁴

Michael Terry's account contains two particularly striking points. First, despite the success the FMLN achieved in developing the medical system of Morázan, the health clinics changed location daily so as to avoid detection and attack.¹¹⁵ This forced critical cases to be relocated further into the mountains, but also meant that healthcare workers were mobile and ready to perform surgery on the spot.¹¹⁶ They may have achieved greater success in their medical structures, but the guerillas nonetheless were restricted in establishing real change for the rural populations. The second striking point in Terry's account is his reference to the inversion in types of care that health professionals felt most comfortable and able to treat. Over the decade, the guerillas had developed advanced skills in dealing with gunshot wounds, injuries from shrapnel, and other war-related injuries, but, as Terry notes, the "more serious problems at the clinic were dengue, psychiatric disorders, fractures, and sexually transmitted infections."¹¹⁷ In the war zones, expertise followed necessity, and so treating and controlling illnesses that may have been more readily treatable elsewhere, became the major struggle for war-zone clinics.

¹¹⁴ Michael Terry with Laura Turiano, "Brigadistas and Revolutionaries: Health and Social Justice in El Salvador," in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home*, ed. Anne-Emmanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 226-227.

¹¹⁵ Smith-Nonini, *Healing the Body Politic*, 84. Smith-Nonini points out that the use of mobile clinics began in 1985.

¹¹⁶ *Ibid.*, 227.

¹¹⁷ *Ibid.*, 227. Michael Terry's account was not the first time I was faced with this inversion of medical expertise. Rather, this seems to be an issue endemic to the war zones of Central America. The same situation occurred in the war zones of Nicaragua around the same time period.

The various accounts on medical care in the guerilla-controlled areas of El Salvador indicate a blurred line between civilians and combatants. The FMLN encouraged the development of a popular health system within communities. The clinics, staffed by community health workers and, at times, international solidarity activists, depended on the expertise of FMLN doctors and surgeons. While working in Las Vueltas and the surrounding communities, Susan Classen and her Salvadoran colleagues relied on FMLN support in handling severe injuries.¹¹⁸ Sandy Smith-Nonini notes the reciprocal nature of the relationship, stating that just as FMLN “physicians treated sick or injured civilians, promoters based in villages sometimes cared for wounded combatants. Several sanitarios and civilian lay workers... assisted physicians in surgeries.”¹¹⁹ This was the nature of the popular health system upon which combatants and civilians depended.

In the accounts of Maria Eugenia, Francisco Metz, Charles Clements, Michael Terry, Susan Classen, and others, the instability and chaos that defined the lives of Salvadorans resulted in a rush to help whoever needed help, regardless of their relationship to the war or their political persuasion. That civilians had no option but to seek care from popular clinics supported by the FMLN made no difference to the Salvadoran military officers who pegged the peasants as subversive. Certainly, for many medical workers, a peasant’s political persuasion mattered little when they required aid.

Although the FMLN ideally saw an El Salvador with medical access for all, the reality of the guerilla’s actions during the war often fell short of that, even in territories they controlled. Peasants reported preferential treatment at clinics, not only for fighters,

¹¹⁸ Susan Classen (U.S. nurse), interview by author, October 24, 2019, Skype interview.

¹¹⁹ Smith-Nonini, *Healing the Body Politic*, 86.

but also those related to guerillas.¹²⁰ Charles Clements alludes to this in the account he gives of his time working as a doctor in solidarity with the guerillas. Clements recalls a series of conferences held to determine the division of medicine in the areas villages, and tells of one medical combatant in particular who spoke at length in favor of unequal distribution of resources to fighters because their heroism.¹²¹ This favoritism meant that some peasants would have been unable to access medical care, as resources were slim. One medical report published in 1989 in the *New England Journal of Health* acknowledged medical neutrality was certainly violated at times by the FMLN, but that the most frequent and most egregious violations were carried out by the Salvadoran government.¹²² This reality is evidenced by how readily the Salvadoran government wielded violence against medical professionals, supplies, buildings, and knowledge.

5. Targeting Health Care

The Salvadoran government deliberately breached international medical neutrality in favor of undermining the enemy.¹²³ The tactic, hardly isolated to the Salvadoran

¹²⁰ Molly Todd, *Beyond Displacement: Campesinos, Refugees, and Collective Action in the Salvadoran Civil War* (Madison: The University of Wisconsin Press, 2010), 70.

¹²¹ Clements., *Witness to War*, 149. Though Clement's story focuses on one particularly disliked and confrontational guerilla fighter, it's clear from other sources that the issue of dividing resources was never isolated to one particularly stubborn individual or region under guerilla control. See Smith-Nonini, *Healing the Body Politic*, 87.

¹²² Jack Geiger, M.D., *et al.*, "A New Medical Mission to El Salvador," *New England Journal of Medicine*, 1989, doi: 10.1056/NEJM198910193211629.

¹²³ Medical neutrality was put forward as an international law under the 1949 Geneva Conventions, of which El Salvador is a signatory. The principle demands that medical care not be disrupted or intentionally harmed during conflict, and that wounded civilians and combatants have a right to care, regardless of their political affiliation. For more on the modern issue of breaching this trend, see Soumitra S. Bhuyan, Ikenna Ebuenyi and Jay Bhatt, "Persisting trend in the breach of medical neutrality: a wake-up call to the international community," *BMJ Global Health*, 2016, doi: 10.1136/bmjgh-2016-000109. For more on the ethics of neutrality, see Michael L. Gross, "From Medical Neutrality to Medical Immunity," *AMA Journal of Ethics* 9, no. 10 (2007) and Adia Benton, Sa'ed

conflict, brought even greater suffering to a population already being massacred and displaced by the thousands. The deliberate attacks on healthcare workers and facilities as well as medical knowledge, and the constant attempts to cut off medical supplies, particularly to guerilla-controlled territories, took a toll, and contributed to the heightened levels of brutality that came to define the civil war.

The Salvadoran military targeted healthcare workers and facilities in their campaign to weed out guerilla forces. The government considered social organization of any kind, including that around health, to be subversive.¹²⁴ That the FMLN healthcare workers often blurred between aiding guerillas and aiding peasants hardly helped this issue. Many health workers, with their promotion of community organization, were “imprisoned or killed by military or paramilitary death squads.”¹²⁵ Simply having gauze resulted in death or imprisonment as possession was reserved for the military.¹²⁶ The threats against health workers prompted many more to flee the country, draining communities of their main resources for health care and medical expertise.

Of the health workers who remained and continued their work in El Salvador, many disappeared during the civil war years. In 1983, Dr. Alfred Gellhorn wrote of a medical mission he undertook to determine the location of twenty missing health workers and scientists. Not only was the delegation unable to determine where thirteen of the

Atshan, “‘Even War has Rules’: On Medical Neutrality and Legitimate Non-Violence,” *Culture, Medicine, and Psychiatry* 40, no. 2 (2016), doi: 10.1136/bmjgh-2016-000109.

¹²⁴ Letter to the Editor, “Health and Human Rights in El Salvador,” 1029.

¹²⁵ *Ibid.*, 1029.

¹²⁶ Medical Aid for El Salvador, *Medical Care in El Salvador Condition: Critical*, 5-6. See also Dr. Charles Clements account in *Witness to War*, 147. He identifies the arrest of a woman for carrying cloth diapers and the murder of a young boy for purchasing a suspicious number of Aspirin in order to care for his uncle, who suffered from arthritis.

missing were, they discovered a list of another twenty who had gone missing in San Salvador in 1982. These numbers likely only represent a fraction of the reality as merely reporting a missing family member could put entire families in danger of government violence.¹²⁷

The Salvadoran military wielded destruction of knowledge as a weapon against the most vulnerable of the country's population. They not only targeted health care workers in war zones, but attacked the very fabric of the system. On June 27, 1980, the Salvadoran Army attacked The University of El Salvador, the national university that hosted the country's only medical school. The army massacred forty students during the takeover, and, in the proceeding four years of occupation, shut down the school and ransacked its libraries and laboratories. In a September 10, 1984 news article, Chris Hedges noted that although the army had allowed the school to be reopened, over half of the books in the library had been stolen or destroyed. Moreover, El Salvador's most important medical school lost "all of the medical equipment and some 75 of the medical books."¹²⁸ The cost of reopening and restocking the country's premier university, and medical school, was tremendous. The cost of losing four years of medical advancement and investigation was priceless.

C. Healthcare Access for Central American Refugees

The violence that afflicted Nicaragua and El Salvador displaced thousands of civilians. Some moved across borders to neighboring countries of Costa Rica and

¹²⁷ Alfred Gellhorn, M.D., "Medical Mission Report on El Salvador," *New England Journal of Medicine*, 1983, doi: 10.1056/NEJM198304283081736

¹²⁸ Chris Hedges, "Salvador university, closed by Army, opens after 4 years," *Christian Science Monitor*, (September 10, 1984), <https://www.csmonitor.com/1984/0910/091044.html>

Honduras, others fled further abroad, including to the United States, and many faced internal displacement. Both El Salvador and Nicaragua also took in refugees from other Central American nations, with the Sandinista government embracing Salvadoran refugees. Between 1981 and 1987, some 22,000 Nicaraguan refugees were estimated in Costa Rica,¹²⁹ while at the same time, an estimated 16,000 Salvadoran refugees moved to Nicaragua.¹³⁰ The displaced populations not only had a harder time accessing health care, they also tended to need health care more frequently because of the danger inherently involved in clandestine movement through the countryside and the poverty that defined a displaced person's existence. Moreover, refugees were often treated poorly, especially as their growing numbers overwhelmed the capacities of receiving countries.

1. Displaced Populations of Nicaragua

The upheaval of the 1970s and 1980s forced thousands of Nicaraguans from their homes. This process began with the Somoza regime. In early 1979, some 50,000 refugees fled to Costa Rica to escape the oppression of the regime prior to its downfall.¹³¹ With the beginning of the Contra war, many more Nicaraguans fled from their homes. As early as 1983, significant portions of the population had been impacted. Though the height of the Contra war came later, the turmoil of the 1970s and the 1979 Sandinista victory, along

¹²⁹ U.S. Committee for Refugees, *World Refugee Survey: 1986 in Review*, 1986, 59, <https://refugees.org/wp-content/uploads/2019/02/1986-World-Refugee-Survey.pdf>.

¹³⁰ *Ibid.*, 64.

¹³¹ Tanya Basok, "Welcome Some and Reject Others: Constraints and Interests Influencing Costa Rican Policies on Refugees," *The International Migration Review* 24, no. 4 (1990): 727.

with the early rumblings of Contra controversy, saw 22,000 Nicaraguans as refugees in Costa Rica and Honduras and another 85,000 internally displaced.¹³²

By 1990, the number of internally displaced Nicaraguans was estimated at 250,000, with many more having fled to other countries.¹³³ Not all who left became registered refugees in other countries. The bulk of Guatemala's 220,000 undocumented persons consisted of Nicaraguans and Salvadorans,¹³⁴ and many more undocumented Nicaraguans travelled elsewhere in Central America, and even further afield, to countries like the United States. Many who fled the warfare became registered refugees. By 1989, Costa Rica hosted an estimated 26,500 Nicaraguan refugees;¹³⁵ El Salvador hosted 500 Nicaraguan refugees;¹³⁶ Guatemala hosted 3,300 Nicaraguan refugees;¹³⁷ and Honduras hosted 23,600 Nicaraguan refugees, many of whom were Miskitu or Mayangna (Sumu) Indians.¹³⁸ By the end of 1989, the United States had 21,693 pending asylum cases from Nicaraguans.¹³⁹

Minority indigenous populations comprised significant portions of the displaced. Though the FSLN committed to wiping out "the odious discrimination to which the indigenous" were subjected,¹⁴⁰ displacement of these populations came from both sides. The Contra attacks drove them from their ancestral homes, but the FSLN forcibly

¹³² Paula Braveman and David Siegel, "Nicaragua: A Health System Developing Under Conditions of War," *International Journal of Health Services* 17, no. 1 (1987): 173.

¹³³ Basok, "Welcome Some and Reject Others," 727.

¹³⁴ U.S. Committee for Refugees, *World Refugee Survey: 1989 in Review*, 1990, 72, <https://refugees.org/wp-content/uploads/2019/02/1989-World-Refugee-Survey.pdf>.

¹³⁵ *Ibid.*, 69.

¹³⁶ *Ibid.*, 70.

¹³⁷ *Ibid.*, 72.

¹³⁸ *Ibid.*, 73.

¹³⁹ *Ibid.*, 89.

¹⁴⁰ Carlos Fonseca, "The Historic Program of the FSLN," 160.

displaced some 8,500 Miskito Indians in 1981, resulting in dozens dead.¹⁴¹ The Miskitus, a tribe that has long inhabited the eastern coast of Nicaragua and the eastern Honduran-Nicaraguan border, faced displacement and internal controversy in the war years. As a result of the forced relocations, many Nicaraguan Miskitus who fled to Honduras claimed “that the Sandinistas were not liberators.”¹⁴² In the case of the Mayangna Indians, Contra attacks forced the internal resettlement and the breaking of this ethnic group from their homeland.¹⁴³ Though not all of the displaced indigenous were anti-Sandinista, many lived in Honduran-based camps that “the Contras tightly controlled.”¹⁴⁴ Of those living in the Contra-controlled camps, some realized they were trapped, unable to return home, while others embraced the Contra cause and the anti-Sandinista propaganda by supporting the Kus Indian Sut Asla Nicaragua Ra (United Indigenous Peoples of Eastern Nicaragua, KISAN), a Contra-backed, indigenous organization that fought against the Sandinistas. When a colleague introduced the creation of KISAN to Roxanne Dunbar-Otis, she saw that the “whole setup smelled of CIA design,” and realized that the leaders of the organization would be “taking orders from the CIA.”¹⁴⁵ The Contras caused displacement through violence and in an attempt to create upheaval, but they also seized the opportunity to manipulate displaced peoples against the Sandinistas. The Contras leveraged the minority-status and long-time neglect of indigenous groups to their

¹⁴¹ Mateo Cayetano Jarquín, “Red Christmases: The Sandinistas, indigenous rebellion, and the origins of the Nicaraguan civil war, 1981-82,” *Cold War History* 18, no. 1 (2018): 91.

¹⁴² Roxanne Dunbar-Ortiz, *Blood on the Border: A Memoir of the Contra War*, (Cambridge, MA: South End Press, 2005), 238.

¹⁴³ *Ibid.*, 173.

¹⁴⁴ *Ibid.*, 242.

¹⁴⁵ *Ibid.*, 245.

advantage. They sought to erode Sandinista authority by turning the population against them, and here was a population ready to be turned.

While the Contras sought the indigenous populations allegiance in an attempt to further undermine FSLN authority, the Sandinistas looked to improve the health conditions of those who faced relocation. The Sandinistas allocated resources to the displaced populations that “in some cases resulted in levels of medical service far surpassing those available prior to resettlement, mainly because of the inaccessible location of the homelands of the majority of the displaced populations and neglect by the Somoza government of rural zones.”¹⁴⁶ Those who experienced displacement maintained hostility toward the Sandinista government while benefitting significantly from social programs around food and health care.¹⁴⁷

Despite efforts to improve health systems for displaced populations, refugees remained at risk for poor health and psychological trauma. In 1986, one Managua-based task force found “that refugee families’ psychological problems stem not only from the war trauma they have undergone, but also from the economic and emotional stresses of being uprooted from their social and familial networks.”¹⁴⁸ Moreover, refugees who fled the country faced not only the associated psychological trauma but also the often poor conditions of the refugee camps. In Honduras, many indigenous Nicaraguans faced a

¹⁴⁶ Braveman and Siegel, “Nicaragua”, 173.

¹⁴⁷ Tanya Basok, “Repatriation of Nicaraguan Refugees from Honduras and Costa Rica,” *Journal of Refugee Studies* 3, no. 4 (1990): 289.

¹⁴⁸ National Central America Health Rights Network (NCAHRN) and the San Francisco Bay Area Committee for Health Rights in Central America, *Health Consequences of the war in Nicaragua, 1985-1986: Report of an investigation sponsored by the National Central American Health Rights Network (NCAHRN)*, 1988, Doe Library, University of California, Berkeley, 3.

government that “tolerated refugees’ presence without offering them any viable means of survival.”¹⁴⁹ The overwhelming number of refugees moving across Central American borders often left governments unable to provide sufficient care. In overwhelmed Costa Rican transit camps, established to provide Nicaraguans the tools needed to assimilate, “refugees suffered from general ill-health.”¹⁵⁰

The displaced populations of Nicaragua no doubt faced psychological and physical trauma. The degree to which they received care depended on their ethnicity and the location to which they fled. Access to health care often times improved for those displaced within Nicaragua. For those who left the country, the likelihood of receiving regular medical treatment was low, particularly in Nicaragua’s overwhelmed Central American neighbors.

2. Displaced Populations of El Salvador

Of the estimated one million Salvadorans displaced by the civil war, half were internally displaced and half became refugees. Of the half million who became refugees, an estimated 25,000 went to Honduran camps, 10,000 to Nicaragua and the rest ended up in Mexico or the United States.¹⁵¹ The displaced populations, particularly those that remained in El Salvador or ended up in refugee camps, faced high barriers to accessing healthcare services. Moreover, displaced populations in El Salvador were often being chased by government forces who sought to massacre them, and, if they were unable to, cut off all supplies.

¹⁴⁹ Basok, “Repatriation of Nicaraguan Refugees from Honduras and Costa Rica,” 286.

¹⁵⁰ Elizabeth M. Larson, “Nicaraguan Refugees in Costa Rica from 1980-1993,” *Yearbook (Conference of Latin Americanist Geographers)* 19 (1993): 74.

¹⁵¹ Peter Sollis, “Displaced Persons and Human Rights: The Crisis in El Salvador,” *Bulletin of Latin American Research* 11, no. 1 (1992): 49.

Salvadoran peasants, particularly those who lived near or in guerilla-held territories, lived in constant danger of being caught in the crossfire or accused of collaboration with guerilla groups. When the government raided villages, Salvadorans were forced to retreat in what were known as *guindas*.¹⁵² During these periods of displacement, silence and discretion were of the utmost importance to the survival of Salvadorans on the run. Those hiding from government forces were at times forced to take extreme measures in silencing their children. In her book *Beyond Displacement: Campesinos, Refugees, and Collective Action in the Salvadoran Civil War*, Molly Todd notes that “the cries of hungry, scared, and otherwise uncomfortable children could betray both the presence and the specific locations of the mobile communities [of campesinos]. Because silence was so essential to survival, adults frequently had to cover children’s mouths to stifle their cries with the unintended result of smothering some children to death.”¹⁵³ International aid helped to curb the number of these tragedies to some degree. Campesinos began using various medications and sometimes liquor provided to them by international medical personnel in order to keep the children asleep.¹⁵⁴ In a 1983 interview, Salvadoran nurse, Maria Eugenia, tells the story of how she used medication to silence a screaming child in the middle of fleeing an attack. She said:

We provide as much medical attention as possible, even during the retreat. One time a compañera was running with a screaming baby in her arms. We knew that the army would hear the crying and figure out where we were, so I prepared an

¹⁵² For more on the *guinda* system that developed in rural El Salvador starting in the 1970s, see Molly Todd’s dissertation “Organizing Flight: The Roots and Moral Economy of the Salvadoran *Guinda* System,” (PhD diss., University of Wisconsin Madison, 2007) and her book *Beyond Displacement*.

¹⁵³ Todd, *Beyond Displacement*, 68.

¹⁵⁴ *Ibid.*, 69.

injection to put the baby to sleep. Imagine yourself running and having to give an injection – without wiping the skin clean or anything! Unfortunately, there was no other way to avoid getting caught by the army.¹⁵⁵

Still, access to medication could never be guaranteed to peasants hiding or running from government forces.

Access to medical care rarely improved for Salvadorans if they reached refugee camps. One group of foreign doctors who travelled to the Santa Tecla refugee camp, a camp for internally displaced Salvadorans located near San Salvador, described its residents as living in subhuman conditions with virtually all suffering from illnesses for which there was little to no medical care.¹⁵⁶ Moreover, many of the diseases from which the refugee population at Santa Tecla suffered resulted from malnutrition and poor sanitary conditions. According to one Congressional report, USAID reports had specifically claimed to be providing humanitarian aid to the Santa Tecla camp mainly in the form of nutritious foods. Upon further investigation, Congress reported that no such aid could be confirmed to ever have arrived at the camp.¹⁵⁷ A 1986 report conducted together by the Instituto de Investigaciones and the Instituto de Derechos Humanos at the Universidad Centroamericana, stated that 85.4% of refugees wished to remain in refugee

¹⁵⁵ Medical Aid for El Salvador, “...with mortars falling all around us”: *An interview with a nurse from El Salvador’s war-torn countryside*, 1983, 17.

¹⁵⁶ Geiger, M.D., *et al.*, “A New Medical Mission to El Salvador.”

¹⁵⁷ United States Congress Senate Committee on Foreign Relations, *Presidential Certification on Progress in El Salvador: Hearing Before the Committee on Foreign Relations United States Senate Ninety-Eighth Congress First Session*, February 2, 1983. The accuracy of the USAID reports in regards to the Santa Tecla camp, and other Salvadoran refugee camps more generally, is called into question in several places in this report. See pages 284, 287, and 289-290.

https://books.google.com/books/about/Presidential_Certification_on_Progress_i.html?id=t_ZL8SDsJ6kC.

camps despite poor conditions because of the safety of the camps.¹⁵⁸ Refugee camps situated across the border in Honduras presented similar issues of insecurity to those located inside El Salvador. A 1982 supplemental report by the Americas Watch Committee and The American Civil Liberties Union noted that the Honduran military treated refugees and aid workers brutally, and that Salvadoran troops frequently crossed the border to capture those suspected of working with the guerillas.¹⁵⁹

Not all refugees experienced the same levels of service. Canadian solidarity activist, Christine Reesor, spent time working in two different camps for internally displaced Salvadorans, Betania camp located in La Libertad, and Calle Real located north of San Salvador.¹⁶⁰ Calle Real, she notes, benefitted from greater food security. She says that at Calle Real, refugees “had three meals a day, whereas in the first one [Betania], there were only two meals a day.” Moreover, at Calle Real, “there was actually a doctor from the archdiocese who came out and provided medical care on site.” At Betania, “the medical care was a little more tenuous. There was a nurse, but there wasn’t a defined clinic site.” There were, she notes, doctors from the French organization Médecins du Monde (Doctors of the World), who “visited the camp on a schedule to provide some medical care.”¹⁶¹ Still, the camp at Calle Real had better medical care available for the

¹⁵⁸ Instituto de Investigaciones and Instituto de Derechos Humanos de la Universidad Centroamericana de El Salvador, *El Salvador 1986: En Busca de Soluciones para los Desplazados*, 15 September, 1986, 10.
<http://repositorio.uca.edu.sv/jspui/bitstream/11674/2321/1/El%20Salvador%201986%20En%20busca%20de%20soluciones%20para%20los%20desplazados.pdf>.

¹⁵⁹ Americas Watch Committee and The American Civil Liberties Union, *July 20, 1982 Supplement to the Report on Human Rights in El Salvador*, 62.

¹⁶⁰ Christine Reesor (Canadian solidarity activist), interview by author, November 12, 2019, phone interview.

¹⁶¹ Christine Reesor, in correspondence with author, April 6, 2020.

refugees. But it came at a price. According to Reesor, the Red Cross and Archdiocese agreed that wounded FMLN fighters would be treated at the clinic operating in the Calle Real camp. While the displaced experienced greater access to care because of that agreement, they also faced heightened danger. Reesor states that the presence of the clinic “made the camp a target for the Armed Forces.” On January 9, 1988, the Armed Forces surrounded the camp fired for an extended period.¹⁶² Discrepancies between the two camps show just how different access to medical care was for the displaced, even when they remained in the same country.

The displaced of Nicaragua and El Salvador faced an extra set of hurdles in accessing health care. In both cases, the violence, as sponsored by the United States, pushed civilians into precarious positions. Not only did refugees suffer greater physical harm, they also dealt with the psychological trauma associated with being forced to flee or relocate. Not all displacement was created equally. While some experienced more consistent access to services, and others even had improved access, trauma and uncertainty permeated the lives of all the displaced.

D. Conclusion

The health systems of El Salvador and Nicaragua underwent major changes as a result of the revolutions and counterrevolutions of the 1980s. The popular health systems that the FMLN and FSLN promoted saw the expansion of community-level health access.

¹⁶² For more information on the attack of the Calle Real camp, see Margaret Swedish and Marie Dennis, *Like Grains of Wheat: A Spirituality of Solidarity* (Maryknoll, NY: Orbis Books, 2004); see also David Hartsough and Joyce Hollyday, *Waging Peace: Global Adventures of a Lifelong Activist*, (Oakland: PM Press, 2014). The account by Swedish and Dennis notes that the song “Don’t Put Your Pictures Away” by Francisco Herrera ends with an audio recording of the gunfire shot at Calle Real.

In Nicaragua, significant improvements resulted from the new system, while in El Salvador, revolutionary forces struggled to maintain health systems in the face of brutal government repression. Solidarity workers played an important role in maintaining the medical networks and supply chains for each country. Internationalist solidarity propped up the community-based revolutionary movement toward healthcare access for all.

CHAPTER 3

HEALTHCARE SOLIDARITY

“It’s not really revolutionary, it’s not really transformative unless we transform our relationship with power.”¹⁶³ – Susan Classen

Within the Central American solidarity movement lay a subgroup of doctors, nurses, community health workers, and others who sent medicine and essential supplies to ensure the functioning of healthcare systems. Some of these activists remained in the United States raising funds and awareness. Others recognized the value of their skill set and made the journey south to offer a helping hand to those in need. Lois Wessel, an activist who lived in Nicaragua from 1985-1991, identified this division in solidarity, saying that for “a U.S. citizen, there’s sort of two sides to the solidarity movement. One side with people living in the United States and one side with people living, in my case, in Nicaragua.”¹⁶⁴ There remained, for both groups, a firm belief that the best way to combat the violence was by healing. For many activists involved in health care in both El Salvador and Nicaragua, there were two main goals. The first was direct: offering services as a doctor or nurse to treat sick and injured patients. The most important goal of these workers, however, was building up the capacity for health work within communities. This was revolutionary work. Sandy Smith-Nonini writes that the building of public health capacity in the war zones of El Salvador, “arose in part out of necessity, and in part out of the openness to new ideologies created by the polarization and the

¹⁶³ Susan Classen (U.S. nurse and solidarity activist), interview by author, October 24, 2019, Skype interview.

¹⁶⁴ Lois Wessel (solidarity activist), interview by author, October 24, 2019, phone interview.

influence initially of church workers and later of urban and ‘internationalist’ health professionals.”¹⁶⁵ The internationalists played a central role in promoting the revolution that was popular health.

This chapter focuses on those solidarity workers who looked to build up the healthcare capacity of El Salvador and Nicaragua. They understood that helping to build a lasting system would carry far beyond their own capacity to care for individual sick and wounded; that solidarity is most effective when those involved see each other as equals; that real change is effected through institution building, and such building must be steered by those most affected. Moreover, they saw the people of Nicaragua and El Salvador as agents of change capable of determining their own needs and improving their own situation. Despite the violence Salvadorans and Nicaraguans endured, they wanted to improve their lives and their communities, and healthcare solidarity workers helped make this improvement possible by engaging with communities in extended and meaningful ways.

A. “Working in the Solidarity Model”

As Nicaraguans and Salvadorans defined their revolutionary goals, solidarity activists from all over the world stepped in to lend a helping hand. Doctors, nurses, community health planners, and other activists made major impacts by offering their abilities to achieve community-set healthcare goals. Many of those who became integral to improving medical care passionately followed what Dr. Arnold Matlin refers to as the “solidarity model.” Matlin explained that this model is when “you work within the system, you don’t set up a shop and say here we are bringing you the gifts of American

¹⁶⁵ Smith-Nonini, *Healing the Body Politic*, 75.

medicine. You go to medical people in the community and you say ‘how can we help you’ and then they’ll tell you, and then that’s what you should do.’¹⁶⁶ Lois Wessel decided not to return to Nicaragua after training as a nurse in part because of her commitment to community agency. In describing her decision, she states:

One of the reasons I ended up not going back in that public health capacity was as much as I adored the people I worked with, I didn’t want to be the gringo who kinda flew in on an airplane and stayed at a nice hotel and told people how to run their health projects. I didn’t see myself doing that, I felt like health projects needed to be more what the people wanted do and not what the funders wanted to do.¹⁶⁷

Focusing on what health goals the people of a community wanted and needed made for effective solidarity. Of course, asking the people what they wanted more broadly was important, too. Health care, though, was a realm in which the people could assert their needs and revolutionary goals, particularly during a decade when health care financially and practically took a backseat to warfare. Following the solidarity model, then, by working on health care at a grass roots level, or, at the least, with a grass roots mentality, helped make the revolutions efficacious. Solidarity workers who clung to this model played a pivotal, if not always leading, role in encouraging and assisting in the revolutionary health goals of the people. In that way, health care solidarity between the U.S., Nicaragua, and El Salvador proved effective and truly radical.

B. The Work of Health Internationalists

Arnold Matlin has been to Nicaragua over thirty-five times since his first visit in 1988. He still visits Nicaragua every year, and he and his wife continue to support health

¹⁶⁶ Arnold Matlin (U.S. doctor and solidarity activist), interview by author, October 23, 2019, phone interview.

¹⁶⁷ Lois Wessel, interview by author, October 24, 2019, phone interview.

care in the country. In 2004, Matlin was awarded the Hero of the Revolution award from the Sandinistas, the only North American to ever receive such an honor. His commitment to supporting the revolutionary goals for health care set out by the Sandinista government in the 1980s came alongside his deep belief in following the solidarity model. Matlin exemplifies the important work done by healthcare solidarity activists in Central America. Many of those who spent time in Nicaragua or El Salvador had a similar mindset, and they often worked for, or even started, organizations that funded and promoted such grass-roots ways of thinking. This chapter in no way outlines all of the people and organizations that committed to medical aid. Instead, it looks to how healthcare workers managed to encourage the revolutionary goals of the people through their solidarity work.

1. Exchanging Ideas

The Committee for Health Rights in Central America (CHERICA), later Committee for Health Rights in the Americas, the National Central America Health Rights Network (NCAHRN), MINSA, and *Federacion de Trabajadores de Salud* (Federation of Health Workers, FETSALUD), came together to “support the new Sandinista government’s efforts to provide medical care to the impoverished majority,” and to “inform the U.S. public of what was taking place.”¹⁶⁸ After consulting with MINSA and Managua’s medical school, CHERICA decided the most effective course of action “was to hold a large colloquium or conference in Managua, which would create a forum for exchange among U.S. and Nicaraguan health professionals about state-of-the-

¹⁶⁸ Paula Braveman, “Find the Best People and Support them,” in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home*, ed. Anne-Emmanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 173-174.

art medical care.”¹⁶⁹ These colloquia, held annually for ten years starting in 1983, asserted important moral support for Nicaraguan health workers and “generated myriad other collaborative efforts” between the U.S. and Nicaragua.¹⁷⁰

U.S. and Nicaraguan medical professionals gathered at the North American-Nicaragua Health Colloquia. U.S.-born public health activist, Maria Hamlin Zuniga, noted that the goal of these colloquia was to introduce “the kinds of things that were going on in modern medicine that Nicaraguans were not able to get.” Moreover:

the colloqui[a] dealt with many different kinds of things. People came and helped people understand more modern scientific thought on different diseases, helped with the women’s groups for sexual health and reproductive health, and for how to deal with trauma, . . . how to deal with anxiety and depression, how to deal with the huge number of people who we had who were suffering loss of limbs because of the war.¹⁷¹

The colloquia brought healthcare solidarity activists and Nicaraguan health workers together to exchange ideas. This gave Nicaraguans, seamed in by sanctions, access to content otherwise unavailable to them. The colloquia were held in part to expose U.S. health workers to the realities of Nicaraguan medicine. Visiting medical professionals saw the progress of the Sandinista policies and the destruction wrought by the Contras, and, in response, they returned home eager to advocate in favor of the FSLN.

The student newspaper *Synapse*, published out of the University of California San Francisco, wrote of a delegation sent by the university to the October 1982 health colloquium. Delegates reported that, “we went to provide updated medical information

¹⁶⁹ Ibid., 175.

¹⁷⁰ Ibid., 175.

¹⁷¹ Maria Hamlin Zuniga (public health activist), interview by author, October 15, 2019, Skype interview.

on a broad range of topics and to observe firsthand the health conditions in the country.” They said that “the most important aspect of our experience was the realization that Nicaragua is at war.”¹⁷² An Ann Arbor publication reported in April 1986, that “North American health professionals returning from a recent health colloquium in Managua confirm the crisis caused by both the shortage of medical materials and displacement of health personnel resulting from the war.”¹⁷³

These delegates returned from Nicaragua with such a sense of injustice that they often founded new organizations that helped spur the U.S. outcry against U.S. intervention in Central America. According to Matlin, “once we travelled to Nicaragua and saw the reality, we were hooked.” In fact, Matlin, along with a colleague, founded the Ciudad Hermana Taskforce in response to his initial experience as a delegate. The taskforce, which formed a vital sister city link between the Nicaragua town, El Sauce, and Rochester, New York, still exists today.¹⁷⁴

As these examples show, healthcare solidarity was vital to the Central American solidarity movement. Though not all organizations were health-focused, all were impacted by the voices of delegates who travelled to the country to attend health colloquia and witness the reality of health care for a country under siege. The Nicaraguan government supported such delegations because they saw how potent such solidarity

¹⁷² Synapse UCSF Student Voices, “This Date in UCSF History: Health care Sandinista-style,” *UCSF Student Voices*, 18 October 1982, <https://synapse.ucsf.edu/articles/2018/10/15/date-ucsf-history-health-care-sandinista-style>.

¹⁷³ Agenda Publications, “Medical Aid Caravan for Nicaragua,” *Agenda*, April 1986, Ann Arbor District Library, <https://aadl.org/node/244465>. *Agenda* was an independent newspaper serving the Ann Arbor area from 1986 to 1998.

¹⁷⁴ Arnold Matlin (U.S. doctor and solidarity activist), in correspondence with author, March 10, 2020.

could be in impacting U.S. policy and curbing the economic squeeze that hindered the FSLN's capacity for change.

Dr. Jill Winegardner, a neuropsychologist, began travelling to Nicaragua in 1988 through an organization known as The Training Exchange. Rather than treat patients, the goal of the exchange “was to support healthcare professionals who provided training, not just service, but [to leave] a legacy of training to their Nicaraguan counterparts.” It was through the exchange process that Winegardner was able to return to Nicaragua and eventually move there. From the beginning, she was involved in supporting cutting-edge growth in the country. She notes that on her first visit, she helped form “a society called the Nicaraguan Neuropsychological Society, or Association... of the psychologists who had just started learning neuropsychology.” Additionally, she “taught weekly classes, usually at the rehab hospital,... visited the individual psychologists in the class in their places of work,... did some tutoring at the University of Central America, and [helped with] their theses and their projects in neuropsychology.”¹⁷⁵

For Winegardner, the purpose of her time in Nicaragua was supportive, not controlling – assistive, not prescriptive. “It was all training. That was the whole purpose of the project, not to do actual clinical work, but to train.”¹⁷⁶ Winegardner introduced a new field of medical practice to Nicaragua. In that process, she easily could have chosen to assert her own expertise and beliefs onto the psychologists she helped to train. But Winegardner and the program she worked through understood the significance of solidarity and the importance of not domineering, regardless of her own background.

¹⁷⁵ Jill Winegardner (U.S. doctor and solidarity activist), interview by author, October 28, 2019, Skype interview.

¹⁷⁶ Ibid.

2. U.S.-Based Solidarity Actions

U.S.-based groups often engaged in solidarity by shipping supplies to Central America. Nicaraguans struggled to access basic goods as well as medical supplies in the face of U.S. sanctions. Winegardner notes that lacking basic supplies was a “constant” while she was in Nicaragua. “There was always a problem getting supplies, getting goods, getting medicines, getting anything. And in my specialized little area, you know, though I didn’t use medicines, the basic materials like paper and pencil, or a typewriter, those kinds of things were not always in easy supply.”¹⁷⁷ In response, Lois Wessel notes, “there were people filling up containers and shipping [them] to Nicaragua that had important things, whether it was medicine, or clothing.”¹⁷⁸ Groups that raised funds and shipped materials to Central America, then, were vital in the maintenance of the healthcare system.

The Nicaragua Medical Aid Project (NMAP) stated as its main goal the collection of “medical supplies and money to meet specific requests by health care facilities in Nicaragua.” In 1986, the Ann Arbor-based group described its work with Nicaragua as:

Delivering requested medical supplies to the Hospital Infantil in Managua and to rural health centers...repairing microscopes throughout Nicaragua and providing spare parts...buying pharmaceuticals at 3% of cost through the Medicines for Central America Fund...sending emergency medical kits for use in war zones and rural health posts...contributing to the purchase of generators for health care facilities needing electric power... [and] supplying repair parts for U.S. made medical equipment.¹⁷⁹

¹⁷⁷ Ibid.

¹⁷⁸ Lois Wessel, interview by author, October 24, 2019, phone interview.

¹⁷⁹ Agenda Publications, “N.M.A.P.”, *Agenda*, April 1986, Ann Arbor District Library, <https://aadl.org/node/244478>.

In April 1986, NMAP participated in a regional caravan that converged in Milwaukee with supplies to fill a 20-ton shipping container for Nicaragua.¹⁸⁰ In October of the same year, NMAP sent a delegation to Nicaragua with “several hundred pounds of medical equipment and pharmaceuticals.”¹⁸¹

NCAHRN funded organizations capable of delivering medications to Central America. The Medicines for Central America Fund (MCAF), sent “hundreds of thousands of dollars of supplies” and promised donors that every “dollar donated” purchased “\$30 of urgently needed medicines.” NCAHRN also worked with Insulin for Life in “response to an urgent need in Nicaragua,” to deliver “monthly supplies of insulin” to the country (Appendix A).¹⁸²

Many other U.S.-based organizations raised funds and collected materials to send to Central American countries, particularly El Salvador and Nicaragua. A 1987 *Directory of Central America Organizations*, published by the Central America Resource Center in Austin, Texas, shows that medical support came from a wide geographic spread in the United States. Many organizations were based in the big cities of California, in Chicago, in New York, and in Boston, but activists organized in smaller regions as well. For example, Missoula, Montana hosted the Montana Committee for Health Rights in Central America and Medical Aid to Central America was based in Madison, Wisconsin.¹⁸³

¹⁸⁰ Agenda Publications, “Medical Aid Caravan for Nicaragua.”

¹⁸¹ Tom Rogers, “Health Care Package: Delegation to Nicaragua stocks up medicine chest,” *Ann Arbor News*, 29 October 1986, Ann Arbor District Library, https://aadl.org/aa_news_19861029-health_care_package.

¹⁸² NCAHRN, *The National Central America Health Rights Network*, pamphlet, in the author’s possession, provided by Dr. Arnold Matlin.

¹⁸³ Central America Resource Center, *Directory of Central America Organizations Third Edition* (Austin, 1987), in the author’s possession.

These organizations played a vital role in upholding the integrity of medical systems constantly threatened by lack of resources.

3. Organizations without a Focus on Medicine

Many solidarity organizations and activists engaged health promotion without focusing exclusively on issues of medical access. The Committee in Solidarity with the People of El Salvador (CISPES), a prominent U.S.-based organization to present, focused on preventing U.S.-invasion, a goal immortalized by the slogan “El Salvador is Spanish for Vietnam.”¹⁸⁴ Though CISPES focused on political advocacy and broad support of the FMLN and grassroots organizing, they also promoted health care via the Bravo Fund. The Bravo Fund, in turn, used the money from CISPES to fund training and the Alejandra Bravo Field Hospital in Chalatenango.¹⁸⁵

At times, activists with little background in public health, found themselves engaged in healthcare solidarity. Aynn Setright travelled to Nicaragua with Witness for Peace (WP) in 1985 with a mind to shift U.S. policy. WP, founded in 1983 in opposition to Reagan’s support for the Contras, “brought thousands of people to Nicaragua to provide protective accompaniment to communities at risk and to document the effects of the U.S.-supported war.”¹⁸⁶ Neither WP nor Setright focused exclusively on medicine and health, but through WP, Setright found herself driving an ambulance in central Nicaragua for a town called Bocana de Paiwas. “Catholic relief services had provided the parish

¹⁸⁴ Cherrene Horazuk and Alexis Stoumbelis, “History of CISPES,” <http://cispes.org/section/history-cispes>.

¹⁸⁵ “Rebuilding Lives and Communities from the U.S. to El Salvador”, 1991, Box 11, Folder 24, Organization in Solidarity with Central America, Walter P. Reuther Library, Detroit, Michigan.

¹⁸⁶ Witness for Peace, “Nicaragua: The History,” <https://witnessforpeace.org/nicaragua/>.

with an ambulance, and the red cross didn't want to be in that zone because it was too conflictual, and MINSA every time they sent an ambulance out, it was ambushed.” The parish requested, through WP, that someone be sent to drive the ambulance.¹⁸⁷

C. Solidarity Based in Central America

In 1982, Maria Hamlin Zuniga, a public health worker who has lived in Central America since 1968, helped establish the organization, Centro de Información y Servicios de Asesoría en Salud (Center for Information and Advisory Services in Health, CISAS). CISAS “was organized to provide health education and work[ed] with communities on community empowerment around health.” The organization exists today, and works in the cities and surrounding areas of Managua, León, and El Viejo. At the same time as she founded CISAS, Hamlin Zuniga worked at MINSA and helped to coordinate internationalist solidarity workers to the health programs run by the Ministry. She notes that “especially during the 80s, [CISAS] collaborated with the different people who were coming to the country to provide services,” though the main bulk of connections CISAS made were with “popular organizations, women’s organizations, women, youth, children and the community or community defense committees that were set up at that time and later were converted into the Nicaraguan Communal Movement [Movimiento Comunal Nicaragüense].”¹⁸⁸

While CISAS remains a community-oriented organization, many solidarity workers joined the organization during the 1980s. Hamlin Zuniga has long been adopted as a Central American, but she worked with many activists who lived in the region for

¹⁸⁷ Aynn Setright, interview by author, August 2, 2019, Brattleboro, Vermont.

¹⁸⁸ Maria Hamlin Zuniga, interview by author, October 15, 2019, Skype interview.

shorter stints. Lois Wessel became involved in CISAS in the late 1980s and describes the organization as “a very hands-on health education center that does a lot of education using really participatory techniques, so theater, and dance, and song, to teach.”¹⁸⁹

Mark Smith, a public health and environmental activist, and Susan Classen helped found the Comisión Diocesana de la Pastoral en Salud de Chalatenango (Diocesan Health Commission of Chalatenango Province, CODIPSA). Founded in El Salvador in 1988,¹⁹⁰ the organization responded to the health needs of repopulating and repatriating populations. CODIPSA, under the protection of the Catholic Church, focused on training community health workers and rebuilding the infrastructure that had been destroyed. CODIPSA coordinated numerous two-day training sessions, vaccination campaigns, and *convivencias* (two day retreats for volunteer health workers to learn new skills), in addition to procuring medicine and supplies from San Salvador.

Smith helped coordinate trainings and ensure that medications remained stocked. To get the supplies back to Chalatenango, he would leave San Salvador in the early morning hours in hopes that guards at the checkpoints would be asleep when he passed through. Though he was questioned at times, he never had the medications taken by the Salvadoran military. Smith worked on campaigns with CODIPSA where the volunteers

¹⁸⁹ Lois Wessel (solidarity activist), interview by author, October 24, 2019, phone interview.

¹⁹⁰ María Argelia Dubón Abrego, and Dagoberto Mejívar López, “La Construcción del Sistema Comunitario de Salud de Guarjila: Sistematización de una Experiencia de Atención Primaria de Salud Integral en El Salvador, Durante el Período de 1987-2007,” (master’s thesis, Universidad de El Salvador, 2013), 60, <http://ri.ues.edu.sv/id/eprint/11101/1/TESIS%20LA%20CONSTRUCCIÓN%20DEL%20SISTEMA%20COMUNITARIO%20DE%20SALUD%20DE%20GUARJILA.pdf>.

carried *pingüinos* (coolers full of vaccinations) obtained from the Salvadoran Ministry of Health into rural Chalatenango.¹⁹¹

Both Susan Classen and Mark Smith worked to coordinate and host trainings for local health volunteers. This aspect of CODIPSA's mission focused on the long-term goal of health sustainability so important to effective solidarity work. According to Smith, the local two-day trainings were created for "semi-literate populations" to "recognize and treat disease," particularly relating to upper respiratory issues and parasitic infections.¹⁹² Susan Classen worked under CODIPSA in a region called Las Vueltas. She was responsible for training health workers in villages located along a sixteen kilometer corridor.¹⁹³

Hamlin Zuniga participated in the founding of the Comité Regional de Promoción de Salud Comunitaria (Regional Committee for the Promotion of Community Health), an organization founded in Guatemala and that worked clandestinely until 1987 when it first participated publicly in an International Women's meeting.¹⁹⁴ The idea for a committee came about in 1975 and encouraged solidarity between health workers and systems in Central America.¹⁹⁵ The committee worked largely in secret because of the violence and

¹⁹¹ Upon further investigation, Mark was able to confirm that these vaccinations were donated to the Salvadoran Ministry of Health and provided to CODIPSA for use in Chalatenango. Being given vaccinations at a time when he and other activists were forced to sneak medications past check-points into the region, seems incongruous. Smith-Nonini provides a possible answer in noting that UNICEF brokered an annual one-day cease-fire treaty between the FMLN and Salvadoran government starting in 1985 to allow for vaccinations (*Healing the Body Politic*, 83).

¹⁹² Mark Smith (U.S. public health activist), interview by author, January 17, 2020, Boston, Massachusetts.

¹⁹³ Susan Classen, interview by author, October 24, 2019, Skype interview.

¹⁹⁴ Maria Hamlin Zuniga, interview by author, October 15, 2019, Skype interview.

¹⁹⁵ Maria Hamlin Zuniga, *Donde comienza la vida, comienza la atención primaria en salud* (Managua: Comité Regional de Promoción de Salud Comunitaria, 2003), 2.

oppression in the region during the 1970s and 1980s, particularly targeting health workers. That same violence made the committee an indispensable resource. In speaking about the committee, Hamlin Zuniga noted: “During the years of armed conflict in Central America, that particular committee was essential to permit people working in... community health, health promotion, [and] health education to come together under very difficult circumstances, but to come together and learn from one another, and... it continues to work to this day, so obviously it had sustainability.”

Hamlin Zuniga emphasized that the committee is not an organization, but rather a network. Through this work, Hamlin Zuniga and her colleagues created a vital link between health workers of Central American nations that boosted the capacity of each country’s respective health system. In explaining the four main activities of the committee during the 1980s, Hamlin Zuniga stated:

The idea was to train community health workers to carry out programs and the like because most worked in development programs... One of the purposes of the committee was to help these individuals and these organizations that they belonged to... What we wanted to do was that in each of the different countries [of Central America], they organize themselves in coordination at the national level so that they could help one another and then when that was done, they became part of a coordinating committee to carry out the strategic planning and programming for the committee as a whole. The committee had as its main activities regional encounters [meetings] around specific themes that were identified by the people who were in the committee and then each country would send people to these regional encounters... The third kind of activity that we had was the interchange between people working in different programs in different countries and that was very important during the repression because that way people from countries in conflict could go and live for a while in health programs in other countries that were not in conflict and be able to learn from that experience. And the fourth kind of activity... was the production and the promotion of educational materials.¹⁹⁶

¹⁹⁶ Maria Hamlin Zuniga in interview with author, 16 October 2019.

The Regional Committee is a healthcare solidarity organization for Central Americans, by Central Americans. Hamlin Zuniga and her colleagues recognized the revolutionary power of health care, and so they encouraged communities to take charge of their physical wellbeing and, consequently, shape Central American revolutions to their own needs. In her 2003 popular history of the Regional Committee, Hamlin Zuniga chronicles the formation of the committee and its focus on community health, which was a response to oppression and a part of the revolutionary actions taken by the Sandinistas and the people.¹⁹⁷

D. Cultural and Economic Struggles for Health Internationalists

“I was pushed to compromise what would be an appropriate level of work... to accommodate circumstances [in Nicaragua], but if I did that, I knew the country wouldn't go forward.”¹⁹⁸ – Dr. Jill Winegardner

For each of the workers accounted for here, respecting the wishes, desires, and knowledge of local populations was crucial to building effective health systems; the activists never placed themselves as central to the process. When asked how she dealt with Salvadoran beliefs that directly contradicted her medical knowledge, Susan Classen responded, “that was the ocean that we swam in.”¹⁹⁹ Classen epitomized a fundamental

¹⁹⁷ Hamlin Zuniga, *Donde comienza la vida, comienza la atención primaria en salud*. Maria was kind enough to share the popular history with me. Written in Spanish and styled as a comic book, it was clearly created to appeal to a broad audience with varying degrees of literacy. Moreover, the history identifies the committee's health goals in the context of oppression and U.S. foreign policy, explaining that the goals of health and infrastructure are vitally important aspects of revolution.

¹⁹⁸ Jill Winegardner, interview by author, October 28, 2019, Skype interview.

¹⁹⁹ Susan Classen (U.S. nurse), interview by author, October 24, 2019, Skype interview.

challenge that healthcare solidarity workers faced. Even as they saw that the best way forward was to build health systems according to the needs and desires of communities, they struggled with the cultural divisions that existed between their own beliefs about medicine and those of the locals. Many of these workers, who had been raised and educated in the U.S. or Canada, had difficulty deciding when to push back against harmful local practices and when to respect and recognize the efficacy of other practices.

While working alongside guerilla and community health workers in El Salvador, Charles Clements recognized that he “was the only fully educated doctor in the region.” Many of the health workers had only basic training in general health, but most were well experienced in handling the injuries prevalent in the war zone. Clements recognized his own limitations as well as strengths in the situation, and rather than viewing himself as the regional expert, he saw his “role as a complement to this system.”²⁰⁰ Even so, friction existed for Clements as he navigated his role as a doctor and an outsider.

Like many healthcare activists, Clements faced a slew of local beliefs detrimental to health practices. In his memoir, he writes:

What I didn't then understand is that in El Salvador medical treatment is viewed as a semi-mystical affair in which every ache or pain is treated with a pill or an injection, if possible. The practice is not fostered by doctors; most rural Salvadorans have never seen a doctor. It is a result of medicines of every type being urged on the people by over-the-counter diagnosticians. Product safety regulation is unknown in that country.²⁰¹

Many other activists echo Clement's experience. Susan Classen stated that aside from traditional “folklore beliefs,” the belief that “injections and IVs are better than pills”

²⁰⁰ Clements, *Witness to War*, 54.

²⁰¹ *Ibid.*, 34.

permeated the expectations Salvadorans had of medical practitioners.²⁰² Classen also encountered misunderstandings about the nature of medications. When talking about administering pills to patients, she noted that many misunderstood the differences between kinds of pills: “The red pill is better than the brown one, everybody wanted vitamins and somebody had a couple leftover antibiotics, so they’d give it to somebody else who had a cold.”²⁰³ Many of these issues arose because the populations had little access to medical care and education prior to the 1980s.

Financial realities impacted Central Americans and activists, both in accessing supplies and in offering sufficient training. Jill Winegardner noted that in Nicaragua, “the financial imperatives... were really severe. So things like, in advanced countries, we have private offices, we have telephones, we have paper, we have test materials, we have secretaries, we have phones, and there, none of those things would be taken for granted.” Access to supplies, including neuropsychological tests, was restricted, but those tests that were available often did not fit with financial realities of the patients. Winegardner noted that, “for neuropsychology, there’s a lot of norming that has to be done, so a lot of these tests didn’t have appropriate norms for use in Nicaragua, so we had to develop some of our own norms and think up some of our own tests.” For example, a boy with no formal education but with extensive experience selling goods on the streets may not be able to pass a test created for a population assumed to have basic math skills, but exchanging money would be a task that neuropsychologists could use as a test for him.²⁰⁴

²⁰² Susan Classen, interview by author, October 24, 2019, Skype interview.

²⁰³ Ibid.

²⁰⁴ Jill Winegardner, interview by author, October 28, 2019, Skype interview.

Winegardner's students also faced financial difficulties that made proper training impossible in some cases. In her time training students, she encountered one particularly difficult situation:

I had a pair of students who were doing a thesis and one of them didn't come to the meetings because her family had a little stall at the oriental market there and they had gotten robbed a couple times, and so she couldn't leave it. And so I had this dilemma that you wouldn't have in the U.S. Everyone [in Nicaragua] told me to pass her anyway even though she didn't do the work, because of her family difficulty and the financial necessity of her staying at the market. But on the other hand, I would perpetuate untrained psychologists, and I really didn't want to do that, so I ended up not passing her, because she hadn't achieved the level of work needed. But people were really angry about that. Those kinds of things have an impact on health care as well.²⁰⁵

Healthcare solidarity workers faced difficult and often unpopular decisions like that which Winegardner made with her student. Determining when and how to interject knowledge and insist on professional expectations was difficult in both El Salvador and Nicaragua because of cultural differences, financial difficulties and, most of all, because of the violence and oppression facing both populations. Nonetheless, Winegardner, and other activists, continued to work within a solidarity model, trying to limit the imposition of their own belief systems, listening to the desires of the local community, but also choosing to push the healthcare systems forward in effective ways.

At times, the differing belief systems and regulations allowed activists to help in unique ways. While working in Managua, Lois Wessel spent a year apprenticing with a Uruguayan obstetrician-gynecologist. Wessel summarized the experience by saying, "I would just show up at the hospital when [the OB/gyn] was working and she let me deliver babies... that would never happen now, like who the hell are you, someone off

²⁰⁵ Ibid.

the street, delivering babies.”²⁰⁶ Susan Classen notes that in her time as a nurse and then training healthcare workers, she and her colleagues “did try hard to work with medicinal plants and lift up that kind of response because a lot of those are not just part of the belief system, they do actually work. So that was one way of trying to work with and not just work against.”²⁰⁷ Promoting natural remedies worked in part because it embraced more traditional beliefs and in part because it responded effectively to shortages in medicine. However, not all activists found the communities they worked in receptive to the use of herbal remedies. In his time in El Salvador, Clements routinely promoted natural options that communities were slow to accept:

The peasants were skeptical at the introduction of natural remedies. Their forebears... had been conversant with the pharmacopaeia growing wild around them. Almost any of their grandparents had ten times the knowledge of natural medicine that I possessed, but that lore had been lost with the advent of easily available drug-store remedies. The willow bark tea was slow to catch on, as was the sedative we showed them how to brew from the leaves of the mock orange tree. Despite the fact that stomach gas, acidity, and ulcer-like pain were common complaints, they showed little interest in learning how to prepare an antacid from the fine ash of their cooking fires.²⁰⁸

What the two contradicting experiences show about working in the war zones of El Salvador is just how adaptable and open-minded healthcare solidarity workers needed to be in order to achieve results.

Dr. Francisco Metzti writes that he became most effective in teaching and treatment when he embraced the beliefs of the local populations, rather than fighting or ignoring them. He writes: “In the middle of class one day, it suddenly occurred to me that I was looking at the problem completely backwards. It wasn’t these young women who

²⁰⁶ Lois Wessel, interview by author, October 24, 2019, phone interview.

²⁰⁷ Susan Classen, interview by author, October 24, 2019, Skype interview.

²⁰⁸ Clements, *Witness to War*, 103.

should sit back and absorb what I taught, but rather, I should learn from them.” This new way of thinking, he says, “radically changed not only my teaching style, but also my relationship to the community as a whole... this proved to be the key to making my work more useful.”²⁰⁹ Moreover, because Metzi aimed to plant the seeds of a successful healthcare system that would take root for the populations of El Salvador he temporarily served, he realized that engaging with civilian beliefs was not just more effective, but imperative. He writes that the new teaching method had a political imperative achieved by “starting from the base of knowledge that already exist[ed] among the people, even if it [was] not always interpreted correctly.”²¹⁰ Building students’ confidence in their own medical knowledge and capability would serve the community for longer than Metzi realized he could. This way of thinking allowed Metzi to engage the solidarity model on a deeper level. Many healthcare activists worked in medicine because they believed that contributing their time and skills would help promote the revolution, and though they often struggled with cultural and economic restrictions, they remained flexible, finding ingenious ways to build lasting networks in Central America.

E. Clinics and Hospitals: Sites of Revolution

“The hospitals are the result of a community effort, a symbol of the people’s accomplishment.”²¹¹ – Francisco Metzi

Solidarity activists so often found themselves working in medicine because hospitals and clinics were sites of revolution. In both El Salvador and Nicaragua, medical

²⁰⁹ Metzi, *The People’s Remedy*, 43.

²¹⁰ *Ibid.*, 45.

²¹¹ *Ibid.*, 35.

facilities were considered revolutionary and targeted by the Salvadoran military and the Contras, respectively. Building a clinic in the war zones was revolutionary; driving the ambulance with sick and wounded on treacherous, land-mine-pocked roads, was revolutionary; the very act of seeking out care at a clinic was revolutionary. Most importantly, these were sites of revolution not only for the Sandinista and FMLN leadership, but also for the people. Communities chose to build health clinics together, solidarity workers helped run and train these clinics, and in so doing, the people of Central America were taking revolutionary stances against systems of oppression.

While working as a doctor and healthcare trainer on the front lines of the conflict in El Salvador, Metzti noted the importance of hospitals to Salvadoran communities. These hospitals were, he writes, “more like a neighborhood café, where friends get together after a late night political meeting.” They resembled small clinics, often piled high with trash, and with inconsistent equipment and supplies across different communities.²¹² In El Salvador, communities created these clinics, and, as Metzti notes, they were proud of them despite the danger they drew. Metzti states:

Everyone has contributed something towards [the hospital’s] construction. The civilians have pointed out the safest location for it and then helped build it. They have also helped carry the wounded there; the crops from their fields have supplied its provisions. As for the militiamen and the combatants, they have risked their lives to protect it, while teams from logistics have lugged heavy backpacks full of medical supplies over dangerous backwoods trails.²¹³

Solidarity workers often took on the role of secreting supplies to the clinics and training community workers to staff them. Solidarity workers fit neatly into a broader system that brought medical care to war-torn El Salvador and Nicaragua. These workers and

²¹² Ibid., 10.

²¹³ Ibid., 35.

community members made the revolutionary goals a reality. The FMLN wanted to provide health care for all, but they hardly had the capacity to do so as they carried out guerilla operations. It was the people who made the revolution real.

In Nicaragua, hospitals and clinics served as sites of revolution, as well. In the war zones, clinics were attacked by Contras, and so there, too, the very act of seeking medical help was revolutionary. Throughout the rest of the country, as the FSLN was forced to divert funds and attention away from stated health imperatives, the people seized on revolutionary fervor by demanding proper health care. The FSLN provided the framework, but the people carried out the daily revolutionary goals. Winegardner saw this take place at the government-run, rehabilitation hospital she worked at in Managua.

She states:

So Nicaragua was really a country where at that point because of the revolution, people were speaking up for their rights, loud and strong so in the rehab hospital, one week or two weeks, we couldn't have classes because the patients went on strike because they didn't like one of the doctors... Nowhere but in Nicaragua is that going to happen... The patients won. They said 'no, this doctor's not good enough, we should get a change' and that's what happened... I think that was the best example of anything that showed the impact of the revolution on day-to-day life. These are hospital patients, they aren't revolutionary actors or anything, but they knew their rights to good health care, and so they demanded them.²¹⁴

While the patients may not have been revolutionary actors in a traditional way – none were guerilla fighters or high-level Sandinistas – they were in fact revolutionary actors. They carried out the soul of revolution by demanding better treatment. They were Nicaraguan citizens, they were patients, and they were the people who made the revolution happen.

²¹⁴ Jill Winegardner, interview by author, October 28, 2019, Skype interview.

F. Conclusion

“Public health was the midwife of Marxism.”²¹⁵ –Richard Horton

This chapter has posited that the rural clinics and urban hospitals of war-torn El Salvador and Nicaragua were key sites of revolution. Healthcare solidarity activists played a key role in this revolutionary motion, and they also offered a clear window through which to view the efforts of the people. Sandy Smith-Nonini argues that “Friedrich Engels’s 1845 study, *The Condition of the Working Class in England*, was the first scholarly effort to examine the health of the public as both materially related to capitalist expansion and a site for revolutionary struggle.”²¹⁶ Though the revolution in Nicaragua was not Marxist, the people did see public health in a revolutionary light. The FMLN, more firmly grounded in Marxist thought, promoted public health as revolutionary, and the people carried out the call. Moreover, U.S. solidarity activists turned against the policies and actions of their country to support the health revolutions of Central America. Understanding the revolutionary nature of free and accessible health care, and the radical idea that community-based health care should be promoted, is integral to understanding how the people of El Salvador and Nicaragua experienced and engaged with revolution, and why so many healthcare workers and public health promoters chose to devote themselves to the cause.

²¹⁵ Richard Horton, “Offline: Medicine and Marx,” *The Lancet* 390, (2017), [https://doi.org/10.1016/S0140-6736\(17\)32805-2](https://doi.org/10.1016/S0140-6736(17)32805-2).

²¹⁶ Smith-Nonini, *Healing the Body Politic*, 75.

CHAPTER 4

GENDERING SOLIDARITY AND HEALTH CARE

“Health work helped move women into new social roles, and liberated many from patriarchal oversight.”²¹⁷ – Sandy Smith-Nonini

The women of El Salvador and Nicaragua navigated the political terrain of the 1980s by interpreting revolutionary rhetoric as an answer to their particular needs. Health care often figured as a central tenet of these feminisms in part because women held responsibility for the health of their family and their own reproductive health, and in part because women as nurses and volunteer health workers stepped into positions of leadership in their communities. This reality looked different in Nicaragua and El Salvador, but the result in both countries was the creation and mobilization of feminist networks that established health clinics, programs, and campaigns to respond to the needs of women and their children. In Nicaragua, the state often supported the efforts; in El Salvador, the guerillas and civilian revolutionaries worked together to promote a feminist agenda. As women navigated the complexities of wartime in both countries, they stepped into positions of leadership as healthcare workers in both hospitals and community clinics. As revolutionaries and counterrevolutionaries fought over ideologies including the right to access health care, women made those rights a reality for themselves, for their children, and for their communities.

²¹⁷ Smith-Nonini, *Healing the Body Politic*, 91.

A. Scholarship

Scholarship disagrees over whether women actively constructed a space for their needs within the revolutionary movements of Nicaragua and El Salvador. Some feminist scholars have argued that the revolutions were less a breaking of chains for women and more a restructuring of power for men, which resulted in a relative shift for women. In 1985, Maxine Molyneux wrote of Nicaragua that “if the revolution did not demand the dissolution of women’s *identities*, it did require the *subordination* of their *specific interests* to the broader goals of overthrowing Somoza and establishing a new social order.”²¹⁸ Rather than challenging gender roles, Molyneux argued that to “the traditional roles of housewife and mother have been added those of full-time wage worker and political activist,” meaning that women continued to support traditional gender roles while also propagating the revolutionary state.²¹⁹ This argument is indicative of Molyneux’s idea of feminine versus feminist. Molyneux, and others after her, have argued that “Feminine demands alleviate women’s roles as caretakers, while feminist demands explicitly challenge sexism.”²²⁰

Scholarship also criticizes the Asociación de Mujeres Nicaragüenses ‘Luisa Armanda Espinoza’ (Association of Nicaraguan Women Luisa Armanda Espinoza, AMNLAE), the prominent Nicaraguan women’s organization under the FSLN. Jennifer

²¹⁸ Maxine Molyneux, “Mobilization Without Emancipation? Women’s Interests, the State, and Revolution in Nicaragua,” *Feminist Studies* 11, no. 2 (1985): 229, doi: https://doi.org/10.1057/9780230286382_3.

²¹⁹ *Ibid.*, 229.

²²⁰ Sierra Becerra, “For Our Total Emancipation,” 284-285.

Leigh Disney argues that “a patriarchal political culture” permeated and impeded the AMNLAE.²²¹

In El Salvador, argues Ilja A. Luciak, women “joined the FMLN to change prevailing social conditions, and almost all of them served in supporting roles.”²²² Even so, women “constituted 27 to 34 percent of the FMLN membership.”²²³ Minimizing these women’s contributions by saying that they held primarily supporting roles is a disservice. Their decision to support the FMLN in whatever capacity developed from a nuanced set of choices and ideas about their position in Salvadoran society; they pursued their own needs, whatever roles they accepted. Moreover, women in health care often played leading roles, a fact ignored by scholars who assume that women were relegated to subordinate positions.

Other scholarship argues that women navigated the revolutions in ways that benefitted them. Diana Carolina Sierra Becerra contends that Salvadoran women defined their own feminist praxis through the Asociación de Mujeres de El Salvador (Association of Women of El Salvador, AMES). Sierra Becerra claims that AMES “redefined socialist revolution to mean the overthrow of both capitalism and patriarchy, and mobilized women to shape the everyday and long-term trajectory of the revolutionary process.”²²⁴ She notes that AMES organized “combatants, peasants, and militants in exiles,” alongside solidarity workers “from Mexico, Costa Rica, Nicaragua, and the

²²¹ Jennifer Leigh Disney, *Women’s Activism and Feminist Agency in Mozambique and Nicaragua* (Philadelphia: Temple University Press, 2008), 47.

²²² Ilja A. Luciak, *After the Revolution: Gender and Democracy in El Salvador, Nicaragua, and Guatemala* (Baltimore & London: The Johns Hopkins University Press, 2001), 71.

²²³ Sierra Becerra, “For Our Total Emancipation,” in *Making the Revolution*, 268.

²²⁴ *Ibid.*, 266.

United States,” to develop new feminist practices of revolution.²²⁵ Further, she argues that the feminist-feminine dichotomy “can obscure their intimate relationship.”²²⁶ This chapter follows with Sierra Becerra’s interpretation by assuming that the health needs of women and their children were both a feminist and a feminine issue, but that women chose to use health care as platform from which to engage feminist ideology.

Margaret Randall argues that in Nicaragua, “women developed a consciousness of themselves as women and of the important role they could play in the fight against Somoza.”²²⁷ In prefacing her collection of interviews with Sandinista women, Randall states that the women’s stories “force us to stretch the notion of what is political so as to include issues usually hidden and dismissed as personal.”²²⁸ This includes women’s efforts to develop community health programs that focused on women’s and children’s health.

Considering how women engaged with health care offers one way of understanding the revolutions of the 1980s. In both countries, women pursued the development of healthcare systems that responded to their and their family’s needs. Even as violence limited resources and destroyed infrastructure, women prioritized health needs as mothers, health workers, and solidarity activists. They chose to interpret revolutionary ideology in their favor, and they embraced opportunities for leadership that broke with more traditional ideas about the role of women.

²²⁵ Ibid., 266.

²²⁶ Ibid., 285.

²²⁷ Margaret Randall, *Sandinista’s Daughters: Testimonies of Nicaraguan Women in Struggle* (New Brunswick: Rutgers University Press, 1995), 10.

²²⁸ Ibid., ix.

Women took up the call for universal health care access for themselves and their children, not in order to carry out the requests of men. Sierra Becerra argues that AMES developed a feminist praxis that embraced women's health issues as central to the efforts of shaping the Salvadoran revolution. Moreover, women centered reproduction and in "the guerilla territories and refugee camps, AMES politicized reproductive labor."²²⁹ Sierra Becerra further contends that "the top FMLN leadership did not monopolize the goals of the revolution."²³⁰ In Nicaragua, the FSLN pursued access to health care as a central tenet, but women defined what that care looked like, and in the process, they carved out new leadership roles for themselves. Women's reproductive needs, and the health needs of their children, were hardly subordinate to the male rallying cries in either country. This chapter assesses how women came to understand their place in society differently in part because of newly developing healthcare systems.

B. Gendered Impacts of Healthcare Instability

Violence and revolution impacted women's health more drastically than men's because of women's entrenched position as reproductive laborers in Salvadoran and Nicaraguan society. As women faced different physical realities than their male counterparts, they also responded in ways to address those reproductive health needs and the health needs of their children. The reality for women in both El Salvador and Nicaragua was a greater physical toll, a rupture with traditional ways of life, and inhibited access to health care. Understanding how women fit into the revolution is essential to untangling their relationship with healthcare development.

²²⁹ Sierra Becerra, "For Our Total Emancipation," 266-267.

²³⁰ Ibid., 292.

1. El Salvador

While the FMLN promoted gender equality and access to health care, the Salvadoran government saw neither as important tenets. Even as the FMLN attempted to implement healthcare networks in the guerilla-controlled areas, violence and lack of access to medical supplies made the task difficult. For many Salvadoran women, this either meant an inability to afford health care in the government-controlled hospitals or a shortage of care in the guerilla-controlled territories.

The Salvadoran government targeted poor and indigenous women by denying health care and by imposing ideas about reproductive health that built on racist and classist notions. A group of American doctors writing on the state of maternal health in 1982 reported on a state-run facility:

At the Maternity Hospital [sic] we observed about 20 women in various stages of labor. Two or three women occupied each bed. Women in labor sat together on a hard bench until shortly before delivery, when they walked up a steep flight of stairs to the delivery room. If they could not pay the fee for admission to the hospital and for medications, they [sic] were sent home immediately after they had delivered.²³¹

Sterilization of these women was an issue in El Salvador. “In a 1981 bulletin, [The Reproductive Rights National Network] reported on the forced-sterilization campaigns of the US government against both American and Salvadoran women.” Sierra Becerra argues that the Salvadoran government “did not forcibly sterilize women,” but that “it did actively promote sterilization over other means of contraception.”²³² At the very least, the threat of sterilization kept women away from state-run hospitals. Susan Classen notes that during her time working as a nurse and public health promoter in Chalatenango, she

²³¹ Health PAC Bulletin, “Health and Human Rights in El Salvador,” 31.

²³² Sierra Becerra, “For Our Total Emancipation,” 282.

encountered many women afraid of sterilization. According to Classen, “At every step hospital workers try to convince the women to be sterilized.”²³³ Classen’s observations indicate that the reality for many women was a choice between harassment and receiving care or avoiding the discomfort but forfeiting medical care.

Moreover, state-run hospitals at times dismissed the suffering of poor women using racist and classist logic. Classen tells of one poor woman, Felícita, who only saw a doctor after her fifth visit to the hospital, and only when Classen went with her. Felícita needed surgery for a prolapsed uterus and was able to get the blood needed for the surgery because Classen “was a foreigner with influence.”²³⁴ Another woman named Marta watched her twelve-year old daughter waste away from malnutrition and diarrhea. Marta and her daughter had been turned away by doctors at the hospital who kicked them out because they were “dirty Indians”. Classen argues that Marta was “considered the scum of the earth, poor, an Indian, a woman, displaced, no husband,” and that her daughter was “killed by the violence of poverty.”²³⁵

The lack of health care for families burdened women more than men. “Older women, mothers with young children, and elderly persons comprised a significant portion of civilians within the liberated territories.”²³⁶ The limited infrastructure in place for Salvadoran peasants prior to the violence of the 1970s and 1980s resulted in poor health that was only exacerbated with the mass destruction of the war years. Young children suffered malnutrition in high rates, a reality that fell upon women to manage. Marta,

²³³ Classen, *Vultures and Butterflies*, 61.

²³⁴ *Ibid.*, 138-139.

²³⁵ *Ibid.*, 138.

²³⁶ Sierra Becerra, “For Our Total Emancipation,” 272.

whose 12-year old daughter died in part due to malnutrition, took on the entire burden of caring for her sick child. Marta's husband was recently deceased, and the woman had barely been able to scrape together the money for bus fare to the hospital, much less medicine and substantial nourishment for the sick child.²³⁷ Marta's story illustrates the reality for many poor women in a country where malnutrition affected as much as 80% of the population of children under five.²³⁸

Women also faced more frequent displacement than men. "Women outnumbered men in the refugee camps, sometimes three or four to one."²³⁹ It follows that the psychological and physical trauma of displacement disproportionately impacted women and their children. Moreover, the *guindas* forced families to forego regular access to medicine or food, which particularly impacted young children and infants.

Women suffered more when proper health measures failed, and they gained more with even minor improvements to the system. Because of their unique relationship to health care, women often championed progress in their local health system in ways that both fit with the revolutionary agenda (and went against the agenda of the Salvadoran government) and reconfigured ideals to match with their particular needs.

2. Nicaragua

Nicaraguan women faced a vastly different set of circumstances than their Salvadoran counterparts. The FSLN strived for gender equality and aimed to establish universal health care. Where Salvadoran women faced heightened oppression,

²³⁷ Classen, *Vultures and Butterflies*, 138.

²³⁸ Carola Eisenberg et al., "Health and Human Rights in El Salvador," *The New England Journal of Medicine* 308, no. 17 (1983): 1029.

²³⁹ Todd, *Beyond Displacement*, 107.

Nicaraguan women saw a series of legal changes that promoted their equality in society and in the family. “The Provision Law of 1982,” for example, “attempted to redefine family responsibilities, making all adult family members legally liable to contribute to the maintenance of their family.”²⁴⁰ The reality proved less than equitable. Even as legislation strove for greater gender equality, women remained largely responsible for domestic care. Further, as men were drawn into a continuous war with the Contras, women found themselves both working outside the home and taking on full responsibility for their households.²⁴¹

Tasked with the practical, emotional, and spiritual upkeep of their families, Nicaraguan women bore the brunt of major economic and political upheaval of the late twentieth century. In an interview with Margaret Randall, Gloria Carrión, a Sandinista, described the significance of women in maintaining Nicaraguan families and the impact of crises on mothers:

Women are the pillars of their families. This is the most fundamental and objective condition of Nicaraguan women’s lives, and perhaps of Latin American women in general. We don’t see ourselves *simply* as housewives, caring for our children, attending to the duties of the home and subordinating ourselves to our husbands. Women are the centres of their families – emotionally, ideologically and economically... Nicaraguan women make up a large percentage of our agricultural workers, accounting for half of our fieldworkers. In many instances they are the first to be affected by unemployment, inflation and shortages.²⁴²

²⁴⁰ Cynthia Chavez Metoyer, “Nicaragua’s Transition of State Power: Through Feminist Lenses,” in *The Undermining of the Sandinista Revolution*, eds. Gary Prevost and Harry E. Vanden (New York: St. Martin’s Press, 1997), 120.

²⁴¹ *Ibid.*, 122.

²⁴² Interview with Gloria Carrión in *Sandinista’s Daughters: Testimonies of Nicaraguan Women in Struggle*, trans. and ed. Margaret Randall (New Brunswick: Rutgers University Press, 1995), 66.

As the main providers for their family, women were also the first to be affected by health crises, lack of medical resources and professionals, and shortages which induced serious medical conditions like malnutrition.

Psychological trauma from the war had a particular impact on women and children. According to one health journal, Nicaraguan children had “become preoccupied with issues of war.”²⁴³ Women, in particular, faced heightened levels of anxiety and depression in response to the loss of sons and daughters.²⁴⁴ As heads of households, women were tasked with the emotional burden of caring for traumatized children and dealing with the loss of husbands, sons, daughters, and other family members. Though all members of Nicaraguan society were at risk for mental health problems, women’s position in the home amplified the trauma they faced.

As health care improved, Nicaraguan women often stood to gain the most. The success of vaccination campaigns, hydration stations for young children, and increased access to family planning methods all improved the lives of Nicaraguan women significantly.²⁴⁵ The stagnation in these programs due to warfare, then, inhibited the liberation for women that came along with improved health care. However, women continued to push for improved healthcare services, even as limitations constricted the growth of state-run programs.

²⁴³ Braveman and Siegel, “Nicaragua,” 174.

²⁴⁴ Ibid., 174.

²⁴⁵ David C. Halperin and Richard Garfield, “Special Report: Developments in Health Care in Nicaragua,” *The New England Journal of Medicine* 307, no. 6 (1982): 389-390. This report states that 92,000 children were treated for diarrhea in the first two years of the program.

The limitations placed on the state as it responded to the Contra War often came in the form of limited health care for women and children. Health *brigadistas* were community-level health workers trained to provide for basic health needs throughout the country. This popular organizing of health workers was effective in Nicaragua, but it underwent important changes in response to the Contra War. As the U.S.-backed counterrevolutionaries wreaked havoc on parts of Nicaragua, the health brigadistas changed their focus to “first aid and acute emergency care”. In response, by July 1984, “the training of mother-child Brigadistas had lagged.”²⁴⁶

Women inhabited the central role in running Nicaraguan households, as solidarity activists, and in developing and implementing effective health programs throughout Nicaragua. This chapter argues that new conceptions of a woman’s role in society flooded in from healthcare solidarity activists, from Sandinistas who went abroad (particularly female Sandinistas), and from Nicaraguan women who found themselves thrust into new leadership roles to develop community health programs.

C. Women Working in Health

Women were mobilized in health care roles as *brigadistas* in Nicaragua and as *sanitarias* in El Salvador. The Salvadoran *sanitarias* were often “Young peasants, usually girls... trained in basic health care in the guerilla hospitals, and sent back to the villages to administer first aid and to treat some of the common illnesses, as well as run public health education campaigns on, for example parasites or vitamins.”²⁴⁷ In Nicaragua, the

²⁴⁶ John M. Donahue, “The profession and the People: Primary Health Care in Nicaragua,” *Human Organization* 45, no. 2 (1986): 101.

²⁴⁷ Jenny Pearce, *Promised Land: Peasant Rebellion in Chalatenango, El Salvador* (London: Latin American Bureau, Ltd., 1986), 268.

state took on the responsibility of training and organizing the *brigadistas*. The women in these roles participated in state-sanctioned revolution while also expanding on their role as women in society. In El Salvador, revolutionary Salvadorans and solidarity workers trained the young *sanitaria/os* so that their role as health workers was revolutionary from the beginning. Women who served as leaders and healers continued to push against traditional gender boundaries; they worked to define their own ideas of revolution and worked to administer the needs they saw as necessary.

Women participated in other healthcare roles, too. They acted as nurses, doctors, community health promoters, hospital union members, and international solidarity workers and promoters. In Nicaragua, they worked through the state to expand healthcare access. In both El Salvador and Nicaragua, women also worked with international organizations, with the Catholic dioceses of their communities, with their local health clinics, and with women's organizations. In many cases, women stepped out of more traditional roles and into positions of leadership in order to develop healthcare systems that were necessary for their communities, their families, and themselves. Women stepped into leadership positions in order to get what they needed, but in doing so, they also defined the revolutions of both countries.

1. El Salvador

Women challenged their position both in the revolutionary zones and government controlled areas of El Salvador. Nursing in either region gave women a position of authority from which to pursue improved conditions as workers, as women, and as Salvadorans. Women working as nurses in the government-controlled areas and hospitals engaged in disobedience against the state. These subversive actions carried out under the

nose of the brutal of the Salvadoran forces allowed women to define their own ideas of womanhood without the support of the revolutionaries. In other words, women in El Salvador pressed for improvements in their lives regardless of their geographic relation to the war. Nurses on both sides held positions of power and influence that allowed them to engage new and changing narratives of power that women expressed.

Francesca Romero discovered union work through her role as a nurse at the Social Security Hospital in San Salvador. In 1976, she became an original member of the Sindicato de Trabajadores del Instituto Salvadoreño del Seguro (Social the Union of Salvadoran Social Security Institute Workers, STISSS).²⁴⁸ Despite the repression from armed forces and fear that her family and fellow nurses had for her safety, she became the only woman alongside seventeen men of the union's coordinating committee in 1982. Romero worked to engage more women (comprising over half of the hospital staff) in union work, and she began planning parties and social events aimed at engaging women; her efforts paid off, and, in 1985, she and other female hospital staff founded a women's committee as part of STISSS.²⁴⁹ The women's committee created a newsletter and continued engaging women through targeted efforts. The men of the STISSS questioned the social aspect of Romero's campaign, and they also wondered why the women's committee insisted on having a separate newsletter. The women, Romero said, wanted to "express [their] thoughts, and talk about the union and about women's problems and how to deal with them."²⁵⁰

²⁴⁸ Interview with Francesca Romero in *A Dream Compels Us*, trans. and ed. New Americas Press (Boston: South End Press, 1989), 66.

²⁴⁹ *Ibid.*, 68.

²⁵⁰ *Ibid.*, 68.

Romero and her fellow healthcare workers defined their own needs within the STISSS and pushed for an expansion of union practices that matched with the needs of the majority of the hospital's staff. These women engaged a feminist rhetoric in expanding their union and their hospital, and in working in solidarity with other unions in El Salvador and Central America. Despite the considerable danger all union members faced under the repressive Salvadoran regime, particularly during the war years, these women considered the struggle for change paramount to the threat of violence. Romero saw her work as honest and beneficial, and believed that if she "was going to be killed, that's the way it would be."²⁵¹

Women responded specifically to the gendered violence they encountered. In El Salvador, state repression manifested in the "gendered ways in which military officials targeted their victims."²⁵² Feminist solidarity between the U.S. and Central America developed partially on the basis of reproductive rights and health. "In short, women intervened to make the revolution relevant to their own lives and dreams."²⁵³

In El Salvador, women organized through AMES to change their conditions and interpret the revolution in their favor. Sierra Becerra notes that in the first three years after AMES was formed, they "mainly organized urban-based women, demanding equal salaries for women, employment, the lowering of food prices, and an end to forced sterilizations."²⁵⁴ However, as "early as 1981, they began organizing popular councils to manage their immediate survival needs, such as security, food, and health."²⁵⁵ The

²⁵¹ Ibid., 67.

²⁵² Sierra Becerra, "For Our Total Emancipation," 283.

²⁵³ Ibid., 292.

²⁵⁴ Ibid., 271.

²⁵⁵ Ibid., 272.

women's organization responded to state violence by establishing "peasant militias and popular health clinics and schools... The clinics treated both serious injuries from government bombings and curable diseases such as diarrhea."²⁵⁶ The association not only wanted to carry out the goals of the revolution, it wanted to do so in a way that benefitted women. In particular, AMES "encouraged the popular clinics to address women's health needs."²⁵⁷ Focusing on women's health was both in keeping with the revolutionary agenda for free and universal health care and a manifestation of women's particular goals for the revolution. Women demanded a place by focusing, at least in part, on their health needs.

Clara Méndez wrote of her time as a nurse and head of an FMLN hospital in Chalatenango. She began supporting the revolution in 1977 in part because she saw that "the democratic revolutionary movement had achieved great maturity in not discriminating according to sex, color or class."²⁵⁸ She established a mobile clinic in San Salvador that put her and her family at great risk. From 1987 to 1991, she served as "Director of an FMLN hospital in Chalatenango, overseeing the work of all the staff in the area."²⁵⁹

Salvadoran women took charge in refugee camps, as well. They addressed needs particular to them by establishing "Committees for Women and Mothers to address issues specific to these groups such as maternal health and child care. These committees became

²⁵⁶ Ibid., 272.

²⁵⁷ Ibid., 278.

²⁵⁸ Autobiographical Statement by Clara Méndez, 1991, Box 11, Folder 24, Organization in Solidarity with Central America, Walter P. Reuther Library, Detroit, Michigan.

²⁵⁹ Ibid.

integrated into the general camp government structure.”²⁶⁰ Molly Todd argues that as refugees, “women participated in community life and moved into leadership positions to an extent far beyond what they previously had done at home in northern El Salvador.”²⁶¹

Women took on a variety of roles in El Salvador as they carved out spaces for themselves. They pursued care for their families and in so doing, they developed new ideas of revolution, gender, health care and leadership. Though the women of Nicaragua often had the support of the state, they, too, carved out new places for themselves in pushing for health care that met their needs.

2. Nicaragua

Women took on the burden of implementing the new health system even as the FSLN funneled resources toward the Contra War. The women saw need in their communities and so worked as Sandinistas, community health planners, and solidarity workers to ensure that the goals of the revolution would be met on their terms. As the Sandinista revolution broke down traditional gender roles, women reimagined their worlds; they challenged gendered boundaries even as husbands and state leaders moved to reestablish gendered expectations. Women used health as a method for expanding their new sense of self. They reinterpreted their reproductive labor, stepped into positions of authority as health planners and health volunteers, and demanded improved services for themselves and their children in spite of the ongoing war.

Nicaraguan women were deeply involved in the political discourse of their country, whether through the intentional support of the FSLN or as wives whose

²⁶⁰ Todd, *Beyond Displacement*, 107.

²⁶¹ *Ibid.*, 107.

husbands left to fight. Already the economic and emotional backbone of the country's households, they found their voices under the Sandinistas. Nora Astorga, who served as a chief prosecutor of Somoza-era war criminals and later the FSLN ambassador to the United Nations,²⁶² explained that women's involvement in the revolution ensured that they would continue to actively participate in Nicaraguan politics. Astorga stated that, "Women won't be apathetic again", implying a significant shift in what women accepted as their role in society.²⁶³ Mónica Baltonado, a revolutionary and Sandinista (and one of only three women to be awarded the title Commander Guerilla immediately following the revolution), said that it "wasn't until [the revolution triumphed] that [women] started to think about [their], about [their] historically unequal condition and about the need to fight for women's rights."²⁶⁴ Randall notes that "Revolution is the only force capable of transforming the structure of society," and that after the Sandinista Revolution the Nicaraguan people were able to "break the chains of dependence and begin to participate as 'architects of their liberation'."²⁶⁵ The revolution in Nicaragua opened up pathways for leadership and community building that many women were unable to access previously.

Aynn Setright, an American solidarity worker, echoed Randall's ideas of a changing landscape for Nicaraguan women when she discussed the empowerment and

²⁶² Richard Pearson, "Nora Astorga, 39, Dies," *The Washington Post*, February 15 1988, <https://www.washingtonpost.com/archive/local/1988/02/15/nora-astorga-39-dies/a284446b-65b9-4a9c-a3f2-fc792da2d66e/>.

²⁶³ Interview with Nora Astorga in *Sandinista's Daughters: Testimonies of Nicaraguan Women in Struggle*, trans. and ed. Margaret Randall, (New Brunswick: Rutgers University Press, 1995), 228.

²⁶⁴ Shelly Grabe interview with Mónica Baltonado, Global Feminisms Project, University of Michigan, June 2011 url: <https://globalfeminisms.umich.edu/sites/default/files//BaltodanoTranslationAnnotatedFINAL.pdf>, 9.

²⁶⁵ Interview with Nora Astorga in *Sandinista's Daughters*, 204.

the consequences that came along with community building in rural Nicaragua. She notes that of the eight hundred families she worked with, “many were female-led households because the men had been killed during the war, and even if they did have a husband or a brother at home, those men were often drafted or recruited into the army, so these sixteen communities were led by women”. Many of the women who led the new community building efforts had never attended school, spoken in public or otherwise been in a position of leadership.

As women were thrust into positions of authority, they began asking for the reproductive health care they needed. Women who previously deferred to their husbands now found themselves in a position to demand things for themselves, partially because they had no choice, but also because they now felt empowered. Aynn Setright discusses how the women she worked with in rural communities had previously lived isolated lives where they had little choice but to birth children as they came. That changed when the women were asked what they wanted and needed in their communities. According to Setright, “women’s reproductive health was a big thing for them, they always came back to that.”²⁶⁶ Milú Vargas, a lawyer and Sandinista, saw an explosion in feminist rhetoric starting in 1987. At that point, women across classes became vocal in their “concerns about motherhood, abortion, family planning, abuse, rape and labor laws... these issues were seen differently by women in different sectors... but we needed to address them according to who and where we were.”²⁶⁷ Reproductive health, decriminalizing abortions,

²⁶⁶ Aynn Setright (solidarity activist), interview by author, August 2, 2019, Brattleboro, Vermont.

²⁶⁷ Interview with Milú Vargas in *Sandinista’s Daughters Revisited: Feminism in Nicaragua*, trans. and ed. Margaret Randall, (New Brunswick: Rutgers University Press, 1994), 139.

and accessing family planning services were, for women of all classes, important revolutionary issues.

D. Motherhood in Revolution

As the traditional heads of household in both El Salvador and Nicaragua, women were tasked with the health and wellbeing of themselves and their children. Practically, this meant that women faced not only their own poor health in times of difficulty but also the poor health of their children. In impoverished areas that lacked basic infrastructure, women dealt with high levels of malnutrition in their young children and struggled to obtain appropriate medical care for them. Symbolically, women's worth was often defined through motherhood. At times, the state defined their worth this way, and at other times, women addressed revolutionary goals by becoming mothers. The deep tie between motherhood and health care (the care required for reproduction and that needed for children) made health care an important site of organization for women and their revolutionary goals. Motherhood was for some a burden, and for others the main focus of revolution. But the integral link between Salvadoran women, Nicaraguan women, and their role as mothers gave them a reason to focus their revolutionary goals on health care.

1. El Salvador

Motherhood was important to many Salvadoran women. This was evidenced in the speeches, memoirs, and interviews women gave during and after the war years. Many women included discussions on their children, positive and negative, and some even claim their children as the reason behind their revolutionary choices. Women dealt with motherhood in vastly different ways, but the significance of motherhood to Salvadoran

women relates to how women approached healthcare needs and their own role in defining community health care.

Clara Méndez, head of the hospital in Chalatenango in the late 1980s, peppers her autobiographical statement with mentions of her children. She claims that her initial decision to support the revolutionary forces was because of her position as a mother of five.²⁶⁸ She proudly notes that her daughters went on to become nurses and “serve the neediest and most exploited class.”²⁶⁹ Maria Eugenia, also a Salvadoran nurse, similarly discusses her two daughters throughout the interview she gives on her time as a nurse.²⁷⁰

Moreover, AMES spent time promoting childcare in Managua for Salvadoran refugees. As Sierra Becerra observes, the “‘Luz Dilian Arévalo’ childcare... center provided for the ‘medical, nutritional, and psycho-emotional needs’ of children and promoted social skills that departed ‘from sexist traditions’ and advanced the goals of ‘equality, mutual respect, and collective decision making’.”²⁷¹ The care of children remained central to women’s identities both practically and philosophically.

While in Nicaragua, the FSLN promoted motherhood, the FMLN discouraged it. The “FMLN leadership maintained that deep emotional bonds limited the willingness of their combatants, both women and men, to take risks. They therefore developed policies that the women thought went a long way towards preventing the formation and

²⁶⁸ Autobiographical Statement by Clara Méndez, 1991, Box 11, Folder 24, Organization in Solidarity with Central America, Walter P. Reuther Library, Detroit, Michigan.

²⁶⁹ Ibid.

²⁷⁰ Medical Aid for El Salvador, “...with mortars falling all around us”: *An interview with a nurse from El Salvador’s war-torn countryside*, 1983.

²⁷¹ Sierra Becerra, “For Our Total Emancipation,” 283.

consolidation of couple relationships.”²⁷² The precarious position of the FMLN and the rough living conditions of the combatants made pregnancy a liability. Smith-Nonini witnessed instances of pregnancy among female *sanitarias* (health workers) “who frequently spent months traveling with a platoon of mostly male combatants.” This reality presented itself despite FMLN “policies promoting the use of birth control pills or IUDs,” and in response, “the Frente would help [these women] either settle in a civilian community or leave the war zone.”²⁷³ In a region that struggled to access even the most basic health care, reproduction was dangerous not only to the cause but also the mother and child. Motherhood, then, remained important to Salvadoran women as part of their upbringing, but the violence of the 1980s eroded the role of it in society.

2. Nicaragua

The FSLN invoked motherhood as central to the female role in promoting democracy, fighting poverty, and fighting off the foreign influence of the United States. The conflict allowed women to push the boundaries even as the new government continued to see women’s main role as reproductive. The official Sandinista position toward women focused on motherhood that both defined women’s relevance in narrow and problematic ways and also ensured a successful campaign for greater reproductive and child health.

The FSLN used propaganda posters to equate being revolutionary with being a mother. One poster published by the Asociación de Niños Sandinistas (Association of

²⁷² Norma Vázquez, “Motherhood and Sexuality in Times of War: The Case of Women Militants of the FMLN in El Salvador,” *Reproductive Health Matters* 5, no. 9 (1997), 142.

²⁷³ Smith-Nonini, *Healing the Body Politic*, 91-92.

Sandinista Children) exclaims “Felicidades Mama: Gracias Madre por Defender Nuestra Alegría” (“Congratulations Mama: Thanks Mom for Defending our Joy”).²⁷⁴ The image depicts a young woman, firearm slung over her back, holding a smiling baby and corralling two blissfully happy young children in front of her. The scene links revolution, femininity, and motherhood. That this woman was apparently able to take up arms in favor of the Sandinista forces while pregnant and raising two young children is nothing short of remarkable.

A more famous image taken in 1984 by Orlando Valenzuela depicts a Sandinista fighter as she nurses her child. The woman in the image smiles broadly, indicating that many women embraced ideas of revolutionary motherhood was promoted by the FSLN. The image, referred to as *madre armada y niño* (armed mother and child) played an important role in developing the state-sanctioned boundaries of the ‘new woman’ in Nicaragua. Penélope Plaza Azuaje argues that images like these, along with a number of other murals commissioned by AMNLAE, served to promote new gender roles and definitions of womanhood.²⁷⁵ That AMNLAE was so heavily influenced by patriarchal political expectations explains why many of the murals linked motherhood, revolution, and womanhood. At the center of women’s new expected identity was motherhood and the promotion of the nation to the next generation.

The mother in both images was not only the protector of her children, but also the protector of her nation. The nationalist imagery was clear: women should have children

²⁷⁴ Asociacion de Niños Sandinistas Luis Alfonso Velazquez F., Felicidades Mamá poster, Jane Norling and Lenora (Nori) Davis Collection, University of New Mexico archives, url: <https://nmdigital.unm.edu/digital/collection/Norling/id/154/rec/2>.

²⁷⁵ Penélope Plaza Azuaje, “*Madre armada y niño*. Representación de la Mujer en los murals de la Revolución Saninista en Nicaragua,” *APUNTES* 23, no. 1 (2010), 8.

to strengthen the nation, and they should defend the nation as they would those children. Bertha Inés Cabrales notes in an interview for the Global Feminisms Project that women faced a tremendous pressure to have children at a young age. As a woman heavily involved in the Sandinista revolution, Cabrales, too, experienced the pressure, but had a son at twenty-four, an age considered old to be having a first child.²⁷⁶ She indicates that the pressure was not for her to get married and then have her child, but rather to have a child as soon as possible. Having children, more than getting married, seemed to be a marker for Cabrales and her peers of their success as women and as revolutionaries. Although, as Cabrales points out, sexual relations outside of marriage were scandalous in Nicaragua at the time, the Sandinistas ushered in the tide against that sort of conservatism. Reproduction, not attachment to a man, defined Cabrales' story and the images of the two mothers used as Sandinista propaganda. New definitions of womanhood were being etched out of old ones. Where Cabrales traditionally would have sought out marriage first, she found herself being pressured instead to have a child; where womanhood would not have included cargo pants and a gun, it now clearly did.

Some women felt that having children limited their ability to support the revolution. Julia García was a poor woman living in Managua's slums who identified strongly with the need for reform in her country. With five children to care for, she struggled to continue her revolutionary activities. She stated that, "It wasn't easy being politically active with my kids and all. I nearly abandoned them, not because I wanted to,

²⁷⁶ Shelly Grabe interview with Bertha Inés Cabrales, Global Feminisms Project, University of Michigan, June 2011 url: <https://globalfeminisms.umich.edu/en/nicaragua>, 9.

but in order to fight for what we have now.”²⁷⁷ García, like many Nicaraguan women, was stuck between her traditional responsibilities at home and her desire for a better world for herself and for her children. The FSLN may have promoted motherhood, but the reality for women was often a movement away from their roles as mothers. García is but one example of a revolutionary woman who navigated the tricky relationship between motherhood and revolution.

The focus on motherhood led to a focus on improving child and maternal health. Solidarity groups and Nicaraguan activists targeted the high infant and maternal mortality rates that existed throughout the country and particularly in rural sectors.²⁷⁸ As Nicaraguan women came together and began questioning their own place in society, they asked for more and developed new understandings of gender. Just as the Sandinistas imprinted a particular idea of motherhood and gender upon Nicaraguan women, so, too, did solidarity activists bring with them particular gendered ideals when they volunteered in Nicaragua. The confluence of these new ideas and experiences allowed women to advocate for themselves in important ways, despite attempts from leadership to reassert gendered boundaries.

E. Gendered Solidarity in El Salvador and Nicaragua

Nicaraguan and Salvadoran activists who travelled abroad to build solidarity networks came back with new ideas about femininity and sexuality that helped further push at gender norms. Cabrales travelled to Sweden in the late 1970s. “In Sweden,”

²⁷⁷ Interview with Julia Garcia in *Sandinista's Daughters: Testimonies of Nicaraguan Women in Struggle*, trans. and ed. Margaret Randall, (New Brunswick: Rutgers University Press, 1995), 20.

²⁷⁸ Donahue, *The Nicaraguan Revolution in Health*, 56.

Cabrales noted, “we started to strengthen the committees in solidarity with the Nicaraguan people.”²⁷⁹ After the revolution, Cabrales returned to Nicaragua where she created programs that focused on women’s access to healthcare, including abortion, a topic that was more widely accepted in Sweden than in Nicaragua, particularly prior to the revolution. Cabrales brought back with her important ideas about family planning and access to reproductive health care, but also how women should be “*muy libres*” in their sexual experiences.²⁸⁰ That women should have a choice over their sexuality, including access to abortion and family planning, broke with the traditional ideas of femininity and motherhood in Nicaragua. Family planning had become more accessible and acceptable under the Sandinistas, but sexual pleasure and abortion remained taboo. Setright notes that in her time working in rural communities, she never discussed abortion, mainly because it was illegal, but also because “it wasn’t part of the discourse.”²⁸¹ Nonetheless, Nicaraguan women, like Cabrales, continued to push the boundaries of Nicaraguan culture and of Sandinista politics to ensure that these new ideas of liberation permeated the new healthcare system being built.

While activists who left their country returned new ideas about gender roles, solidarity organizations from around the globe funneled their own ideas about women’s health into Central America. Sierra Becerra argues that, in El Salvador, “Part of AMES’ support in the United States came from reproductive rights organizers. The Reproductive

²⁷⁹ Shelly Grabe interview with Bertha Inés Cabrales, Global Feminisms Project, University of Michigan, June 2011 url: <https://globalfeminisms.umich.edu/en/nicaragua>, 9.

²⁸⁰ Ibid., 9.

²⁸¹ Aynn Setright (solidarity activist), interview by author, August 2, 2019, Brattleboro, Vermont.

Rights National Network advocated a broad vision of reproductive justice, defending access to abortion and contraception, while simultaneously denouncing forced sterilizations and cutbacks of social services that pushed pregnant mothers into poverty.”²⁸² Other U.S.-based organizations supported revolutionary goals of promoting women in leadership. The FMLN Women’s Paramedic Training Project, funded by the Bravo Fund through CISPES, educated poor women in basic literacy and medicine. The project, started in 1990, came at the end of the conflict in El Salvador, but in just one year provided fifty women with their “first opportunity to learn to read and write,” and placed them in the field as “core medical personnel” where they helped “organize the medical system.” The program took both a local and gendered approach, promoting a “community-wide approach to health” and placing “special emphasis on women’s, infant and family health.”²⁸³

From 1988 to 1990, Lois Wessel worked in Nicaragua’s Department of Maternal and Child Health through an organization called Ipas, based in Chapel Hill, North Carolina. The official reason for her work was the reduction of maternal mortality in the country, but they also, less openly, promoted access to safe abortion. She described the organization by saying: “It’s really an abortion rights organization that looked at things to reduce maternal mortality from self-induced abortion both from post-partum hemorrhage, and it does this looking both at policy and access to abortion services.”²⁸⁴ Abortion was illegal in Nicaragua, however, and so Ipas promoted education of procedures that were

²⁸² Sierra Becerra, “For Our Total Emancipation,” 287-288.

²⁸³ The Bravo Fund: Project Docket, June 1991, Box 11, Folder 24, Organization in Solidarity with Central America, Walter P. Reuther Library, Detroit, Michigan.

²⁸⁴ Lois Wessel, interview by author, October 24, 2019, phone interview.

used for gynecological purposes as well as abortion. In describing this work, Wessel stated:

Ipas promoted the use of a vacuum aspiration syringe that could be used for many different gynecological procedures and it didn't take any electricity and it was able to be cold sterilized... It was promoted for when there are pieces of the placenta that don't come out when the baby's born or when someone's got some kind of dysfunctional uterine bleeding, but everyone knew you could also use it to terminate early on. So we taught this technology, and on the official line was that we were using it for all these other medical problems, but anyone who learned could also use it for abortions. But at the same time, the very active women's movement was also working on this in their own abortion clinics that existed and probably still exist today that were not part of the Ministry of Health.²⁸⁵

Abortion was a particularly important issue for many women, as they saw the right to choose a pregnancy as lining up with revolutionary ideology. Ideas about abortion, and the means that funded abortion capabilities, often came through internationalist solidarity workers.

In her time at the Ministry of Health, Wessel also worked on improving record keeping and statistical understandings of maternal health. For example, it was common practice at the Ministry to "write that a woman died of hemorrhage or infection," but not to indicate whether it was "from a self-induced abortion,... a back-alley abortion,... a poorly managed pregnancy, [or] hemorrhage after delivery." Encouraging better record keeping was an important step in saving women's lives and improving the Ministry's capacity to serve the most vulnerable populations of Nicaragua.²⁸⁶

International solidarity played an important role in influencing Nicaraguan women and the reproductive medicine they were able to access. Beliefs about sexuality and reproduction shifted as Nicaraguan and Salvadoran women interacted with feminist

²⁸⁵ Ibid.

²⁸⁶ Ibid.

ideologies from all over the world. Women adopted ideas about abortion and sexual liberation that they felt matched with their own interpretations of the revolution. They actively engaged with opportunities for leadership in health care that were funded by international sources. Solidarity in both directions, then, proved vital to the development of feminist health practices in both El Salvador and Nicaragua.

F. Conservative Backlash

In both Nicaragua and El Salvador, women faced opposition to their revolutionary goals. In Nicaragua, as men returned home from the revolution and the FSLN took the reins, leaders and husbands attempted to reintroduce traditional expectations of gender roles. In El Salvador, women faced backlash from a patriarchal government as well as their husbands when they tried to step into positions of leadership. Often, this conservative backlash came in response to women's roles as healthcare workers and in reaction to more accessible family planning services.

Aynn Setright claimed that in Nicaragua, men “were very suspicious of the women not just accepting the children that god gave them, but doing any kind of family planning”. The conservative backlash came with a “shocking amounts of domestic violence”. She notes that women's new leadership roles “created a lot of tension as the men came back” from fighting.²⁸⁷ Women addressed the domestic violence publicly. Setright saw a number of attempts to combat the violence including the beating of pots and pans outside of a home where a man could be heard abusing his wife.²⁸⁸ Rosario Montoya tells of Doña Julia who hung her torn underwear for all the neighborhood to see

²⁸⁷ Aynn Setright, interview by author, August 2, 2019, Brattleboro, Vermont.

²⁸⁸ Ibid.

in order to embarrass her husband. Montoya points out that such an act “would have been inconceivable before the revolution.”²⁸⁹

Gloria Carrión, a Sandinista, discussed the tension as well. Carrión stated that:

Women’s political involvement had its effect on relationships between women and men. Women began to develop their own points of view on issues and began to express their ideas. In homes where both the husband and wife lived together new relationships developed. Women started to make their feelings and opinions known. They would disagree with their husbands on issues where they never had before. And as women got involved in activities outside the home their time was less fully devoted to the home and the division of labour within the family began to change. All this demanded a re-evaluation of the family situation. And our women’s movement became stronger through this whole process.²⁹⁰

Women faced tension with husbands and increased rates of domestic violence. They actively responded to these new challenges by mobilizing community networks. In El Salvador, “Women’s organizing set limits to sexism.”²⁹¹ As AMES worked to address marital rape, the organization also tried not to alienate the “many peasant women who had lost their partners, sons, and male relatives to state violence.”²⁹²

Navigating changing gender norms proved difficult in both countries, but women rallied together to address the backlash that resulted. Women would not go back to the lives they led before, particularly those women who had stepped into healthcare leadership roles. Setright noted that the women who had come to live in community following displacement chose to involve themselves in building their communities, in part through creating healthcare systems beneficial to all of the women. When their husbands returned from the war, the women wanted to stay and enjoy the benefits of the

²⁸⁹ Rosario Montoya, *Gendered Scenarios of Revolution: Making New Men and New Women in Nicaragua, 1975-2000*, (Tucson: University of Arizona Press, 2012), 151.

²⁹⁰ Interview with Gloria Carrión in *Sandino’s Daughters*, 14.

²⁹¹ Sierra Becerra, “For Our Total Emancipation,” 279.

²⁹² *Ibid.*, 282.

networks they had built, but the men wanted to move back to their isolated homes.²⁹³

Women's desire to stay in community fundamentally changed their way of life, as well as their children's lives. The decisions that women made, despite the backlash and tension with their husbands and male leadership, contributed to important shifts in gender roles. Women who stood up to their husbands in both Nicaragua and El Salvador contributed to these feminist revolutions that had profound impacts in both societies.

G. Conclusion

Health care played an important role for women in the revolutions of both Nicaragua and El Salvador. In both countries, women pursued the revolutionary goals of increased access to health care, particularly reproductive and child health, even as the revolutions were forced away from those goals to attend to warfare. As the need for healthcare workers increased, women stepped up. They used the platforms they gained as volunteers, community health workers, and nurses to navigate the revolution in ways that benefitted them. Women did not subjugate their own demands to support the broader revolution, but rather they built a feminist understanding that can be understood through their roles in health care.

²⁹³ Aynn Setright, interview by author, August 2, 2019, Brattleboro, Vermont.

CHAPTER 5

CONCLUSION: AFTER THE REVOLUTIONS

“everything went on the same only different after the revolution: the same only different.”²⁹⁴ – Sara Miles

On January 16, 1992, the Salvadoran government and FMLN signed the Chapultepec peace accord, ostensibly ending over a decade of violent warfare in the country. Less than two years prior, Violeta Chamorro de Barrios defeated the FSLN in Nicaragua’s presidential elections, bringing a decade of Sandinista rule to a close. Under these new terms, and with a pivot toward the Middle East, U.S. intervention in the region slowed dramatically, and the armed violence that characterized the 1980s dissipated.

International solidarity workers left the region en masse (though many remained in close contact with people and organizations). Those who stayed experienced major changes in the relevance of their previous roles. Jill Winegardner lived in Nicaragua during the transition years. As an educator, she felt the election of Chamorro through her students. “One of the things that happened was the students in my [neuropsychological] course started having economic problems, so they weren’t able to participate in the training. Some of them had to take other jobs or move to other countries.”²⁹⁵ Aynn Setright watched a major change in access take place. The Chamorro government worked to privatize pharmaceuticals, so while Nicaraguans continued to have access to doctors, as per the constitution, they often lacked the funds to buy the medicines prescribed to

²⁹⁴ Sara Miles, “Sara Miles” in *Brigadista: Harvest and War in Nicaragua*, ed. Jeffrey Jones (New York: Praeger, 1986), 1.

²⁹⁵ Jill Winegardner, interview by author, October 28, 2019, Skype interview.

them. “You could go see a doctor, but the doctor no longer had a pharmacy to give away the medicine.” This, according to Setright, led to “a huge deterioration of the health services provided.”²⁹⁶

As international solidarity shrank, leftist activists continued to fund health initiatives in Nicaragua, just not through the government. “Aid that had formerly been provided to [MINSAL] was rapidly shifted for distribution to nongovernmental organizations in what must be the first international campaign to privatize leftist assistance for public health.” A call to refuse funding from USAID was published in a 1990 edition of *Links*, a magazine produced by NCAHRN.²⁹⁷ Some rightist political and religious groups stepped in, “including the Dooley Foundation, Freedom Medicine, and the Pan American Development Foundation.”²⁹⁸

Government aid shifted inversely to solidarity aid. Whereas the United States backed the Contras and economically undermined the Sandinistas through sanctions, less than one month after Chamorro was elected, President Bush lifted sanctions and requested \$300 million in aid for Nicaragua.²⁹⁹ The irony, Garfield and Williams point out, came when USAID encouragement of “community participation and public health-oriented health professionals” matched with former Sandinista policies. Moreover, the health workers most qualified to carry out USAID work “were FSLN-related groups and

²⁹⁶ Aynn Setright, interview by author, August 2, 2019, Brattleboro, Vermont.

²⁹⁷ Garfield and Williams, *Health Care in Nicaragua*, 223-224.

²⁹⁸ *Ibid.*, 224.

²⁹⁹ Mark A. Uhlig, “Nicaraguans on Both Sides Praise Embargo’s End,” *The New York Times*, (March 14, 1990), <https://www.nytimes.com/1990/03/14/world/nicaraguans-on-both-sides-praise-embargo-s-end.html>.

individuals.” USAID found itself in a position “to encourage primary care without supporting the Sandinistas.”³⁰⁰

In the immediate aftermath, Nicaragua struggled to maintain “a health system” that “limped along bravely.”³⁰¹ The movement away from socialized health care unraveled many of the achievements gained by the FSLN. Cheasty Anderson attributes the deterioration to “a loss of popular participation and public involvement in the health sector,” and “a failure at the Ministry level to adequately budget and provision the health care system.”³⁰² Garfield and Williams, too attribute the lagging health system to loss of popular support, arguing that “by 1991 organization and motivation were in short supply,” and claiming that the anticipated number of health *brigadista* volunteers fell far short of the necessary target.³⁰³

Throughout the 1990s, the Chamorro government pursued a policy of healthcare decentralization defined by four major qualities: “overall health spending reductions, spending priorities for secondary care over primary care, privatization, and the promotion of user fees.”³⁰⁴ The results of decentralization and decreased social spending included a twelve percent drop between 1992 and 1996 in real health spending,³⁰⁵ as much as a fifty percent drop in prenatal coverage and vaccination rates in certain provinces,³⁰⁶ and a

³⁰⁰ Garfield and Williams, *Health Care in Nicaragua*, 224-225.

³⁰¹ *Ibid.*, 225.

³⁰² Anderson, “Health Care Reform in Sandinista Nicaragua,” 271.

³⁰³ Garfield and Williams, *Health Care in Nicaragua*, 225.

³⁰⁴ Anne-Emanuelle Birn, Sarah Zimmerman, and Richard Garfield, “To Decentralize or not to Decentralize, is that the Question? Nicaraguan Health Policy Under Structural Adjustment in the 1990s,” *International Journal of Health Services* 30, no. 1 (2000), 114. <https://doi-org.silk.library.umass.edu/10.2190/C6TB-B16Y-60HV-M3QW>.

³⁰⁵ *Ibid.*, 116.

³⁰⁶ *Ibid.*, 118.

tripling in incidence of malaria on average between 1995-1997 when compared to the 1980-1990 average.³⁰⁷

Decentralization was encouraged by international institutions like the International Monetary Fund (IMF) and World Bank, as part of a neoliberal agenda, and led to a decline in the health system and an undermining of medical workers. For nearly four months in 1998, some 4,000 Nicaraguan doctors went on strike to protest their poverty wages.³⁰⁸ The debt accrued by Nicaragua in the 1990s further devastated the revolutionary spirit that came to define the decade prior.

In El Salvador, the FMLN became a political party, and the government moved back in to war zones previously evacuated of all government services. These FMLN-controlled zones, where popular medicine had developed with the help of solidarity activists, revolutionary actors, and volunteer community health workers, came back under the infrastructure and health sphere of the central government. Mark Smith recalled the plight of those who had devoted their lives to providing medical care for their communities. “After the war, as the ministry came back in... the promoter’s organized and tried to become employees of the ministry so they would be paid for what they were doing because up until this point, they had received no compensation, this was all volunteer work.” Many wanted to remain village health workers under the ministry, but “it didn’t work out.” Smith recalled “maybe two or three who became ministry

³⁰⁷ Ibid., 120.

³⁰⁸ Ibid., 123. Even after a one hundred percent raise, new physicians made on average \$150 U.S. per month for a family of four.

employees.” He went on to say that “the Ministry wanted to put their own people in.” The community health workers were “seen as kind of a threat by the Ministry.”³⁰⁹

Susan Classen recalled the uncertainty surrounding the return of the Ministry of Health to Chalatenango department. “It was a real question for a lot of people. Is it the best in the long run to work with the Health Department or is it best to keep the alternative health care system?” Classen went on to note that different regions of the department agreed to cooperate to varying degrees.³¹⁰ The popular health system, which had functioned for years underfunded, understaffed, and understocked, continued on throughout the country even after the cease fire.

Over a five-year period, between 1992 and 1997, Sandy Smith-Nonini witnessed the power struggle between health workers reluctant to cede control to the government and the “ministry’s gradual reentry and assertion of control over the ex-war zone’s health services.”³¹¹ The rural areas of Chalatenango, many of which had been left empty during the war, were repopulated starting in the late 1980s. Smith-Nonini notes that in her five years there, the “situation of the rural population in government-controlled areas was little changed... compared with before the war.”³¹² The post-peace accord struggle over health “reflected a dialectic between the ministry’s commitment to a centralized biomedical model dominated by physicians and the popular system’s commitment to a strong degree of community control over health and reliance on local lay health promoters.”³¹³

³⁰⁹ Mark Smith, interview by author, January 17, 2020, Boston, Massachusetts.

³¹⁰ Susan Classen, interview by author, October 24, 2019, Skype interview.

³¹¹ Smith-Nonini, *Healing the Body Politic*, 151.

³¹² *Ibid.*, 153.

³¹³ *Ibid.*, 195.

As in Nicaragua, structural readjustment imposed by the World Bank in 1995 encouraged restructuring of the El Salvador's healthcare system.³¹⁴ Ironically, while USAID funded as much as 75% of the Salvadoran Ministry of Health's pharmaceutical purchases in the 1980s in an attempt to bolster the central government, by the early 1990s, funding was being funneled toward local health promoters.³¹⁵ Physicians at the Ministry resented this fact. By the time USAID funding was phased out in 1994, the health promoter program had been thoroughly undermined by physicians who saw it as dangerous and threatening.³¹⁶

Political and economic changes in the 1990s severely undermined the revolutionary momentum of the 1980s. The healthcare policies, the impact of solidarity, and the fracturing of gender norms that occurred remain important legacies of a revolutionary period in Central American history. Understanding the revolutionary nature of popular health care in 1980s Central America helps illuminate how revolutionary medicine still can be. Taking up the call for popular medicine of FMLN and FSLN revolutionaries remains as vital today as it was then. The privatization of medical care and pharmaceuticals across the world threaten the lives of billions of people. The revolutionary spirit of Central America in the 1980s has much to teach us about how we can combat flawed and dangerous healthcare practices across the globe.

³¹⁴ Ibid., 220.

³¹⁵ Ibid., 221.

³¹⁶ Ibid., 222.

APPENDIX A. POPULAR HEALTH WORK DAY PROGRAM

Program for a Popular Health Work Day held in Managua, Nicaragua on October 21 and 22, 1988. In author's possession, provided by Dr. Arnold Matlin.



SALON AUDITORIO

Viernes 21 de octubre de 1988

- 8:00
9:00 A.M. Acto inaugural
- 9:00 A.M. Sesión de trabajo
- Presidente: Dra. Zoila Miranda
Secretario: Dr. Mario Lacayo
Vocal: Dr. Francisco Ubeda
- 9:00
9:20 A.M. Estado nutricional y prevalencia de la desnutrición en los niños de 28 días a 24 meses que asisten a la consulta externa del Hospital Infantil Manuel de Jesús Rivera.
- Dr. José L. López P. Dr. Bismarck Valverde V.
Dr. Francisco González S. Dr. Alfonso Matus Sequeira
- 9:20
9:40 A.M. Morbi-Mortalidad Neonatal, Hospital Materno Infantil Fernando Vélez Paíz.
- Dr. Nelson Rivas Dr. Francisco Martínez Guillén
- 9:40
10:00 A.M. Situación nutricional en niños menores de 5 años. CIES-MINSA REGION III.
- Dra. María Jesús Largaespada
- 10:00
10:20 A.M. Mortalidad por diarrea. Análisis del primer semestre 1988. Hospital Infantil Manuel de Jesús Rivera.
- Dra. Sandra Gutiérrez Dra. Indiana Talavera
Dra. Leslie Urbina
- 10:20
10:40 A.M. Tétanos en niños de 1-15 años de edad. Hospital Materno Infantil Fernando Vélez Paíz.
- Dr. Ernesto Mendoza Dr. Romeo Osegueda
- 10:40
11:00 A.M. RECESO
- 11:00
1:00 P.M. Mesa Redonda "Mortalidad Perinatal"
- Coordinador: Dr. Francisco Martínez G.
Dr. César Gutiérrez Q. Dra. Clelia Valverde
Dra. Lilliam Luna
- 1:00
2:00 P.M. ALMUERZO
SESION DE LA TARDE
- Presidente: Dr. Pedro Rafael Pérez
Dr. Romeo Osegueda
Dr. Ricardo Caldera
- 2:00
2:20 P.M. Factores sociales de mayor incidencia en niños desnutridos de 0-5 años C/S Ciudad Sandino.
- Lic. Melba Tijerino Lic. Patricia Alfonso
Enf. Katy Rueda
- 2:20
2:40 P.M. Tumores retroperitoneales en niños. Hospital Infantil Manuel de Jesús Rivera.
- Dr. Francisco Gutiérrez Dr. Heberto Vanegas
- 2:40
3:00 P.M. Causas de fuga y abandono de pacientes. Hospital Materno Infantil Fernando Vélez Paíz.
- Lic. Lourdes Flores Lic. Victoria Silva
- 3:00
3:20 P.M. Epidemiología de las enfermedades diarreicas en América Latina. Dirección de Higiene y Epidemiología Región III.
- Dra. Dorisella Torres
- 3:20
3:40 P.M. RECESO
- 3:40
4:00 P.M. Factores que influyen en la asistencia por primera vez de los niños con parálisis cerebral infantil a los centros de re-

habilitación Aldo Chavarría y Policlínica Oriental Enero-Mayo 1988. Instituto Politécnico de la Salud "Luis Felipe Moncada".

Estudiantes de III año de Fisioterapia

- 4:00
4:20 P.M. Síndrome nefrótico, experiencia de 5 años. Hospital Infantil Manuel de Jesús Rivera.
- Dr. Roberto Jiménez E. Dr. Ricardo Caldera A.
- 4:20
4:40 P.M. Infecciones de vías respiratorias y estado nutricional. Hospital Infantil Manuel de Jesús Rivera.
- Dr. Luis Urbina Dra. Martha Montalván M.
- 4:40
5:00 P.M. Ideas de colaboración entre el Hosp. Carlos Marx y el Centro de Salud.
- Dra. Ursula Fischer

Sábado 22 de octubre 1988

- Presidente: Dra. Isayda García
Secretario: Dra. Carmen González
Vocal: Dra. Ana Largaespada
- 8:00
8:20 A.M. Tumores intra-abdominales en niños. Hospital Infantil Manuel de Jesús Rivera.
- Dr. Francisco Gutiérrez Dr. Heberto Vanegas
- 8:20
8:40 A.M. Mortalidad del niño mal nutrido carencial de III grado. Hospital Infantil Manuel de Jesús Rivera.
- Dra. María Elena Delgado Dr. Manuel Sánchez
- 8:40
9:00 A.M. Duplicación ureteral como causa de incontinencia urinaria permanente.
- Dr. Karin Mierjanobch
- 9:00
9:20 A.M. Factores de riesgo asociados a muerte en menores de 1 año. Hospital Materno Infantil "Fernando Vélez Paíz".
- Dra. Patricia Rodríguez Dr. Bernardo Hernández
- 9:20
9:40 A.M. Confiabilidad de los resultados de laboratorio emitidos en la sección de Química Clínica en hospitales y policlínicas de la Región III, durante el mes de agosto de 1988. Instituto Politécnico de la Salud "Luis Felipe Moncada".
- Estudiantes del III año de Laboratorio Clínico
- 9:40
10:00 A.M. Mortalidad en niños de 1-4 años, 1984-1986.
- Dr. Jorge Sequeira A.
- 10:00
10:20 A.M. Correlación clínico-radiológica. Medicina pediátrica, Estudio comparativo 1987-1988.
- Dr. Telvis Mejía
- 10:20
10:40 A.M. Informe sobre la atención médica del absceso en el Hosp. Carlos Marx.
- Dra. Marina Escobar
- 10:40
11:00 A.M. RECESO
- 11:00
1:00 P.M. Mesa Redonda "MANEJO DEL PACIENTE CON SIDA"
- Coordinador: Dr. Luis E. Gutiérrez
Dr. José Hernández Dra. Socorro Álvarez
Lic. Reyna Ma. Gutiérrez Dra. Jeaneth Alonso
- 1:00
2:00 P.M. C L A U S U R A
- 2:00 P.M. Almuerzo-Recepción
- SALON "ROJO"**
- Viernes 21 de octubre:**
- Presidente: Dr. Alvaro Avilés Gallo
Secretario: Dr. Julio César Mendieta
Vocal: Dr. Walter Zamora

9:00
9:20 A.M. Maduración placentaria y resultados perinatales. Correlación ecográfica-anatómica.

Dra. María Elena Miranda M. Dra. Rhina García N.
Dr. Oscar Caldera

9:20
9:40 A.M. Perfil patológico y calidad de atención en la sala de alto riesgo obstétrico en el Hosp. "Bertha Calderón", Julio-Septiembre de 1987.

Dra. Ana Ma. Pizarro J. Dra. María Elena Miranda

9:40
10:00 A.M. Prevalencia, aspectos clínicos y tratamiento de la Ectopía de cuello uterino. Enero 1986-Mayo 1987. C/S. Sócrates Flores.

Dr. Alvaro Ruiz L. Dr. Christiam Zeledón

10:00
10:20 A.M. Mortalidad materna: causas básicas. Análisis Clínico-estadístico. Abril 1983-Julio 1988. Hosp. Bertha Calderón.

Dra. Cándida Chávez P. Dra. Ligia Altamirano G.

10:20
10:40 A.M. Comportamiento del aborto inducido ilegalmente, en el Hospital de la Mujer "Bertha Calderón R.", Julio 1985-Agosto 1988.

Dra. Ana Ma. Pizarro J. Dra. Ligia Altamirano G.

10:40
11:00 A.M. **RECESO**

11:00
1:00 P.M. Mesa Redonda "Importancia del control prenatal".

Coordinador: Dr. Oscar Flores
Dra. María Elena Miranda Dr. Róger Chávez
Dr. Néstor Benavides

1:00
2:00 P.M. **ALMUERZO**
SESION DE LA TARDE
Presidente: Dr. Freddy Cárdenas
Secretario: Dr. Victor Mantilla
Vocal: Dr. Rudy Gómez

2:00
2:20 P.M. Revisión del subprograma No. 7: atención integral de la mujer. Estudio de la fertilidad humana. Enero-Diciembre de 1986. C/S. Edgard Lang.

Dr. Mauricio Rodríguez L. Dra. Carolina Velásquez
Dr. Denis Alemán

2:20
2:40 P.M. Características de las usuarias del servicio de control definitivo de la fertilidad humana del Hospital "Bertha Calderón", Febrero-Agosto 1987.

Dr. Alvaro F. García G. Dra. Ligia Altamirano G.

2:40
3:00 P.M. Morbimortalidad materno-fetal del fórceps en pacientes con cesárea anterior en el Hospital "Bertha Calderón R.". Enero 1984-October 1987.

Dr. Allan Juárez Dr. Alvaro Avilés G.

3:00
3:20 P.M. Conocimientos de la población sobre el uso de anticonceptivos en las mujeres en edad fértil. C/S. Carlos Rugga.

Dr. Freddy Solís

3:20
3:40 P.M. **RECESO**

3:40
4:00 P.M. Amenaza de parto prematuro y dosis de ataque.

Dra. Carolina Brenes P. Dr. Denis Alemán

4:00
4:20 P.M. Incidencia del aborto terapéutico en 1er. semestre 1987.

Dra. Julieta Alvarado V. Dra. Ligia Altamirano G.

4:20
4:40 P.M. Rubéola. Interrupción del embarazo en el Hosp. "Bertha Calderón R."

Dr. Juan J. Ordóñez H. Dr. Victor Mantilla G.

Sábado 22 de octubre:

Presidente: Dr. Leopoldo Delgado
Secretario: Dr. Petronio Delgado
Vocal: Dr. Manuel Madriz

8:00
8:20 A.M. Algunos indicadores sociolaborales y familiares en una población crónica ambulatoria en consulta externa. Hosp. "José Dolores Fletes". Abril-Junio 1988.

Lic. Celia Ruiz Lic. Libia Boedecker
Dra. Clara Sánchez

8:20
8:40 A.M. Caracterización de servicios de emergencias del Hosp. "José Dolores Fletes". Junio 4-17, 1988.

Dr. Luis E. Alemán Dra. Clara Sánchez A.

8:40
9:00 A.M. Informe preliminar sobre atención de salud mental a los heridos y lesionados del operativo "Danto 88". Hosp. Militar Escuela "Dr. Alejandro Dávila Bolaños".

Lic. Martha L. Taboada A. Dr. Manuel Madriz M.

9:00
9:20 A.M. Factores de riesgo predisponentes de reingreso. Hosp. "José Dolores Fletes".

Lic. Ma. Auxiliadora Sevilla Lic. Alma A. García C.

9:20
9:40 A.M. Algunas consideraciones sobre la rehabilitación del enfermo esquizofrénico. "Brigada Médica Cubana".

Lic. Luisa Molina F. Lic. Estela Selva U.

9:40
11:00 A.M. **RECESO**

11:00
1:00 P.M. **MESA REDONDA**

1:00 P.M. Almuerzo y Recepción

SALON "CAFE"

Viernes 21 de octubre:

Presidente: Dr. René Argeñal
Secretario: Dr. Abraham Montealegre
Vocal: Dr. Sergio Palacios.

9:00
9:20 A.M. Experiencia ultrasonográfica en el Hospital "Dr. Alejandro Dávila Bolaños" en un período de 3 años.

Dr. Eduardo Salazar M. Dr. Marvin Gutiérrez S.

9:20
9:40 A.M. Consideraciones sobre medicación antiparkinsoniana en la cura neuroléptica.

Dra. Alicia Irazabari Dr. Alberto Catalá Toledo
Dr. Carlos M. Fernández Dr. Hugo González
Dr. Ladisberto Moya

9:40
10:00 A.M. Resultados obtenidos en el tratamiento de la pseudoartrosis en el Hospital "Dr. Alejandro Dávila Bolaños".

Dr. Carlos Altamirano A. Dr. Marcos A. Salas C.

10:00
10:20 A.M. Arritmia en el infarto. Hospital Antonio Lenin Fonseca.

Dr. Julio César Flores

10:20
10:40 A.M. Criterios clínicos en el proceso de dispensarización del paciente con Hipertensión arterial. Hospital "Carlos Roberto Huembes".

Dr. Daniel Rivas B.

10:40
11:00 A.M. **RECESO**

11:00
1:00 P.M. Mesa redonda "Manejo del paciente diabético".

Coordinador: Dr. Juan I. Gutiérrez
Dr. Norman Jirón

Dr. Alfonso Matus
Dr. Francisco Bolaños

1:00 P.M. ALMUERZO
SESION DE LA TARDE

Presidente: Dr. Mario Espinoza
Secretario: Dr. Oscar Jirón
Vocal: Dr. Sergio Martínez

2:00
2:20 P.M. Estudio del rinoscleroma en Nicaragua; informe inicial.
Hospital "Dr. Alejandro Dávila Bolaños".
Dr. Raúl Campos R. Dr. Francisco Moreno M.

2:20
2:40 P.M. Tuberculosis. El hospital y su roll en la terapia del pa-
ciente tuberculoso. Revisión de los casos atendidos en
el primer semestre 1988. Hospital "Antonio Lenin Fonseca".
Dra. Lucy Villagra.

2:40
3:00 P.M. Tratamiento de verrugas vulgares múltiples con dinitro
cloro benceno y placebo. Estudio doble ciego.
Dr. Alejandro Varela Merlo.

3:00
3:20 P.M. Frecuencia de hiperglicemia en 1.000 personas sanas.
Hospital Militar Escuela "Alejandro Dávila Bolaños".
Dr. Denis Castillo.

3:20
3:40 P.M. RECESO

3:40
4:00 P.M. Caracterización del paludismo. Hospital "Antonio Lenin
Fonseca".
Dr. Pablo Castro M.

4:00
4:20 P.M. Cardiopatía reumática en Policlínica Oriental.
Dr. Amán Sandino.

4:20
4:40 P.M. Complicaciones sépticas encontradas en pacientes con
alimentación parenteral en la U.C.I. Hospital "Dr. Alejan-
dro Dávila Bolaños".
Enf. Elieth Chávez Ch. Enf. Norma Gómez H.

4:40
5:00 P.M. Estructura del Dpto. de enfermería en el Hosp. Carlos
Marx.
Enf. Ismari García.

Sábado 22 de octubre:

Presidente: Dr. Daniel Rivas
Secretario: Dr. Sergio Ordóñez
Vocal: Dr. Wilfredo Álvarez

8:00
8:20 A.M. Determinación de grupos de riesgo y detección de anti-
cuerpos anti-HIV en repatriados en la Región Autónoma
del Atlántico Norte. Mayo-Diciembre 1987.

Dr. Guillermo Porras C. Dr. Juan P. López
Dr. Gustavo Porras C. Dr. Pablo A. Cuadra

8:20
8:40 A.M. La atención primaria en el traumatismo craneo-encefá-
lico. Brigada Médica Cubana.

Dr. Fermín Garmendia Dr. Reginaldo Ramos
Dr. Néstor González

8:40
9:00 A.M. Estudio clínico-epidemiológico de 100 casos de esca-
bias.
Dr. Uriel Aguilar M.

9:00
9:20 A.M. Utilidad de la prótesis de miembros superiores de los
discapacitados de guerra egresados del Hospital Aldo
Chavarría, en el período 1984-1988 en la Región III. Instituto Politécnico
de la Salud "Dr. Luis F. Moncada".
Estudiantes de III año de Fisioterapia.

9:20
9:40 A.M. Evaluación del uso de antibióticos en el Hospital Manolo
Morales Peralta.
Dr. Guillermo Porras C. Dr. Dayton Castañeda
Dr. Gustavo Porras C.

9:40
10:00 A.M. Utilización de los corticosteroides en el Hospital Manolo
Morales Peralta.

Dra. Socorro Alvarez Dr. Arsenio Prado
Lic. Martha Weil

10:00
10:20 A.M. Tuberculosis en el Hospital Manolo Morales Peralta.
Dr. Jaime Cortés S. Dr. Sergio Palacios M.

10:20
10:40 A.M. Transportación ósea mediante la fijación externa. Hosp.
"Alejandro Dávila Bolaños".

Dr. Marco A. Salas C.

10:40
11:00 P.M. RECESO

11:00
1:00 P.M. Mesa redonda "Manejo del paciente con SIDA". Auditorio.

1:00 P.M. CLAUSURA
SALON BARRO

Viernes 21 de octubre 1988

Presidente: Dr. Róger Díaz
Secretario: Dr. Roberto Solorzano
Vocal: Dr. Valerio Guevara

9:00
9:20 A.M. Traumatismo de la incontinencia urinaria de esfuerzo
con la técnica Marshall Marchetti Krantz. Hospital de la
Mujer Bertha Calderón.

Dr. Mario Gutiérrez N. Dr. Frank Bermúdez

9:20
9:40 A.M. Trauma de uretra posterior. Hospital Antonio Lenin Fon-
seca.
Dr. Adrián Hernández.

9:40
10:00 A.M. Infecciones en el herido por arma de fuego crítico en el
Hospital Militar Escuela "Dr. Alejandro Dávila Bolaños",
durante el año 1987.

Dr. Alfonso Zamora S. Dra. María Luisa Aguilar M.

10:00
10:20 A.M. Características de pacientes quemados egresados de
U.C.I. Hospital Antonio Lenin Fonseca.
Dr. Francisco Cortés H.

10:20
10:40 A.M. Heridas penetrantes de abdomen. Hospital Militar Es-
cuela "Dr. Alejandro Dávila Bolaños".

Dr. José G. Madriz Dr. Milton Mairena

10:40
11:00 A.M. RECESO

11:00
1:00 P.M. Mesa Redonda "ATENCIÓN DEL PACIENTE POLI-
TRAUMATIZADO".

Coordinador: Dr. Efraín Fajardo

Dr. Rafael A. Díaz Dr. Enrique Vega
Dr. Gilberto Vigil Dr. Benjamín Urizar
Sub. Cmdte. Luis E. Rodríguez

1:00
2:00 P.M. ALMUERZO
SESION DE LA TARDE
Presidente: Dr. Reynaldo Porras
Secretario: Dr. Alberto González
Vocal: Dr. Cristóbal López

2:00
2:20 P.M. Influencia del relajante muscular sobre la presión intra-
ocular en cirugía intra-ocular. Hospital Antonio Lenin
Fonseca.
Dra. Sheyia Aragón B.

2:20
2:40 P.M. El herido oftálmico por arma de fuego, perfiles y análi-
sis. Hospital Bertha Calderón.
Dr. Alvaro Zambrana Dr. Julio Quezada

2:40
3:00 P.M. Correlación endoscópica del diagnóstico macroscópico y el estudio histológico en las biopsias gástricas en los años 1981-1987 en el Hospital Militar.

Dra. Reyna Palacios G. Dr. Juan Ignacio Gutiérrez
Dr. Hugo Argüello M.

3:00
3:20 P.M. Incidencia de Mielomeningocele en el Hospital "Antonio Lenin Fonseca". 1983-1986.

Dr. Augusto Ríos F.

3:20
3:40 P.M. R E C E S O

3:40
4:00 P.M. Frecuencia de infecciones en las heridas quirúrgicas potencialmente contaminadas. Hospital Militar Escuela "Dr. Alejandro Dávila Bolaños".

Enf. Rosa María Espinoza Enf. Lucila Rodríguez R.
Enf. Ligia Rodríguez R.

4:00
4:20 P.M. Análisis de causas de cancelación de procedimientos quirúrgicos Enero-Agosto 1988. Hospital Materno Infantil "Fernando Vélez Paíz".

Dr. Danilo Quintanilla.

4:20
4:40 P.M. Lesiones debido a heridas por arma de fuego. Hospital Materno Infantil "Fernando Vélez Paíz".

Dr. Pablo Escobar Dr. Fidel Morales G.

4:40
5:00 P.M. Mortalidad y problemática social del Hospital Antonio Lenin Fonseca, correspondiente al período de Enero-Junio 1988.

Lic. Lucila Zelaya Lic. Gloria Ruiz

Sábado 22 de octubre 1988:

Presidente: Dr. José Hernández
Secretario: Dr. Mauricio Moreno
Vocal: Efraín Fajardo

8:00
9:00 A.M. Distress respiratorio del adulto.

Dr. Rafael Díaz.

9:00
9:20 A.M. Trauma abdominal en el Hospital Manolo Morales Peralta.

Dr. Roberto C. Bojorge Dr. Juan B. Salinas
Dr. Wilfredo J. Uriarte Dr. Rodolfo Argüello
Lic. Orlando González

9:20
9:40 A.M. Citología por aspiración con aguja fina (correlación histológica). Hospital Manolo Morales Peralta.

Dr. Walter Cuadra A. Dr. Luis Sáenz M.

9:40
10:00 A.M. Cirugía biliar de urgencia. Hospital Manolo Morales Peralta.

Dra. Nora Sánchez Dr. Sergio Palacios M.

10:00
10:20 A.M. Histerectomía, Evaluación clínico-patológica. Estudio de casos, control de hospitales Bertha Calderón, Antonio Lenin Fonseca y Manolo Morales P. 1987.

Dra. Mariana Moreno Dr. Luis Sáenz.

10:20
10:40 A.M. Uso de los TES en cuidados intensivos. Hospital Manolo Morales P.

Dr. Oscar Cornejo Dr. Sergio Palacios

10:40
11:00 A.M. R E C E S O

11:00
1:00 P.M. Mesa Redonda "MANEJO DEL PACIENTE CON SIDA". Auditorio.

1:00 P.M. C L A U S U R A

APPENDIX B. NCAHRN PAMPHLET

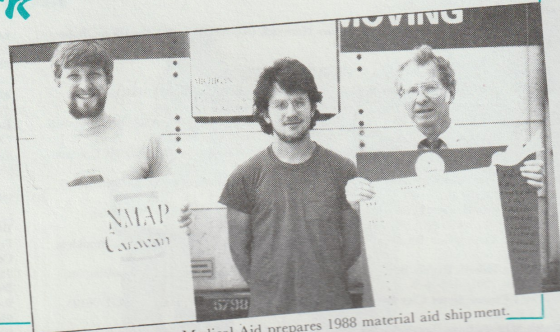
NCAHRN pamphlet. This pamphlet exemplifies the campaign efforts undertaken by solidarity activists in the 1980s. It includes information on the activities of NCAHRN, including the North America-Nicaragua Annual Health Colloquium and Insulin for Life. In author's possession, provided by Dr. Arnold Matlin.

Join the National Central America Health Rights Network

Join with people who believe that every Central American has a right to quality, affordable health care. . . .

Join with people who want to change U.S. policy and put our tax dollars to use building health care systems, not for military intervention. . . .

Join with health workers who seek to serve people in need, in Central America and at home. . . .



Ann Arbor Nicaragua Medical Aid prepares 1988 material aid shipment.

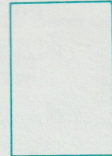
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The National
Central America
Health Rights
Network

National Central America Health Rights Network

853 Broadway, Suite 416
New York, N.Y. 10003



Health Care in Central America

Health conditions are precarious in Central America. Most of the region's 22 million people are without adequate medical care, jobs, housing, food, or education. War and economic decline in the 1980's have made health conditions critical:

- Over 120,000 civilians have been killed, wounded or disabled since 1980.
- 80% of the deaths among children are caused by easily preventable diseases;
- 40% of Central Americans lack access to health care of any kind
- Two-thirds of the children under five are poorly nourished.
- In each country of the region, health care reflects the changing political and economic conditions.

In **NICARAGUA** the number of health centers and medical visits have tripled since the 1979 revolution. Large sectors of the population have gained access to health care for the first time. Immunization rates more than doubled and infant mortality dropped over 30% from 1979-1983. But these gains are in danger as U.S. economic pressure and the "contra" war have strained the Nicaraguan economy to the breaking point.

An army counterinsurgency campaign in **GUATEMALA** has killed an estimated 20,000 indigenous people and displaced hundreds of thousands more since 1980. Violence has continued under civilian rule and has driven many into exile. Health workers are special targets of the continuing war, but direct health care and training of health workers is still carried out through community organization in the rural areas.

Most people in **EL SALVADOR** lack access to health care. The country's health system has deteriorated steadily over nine years of war. The Salvadoran army has bombed hospitals, clinics and other civilian targets in rural areas. These rudimentary health facilities, many established by international assistance, often provide the only available care for thousands of people.

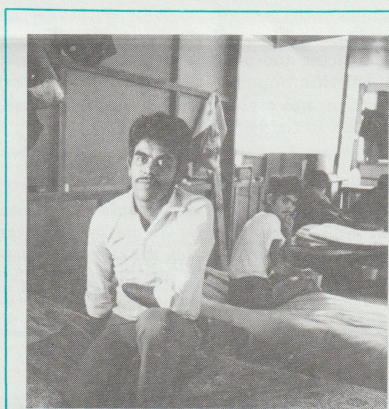
In **HONDURAS**, infectious diseases such as polio, tetanus and tuberculosis are spreading at a dangerous rate. Hondurans are experiencing a rapidly declining standard of living. The U.S. military and contra presence has brought new ills, such as penicillin-resistance gonorrhea and AIDS.

COSTA RICA, which has the best health profile in the region, has been drawn into the crisis. Militarization and the foreign debt, one of the world's highest per capita, have forced the government to cut social services and food supplement programs.



Prosthetics Workshop, Aldo Chavarria Rehabilitation Hospital, Managua, Nicaragua

Marvin Collins, Impact Visuals



Amputee in a Salvadoran refugee camp hospital

Kathleen Foster



NCAHRN El Salvador Delegation: Prof. Frances Hubbard and intern Jim Mittelberger examine a refugee.

National Central America Health Rights Network

NCAHRN, formed in 1983, has grown into an organization of more than fifty member groups and hundreds of individual affiliate members nationwide. Students, public health professionals, nurses, physicians, nutritionists, educators, psychologists, technicians and other concerned citizens are active with **NCAHRN** groups.

NCAHRN groups have donated over \$9 million dollars in money, medicine and equipment and services in kind to Central America, organize educational forums, sponsor speaking tours and exchanges with health workers, and conduct tours to the region.

On a national scale, **NCAHRN** sponsors a wide range of activities to promote health in Central America, to educate people in the United States on the impact of poverty and U.S. intervention in Central America through the perspective of health, and to work towards a more humane U.S. foreign policy.



Nicaraguan Minister of Health Dora Maria Tellez speaks at a NICMAC and 1199 sponsored forum.

Mel Rosenthal, Impact Visuals

Projects and Activities

THE MEDICINES FOR CENTRAL AMERICA FUND (MCAF): Every dollar donated to this fund purchases \$30 of urgently needed medicines. Hundreds of thousands of dollars of supplies have already been delivered through this fund.

PERSONNEL EXCHANGES: **NCAHRN** groups have helped build and staff health clinics, day care centers and nutrition projects in Nicaragua and El Salvador. Maternal child health programs have trained obstetrical nurses and supported midwives in the region. The national office and many member groups send short-term work-study delegations and assist in placing health care professionals in longer term positions through the Vecino Project and the Personnel Exchange.

NORTH AMERICA-NICARAGUA ANNUAL HEALTH COLLOQUIUM: Each fall since 1983, **NCAHRN** has co-sponsored with Bay Area **CHERICA** a health colloquium in Nicaragua. This annual gathering has brought together hundreds of doctors, nurses and other health workers from North America with their counterparts in Nicaragua.

LINKS: The network publishes **LINKS**, a quarterly journal on health in Central America and health rights organizations in the U.S.

INSULIN FOR LIFE: In response to an urgent need in Nicaragua, this **NCAHRN**-sponsored group purchases and delivers monthly supplies of insulin that literally means life to many diabetic Nicaraguans.

GUATEMALA HEALTH RIGHTS SUPPORT PROJECT: Founded in 1985, the GRHSP supplies direct aid to the people of Guatemala, encourages people-to-people ties between U.S. and Guatemalan health workers, and provides educational resources about the Guatemala Health Movement, a broad-based humanitarian response to the urgent health needs in Guatemala.

MENTAL HEALTH: Mental health committees sponsor symposia, speaking tours, train Central American refugees as mental health promoters and facilitate the participation of Central Americans in U.S. professional organizations. Resource materials on mental health, refugees and survivors of torture are available through **NCAHRN**.

DIRECTORY

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Bikes Not Bombs, P.O. Box 5595, Friendship Station, Washington, D.C. 20016, Contact: Michael Replogle (301) 587-6137
Boston Committee for Health Rights in Central America, Box 796, Astor Station, Boston, MA 02123 (617) 492-4169
Central Jersey/Masaya Friendship City, 525 East Front St., Plainfield, NJ 07060, Contact: Jim Burchell (201) 765-9102
Downstate Association for Health Rights, c/o Bob Marsh, 483 Clinton Ave., Brooklyn, 11238, (718) 638-1846
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Hartford/Ocotal Sister City Project, c/o CRCC, 30 Arbor Street, Hartford, CT 06105, (203) 659-1965
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ProNica, c/o 130 19th Ave. SE, St. Petersburg, FL 33705, (813) 896-0310, Contact: Shawna Doran
Rhode Island Committee for Health Rights in Central America, c/o David Egilman, 70 Beachwood Dr., East Greenwich, RI 02818, (401) 885-6842
Vecino/Neighbor, P.O. Box 1684, Jamaica Plain, 02130, (617) 776-8186

MIDWEST REGION:

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Cleveland Central America Health Rights Network, c/o Carol Epstein, 3055 Lincoln Blvd., Cleveland Heights, 44118, (216) 932-1422
Iowa Central America Solidarity Committee, IMU/SAC University of Iowa, Iowa City, IA 52242, Contact: Rose Hayslett (319) 354-7919

Lacrosse-Winona Medical Aid to Central America, c/o Joan Schnabel, P.O. Box 2731, Lacrosse, WI 53703, (608) 687-8486
Madison Medical Aid to Central America, 731 State Street, Madison, WI 53703, (608) 251-3241
Minneapolis Central America Medical Aid, P.O. Box 7602, Minneapolis, MN 55407, (612) 827-6109
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Wisconsin Coordinating Council on Nicaragua, P.O. Box 1534, Madison, WI 53701, (608) 257-7230

WESTERN REGION:

Bay Area Committee for Health Rights in Central America, 347 Dolores St., San Francisco, CA 94110, (415) 431-7760
Central America Health Rights Project, P.O. Box 366, Santa Cruz, CA 95061, (408) 462-2563
Denver Committee for Health Rights in Central America, c/o Lucy Loomis, 4323 E. Barvia Place, Denver, CO 80220 (303) 321-6401
Help Kids Communicate/TecNICA, 2727 College Ave., Berkeley, CA 94606, (415) 848-0292
Insulin for Life, 1868 Church St., San Francisco, CA 94131, Contact: Bob Greenberg, (415) 552-1870
Los Angeles Committee for Health Rights in Central America, P.O. Box 34533, Los Angeles, CA 90034, Contact: Lynn Kersey, (213) 838-1682
Medical Aid for El Salvador, 6030 Wilshire Blvd., Suite 200, Los Angeles, CA 90036, (213) 937-3596
NEST Foundation, P.O. Box 410492, San Francisco, CA 94141, (415) 864-7755
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Nicaragua AIDS Education Project, 3181 Mission #3, San Francisco, CA 94110, Contact: Naomi Shapiro (415) 648-4437
Nicaragua Hospital Emergency Generator Fund, P.O. Box 473, Santa Clara, CA 95052, (408) 243-4359
Palo Alto-Stanford Medical Aid Committee, P.O. Box 9392, Stanford, CA 94309, (415) 327-9585
Partners for Health, P.O. Box 20335, Seattle, WA 98102, (206) 632-6302
Salvadoran Medical Relief Fund, P.O. Box 1194, Salinas, CA 93902, (408) 758-4001
San Jose de Bocay Medical Laboratory Project, 77 Merriewood Circle, Oakland, CA 94611, Contact: John Roark/Susan Ito (415) 339-0622
Technical Aid Project to Nicaragua, P.O. Box 9369, Berkeley, CA 94709, Contact: Karen Cohn, (415) 824-5143
UCSF Committee for Health Rights in Central America, 500 Parnassus Ave, 249 Milberry Union, San Francisco, CA 94143, Contact: Jill Letterman (415) 476-2010

INTERNATIONAL:

Association Medicale pour l'amerique latine et les caribes (AMALC), c/o Raymond Herrera, CP 458 Station H, Montreal, Canada H3G 2L1
Committee of US Citizens Living in Nicaragua (CUSCLIN), AP 4110-25, Managua, Nicaragua

I want to help NCAHRN grow as a voice for peace and health in Central America. Enclosed is my contribution.

\$500 \$250 \$100 Other _____

I want to join NCAHRN. Here's my \$40 for a Links subscription, NCAHRN t-shirt and national mailings.
 Circle one: **S** **M** **L** **XL**

Please let me know how I can join or start a group in my area to organize for health and peace in Central America.

Send me information on how my group can participate in NCAHRN

All checks are **tax deductible**. Make checks payable to **NCAHRN**, 853 Broadway, Suite 416, New York, NY 10003 (212) 420-9635.

NAME	PHONE		
ADDRESS			
CITY	STATE	ZIP	ORGANIZATION

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University of New Mexico, Jane Norling and Lenora (Nori) Davis Collection (online)

Wayne State University, Walter P. Reuther Library, Organization in Solidarity with Central America Records (online)

University of Michigan, Global Feminisms Project (online)

Interviews Conducted by the Author

Joseph Levine – September 26, 2019.

Aynn Setright – August 2, 2019.

Arnold Matlin – October 23, 2019.

Maria Hamlin Zuniga – October 16, 2019.

Lois Wessel – October 24, 2019.

Jill Winegardner – October 28, 2019.

Christine Reesor – November 12, 2019.

Mark Smith – January 17, 2020.

Susan Classen – January 30, 2020.

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