



# Doctors for Global Health *Reporter*

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## I'LL BRING YOU HOPE WHEN HOPE IS HARD TO FIND

By Charlie Clements

I believe that we grow and get far more from these experiences than we give. They change us forever in ways that continue to unfold throughout our lives.

This year I returned to El Salvador for the first time since just after the Peace Accords. On that trip in 1992 I had hoped to visit Lanny in Morazán, but the military did not forgive or forget that easily. Though their Ambassador at the U.N. had personally issued my visa, the military pulled me into an interrogation room and read my yard-long 'rap-sheet.' They reminded me that the Ambassador lived comfortably in NYC and had not fought in the war. I was able to meet with some of the demobilized guerrillas from Guazapa. Unable to clearly

read the signals of security forces that continued to watch and harass me, I cut the trip short.

I returned this year for the 25th memorial of Archbishop Oscar Romero's assassination. It was a very powerful occasion: the Memorial of Cuscatlan, which is the wall of names of civilian dead reminiscent of the Vietnam Veterans Memorial; meeting with many people I had not seen since the war, whom I was not sure had survived; meeting a college student whom I was told by his father I delivered under difficult circumstances under the noses of a military garrison atop the volcano; seeing a thriving cooperative of ex-combatants that includes men who fought on both sides of the war; seeing how very little has materially changed for the lives of peasants and urban poor.

I saw person after person who had a story that I hardly recognized about how I had saved them or their child or family member. It began to dawn on me that what had been important and perhaps lasting about my moment in their lives was that I brought them hope where hope was hard to find.

Those encounters with them were usually brief. I walked a circuit of some dozen villages in a 225-square mile area, seeing patients from 7am to about noon. Then I would visit those who could not make it to the clinic, eating a couple of tortillas and a few beans for lunch. After that I would walk to the next village, which might be four or six hours away, depending on whether it was the rainy sea-

DGH and I both have our roots in El Salvador, in witness, and in accompaniment. Looking in the rearview mirror of my own life, I

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**Dr. Charlie Clements giving a keynote address at the DGH Tenth Anniversary General Assembly on August 6, 2005, at Columbia University in New York City.**

son and whether I could hide amidst the lush ground cover. In those morning clinics, I would see fifty to sixty patients, so there could not have been more than a few minutes with each patient.

I would give them a little medicine, sometimes a placebo of vitamins and as much kindness and gentleness as possible. As I look back at their memories of those encounters, I think more than anything I offered them dignity, of which there was not a lot of in their lives. I think the gift of dignity is what also gave them hope. They remember those encounters in grossly exaggerated ways that would lead you to believe I was a Bernard Cooley instead of a young physician who had only completed the first year of a Family Practice residency.

I know what I say will have a resonance with your own experiences. And I think we can generalize even further. I think the act of accompaniment, the act of standing beside people in stress, whether the stress is violence, injustice or poverty, “brings hope to people in whose lives hope is hard to find.”

And, of course, as physicians we bring hope as well, even when hope is hard to find. I applaud all the partners who have traveled from afar, and all of you, who have struggled to continue to provide not only the avenues for service and witness, but the opportunity for personal transformation that comes with the kind of work you do, and the hope you have brought to so many.

I think that what you have done and what you are doing there and elsewhere is

incredibly important on many levels. One that we should not discount is the power of witness. Quakers call it ‘speaking truth to power.’ There is incredible power in the stories we can tell as health care providers, because the language of health is universal transcending borders, cultures, languages and politics of all varieties.

I was on an emergency human rights mission to Iraq just prior to the outbreak of the current war. We were taken to a small pediatric hospital. We had translators with us from Jordan because we wanted to have our own translation, and they were used to translating everything both ways immediately. The pediatrician in the small hospital with 50 beds said the census was now 156. Of course there were mothers with each of the children at the hospital and two slept on the floor and

they rotated the beds so each of the mothers and her child got the bed every eight hours.

The pediatrician led us to a mother who was holding her daughter of about three or four in her lap quite emaciated, mewling like a kitten. He explained that the mother had traveled eight hours because she had heard this hospital had the medicine to treat Kala Azar (leishmaniasis). The disease had been well controlled before the first war but, when the import of pesticides were prevented by the US embargo, the sand fly that transmits it began to cause an epidemic.

Then the doctor said in perfect English, “I haven’t told the mother yet there’s no medicine. It would be kinder if we shot this little girl in the head rather than send her home to die the lingering death that awaits her.” He had said it in English so the mother would not understand but the translators, used to translating everything immediately, translated it to Arabic. And the mother’s eyes overflowed with tears.

I believe pediatricians are the kindest physicians in the world and it was the sting of what that pediatrician had said that said the most about pre-war Iraq.

I went back to an Internet Café in Baghdad that night and sent that story to about twenty friends whose e-mail address I could remember. You could not surf the Internet but you could send and receive e-mail from an address that was undoubtedly monitored. I encouraged my friends to share the letter with their colleagues. Within hours that story was ricocheting around the world. Within ten days I was getting responses from activists in the West Bank, Argentina, China, India, Austria, Kenya and Vietnam.

Our stories, our witness, the plight and lives of our patients have a poignancy that is at times transcendent. I hope you encourage participants in DGH opportunities to keep diaries. Had it not been for my diary in El Salvador, I don’t think I could have written my book, *Witness to War*.

As we move from one stressful situation to another, one improvisation after another, one heartbreak to one triumph, it is easy for the details to fall by the wayside. Though I wrote *Witness to War* only six months after leaving Guazapa, I would read a page of my diary and twenty pages of memory would come flooding back, but without the diary those details might not have been accessible. I think a diary is also invaluable in documenting our own subtle transformations that we might not otherwise recognize, or worse yet, want to acknowledge.

Another level of impact of accompaniment on me has been how I come to understand the US, its culture, and its impact on the world by living in another culture. Most Americans never have that privilege and so they are puzzled by how we are regarded in the world today. They are perplexed about the origins of terrorism. They are too often deluded by our own propaganda, which I think is one of the greatest dangers in the world today.

If the President can lie about weapons of mass destruction, if he can fool the world that Saddam’s toothless army was a threat to his neighbors, if he can convince the public that there

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# EDUCATION IN EL SALVADOR: AN EVERYDAY STRUGGLE

By Sarah Doorley

the country was ravaged by a 12-year civil war that destroyed infrastructure, demolished communities and depleted resources. Between 1980 and 1992, approximately 70,000 Salvadorans were killed and \$2 billion USD worth of damage was done. The community of Santa Marta was forced to flee to safety in a refugee camp in Honduras. In the Mesa Grande refugee camp, where the community lived for 6-10 years, access to education was limited. It was during this time of war and scarcity that the practice of popular education was born in this community.

The basis for popular education is to utilize internal resources when external resources are limited. With a third grade education one should be able to teach second grade. With a second grade education, one should be able to teach first grade. Chila, a teacher in Santa Marta's current school has been a teacher since she was 13 years of age. Popular education for the community of Santa Marta was a form a resistance and transformation. As Paulo Freire, one of the most influential educational thinkers of the late 20th century, stated, "Education becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world."

The return to Santa Marta after the war signified the end of the violence but the beginning of the struggle to rebuild their war-torn community. For the past 13 years, the people of Santa Marta have been relentless in their efforts to provide an education for the community's youth and adults. To add to their difficulties, Santa Marta is a community that is still discriminated against by the government of El Salvador, being viewed as a guerrilla community, a community that fought on the "other side." As a result, funds and governmental support are limited.

Up until last year, the Ministry of Education, which only runs a primary school in the area, had refused to provide a sufficient number of salaries for the teachers of Santa Marta. Showing amazing solidarity, the salaried teachers of Santa Marta pooled together a bit of funds in order to support those teachers without a salary. A peaceful protest was organized by the teachers, the director and the students that succeeded in obtaining eight more paid positions.

Fortunately the practice of popular education established during the war has persisted. The community developed an adult literacy program, providing opportunities for educational services for the older population of Santa Marta. Five years ago a high school did not exist in Santa Marta. The community came together and, with the help of various international organizations, established the first high school in Santa Marta. In December of 2004, the first group of high school students graduated from the Santa Marta high school. Out of the 42 graduates, 18 enrolled in the university, far exceeding the 10% of pupils who go on to college throughout El Salvador. An additional eight students have gone to Cuba, participating in an educational exchange program between the two countries that includes medical school for some.

Still pursuit of a university education is extremely difficult for Santa Martans. One student eloquently explained, "the 18 that are currently enrolled in the university are there by the strength given to them by their dreams." The majority of the families that live in Santa Marta do not have a steady source of income. Most rely on agriculture but this, as one student stated, is barely enough to survive. Merlin, one of the students enrolled in university said that her family was able to help her pay for matriculation fees but she feels sad because the money that her family gives her is needed to pay for their food.

Most universities in El Salvador are located in San Salvador, the capital, which is a three-bus, four-hour, trip from Santa Marta. The majority of the Santa Marta students are living in crowded apartments without sufficient supplies or household items. Marleny, a student who lives in a house with eight

Education in El Salvador has always been a privilege of the few and not a right of the many. To make matters worse,

others, described the living situation: "At times because we don't all fit in the chairs, we sit on the floor. We have one table, no more, that the books don't fit on, nor can we study there because there are so many of us. At times we all have to study, and for this perhaps it is better to study on the floor or lay down on the cot." The majority of the students stay in the city during the week and return to Santa Marta for the weekends.

Because food is expensive in San Salvador, most students bring tortillas and food back with them from Santa Marta in hopes of lasting the week and preventing an additional expense. The financial situation for the students is difficult. Lila reveals, "There are moments when I go hungry because I am saving the money for my child and for my return trip to my house (in Santa Marta)."

Regardless of the difficulties, the 18 students from Santa Marta enrolled in university are studying Math, English, Sociology, Philosophy, Communications, and Psychology. "I am always with the hope to have a career, to be a professional, and through this to earn a more dignified life," explained Lila.

The education that the students are getting extends far beyond the requirements necessary to obtain their respective degrees. They are taking university classes but they also are organizing community services, educational *charlas* and forums to pass along their newly acquired knowledge.

The dream of obtaining an education is motivated not only by personal success but for community development. As Jose Ramiro put it, "I have so many dreams for

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Students in Santa Marta, El Salvador.

# CONFERENCE EXPLORES EXPERIENCES IN HEALTH AS A HUMAN RIGHT

By Audrey Lenhart

Over 300 health professionals, students and community activists working in the areas of health and human rights around the world came together for an unprecedented conference entitled *Lessons Learned from Rights-Based Approaches to Health*. Doctors for Global Health was proud to co-sponsor this international health and human rights conference, held at Emory University in Atlanta, Georgia, from April 12-14, 2005. Fellow sponsors included the World Health Organization, the Centers for Disease Control and Prevention, CARE, the Carter Center and the hosting institution, Emory University's Institute of Human Rights.

DGH board member, Audrey Lenhart, and DGH founding member Tim Holtz, represented DGH on the conference planning committee. Many DGH board members, advisory council members and friends participated in the conference.

DGH President Jennifer Kasper spoke during the opening plenary session of the conference on a panel that included former US President Jimmy Carter and other distinguished leaders from the co-sponsoring global health and human rights organizations. Other featured speakers included the United Nations Special Rapporteur on the Right to Health, Paul Hunt, and former President of Ireland and former UN High Commissioner for Human Rights, Mary Robinson.


The conference featured concurrent sessions on a wide variety of topics pertinent to rights-based approaches to health. Ramiro Cortez, president of *Asociación de Campesinos para el Desarrollo Humano*, DGH's partner organization in Estancia, El Salvador, was invited to the conference to share his experiences in a grassroots community organization dedicated to promoting health and other human rights related to development. His talk, "Health, Human Rights and Community Development: A Case Study from Rural El Salvador," presented with DGH

advisory council member and volunteer Joel Sawady, was to a standing room only crowd and was both moving and inspirational as he described his community's struggles and successes.

DGH members were prominently featured during sessions on food security (Jen Kasper), AIDS and discrimination (Karen Leiter), mental health and human rights (Tim Holtz), documenting war crimes (Karen Leiter), substance abusers and sex workers with HIV/AIDS (Tim Holtz), and the People's Health Movement (Lanny Smith).

A workshop entitled "Health for ALL, NOW!" was organized by DGH on behalf of the USA circle of the People's Health Movement (PHM), and was one of the most well-attended events of the conference. Since DGH is the co-convenor of the PHM-USA circle, the conference provided an excellent networking opportunity, both in mobilizing people around the PHM and coordinating activities between PHM-USA and groups from India, Vietnam and elsewhere.

The PHM also organized an impromptu evening of food, drink, dancing and education at the home of DGH board members and founders Clyde and Renée Smith, which was attended by over 70 people and offered an informal and fun atmosphere for conference attendees to learn more about the PHM and how to become involved in their home countries. The PHM was instrumental in urging the conference attendees to discern concrete 'next steps' in making rights-based approaches to health a force for positive social change in their communities. The need for grassroots social movements that actively promote and enact a rights-based agenda was discussed on several occasions during the conference, and the PHM seemed eager to help fulfill that need.

The conference provided a springboard for mobilizing people around rights-based approaches to health. The conference planning committee is actively working to continue the momentum through the creation of a listserv and an interactive database and website, (to be linked from <http://humanrights.emory.edu>). A follow-up meeting evaluating the effectiveness of the conference will take place in January 2006, and will bring together a diverse cross section of people who attended the conference. A major goal of this follow-up meeting is to help devise and enact the 'next steps' that will allow the themes discussed at the conference to achieve greater visibility and the necessary social mobilization to occur. DGH will continue to be involved with the activities that stemmed from this exciting event. 

## Award Presented to DGH Founding President

Heartfelt messages of congratulations, thanks and appreciation came from all corners of the globe to recognize Dr. Lanny Smith as founder and first president of DGH. Health promoters from Albania, El Salvador, Mexico and Phillipines, and physicians and social justice activists from Iran, Argentina, Cuba, France and Uganda all sent their special words and memories.

DGH's 10th Anniversary General Assembly was the chosen forum to honor Lanny for carrying out the vision he put forth just over ten years ago. Lanny, the man with a dream who had invited others to come along, was at the roots of creating what today is a vibrant, growing NGO with an impressive ten-year history.

DGH advisory council's Dr. Victor Sidel and board member Shirley Novak presented Lanny (see photo) with a striking photo of the Jaime Solórzano Bridge in El Salvador. Often used as a concrete example of Liberation Medicine in action, the photo was surrounded by select quotes from people who had been part of DGH's birth and growth. The framed photo, along with a bound compilation of all the sentiments contributed, represents the epitome of Lanny's imprint on communities and individuals around the world.



# WHAT WE KNOW AND SHOULD BE DOING ABOUT DISPARITIES IN HEALTH CARE

By H. Jack Geiger

The phrase “health disparities” is thrown around in multiple ways without appropriate clarification. As it is usually used, it refers to two quite different things, and it is important to know which is being discussed. I want to discuss racial and ethnic disparity in the quality, comprehensiveness, adequacy, and intensity of medical care itself. If you are African-American, Hispanic-American, Native American or from a variety of the Asian subgroups, you have a strong probability of being treated differently, less intensively, with less quality than a white counterpart who is identical in all of the other variables of insurance status, income, education, severity of disease, co-morbidity, hospital resources, and the like.

I will not spend hardly any time on the evidence of racial and ethnic disparities in medical care because, as far as I’m concerned, the case has been proven over and over and over again. Over the last four years, my colleagues and I have abstracted and annotated close to a thousand peer-reviewed articles on racial and ethnic disparities in care that met adequate criteria for sample size, control of confounding variables, and all the other things that health care research studies and epidemiologic studies properly worry about. This report, *The Right to Equal Treatment*, and a complete annotated bibliography, organized by disease, are available online ([www.phrusa.org/research/domestic/race/race\\_report/index.html](http://www.phrusa.org/research/domestic/race/race_report/index.html)).

We also know that the causes are multi-factorial and complex. There is no single smoking gun. Negative racial and ethnic stereotyping on the part of physicians and other health care providers is just one of multiple contributing causes, some of which we know about, most of which we need to know more about.

**Patient-Level Factors.** These include patients’ knowledge and beliefs about health and illness, as well as the issue of patients’ trust in the physician and in the health care system. I started out in looking at this literature on the issue of trust thinking, “Well, here is another victim-blaming attempt to say that all minorities are paranoid and it’s their own damn fault.” In fact, the evidence is compelling. A recent survey of African-American respondents—we need similar studies of Hispanics and other groups—found a significant plurality of African-American respondents said that their own physician was capable of experimenting on them without their consent, giving them potentially dangerous experimental drugs without telling them, even in the face of evidence that continuity of relationship does mitigate this kind of mistrust. The message of the data on mistrust is that this is yet another element that physicians, other health providers, and institutions and organizations of health care need to be aware of and address.

Patient-level factors also include the out-of-pocket cost of health care independent of the adequacy of health insurance (affordability), fluency in English, health care literacy (knowing something about your disease, disease in general and your recommended regimen), and what are called “preferences,” which is a code word for “I refuse to do what the doctor is recommending.” There is good evidence for the existence of these preferences. However, in the studies that have looked at it prospectively and elicited evidence of patient preference as a contributor to differential treatment, in no case has that factor been anywhere near sufficient to account for the magnitude of the existing disparities. It is a contributing factor, but not the main element.

**Provider Factors.** The classic study of negative racial and ethnic stereotyping by physicians is by Michelle Van Ryn and Jane Burke (*Social Science & Medicine*, March 2000, pp. 813), in which they talked to the patients and the decision-making cardio-thoracic surgeons after angiograms had been performed. They found a profound differential by race in the decision of whether to perform angioplasty or bypass grafting, all other things being the same (how many lesions, where the lesions were, income, health insurance status, co-morbidity, all the rest). They were able to determine, first of all, whether patient preference was a factor. They were also able, subtly and

cleverly, without the decision-making physicians knowing that race was the area of inquiry, to determine some of the attitudes that dictated those decisions. It turned out that the decision-making clinicians, usually on the basis of an average 12-minute interview, had decided that the African-American patient did not have the energy to do cardiac rehab; was not smart enough to stay with rehab and really understand all the things that he or she needs to do to manage the disease; did not have a good social support system; did not have a stressful job. Recognize the relationship of these decision-driving views to

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classic stereotypes provided by our culture. They have their analogues for other minority groups.

This is a double violation. It is a violation of what society professes to be about, and of medical ethics and the commitment of medicine to treat everybody equally.

I also refer you to one other study, from the Cleveland Veterans Administration Hospital. In this study the cardiology fellow worked up the patient and presented all of the clinical and cath lab and history and echocardiograms and other findings to a panel of cardiologists and surgeons. They then discussed each case—some 900 in all—and reached a consensus as to what should be done—medical treatment, angioplasty, bypass grafting. In those 900 cases, there was complete presentation of all of the data, but no mention of race and there was no difference between blacks and whites in who got angioplasty or bypass grafting. Removing the one variable removed any signs of disparity, which is pretty powerful evidence for what is going on.

Other provider factors include clinical uncertainty, stemming from lack of cultural competence or linguistic competence, competing demands and cognitive overload (leading to shorthand thinking and stereotyping), and whether the physician has a patient-friendly style or an authoritarian

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# Human Rights around the World

## COLOMBIA

By Ed Kinane

In the United States we do not hear much about it, but the war in Colombia keeps raging. That war is fueled by US money, US soldiers, and by US military training.

In early February Ann Tiffany and I [both DGH advisory council members] led an 11-member, 11-day Witness for Peace/SOA Watch delegation to Colombia. We wanted to see the footprint of US policy on this lovely, but war-torn land. And to return home and help make US-Colombia policy more humane.

Most of our delegation have been active protesting the US Army's "anti-insurgency" training at the School of the Americas at Fort Benning, Georgia. (The notorious SOA, donning camouflage, now calls itself the Western Hemisphere Institute for Security Cooperation, WHINSEC.)

Colombia is the SOA's best customer. Of all the Latin American countries, Colombia has had the most soldiers trained there (well over 10,000). Colombia is also the Latin American country whose military has had the worst human rights record—earned in over four decades of civil war. Nowadays the Colombian military outsources much of its dirty work to paramilitaries and to mercenaries working for US contractors.

Under "Plan Colombia" the US has provided \$3.3 billion in military aid to Colombia. The five-year Plan Colombia is bipartisan, beginning under Clinton in 2000 and continuing under Bush. After Israel, Egypt and the puppet Iraqi government, Colombia is the US' major aid recipient.

The US government now seeks to renew the expiring Plan Colombia to spend billions more to promote US corporate interests in that income-poor but resource-rich region.

### Our Dual Addiction: Cocaine and Oil

From Bogotá, the country's capital, our delegation flew south along the Andes to Putumayo, the department bordering Ecuador. Remote Putumayo is the vortex of the war. It's long been the heartland of Colombia's largest *guerilla*, the FARC.

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## WORLDWIDE

By iAbolish

As many as thirty million people are enslaved today worldwide, forced to work for no pay under the threat of violence. Contemporary slavery includes forced labor, debt bondage, forced prostitution, and chattel slavery. Cases of human bondage exist around the world, including in developed countries. Here are some facts on modern-day slavery around the world today:

► The *1927 Slavery Convention* outlawed slavery worldwide. Article 2 states that the members will take the necessary steps "to bring about, progressively and as soon as possible, the complete abolition of slavery in all its forms." Slavery is defined as forced labor without pay under the threat of violence.

► Though the legal argument against slavery has been won, slavery persists and even thrives in some parts of the world. By a conservative estimate, 27 million people are enslaved today worldwide—more than at any time in history.

► The classic form of **chattel slavery**—in which slaveholders maintain ownership no longer through legalities but through the use of violence—persists to this day in a few countries. In Sudan, a radical ruling regime has revived a racially-based slave trade, arming militia forces to raid civilian villages for slaves. In Mauritania, slave raids 800 years ago began a system of chattel slavery that continues to this day, with Arab-Berber masters holding as many as one million

black Africans as inheritable property.

► The most common form of slavery is **debt bondage**, in which a human being becomes collateral against a loan. With a massive population boom in regions of staggering poverty, some families have nothing to pledge for a loan but their own labor. With inflated interest rates, debts are often inherited, ensnaring generations. 15–20 million slaves are in debt bondage in Bangladesh, India, Nepal and Pakistan.

► Another common form of slavery is **forced labor**, where individuals are lured by the promise of a good job and instead find themselves enslaved. Migrant workers are particularly vulnerable, and small organized-crime rings fuel a booming international trade in human beings. Trafficking often flows from developing nations to the West. For instance, the United States Central Intelligence Agency (CIA) estimates that 50,000 women and children are trafficked into the US each year as slaves.

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*Did You Know?*

Today, 600 million women are illiterate as compared to 320 million men. While access to primary education is increasing, only 69 per cent of girls in Southern Asia and 49 per cent in sub-Saharan Africa complete primary school. At the secondary level, the gap is even wider with only 47 per cent and 30 per cent enrollment respectively.

— UNFPA *State of World Population Report 2005*

## UNITED STATES

By Denise Zwahlen

It is just another day at the Immigration Court in Boston JFK Building. In the course of 40 minutes, detainees housed at distant prisons have filed, one after the other, across the video screen. The faces are hard to make out and the voices difficult to hear, but you can discern distress, fear and frustration. On the benches of the court, families are trying to connect with their loved one: "Wave to your father." "We love you." "We miss you." "Don't lose courage." Soon the court is called to order. Eventually one woman overpowered by emotion breaks out in tears and screams, and is escorted out.

Now the detainees held in local prisons are brought in. They are dressed in orange jumpsuits and walk in small steps, their ankles and hands tightly shackled. By the end of the morning as many as 15 detainees have come before the judge. Most do not have lawyers to represent them and are not eligible for bail. Rare are those who qualify for some form of relief under the current system. Many beg the judge to pass judgment quickly so that they do not linger for months, if not years, in detention. But they do not understand that by doing so, they may give up their right to ever return to the US.

Who are these people and what crimes did they commit?

It could be Rosalia who came to this country from Mexico to be reunited with the father of her child. He repeatedly raped her and abused their child. When he was convicted of child abuse and deported, she was charged with criminal child neglect and both her children were taken away from her and placed in foster care. She is under an order of deportation and is detained because she did not leave, staying here to fight in court to regain the custody of her children.

Or Thea, a young man from Thailand who came to the US with his family at the age of five. They were refugees from the Killing Fields of Cambodia but he never lived there. As a youth, like many others in his impoverished community, he got in trouble with the law. He served two-and-a-half years, and upon release was transferred to immigration custody where he was detained for another 18 months. Even though he has paid for his crime, has since turned his life around and is now employed by a local NGO working with youth, he may be deported to Cambodia at any time.

Or Mohammed, who came to this country 14 years ago from Algeria and was granted political asylum. He used to work as a computer programmer. He was in the process of appealing the revocation of his status when he was arrested and placed in the custody of the Department of Homeland Security, where he spent an entire year before being deported back to this country. He is married to a Colombian woman who is herself in immigration limbo. They have a three-year-old child.

The stage for this policy of detention and deportation was set under the Clinton Administration with the enactment of two federal statutes:

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## DARFUR

By Monica Sanchez

For the past two years, the government of Sudan and its allied nomadic militia, the Janjaweed, has carried out a rampage across the vast, arid terrain of the Western Sudanese region of Darfur, resulting in a widely documented catastrophe of massive displacement, killing of civilians, torture, rape of women and girls, and utter destruction of village communities. Up to 400,000 people have lost their lives since the conflict began, 700-2,000 villages have been destroyed, and more than 2.5 million people have been displaced.

Even though reports of large-scale attacks have decreased—perhaps because there is so little left to destroy—the security situation is deteriorating. Recent reports confirm that the government-sponsored violence continues. The Janjaweed has turned on its former government sponsors and the rebel groups are dividing and fighting amongst themselves, deepening the chaos, escalating the violence and forcing ever greater numbers of villagers to flee to refugee camps.

More than 3.5 million people currently face starvation in the Darfurian diaspora. The humanitarian crisis that has resulted from these widespread human rights abuses shows no sign of abating, as the government of Sudan continues to obstruct aid operations, creating famine conditions for millions of vulnerable people. Only the presence of humanitarian NGOs has prevented additional deaths by starvation and disease and stayed the annihilation of the Darfurian population. These efforts are now themselves targets of looting, robbery, kidnapping and other violence. As a result, in October 2005 the UN pulled all "non-essential staff" out of Sudan.

Despite the urging of human rights organizations, which have repeatedly documented the ongoing atrocities, the international response—legal, political and humanitarian—remains anemic in the face of this ongoing tragedy. Toothless sanctions, inadequate aid despite UN pleas, and failure to meet the voiced needs of the many displaced persons and refugees from the region, have been the order of the day.

Perhaps this should not be a surprise. For years the international community has failed to hold accountable the Sudanese government and to act to protect the populations ensnared in the multiple intertwined conflicts there, chiefly the 20-year old civil war, and the more recent ethnic violence in Darfur. Peripheral debates about whether or not genocide or "ethnic cleansing" is occurring—despite the universal acknowledgement of the perpetration of myriad crimes against humanity and a continuing unfolding of a massive human rights tragedy—have sometimes taken center stage.

Referral of the war crimes and human rights abuses in Darfur to the International Criminal Court on May 31, 2005 was a strong statement

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*Did You Know?*

**Secondary education for women is associated with improved economic prospects, better reproductive health, improved HIV awareness and altered attitudes towards harmful practices such as female genital mutilation/cutting. Their children also benefit: Every year of a mother's education corresponds to 5 to 10 per cent lower mortality rates in children under the age of five.**

— UNFPA *State of World Population Report 2005*

## DISPARITIES IN HEALTH CARE

(Continued from page 5)

approach when interacting with patients. In all of these, there is evidence of differentials in care.

**Institutional and Community Factors.** Finally, there are institutional or organizational factors that contribute to racial and ethnic disparities in the quality of care. We all know about the location of physicians' offices, the neighborhoods where resources are and are not. These factors also include interactions with office staff, the experiences that minority patients report. It is not just the physician. It is the triage nurse, the clerk, all kinds of other people in the health care apparatus who may be contributing in significant ways. What might be called the organizational culture of the health care-providing institution is important including, for instance, the reading level and cultural appropriateness of written or other materials that are provided. I taught for a long time on the faculty of Tufts' Medical School, which sits right on the edge of Boston's Chinatown, and I was there six years before it occurred to Tufts that it might be a sensible thing to put up some signs in Chinese. There is the matter of how co-pays and deductibles are handled. And there is the question of whether a quality oversight and improvement program is in effect at the health care institution. And I would add community-level factors. Are there safety net providers in the community? What are the levels of insurance coverage in that community? What is the level of what might be called "community trust" in the health care system?

**Further Study.** We need to know much more about the variations in disparities. If we want to find effective interventions, we need to know the relative contribution of each of the multiple factors I have mentioned. If we do not know what is really going on in a given set of circumstances, our intervention—however well-meaning—may totally miss the mark. We do not know what works for cultural competence training, which is all the rage at this point. Many of the early cultural competence curricula are simply lists of the strange behaviors of other people, stereotype-reinforcing items one after the other, never addressing the idea that medical and other health profession students bring two cultures to their work: their own culture—including biases conscious and unconscious—and the culture of medicine. Cultural competence begins with self-examination, rather than the idea that culture is something that is just an attribute of other people.

We do not know very much about how to intervene in physician-patient communication styles. We do know that it is better when there is physician-patient racial or ethnic concordance. We do know that African-Americans and Hispanics will almost always choose preferentially for physicians and providers of their own racial or ethnic or language group.

And we do not know very much about community variations. Why is it, for example, that

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## EDUCATION IN SANTA MARTA

(Continued from page 3)

the future. The dream of an educated, healthy population with sufficient work and safe houses. The dream of a country where democracy, justice and equality truly exist. The dream of a future where collaboration and permanent peace exists."

Lorenzo feels a similar drive, "I want to continue studying despite all of the difficulties I face. I have many dreams for the future, which start with a college education and include improving the living conditions for my people. I plan to continue sharing my knowledge and contributing what I can to my community."

It was with the 18 aspiring students of 2005 and the many future prospective students from Santa Marta in mind that Matt Pellerite, in a collaborative effort between Wright State University and DGH, developed the *Food For Thought* program. The concept is for each participant to set aside one meal a month in order to donate five dollars to help the students of Santa Marta pay for their college education. As a sign of solidarity and a chance to reflect on what is most important in one's life, *Food For Thought* is an excellent opportunity to break out of one's isolation and join a global effort. If interested in participating in *Food For Thought*, please e-mail Matt (Pellerite.2@wright.edu) or Sara Doorley (Sdoorley@gmail.com).



African-Americans do as well or better than whites at getting pap smears but much worse than the white elderly at getting flu vaccines or pneumococcal immunizations?

**What can we do now?** First of all, we have to see to it that all clinical data in every organized setting of care is recorded by race and ethnicity. Minority group respondents are understandably skeptical of doing that. However, there is no way we can monitor what is happening by race and ethnicity, in terms of the quality of care, unless we are collecting data in this way, and it is legal and even federally-mandated to do so.

Secondly, we need to push every organized provider of care to have a quality improvement program and to use practice guidelines for all their patients. One of the reasons quality improvement is useful is that it is something that every physician almost has to subscribe to, and it is less challenging than going head-on with many physician groups about the issues of negative racial and ethnic stereotypes. And there is evidence that it works. There are now about a hundred community health centers, to give one example, that are part of the Health Disparities Collaborative, in which quality improvement guidelines and a set of related mechanisms have reduced disparities in treatment and outcomes.

We should also be training patients from minority groups to be more assertive and demanding. There is evidence that it makes a difference. By changing the nature of physician-patient communication it has an effect on what happens, what is prescribed, and on the quality of the follow-up.

And that leads me to my final point: I do not think change in all of this is going to happen if it is all top-down. This effort has to also involve community-based advocacy groups and community organizations. We have been at this for a decade (we, collectively people researching in this area). We have obviously a lot of work yet to do, but this is a problem that we can and will solve.

—Excerpted with permission from a talk given by Dr. Geiger at a forum sponsored by the NY Metro Chapter of Physicians for a National Health Program.





## COLOMBIA

(Continued from page 6)

Our Witness for Peace guides set up a meeting for us with the commander of the Villagarzone army base. Coronel Quintero had spent six months in the state of Georgia at the School of the Americas. Practically the first thing Quintero told us was that Putumayo had "two special conditions: coca and oil." When asked to tell us more about Putumayo's oil (rarely mentioned by Washington or our mainstream media), Quintero changed the subject.

Coca, the source of cocaine, is Colombia's major export. The unwholesome consequences of cocaine in the US provide the pre-

text for the so-called "war on drugs." However, in both the US and Colombia that war is a fig leaf for the war on the poor.

At one level, the "war on drugs" is really a war on drug revenue. Coca is the major source of income for both the paramilitaries and the FARC. As if to deny the intimate link between the army and the paramilitaries, Coronel Quintero told us the army's goal was to deprive both "bandit" groups of their drug income.

Both sides terrorize the other's civilian supporters. Both sides wage economic war on the other: the FARC prevents oil production and sabotages pipelines; the military fumigates the coca. Conveniently, this toxic fumigation clears the land of small farmers—land which may have oil beneath its surface. Over two million Colombians have been cleared from their land by such fumigation or by the armed actors' terrorism.

The Pentagon is keenly aware that the region—Colombia, Venezuela and Ecuador—is rich in oil. It knows that without abundant and sustainable supplies of oil, its ability to wage ground warfare would be hamstrung. It also knows that the world oil reserves are dwindling. And it knows that whoever controls those reserves controls the world.

Some call oil "black gold." But, since virtually every nation is hooked on it, an equally apt nickname would be "black drug."

The "war on drugs," despite its almost willful failure to stem the flow of cheap and pure cocaine into the US, is indeed a drug war. It's a war for drugs: for the black drug. It aims to keep this utterly essential substance flowing north.

— For more information about the situation in Colombia and US involvement there visit the web sites of the following organizations:

- ▶ *Witness for Peace*  
www.witnessforpeace.org/sites/colombia.html
- ▶ *The Colombia Support Network*  
www.colombiasupport.net
- ▶ *Global Exchange*  
www.globalexchange.org/countries/americas/colombia

Did You Know?

**Every year, 76 million unintended pregnancies occur in the developing world alone. Nineteen million of these end in unsafe abortion—a leading cause of maternal death. Access to family planning could prevent unplanned pregnancies, reduce the incidence of abortion and cut maternal deaths by 20 to 35 per cent.**

— UNFPA *State of World Population Report 2005*

## WORLDWIDE

(Continued from page 6)

▶ A form of slavery most common in South Asia is **sex slavery**, where girls are forced into prostitution by their own husbands, fathers and brothers to earn money for the men in the family to pay back local-money lenders. Others are lured by offers of good jobs and then beaten and forced to work in brothels.

▶ Slave labor produces goods we use every day. Examples include sugar from the Dominican Republic, chocolate from the Ivory Coast, paper clips from China, carpets from Nepal and cigarettes from India.

▶ Slavery occurs in every continent in the world except Antarctica. A few selected hotspots include: **Albania:** Teenage girls are tricked into sex slavery and trafficked by organized crime rings. **Brazil:** Lured into the rainforest, families burn trees into charcoal at gunpoint. **Burma:** The ruling military junta enslaves its own people to build infrastructure projects, some benefiting US corporations. **Dominican Republic:** Haitians are rounded up

at random, taken across the border, and forced to cut cane in sugar plantations. **Ghana:** Families repent for sins by giving daughters as slaves to fetish priests. **India:** Children are trapped in debt bondage rolling cigarettes 14 hours a day. **Ivory Coast:** Child slaves are forced to work on cocoa plantations. **Mauritania:** Arab-Berbers buy and sell black Africans as inheritable property. **Pakistan:** Children with nimble fingers are forced to weave carpets in looms. **Sudan:** Arab militias from the North take Southern Sudanese women and children in slave raids. **Thailand:** Women and children become sex slaves for tourists. **United Arab Emirates:** Bangladeshi boys are transported and exploited as jockeys for camel racing. **United States of America:** The CIA estimates that 50,000 people are trafficked as sex slaves, domestics, garment and agricultural slaves.

— Reprinted from [www.iAbolish.com](http://www.iAbolish.com), *the Anti-Slavery Portal*, which links activists, human rights organizations and slave survivors across the globe. The portal is run by the American Anti-Slavery Group (AASG), which has a unique historic mission: it is the only human rights organization in the United States dedicated solely to abolishing modern-day slavery worldwide. That mission is also incomparably urgent because contemporary slavery in Africa is a central component of a policy of physical and cultural genocide. In fact, in 1994, it was AASG's New York Times op-ed that broke the silence on slavery in Sudan and Mauritania. Based in Boston, MA, the historical center of the American abolitionist movement, AASG works ceaselessly through every available means—building public awareness, leading advocacy campaigns, conducting research, bartering for the freedom of those in chains, empowering survivors to tell their stories and transform hearts and minds—to liberate the millions of people trapped in the virtually indescribable and unimaginable degradation and horror of bondage.

was a direct link between Saddam Hussein and Al Qaida where there was none, if he can rationalize a war whose ultimate victims are largely civilian because we need to 'liberate' them in the name of democracy, we are seriously endangered as a culture and as the world's sole superpower.

In the US, we spend half of the world's total military expenditure, more than \$500 billion annually, and we still are not secure.

We seek inexpensive sources of oil, and we pay the price in blood, a little of our own but mostly that of others. Iraq costs us \$4 billion a month but those are only the monies we are allowed to know about. We know the real costs of wars only come out when the 'black budgets' are revealed years later.

And so how do I tie this all together—your anniversary, the transformative work, and witness of DGH; the hegemony, arrogance, and abuse of the United States in the world today; the tragedy of Hiroshima and the trashing of the non-proliferation treaty by the US as it seeks new nuclear weapons?

I think this is tied together by the incredible privilege and responsibility we have as citizens of the United States. We elect the men and women who rubber stamp or do not

rubber stamp what the president wants. We elect the most powerful figure in the world. He is accountable only to us, the electorate.

Several days after the last election I got a letter from a dear friend in Lima, Peru, Bill Monning. He is a lawyer and co-founder of the Salvadoran Medical Relief Fund. Bill related his conversation with a taxi driver, who told him, "Everybody in the world should be able to vote in your elections since your government controls what happens in the world." Bill then spoke of 'the global majority' who are not unlike most of the people DGH works with throughout the world. What follows is what Bill called his 'post-election rant.'

"Living at poverty or below. Unrepresented by political parties or incumbent governments. The global majority is working to survive, uneducated, without political power, and without voice. We

should regard them as our allies who deserve to be heard, to be included in the division of the global pie, globalization's dispossessed. Give them all the vote. Send the exit poll experts into the field. Conduct some exit interviews when workers leave the gold mines, the sugar plantations, the textile sweat shops, the high tech assembly lines, and the subsistence farmer's waterless plot of land. Ask the global majority whether they favor tax cuts for the rich or education, abstinence or family planning. Ask the surviving family members of innocents killed by precision smart bombs or car

bombs if they favor more war like the massive assault about to begin in Fallujah or do they support negotiation and mediation that could lead to an American exit from Iraq.

"Give them each a vote, give them all a vote, expand democracy, build democratic institutions, expand the franchise. Include the immigrant workers forced to leave their families to cross armed borders as economic refugees. Since they can't vote, convince your dispirited colleagues to link arms, keep marching, and pretend they are voting for them...We cannot rest, the global majority never rests, the working people only dream of rest."

Whatever else we choose to do in life, we must attend to and take seriously our responsibilities as citizens in the global super power, because in reality we are voting for the disenfranchised of the world.

I want to share a few words with you that sustain me in times when I am feeling overwhelmed. They were sent to me from someone in the West Bank as the war with Iraq was about to begin. I was distraught that we had not been able to quiet the drums of war and that 'shock and awe' was commencing. These words are from the Talmud: "Do not be daunted by the enormity of the world's grief. Walk humbly now. Do justly now. Love mercy now. You are not expected to complete the work, but neither are you free to abandon it."

— Excerpted from the keynote address given by Dr. Charlie Clements at the DGH Tenth Anniversary General Assembly on August 6, 2005, at Columbia University, New York, NY. Dr. Clements is a public health physician and a human rights activist. His MD and MPH are from the University of Washington, where he's a Distinguished Alumnus of the School of Public Health and Community Medicine. Dr. Clements has been widely recognized for his humanitarian efforts working as physician in a 'free fire zone' in El Salvador during the civil war. He has served on the boards of both Physicians for Social Responsibility (PSR) and Physicians for Human Rights (PHR). He represented PHR at the treaty signing in Ottawa and a week later at the Nobel peace prize ceremonies in Oslo for the International Campaign to Ban Landmines. He is the author of *Witness to War* (Bantam, 1984) and subject of an Academy Award winning documentary of the same title. He is currently President and CEO of the Unitarian Universalist Service Committee in Cambridge, Massachusetts. Earlier in his life he was a Distinguished Graduate of the United States Air Force Academy and was a pilot in Vietnam until he was discharged because his conscience led him to refuse to drop bombs on Cambodia.

“ Whatever else we choose to do in life, we must attend to and take seriously our responsibilities as citizens in the global super power, because in reality we are voting for the disenfranchised of the world. ”

DGH Reporter

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## UNITED STATES

(Continued from page 7)

the Antiterrorism and Effective Death Penalty Act and the Illegal Immigration Reform and Immigrant Responsibility Act.

Under these laws, many types of immigrants are subject to being detained and deported: green card holders who have committed any crime, no matter how small (even if it was a long time ago and no jail time was ever imposed); people fleeing persecution in their native country; and the undocumented, whether they crossed the border without papers, overstayed their visa, came on a false passport or are in the process of adjusting their status.

The number of immigrants who have been affected by these policies are staggering. Since 1996, over one million have been deported. Immigrant detainees are the fastest growing portion of the US prison population (detention facilities receive higher compensation for an immigrant detainee than for other inmates). Also since 9/11, the FBI has encouraged more and more detentions as part of a public relations strategy to convince the public that they are fighting against terrorism.

Once arrested, immigration detainees are scattered throughout a network of county jails and prisons, federal detention centers, and private prisons. They are often moved arbitrarily from one facility to another, sometimes ending up thousands of miles away from their family and community. They are subjected to the same harsh conditions as any other inmate (overcrowding, inadequate nutrition, poor health care, economic exploitation, and abuse at the hands of corrections officers and other inmates) even though they may never have committed a crime or, if they did, have already served their time.

To respond to this crisis, immigrant communities have started to organize. In New York, Families for Freedom, a multi-ethnic defense network for and by immigrants, seeks to repeal the laws that are tearing apart their homes and neighborhoods, to build the power of immigrant communities and to provide a guiding voice in the growing movement for immigrant rights as human rights. Most immediately, they fight to stop deportation now.

Keeping Hope Alive, based in Boston, helps immigration prisoners across the US and their families investigate, document and take action against abuses perpetrated in detention facilities. It aims to create accountability, improve access to legal resources and bring national attention to human rights abuses in the detention industry.

The National Lawyers Guild is seeking to replicate in other parts of the

country the study conducted by the Boston-based Detention Working Group, which documented issues of due process in the handling of immigration detainees in Massachusetts. Their observations in court and the information they collected from interviews with former detainees, their families and immigrant rights organizations, confirmed the wide spread violation of the human rights of immigrants.

*Did You Know?*

**Even though women are entering the paid workforce in increasing numbers, they risk dismissal should they become pregnant and generally enjoy less overall income and job security than men. According to the World Bank, in developed countries, women earn 77 cents for every dollar men earn, and in developing countries, 73 cents.**

— UNFPA *State of World Population Report 2005*

## DARFUR

(Continued from page 7)

of condemnation by UN member states. However, it still awaits to be seen whether this will be accompanied by additional action and support, including for the too few and poorly equipped African Union troops currently charged with peacekeeping and protection in Darfur.

As for the Bush Administration, despite its declaration that genocide was under way in Darfur in 2004, it has been unwilling—as led in UN negotiations by Ambassador John Bolton—to take up the mantle of the responsibility to protect the threatened civilian populations. As of this writing, in October 2005, the ceasefire agreement has failed to hold and the peace process for Darfur is at a standstill. A now sixth round of largely technical talks taking place in Abuja, Nigeria adjourned until November 21, 2005. Meanwhile, impunity reigns and loss, displacement and mortality mount.

There are a few groups seeking to make heard the voices of the Darfurians. Contact the groups listed below to learn more and take action by demanding: protection and humanitarian relief and redress for Darfurians; an active, comprehensive Darfur peace process; and accountability for perpetrators for crimes and violations in Darfur.

► The Save Darfur Coalition ([www.savedarfur.org](http://www.savedarfur.org)) is a group of over 100 human rights, faith-based and other NGOs (including Amnesty International, the Unitarian Universalist Service Committee and Physicians for Human Rights), which maintains a comprehensive website of the latest news on Darfur, along with resources on the background to the crisis and advocacy tools for taking action.

► Human Rights Watch and Amnesty International ([www.hrw.org](http://www.hrw.org) and [www.amnesty.org](http://www.amnesty.org)) have been active in documenting crimes and violations in Darfur. Amnesty has been one of the earliest and most consistent voices, first drawing attention to Darfur in early 2003. Read reports and view videos from these groups on their web sites.

► The International Medical Corps ([www.imcworldwide.org](http://www.imcworldwide.org)) is providing emergency assistance in Darfur through seven primary health

care centers and two mobile clinics. In June 2005 IMC conducted an assessment of 1,200 internally displaced women living in camps in Nyala district, highlighting women's health and the mental health needs of refugees. Read the assessment.

► Physicians for Human Rights ([www.phrusa.org](http://www.phrusa.org)) has conducted three research investigations in Chad and Darfur in 2004 and 2005, most recently in Chad in July 2005, focusing on the systematic destruction of the livelihoods of

non-Arab Darfurians. On their web site you can read a June 2005 case study of the destruction of the village of Furawiya, including photographs and testimonies; watch the short film, *Darfur: Lives Destroyed* and read accompanying reports; learn how you can support the Darfur Peace and Accountability Act currently before Congress; and stay apprised of other legislative activities.

**“What you leave behind is not what is engraved in stone monuments, but what is woven into the lives of others.” – Pericles**

Doctors for Global Health thanks you for helping to weave hope into the lives of the people, communities and organizations with which we work around the world. We wish you and yours all the best for a joyful, loving and peaceful holiday season and 2006.



Photography by Illille Sawady



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