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CALLING ALL AGES: ESTANCIA, EL SALVADOR

By Maggie Newburger

As we entered the mountains of Morazán, approaching Estancia, clouds filled in spaces between peaks. It was the rainy season, and lush vegetation covered the mountains and lined the roads. I approached Estancia for the first time in the pickup truck—dubbed *El Anciano* (the old man) by the community—with Ramiro and his sons Javier and Juan Carlos.

Ramiro, one of the first health promoters trained in Estancia nearly fifteen years ago, is one of the founders of the grassroots community group *Campesinos para el Desarrollo Humano* (CDH—Peasants for Human Development) and now serves as its director. His eldest son Juan Carlos is studying medicine in Cuba and will be the first member of the community to become a doctor.

“This,” I told them, “is the most beautiful place I have ever been.” Juan Carlos agreed on the beauty of his homeland, but pointed out how the treacherous terrain had made it a perfect base for the revolutionary guerilla fighters during the civil war, which forced many to leave their homes. Estancia is a *cantón* of about 3,000 people located in the mountains of the department of Morazán, in the northeast corner of the country bordering Honduras. Many have lost family members, all have suffered. Claribel, for instance, gave birth without a midwife amidst the thunder of dropping bombs, thinking she would die. She survived, was arrested and tortured a few years later, and now works in community health. (*Some names have been changed for privacy.*)

I am told that conditions are marginally improved since the Peace Accords were signed in 1992, but more recently the economy has been “dollarized,” so everything is more expensive. People continue to live with inadequate shelter, insufficient food for their families, non-potable water, and limited access to health care and education, especially beyond ninth grade.

Still, the people of Estancia are well-organized. All who work at CDH, DGH’s community partner, live in Estancia and the organization is an integral part of the local struggle for health and dignity. For example, CDH has taken on the supervision and maintenance of six kinders first created by DGH and other international organizations, which give 2–6 year-olds at least one nutritious meal a day, monitor them for malnutrition, as well as facilitate early childhood development and preparedness for school.

Along with Krista, the other DGH volunteer here now, I care for patients together with health promoters in the clinic, accompany health promoters on community visits, and sometimes attend parent meetings at the kinders. We also continue the work begun by past volunteer Alexis and the health promoter Aurelia in the *campana de la tercer edad* (third age campaign), in which groups of elderly people in each *caserío* meet for educational chats, activities and health screenings.

In the clinic, common problems we see include diarrhea (especially during the rainy season), respiratory illnesses and malnutrition (especially in children and the elderly). There are also several new cases of



In Defense of the Rivers

By Juan Nelson Rojas

On August 17, 2006 those threatened by hydro-electric projects came together with their allies for the Third Forum Against Dams in El Salvador in Carolina, San Miguel. The event drew more than 300 people, including representatives of communities, mayors from parties from the left and right, delegates of the National Left and the Central American Parliament, priests and clergy, lay religious men and women, environmentalists and social activists.

This third popular assembly for the defense of the rivers permitted us to analyze the context in which these projects have come to be developed in our country and on the entire American Continent, the threat that these projects represent to the socio-environmental equilibrium, and to define the strategy for defending our scarce resources.

The construction of more dams represents a danger for Salvadorans for several reasons. First, the subsequent environmental degradation results in high rates of death from dengue (caused by mosquitoes that live in stagnant water), acute respiratory illnesses (bad air quality), and intestinal illnesses (caused by rota virus and parasites). Second, because the country is densely populated, more flooding of limited farmland would provoke an internal exodus and generate conflict over resources. Third, a national policy for the protection and distribution of water does not exist, and that creates uncertainty about the future of the nation due to the growing scarcity of fresh water, made worse by dams. And lastly, the construction of these hydro-electric projects are the result of external energy demands (Plan Puebla Panama, CAFTA, ALCA), not of internal demands of the Salvadoran population. They would essentially benefit a handful of foreign magnates and their domestic middlemen.

In a study of 125 mega-dams around the world, finished in 2000, the World Commission on Dams and Development concluded

tuberculosis in addition to those we learned were incompletely treated in the past. Women speak during medical visits of domestic violence and other manifestations of gender inequality.

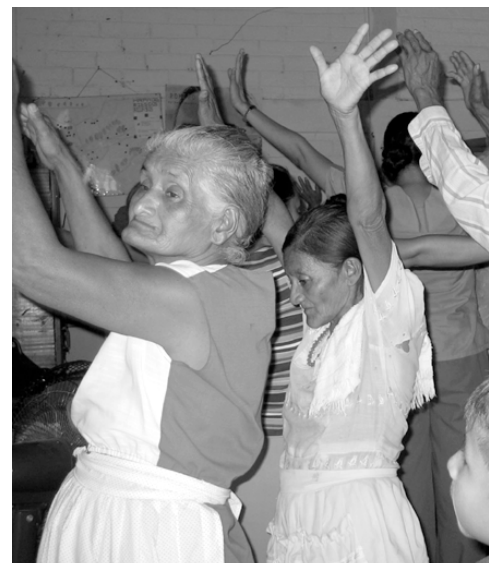
Health promoters are essential to the work of the clinic and the community, and they have been incredible teachers to us. Abraham, for example, is a skilled communicator who treats patients with dignity and humor. He has been an important guide not only to the local culture, customs and history, but also to the common illnesses seen in Estancia. I call him the “chief surgeon” for his expertise in removing *torsanos*, larvae passed by botfly bites that grow into large white worms under the skin.

Especially at first, he was also my translator for the patients whom I could not understand. He helped me recognize how symptoms are expressed here, reminded me of the realities of what happens when patients are referred to the public health system, and provided key emotional support as I encountered the barriers to health care with which the entire community struggles.

For the sickest patients, we advocate for access to care in the public health system—triaging emergencies in the community and accompanying patients to the hospital; securing outpatient appointments and coordinating transport; and supporting patients during hospital care. Just getting to the nearest hospital on two buses (\$1.25 total) is too expensive for many patients. Access to specialists is limited, and specialized care for poor patients is often hasty and undignified, especially when a foreign volunteer is not accompanying the patient. Obtaining necessary care for more complicated medical problems is especially difficult, so DGH Advisory Council member and Estancia Volunteer Coordinator Joel Sawady has secured at least a year of funding to help support transportation, medical exams and medication costs for community members.

The work is full of sorrow, joy and surprises. For instance, today I will stop by the hospital to visit a patient with HIV and newly diagnosed TB, and get charts from the archive to try to figure out the medical histories of some patients I have seen at the clinic. Tomorrow, I plan to visit a patient who lives a two-hour hike away and did not make it to the clinic this week, a health promoter's father who just had a stroke, and a patient who just signed out of the hospital. In addition, Krista and I never know who is going to show up at the door with news of a patient who is in “grave” condition; or mention in passing at 10:30 at night that three neighboring kids were bitten by a possibly rabid dog in the last few days—“but the bites were little.”

“Health promoters are essential to the work of the clinic and the community, and they have been incredible teachers to us. Abraham, for example, is a skilled communicator who treats patients with dignity and humor.”



Older community members making the most of the services provided by the *third age campaign*. Clinic waiting “room” (top-left), blood pressure check (bottom-left), and group exercise program (right).

One afternoon a thin man showed up with his small daughter in his arms and his equally thin eldest daughter by his side. Eighteen-month-old Reina fell into the “moderate malnutrition” category on a growth chart. She had thin hair, small limbs and a protruding belly. She was breathing rapidly and a stethoscope examination revealed loud crackles in her lungs. Though her father had carried her to the clinic from their home (over an hour’s walk), he did not want to take her to the hospital for fear of its expense and its reputation as a place where patients are maltreated or—worse—go to die.

After a discussion that included the health promoter Abraham, the father was convinced to take his child to the hospital. Reina was sick enough that Ramiro drove her to the hospital in *El Anciano* and we gave the family a few dollars for the bus ride back from CDH’s emergency fund. We visited her in the hospital and followed her slow improvement upon her return.

We discovered that not only Reina but also one of her sisters had pneumonia, and another sister had an ear infection. They walked to the clinic the next day and we were able to treat them.

The next week, I hiked out to the family’s house with Abraham. They lived in a tiny stick hut on someone else’s land, without a latrine, and isolated from the rest of the community of Guacamaya. An indoor space for a fire filled the house with smoke every time they cooked. Reina was somewhat better, but still appeared frail. Her sister with pneumonia had not improved at all. Their father told me that he was giving them their medicines and recited the right way to administer them. Abraham asked to see the medicines, which showed us that the older sister with pneumonia was not taking her medicine at all. We learned that she did not like to swallow pills, so we taught her father to mix the powder inside the capsule with a drink. The next time we visited the house, she was better. At the same time, Abraham was able to convince the family to send the 5-year-old daughter to one of the CDH-run kinders.

My college major, development studies, gave me the tools to apply theory to the Salvadoran health care system, but not how to get a poor child there when her parents do not want to or cannot take her, nor how to negotiate the system once a patient has entered. My medical school training thus far has taught me the basics of diagnosis and treatment, but not how to redistribute power so that the people of Estancia can access the medical care they deserve. To that end, I had been deeply involved with various activist student groups, but those feel very far away when looking through the Sanford guide of antibiotic treatment in the hot clinic pharmacy, trying to figure out how best to use the few available drugs to treat a given infection.

People in Estancia tell me that the volunteers do “good work,” and that we have “good medicine.” At the same time friends in the United States have questioned whether it is ethical for me to work in the clinic as a medical student with far less supervision than I would be required to have in the US. To those in Estancia, I answer that they deserve more: that we continue to look for a good, long-term doctor to work at the clinic and that I plan to come back when I have more training. To those in the US, I reply that my unease in the mismatch between my experience and my level of responsibility here has become outweighed by my outrage at the clear lack of ethics in the deprivation of access, not only to modern medical treatment but also to the most basic living conditions conducive to health: access to clean water, sanitation and nutritious food.

We have numerous challenges: to hold our own government accountable in its political and economic relationships with the rest of the world; to demand that the Salvadoran government treat health as a human right; and to continue to work alongside community members in creating change. I plan not to be another *extranjera* (foreigner) who disappears but rather to continue to work with DGH and CDH in solidarity with the community.



Protest in front of CEL (Salvadoran Hydro-electric Company) headquarters in Carolina, San Miguel.

that many of these mega-projects resulted in inefficiencies and were sources of conflict. It also found that the 45,000 dams that exist in the world have displaced between 40 and 80 million people, obstructed the natural flow of 64% of the rivers on the planet, and have contributed to a good share of global warming.

This national meeting was for people who would be affected by five proposed dam projects in El Salvador

(one extends into Honduras). This gathering stood out because of the confluence of community leaders along with religious and governmental leaders that joined together in the places that would be affected by these mega-projects.

The meeting greatly strengthened and gave energy to the struggle against the dams at a national level. The defined strategy of the movement is one of active, pacifist resistance to the construction companies that would work on these projects. In addition, the movement puts constant pressure on governmental complicity with energy transnationals for their part in exploiting domestic natural resources.

We concluded the Popular Assembly with the formation of the National Movement Against Dams in El Salvador, which will guide the struggles to stop these projects and offer alternatives of sustainable energy for the country.

—Juan N. Rojas is an environmental activist and Permaculture Consultant who has been working for the past 13 years with the people in the Estancia region of Morazán.

Estancia remains a principal DGH project site where volunteers are engaged regularly. A dam built on the Río Torola could put all of Estancia under 30 meters of water, washing away the progress that has been made through years of community struggle, aided by international solidarity.

GOT MILK, BABY?

By Peter Sherman, MD

I run a program that trains doctors to become what is called “community pediatricians.” It is a pretty cool position and I consider myself lucky to be the director of the only program of this type in the country. The focus is on educating young pediatricians-in-training to provide care for children and adolescents in poor communities. “Poor” is kind of a politically incorrect word these days and has been replaced by the euphemism “underserved.” These neighborhoods are anything but underserved. There are clinics every few blocks dishing out underfunded “ghetto” medicine at problems that overwhelm the capabilities of the personal health care system.

In the clinic where I train my residents you will meet doctors that are as smart and compassionate as you are ever going to find, but the phones don't work and even if a patient called in to ask a question about their sick child or leave a message for their doctor, it's a good bet that no one will pick-up the phone. The focus is on productivity...a vain effort to eke out a margin of profit in one of the poorest communities in the country. Interestingly, the clinic is only a few blocks from Yankee Stadium. I can't help but notice the irony of this as I pass to and from work in front of the construction on the new stadium, which is being footed by millions in tax dollars.

However, today I am writing about good old detective work and medical knowledge that is light years removed from liver trans-

plants, face lifts and arterial stents. One of the residents, an extremely bright person, presented a newborn baby to me who was not gaining weight properly. We train our doctors by having them tell us about a patient that they are seeing and guiding them in their decision-making process. As any pediatrician worth his salt can tell you, seeing a newborn that is not gaining weight throws up all sorts of red flags. Poor weight gain in someone who has just entered into life can be a signal that there is something terribly wrong in some part of their little organs, such as malfunctioning kidneys or a reluctant thyroid gland. It can also indicate that the child is not getting enough nutrition. This can profoundly impact brain development with dire consequences.

Little does she know, but that little baby has enough barriers to overcome growing-up in the South Bronx, including a dysfunctional school system, parents working long and hard hours at minimum wage or less, drug dealers, teen pregnancy and gang violence. Though a lot of our babies are overstuffed and fat—a harbinger of obesity and diabetes—it is much worse not having enough nutrition to ensure that the maximum number of neurons and neuronal connections are developed.

This community has many caring and concerned parents and a lot of amazing resources, contrary to the usual stereotype. When I walk into the room not only is mommy there with the baby, but also grandmother, and both are looking appropriately concerned. And this happens all the time; my exam room is constantly filled with mothers, fathers, grandmothers, godmothers, friends, aunts. Sometimes it is a chore to keep straight who is who and I need to scribble notes in the margins of the medical record to avoid getting everyone mixed-up. This sort of social networking, as we like to call it, flies in the face of the disparaging myth of the single-parent family.

So the resident is presenting the story to me and I'm asking a lot of questions. I quickly move out of what's called a “teaching moment” and am more into “Geez, I better figure out what is going on with this kid.” The watch is ticking, as children who do not grow can end-up quite damaged. Everything is coming-up negative: pregnancy and birth history, the newborn blood tests that are done on all newborns. I point out a few things I want the resident to do that are an important part of examining this problem, such as plotting out the changes of height and head circumference, in addition to that of weight. And we get into the nitty-gritty: was the same scale or a different scale used each time the baby was weighed?

Being a physician is a lot like being a detective, examining and exploring the evidence. In the South Bronx we also have to consider other possibilities. Can the parents afford formula? Though most of our babies qualify for the federal program that provides food for poor children, not all parents understand how it works and dilute formula in a desperate attempt to feed their child. I've seen parents starve themselves to ensure their kids get enough food.

More concerning, does the parent have a drug habit that is supported by selling the child's formula? In cases like that pediatricians enter into the uncomfortable position of pitting themselves against the parent in their need to protect the child, with the possibility of the child being removed from the parent. My residents are generally young and courteous and I continually push them to think and ask about these types of issues, which are generally not brought up in polite company.

The resident answers most of my questions and I'm not coming up with anything. I decide to take a look at the baby, who looks fine and is being held in a very motherly fashion by a healthy and intelligent woman. The grandmother is also there with a look of concern that speaks volumes of grandmotherly knowledge. Everything really looks fine to me. If the baby has a congenital problem it is subtle and I'm not worrying about selling crack for formula schemes. So I bring myself back to the obvious and mundane. I ask the mother how she is making the formula.

“Being a physician is a lot like being a detective, examining and exploring the evidence. In the South Bronx we also have to consider other possibilities. Can the parents afford formula?”



Residents of the primary care and social medicine program at Montefiore Medical Center at a health fair in the South Bronx.

Though I think it is a tremendous waste of resources, I can understand why there are 15 brands of toothpaste or deodorant when you walk into a supermarket. Someone is trying to make a buck. I can't for the life of me fathom why one would want to put an infant at risk and do the same with formula. Yet, that is what happens. There are a zillion different formulas and several different ways they can be mixed. Parents are always asking if they should change formula because they don't like the way their baby is pooping or farting. However that is not the frightening part. The scary part is that formula can come ready-mixed, nothing has to be done to it other than pour it into the bottle. It also comes concentrated, where it needs to be mixed one to one with water. And to make it really complicated, it also comes as a powder that is mixed one scoop to two ounces of water. And if you've been paying attention to this story, it should now be obvious that mixing a formula incorrectly can quickly lead to disaster for a newborn.

The mother had told my resident that she had been giving the baby the powder formulation and described mixing it correctly. I went over this again and the mother now related that she had started giving the baby the concentrated formula and was mixing it with 1-1/2 cans of water rather than with just one. Sounds like a little mistake. Maybe it is for mixing an apple martini, but not with a baby. This meant the baby was only getting 2/3s of the calories needed for normal growth.

This is not to imply that the mother was remiss or stupid. I challenge anyone to keep their wits about them with the emotional exhaustion and elation that goes with giving birth and raising a new human being. Not to mention that doctors and patients are frequently speaking a different

language, even when we are speaking the same language—not a given in my multi-cultural clinic. Studies show most of the time patients don't have the slightest idea what their doctor is saying. Ask a patient to repeat back what their doctor has just told them to do and what you hear will bear little resemblance to what was said. One of my faculty members' research found that only 30% of parents measured a correct dose of Tylenol after receiving instructions from a physician.

Everyone in the room heaved a collective sigh of relief when we got to the bottom of the problem. Or maybe it was my imagination running wild as a physician and assuming that what I said is what the family heard.

— Peter Sherman, MD, is the Director of the Residency Program in Social Pediatrics at Montefiore Medical Center, Bronx, NY. 🌿

HEALTH AND HUMAN RIGHTS POST HURRICANE KATRINA

By Jim Wallace

In August of 2005, Hurricane Katrina devastated the United States Gulf Coast region, including parts of Mississippi, Alabama and Louisiana. Most noticeably hit was the city of New Orleans, suffering major damage in many areas of the city and creating a national fiasco in the response of the local, state and federal governments to the disaster. Many of the major news networks equated the situation in New Orleans and the images coming from it to a “third-world country”: men and women scrounging for food and clothing, wading through fetid water to get to aid, and finally being relegated to the now infamous SuperDome.

The comparison of a major port city in the world's wealthiest country to a disaster-plagued slum in a poor country brings to light some very interesting questions, not the least of which is, “Why is such devastation and man-made suffering considered acceptable in the third world?” Does it simply go without saying that people in the developing world do not deserve the kind of response that would be humane and expected in a developed country, but was so blatantly missing in New Orleans?

Prompted by the events and reactions to the Katrina response, in February 2007 DGH, in partnership with Tulane School of Public Health and Tropical Medicine, held a symposium entitled *Public Health and Human Rights: Global Struggles Brought to Light in Post-Katrina New Orleans*. Visiting speakers included Paul Epstein from the Harvard Center for Health and the Global Environment, Joia Mukherjee from Partners in Health, and PV Unnikrishnan from ActionAid International. The majority of speakers, however, were from New Orleans itself. They included Tom Farley from Tulane University, Stephen Bradberry from the Association of Community Organizations for Reform Now (ACORN), Shelia Webb from the Center for Empowered Decision Making, and Greg Griffith and Ravi Vadlamudi from the Common Ground Health Clinic, which has been providing free basic medical care to the people of New Orleans since Katrina hit (see *DGH Reporter*, Fall 2006 edition for more information on their work). The keynote speaker was Dr. Lanny Smith, founding president of DGH and Assistant Professor of Medicine at Montefiore Medical Center in the Bronx.



The conference organizer, Dan Bausch, DGH Board Member and Tulane University Faculty Member, with Dr. Lanny Smith.

This symposium brought to light the simple fact that seems to be evading current news coverage and policy-makers' agendas—New Orleans is still in bad shape. There is very little low-income housing available or accessible healthcare, with little change in sight. Inspirational volunteer organizations such as Common Grounds Clinic have stepped up to fill the gap, but new or even repaired old sustainable infrastructure is sparse.

Some speakers left us with implicit questions to ponder. Are we beginning to associate images of poverty with New Orleans as well as developing countries? Is the association being blurred into acceptance? 🌿

US INTERFERENCE IN NICARAGUAN ELECTIONS

By George Pauk, MD

I left my home in Phoenix to participate in a week-long delegation to Nicaragua in the weeks just before their national elections, which were held on November 5, 2006. Our Elections Observation Delegation traveled in Nicaragua, meeting with representatives of all political parties, the Organization of American States, the Nicaragua Supreme Electoral Council and a broad spectrum of civil society: NGO's, human rights groups, women's organizations and university students. Nicaragua Network and Quest for Peace organized educational interviews with many organizations involved with the national elections of Nicaragua. Our delegates came from many states and organizations, such as my own membership in DGH. Like a similar group last June, our delegation was dismayed by the very poor, in fact outrageous, behavior of our US government in Nicaragua.

For over 20 years, since Nicaraguans overthrew the dictatorships that our government supported, Nicaragua has been having elections that may be more fair and open than recent US national elections. Voter turnout in Nicaragua is usually 70–80 percent.

Unfortunately, while our government talks of fostering democracy, it is doing much

to undercut and subvert the adequate democratic election processes of Nicaragua. It is apparent that our leadership in Washington is entrenched in a policy of vendetta against the revolution that freed Nicaragua from a cruel dictatorship to become a democratic and peaceful nation.

On a September visit to Nicaragua, Indiana Congressman Dan Burton publicly declared that diplomatic and economic relations with Nicaragua would likely suffer if a candidate unacceptable to the US were elected. Our Ambassador Paul Trivelli has repeatedly made similar threats, tried to combine some of the right wing parties to consolidate the conservative vote, grossly promoted one candidate and suggested that Millennium Challenge Account funds would be at risk if one of the candidates he does not favor is elected. US Commerce Secretary Carlos Gutiérrez also made threats during a recent visit. Statements like this have prompted the Secretary General of the Organization of American States to bluntly ask foreign officials in Nicaragua to stop meddling in the internal affairs of the country.

Another shocking situation is the use of US tax dollars to support the interference of a right-wing organization masquerading under the guise of promoting democracy. The International Republican Institute (IRI) has been quietly intervening in the elections of many nations. This organization is using huge amounts of money that it gets from the US Congress to push the election of right-wing parties and candidates in Nicaragua. My own Senator from Arizona, John McCain, is chairman of the IRI board.

Unfortunately, it seems that the general public here in the United States is unaware of the continuing aggressive interference of our officials in the elections of other nations. If other countries interfered in our elections in similar ways, we would certainly not tolerate it. Remember the scandal in the mid-90's over Chinese officials funding some elections here? Yet our tax dollars are being used to propagate this counterproductive foreign policy.

Fortunately, the Nicaraguan people do not hate Americans because of it. They know how to separate people from their government. In fact, they are truly warm and friendly to visitors from the United States. However, I think that they do feel dismay and fear of our government's misdirected and failing foreign policy for Latin America and US interference in their elections. It is time for us as American citizens to take responsibility for the actions of our own government, to learn the reality about the important issues affecting Central America and to correct the policies of our government that keep people from determining their own future.

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DGH Reporter

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Health promoters from the municipality of El Crucero in Nicaragua, at their monthly training day.

A Day's Life...

Chiapas. It has been very busy, as always, but for the most part my mind and soul has been occupied by one patient these past few days: a little girl named Juana who will soon die. Her mother as well may die. A simple yet absurd and incomprehensible fact. I have never seen this before. Children in the United States don't die, at least not regularly. And rarely in birth. It is a phenomenon of my international public health classes, gathered into objective statistics of infant and maternal mortality, which has become real to me today like never before.

Several days ago I had started working in pediatrics with one of the Mexican general practice doctors and we were going to share call over the weekend. Friday at 1pm, while everyone else was off at lunch, mom and her husband and family arrived with more fanfare than most patients arrive at Hospital San Carlos. They live very far from the hospital, so far that it took them eight hours to arrive, even though they took a small airplane and a Red Cross ambulance. And we were the closest hospital. Mom arrived on her third day of labor and baby was already crowning, but so much time had gone by already. We knew that because of the prolonged delivery it was likely that the umbilical cord had been compressed and it was possible the baby had become hypoxic [not enough oxygen in the blood]. That is exactly what happened.

Little Juanita was born weighing just less than 3 kilos and did not breathe. She was limp and lifeless and blue. She was intubated and eventually did begin to breathe somewhat on her own. For 24 hours now we have taken shifts compressing the bag mask over her face because the hospital has no ventilator. We sit on chairs under warm lights to keep her warm and breathe for her whenever she stops, which is frequently. She has a severe infection from the delivery and is receiving intravenous antibiotics. At some point yesterday evening she began having convulsions, an ominous sign of severe neurological damage. We gave her maximum doses of anticonvulsants, which caused cessations in her breathing for up to 2 minutes at a time and still the convulsions continued. I have slept only 2 hours in the past 24, and my awake time has been spent staring helplessly at this little girl's chest, willing it to rise, and watching her arms or legs twitch rhythmically, or the muscles of her face—signs that the seizures continue.

I feel tears well up, but still I am protected by my medical training—my efforts spent mentally analyzing what more can be done, what may have gone wrong. It is not until I arrive at home, tired and dehydrated and more overwhelmed than I thought, that I start to process what is happening. A song suddenly runs through my head of a band long-forgotten that I used to listen to in high school, who sing of the death of a mother in childbirth, and “the confusion sets in before the doctor can even close the door.” And I weep, deeply, completely, as I have not done in a very long time. Feeling the fury and rage build up in my throat because...I get it. This is not abstract—these are real people who must carry on long after they have passed through my life. This is about the fact that we live with too much—too greedy and blissfully ignorant, and it would take so little of what we have to make the lives of others better. How can we go on as if nothing is happening?

— Jessica Eichelberger, DGH volunteer in Chiapas, Mexico, April 2006

El Salvador. Never a dull moment here! Tuesday night I was half asleep when we heard the pick-up truck outside our house, which happens rarely since there is really no road. It was Ramiro and all I could understand was, “Emergency! There was a baby born on the side of the road!” So it was dark and had been raining and I had this image of a woman giving birth on the side of the road. Maggie and I hopped in the truck and off we went. Ramiro was in a hurry and we were sliding all over the place even though we weren't going very fast. We get to the clinic and there was nobody there. We headed back out thinking they must have gone to the hospital when we saw a truck coming, so we went back the clinic. It turns out she had the baby in the front of the truck on the way to the hospital. They literally handed us a newborn baby still attached to the placenta, which had been completely delivered.

— Krista Summers, DGH volunteer in Estancia, El Salvador, September 2006

Nicaragua. My wife, Amy, and I traveled to each of the communities on the island of Ometepe doing an evaluation of the health promoters working there. We really enjoyed how this allowed us to interact with the people in the communities. Some of the communities could only be accessed by trails but the campesinos in the fields never failed to give us friendly and accurate directions. There are very few restaurants on the island, so if we were away from our home community, as we usually were, we would have lunch in the homes of families on the island. This resulted in some very nice experiences and several relationships which we hope will continue.

— Brian Wetzel, DGH volunteer in Ometepe, Nicaragua, September 2005

Uganda. Like any teaching hospital, the senior house officers run the show. Before Steve left, the two of us found ourselves taking the interns out to lunch and easing them through their breakdown. They talked about how all of their patients were sick, none of them got better, the hospital was always out of supplies. One of them was ready to quit medicine. Sadly the discussion reminded Steve and I of our intern years, but I also know that as rough as Grady got, we never ran out of antibiotics or surgical gauze, and I can only recall two times we ran out of intravenous fluid. The interns and house officers here have amazing strength to put on the fight that they put on every day against such enormous obstacles.

— Jason Prystowsky, DGH volunteer at MUST (Mbarara University of Science and Technology) Hospital, Uganda, September 2006

DGH Announcements

- **Rufina Amaya passed away on March 6, 2007.** Rufina was the only survivor of the massacre of El Mozote, in rural El Salvador, where nearly 1,000, mostly women and children were brutally murdered by US-trained Salvadoran Army soldiers on Dec. 11, 1981. She became the voice of those who were mercilessly silenced, speaking out on every occasion about the human rights abuses that occurred that day. El Mozote is very close to the communities of Morazán, where DGH works and where similar atrocities took place during the armed conflict. We stand in solidarity with the victims and survivors.
- **First US Social Forum, June 27 – July 1, 2007, Atlanta, GA.** “The USSF will provide space to build relationships, learn from each other’s experiences, share our analysis of the problems our communities face, and bring renewed insight and inspiration. It will help develop leadership and develop consciousness, vision, and strategy needed to

realize another world.” DGH and the People’s Health Movement-USA (of which DGH is a founding member) are organizing workshops focusing on health as a human right and the socioeconomic determinants of health. Plans are also in the making for a four-day intensive course by the International People’s Health University (IPHU) entitled *Social Determinants of Health*. Help is needed to organize workshops, raise money, recruit organizations from your local area to participate and assist with logistics in Atlanta. If you are interested in participating, contact Denise at denisezwahlen@yahoo.com.

► **First Global DGH General Assembly will be held October 2007 in El Salvador.** Details will be forthcoming on the DGH website. If you would like to volunteer on the planning committee, contact Shirley Novak at shirleynovak@yahoo.com.

► **Six Degrees.** Do you have a blog or web site? Add a personalized badge from www.sixdegrees.org that lets you support the causes close to your heart, like DGH.

- **Are you an eBay aficionado?** If you enjoy selling products on eBay, please consider supporting DGH at the same time. At the time of sale, you can donate 10-100% of the proceeds to DGH projects and programs. Power sellers become power donors! For more information visit www.missionfish.org.
- **Solidarity Resurgent: Nicaragua & US Solidarity Conference, July 13-15, 2007 in Managua.** Learn more about this conference, organized by the Nicaragua Solidarity Network, at www.nicanet.org.
- **Update your contact information.** About to move? We don’t want to lose touch with you! Please update your address at www.dghonline.org by following the link at the bottom of the home page.
- **Upcoming Board Elections.** This year’s DGH board election will be done by mail. If you are a DGH Voting Member, you should receive information about how to vote in April. E-mail any questions about the election to lcapps@igc.org. Learn about membership at www.dghonline.org/membership.html.



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Join Us at the 12th Annual & 1st International
DGH General Assembly in San Salvador, El Salvador
**Community to Community: Collaborating
for Healthy, Peaceful & Just Societies**
October 26-28, 2007