Spring 2014 • Volume 18, Issue 1

Doctors for Global Health Reporter

Chiapas Then and Now

By Linnea Capps

When DGH began its work with Hospital San Carlos in Altamirano, Chiapas, Mexico in 1998, it seemed far away from the tourist path in Mexico. The airport in the capital of the state, Tuxtla Gutierrez, was very small and had little in the way of amenities. The road to the small colonial city of San Cristobal de las Casas was a narrow highway winding through the mountains. The trip to Altamirano was another two hours on similar winding mountain roads, requiring multiple methods of transportation. That was four years after the Zapatista rebellion began on January 1, 1994, the day after NAFTA took effect (to learn about the effects of NAFTA see page 4). The Zapatistas, a previously unknown group, began an uprising in defense of the rights of indigenous communities in Chiapas. The charismatic leader of the rebellion, Subcomandante Marcos, became the spokesman for the movement. His many writings proclaimed with passion and eloquence that poverty, discrimination, poor education and unfair distribution of land were among the underlying causes of the social injustices.

> **"The health promoters choose topics for training classes, and design the construction of the autonomous model of health. We can suggest and propose, but we do not impose our will."**

When DGH began working in Chiapas it was at the invitation of the Daughters of Charity, the order of Catholic sisters who manage Hospital San Carlos, and a Mexican physician who planned to begin a project accompanying health promoters in a few of the Zapatista autonomous communities. In those days the whole atmosphere in Chiapas was still very tense with a large and obvious military presence, check points along the highways, and scrutiny of foreigners found outside the usual tourist routes.

Much has changed in the twenty years since the rebellion began. The airport in Tuxtla is a new, much larger one with shops selling jewelry and other expensive souvenirs. The road to San Cristobal is a modern highway cutting through the mountains with bridges over the deep canyons. It has cut travel time in half. However, the trip to Altamirano has changed very little and the indigenous communities surrounding Altamirano have also experienced very little change.

Mexico as a country has changed in many ways. In the capital, Mexico City, it is possible to see great wealth on display. One of the richest men in the world is reported to be Carlos Slim, the owner of the company that has a near monopoly on telecommunications in Mexico. The overall economy has expanded but economic inequality has increased. Despite a wealth of natural resources, a hardworking populace and a vibrant culture, the majority of Mexicans are poor and Chiapas is the poorest state. There are many new national programs, including *Seguro Popular*, a government health insurance plan that

FRONT PAGE: Children at a vaccination day in a Zapatista autonomous community. LEFT ABOVE: *Casa de Salud* (House of Health) in a Zapatista community. The mural reads "Pharmacy of Herbal and Patented Medicine." RIGHT ABOVE: Pediatrics ward in Hospital San Carlos.

claims to have made health care universally accessible in Mexico. But it hasn't really made health care available to indigenous people who live in poverty in isolated rural communities. They often live in simple houses with dirt floors. Many of them have no running water. Some have electricity but many remain without. They don't have money for transportation to the government facilities. Community health programs have not been able to achieve good vaccine coverage and other basic preventive activities in the more isolated communities. The government facilities rarely have interpreters and so patients who speak only indigenous languages cannot communicate with the doctors and nurses.

Many of the people in the Zapatista communities where DGH works with health promoters live in these same conditions of poverty. Tired of being economically and culturally marginalied and brutalized, they have decided to take action and remain "in resistance," refusing to accept any services from the Mexican government that mean government control. They are striving to create an autonomous community, including a health care system, that meets their needs. They make their decisions communally and carry them out that way too.

Since 2000 DGH has been accompanying Zapatista autonomous communities and working with the health promoters, improving preventive care in their communities and teaching these health workers how to treat simple illnesses. Dr. Juan Manuel Canales has been the physician directing this program since the beginning. He studied medicine in Mexico City, and first worked in Chiapas during his social service year in the 1980s. When he returned to work with DGH and Hospital San Carlos, he noted that he was seeing the same problems he had seen twenty years before in these same communities. These illnesses then and now are often still related to poverty and the lack of access to clean water, sanitation and basic health care.

DGH has also long supported Hospital San Carlos (HSC) with volunteer physicians and other health professionals. Many patients still go to HSC from long distances, bypassing several government hospitals and clinics, either because they come from the autonomous communities and will not use government hospitals or because they appreciate the respectful treatment they receive at the HSC facility. This is in part because most of the nursing staff and other employees are indigenous and thus able to communicate with the patients in their native language.

Community health work is a slow process. The promoters are all volunteers who are appointed or selected by their communities. Their philosophy of collective work means that they could not accept stipends even if it were possible for DGH to fund them. Juan Manuel has worked with these health workers for twelve years and now is working with more than sixty promoters from three Zapatista autonomous municipalities.

Here is Juan Manuel's description and analysis of this important work: "The health promoters choose topics for training classes, and design the construction of the autonomous model of health. We can suggest and propose, but we do not impose our will. Over the years that we have been accompanying the people, they have constructed, deconstructed, and reconstructed again, but have never stopped looking for new ways to advance their work."

At times, we feel we can see the results of popular education in health. We watch the promoters confronting health problems in their communities with humility, patience, calm, and confidence, trying to help people who come to them seeking relief. It strengthens us and encourages us to continue supporting and accompanying them in this effort to share experiences and wisdom. DGH is fortunate – indeed privileged – to have Juan Manuel coordinating this important work in Chiapas, which is a vivrant example of DGH's commitment to Liberation Medicine.

That is one of the many reasons we are so excited to be holding the 2014 DGH General Assembly in San Cristobal, Mexico, August 1-3. Join us as we explore the theme, "Liberation Medicine: Rise Up In Solidarity," with members of the local communities.

It's the Small Things: Pre-School in Rural El Salvador

By Caitlin Lassus

This past visit to Estancia, my 18-month old son and I traveled with Salvadoran health promoter Abraham to the pre-school classroom of Copante (called CIDI or *Centro Infantil de Desarrollo Integral* – Comprehensive Early Childhood Development Center). As we walked in, the teacher, Ana, was conducting a review of "The Rights of Children." With much energy, she directed her squirmy crowd to repeat after her, "*tenemos derecho a ser escuchados*" (we have the right to be heard). We sang. A few children started to wander and were promptly called back into a circle of tiny chairs. Then, the group moved on to color while sitting at the low tables.

That day at the early education center in rural El Salvador was typical. Learning is always followed by a meal. Not only are basic dishes like rice and beans provided, but children also receive a high-protein nutritional supplement known as *la harina* (the flour). This is a powder created by parents of the children, under the supervision of Abraham, by toasting and grinding *Las Siete Semillas* (the seven seeds): cocoa, peanuts, sesame seeds, corn, soy beans, rice and morro (native to Central America and southern Mexico, these are seeds of the Jicaro tree, which are edible and high in protein with a licorice-like sweet taste). Their work is accomplished in two work days when the parents come together to create *la harina*, which is given to the children mixed with water and powdered milk or hot cereal.

Children receive new books of their own every year through Estancia's version of the Reach Out and Read Program, so learning can be expanded into the homes. At book distributions, parents' presence is expected and Ana does a beautiful job demonstrating to parents how they can 'read' and share a book with their children, even if they themselves can't read.

I was impressed by the way this project is truly as *integral* (comprehensive) as the name implies. Children are stimulated to think, to sing, to know that they, too, have rights. In the same two hour window, their bodies are also fed on a local creation that brings one segment of the community together, parents with children who are undernourished. Ana not only utilizes her talents as a teacher, but she also has steady employment and is continuously learning more skills through various workshops led by DGH volunteers and others. The CIDIs are truly an essential part of the early childhood development for these little ones in Estancia, El Salvador.

LEFT: CIDI class and the teacher. RIGHT: Mixing the seven grains that will be toasted and ground to create *la harina* by the parents of the CIDI students.

NON-MEDICAL DGH MEMBERS AND VOLUNTEERS

By Michèle Brothers

Several weeks ago, I attended a meeting in Paris where the featured guest was an English children's author and story teller; a former schoolteacher who spoke to us about her experience as a gatherer of local tales in the Ethiopian highlands in an educational project for the British Council. Our 20 plus group was intrigued. The speaker, who looked very much the cliched British school marm, was an amazing teller of tales. We were all inspired and connected to her stories from the very beginning. After the lecture, we – from various countries, cultures and experiences – exchanged our thoughts and questions. Though perhaps in an indirect way, the evening very much reminded me of being a part of the DGH community: thoughtful exchanges and discoveries, meaningful and concrete projects, inspiring, exhausting, energizing and yes – fun times, respect and a sense of community and belonging. The discussions brought to mind the many ways that people with different skills and backgrounds can come together in working towards a common goal founded on values of social justice. DGH, as clearly stated in its mission statement is dedicated "to improv(ing) health and foster(ing) other human rights with those most in need by accompanying communities, while educating and inspiring others to action." To carry out its mission, DGH also recognizes the importance of education, economic well-being, environmental safety and human rights as fundamental to health care. To this end, DGH invites and embraces people from all walks of life: students, retirees, medical and health related professionals as well as lawyers,

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Human Rights around the World

NAFTA Taught Us The TPP Will Be Bad for Health

By Linda Sharp

The North American Free Trade Agreement (NAFTA), which turns twenty this year, has not lived up to its rhetoric. It was supposed to increase economic activity, spur American purchases of Canadian and Mexican goods and raise the wages of workers in all three countries. Instead, NAFTA has left a legacy of vast health and social inequities. In spite of these negative effects, governments and corporations are rapidly and secretly moving forward with an even wider-reaching trade agreement called the Trans-Pacific Partnership (TPP). Currently under negotiation between 12 countries (Australia, Brunei, Chile, Canada, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, Vietnam and the US), the TPP has been called "NAFTA on steroids" and a "corporate coup d'état." If passed, it will become the largest free trade agreement in the world, undermining public health efforts in environmental and occupational health, as well as the regulation of food and medicines. TPP proposals pave the way for new extremes of economic inequality, enable environmental destruction and allow for the deregulation of health and safety standards.

I am a doctor in a public hospital in South Los Angeles. I also work with DGH, in partnership with communities throughout the world, to promote health and human rights. Many of my patients in LA are migrants from Mexico and Central America, where the economic impact of free trade agreements has weakened the social fabric, causing more people to cross borders to find work. Under NAFTA, over one million small farmers in Mexico have been forced off their land and migration to the US has doubled as these displaced workers seek a new way of life.

Powerless in the face of global economic treaties, thousands of migrants die every year as they attempt to pass through increasingly militarized zones in order to earn a living. For those who do make it across the border, life remains difficult in the absence of health insurance, social security benefits or the protections of union membership. One such migrant, a man in his 40s, became my patient after months of pain through which he kept working, until one day it became unbearable. After I broke the news that he has metastatic cancer, he requested a pill he could take "so I can go back to work" to support his family on the other side of the border. Taking time off for cancer treatment was not a reality he could afford to entertain.

After working in this hospital for almost a decade, I see direct connections between the desperate state of health of many of my patients and the global economic policies that drive these health inequities. The WHO's Commission on Social Determinants of Health summarizes the issue: "Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies, and practices that tolerate or promote unfair distribution of and access to power, wealth, and other necessary social resources."

Another example of this is a young man in his 20s who came to my clinic suffering from chronic myelogenous leukemia (CML), a cancer of the bone marrow. His cancer is curable with imantinib, a medicine which, when produced generically, costs about $121 a month. However, he has to find a way to pay $7,666 a month because of current international patent agreements for this life-saving medication. Without it, he will die. Oncologists in the US have denounced the astronomical price of imantinib (about $92,000 a year) as unfair and unjust. And imantinib is not an isolated case: studies have shown that free trade agreements increase prices and limit access without the promised benefits of new products becoming available to the public. Under the TPP, which expands pharmaceutical patents and creates new drug monopolies, more patients' lives will be put in jeopardy as they struggle to pay outrageous prices. In short, *(Continued on page 6)*

Affordable Care Act: The View from Texas

By Elliot Trester

When I first moved to Texas in 1978 for my residency, I knew that I wasn't moving to the most progressive area of the US, but I didn't realize that I would be moving into what has become a bell weather for the conservative movement. Given that, I have an interesting view from Texas of the Patient Protection and Affordable Care Act (ACA), which has had a difficult birth. Passed by Congress in 2010, it was meant to decrease the outrageously high number of uninsured and help contain the incredible rise in health care costs.

Texas is a stellar example of the uninsured. We have hovered at about a 25% uninsured rate for the past several years while the overall rate in the country is near 16%. It is also interesting to look at the public health percentages: 28% of Texans who have insurance are covered by Medicaid and other local government programs while the average in the US is about 33%.

The roll out of the ACA's insurance exchanges on October 1st was, as everyone knows, quite a nightmare. One key element of the act is to have a Health Insurance Marketplace, which states can create and run themselves or have the federal government do it. Texas, in seeming contradiction to its state's rights rhetoric, opted to let the federal government run its marketplace. Part of this process involves navigators, and our Governor, Rick Perry, decided to have the Texas Department of Insurance (TDI) regulate the navigators to make the process for people more difficult (if he had known about the original problems with the web site, it might not have mattered that much). The TDI did come up with requirements for an extra 20 hours of training for some navigators, but that became a moot point since they had until May 1 to complete the training, but enrollment ended at the end of March for individuals.

The individual mandate is at the heart of the law, requiring Americans who can afford health insurance to purchase a policy or be *(Continued on page 7)*

Drones in Our Skies: Why We Should Care

By Ed Kinane

Weaponized unmanned drone aircraft – the Predator, the Reaper, the Global Hawk – have no crew on board; hence no head, no heart. These drones are amoral robots exquisitely designed to spy and to kill, to maim and to demolish. Out of the blue, their 500-pound bombs and Hellfire missiles strike like lightning bolts. And they too often fall on innocent civilians.

A report by Amnesty International (AI), "Will I Be Next? US Drone Strikes In Pakistan," gets its title from the eight-year-old granddaughter of a US drone strike victim, who said: "I wasn't scared of drones before, but now when they fly overhead I wonder, will I be next?" According to the report: "On a sunny afternoon in October 2012, 68-year-old Mamana Bibi was killed in a drone strike that appears to have been aimed directly at her. Her grandchildren recounted in painful detail to Amnesty International the moment when Mamana Bibi, who was gathering vegetables in the family fields in Ghundi Kala village, northwest Pakistan, was blasted into pieces before their eyes. Nearly a year later, Mamana Bibi's family has yet to receive any acknowledgment that it was the US that killed her, let alone justice or compensation for her death."

Stateside technicians piloting the drones see their human targets as through a soda straw. Their computer screen vision is severely constricted, compartmentalized. How could it be otherwise? Military training tells them to follow orders without question. Extensions of the drones, they too become robotized. Drone strikes are classified, anonymous. Often they defy investigation. Often the victims can be neither named nor counted. But we know drone strikes occur in Iraq, Afghanistan, Pakistan, Yemen, as well as in Muslim areas of Africa and the Philippines. We don't know if they are being used in other places as well. In executing non-combatants without judge or jury – without due process – the legality of these strikes is being challenged.

For example, the American Civil Liberties Union (ACLU) has filed a lawsuit challenging the government's targeted killing of three US citizens in drone strikes far from any armed conflict zone, as a violation of the Constitution's fundamental guarantee against the deprivation of life without due process of law. The ACLU has also filed Freedom of Information Act (FOIA) lawsuit demanding that the government disclose basic information about the use of drones to conduct targeted killings, including "the legal basis, scope, and limits on the targeted killing program; information pertaining to the training, supervision, oversight, or discipline of UAV operators and others involved in the decision to execute a targeted killing using a drone; and data about the number of civilians and non-civilians killed in drone strikes."

The ACLU position on these drone strikes is clear on its website: "Outside of armed conflict zones, the use of lethal force is strictly limited by international law and, when it comes to US citizens, the Constitution...The US continues to carry out illegal targeted killings in Pakistan, Yemen, Somalia, and elsewhere. The government must be held to account when it carries out such killings in violation of the Constitution and international law."

But why should we care? Out of self-interest – whether narrowly or broadly defined – if nothing else. The resentment generated by drone strikes triggers blowback. The world is not made safer. As reported by Jordan Michael Smith in *Salon*, "Drone 'Blowback' Is Real," September 5, 2012, an article published in the *Middle East Policy Journal* "looks at Yemen and concludes that increased drone strikes 'will produce distinct forms of blowback,' the CIA-coined term describing the unintended actions that harm America resulting from US policies... Written by three scholars at the University of Arizona, 'Drone Warfare in Yemen' finds five distinct forms of blowback: Attacks on American targets such as the 2009 Khost bombing of a CIA Camp; increased ability of Al Qaeda to recruit new members, particularly those who had loved ones killed in drone attacks; decreased US accountability, resulting from control of the drone program oscillating between the CIA and Joint Chiefs of Staff; continued destabilization of Yemen; and an increasingly precarious alliance between the American and Yemeni governments."

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Reflections on Health and Human Rights from Israel

By Nir Ben-Shlomo

The bus lurched to a stop after the roundabout, emptying all its passengers onto the sidewalk – from this point public transportation would go no further. Jerusalem's Old City lay 15 minutes behind and the hilltops of Bethlehem should have been visible, but all I could see was a sinister amalgam of concrete and barbed wire. The winter sky was gray, the wall even grayer, and there was an ominous feeling in the air.

As an Israeli citizen growing up in America, every prior visit I had made to Israel had been about visiting family and friends, enjoying delicious food, exploring religious and cultural sites, and studying the nuances of Israeli life. This trip I had the privilege of showing a few friends around for a couple weeks and they had expressed interest in seeing the West Bank, to look beyond what they had read in the news. At first I was hesitant, but in the end they convinced me to explore a different side of Israel. I had been teaching them some key Hebrew words and expressions, but as we stepped off the bus, our conversations switched exclusively to English.

As we approached the wall I couldn't help thinking to myself that only about 5% of the Security Fence separating Israel and the West Bank is a concrete wall like this one, the rest is little more than a guard fence, but the ominous power before me was nonetheless unsettling. The Security Fence was sanctioned by the Israeli Government under Prime Minister Ariel Sharon to quell the rate of suicide bombings carried out against Israelis during the second Intifada.

According to the Israeli Ministry of Defense the fence "deeply affected the ability of terrorists to carry out attacks" and in the year after construction began, the number of Israelis killed by terror attacks dropped by 84%. I was quite familiar with this statistic and had employed it in debates back in the states. Many discussions with friends and

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Non-Medical Volunteers

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teachers, anthropologists, agriculturalists, IT experts, generalists, artists – the list goes on! What strikes me as a non-medical person is that people in DGH can actively participate in the organization's work to promote health care and social justice, and be valued – a factor that is not necessarily true of many health oriented humanitarian organizations.

When I asked Alfredo Mela, urban sociology professor in Turin, Italy why he became an active member of DGH, he replied, "I think there is a strict complementarity between physical health, psychological welfare and social improvement, as well as in human rights promotion, and I see that DGH is willing to guarantee all these goals in its interventions, not only as a theoretical approach but also in practice." To that end, he volunteers time in partner communities in El Salvador and Mexico and is also part of the ongoing effort to develop the DGH network via DGH Europe.

Shirley Novak, a DGH board member and active volunteer from the organization's earliest days, adds that "within DGH, we believe that for social justice to exist, we need to consider the person as a whole... Art, music, justice, food, shelter, education... Just like a multitude of systems is needed to make one healthy, DGH needs a cadre of individuals from each of these systems, each contributing her/his own talents to contribute to the struggle to create a healthy world. No more, no less. All are needed and welcome. Why am I part of DGH? No, I am not a member of the medical healing community, but indeed my skills as a teacher and community organizer certainly add to the mix of what makes – and keeps – people and communities healthy." In an article about Liberation Medicine, editor and longtime DGH member Monica Sanchez writes, "upon hearing the term for the first time my mind immediately extrapolated the concept to my own profession," adding that by doing so, "it proves that anyone can use their own field of expertise to help others and to make this a better world." Monica gives a concrete example: "I do my best to support the promotion of health and human rights by volunteering with a non-profit organization called Doctors for Global Health, producing their newsletter and PR materials. Thus, you could say I am practicing Liberation Editing."

> **"Just like a multitude of systems is needed to make one healthy, DGH needs a cadre of individuals from each of these systems, each contributing her/his own talents to contribute to the struggle to create a healthy world."**

My own introduction to DGH presented itself when I worked at a well known humanitarian organization based in France. Dr. Lanny Smith, DGH founder, first president and a writer, sincerely convinced me to become involved with DGH in explaining that there is a definite and welcome place for non-medical people to participate and volunteer. In becoming a member of DGH, I came to find a local and global community where I could develop that belief in a realm where I had organizational experience. After attending several General Assemblies, I became more involved by becoming a judge in a DGH photo contest and later the organization's first video contest. Now as a board member, I am helping to extend and develop the DGH base in Europe alongside volunteers from France, Italy, Spain and Switzerland.

When thinking of non-medical individuals becoming involved with DGH, I can't help but remember Jean Michel who contributed the use of his lovely Parisian gallery and donated wine for the first DGH Europe event along with artists who have donated paintings, photos, sculptures to raise funds for our projects. There are lawyers who have cleared up legal situations, translators who tirelessly volunteer at our annual meetings, IT experts who help us develop and keep up to date on ever changing digital updates, accountants and managements professionals who help keep us on the right financial path, etc. Truly, this is a Community. The list of contributors and pragmatic,creative ideas they bring to DGH are ongoing and amazing! And I'm happy to say that I was able to interest some of the guests at the aforementioned meeting, who include professional story tellers, actors and journalists, to learn about and hopefully join DGH!

NAFTA

(*Continued from page 4)*

TPP proposals threaten the health of millions, especially the poor and marginalized.

In addition, NAFTA was promised to create tens of thousands of jobs in the US. The reality is that over one million net US jobs have been lost, and some of the hardest-hit areas, such as Detroit, have literally collapsed under the pressure. Without a way to make a living, poverty increases and health deteriorates. The TPP threatens more of the same.

We need to understand that economic policies in trade agreements like NAFTA and TPP have human consequences that make them public health and human rights issues. In 1978, the World Health Organization (WHO) declared, "The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

DGH joins many other human rights and health groups in demanding that health equity and human rights be considered fundamental priorities for the TPP and all trade agreements. Specifically, all proposals should be required to provide a health impact assessment, and all proposals that interfere with public health or that are in conflict with basic human rights must be removed. No pharmaceutical regulations that limit the ability to enact best practices in medical and public health policies should be allowed. And negotiations must be made available for public scrutiny and a way created for the democratic voice of those affected to have a vote in the negotiations.

The good news is there are solutions to global economic governance that do not involve the erosion of democracy and human rights. For example, the Bolivarian People's Trade Treaty of South America is an international trade cooperative that emphasizes the values of solidarity, complementarity, justice and cooperation. It can be done, but we have to demand it.

Affordable Care Act

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fined. For 2014, the fine is $95 or 1% of your income (whichever is higher), then in 2015, $325 or 2% and finally, in 2016, $695 or 2.5%. There are approximately 24 million Americans who are exempt, including certain religious groups, Native American tribes, undocumented immigrants, people in jail, and people whose incomes are below 133% of the Federal Poverty Level ($15, 521 for an individual in 2014) since they don't file taxes.

The most problematic group, however, may be the 18-34 year olds. This group is being called the young invincibles because they believe nothing can happen to them and thus they do not need health insurance (check out the web site *www.younginvincibles.org*). The ACA needs them to sign up, however, so that more young, healthy people are in the risk pool bringing costs down, and so they are covered for any unforeseen emergency, like appendectomy or accidental trauma. Unfortunately, for some of these young adults, insurance may still be unaffordable.

The Kaiser Family Foundation (*www.kff.org*) estimates that there are 29 million people eligible for coverage and 17 million who will qualify for subsidies. But to add another Texan twist, our governor and legislators have decided that we will opt out of the expanded Medicaid coverage that the federal government will fund at 100% for the next three years, going down to 90% by 2020. A large majority of Texans are in favor of this Medicaid expansion (*www.texasleftmeout.org*). Four in ten Blacks fall into the Medicaid expansion criteria for income as do 1 in 4 Hispanics, leaving a lot of racial inequity in insurance coverage in my state.

Certainly, health care has been in disarray in the US for the past several decades. We spend a lot more money and have worse outcomes than countries that have universal coverage systems. The ACA was a good effort, but it is clear that a plan that starts off with needing to have "navigators" to help people sign up for insurance is a troubled program. It is also clear to me that insurance companies were worried that their egregious ways would finally be penalized somehow, so they made some concessions like increasing the age kids can be covered under their parents insurance to 26, not excluding preexisting conditions, covering preventive care with no copays, and having no annual limits on benefits. They did not promise affordable care, and they are not giving it, though government subsidies will help more people afford health insurance.

Considering how difficult it was to get the ACA written and passed, it seems unlikely that a single payer system could have made it through Congress. However, with the help of Texas and what I believe will be the discontent of many Americans, the stage may be set for a more reasonable approach to universal coverage. Ask me – and million of others – if they are happy with their Medicare and the answer will be a resounding "YES!" DGH supports an expanded Medicare for All. Learn more at (*www.dghonline.org/news/dgh-position-statement-nationalized-health-care-us* and at Physicians for National Health Program (*www.pnhp.org*).

Drones: Why We Should Care

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Chickens are coming home to roost in more ways than blowback. With billions in contracts and research grants, the US drone industry is burgeoning and busy lobbying. According to an article in *TruthOut* by Candice Bernd, "The Coming Domestic Drone Wars," September 2013, "In just a couple of years, the Federal Aviation Administration (FAA) estimates, thousands of civilian unmanned aerial vehicles (UAVs) could be operating in US skies as the administration continues to integrate drone technology into the National Airspace System (NAS) to comply with a federal law enacted last year. The FAA Modernization and Reform Act of 2012 mandates that the FAA draw a comprehensive plan to define the standards of operation, certification, registration and other regulations of domestic unmanned systems to accelerate the systems' integration into US skies. Presently, most types of UAVs largely are controlled and used by the US military."

Police and intelligence agencies drool at the prospect of using these toys – initially unweaponized – here at home. As William M. Welch reported in *USA Today,* "At Nation's Doorstep, Police Drones Are Flying," January 28, 2014: "Tijuana police recently purchased three specially configured commercial drones and are testing their use in flight... The Mexican drones are far smaller than the large military Predator drones the US Customs and Border Patrol agency has deployed along the border... A recent report by the Electronic Frontier Foundation said the Border Patrol flew 687 surveillance missions on behalf of other agencies, some of them police, from 2010 to 2012. While the US develops its drone laws, the experiment on its doorstep offers a glimpse of how domestic police could soon use the technology if permitted. Tijuana's drones are off-the-shelf commercial units... They are equipped with video cameras and night-vision capability."

The FBI has already admitted to using surveillance drones over US soil. As *The Guardian* reported on June 19, 2013, "Speaking in a hearing mainly about telephone data collection, the bureau's director, Robert Mueller, said it used drones to aid its investigations in a 'very, very minimal way, very seldom.' However, the potential for growing drone use either in the US, or involving US citizens abroad, is an increasingly charged issue in Congress, and the FBI acknowledged there may need to be legal restrictions placed on their use to protect privacy."

The ACLU is also concerned with the use of drones by police here at home: "US law enforcement is greatly expanding its use of domestic drones for surveillance. Routine aerial surveillance would profoundly change the character of public life in America. Rules must be put in place to ensure that we can enjoy the benefits of this new technology without bringing us closer to a 'surveillance society' in which our every move is monitored, tracked, recorded, and scrutinized by the government. Drone manufacturers are also considering offering police the option of arming these remote-controlled aircraft with (nonlethal for now) weapons like rubber bullets, Tasers, and tear gas."

– Ed works with Upstate Drone Action to expose and indict US Reaper drone attacks. Check out www.upstatedroneaction.org.

From Israel (*Continued from page 5)*

family who served in the Israeli Defense Forces (IDF) left me certain that the Israeli army does its best to minimize conflict and does only what is absolutely necessary for national security. But now, crossing the wall in person was the first time I began to comprehend the repercussions that stretched far beyond security. Seeing this barrier – so blatantly separating the two populations – shook my resolve. The wall directly impedes residents of nearby towns from making the short commute to Jerusalem to get to daily work, social or religious gatherings, schools, and health care facilities. According to a study by the Johns Hopkins University Center of Refugee and Disaster Response, "distances and travel times to health facilities increased since construction of the barrier by factors of 1.5 and 2.5 time."

This extended transit time can mean the difference between life and death in an emergent situation. The IDF is aware of this but there have been cases of ambulances used to smuggle weapons, so medical personnel and response vehicles are not exempt from the checkpoint searches and restrictions. The many impediments to free movement also impair the ability of West Bank hospitals to function properly. The checkpoints delay staff on their way to work and make it difficult for Palestinian medical professionals to undergo training in Israeli hospitals.

Once on the other side of the wall, my friends and I met with a Human Rights Activist and Biology Professor to hear the perspective of a community intellectual on the issue. He took us through the town of Bethlehem and showed us streets that once boasted a hustle and bustle of the city center. Now all that was left was a cluster of dilapidated buildings and closed shops – the looming shadow of the wall made the area much less inviting, forcing many out of business.

The electricity cut out mid-sentence during our tour, but our guide politely informed us these outages have become an everyday occurrence. I wondered how medical services would respond to a power outage. Once back on familiar streets we sat at a café in the Old City to digest the experience, and I remember my thoughts were as "upside down" as the latte on the menu.

In a 2002 statement, DGH calls upon "the Palestinian authority to clearly reject suicide bombings and other acts of violence" and on the IDF to "establish guidelines that will allow Israel to maintain security and meet its obligations under international humanitarian law, so the needs of a medically-distressed population are not compromised, and individuals are able to reach appropriate medical services." (*www.dghonline.org/news/statement-israeli-palestinian-conflict*)

I will continue to defend my friends and family in Israel, and I will continue to love Israel and all it has to offer. Yet this visit has left me questioning my deep-seated convictions – for which I am grateful. Although it may be more comfortable to blindly defend our beliefs, we are only forced to define them when they are put into question. This trip was about seeking the truth and expanding my horizons, and now I cannot help but feel like I sit with my feet on both sides of the fence.

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The DGH 2014 General Assembly will be held August 1-3 in San Cristobal, Mexico.

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