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Doctors for Global Health Reporter

DGH has been accompanying communities in Chiapas, Mexico, in two important ways: providing volunteer health professionals to rural Hospital San Carlos and supporting a Community Health Worker (CHW) project. The CHWs are from 35 isolated, indigenous, autonomous communities that have decided not to accept services from the Mexican government because of its maltreatment of the indigenous people, and are struggling to manage their collective resources. A DGH-supported Mexican physician coordinates the CHW training in nutrition, vaccination, parasite treatment and giving vitamin A to prevent night blindness. They are also starting community vegetable gardens and constructing environmentally-friendly stoves. The articles on the following three pages provide a glimpse into both types of work being carried out in Chiapas.

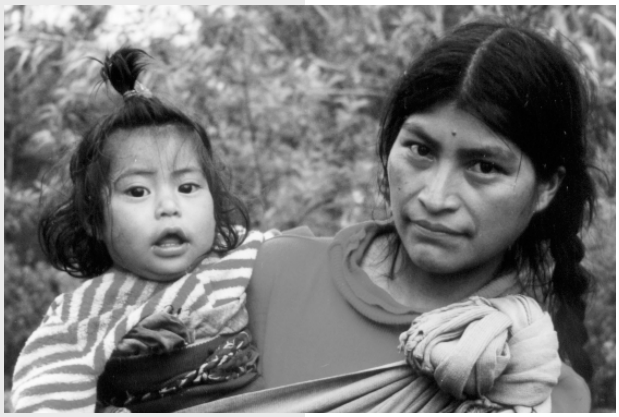
My Six Months in Chiapas

By Lleni Pach, MD

After over 30 years of teaching and practicing general, child and adolescent psychiatry as a Clinical Associate Professor at Upstate Medical University in Syracuse, NY, I decided that my next professional and personal stage would be working with underserved populations through the practice of general medicine, since it is difficult to reach such populations through the practice of psychiatry alone.

As a Peruvian and having done my Medical Education at San Marcos University in Lima, Peru, it seemed that the best place to pursue such an endeavor would be in a Spanish-speaking country. I thought that it would be easy to attain such a goal, since I had the academic credentials, experience and Spanish fluency. Yet it took me about two years to find an organization that supported and facilitated my re-tooling in clinical medicine. Those two years were marred with frustrations as I found myself blocked by the fears of different medical environments about legal constraints. Fortunately I found Doctors for Global Health, an organization made up of supportive, flexible and forward-minded people whose main goal is serving the needy, rather than getting snarled by misplaced fears that undermine the original purpose of the Socratic oath.

My quest finally took me to Altamirano, a town in Chiapas, Mexico, where I came to work as a volunteer in Hospital San Carlos. The Sisters of Charity from Saint Vincent de Paul have administered and worked in Hospital San Carlos since 1976. They have received many volunteers from DGH, and they accepted my coming under the condition that I would stay for six months and be supervised the first two months by Linnea Capps, MD, a DGH board member who coordinates DGH's Chiapas projects and has worked in the hospital several months a year for many years. She is also the Residency Program Director of Internal Medicine at Harlem Hospital in New York.



Present-day Altamirano has a few primary schools, one secondary school with about 300 students, and two Prep Schools (one for technical training, CONALEP, where the majority of stu-

Chiapas: Then and Now

Chiapas is the southernmost state of Mexico, bordering with Guatemala. During colonial times Chiapas was administered by Guatemala and victimized by Spanish landlords whose excesses and abuses of the indigenous population during that period came to be known as the "Black Legend."

Ecclesiastical figures began to call for the protection of the indigenous people. Fray Bartolomé de Las Casas, who became the first Chiapas Bishop in 1545, advocated for King Charles I to decree laws to forbid forced labor and indigenous slavery. The advocacy of Las Casas in defense of the human rights of indigenous people helped to mitigate the abuses, and served as a model to future ecclesiastical generations, who have worked to alleviate their poverty and have fought to protect them against the continuous abuse of their rights.

In 1824, Chiapas was annexed to Mexico by referendum. In contemporary times the pre-eminent figure that has continued this tradition has been Monsignor Samuel Ruiz Garcia, who for many years was the Bishop of San Cristobal de las Casas. He advocated tirelessly for the indigenous populations to the point that they considered him their Guardian Angel.

Yet Chiapas has been consistently abandoned and abused by the country at large. Chiapas provides almost 50% of the hydroelectric energy for Mexico, and contributes 8% of the electric energy and 6.5% of the oil production. Yet in 1990 15% of the houses lacked a kitchen and a third did not have electric energy or safe water. The level of illiteracy and child mortality is one of the highest in Mexico. According to official reports, Chiapas has the highest level of discrimination. More than half of the work force receives less than the minimum salary. Chiapas is the poorest state in the Mexican Republic. In the areas where there is a higher concentration of indigenous populations, the poverty is even higher.

Chiapas is an agricultural state; 58% of the workers earn their living as laborers.

dents come from both Tzeltal and Tojolabal indigenous-group communities, and the other, COBACH, which most of the town children attend). During my time there I stayed at the home of Juan Manuel Canales, MD, a member of DGH and its in-country project coordinator. He was a most gracious host, who helped ease my transition to the hospital.

A new Hospital San Carlos was inaugurated in November 2004. It has 60 hospital beds: 30 for adults with an area for isolation, and an Obstetrics and Gynecological floor; and 30 for children with a prenatal and intensive care component. There are five outpatient offices, a pharmacy with donated medications, a very basic clinical laboratory (no cultures), and two operating rooms.

The hospital, which is open 24 hours a day, seven days a week, is oriented to providing care predominantly to the poor indigenous population in the surrounding villages. The outpatient service has five nursing auxiliary-translators, and the various floors have nursing staff that speaks the different native languages.

"It took me about two years to find an organization that supported and facilitated my re-tooling in clinical medicine. Those two years were marred with frustrations... Fortunately, I found Doctors for Global Health, an organization made up of supportive, flexible and forward minded people whose main goal is serving the needy."

The hospital also provides milk to families in need. The old hospital building is partially dedicated to attend to a limited number of convalescent patients. It has a humble Inn for family members that need to stay overnight and it also provides food for many of them. In the inpatient services the hospital allows up to two relatives to stay overnight with each patient, giving them blankets for the night.

Besides the predominance of respiratory infections, the hospital also sees typhoid fever, malaria, tuberculosis and, recently, an increasing incidence of HIV. There is also a lot of alcoholism in the area, but most of those patients are not seen at the hospital.

The design of the new hospital is such that it is easy to go quickly between the outpatient and inpatient service areas. This facilitated my ability to consult with the other physicians, who were most receptive and helpful. The situation encouraged me to start seeing patients independently after just three weeks. Soon afterwards I was asked to help out with the on-call schedule, initially during the weekdays and later on weekends. Their support and trust in my recovered clinical skills was of much value and I am very thankful.

I also was asked to give psychiatric consultations, and provided therapy to individuals and families. The psychiatric problems most commonly seen are related to alcoholism, family violence, depression and psychosis. There was a consensus by several people that the problems of alcoholism, violence and prostitution exploded as a result of the presence of the Mexican military station that had settled in the outskirts of town after the Zapatista uprising in 1994.

I was confronted with the suffering and injustice of the economic disparities that caused the uprising in my daily work in the hospital. I will never forget the patient who came to the hospital because he had been loosing his vision. One eye was already blind and we wanted to save the other. Unfortunately, we could not do what we needed to in the hospital and the cost of such an intervention elsewhere was too high. The patient and his family decided that they could not spare the little money they had on the operation, so they started the long trek back to their village with the knowledge that one of their family members soon would be completely blind.

Still, I quickly settled into a comfortable routine. In the early morning when there was still mist and fog in the mountains that surround Altamirano, I would take my daily walks towards the forested areas. I found laborers holding their machetes, schoolchildren walking or riding bicycles. There was an abundance of greetings. "Good morning, Sister or Brother," was the typical greeting. I would cross the streets watching the roosters, dogs, horses, goats,

(Continued on page 7

Chiapas Women's Cooperative

By Linnea Capps, MD

The women gather in the "women's house," a simple room under a laminated tin roof. They sit on wooden planks or on the dirt floor. There are about 30 of them representing 15 small isolated communities. They will be meeting with Juan Manuel Canales, the DGH physician who coordinates community health work in this area of Chiapas, Mexico.

They are all indigenous Tzeltal-speaking Mayan. Most speak little or no Spanish and most cannot read or write. They are part of one of the autonomous municipalities, supporters of the Zapatista movement. Twelve years after the Zapatista uprising that brought world attention to their poor isolated corner of Mexico, they still live in tiny communities without electricity or running water. Recently, they have begun to break through traditional gender roles and asked that DGH help them establish sustainable income opportunities.

Today, I have accompanied Juan Manual planning to teach the women how to make beaded necklaces in hopes that this is something some will be able to do to further the goal of their collective, which is to improve the economic circumstances of their families.

As the women prepare for the meeting, they talk animatedly among themselves, but when the time comes to introduce themselves, they are very quiet. Many hesitate and have to be coaxed to speak by the one who is translating for us. We talk about the problems of their communities and their hopes of finding some way to make a little money for their families. They are subsistence farmers but their only cash-producing crop is coffee. Due to the world-wide fall in coffee prices, they earn very little for the many hours it takes to harvest, clean and roast the coffee beans.

The women all make small embroidered articles; they seem to have their embroidery in their hands during every idle moment. It is not a way to make much money, however, due to their isolation with no place to sell goods to tourists. They have also tried starting a small restaurant and have plans to learn to make articles of clothing for children that they can sell to other families in the communities. DGH has also helped them to start a small bakery with a brick oven, but they have run into the same problems of having no easy access to a market.

They face the additional problems that come from trying to assert their independence from men. It was difficult for Juan Manuel to get the permission of community authorities to work with the women and they still have to clear their projects with the male authorities.

We sometimes wonder how DGH's work with the women's collective fits with our purpose to improve community health. It is certainly accompaniment that we are doing and the women have been very faithful in attending meetings over the past two years, but we do not always feel prepared for the task of advising them on economic development. (We would love to find a volunteer with experience in this field. If you are interested, e-mail *volunteer@dghonline.org*.)

When we get to the part of the meeting when we start to make beaded necklaces and earrings, they all participate enthusiastically. The colorful beads quickly disappear from the table and I help them string and tie their creations. I assure them that they can keep what they made and we talk about how they can buy the beads and string, and the possibilities of selling the necklaces to other indigenous women. When they are finished, two of the women gather up the necklaces from the others and take them out of the house. We do not understand what is going on, but soon the two women return and give the necklaces back to those who created them. The translator explains to us that they had promised the men that they would show them whatever they made with us and get permission for the women to keep it.

Two thirds of the land is dedicated to cultivating corn. The rest is used to grow coffee, *frijol*, melon, banana, mango and sugar cane.

Altamirano is located in the area of Chiapas called Los Altos, a mountain zone between 2,000 to 3,000 meters high. Its forests have a variety of trees: pine, cedar, caoba, encino, amate and others.

The main street of Altamirano is paved but not many more are. The majority of houses are made of wood, some of cement; all have corrugated roofs. There is no movie theater but you can rent movies. There is a central square where you find the municipal offices and the Dominican Church. Close by you find the market with an area reserved for products brought daily from outside the area for the locals to buy, including mustard greens, *chayote*, *cilantro*, basil, maize, *frijoles*, *guineos*, fava beans, green beans and beets.

The town has about 20,000 inhabitants, most of which are Mayans of Tzeltal origin; a minority are of Tojolabal origin. Their diet consists of *Pozol* (a mixture of ground and cooked maize mixed with water), tortillas, *frijoles* and coffee, in small or moderate quantities. This leads to many cases of protein deficiency and malnutrition, in addition to parasitic infestation, producing severe health problems, especially in children.

Hospital San Carlos was started in 1969 by the Dominican Nurse-Sisters from South Dakota and San Francisco. They transferred the hospital to The Daughters of Charity in 1976.

At that time, there was only one road that allowed a truck to bring the sick from Ocosingo and vehicles had to leave by 5pm. During the rainy season the Sisters could be isolated for several months. Occasionally patients were brought by foot, in chairs tied to the carrier's back. The Sisters could also borrow a small airplane from a nearby protestant community. This was useful in bringing the ill from the jungle and, during the 1980's, in bringing wounded war victims and the malnourished children of Guatemalan refugees to receive medical care.

DGH in the US:

Common Ground Health Clinic, New Orleans

By Max Fischer

Just after Hurricane Katrina, when activists Malik Rahim and Sharon Johnson put forth a call for a health care response in the mostly poor black neighborhood of Algiers, across the Mississippi from downtown New Orleans, they could never have imagined the cascade that would lead to the establishment of an on-going multi-disciplinary, free clinic. Even prior to the storm, this community had little access to free or low-cost health care, with no more than a maternal/newborn clinic within a reasonable trek. Otherwise, individuals were limited to the Charity Hospital Emergency Room, with waits of more than 12 hours for non-urgent care.

Katrina destroyed the Charity Hospital, leaving residents with nowhere to go for diabetes and hypertension medications, wound care, asthma exacerbations and other primary care needs. Initially, three Street Medics joined Rahim and Johnson to create a first aid station. As more volunteers arrived, this grew into a makeshift clinic, operating out of the donated space of a mosque.

As medical students, my fiancée Sheila and I wanted to go and assist in any way possible. Immediately post-Katrina, we were deterred from traveling to New Orleans, being told that things were far too chaotic for our presence to be useful and safe. We signed up as potential volunteers through the American Medical Student Association (AMSA) and the Red Cross. To our surprise and excitement, AMSA soon gave us a choice of several locations in the Gulf Coast. We chose to work in New Orleans at this new clinic, appropriately called Common Ground.

The Common Ground Health Clinic, part of the Common Ground Collective, is an excellent domestic example of Liberation Medicine. A placard outside reads, "This is Solidarity, NOT Charity." It was founded with the goal of breaking through established paternalistic and often race- and class-biased provision of health care. Among those residents who had access to routine health care before the hurricanes, many were on confusing and antiquated drug regimens, and had never received thorough self-care education. For some, Common Ground became their first source of medical care in years, largely a tribute to the welcoming and non-judgmental environment that one finds at Common Ground. Moreover, in the post-hurricane medical system chaos, the clinic was usually an endpoint rather than a gateway for health care, with most hospitals and clinics still closed. The concept of follow-up care was also new to many of our visitors. One middle-aged man, Rodney, had been nursing a wound in his big toe for a month before he came to the clinic. After I extracted an old bullet shell that had migrated to the surface, I became very anxious when he did not return for wound care. Days later, he was seen joyously running down the street to thank some Common Ground volunteers and invite them to his home.

Herbalists, acupuncturists, physical therapists, massage therapists and clinical social workers also staff the clinic. This integrative approach provides the people of Algiers with options that many never had due to the socioeconomic stratification of these services. There is an unyielding passion among the providers at Common Ground to transform the disaster into an opportunity for growth and solidarity. Given a predominantly white, middle-class volunteer base, volunteer orientation sessions emphasize recognizing racism and classism in medical care, and how we can move towards a clinical model based on partnership rather than paternalism and hierarchy.

Clinic organizers work tirelessly to ensure that everyone feels welcome and treated with high quality, humane medical care, despite the limited resources. Since no one is turned away, the clinic – volunteer-run and working from donations – was also frequented by government-paid workers brought into the area, who apparently were not provided with their own health services.

Advocacy has also been a large part of the work. We saw families with young children who were living in homes deemed 'safe,' yet the children exhibited a multitude of signs and symptoms indicating otherwise. We documented our findings and wrote letters to landlords, advocating for the health of the children and elderly. For patients requiring emergency care, we accom-

Opportunities at Home

panied them to the hospital as patient advocates. Common Ground also holds a legal clinic to help residents fight illegal evictions, and a "cop watch" video surveillance project to monitor unwarranted police activity against community members, an occasionally dangerous effort as two volunteers were beaten up, and one had his life threatened by officers of the New Orleans Police Department. Other major work includes distribution centers and community outreach.

During the month we spent at Common Ground, the outcomes were strikingly positive. Over 100 patients were seen each day at the main clinic, many coming for follow-up. Satellite clinics in the Ninth and Seventh Wards and in Latin American and Vietnamese immigrant communities brought increasing numbers of people into the Common Ground circle. Patients frequently expressed the desire to continue receiving long-term follow-up care with providers they had seen at the clinic, and many have become involved themselves as volunteers.

The challenges remain to transform this into a truly community-owned initiative, to find harmony between anarchist ideals and tight clinical standards, and to continue operating as an all-volunteer free clinic. One organizer, Scott Weinstein, aptly described the process as "building the plane while flying it." Now housed in a more permanent space with regular coverage by local physicians and greater numbers of local volunteers, Common Ground continues to grow.

However, outside volunteers are still critical. The Louisiana Department of Health and Hospitals has certified the Common Ground Health Clinic, so out-of-state health professionals can get credentialed to volunteer with the clinic for up to 60 days at a time. This period has been extended indefinitely. The clinic also needs more diagnostic instruments, including glucometers and test strips, blood pressure cuffs, stethoscopes, urine dipsticks, pregnancy tests, pulse oximeters, dopplers, a 12-lead EKG machine and an automated defibrillator. The in-house pharmacy accepts donations of unexpired medications in unopened bottles or packages. To learn more, visit *www.cghc.org*, *www.commongroundrelief.org*, or e-mail *healthalgiers@yahoo.com*.

Topahkal Health Collaborative
Albuquerque, New Mexico

By Andru Ziwasimon, MD

Over eight years ago, a group of women of color came together to promote Traditional Medicines and speak out about environmental racism. Each woman was already trained in aspects of natural medicine, from herbs to *Limpias* (Indigenous Mexican healing), to massage and reiki. The group offered many health education sessions to their community and created a monthly donation-based clinic accessible to anyone in need, regardless of their ability to pay.

In 2004, a physician and a naturopathic doctor were invited to create an allopathic urgent care clinic to complement the ongoing work of the monthly traditional medicine clinic. We were joined by one of the traditional medicine practitioners who was also trained as a Family Nurse Practitioner. Together we formed the Topahkal Family Practice Office.

The health needs of immigrants and the uninsured in Albuquerque are desperate. Institutional leaders focus on political games and competitive market edge instead of collaboration and creativity. The safety-net system in particular is overwhelmed. Funds are diverted to huge building projects and appointments can be as long as 3-4 months, with almost no same-day access available, forcing poor people to rely on the emergency room for routine care. Given this dire state of affairs, we opened our clinic with 100% same-day walk-in scheduling: no insurance or social security card needed, a fair price collected after the visit is over (not up front), and a very personal, homey environment.

Our clinic is in a small "converted" house at the back of the property of Sylvia Ledesma, one of the founding members of the Tophakal. The clinic has the capacity to do many services on-site, including labs, microscopy, ultrasound, procedures and biopsies, stitching, IV antibiotics/fluids and, of course, advocacy.

We charge $25 a consultation with small fees for medications and labs. To reduce unnecessary and bureaucratic overhead, no insurance is accepted and no malpractice is carried by practitioners. We are guided in our work by the leadership of the original circle of women. As we learn, we incorporate natural medicines into medical care, safely helping people reduce their dependence on antibiotics and quick-fix pills.

To date, we find that over 97% of our patients pay their bills. We have excellent feedback from patients and each month we are getting busier, growing by word of mouth. Our patients are predominately Spanish-speaking immigrants with a growing number of alternative-minded New Mexicans who appreciate the personal treatment and wider array of options offered.

A core part of our clinic is our serious involvement in patient advocacy and system change. We collaborate with community leaders, health workers, non-profits, the health department and any other agencies that are dedicated to putting the health of people and populations before profit.

Presently, we are looking to expand our practitioner team by another member. If you are interested in a two-year experience working as part of an independent, integrative/holistic, health justice clinic serving anyone in need, get in touch! We would love to meet you. You can e-mail us at *aziwa@null.net* or call us at 505-319-3750.

Give Us a Medicare Drug Benefit

By Robert Hayes

Starting this year, the United States is appropriating hundreds of billions of dollars to meet a basic human need – affordable prescription medicine for older Americans and people with disabilities. This should be a moment of celebration. But it's not.

For nearly 40 years, Medicare has been a national treasure. It is a program that has done what it promised: Americans live better and longer thanks to Medicare. Illness in old age is no longer a straight line to the poorhouse, and the efficiency of this single-payer, national health plan far outpaces the most profitable private health plans.

As the new federal drug program began rolling out this January, millions of Americans are confused, angry and frustrated. Many could not get the medicine to which they were entitled. There is a simple reason for this: the designers of the new drug benefit ignored the lessons of what has made Medicare great. And the route to fixing it is to go back to what we know works.

President Lyndon Johnson signed legislation creating Medicare on July 30, 1965. Just 11 months later the program was up and running, and 93 percent of eligible men and women voluntarily enrolled in the new, untested program. Today, Medicare achieves the highest satisfaction rates of any health coverage program by far. Why?

Medicare allows doctors to decide what health care is necessary for a patient. Medicare allows people to choose their doctors, therapists and hospitals. Virtually all health care providers accept Medicare. People with Medicare understand the services that are covered, and they can calculate ways to meet their out-of-pocket health care costs.

Reliable and affordable: these are the principles that have made Medicare a success story. And cost containment has been achieved with a largely winning formula of paying health care providers just enough to keep them in Medicare but not so much that commercial profiteering takes control.

"Today, Medicare achieves the highest satisfaction rates of any health coverage program by far. Why? Medicare allows doctors to decide what health care is necessary for a patient. Medicare allows people to choose their doctors, therapists and hospitals. Virtually all health care providers accept Medicare."

These are the lessons that were lost on the designers of the new drug benefit, and a return to these values – reliability and affordability – should lead Congress to enact a real Medicare drug benefit.

Wait, isn't that what was launched on January 1?

To the contrary, this drug benefit has little to do with the Medicare program that has so enriched our nation. What Congress enacted is a cottage industry of for-profit drug plans competing for the business of people with Medicare.

When for-profit drug plans commit hundreds of millions of dollars to promotional and advertising campaigns to win enrollees to their tax-subsidized bill of goods, something is wrong. And when one-time statesmen, such as former Senators Robert Dole (R-KS) and John Breaux (D-LA), become mercenary pitchmen for these plans, something is very wrong.

The for-profit drug plans force older Americans and people with disabilities to make choices that no one in our nation should have to make – between a drug plan that covers their drugs but is not affordable and one that is affordable but does not cover their drugs; between a drug plan that covers their drugs today but may not meet their needs tomorrow; and a drug plan that does not meet their needs today but may meet their needs tomorrow.

Medicare is about providing health security, affordable coverage and reasonable choice. The new drug program is the opposite. Some people – especially poor people without any drug coverage – will receive substantial help if they can make their way through the application process for the low-income subsidy and find a plan that meets their needs. Many more will receive inadequate help. The benefit is limited, and people will be forced into wrong choices by the complexity of the plans and by the misleading promotions blanketing the market.

Perhaps most will ignore the program. These are people in need of affordable medicine but unable to navigate the crazy quilt of plans with their dizzying array of copayments, deductibles, coverage gaps and changing list of covered drugs. To date only 7 million people with Medicare have voluntarily enrolled in the new drug benefit. The American taxpayer should be getting a lot more for the 1.2 trillion dollars this "benefit" is projected to cost over the next 10 years.

This is the beginning, not the end. A more enlightened Congress will see the waste and hardship this program presents and enact a real Medicare drug benefit. Drug coverage should be like all other Medicare benefits: available under Original Medicare anywhere in the country in a reliable, comprehensible and comprehensive way. It should be a Medicare benefit, managed by Medicare to drive drug prices to a level that will enable people with Medicare and the American taxpayer to get a dollar's worth of medicine for a dollar paid.

—Robert Hayes, an attorney, is president of the Medicare Rights Center (www.medicarerights.org).

DGH *Reporter*

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DGH has no paid employees in the US. DGH is administered by a volunteer **Board of Directors** whose members have volunteered with DGH a minimum of two years and are elected by DGH **Voting Members**. The Board is assisted by an **Advisory Council** composed of over 200 physicians, students, retirees, artists, nurses, business people and others. A diverse group of volunteers provides the vital core of DGH's resources, including this newsletter. Incorporated in the state of Georgia and registered with the IRS as a 501(c)3 not-for-profit, **DGH welcomes your donation, which is tax deductible.** To donate, please make your check out to *Doctors for Global Health* and send it to the address above. You will receive a letter stating the amount of your gift for tax purposes, and the very good feeling of having helped make a difference.

My Six Months in Chiapas

(Continued from page 2)

sheep, pigs and cows. I could hear, from early on, the sounds of the radios playing both Mexican and American music coming from the households or the stores.

Towards the outskirts of the town I found the *campesinas* carrying wood on their backs with a strap that they held on their forehead. Others carried baskets with white lilies, amaryllis or alcatraz (the calla flowers that one sees in many of Diego Rivera's paintings). They brought all these to sell in the market. In the region they also grow chrysanthemum for wholesale distribution.

There is a remarkable abundance of bird life here as well—blackbirds, magpies, hummingbirds, vultures, finches, blue bird, warblers, flycatchers, herons, egrets, oriole and more. Their songs kept me company while I walked, their melodies competing with the noise of the chainsaws – the deforestation in Chiapas is of alarming proportions.

In February the town celebrates its Patron Saint, Caralampio. I have been told that this holiday was instituted by the merchants who wanted to take advantage of the coffee profits that occur at this time of the year when residents have money to spend on household goods.

My time in Altamirano was an invaluable experience. I was able to recover my diagnostic skills in general medicine, see a diversity of unique clinical presentations and experience the generous support of other professionals. And, most importantly, I had the privilege of experiencing the Chiapanesca culture and its people in all their historic-social richness.

I plan to continue on this new path I have been lucky enough to embark upon. I foresee continuing to work with other marginalized populations under the auspices of DGH and being supported in this aim by DGH's philosophy of Liberation Medicine–the conscious, conscientious use of health to promote human dignity and social justice.

Human Rights In the Arts

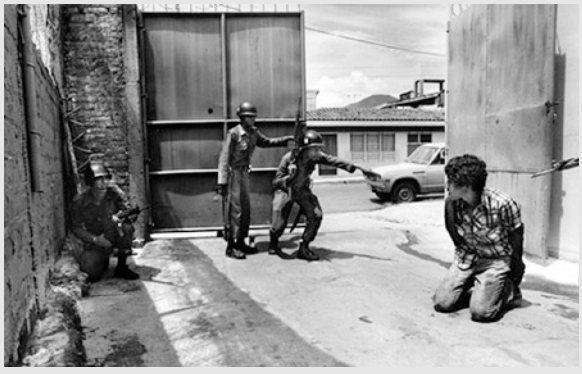
El Salvador: Work of Thirty Photographers

In 1983, at the height of the civil war in El Salvador, 30 international photojournalists covering the conflict contributed to a project to raise awareness about the crisis. They believed that these images, if more widely seen, could facilitate a deeper understanding of the situation in El Salvador and prompt a crucial dialogue about the conflict and the US government's role in it. This spring the International Center of Photography (ICP) in New York City rehung the exhibit, which was first presented at ICP in 1984. Here are a few haunting images from the exhibit. (All images © Collection of the International Center of Photography.)

Top Left:
Harry Mattison, Neighborhood known as "La Fosa" (The Grave), San Salvador, 1979-83

Top Right:
Susan Meiselas, Wedding reception in the countryside, Santiago Nonualco, 1979-83

Bottom Left:
Etienne Montes, National Policeman using ice-cream vendor as a shield during skirmish with demonstrators, San Salvador, 1979-83



Bottom Right:
John Hoagland, Arrest of auto repair mechanic for failure to carry an ID card, San Salvador, 1979-83

¡La Justicia de Hoy!

Por Alfredo Villatoro

Las cárceles están muy llenas
De prisioneros sin ser juzgados
No hay pruebas, pero si penas
De juicios mal procesados

Los derechos del ser humano
No son respetados ahora
Se entra a prisión muy sano
Y se sale muerto a la hora

Los derechos humanos son
Violados al ser humano
Los jueces dan la razón
Al que compra al jurado

Vivimos en un mundo cruel
Donde la vida no vale nada
Códigos pétreos escritos en papel
Con leyes ya caducadas

¡Justicia! ¡¡Justicia!! O vendrá la rebelión
Así lo piensa nuestra gente
Volveremos a la ley del talión
Ojo por ojo, diente por diente

Today's Justice!

By Alfredo Villatoro

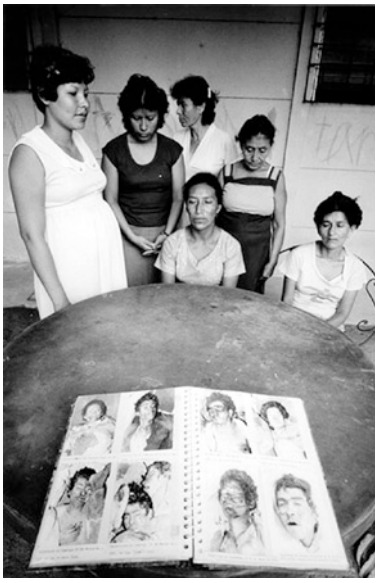
The jails are too full
Of prisoners who have not been judged
There is no proof, but there is pain
From trials badly processed

The rights of the human being
Are not respected now
One enters prison very healthy
And leaves dead on the hour

Human rights are
Violated to the human being
The judges give the right
To the one that has bought the jury

We live in a cruel world
Where life isn't worth anything
Petrified laws written on paper
With laws that have died long ago

Justice! Justice!! Oh, rebellion will come
That is how our people think
We will return to the law of the Talion
An eye for eye, a tooth for a tooth



Eli Reed, Families looking for "disappeared" relatives in the "Book of the Missing," Human Rights Commission Office, San Salvador, 1979-83, from the collection of the International Center of Photography–see more on page 7.

– Alfredo Villatoro is a native of Honduras who now lives in the South Bronx, where he volunteers as a community health promoter.

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July 28-30, 2006