



# Doctors for Global Health Reporter

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## TEACHING PREVENTIVE HEALTH IN RURAL GUATEMALA

By Robin Levine

*“¡Buenos días, señoritas! ¿Pasen adelante, como están?!”* yell a classroom full of sixth graders in a friendly, rhythmic chant as my teaching partner Ani and I enter and prepare

to teach a sex education lesson at a school in the rural community of Xecaracoj, Guatemala. Despite our two weeks of training to be children’s health educators, I’m still nervous as I stand in front of a classroom filled with twelve year-olds, clutching flashcards with notes about reproductive health, diagrams of the human body and a condom for demonstration purposes. I quickly quiet my nerves, take a deep breath and begin the lesson as planned by asking the students to share any thoughts they have about the difference between the terms sex and gender.

The summer of 2010, I had the privilege of volunteering with *Primeros Pasos* (First Steps), a primary care clinic that also runs a youth health outreach and education program in ten rural schools located in the surrounding Palajunoj Valley communities that it serves. *Primeros Pasos* recognizes the close connection between preventive health education and improved quality of life, so volunteers have the opportunity to learn about how both the public education and the health-care systems in this area work – or fail to work.

“ By the end of my two months at *Primeros Pasos*, Ani and I had taught classes on topics ranging from hygiene and parasite transmission, to rights of the child and domestic violence. ”

When I arrived in Guatemala, I had expected to encounter significant disparities between the public services offered in the United States and those offered in Guatemala, but I was not prepared for the striking differences in access to and quality of healthcare and education for people living in Xela as compared to those living in the Valley. Xela is the second-largest city in Guatemala and it is home to numerous universities, a multiplicity of foreigners like myself sporting Patagonia gear and taking Spanish lessons, and

many middle- and upper-class families who send their children to private schools. The Valley, on the other hand, is home to an impoverished population that is approximately 95 percent Quiche Maya, an indigenous group historically and continually marginalized by national and international governmental policies.

For my first two weeks as a volunteer, I was charged with leading nutrition and hygiene classes for the students who come to the clinic for their annual check-ups, and assisting with some operational tasks. We helped to register patients, collect their *muestras*, or stool samples, and take basic height and weight measurements. Although I didn’t have much time to reflect on these tasks while working hurriedly alongside other volunteers and staff to complete this process in an efficient manner, I always found myself thinking



about the basic level of health that I take for granted in the US as I rode the bus along the pothole-filled dirt road back to Xela.

When I go in for my annual check-up, my doctor does not test for parasites and my mom has never had to worry about providing me with sufficient calories and clean drinking water to support healthy development and growth. I'm also privileged to have a large pool of doctors and specialists to choose from when I get sick and my mom's health insurance makes these visits relatively affordable.

All children who visit *Primeros Pasos*, on the other hand, are strongly encouraged to bring in stool samples so that the lab technician can test for parasites since many indigenous families living in the Valley lack the

means to prevent feces from contaminating their food supply. Furthermore, although the high rates of parasitic infections in the area are exacerbated by pervasive malnutrition and rural poverty, the more than 15,000 people living in the Valley are served by only one government-employed doctor and one nurse (the WHO recommends one doctor for every 600 people).

After completing my training in the clinic, I spent the rest of my two months at *Primeros Pasos* teaching approximately three lessons each day at the public school in Xecaracoj. I was struck by the fact that students only attend school from nine in the morning to one in the afternoon each day with breaks for lunch and recess, and that classes are routinely canceled for often unclear reasons. Despite these challenges, the students were extremely attentive, kind enough to let us know when we needed to explain something in a different way, and eager to participate in the review games and activities that we played at the end of each class. By the end of my two months at *Primeros Pasos*, Ani and I had taught classes on topics ranging from hygiene and parasite transmission to rights of the child and domestic violence.

I initially struggled with the idea that these brief twenty- to forty-minute lessons taught in my less-than-perfect Spanish might be these students' primary source of information for preventive health measures. I worried that my identity as a complete outsider, in terms of nationality, socioeconomic status and religion, would make students even more uncomfortable and

hesitant to engage in topics that usually generate uneasiness among children and adolescents. Yet I felt reassured in knowing that the lesson plans were prepared and reviewed by *Primeros Pasos* staff, and that I was contributing to the clinic's goal of providing the necessary tools for children to make more informed choices about their own personal health.

I was continually impressed by *Primeros Pasos*' tireless commitment to education and clinical outreach. During my last week in Guatemala, I also had the opportunity to participate in "mobile clinics," which involved hiking to the remote community of Bella Vista with doctors, health educators and staff members carrying medicine and kid-friendly healthcare flyers in our backpacks.

I absolutely believe in the importance of preventive health education as the first step of many toward improved quality of life. I'm so grateful to have had the opportunity to work alongside the *Primeros Pasos* staff toward this goal. 🌿



Health educators waiting for the bus in front of *Primeros Pasos*.

## SIERRA LEONE: ARMED WITH HUMOR

By Sean Trafficante

When I first arrived in Sierra Leone, in an attempt to bridge some cultural gaps, I asked an elder if he knew any Sierra Leonian jokes. "We don't have time for such things," was his deadpan reply. I was disheartened at the time, but in retrospect I recognize the "sufferers' humor" of his reply. Such wit punctuates the steady parade of problems, false starts, dead-ends, and tragedies people here regard like the weather. It goes beyond that, however, continually providing a sense of courage and a way forward.

One of my favorite things about being in Sierra Leone is speaking the Krio language

and hearing its nuances of sufferers' humor. Krio, a fusion of English, French, Portuguese and a variety of African languages, arose in the melting pot of 18th century Freetown as a result of the repatriation of ex-slaves from the New World. Krio is utilitarian and gets the point across. Its subtleties are not in abundant vocabulary, but in tone, vocalized sounds and word play. Any daily encounter begins with a series of exchanges following the typical pattern, "*Aw di...*" which means, "How's the..." You can ask about the day, health, family, work, etc. Sufferers' humor can enter in many ways. For example, when asking, "*Aw di bodi?*" (How's your body, ie. health) the response can be, "*I de na clos,*" or "It's in the clothes." When asking about the family, "*Aw di fambul dem?*" the response can be, "*Dem de,*" or "They are there." In both examples an answer is given, but the actual condition can be playfully avoided. Such word play provides a brief break from the daily struggle.

Local "Comedians" offer another glimpse into the country's humor. These Comedians paint a white beard on their face and dress in the most ridiculous western style clothing they can find. Usually it is extremely oversized, and they stuff it to create absurd obesity in the front and in the rear. The outfit is completed with an English style cap and dark sunglasses. Their

“Certainly the danger of such humor is falling into fatalism... I have not seen that here... What I do see is more along the lines of laughing to keep from crying.”



Luis Diego Aguilar Allen, a volunteer from Costa Rica, cleaning a boy's leg wound.


routine involves dancing, singing, slapstick humor a la The Three Stooges, and telling humorous stories, usually centering on suffering. The rhythm and dexterity of the dancing is distinctly African and the singing resembles the gritty chanting of Jamaican dancehall artists. I hear they are mocking

the elders, but my unconfirmed suspicion is that the origin of the tradition is either in ridiculing white colonial masters or the Africans who imitated them. The most successful of these Comedians release songs that get radio airplay. In one such song the Comedian sings of the difficulties that marriage presents to a man without money. He complains that even at his own wedding he will be lucky to even smell the food, let alone taste it. Another artist with a nationally popular tune called "Injection" describes the experience of going to the government hospital delirious with severe malaria. Initially he is firmly set on seeing the doctor to relieve his condition, but when the doctor finally arrives he insists that only a nurse will do.

As volunteers, we have had our own experiences that offered humor as a means to reduce the tension. One such experience came as Luis was caring daily for a boy with a leg wound. After cleaning and dressing the wound, he instructed the boy to please keep the bandage clean. This is not an easy task during the dusty dry season in Sierra Leone. However, one day the boy arrived with the bandage brilliant white in color, while the wound was in worse condition than the previous day. The boy had been out playing and when he returned home his mother was horrified at the dirt on the bandage as she knew of the strict instruction given by the white doctor. "How can you go see the white man with such a filthy bandage; he will not even touch such a thing!" she scolded her son. She then proceeded to thoroughly clean the bandage as well as scrub away the newly formed tissue in the child's wound.

From my own experience, I have new respect for the versatility of the female mammary glands and the process of lactation. As of last year, the government of Sierra Leone has introduced a drastic initiative to provide free health care to children under five, pregnant women and lactating mothers. While the intentions are good, patients still have to fight for access to this program as practitioners and drugs remain in short supply. While the first two groups are easy enough to identify the third is not as immediately apparent. As such, I have had breast milk squirted in my general direction on several occasions as women demonstrate their right to free health care and government-supplied medication.

Certainly, the danger of such humor would be to fall into fatalism. However, I have not seen that here and people continue forward despite the ups and downs. What I do see is more along the lines of laughing to keep from crying. The blues is a rich source of such sentiment in America, so it is no surprise to find similar traditions here in West Africa.

As for myself, coming to Sierra Leone was something of a shock. I had talked about poverty before, yet looking it in the eyes daily is another matter. Humor has fortified me but I am just following the locals' example. As one Sierra Leonian man joked with me, "Everybody here is a Manager. We all know how to manage." 

## LIFE, HEALTH AND COMMUNITY IN JAPAN AFTER NATURAL DISASTERS

By Masaya Kato

I arrived at the shelter in Otsuchi-cho town, Iwate Prefecture, late afternoon on the 25th of March. Iwate is approximately 450 km north of Tokyo – about a nine-hour drive. The shelter was arranged at the Terano Kyudojo (indoor archery facility).

I joined the relief mission of the Nagasaki University as a volunteer. Professor Taro Yamamoto of the University, who chairs Department of International Health, entered the affected areas immediately after the quake and prepared the mission from his University to the Terano Kyudojo shelter. Nagasaki University sent three teams in rotation, one after another. I was with their third team, which operated from the 25th to the 30th of March 2011. The team consisted of a physician, a surgeon, a pharmacist, a nurse, a public health worker (myself) and a graduate student. The team worked with the local clinic team of Dr. Toshiro Ueta.

Dr. Ueta and his family were victims of the massive Tsunami themselves. They were in their four-story clinic when the Tsunami hit on March 11. Some people in the neighborhood ran into his clinic and climbed to the roof. Dr. Ueta's family followed. From there they observed the series of massive Tsunami waves that swept away the whole town. They stayed in the building the whole night surrounded by contaminated water.

The following day, a Self-Defense Forces' helicopter rescued them. They were taken to the Terano Kyudojo shelter. Dr. Ueta acted immediately. He set up a desk and started providing medical services to people in the shelter and in the nearby communities.

One the way there we saw little damage to the exterior of buildings in the Tohoku region, where the Tsunami did not reach. This suggests many of the houses survived the quake. However, the scene completely changed at the line where the Tsunami had reached. It was like the area had been hit by an air attack. One of the team members com-

pared it to the aftermath of an atomic bomb.

Otsuchi-cho town had an estimated population of 15,256. According to the local authority, as of March 25th, 508 people were confirmed dead, 989 people were reported missing, 4,778 people were in the 36 shelters arranged around town, and there was no information on nearly 9,000 residents.

The team from Nagasaki University worked with Dr. Ueta at the Terano Kyudojo Shelter. At first the Terano Kyudojo shelter had 580 people. Many left in the first two weeks as family members from other parts of the country came to pick them up. As of March 28, 221 people were still there.

The shelter-based clinic served both residents of the shelter and people who lived in the surrounding communities. Our team arrived two weeks after the quake and the situation was already moving from the sub-acute phase into the chronic phase. This shelter-based clinic primarily functioned as a primary care site, while a few serious cases were sent to the referral facilities. The doctors estimated about one-third of the cases presented due to common cold and another third requested the routine medication refill for their chronic conditions, such as hypertension and diabetes. The remaining third also had chronic conditions and required the medicine refills, but they suffered additional symptoms. The doctors reported the increasing trend of cases seemingly related to physical and psychological stress.

Approximately 100 types of medicines were available. One of the tasks for doctors and pharmacists was to choose substitutes for the patients' routine medications from the set of available medicines. Some had their medicine book or remaining pill bottles, which was a great help for this task. However, one of the big challenges for doctors was to identify medicines when they had no clue as to which medication the patients had been taking, especially when all the information had been lost in the Tsunami. Many elderly patients were unable to remember the names and/or dosages of the medications they had to take regularly.

The morning of March 27, a patient came in with severe diarrhea and nausea. The doctor suspected acute gastroenteritis caused by a Norovirus infection. Soon a few similar cases were also reported from the community. We immediately acted to increase hygiene measures. Noroviruses can be transmitted by fecally-contaminated food or water and by person-to-person contact. The resulting dehydration can be dangerous, particularly for infants, children and the elderly.

“ I was extremely impressed to see that they were already forming a strong community at the shelter. ”

In the shelter, tap water was not functioning and there was no running water. Drinking water had to be brought in by truck every two to three days. The rule for toilet use had been to defecate on a newspaper, wrap it up and place it in a big plastic bag. There was certainly easy opportunity for people to have direct hand contact with stool. People were also washing their hands in the water in a shared bucket. We had a discussion with the community leaders of the shelter and agreed to make some changes to prevent further infections.

First, we made chlorine-based disinfectants available at all the toilet facilities around the shelter (previously only the alcohol-based ones had been available). Second, we asked people to stop washing their hands in the bucket and use the disinfectants instead. Third, we introduced plastic bins with a lid that can be opened with the foot to minimize direct contact with the stool and contaminated areas. Fourth, we also agreed to introduce sandals for people to change into when going to the toilet so that they would not bring contaminated footwear into the living area.

Aside from the physical consequences of the natural disaster and its aftermath, it was obvious that people were suffering from a great deal of stress. Many had experienced a life-or-death situation themselves when the massive Tsunami hit the town. The following are two examples of stories that I heard first-hand:

► Immediately after the earthquake, Mr. A (male in his 50s) went back home to pick up his parents. He then drove straight toward the hill where the community center was located. On the way, there was a primary school building that was being used as the evacuation site, but he did not stop there. Mr. A says if he had decided to go to the school, they might have not survived because a fire broke out there. He got into a traffic jam on the way up to the community center.



Doctors providing consultations at the clinic in the Terano Kyudojo Shelter.



Volunteers preparing new hygiene instructions for toilet use in the shelter.

# LETTER IN SUPPORT OF FATHER ROY BOURGEOIS

From the DGH Board of Directors

April 5, 2011

Father Roy Bourgeois  
School of the Americas Watch  
P.O. Box 3330  
Columbus, GA 31903-0330

Father Roy Bourgeois (left), founder of SOA Watch, at the DGH 2009 General Assembly in Washington, DC, with Dr. Juan Manuel Canales (center), DGH project coordinator in Chiapas, Mexico, and Dr. Lanny Smith (right), DGH founding President and Liberation Medicine Counsel.



Dear Esteemed Father Roy,

It has been brought to the attention of the Board of Directors of Doctors for Global Health that the Catholic church – via Maryknoll's Fr. Edward Dougherty, the order's superior general, and Fr. Edward McGovern, its secretary general – has recently taken a stand against peace and social justice. More specifically, it has taken a stand against the brave and courageous position you have taken in support of women's rights. We understand you were given fifteen days to "publicly recant" your support of women's ordination or face dismissal from the Maryknoll Fathers and Brothers, stemming from your support of women priests in the Catholic church. You added yet another commitment in your long chain of actions to seek justice for minorities, the marginalized and the poor, always willing to face the consequences.

In early 2000, DGH board members began to study the School of the Americas (SOA), now called the Western Hemispheric Institute for Security Cooperation (WHISC). This led to a unanimous board decision in July of that year to join the growing number of NGOs and other organizations publically calling for the closure of the SOA. From that time of awareness, and more recently when you served as keynote speaker at our Washington, DC General Assembly, DGH has been impressed with the peace and social justice work to which you have devoted your life; we have been inspired by your commitment to improve life for, paraphrasing your own words, the poor, the people in Latin America who call for reform, the landless peasants who are hungry, health care workers, human rights advocates, labor organizers – "those who become the targets of those who learn their lessons at the School of the Americas." We are well aware that project partners of DGH in Mexico and Latin America have suffered at the hands of their own military graduates of the SOA.

Father Roy, you have educated and inspired thousands of people to join the movement to Close the SOA. You have become an outspoken critic of US Latin American policy and links to the SOA. You have tirelessly spoken out against human rights violations, vowing to continue protesting the SOA until it is closed.

Doctors for Global Health stands with you and your message of non-violence, social justice, and human rights for all; that message includes recognizing the connection between non-violence and the equality of women. We will proudly remember and support your statement in whatever ways we are able: "No matter how hard we may try to justify discrimination, in the end it is always wrong and immoral." We also join with all the great peacemakers believing that "the truth cannot be silenced. It simply cannot be silenced."

With admiration, respect and solidarity,

The Board of Directors of Doctors for Global Health

He decided to walk with his parents. The Tsunami wave reached just two meters behind them. They made it to the community center, but soon the surrounding forest started to burn. Mr. A and his parents had to keep walking in the snow to escape to the other side of the mountain.

► Mr. I (male in his 40s) was attending the emergency meeting that the town mayor convened right after the earthquake. The Tsunami reached the site of the meeting and Mr. I was pushed into the restroom by the rushing water. The room filled up with water very quickly. He saw a window but he could not open it. The water was extremely cold and soon reached the ceiling. Mr. I could not breathe. He thought he would not survive, but then the window somehow opened and his body floated up and out through it. Luckily, he surfaced alongside the building and was able to get to the rooftop. The water was heavily contaminated with oil. He says the smell of the oil stayed on him for a week. Mr. I stayed overnight on the rooftop. It was extremely cold. The following day he was rescued by helicopter and taken to the Terano Kyudojo shelter, where he immediately started working as town staff to support the shelter.

In addition, most of the people in the shelter have loved ones who are dead or still missing. Most are likely suffering from survivor's guilt. Many lost literally everything – house, car, television, refrigerator, washing machines, computers, books, photographs. They had already lived in the shelter for more than two weeks with over 200 people without potable water, electricity, television, telephone or privacy, and they do not know how many more months they will have to stay here. Everything is uncertain for the future:

*(Continued on page 8)*



# Human Rights World

around the

## THE DGH HUMAN RIGHTS AND ADVOCACY COMMITTEE

By Linda Sharp

DGH is, in many ways, an instrument of those who want to improve the health of people around the world and who want to build solidarity with those tackling social and political injustices that cause poor health. Our members understand that ill health is much more than a problem of disease, geography or bad luck. We understand that the current state of global health is an outcome of political and economic choices that have created a great divide between a few rich and the many poor. Political and economic policies are health determinants, and global health is therefore fundamentally political in nature. That is why the DGH Human Rights and Advocacy Committee (HRAC) is a critical part of DGH's mission. It is also why DGH is always struggling with the question of what is the most impactful way for DGH to do its advocacy work: How do we best "amplify the voices" of those we accompany?

First, we must understand what we mean by advocacy and what it is, specifically, we want to advocate for or against. We find an affinity with the sentiments expressed in the introductory chapters of *Global Health Watch 2 (GHW2)*, an alternative world health report that calls for radical changes, both politically and socially, in order to reverse the current alarming trends in global health ([www.ghealthwatch.org](http://www.ghealthwatch.org)): "We are in the current situation largely because the global system is effectively run by rich-country governments, which are disproportionately influenced by commercial interests and which have consistently demonstrated their determination to preserve their power and to use it to advance their own interests. The current system of global governance is seriously lacking in inclusiveness, equality of voice, transparency and accountability – basic preconditions for democracy... The most important priority for civil society activism is arguably the democratic reform of global economic governance."

As a partner of vulnerable communities, DGH is called upon to use any and all influence and political will it can muster to counterbalance the profoundly undemocratic nature of the global governance system. Similarly, as members of high-income nations, we need to demand that low-income countries and global civil society get full representation in political and economic decisions, and insist on reform of international institutions that remain undemocratic. Such a fundamental paradigm shift will not come from the current international institutions themselves since it would mean a loss of power for them. Therefore, the work needs to be rooted in a broad social mobilization, across the whole spectrum of society by way of a radical empowerment of people.

Similarly, local actions need to be framed in the context of global justice issues. For example, the advocacy work with our communities in Cabañas, El Salvador against the Pacific Rim mining company is about amplifying the voice of our partner community as it struggles to help protect friends and families make their own health decisions, and to stop the brutal killings and death threats that have occurred. It is also about working to change the dominant power structure that allows private corporations to make profits at any cost and without the consent of the people directly affected. When we advocate stopping Pacific Rim specifically, we are also expressly advocating for the larger struggle of human rights over corporate rights.

Such a daunting task can feel impossible, but we are inspired to carry on: "If we dismiss the reforms which are so desperately needed as politically infeasible, and focus our efforts exclusively on piecemeal damage limitation within the current paradigm, this will be a self-fulfilling prophecy: a more viable alternative will remain politically infeasible." (GHW2)

This certainly rings true for the health care reform law that was passed in the US in 2010. In

regards to human rights, it falls far short of the goal of health care for all. What began with a courageous effort to pass "Medicare for All," quickly fell victim to a political process that serves the needs of private insurance over the health of citizens. Many groups were unwilling or unable to call for a true and fundamental change, and what we got is piecemeal damage limitation. Yet, the struggle continues and there is hope. Vermont is leading the way!

There are many other examples of this work happening: global networks such as the World Social Forum have been advancing alternatives to neoliberal policies and promoting global justice for over a decade. The work of the People's Health Movement (PHM) aims to create a strong mobilization of civil society committed to the fulfillment of human rights ([www.phmovement.org](http://www.phmovement.org)). Other examples include low-income countries that have refused to borrow from the IMF and World Bank, and governments that refuse to send their citizens to the U.S. Military School of the Americas ([www.soaw.org](http://www.soaw.org)) in Columbus, GA. If more countries are able to take these courageous steps, it will greatly undermine the influence of these sited institutions.

DGH, through its advocacy work in solidarity with PHM, the World Social Forum, its partner communities and others, will continue to push for the changes needed to achieve a global political and economic system for the health of the many rather than the wealth of the few. I hope others are inspired to join the HRAC to help us find creative and meaningful ways to do this work. Of course, I didn't even begin to touch on all the exciting work that is being done. Anyone interested in these issues is encouraged to read the entire GHW report, and be on the lookout for GHW3, currently at press with contributions from DGH and PHM members. Also, join us in Los Angeles, CA, July 28-31, 2011, for the PHM-USA strategic planning meeting and the DGH General Assembly (GA), where we will further discuss our unique role in this struggle.

For more information on the HRAC or the GA e-mail us at [dghinfo@dghonline.org](mailto:dghinfo@dghonline.org) or visit [www.dghonline.org](http://www.dghonline.org).

# THE RIGHT TO HEALTH – PART 2

By Laura Turiano

The first part of this series on the Right to Health summarized what this right requires of governments (*DGH Reporter*, Spring 2010). Human rights are more than just prescriptions for governments, however. They are an ethical system that applies to everyone and are the responsibility of everyone to practice. Human rights treaties, the written comments of the treaty committees, and the experiences of people practicing human rights, are a guide to living together with the values that are the foundation of human rights: justice, dignity, inclusion, equity/equality and solidarity.

Practicing human rights in our daily lives and work is often referred to as a 'rights-based approach.' The concepts that form the core knowledge base of the rights-based approach (RBA) grew out of the work of the international development community. After many years of failing to significantly decrease poverty, some development organizations began to look critically at their work. They realized that poverty is not merely an absence of resources but results from human rights violations. Simply trying to meet material needs, whether through the government or the market, will not decrease poverty and marginalization over the long term. Neither addresses the deep injustices and societal systems that produce poverty in the first place. Only empowering people whose rights are violated can change those systems.

As people who work mostly in health, we are very comfortable with a needs-based approach. When faced with a health problem, we know what resources or actions are needed to treat and prevent it. For example, when diarrhea is common in a community, there are a couple of strategies we commonly use. First, we try to change community members' behaviors that promote diarrhea. We provide community education to teach hand washing and how to boil or chlorinate drinking water. Another strategy is to provide so-called appropriate technology and small-scale infrastructure. We fund wells or village level water purification systems and latrines. These projects may decrease diarrhea and lead to other improvements in the short term, but over time the human rights violations that maintain the system that produced the living conditions of the community will limit and undermine the positive change. Maintaining a low-tech composting latrine is gross and difficult so many people won't use it properly. The community might not have the know-how or resources to maintain the well. Because they live on marginal land, a flood or landslide might destroy the well.

A RBA explicitly uses different strategies to solve problems. It doesn't exclude addressing needs, but it emphasizes realizing rights by uncovering and addressing the root causes of problems – the systems that perpetuate human rights abuses. A RBA protects and takes into account the groups most at risk of human rights violations due to marginalization and discrimination. The people affected by the problem are always included in all aspects of the program to solve it. A RBA program often focuses on building the capacity of marginalized needs groups and victims of human rights violations to claim their rights from governments or other duty bearers. But it also targets duty bearers to increase their willingness and capacity to fulfill their responsibilities. By identifying underlying causes, claim holders and duty bearers, a RBA enables people to specifically change systems of power.

### A Needs-Based Approach Would:

- ▶ Emphasize meeting needs;
- ▶ Focus on input and outcome;
- ▶ See individuals as deserving assistance;
- ▶ Focus on immediate causes of problems;
- ▶ Recognize needs as valid; and
- ▶ Make individuals objects of anti-poverty interventions.

### A Rights-Based Approach Would:

- ▶ Emphasize realizing rights;
- ▶ Focus on process and outcome;
- ▶ See individuals as entitled to assistance;
- ▶ Focus on manifestations of structural causes;
- ▶ Recognize individual and group rights as claims on duty bearers; and
- ▶ Strive to ensure individuals and groups are empowered to claim their rights.

The next installment of this series will examine in detail what a rights-based health project might look like and the key element of participation. For example, when people first hear about the idea that health is a human right, they often think that means that people should be able to receive whatever health care services they want from any provider. One physician wrote, "[Do] individuals – irrespective of their economic status, insurance coverage or immigration status – have the right to demand high quality, time-consuming medical care from me without compensating me to the level I request? I want to be a liberal on this issue, but I am not sure that I have a societal obligation to provide discounted or free health care while assuming all of the costs and liability that entails, without being compensated to the level that supply and demand dictates. How can I reconcile my liberal feelings that no one in America should be deprived of basic health care while functioning in a capitalist society? I have a right to basic plumbing, but I can't get a plumber out to my house at midnight and pay them 20 percent of what they ask and expect a high quality job."

– NOTE: Much of the information in this article was condensed or copied from, "A Rights-Based Approach to Social Justice Work: Training of Trainers Manual," from *The Advocates for Human Rights*, by Emily Farrell and Madeline Lobman.

## 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 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.

## LIFE, HEALTH AND COMMUNITY IN JAPAN

(Continued from page 5)

where they will be able to find a place to live and how they can secure their income.

Despite such an extremely challenging situation, many people were working tirelessly. In the shelter there was no privacy. No place for crying. Instead, people smiled. People spoke with humor and tried to see hope. Those whose houses were still standing started to clean them up. The houses were filled with mud. They had to throw away everything that was soaked with seawater. One lady told me she gets very dirty when she goes back home to clean her house, but "I do not have clothes and shoes to change into."

However, I was extremely impressed to see that they were already forming a strong community at the shelter. The shelter residents were divided into five groups. Two leaders were selected from each group. The group leaders held meetings every night with the shelter leaders to facilitate communication and discuss the rules of the shelter.

New toilet rules to prevent Norovirus infection were also discussed among them to determine if the proposed measures were feasible. One idea – the use of shoe boxes at the entrance of shelter – was actually rejected at the meeting. They were concerned that people would be afraid to lose their shoes if they had to leave them at the entrance. Once the rules were agreed upon in the meeting, group leaders passed them on to the members in his/her group.

The residents shared in the everyday tasks of the shelter, such as serving meals, cleaning the floors and cleaning the toilet twice a day. They set rules to regularly open the windows for ventilation. They also participated in "Radio Taiso" physical exercise at 7 o'clock every morning.

I felt a great deal of potential and hope that such power of community will definitely facilitate the recovery of the Otsuchi-cho town.

– Read Masaya's full report, with more photos, on the DGH website at [www.dghonline.org](http://www.dghonline.org). 🌿



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## Save the Date!

**Join us July 29-31, 2011 for our 16th annual General Assembly (GA):**

*Community Action for Health and Social Justice: Health Begins Where We Work, Live and Play.* The GA will be held at Loyola Marymount University in Los Angeles, CA.

Come be inspired by keynote speakers America Bracho, MD, Executive Director of Latino Health Access, and Theresa and Blase Bonpane, founders of Office of The Americas; panel discussions on the Health and Human Rights of Migrant Communities, and the Right to Food and Food Justice; lively discussions and updates from our partner communities around the world; and a tour of Father Greg Boyle's Homeboy Industries and Skid Row. You can also participate in the PHM-USA meeting before the GA (July 28-29).

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