



# Doctors for Global Health Reporter

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## PROVIDING CARE TO VILLAGERS IN PERU

By *InTouch*

Daniel Newman, a fourth-year medical student, thought he'd be shadowing a physician this past February during a one-month elective at a clinic in Cusco, Peru. To his astonishment, he sometimes found himself alone in a room examining patients on his own. Some of the more common illnesses seen in the clinic are intestinal parasites, back pain from manual labor, respiratory infections, and failure to thrive due to malnutrition. A few patients suffer from typhoid fever and other diseases rarely seen in the United States. So he rose to the occasion—and everyone seems to have benefited.

Mr. Newman was volunteering for Doctors for Global Health, a private, not-for-profit organization promoting health, education, art and other human rights throughout the world.

“To be put in a role where I had some responsibility and autonomy was very different. It was a lot more autonomy than I ever would have in the United States at this time in my studies,” Mr. Newman said. “Of course, if I ever felt unsure about anything I would always get a second opinion from the Peruvian doctors. But I learned so much about how to deal with people and their situations in the context of disease.”

“Peru faces daunting challenges in basic medical care and public health,” Mr. Newman said. The infant mortality rate is among the highest in South America, as is the mortality rate for women during childbirth. Peru also suffers from relatively high rates of tuberculosis, dengue fever and malaria. Complicating matters is an underfunded and unevenly distributed health system that does not reach many of the remote Peruvian communities that are tucked away in the mountainous regions of the Andes.

About 25 percent of the population has no access to health care at all, and more than 50 percent of the population are so poor they could not afford medical care even if it were more accessible. Most people seek help only when they suffer an acute illness and often when symptoms are dire.

Mr. Newman worked at the Belen Clinic in the Santiago district, one of the poorest and most populated areas in the city of Cusco. Santiago, home to the clinic, is located on a former garbage dump, about a ten minute walk from downtown Cusco. Added to the dearth of health services for the impoverished population are high incidences of domestic violence, spousal abandonment, malnutrition, post-traumatic stress disorder, infectious diseases and labor exploitation.

The Belen Clinic provides services in general medicine, obstetrics, alternative medicine (used by most of the patients in conjunction with conventional therapies), a weekly orthope-

“ I saw numerous patients over the age of 50 who had never seen a doctor in their lives. It was incredible. ”



edics service, physical therapy, dentistry, basic laboratory services and a pharmacy. The clinic also has an ambulatory team that serves several outlying communities within a two-hour radius of Cusco. The team consists of a physician, a nurse, a dentist and an obstetrics nurse.

Mr. Newman said the patients pay about the equivalent of \$2.00 for a visit. "I learned a lot about how to weigh my patient's economic situation when I managed their treatment course, because \$2.00 was a lot of money for many of them," he said.

For example, patients with sexually transmitted diseases often come to the clinic looking for treatment. In a more developed area, a physician would call for some laboratory tests to isolate the infectious agent before treating. But in the clinic, many patients were unable to pay the costs of outside laboratory testing. If they did not receive treatment during their initial visit, they might try to save money by not following up with lab studies. Instead they'd go directly to a pharmacy to purchase over-the-counter antibiotics. For this reason, some of the doctors in the clinic were in the habit of treating the most common STDs without testing and following up with the patient to make sure they had improved.

Mr. Newman also said there was a lot of discussion among the Peruvian doctors about an impending drug resistance epidemic.

"Antibiotics are sold over-the-counter almost like candy," he said. "A patient complains of a headache or fever to the pharmacist and is given an antibiotic. The patient might take one or two doses. The physicians I spoke to are really fearful that they'll be facing the repercussions of this soon."

Belen Clinic is administered by the Santiago Parish. It began in 1987 through the efforts of Father Nicanor Acuna Yaya, who started offering basic health services in the parish house after witnessing the high infant mortality in the congregation. The Santiago Parish also has a farm where members of the young indigenous population can go to learn about organic farming, honey production and guinea pig breeding.

Twice Mr. Newman, who is fluent in Spanish, went with the ambulatory team to visit the mountain communities to treat patients who did not have access to medical care.

"The first time, we saw around 50 patients," Mr. Newman said. "I saw numerous patients over the age of 50 who had never seen a doctor in their lives. It was incredible. Many of them have great mistrust of the medical system so I tried to listen to them and understand where they were coming from. It was an experience that I am sure I will always be able to draw on."

—Reprinted from the April 2009 issue of *InTouch*, the New York Medical College newsletter ([www.nymc.edu/pubslintouch.asp](http://www.nymc.edu/pubslintouch.asp)).



Daniel Newman (standing) during a patient consult at Belen Clinic.

## DGH IN EUROPE

By Isabel Quintero

Since its founding in the US in 1995, Doctors for Global Health has been active in supporting and taking part in various movements, groups and networks around the world, such as the Center for Community Responsive Care, the Mexico Solidarity Network and the People's Health Movement.

DGH's work is strengthened by the continued support of volunteers who have held exhibitions, public-awareness programs and talks in universities, churches and other venues, often with the help and support of local organizations, which have traditionally been largely US-based.

“The future of civil society and social movements on global issues remains tied to their roots in society, and their autonomy in asserting their values and identities, carrying out activities, proposing alternatives and achieving change.”

According to the DGH Principles of Action, members are encouraged: "To take action in their own communities and participate in the accompaniment of communities around the world." A concept akin to the much paraphrased, "Think globally, act locally." Taking this idea to heart, DGH supporters in Europe met for the first time in Paris in September 2007 in order to form DGH-Europe, a European network for global health on the 'other' side of the Atlantic.

Thanks to the contacts of DGH Board Member Michele Brothers and French pediatrician Violaine Duflo, both based in Paris, an informal meeting and brain-storming session was held along with a cocktail reception at atmospheric Montmartre Art Gallery 3F, introducing those interested to the work of DGH.

DGH-Europe comprises volunteers of varying nationalities and professions. We are delighted to have Audrey Lenhart among us, one of the founding members of DGH (currently working in research at the Liverpool School of Tropical Medicine), as well as strong support from Swiss-born DGH Board Member Denise Zwahlen, who now lives in the US.

Many of our members are based in Spain, such as physical therapists like me, Luis Barrio and Virginia Carbonell, as well as Moroccan doctor Mina Rhouch. A representative part of our group comes from Italy, including Italians Ester Chicco, Alfredo Mela, Maria Teresa Fenoglio, Gian Carlo Franceschetti and Daniele Luzzo. Finally, we are very fortunate to have Carlos

Rauda from El Salvador, who provides invaluable insight to this part of the world where DGH was born and continues to be very active. All our members share common interests and many collaborate with a number of respected European NGOs, such as L'Appel of France, Italian Psicologi per I Popoli and CIMME from Spain.

Our first DGH benefit concert was held in March 2008 in a beautiful century-old restored Andalusian hospital in the coastal town of Málaga on Spain's Costa del Sol. During this meeting and benefit concert, our aim was to educate, raise awareness and ultimately inspire the local community, including university students, regarding the work of DGH, as well as to publicize the critical situation relating to healthcare accessibility and human rights issues across the globe.

The event was extremely well received. Málaga University granted us an exhibition space, a concert hall was made available, various local organizations supported the initiative, and the participating professional Spanish musicians and dancers performed for free. Approximately 170 people attended the event, which was covered by the local media, including press, TV and radio. As a result, US\$1,500 was raised to support DGH projects. In addition, a photo exhibition about the rehabilitation center in Santa Marta, *El Salvador: Rehabilitación desde la Comunidad*, was displayed at the University of Health Sciences and more than three social centers around Málaga, reaching many diverse sectors of the public.

Building on this promising beginning, DGH-Europe plans to hold biannual meetings, one of which will include a fundraising event. The last encounter took place in December in Turin, Italy, hosted by the Italian NGO Psicologi per I Popoli (Psychologists for the People). This group, together with its important work in Italy, is currently working with DGH on a five-year project *Bienestar en El Salvador* to promote mental health in the rural town of Santa Marta.

Our next meeting will take place this spring in Liverpool. In October, we will meet once again in Turin to coordinate an introductory seminar for a future training course for volunteers interested in accompanying communities and global health issues. Organized by Psicologi per I Popoli Torino and supported by members of DGH-Europe, the course will begin in 2010.

On a logistical level, we are establishing our own mail address and have created an internal e-mail list. We have also set up a separate contact-list of e-mail addresses collected at our two public events to inform interested people of upcoming activities and DGH news. In order to make DGH more accessible around the world, we are also overseeing the translation of the main DGH web page (already in English and Spanish) into Italian and French for our global readers.

We believe that, increasingly, organizations and social groups should work together towards achieving common goals. For example, three years ago, the repopulated community of Santa Marta, El Salvador underwent a serious land crisis. When faced with potentially losing their homes, the Salvadorans called out to the international community to support their plight. By

linking up networks in the US and Europe, we gathered hundreds of signatures and support across the world, and a Madrid newspaper published an article on the crisis.

In Europe itself, we are experiencing a difficult time of change under the European Parliament and its protectionist economic policies. Our proximity to Africa (8.7 miles away from the coast of Spain) means that several tens of thousands of sub-Saharan Africans risk their lives trying to cross the Mediterranean each year. Much polemic surrounds the latest European Parliament Agreements concerning immigration, working hours and anti-terrorism acts that will affect all of us, by tightening the borders, lengthening our working hours and violating important human rights for undocumented immigrants.

The formation of DGH-Europe represents an important step towards achieving change within our own communities. Being part of this group provides us with an invaluable opportunity to actively support the organization on a local level, while interacting with other like-minded groups. To quote Italian Professor Mario Pianta: "The future of civil society and social movements on global issues remains tied to their roots in society, and their autonomy in asserting their values and identities, carrying out activities, proposing alternatives and achieving change."

For more information on upcoming DGH-Europe events, contact Audrey Lenhart at [audreylenhart@gmail.com](mailto:audreylenhart@gmail.com). 🐦



### DGH Reporter

**Edited and designed by Monica Sanchez. Send suggestions by mail to P.O. Box 1761, Decatur, GA, 30031, USA, or by e-mail to [newsletter@dghonline.org](mailto:newsletter@dghonline.org).**

**DGH has no paid employees in the US.** DGH is administered by a volunteer **Board of Directors** whose members have volunteered with DGH in the past 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.

# Health Care Reform in the U.S.

## MASSACHUSETTS REFORM: ARE WE BETTER OFF?

By Denise Zwahlan

It's Monday morning in Urgent Care at Codman Square Health Center, a neighborhood clinic serving mostly African-American and Caribbean patients, many of whom are working poor, many recent immigrants. By 9am, the waiting area is full. The triage nurse is screening patients, assessing if they need care right away, trying to find an empty slot in one of the primary care provider's schedules.

The next step before they can be seen is registration. This means assessing their insurance status and that is where things come to a screeching halt. This may be somebody's first visit. Often, their insurance may no longer be active (it has to be renewed every year), they may have never been insured (urgent care is often the entry point for people who just arrived from the Islands), or may have lost their job and their health coverage.

To get their insurance established or reinstated can be challenging, requiring many documents that can take a long time to gather. In the meantime, patients who don't have insurance are responsible for the cost. If they are lucky and motivated, the process may be completed in two weeks and the cost of this visit will be covered. But that does not always happen. Some may choose to not be seen that day, concerned about owing the cost of care.

It may be two hours before a new patient is finally in the exam room to be evaluated. Then the challenges are in my hands. A sticker with demographic information will alert me to the status of their insurance—self insured, Medicaid, Safety Net, CommonwealthCare, BSCBS, to name a few.

*Why do I need this information?* Because it will affect the ability of the patient to pay for his medications. Are they going to bear the full burden? Is the copay going to be so high they cannot fill the prescription? Will I need to fill out a prior approval form for a drug?


In the case of patients who do not have any coverage yet and thus are considered responsible for their bills, I have to take into consideration their ability to pay. Can I wait to perform that baseline EKG or basic lab tests that would help me to decide on the best possible treatment or screen out life-threatening conditions? Can I wait to have them seen for a follow-up visit in three weeks time, hoping that by then their insurance will have been put into place? God forbid they need an urgent and necessary diagnostic test that is not available on site such as an ultrasound, CT scan or MRI. My only recourse will be to send them to the Emergency Room. And what if they are unstable and require an expensive ambulance ride?

I never thought that I would be sending patients to Target or Walmart to get their prescriptions filled. But they have a program that provides a month's supply or a treatment course for certain low-cost medications for just \$6 a prescription. But that service does not do nearly enough to cover most of the essential drugs for which I write prescriptions every day. These retailers' programs are not based on necessity but only on whether a drug is inexpensive. For example, their program does not cover inhaled medications for the treatment of asthma. But my problem does not stop with the uninsured. Many patients I see have different medical conditions and cannot afford the added cost of several copays. They will pick and choose which prescriptions they will get filled or take them every other day. They may have to forgo an office visit because they cannot afford the \$20-\$40 copay for each visit.

*What does this have to do with the new health care law?* First of all, the cost of health care reform has been much higher than anticipated. In the face of the 2008 budget crisis, it will be necessary to take money away from safety net hospitals and health centers and to increase the contribution of the participants to keep the program afloat. Before the law was enacted, the old free care pool covered patients who qualified for it for six months prior to the time they got approved for free care. So if a patient came in for services without insurance, qualifying for free care meant that they would be covered for the visit that day. If patients who are enrolled in some insurance program fail to pay their premiums, our health center will not be reimbursed. But we will still continue to provide services regardless of the patient's ability to pay. The health center's bad debt has increased by 50 percent since last year. And the new law has increased the already high administrative cost of health care in Massachusetts with an added 4 to 5 percent for the administration of the Health Connector. At our health center, we had to hire a new full time financial counselor to help us enroll more patients. And the new law has done nothing to reduce our reliance on expensive high-technology services. On the contrary, it rewards it by giving higher reimbursement for procedures while cutting Medicaid reimbursements for primary care services.

I am proud of working at my health center. Our mission statement and some of the programs we have developed over the years make it very much in line with the DGH Mission and Principles of Action. It is: "To serve as a resource for improving the physical, mental and social well-being of the community...our goal is to promote a culture of health in our community." But the daily practice of medicine has become more of a challenge every day. And it may be increasingly difficult for our health center to stay true to its mission, given the current financial challenges.

Massachusetts reform has not helped us meet those challenges because it has not confronted the private health insurance industry. That is what needs to be done if we are to have real reform.

► **For more information:** *Massachusetts' Plan: A Failed Model for Health Care Reform* ([www.pnhp.org/mass\\_report/mass\\_report\\_Final.pdf](http://www.pnhp.org/mass_report/mass_report_Final.pdf)); *In Debt But Not Indifferent: Chapter 58 and the Access Project's Medical Debt Resolution Program* ([www.accessproject.org/adobe/InDebtButNotIndifferent.pdf](http://www.accessproject.org/adobe/InDebtButNotIndifferent.pdf)); *Massachusetts Health Reform: Near Universal Coverage, But No Cost Controls or Guarantee of Quality, Affordable Health Care for All* ([www.ourfuture.org/files/MA\\_Health\\_Reform\\_Final.pdf](http://www.ourfuture.org/files/MA_Health_Reform_Final.pdf)). 



# HEALTH CARE REFORM: CHANGE WE CAN BELIEVE IN OR MORE OF THE SAME?

By Jyoti Puvvula

I intently watched the presidential debates of then Candidate Obama, who after being pushed several times said he believed “healthcare should be a right.” Many of us sighed in relief. He had said the taboo words: Healthcare, a Right. Today as we stand on the verge of a real possibility of health care reform, one has to wonder how, as the world's richest nation, did we get to this point, isolated from other industrialized nations in not providing basic health coverage for all? A historical perspective tells us that universal health coverage has been intensely debated for over a century.

As far back as 1912, Theodore Roosevelt tried to make national health insurance a platform plank for his presidential campaign, and Franklin D. Roosevelt, as a part of his New Deal Programs, attempted this again in the 1930s. However, both of these were defeated largely by strong opposition from organized medicine groups like the AMA, which tried to convince the public that these were foreign, un-American ideas: socialized medicine. Despite such opposition, local prepayment initiatives for teachers and others groups started to rise and became the prototype on which Blue Cross plans were based. The earlier years of the Blues (Blue Cross and Shield), while they were still nonprofit, used community rating, where they tried to share risk across a broad pool in order to cover the sick and still keep premiums affordable. They would eventually cave in to competition from the rapidly growing commercial profit insurers after World War II. Driven by profit these companies fragmented the risk pool by denying coverage or charging higher premiums to sicker patients and passing along their care to an overburdened safety net public system.

Currently the 1,300 private insurance companies, under the trade group America's Health Insurance Plans (AHIP), have a workforce 10 to 25 times larger than Canada's entire single-payer system; by maintaining one of the largest lobbying presences in state capitols across the country, they have managed to get some industry friendly, lenient regulations with tax exemptions and other perks. They continue to increase profits by offering a variety of incomplete policies (such as high deductible, short-term policies excluding pre-existing conditions), and finding new lucrative markets such as the privatization of public programs like Medicare and Medicaid.

Healthcare reform is back on the agenda As we try to find solutions to a problem of now at epic proportions, with upwards of 46 million uninsured, 25 million underinsured, and where most Americans find their health care costs climbing at rates two to three times faster than their household income. Many proposals have been suggested, most of which build on the current non-system of health care using the existing network of physician and hospital choices. Without going into the issues of whether or not to mandate health insurance coverage, or how to pay for any of the proposals, the following are highlights from a few of the proposals being debated:

**The Obama/Biden Plan:** Besides requiring private insurance companies to cover individuals with pre-existing conditions and other regulations, it also offers incentives for small businesses and employers. However, its main push is to establish a National Health Insurance Exchange with a range of private insurance options as well as *a new public health insurance plan like Medicare* based on benefits available to members of Congress that will allow individuals under 65 and small businesses to buy affordable health coverage. Max Baucus, Chair of US Senate Committee on Finance, has a similar proposal with a few additions, such as increasing access to Medicaid, the State Child Health Insurance Program and allowing people between 55 and 64 to buy into Medicare. *To learn more about the proposed new public health insurance option visit: [www.ourfuture.org/healthcare/public-health-insurance](http://www.ourfuture.org/healthcare/public-health-insurance).*

**H.R. 1841—The Americare Health Care Act:** This proposal by Congressman Pete Stark, Chair of the Health Subcommittee of the House Committee on Ways and Means is similar to the President's proposal where those who are happy with their current employer-based coverage could keep it, while everyone would have the option of enrolling in AmeriCare—a new, universally avail-

able program modeled on Medicare with a public or private option.

**H.R. 676—Comprehensive Health Insurance Coverage for all United States Residents:** Introduced by Rep. John Conyers Jr., this bill is the only single-payer option that proposes to provide all individuals in the US with the same free government health coverage that includes medically necessary care from any health care provider in the US. Benefits covered include primary and preventive care, hospital care, prescription drugs, emergency care and mental health services. It prohibits an institution from participating in the program unless it is a public or nonprofit institution. It allows nonprofit HMOs (such as Kaiser) that actually deliver care in their own facilities to participate in the program, while prohibiting for-profit health insurance companies from selling coverage that duplicates the benefits provided under the program. However, it allows such insurers to sell benefits that are not medically necessary, such as cosmetic surgery benefits.

**American Health Solutions:** Realizing that healthcare reform is inevitable, the health insurance industry—through AHIP—has presented a proposal of its own to appear as the “reformed good guy” that will not deny health coverage to individuals with pre-existing conditions and may be willing to use community rating *if everyone has to buy one of their policies. They are fervently opposed to a public health insurance plan option.*

We have to be very conscious of the fact that some of the most powerful lobbies, including PhRMA, will oppose a public health insurance option in order to hijack any potential for real change. I remind myself that a grassroots movement (and a little help from the economic crisis and Wall Street) helped elect President Obama with his messages of Hope and Change. It will take a similar grassroots effort to see true healthcare reform that will bring the residents of this nation closer to the concept of Health Care as a Basic Right.

**Call to Action:** Healthcare reform legislation is being debated and formulated in Congress now. Call your representatives today and let them know exactly what you support! 🐾

# BURUNDI: WHERE THERE'S HEALTH THERE'S HOPE

By Lanny Smith

The elements most infectious in Burundi's Kigutu project are enthusiasm, teamwork and hope—so much so that the Village Health Works (VHW) motto is “where there's health there's hope!” VHW in Burundi is the newest partner of Doctors for Global Health, yet the theme of “health as reconciliation” and the methodology of community-oriented primary care combined with human rights recall DGH's roots in post-war El Salvador.

Like El Salvador in the 1990s, Burundi has just emerged from more than 12 years of armed civil conflict that left about 200,000 dead. Its peace accords were finalized in March of 2008, after the terror of a genocide much less known globally than that of neighboring Rwanda. Deo Deogratias,\* VHW's founder and executive director, survived that trauma and channeled his desire for healing into an extraordinary community-oriented process that has helped change lives locally and around the world.

The project itself is a health center serving a rural, mountainous community that looks over Lake Tanganiki to the neighboring Democratic Republic of Congo. At night a mélange of fireflies, boat-lights and stars appear in that direction. The people are literally dirt poor, surviving on cassava and palm oil. Until VHW grew there, the community had little access to health. The nearest hospital was several hours away, and at that hospital as in others in Burundi, patients are imprisoned until they pay their user fees—the World Bank's perverse legacy of cost-recovery and user fees in health care.

“One of the essential elements in any volunteer is the solid humility born of self-confidence and respect for others, knowing that the Burundi professionals as well as staff and community members have themselves a wealth of knowledge and ability.”

Community Health Workers, or *Accompanateurs*, work with the sickest VHW patients, especially those with tuberculosis or HIV/AIDS, to facilitate access to medications, transportation and other basic needs. The ambulatory care clinic is open daily, seeing upwards of 60 patients, staffed by the local medical director Melino (formerly the teacher of the local elementary school and beloved by the community), a nurse practitioner-level clinician, several nurses and a laboratory technician. There is a small pharmacy stocked with essential medicines (including anti-retrovirals and tuberculosis meds), an organic, permaculture-designed garden that is beginning to help supply food and housing for the staff and volunteers.

There is a healing magic in the VHW Kigutu program that comes from working together with purpose. The unspeakable horrors of the Belgian colonial legacy and civil war killings—nightmares shared by too many lives around the world—are acknowledged as part of Burundi's history. They are buried as compost to the current, practical struggle of creating an environment where human dignity is paramount and its celebration normal.

There certainly still is poverty in the community. Some people continue living in dirt huts where no one in the US would think of housing a dog, but many families have been able to build brick structures in the two years since VHW began. And there are more and more times when patients arriving to the clinic at death's brink return to their village fit and full of desire to serve as a way of celebration—miracle children as well as adults.

Kigutu is looking for volunteers to further its mission of hope. So what would a volunteer do? Prior to arrival, learn the basics of Kirundi. (VHW has a primer. Knowing French would be helpful with the professional staff, but not essential thanks to the clinic's translator, Elvis.) While there, how to serve depends on one's skill set. Experienced clinicians (physicians, physicians assistants and nurse practitioners) can work with the local health professionals, seeing patients and teaching (and, for the first months especially, learning). Someone experienced in permaculture could work in the garden, while someone with administrative and computer skills could also be very useful.

As with any DGH partnership, one of the essential elements in any volunteer is the solid humility born of self-confidence and respect for others, knowing that the Burundi professionals, staff and community members have a wealth of knowledge and ability to impart. Melino, for example, is an extraordinary clinician by any standard. Whatever the task, any volunteer can be certain that it will be done in community. Meals are simple, often vegetarian (because that is the most economical), and delicious. Music is an essential element of sharing—Burundi is world famous for its drumming, a rhythm that makes for purposeful and very fun coordination.

Connecting with the global struggle for health and social justice, through volunteers and other resources, through shared philosophy and learning—this is the reason Doctors for Global Health and Village Health Works have begun a partnership. What an exciting responsibility for both groups to explore. And, for the persons lucky enough to be part of this healing struggle, what joy.

*\*“Strength in What Remains: A Journey of Remembrance and Forgiveness,” by Tracy Kidder, author of “Mountains Beyond Mountains,” tells the story of Deo's wondrous journey and will be available on August 25, 2009 from Random House, ISBN: 978-1-4000-6621-6.*



World AIDS Day 2008 march for prevention and cure in Kigutu.

# A BEAUTIFUL DAWN: EL SALVADOR ELECTIONS

By Shirley Novak

The following first two paragraphs are excerpted by permission from “The Left Triumphs in El Salvador,” (<http://americas.irc-online.org/am/5989>) written by Ana Martínez, Americas Program, Center for International Policy (CIP). They provide a brief summary of the March 15, 2009 presidential elections in El Salvador. After that, there are quotations from individuals from our DGH partners in El Salvador, who comment on the significance of the election to their families, their communities and their country.

“The historic victory of the leftist Farabundo Martí Front for National Liberation (FMLN) party in the presidential elections held in El Salvador March 15, marked the end of governance by the rightist Republica Nationalist Alliance (ARENA). With 99.02% of the ballots counted, Mauricio Funes of the FMLN had won 51.3% of the votes while Rodrigo Avila of ARENA had won 48.7% according to the Supreme Electoral Tribunal (TSE). Accordingly, Funes' administration has become the first leftist presidency in the history of El Salvador, which have previously been characterized by military regimes on the right.

The Salvadoran people along with the FMLN were able to overcome the multi-million dollar scare campaign launched by ARENA, the structural problems of the current electoral system, and the political intervention of right-wing groups that attempted to subdue another leftist triumph in Latin America. The electoral triumph of the FMLN was the product of on-the-ground campaigning carried out by party members, the support of various social organizations that backed the movement for change, as well as the grassroots work through different citizen campaigns that highlighted the economic and social situation in the country...Five members of the U.S. Congress supported the scare campaign of ARENA, when four days before the Salvadoran elections they declared before the House of Representatives that US-Salvadoran relations would be affected if the FMLN was victorious.”

**Lucia Sanchez Martinez**, the Acting Director of *Asociación de Campesinos para el Desarrollo Humano* (CDH, Peasant Association for Human Development), DGH's partner organization in Estancia, Morazán: “The FMLN looked at which ways they could be with the people, supporting them and making sure they didn't believe the negative propaganda. The people this year were more conscious of voter fraud, and this time they weren't interested in bribes—they voted for their children, for the country. Sure there was fraud, but this time there was less.”

**Don Santos**, an older indigenous member of the Estancia community: “It was El Salvador that received and achieved the government that we wanted... The triumph was ours; no one could deny that, despite so many circumstances and political propagandas of fear and terror... We feel very happy and content because we have been sent a step forward toward liberation... There is a hope that change will arrive at the corners of the country where the people are the poorest and most isolated. We feel happy because we have a government that is going to fight for the poor and is no longer going to be associated with the most powerful. The government is going to be more with us, because it was the *pueblo* who elected the government.”

Salvadoran **Roberto Zamora**, who lived in the US in exile for two years during the 1980s: “This is a new dawn, not only for my family that gave its blood so that the seed of hope finally is able to be born, but also for the thousands of *campesino* brothers and sisters, students, teachers, priests, politicians, and all of the foreigners who died in our struggle to bring peace, justice and democracy to the Salvadoran people.”

**Luis Rivas**, a Health Promoter in Santa Marta, Cabañas: “Change doesn't happen overnight; people are prepared to be patient. Funes will be receiving a country that's practically broke, and

broken, and it will take a lot to start to see changes... There is the need to be inclusive, that just because people voted for ARENA doesn't mean that they shouldn't be part of change too... It's not about being antagonistic among party rivalries, but rather about everyone coming together and benefitting from the change that is happening.”

**Juan Nelson Rojas**, a Salvadoran permaculture specialist and leader in regional anti-dam movement: “Funes, the elected President, and the FMLN are confronted by the worst global economic situation ever, a continuous fall of US remittances from Salvado-

rans abroad and a bankrupt state... According to my personal point of view, the new government will handle the crisis in a better position; it will avoid the riots with dialogue and negotiation but in the end trouble will come anyway, because

of the violent society we live in today. Environmentally, ours is a country in despair: there are 38 mining sites waiting for the go-ahead permit from the ministry, a couple of big hydro-dams threatening the country's already troubled big rivers. If the above comes to be true, it means that all of El Salvador's territory will be condemned to pollution and drought... There is a lot of enthusiasm and positive energy in the majority of the population; it is like slaves who have achieved freedom even knowing they are swimming upstream. They are willing to take on the challenge at this time in history; good vibes are around... A new era is opening for the Salvadoran people. The FMLN is taking a preferential option for the poor, so we will see drastic changes from now on. Unfortunately we do not have time in our favour as the entire planet is in trouble due to climate change. Scientists are warning humanity about the dramatic increase in temperature lately, so we need to hurry up in that respect as well. I am very confident that at least this time we are not having our government against the good way of tackling things; we are going to work in the same direction even though we are on different paths.”

## DGH Announcements

► **Save the Date!** Join fellow health and human rights activists July 31–August 2, 2009 at the 14th Annual DGH General Assembly: "Global Impacts of Local Action: Walking the Walk at Home and Abroad," at The George Washington University in Washington, DC. Check the DGH web site for details.

► **Give DGH Your E-mail.** We will keep in touch through two e-mails each year and announcements about DGH events in your area. And let us know if you would prefer to receive only an electronic copy of this newsletter. Update your contact information at: [www.dghonline.org/updatemailinglist.html](http://www.dghonline.org/updatemailinglist.html).

► **New Book: *Women's Global Health and Human Rights*.** Co-edited by DGH Founding President Lanny Smith, with many chapters written by DGH members and supporters, this book from Jones and Bartlett Publishers serves as an overview of the challenges faced by women in different regions of the world. Ideal as a tool for professionals and

students, this book discusses the similarities and differences in health and human rights challenges that are faced by women globally. Best practices and success stories are also included in this timely and important text. Major topics include: globalization; gender-based terrorism and violence; cultural practices; health problems; and progress and challenges. Stephen P. Marks, François-Xavier Bag-noud Professor of Health and Human Rights, Harvard School of Public Health, raves: "Drs. Murthy and Smith deserve great credit for assembling an outstanding team of human rights activists, health practitioners and scholars, who define with passion and compassion the challenges of transforming the slogan of 'women's rights are human rights' from aspiration to realization." Order a copy online at: [www.dghonline.org/readinglist.html](http://www.dghonline.org/readinglist.html). Part of the royalties will be donated to DGH.

► **New Book: *Textbook of International Health: Global Health in a Dynamic World*.** Co-written by DGH founding member Tim Holtz, this publication from Oxford Uni-

versity Press is an international health primer and a critical political economy perspective on global/international health. It relates to many of the themes that DGH holds dear and DGH is featured throughout the topics discussed, which include: origins of modern international health; political economy of health and development; epidemiologic profiles of global health and disease; societal determinants of health; globalization, trade, work, and health; health and the environment; the economics of health; toward healthy societies; and doing international health. In the foreword, Archbishop Emeritus, Desmond Mpilo Tutu, writes: "I highly recommend this textbook to students and professionals of international health, as well as to anyone who is interested in the ingredients of human health and well-being in an international context." Order a copy online at [www.dghonline.org/readinglist.html](http://www.dghonline.org/readinglist.html).

► **Buy DGH!** Spread the word about DGH and support our projects at the same time by buying DGH t-shirts, mugs and much more at: [www.dghonline.org/dghstore.html](http://www.dghonline.org/dghstore.html).



### DOCTORS FOR GLOBAL HEALTH

Promoting Health and Human Rights  
"With Those Who Have No Voice"

Box 1761, Decatur, GA 30031 U.S.A.

Tel. & Fax: 404-377-3566

E-mail: [dghinfo@dghonline.org](mailto:dghinfo@dghonline.org)

[www.dghonline.org](http://www.dghonline.org)

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