



Doctors for Global Health Reporter

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TWO MONTHS IN THE "PEARL OF AFRICA"

By Shirley Novak

As the first month as a DGH volunteer in Mbarara, Uganda, was coming to a close, I had already begun to view the trip as a true privilege, living in a different part of the world with the opportunity to experience the rich African culture I had known previously only from a distance. My husband, Dr. Larry Novak, and I would have yet another month in which to learn, to share and to be stretched.

For years I had been exposed to lives lived in poverty in El Salvador, and now the poverty of Ugandans was in front of me. Both groups of people work very hard, live quite simple lives, have very little, and yet all are very willing to share whatever they have available. It is this generous,

warm, loving spirit that I had quickly grown to love and admire over the many years of working in solidarity with the people of El Salvador. In Mbarara, I found a great similarity in the Ugandans I encountered.

Within a few days of our arrival, I was struck by how comparable life in small Ugandan communities was to

what I had known in El Salvador. Familiar sights were latrines positioned behind simple brick and adobe houses; dare-devil-like drivers maneuvering on pot-holed and often unpaved roads; cows rambling in and alongside the roads; people of all ages balancing goods on their heads as they walk beside the roads; bicycles loaded down as wide as the bike is long with bananas, cooking oil, milk cans and building supplies. And all over the country too are advertisements for Coca Cola, Close-Up toothpaste, Kiwi Shoe Polish and Shell.

Two months can seem like an eternity or an inadequate amount of time to really know a situation or community. While my husband volunteered at the Hospital and Medical School, I

was able to tap into many resources that afforded me—a non-physician DGH volunteer—the opportunity to engage in a variety of experiences in Mbarara.

DGH has been accompanying the Mbarara University of Science and Technology School of Medicine (MUST) in Uganda for over three years. A small country in Eastern Africa, Uganda is surrounded by the much larger nations of Sudan, Ethiopia and the Democratic Republic of Congo (formerly Zaire). Mbarara University was founded twelve years ago with the express purpose of promoting Community Health, and bringing responsible health care into rural

“For years I had been exposed to lives lived in poverty in El Salvador, and now the poverty of Ugandans was in front of me. Both groups of people work very hard, live quite simple lives, have very little, and yet all are very willing to share whatever they have available.”



areas. This fits perfectly with DGH's focus. We have been sending medical volunteers to help teach students at MUST, which is located in an area of Uganda where it is difficult to recruit and retain physicians. DGH has recently lent support to three Ugandan physicians who are committed to bringing health care to rural Uganda. These doctors will help train other Ugandan students in the Community-based Primary Health Care approach after their training ends.

My volunteer time at MUST included assisting in weekly "Introduction to Computers" classes. I was also invited to accompany a group of nursing students and their instructor to a presentation of music and traditional dance by a local community AIDS education and support group, TASO (Task Force on AIDS Support Organization). This provided a great opportunity for listening, learning and interaction. All present came away with a better understanding of the disease and its effect on the community. TASO takes the message of HIV/AIDS prevention into rural communities, reaching many young people whose isolation and inability to attend school might otherwise prevent them from receiving some important personal and public health information.

Part of my volunteer time in Mbarara was spent accompanying the staff of Hospice Uganda, at its second site in Mbarara (the first located in Kampala, the capital). I had the opportunity to spend a day on the road with one of the nurses, Martha, on the

Mobile Hospice Uganda unit. Every Wednesday a driver and nurse venture out in a land rover on a regular route that takes most of the day. The vehicle pulls off to the side of the road at various trading centers (a series of long, low houses and stores strung together every ten minutes or so along the roadway, often with open air markets in front). The waiting patients climb into the back seat of the land rover in turn, engage in a brief consultation with the nurse, after which medications are handed out. Those who can afford to pay do, often in the form of a live chicken, a bag of avocados or a bunch of *matooke* (hard, green bananas). No one is denied medicine for lack of payment. Regular weekly clinics are scheduled at the Mbarara site, and a full day, once-a-month daycare program is offered for patients, caregivers and/or family members. Besides clinic checkups, support group meetings, socialization, games, activities, and lunch, the day provides a break for the principal caregivers at home.

Uganda's reality is that many infected with HIV resist testing that would confirm or deny their suspicions. A social stigma still accompanies the disease and, up to now, there has been little affordable medicine available for treatment. Thus, there is little incentive to be tested. People with cancer have similar problems. Screenings, like pap tests and mammograms, a routine part of preventative health care in developed countries, are just not routinely available in Uganda. By the time a diagnosis is made, many diseases are in the final stages. Radiation and Chemotherapy treatments are generally unavailable outside the capital (three hours away), but would be too expensive for most anyway. Therefore, as the work of Hospice is becoming more known in Mbarara, it is more common for patients at the hospital to be referred there for support.

Part of my volunteer time was also spent at Primary 1 and Nursery school classes. There the teachers were most interested in learning about schools in the US and in having me teach their students new songs. No books, educational manipulative toys or materials were to be seen. Each child brought a small exercise book from home, and the teacher sharpened each chewed up pencil with a two-edged razor blade before handing it out. Armed with few resources, schools face a huge challenge in educating children eager to learn.

In Uganda, the government proudly offers free primary education to the first four children in every family. Yet at the Uganda Martyrs Primary School, the head master, Betunga Deus, shared this reality: Education is free in rural areas where school communities need not pay for non-existent piped water or electricity; town and city families must pay a fee to subsidize these basic services. The government goal of 1 teacher to 55 students, still waits; this school's reality is 1 to 80. In some rural schools, I was told a teacher could face a classroom with as many as 150 children. Currently there is an average of 1 book for every 5 students (the official national goal is 1 to 3).

In addition, my time there helped strengthen the connection between DGH and the Department of Community Health at MUST. The Chair of the Department of Community Health, Dr. Jerome Kabakyenga, and Gad Ruzaaza, Administrator of Community Based Medical Education and coordinator for its course specific to fourth year medical students, invited us to participate in a required five-week Community Health lecture series for fourth year medical students. Here students learned about the structure of rural Ugandan communities, how food production

“It was an emotional experience for me when the children in each class stood up to greet me as I entered their classrooms. “Good Morning, Madam,” was followed by their singing to me the songs I had taught them during the previous visits.”



Dr. Larry Novak preparing materials for a health talk at outdoor immunization clinic.

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Beneath a Nicaraguan Volcano

By George Pauk, MD

Five of us crowded into a very small car and were off to one of the most beautiful spots in Nicaragua, the *Isla de Ometepe*. The island in Lake Nicaragua consists of two huge inactive volcanoes with farms and small villages that have sprung around their fringe. Clouds constantly bathe the tops of the inactive twin volcanoes that tower above the villages.

We were on our way to visit the farmer's cooperative (*Union Cooperativa de Alejandro Smith: Asociación de Pequeños Productores de Granos Basicos*) in Myogalpa, a town on the island. DGH had donated money to the Cooperative, which serves many of the families of Myogalpa and the other smaller villages of the island.

Lake Nicaragua is not a sea, but with its massive size and reputation as the only lake in the world that is home to sharks, it certainly seems like one. At Rivas we got on the boat with returning locals and watched the freight being loaded by a line of incredibly fast workers into the hold below our feet.

There are no front-end loaders or belt conveyers. To secure a line to the pilings a crewman jumps and swims the heavy line to the piling. We splashed through rough seas for an hour to reach the village of Myogalpa on Ometepe Island, enjoying getting soaked by the splashing water.

The Cooperative recently bought a large old building in town. Huge trees, mango and other fruit bearers, surround the building and attract flocks of birds. The building is undergoing extensive restoration and remodeling. A new reservoir tank is installed to provide a steady water supply. The leaders of the Cooperative made plans for the next steps to replace the front adobe wall with cement blocks and make offices on the second floor. The old wood beams and braces will remain in parts of the building. We slept in unfinished rooms and were treated to private bathrooms. The Cooperative hopes that these rooms will attract the tourists that come to the island and provide some cash flow.

Music played most of the night from a band at a home a few doors down. A matriarch of the island, a lady over 100 years of age, had died and she had requested music for the people. Nevertheless, we slept well and it is comfortable to hear the night sounds. In the villages, cities or countryside, it is routine to hear roosters periodically throughout the night trying to be the first to anticipate dawn. Pigs grunt, geckos click, and birds have night conversations. And dawn is not a time to be in bed. The activity of life starts early and loudly.

A custodian family with charming young children lives in one part of the building and cooked meals for us. After breakfast, students and teachers began appearing for the special Saturday classes. One busy classroom has chairs, tables and manual typewriters provided by DGH. The teacher and her students industriously pounded the keys and enjoyed our intrusions to get photographs. It is good news that soon after the Cooperative typing school started, the public school added its first typing classroom. We donated an old laptop and perhaps it will soon give the students a chance to put their typing skills to new use.

One of the Cooperative Directors, a very dedicated community leader, took us to visit the small local hospital. He sketched out an idea that is one of the highest concerns of the members of the Cooperative. Medicines are so costly for the economically poor people of Nicaragua that usually a prescription is not

filled. After the Sandinistas lost the election in 1990, a dual system of privilege was reinstated, just as there is in the USA. Patients without "insurance" may get medicine for conditions such as diabetes or hypertension while hospitalized, but then go home without continuing medication. There are also stories of "free" or donated medicines being sold.

The Cooperative Director is eager to have a supply of medications to be dispensed from the Cooperative. At the hospital we were welcomed and given a tour by the physician Director. There are many needs for patient care such as specialist consultation. A new X-ray machine is not used apparently for lack of technical assistance. The Director of the hospital was very enthusiastic about potential interaction with DGH volunteers.

The next day we used an old truck to pick up the children in their villages along the way to a beautiful beach. We carried melons and papayas through the jungle along the edge of the beach to an even more beautiful and isolated site. Monkeys watched us pass on the trail. The swimming was delightful. As customary, at first the boys and girls remained separate in their groups. Then suddenly, a soccer ball tossed into the water became a game of "keep away." The children had tremendous and vigorous fun with the game. Boys caught holding the ball were tickled out of their senses, and the ball was wrestled away. The game went on for over an hour.

On the boat back to the mainland we watched rainbows arc over the 5,000 foot high volcanoes of the beautiful island. Volunteering with Doctors for Global Health is definitely a mixture of exposure to extreme needs and the sublime.



REHABILITATION IN EL SALVADOR

By Brenda Hubbard

Sixteen-year-old Isabel Gamez had a baby boy. She was rushed to the hospital five weeks before her due date, had a cesarean and was released two days later. Less than a week after returning to her home in Santa Marta, not even healed from her surgery, she was on an old bus, bumping and bouncing, to take her new born to the hospital. He was suffering from his first bout of respiratory illness.

This is all too common in our repopulated communities. Every month I hear of a baby born with either congenital heart disease or weak lungs, prone to respiratory disease, or even malformation. Every month in our *Centro de Rehabilitación*, health promoter René Beltran treats newborn babies for respiratory illness. Why? For a population that does not reach 5,000 in our five communities, the statistics are overwhelming.

According to the Rector of the Jesuit Central American University, 75% of El Salvador is impoverished. One half of those live in extreme poverty. There is no work, no jobs. The Ministry of Education is spending 1.5% of its budget on education, mostly primary education. Sixty out of 100 children enrolled in the 1st grade will reach 6th grade. Only 20 will complete high school, and only four will receive some kind of professional certificate, most likely not from a university.

This means that the government of El Salvador is educating an entire generation with only enough skills to enable them to work in the *maquilas*, the sweat shops.

Our rehabilitation center is located in the Cantón of Santa Marta, in the department of Cabañas, in the northern mountains just east of the center of El Salvador, where the Rio Lempa borders Honduras. There are five communities here that have been repopulated by the same people who were driven from their homes by the military during violent government repression in 1981. These people, after losing everything, lived in refugee

camp in Honduras for up to ten years. When they returned to the land where their umbilical chords are buried, war was still raging in their mountains. Their lands had been raped of their trees by men friendly with the government, who sold the wood for profit. They returned to nothing and with nothing. Survival dictated that they cut trees to get shelter over their families' heads.

People work the lands, farming for their basic food needs: corn and beans. In the 70's pesticides were introduced and now people do not believe they can grow their food crops without these toxic poisons. Twelve-year-olds can hop on a bus or cattle truck, go to the *agroservicio*

store in Sensuntepeque, capital of Cabañas, and buy the most toxic agrochemicals imaginable. These same children, with no protection, are sent to work spraying the poisons.

Often these young boys are the heads of their households and have to do the *milpa* (plant the corn fields) with only the help of their younger brothers and sisters. These small children are sent to the *milpa* to haul water so their fathers or older

brothers can mix the poisons. They are there while the poisons are being sprayed.

The entire population is exposed to these deadly poisons. We breathe them in regardless whether we work the lands or not, because we are surrounded by agricultural lands.

To make matters worse, the poisons are not working as well as they used to. There seems to be resistance building in the weeds. So now they mix several of the herbicides together. This is not something people are receiving any formal training in. They simply buy the poisons and experiment, hoping these combinations will give them the effect they need.

Meanwhile, the Santa Marta Clinic, our *Centro de Rehabilitación* and even the Hospital in Sensuntepeque, are attending daily to our community members with acute respiratory disease.

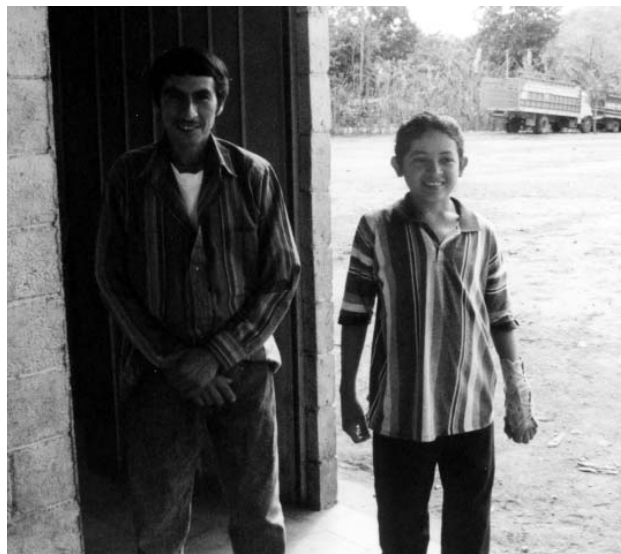
DGH volunteer Masaya Koto, who has a degree in Public Health, came to Santa Marta to do a qualitative investigation of pesticide use and abuse. This is very exciting for us and a long time in coming. It is tragic that the government of El Salvador has shown no will to improve these environmental health hazards. There are several very active non-governmental environmental agencies advocating to bring change at a governmental level, but their efforts fall on deaf ears. So it is up to us to do these studies and support their efforts.

Other environmental health hazards we face include the animals that run loose in our communities. Of course, everyone has to have a pig or two, some goats, perhaps a cow and even horses. The animal feces is a huge contributor to our critical health concerns. To add to that, there has been no plan for the garbage since folks first returned here in 1987, so we are now living on top of a garbage dump.

An Environmental Health proposal has been developed by the local NGO I volunteer with, ADES (*Asociación de Desarrollo Económico*), but has yet to find funding. They are making efforts to implement the basics for treating garbage. They have been working with youth in our communities who have identified the garbage crisis as the most urgent problem we need to confront.

The youth in our communities are beginning to

“ A 12-year-old can buy the most toxic agrochemicals imaginable. These same children, with no protection, are sent to work spraying the poisons. ”



Health promoter, René Beltran, with a young patient in front of the *Centro de Rehabilitación* in Santa Marta, El Salvador.

DGH Through the Years: Los Chavalitos in Nicaragua



Photo taken by DGH Board member, Lanny Smith, July 1999



Photo taken by DGH Board member, Monica Sanchez, September 2001

organize and have a voice. Extremely intelligent, they are identifying the roots of our health problems. They hold the future of our community development in their young hands and have the energy to work towards improving living conditions. Our biggest challenge is providing them with adequate health care. With all the environmental health hazards, their immune systems are constantly working overtime. If the roots of our health problems are not confronted we will never improve the quality of health and peoples lives. If children can't receive an education because of their poor health, their standard of living can never improve.

For many years we have concentrated on the curative aspect of health. Now it is time to make preventative medicine a priority. Do we merely put Band-Aids on our health problems, as the Ministry of Health continues to do? Or do we also start implementing preventative measures to improve the health standards of the community as a whole?

Our *Centro de Rehabilitación* has not closed it's doors because of lack of funding in three years. We are grateful to DGH for its economic support and for sustaining our stock of medication for our nebulizer (machine that allows patients to inhale medicated liquid into their lungs). The money our health promoter, René, earns in our little rehab center has enabled him to have a dignified house for his family and also provides a service for the community that reaches people who would never otherwise receive physical therapy.

Another international NGO just finished an integrated health project in Santa Marta. They built latrines, are reforesting a small area and brought water to the houses in the communities of Santa Marta and Valle Nuevo.

DGH has also contributed to water being piped into the Center and a *pila* (cement tub that holds water) that is being built. At long last our rehab center is going to have water. In the 10 years I have been working here, this will be the first time we have an indoor water supply.

Three years ago the community of Santa Marta made a decision to hand over responsibility of its clinic to the Ministry of Health (separate from the rehab center). It has been difficult to say the least. A short while back the director of the clinic is a young woman doctor who is doing her *año social* (year of community residency), with absolutely no supervision. Not long ago antibiotics came close to their expiration date and, instead of returning them to the Ministry of Health, the doctor chose to hand them out to school children with runny noses simply to use

“ The youth in our communities are beginning to organize and have a voice. They hold the future of our community development in their young hands and have the energy to work towards improving living conditions. ”

them up. Health promoters and a few mothers reported this. The director of ADES and I went and met with her to confront this abuse of antibiotics and also prevent further abuse. The doctor was quite upset until we explained that we did not feel it was her fault. She should never have been expected to do her residency under such extreme conditions with no professional supervision. Witness to the abuse of antibiotics were DGH volunteers Bina Patel and Becky Blankenburg, who spent a month with us last year before beginning their residency in the US.

Another DGH volunteer we are very grateful for is the vibrant and brilliant Denise Zwalen, PA, MPH. She spent three months with us during those first difficult months of the earthquakes (January–April 2001), and now has returned for another six months here. Denise is an angel sent to us to provide health care to the community, work in the clinic and befriend our health promoters. Denise worked with our promoters in health brigades that went to earthquake-affected villages and attended those who were so sick. She also organized several activities and outings with the health promoters.

– Brenda, a physical therapist from Oregon, opened the rehab center ten years ago. She has funded it, in part, by working as a translator and guide to groups visiting El Salvador. 🐦

Human Rights around the World

NIGERIA

By Owens Wiwa, MD

Rapid globalization exposes indigenous communities like the Ogoni in the Niger Delta of Nigeria to social, economic and health risks. Many of the health risks, though avoidable, are overlooked by the government, corporate agents and, until recently, health activists. These risks are associated with the activities of transnational corporations (TCs), the engines of the globalization train. These engines could be seen as vectors of diseases. I believe that as public health activists, we have a responsibility to analyze the processes of these engines, sanitize them, or suggest ways they can be cleaned. We can also assist the communities in getting well by making sure that the TCs put part of their profit into cleaning up the environment. In many cases, we must insist that they leave the area.

A vivid example of a TC as a vector of disease is the case of Shell in Ogoni. The Ogoni people number approximately 500,000 and inhabit a 404-square-mile-area in the Niger Delta in Nigeria. They are considered a small minority of the Nigerian population.

Since 1958, \$30 billion worth of oil has been taken from Ogoniland. When the World Council of Churches sent observers to Ogoniland in 1995, they found no piped water supplies, no good roads, no electricity, no telephones and no proper health care facilities despite the wealth of oil obtained from their land. Overall, the Gross Domestic Product per capita has been reduced since the start of oil drilling in Ogoniland.

Royal Dutch Shell is the tenth largest corporation in the world and number one in profits. Shell has ninety-six oil production wells in Ogoniland Nigeria, five flow stations (large pumping stations), and numerous gas flares, which have operated continuously for thirty-five years. In addition, Shell maintains many above ground high-pressure oil pipelines crisscrossing Ogoniland, carrying oil from other parts of Nigeria to shipping terminals. Between 1976 and 1980 alone, Shell operations caused 784 separate oil spills in Nigeria. Frequent spills are still occurring due to poor engineering and maintenance standards.

Shell admits to 3000 polluted sites affected by oil operations on

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COLOMBIA

By Harry Kelber

Since 1986, when the Colombian Labor Federation (CUT) was formed, 3,800 union activists have been murdered. None of their assassins has ever been prosecuted, a delegation of Steelworkers from the United States learned during a fact-finding visit in March, 2001. Yet the Colombian government, which tolerates these and other murders by right-wing paramilitary groups, is receiving \$1 billion in financial and military aid from the United States—ostensibly to cut cocaine production and drug trafficking.

In fact, the Colombians are using much of the money to carry on their civil war against “leftist rebels” that began half a century ago.

On the second day of their visit to Colombia, the eight US unionists were informed at a CUT meeting that the president and vice-president of the mine workers’ union had been assassinated by right-wing gunmen while trying to negotiate a contract with the US-owned Drummond mining company. The two mine workers’

leaders were aware of death threats and had asked the mine managers for permission to stay in the plant overnight for their own safety. When Drummond officials refused their plea, they had to leave on a company bus with the workers.

Soon after, the bus was stopped by the paramilitarists, who seized the union president, Valmore Rodriguez, and shot him in the head as the terrified workers watched. Vice President Victor Orcasita was tied up, taken away and killed. “We found ourselves right in the middle of it,” said Glynda Williams, the coordinator of the Steelworkers’ delegation. “When we heard the news, we felt the terror and the sadness they felt. The courage of these people is incredible.” Some 1,200 miners went on strike at Drummond’s Loma mine in northern Colombia to protest the murder of their union leaders.

The nation’s unionized teachers have been among the hardest hit by right-wing military violence. In the past 15 years, CUT estimates that 418 teachers have been murdered. “We have teachers who are political prisoners in the country’s jails when their only crime had been to interpret the needs of the students and people,” said Tarsicio Muñoz, vice president of the teachers’ union.

The Steelworkers’ delegation met with four teachers who were on

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Did You Know?

The human costs of unfair trade are immense...When developing countries export to rich-country markets, they face tariff barriers that are four times higher than those encountered by rich countries. Those barriers cost them \$100 billion a year—twice as much as they receive in aid.

—“Rigged Rules and Double Standards,”
Oxfam, www.maketradefair.com.

BANGLADESH

By Kohinoor Yeasmin

The following are case histories of sex workers in the Goalondo Brothel.

MITU. Mitu was born in a very poor

family of a rural village of Kushtia District. Mitu was the firstborn of four children. Her father could not afford adequate food. As a result they often went hungry. Mitu's father died suddenly when she was 10 years old. Her mother was left with severe economic problems and her four children to feed. One day a female relative of her neighbor approached Mitu's mother and assured her she could arrange a good job for Mitu in Dhaka. Mitu's trusting mother agreed to hand over her daughter to the lady, who took Mitu with her.

What the woman did was take Mitu to the Goalonda Brothel and sell her to a woman leader (Mashi) of the brothel. At first, the Mashi let Mitu do some smaller jobs in the brothel in exchange for food. But Mitu realized the situation of the brothel and tried to escape several times in vain. Mashi beat her severely every time. Mitu spent several months this way. She had not had her first menstruation yet.

One day at noon, Mashi took Mitu to a room in the brothel where a male customer was waiting. Mashi told Mitu to take off all her clothes, but Mitu would not agree to do so. At one point both Mashi and the client took off all of Mitu's clothes. The client raped her with the active assistance of Mashi, who held Mitu down.

After the rape Mitu became very sick. She had heavy bleeding, urinary trouble and severe weakness for 12 days. Mashi arranged treatment for Mitu to protect her own interests. Since then Mitu has been working in this brothel as a professional sex worker. But her entire income is going to the pocket of Mashi. Whenever Mitu wants to leave the brothel, the Mashi asks for TK 20,000, claiming that she purchased Mitu for that amount. Mitu is now approximately 17 years old.

MOSHEDA. Morsheda is a 21-year-old sex-worker from the village Panchful of Trisaal Upazila under Mymensing district. Her family name was Helena. She is known as Morsheda in the brothel. She has two sisters and two brothers in her family at Trisaal, Mymensing.

Helena's father was a day laborer who provided for her family in hardship and lived from hand to mouth. When Helena was 14 years old, three unknown young people came to her village, rented a house and said they liked the village very much. They expressed their desire to marry in this village. They announced that they would marry without dowry. One day the young men went to Helena's house. One of them proposed to marry Helena and her parents were very pleased and accepted the proposal, but told the young man that they were unable to arrange the food and other materials for the marriage ceremony. The strangers gave them money to arrange the wedding. They were married that very night.

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UNITED STATES

By Amnesty International

In the two months following the September 11 attacks, more than 1,200 non-US nationals were taken

into custody in the USA, in nationwide sweeps for possible suspects. Partial data released by the government last November revealed that most were men of Arab or South Asian origin detained for immigration violations. Another 100 or so were charged with criminal offenses, none directly relating to the events of 11 September.

Six months on, some 300 people arrested in the post 9.11 sweeps are believed to remain in the custody of the Immigration and Naturalization Service (INS); an unknown number of others have been deported or released on bail, sometimes after months in custody. This report examines the circumstances of these detentions.

There continues to be a disturbing level of secrecy surrounding the detentions, which has made it difficult to monitor the situation. To date, the government has provided only limited data, which includes neither the names nor the places of detention of those held in post 9.11 INS custody, and immigration proceedings in many such cases have been ordered closed to public scrutiny. However, AI has gathered information from various sources, including a recent visit to two jails identified as housing detainees and extensive interviews with attorneys, detainees, relatives and former detainees.

AI's findings suggest that a significant number of detainees continue to be deprived of certain basic rights guaranteed under international law. These include the right to humane treatment, as well as rights essential to protection from arbitrary detention, such as the right to be informed of the reasons for the detention; to be able to challenge the lawfulness of the detention; to have prompt access to and assistance from a lawyer; and to the presumption of innocence.

According to immigration attorneys, many post 9.11 detainees have been charged with routine visa violations for which they would not normally be detained. While technically in INS custody, some

have been held for weeks or months pending security "clearance" by the Federal Bureau of Investigation (FBI), a process shrouded in secrecy. Lack of information given to detainees or their attorneys as to why they are being held has made it difficult for them effectively to challenge their detention.

AI recognizes that governments need to be vigilant in investigating potential "terrorist" links. However, the secrecy surrounding the current proceedings creates the potential for abuse.

There is also concern that the immigration system is being used to hold non-nationals on flimsy evidence pending broad criminal probes, without the safeguards which are present in the criminal justice system.

For example, unlike people detained in the context of criminal procedures, INS detainees have no right to court-appointed attorneys. Contrary to assertions made by Attorney General Ashcroft in Novem-

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Did You Know?

The IMF, the World Bank and most Northern governments are strong advocates of trade liberalism. In the case of the IMF and the WB, advocacy has been backed by loan conditions which require countries to reduce their trade barriers.

— "Rigged Rules and Double Standards,"
Oxfam, www.maketrade-fair.com.

Racial Equality: A Means to Good Health

Presented by Susan Moscou, Keynote Speaker at the DGH General Assembly, July 2001

I am a family nurse practitioner. I provide health care services to HIV/AIDS adults. I spend my time in the Bronx. Lanny Smith, colleague and friend, asked me to speak to you this morning about several topics near and dear to me: revolution, racial equality and health care. I feel truly honored to be asked to speak to you.

Sojourner Truth, was born (1798) into slavery in upstate New York, obtained her freedom (1827) and moved to NYC. Sojourner became a traveling preacher and developed a reputation as a powerful speaker. A turning point in her life occurred when she visited the Northampton Association in Massachusetts.

The members of this association included many leading Abolitionists and women's rights activists. Sojourner Truth discussed issues confronting Blacks and women. Sojourner refused to tolerate the indignities of Jim Crow segregation on street cars and had the Jim Crow car removed from the Washington, DC, system. She brought a local street to a standstill when a driver refused her passage and with the support of the crowd, forced the driver to take her.

Throughout her life, Sojourner challenged injustice whenever she saw it. She was an Abolitionist, women's rights activist, and a preacher—the kind I can live with.

For those of us involved in social justice struggles, we all have a little bit of Sojourner Truth in us—we bring the struggle to the people.

She was the first person to link the oppression of black slaves with the oppression of

women. Oppression, a powerful tool of an elite, creates unhealthy environments for all who experience oppression.

In the US, slavery ended in 1865, but the social vestiges remain. Women, Blacks, Latinos, Asians and other minorities still do not enjoy the wealth of this country or participate as equals. Most of my work and volunteer career has been in communities that lack adequate health services, livable housing stock, and good educational systems—the very social services necessary to grow up healthy in our society.

Call me naive, but I am still shocked that we continue to see these conditions and even more amazed that these communities are still blamed for their problems.

In America, the poverty rate for Whites is 11%; Blacks 32%; Hispanics 31%; Other 20%. The median family income for Whites is \$36,067; Blacks \$23,000; Hispanics \$22,033; Other \$27,000. Currently, we are a country of about 269 million people. However, 43 million of us are uninsured—that translates to 1 in 6 Americans. 1 in 3 Americans ages 18-64 are uninsured or have gaps in coverage. 26.2 million immigrants reside in the US, 9 million of them are uninsured. 1 million immigrant children are uninsured. (Kaiser Foundation statistics 1997-1999.)

What does it mean to lack health insurance? As practicing clinicians, we see the impact on a daily basis: treatable disease (asthma, diabetes, hypertension) get worse; children lack the requisite immunizations; patients delay care and utilize emergency rooms; patient care is fragmented; our precious prescriptions don't get filled; oral health gets ignored.

Prior to my current job, I worked with homeless families—baby bottle tooth decay was rampant. So were mental health problems (depression, anxiety, sadness) and lack of prenatal care (pregnant women are automatically eligible for Medicaid—they just don't know it).

So, knowing what we know—where do we, and I do

mean the collective we, fit into this scenario. What is our role? We are the health care professionals who work in the communities ignored by many in our society. We are not just the safety net providers—we are the providers of health care services to poor and remote communities. We are bringing a brand of health care services that our patients deserve, not just need. We have a unique vantage point—we understand and know oppression, we understand and know racial inequality, we understand and know how to fight for and struggle for social justice issues: A living wage (take heart, cities are passing laws); Access to quality health care (take heart, this struggle continues—think Physicians for a National Health Plan); Death penalty moratoriums (think Illinois and other states are following); Ending sweat shops and child labor (think unions and their need to take on international corporations).

We understand these realities. We are involved in many of these struggles and ones I have not mentioned. We know that we must advocate for and teach others to advocate for the very things that keep us strong, healthy and committed to ensuring equality for everyone.

Think of Stephen Biko, the South African political leader in the late 1960s. He entered the University of Natal in 1966 to study medicine. In 1972, he was expelled for his political activities—he was against the white-minority government of South Africa and its restrictive racial policies. Biko sought to liberate the minds of Africans. He argued that liberation grows out of “the realization by Blacks that the most potent weapon in the hands of the oppressor is the mind of the oppressed.” He was the founder of the black consciousness movement.

Stephen Biko was beaten to death in August 1977 by the police while in custody. Stephen Biko lives on in the consciousness of those who fight oppression.

If I understand the goals of Liberation Medicine and DGH, we must carry with us the collective memories of Sojourner Truth and Stephen Biko. Confront injustice, fight for racial equality and raise the consciousness of the oppressed and, if we can, of the oppressor.



Lanny Smith, Assistant Professor of Medicine in the Residency Programs of Primary Care and Social Medicine at Montefiore Medical Center, with residents at a health fair in the Bronx.

NIGERIA

(Continued from page 6)

Ogoni soil. According to the World Council of Churches, Shell has also admitted to flaring 1.1 billion cubic feet of natural gas each day for thirty-five years, causing acid rain and rain filled with fine particles of soot in the Niger delta. Observers sent by the World Council of Churches were shocked by the environmental abuses they witnessed. They wrote, "Having followed all the events in Ogoniland, reading all the reports and seeing the videos such as Drilling Fields and Delta Force, did not prepare us for the devastation we saw at the numerous spill sites we visited."

The impact of this practice on the Ogoni people has been a destroyed livelihood. In the early 90's, the life expectancy of the Ogoni people was 48 years, which was six years less than the Nigerian national average. The perception of the Ogoni people is that the processes involved in oil extraction is associated with the lowering of their quality of life and life expectancy.

Empirical data about the relationship between exposure to crude oil and population health is scant. However, observations from my experience as a physician in Ogoni for seven years and reports by other observers in the Niger Delta, agree with studies that have been done in other areas, such as Ecuador and the Sea Empress Spills in Britain, which document a rise in illnesses due to the oil extraction, including a rise in skin diseases, respiratory diseases (asthma and lung cancer), miscarriages, and more. Their right to health was violated.

In simple terms, Shell's practices deprived the Ogoni people of their basic human rights; of their economic, social and cultural rights. Furthermore, when the Ogonis complained of this deprivation, the corporation, using corrupt practices, seduced the military dictatorship of Nigeria to deprive the Ogonis of their civil and political rights and hundreds were arrested and tortured.

The Ogoni peoples' struggle against Shell received headlines on November 10, 1995 when the Nigerian dictatorship executed nine Ogoni environmental activists, including Ken Saro-Wiwa (my brother). Ken Saro-Wiwa was well-known in his homeland and internationally as a poet, essayist, environmentalist and community leader who served as the spokesperson for the Movement for the Survival of Ogoni People (MOSOP) until his death.

Sara-Wiwa had received the Goldman Environmental Prize for Africa in 1995 and the Right Livelihood Award in 1994 for his efforts on behalf of the Ogoni people. Both awards are said to carry prestige equivalent to the Nobel Peace Prize. According to the World Council of Churches, key witnesses for the prosecution at Ken Saro-Wiwa's trial have signed sworn affidavits saying they were bribed by Shell to testify against Saro-Wiwa.

Did You Know?

If developing countries increased their share of world exports by just five per cent, this would generate \$350 billion—seven times as much as they receive in aid. The \$70 billion that Africa would generate through a one per cent increase in its share of the world exports is approximately five times the amount provided to the region through aid and debt relief.

— "Rigged Rules and Double Standards,"
Oxfam, www.maketrade.com.

COLOMBIA

(Continued from page 6)

the run because they are on a hit list maintained by the paramilitary. Denouncing the violence can be the most dangerous action a citizen in Colombia can take, according to one of the teachers.

"Our union's commitment to the fundamental rights of workers in every nation is unyielding. That's why we sent a contingent to Colombia to show our solidarity and bring attention to the workers' plight," said Leo Gerard, president of the Steelworkers. "We are also sending a message to the U.S. government that we are strongly opposed to the amount of military aid being sent to the Colombian army when trade unionists and innocent people are being killed by the very military forces we are financing."

The AFL-CIO and its affiliates must demand that not a penny be delivered to Colombia until the human and civil rights of its workers and other citizens are protected and the wanton murders of labor activists are stopped.

— Reprinted with permission from "LaborTalk," which appears every Monday at www.laboreducator.org. The column "Inside the AFL-CIO," can be viewed every Tuesday.

UPDATE: According to the *Colombia Monitor*, March 2002 issue, on February 1, 2002, seven human rights organizations met with State Department officials and uniformly affirmed that the Colombian government had not met the human rights conditions laid out in US law. The Secretary of State is required to certify that the Colombian government is meeting human rights conditions before releasing aid to the Colombian Armed Forces. Similar restrictions were placed on the 2000-2001 package. Using a provision included in the law, President Clinton waived the human rights conditions on that package, even though the State Department acknowledged that the Colombian government had not met three of the four conditions.

This year, there is no waiver provision attached. A report issued jointly by Amnesty International, Human Rights Watch and the Washington Office on Latin America, provided extensive evidence of non-compliance and concluded that the Colombian Armed Forces were therefore not eligible for US assistance for FY2002.

The report demonstrates that members of the Armed Forces credibly alleged to have committed gross violations of human rights were not being suspended, that the Armed Forces were not cooperating with civilian judicial authorities, and that the Armed Forces continue to collaborate both by omission and commission with paramilitaries.

Yet on May 1st, Colin Powell certified that the Colombian military has met congressionally mandated human rights requirements.

— Colombia Monitor is a new bimonthly publication published by the Washington Office on Latin America (www.wola.org). It provides analysis of policy dynamics in Washington with on-the-ground monitoring of the impact of US drug control policy in the Andean region.


TWO MONTHS IN THE "PEARL OF AFRICA"

(Continued from page 2)

and preparation affect health, the role of natural healing and medicines, common illnesses in rural areas and the availability of primary preventive health care. While Gad was arranging the logistics for the students' five-week rural site placements, Larry and I went along on day trips to visit various rural centers. These trips were extremely helpful to us in better understanding the different levels of health centers in Uganda, the communities, and the students' field experience possibilities. Toward the end of our stay, we accompanied a group of seven students to Bughoye Teaching Health Center for ten days. This isolated Community Health Center had no regular physician, but provided primary health care through a capable team of health care workers and a midwife. This clinic had been operational for several decades; a newer part of the facility, completed in the late 1990's by the government of Finland, had gone unused due to safety concerns with rebels in the nearby mountains. We were the first group from MUST to use the full complex, which includes comfortable housing for more than twenty volunteers and a furnished house for us as "visiting lecturers." Ugandan soldiers present in the town provided adequate security to the area.

We accompanied the students on daily excursions into the mountains as they learned about protected water supplies, and prenatal care and home births in the homes of TBAs (Traditional Birth Attendants). In addition to seeing patients in the clinic each morning, the students hiked over an hour on several occasions to provide immunizations and informal educational talks to mothers with their babies tied to their backs, gathered under the trees in these communities. We also listened to an HIV infected single parent explain special stresses the disease causes in her life.

Larry and I returned to Mbarara with a mixture of feelings as our time in Uganda drew to a close. On my last visit to the Uganda Martyrs Primary School, I was filled with emotion when the children stood up to greet me. "Good Morning, Madam," was followed by the boys and girls singing to me the songs I had taught them during my previous visits. My heart also swelled as they later, all uniformed but several in bare feet, waved good-bye and sang a farewell song.

The warm, smiling faces of so many Ugandans—both children and adults—are etched in my mind. I don't need photos to remember their love of life, nor are photos necessary to recall the tragedies—five tiny, crying, abandoned babies taken into an orphanage. Most are believed to be HIV infected. I often find myself wondering how many of them are still alive. Suffering, poverty and over-burdened lives must be remembered when I think of the present-day reality in Uganda. But images that remain just as vividly are of people living and working together in an atmosphere of love and friendship. Young and old live in Community, rich with a culture that honors and respects those who came before, as all look together to the future with vision and hope. 



Steve Miller, DGH President, listening to the heart of a young patient in Hospital San Carlos, Chiapas, during a recent five-week evaluation of DGH projects in Central America and Mexico.

DGH Announcements

► **DGH General Assembly.** Join us in Boston, MA, on August 2 to 4, 2002, for **Health & Justice: For All or "Just US,"** the 7th Annual DGH General Assembly. See www.dghonline.org for details and the registration form.

► **Annual Vigil at Ft. Benning to Close the School of the Americas.** Join SOA Watch in Georgia the weekend of November 15 to 17 (www.soaw.org).

► **The Relevance of the UN Convention on the Rights of the Child for US Domestic Policy: Welfare Reform and Children in Immigrant Families.**

This article, by DGH Board member Jennifer Kasper, MD, MPH, and Paul Wise, MD, MPH, (*FXB Journal Health and Human Rights*, Vol 5, No 2, 2001), discusses how welfare reform's effect on children in immigrant families offers an illustrative case of how US social policy could be examined and potentially altered through the lens of the Convention on the Rights of the Child. Use of the Convention to focus on children and reframe welfare legislation could help underscore the nature of children's social claims and help generate a national consensus as to how to address them more effectively. The Convention could provide specific guidance to the medical profession on how to address these challenges.

DGH Reporter

Edited and designed by Monica Sanchez.
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to newsletter@dghonline.org.

DGH is administered by a volunteer **Board of Directors** whose members have volunteered with DGH a minimum of three years and are elected by **DGH Voting Members**. The Board is assisted by an **Advisory Council** composed of over 200 physicians, students, retirees, artists, nurses, business people and others. A diverse group of volunteers provides the vital core of DGH's resources, including this newsletter. As of May 2002, DGH has one paid employee. 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.

BANGLADESH

(Continued from page 7)

The next morning they left the village for Comilla. Helena stayed with her husband there for three days. Then they went to Durgapur in India and handed over Helena to a broker from the Durgapur Brothel. Helena burst into tears and sought their sympathy, to no avail. She was forced to stay in the brothel as a sex worker. After three months, a Bangladeshi went to the brothel and met Helena in her room to have sex with her. The man did not pay for having sex with Helena. Instead he promised he would get her away from the brothel.

He returned and took her with him, but he did not set her free. Instead he sold her to the Goalonda brothel in Dhaka City, where Helena was renamed Morsheda. Morsheda has been in the brothel for seven years. She has a daughter who is three years old.

REHENA. This 18-year-old comes from the village of Norsingdi. Rehana became an orphan when she was about seven years old. She has one brother and one sister. Her brother and sister-in-law were her only relatives to look after her, but her sister-in-law did not give her enough food and often punished her unnecessarily. When Rehana was nine years old, she got out of the house at about 11pm. The policemen on duty caught her and three of them gang raped her. The policemen kept her in prison for about four days and raped her every night.

When Rehana become very sick and feverish, the policemen released her. She was walking down the road in severe pain when an aged man asked her where she was going. Rehana replied that she was very sick and she had no destination. She asked for help. The man assured Rehana he would give her job and he took her to Dhaka City.

The man took her to a residence that looked very nice from outside. There were other girls in the house. She was given medicine and provided with good food. But the following day she was again victimized. She was kept in a room by force where she was raped every night and she was severally punished if she refused to enter that room. This went on for about three months. By that time she was very sick from STDs.

One day Rehana managed to escape from the house through an open gate. On the way, she met a lady and asked for her help. The lady assured Rehana she would help and find her a job. With these promises, she took her to the Narayganj Brothel where she sold

her for Tk. 500. Rehana spent about two years there before she was able to escape once more, but she could not return to a normal life.

At present, she is working as a street-based sex worker to earn money for her livelihood. She got a small house in the slum area on a rental basis where she is not free from danger and other abusive people. She has become addicted to drugs and continues to suffer from serious STD infections.

Did You Know?

Persistent poverty and increasing inequality are standing features of globalization. In the midst of the rising wealth generated by trade, there are 1.1bn people struggling to survive on less than \$1 a day—the same number as in the mid-1980's. Inequalities between rich and poor are widening, high-income countries account for 75 per cent of global GDP, which is approximately the same share as in 1990.

— “Rigged Rules and Double Standards,”
Oxfam, www.maketradeair.com.

UNITED STATES

(Continued from page 7)

ber 2001 that all INS detainees had the opportunity to seek legal assistance through pro-bono legal service providers if necessary, AI has learned that many detainees have been without access to lawyers for far longer than was initially reported. This is of particular concern given that some are being simultaneously investigated by the FBI and subjected to lengthy—and possibly indefinite—detention.

The INS has broad powers to arrest and detain people for suspected immigration violations and has been given further powers since September 11. This includes the power to detain people without charge for up to 48 hours or for a further undefined period in “an emergency, or in other extraordinary circumstances.” This latter power is broader than the provision under anti-terrorist legislation passed by Congress, which allows the Attorney General to hold certified “terrorist” suspects for up to seven days without charge. Data examined by AI reveals that scores of people picked up in the post 9.11 sweeps were held for more than 48 hours, and several for more than 50 days, before being charged with a violation.

Another regulation allows the INS to override Immigration Judges' decisions to grant bail in certain cases, thus reducing the power of the courts to oversee and rule on continued detentions. This regulation also undermines the principle of the separation of powers between the executive and the judiciary.

AI also remains deeply concerned that, although they are not charged with crimes, many post 9.11 detainees are held in punitive conditions in jails, sometimes alongside people charged or convicted of criminal offenses. AI has received reports of cruel treatment, including prolonged solitary confinement, heavy shackling of detainees during visits or court appearances, and lack of adequate outdoor exercise. There have also been allegations of physical and verbal abuse.

The Justice Department promulgated new detailed INS standards in late 2000, covering better attorney access and improved conditions,

which were due to be introduced over time to all facilities housing INS detainees. However, these standards are still not being fully applied or adequately monitored, and many of the conditions under which 9.11 detainees are detained appear especially punitive.

Other issues addressed in the report include deportations and asylum cases. There are concerns that some detainees risk being deported to countries where they would be subjected to serious human rights

abuses. The manner in which some detainees have been removed—one man, for example, was put on a plane without proper clothing or any of his possessions, and two people were deported without their families being informed—is also of concern.

— Excerpted with permission from the March 14, 2002 report, “Amnesty International's Concerns Regarding Post September 11 Detentions in the USA.” Read the full report at www.amnesty.org.

Karen's Tots Fund: A Loving Memorial

Karen's Tots Fund was founded in October 2001 by DGH Board Member Jerry Paccione, and his family, in loving memory of his sister Karen Monjello. Twenty five years ago, Karen's love of children led her to open Tots' Village, a workers' day care center in Connecticut, which she directed and worked at until the day before she died.

In life, Karen's way of impacting our world embodied the aphorism, "Think globally, act locally." Now that she's left us in body, we hope that through this memorial, her spirit can act globally in a profound way, supporting the lives of many hundreds of needy children.

Donations to Karen's Tots Fund go to support, dollar for dollar, DGH projects that do the kind of work Karen did at Tots' Village. In this way, we can help spread the love she offered the lucky kids at Tots' Village to some of the world's most disadvantaged children.

This is a very fitting tribute to a woman whose life was dedicated to children and, with them and through them, to making an impact.

To date, Karen's Tots Fund has raised over \$13,000 that has: gone towards the building of a much needed new dormitory for the abandoned and abused children who have found a home in Los Chavalitos, Nicaragua; helped keep the kinders (Centers for Integral Child Development or CIDI's) open in Morazán, El Salvador; and supported youth literacy in Santa Marta, El Salvador.



Karen Monjello and Jerry Paccione



Lunchtime at a kinder in El Salvador



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Health & Justice: For All or "Just US"

Take part in the 7th Annual DGH
General Assembly in Boston, MA
August 2-4, 2002