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Doctors for Global Health
Reporter

A View from the Communities: Santa Marta and the "Return to Normal"

By Xavier Coughlin

In the US, there is a lot of focus on vaccine distribution and a desperately wished for "return to normal." Everyone wants to be able to hug family and friends without fear, to return to our in-person communities and to bring an end to the devastation wrought by Covid-19. But we can never forget that "normal" included so many injustices and oppressions both nationally and globally. In the US, we see a clear predilection for higher infection and mortality rates for lower-income families and communities of color. These statistics should come as no surprise given the United States' historical oppression of marginalized communities, institutional racism, genocide and the ongoing tragedy of a for-profit medical system. Globally, we are shocked but not surprised by a continued injustice in vaccine distribution.

> **"But we can never forget that "normal" included so many injustices and oppressions both nationally and globally."**

Santa Marta, one of our long-standing partner communities in El Salvador, reminds us that beyond vaccines, their "normal" includes a lack of basic access to medical care. Even though there is a Clinic run by the Ministry of Health in the community, necessary medical supplies, such as oxygen and some medications, are not always available. The distance to hospitals providing care to Covid-19 patients means that most stay in the community even if they have respiratory difficulties. The pandemic had left the community without access to medical oxygen, a key component for treatment of Covid-19.

However, the community, as it has done for more than 30 years since their repatriation from the refugee camps in Honduras, fought for its own autonomy. Marta Mijango, from the *Ventana Abierta* (Open Window) Project, whose focus is addressing the needs of the most disenfranchised in the community, initially approached DGH with an appeal for oxygen supplies. Funds were raised to purchase two oxygen concentrators – two simple machines that will undoubtedly support the members of the community. DGH and our dear friends at *Psicólogos para el Mundo* (Psychologists of the World), Italy are proud to have been able to offer some solidarity in this struggle. We could not have done this act of solidarity without the financial help and love of the DGH community and their friends. Below is a thank you note from the community of Santa Marta, followed by a translation and photos of their dedication ceremony for the new oxygen concentrators.

La comunidad Santa Marta expresa:

Su enorme agradecimiento a Doctores para la Salud Global, DGH. A sus miembros afiliados, en su mayoría ex-voluntarios en la Unidad de Salud de la comunidad, que hicieron posible sus donaciones solidarias para alcanzar la meta.

También agradecemos de todo corazón a Psicólogos para el Mundo de Italia y a la Iglesia Valdense que hicieron posible otra parte importante de la donación económica para esta valiosa compra.

Estos generadores ayudaran a salvar muchas vidas en nuestra población. Hemos pasado momentos muy trascendentales para la vida de muchas personas en estos meses de alta presencia del COVID-19 a nivel local.

Razón justa para valorar esta adquisición de equipos generadores de Oxigeno Médico, en algo sumamente estratégico.

Siempre estaremos muy agradecidos con la solidaridad mostrada por ustedes hermanos y hermanas por más de 20 años.

Comunidad Santa Marta, 23 de marzo del año 2021

Translation:

The community of Santa Marta expresses:

Their enormous gratitude to Doctors for Global Health, DGH. To all the members and affiliates, the majority of them being previous volunteers with the Health Center in our community, whose donations and solidarity have made possible the achievement of this goal.

We also thank with all our heart Psychologists of the World, Italy and the Valdense Church, who made this valuable purchase possible with their financial donation.

These concentrators will help to save many lives in our populace. We have experienced many life-changing moments in the lives of people during these months of high COVID-19 infection levels locally.

All the more reason to value the purchase of these medical oxygen concentrators, a highly strategic and necessary move (for our community).

We are always so thankful for the solidarity shown by you, our brothers and sisters, for more than 20 years.

Community of Santa Marta, March 23, 2021

COVER: Santa Marta (SM) medical and community team around new oxygen concentrators. TOP LEFT: SM group members speaking to medical staff about community effort to purchase the machines. TOP RIGHT: DGH Board Member and SM community member, Peter Nataren explaining how oxygen concentrator works.

DGH Participates in the 2021 St. Petersburg Conference on World Affairs

By Michele Brothers

Opportunities to speak about health care and social justice arise in different circumstances. In concordance with DGH's mission to accompany underserved communities and provide awareness about social justice and Liberation Medicine, we welcome these forums to speak, inform and exchange.

DGH was invited to participate in the annual St. Petersburg (FL) Conference on World Affairs held virtually for the first time in February 2021 because of the pandemic. Though the focus of this year's conference was based primarily on the COVID-19 pandemic, Dr. Lanny Smith, founding president of DGH, was asked to participate on the Human Rights panel along with a distinguished group of colleagues who spoke about women's, immigrant, disabled and indigent rights.

Dr. Smith principally spoke about the very clear biases, whether subtle or outright, experienced by persons of color and gender in health care within the US and globally.

When asked how "such a conference composed of panel discussions on world affairs can lead to changes to some of the world's most intractable problems," DGH member and former *Médicos del Mundo* (MDM) press officer, Diane Seligsohn, President of the conference responded that "knowledge is key to moving forward." With over 2,000 persons registered in countries around the world, information has hopefully been shared widely.

Note that the conference recordings will soon be available for viewing on the conference website: *worldaffairsconference.org*.

Global Vaccine Equity

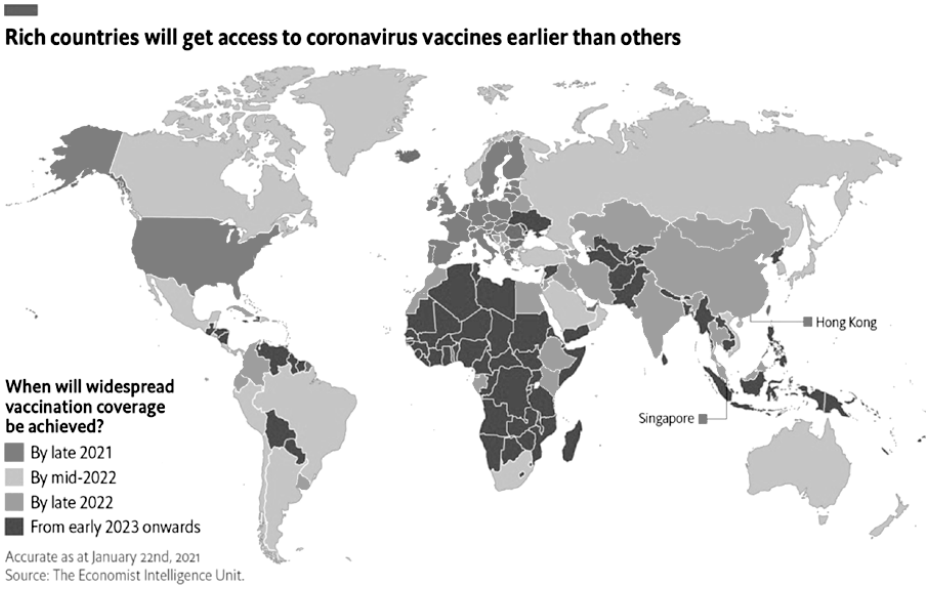
By Fiona Davey

As blossoms begin to unfurl, temperatures begin to warm, and the days begin to lengthen in the Northern Hemisphere, spring is not the only harbinger of hope. In the US, the increasing vaccination rate is beginning to spread a cover of hope and optimism back over the country. As of March 27th, 140 million vaccine doses had been administered in the US, 27.4% of the population (91 million people) had received at least one dose, and 15% (50 million people) were fully vaccinated. But this is not the picture everywhere. In fact, globally it is mostly not a representative picture of COVID-19 vaccine access. In February, UN Secretary-General Guterres warned that while 10 countries had administered 75% of the total vaccines, more than 130 countries still had not received even one vaccine. Meanwhile, healthcare workers die, unprotected from the virus they continue to treat and prevent in their communities, struggling to combat a pandemic that could continue in their home countries for years to come without equitable global vaccine access.

> **"In February, UN Secretary-General Guterres warned that while 10 countries had administered 75% of the total vaccines, more than 130 countries still had not received even one vaccine."**

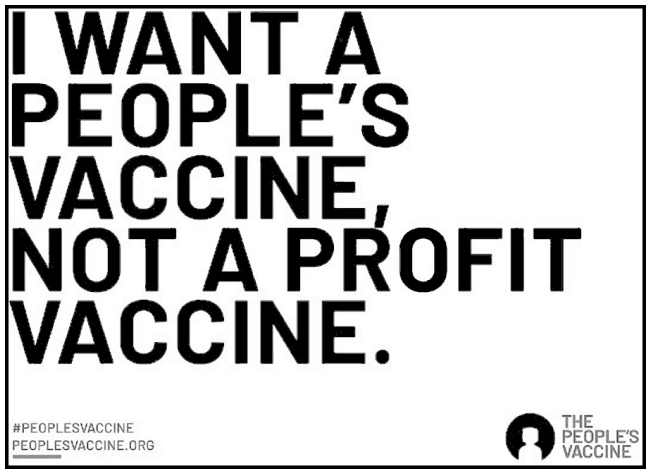
Worldwide, there are currently 14 vaccines approved for use in various countries and reports indicate a possible 21 billion vaccines could be manufactured in 2021. Of these, 10.5 billion vaccine doses have been secured in agreements between pharmaceutical companies and governments or groups. The vast majority of vaccines have been purchased by high-income countries in a manner that is disproportionate to population size. At the beginning of this year, the EU had purchased 1.6 billion doses (3.5 per person) and the US 1.2 billion (3.7 per person). The UK had purchased 367 million doses (5.5 per person) and Canada had purchased 362 million, enough for each Canadian to receive 9.6 doses each. In contrast, the African Union had been able to purchase 270 million doses (0.2 doses per person) and all of Latin America had purchased 150 million doses (0.4 doses per person). This vaccine hoarding means that while some countries could theoretically vaccinate their populations in multiplicate, others are left behind, unable to vaccinate to protect their people even once, and the world will be more vulnerable to the creation of new, perhaps more dangerous variants of the virus.

Within each supply agreement, pharmaceutical companies and their licensed manufacturers dictate prices, and not all bidders get the same price. While the EU negotiated for a $3.03 price tag on their AstraZeneca vaccine purchases – a deal which has been rationalized in part by EU financial contributions backing research and development of the vaccine, South Africa has been dealt a devastating price of $5.25 for the same vaccine. Further entrenching this disparity and the murky lines drawn around what types of contribution are valued is the fact that South Africa hosted clinical trials for the AstraZeneca vaccine. The price set for South Africa was based on the country's classification as an upper-middle class country by the World Bank, presumably indicating that the country should be able to afford purchasing millions of doses at that price point. Yet this classification system fails to account for the economic realities experienced by low- to upper-middle class countries which have been hit by economic crises. They are still forced into the position of making debt payments before directing governmental resources towards protecting their populations from the pandemic by purchasing vaccines and treatments and improving public health infrastructure.



COVAX, managed by The Vaccine Alliance (Gavi), the Coalition for Epidemic Preparedness Innovations (CEPI), and the WHO, is currently the only global mechanism to pool vaccines in the effort to ensure access for poorer countries. The initiative aimed to secure and "fairly distribute 2 billion doses of COVID-19 vaccines across almost 200 countries and economies by the end of 2021" so that low-income countries could equally access vaccines at the same time as high-income countries. Under the COVAX system, participating countries gain access to the portfolio of vaccines, with richer countries paying more to subsidize poorer countries, with additional support from private and public donations. Thus far at least 170 countries have joined the mechanism, 92 of which are low- and middle-income countries receiving much needed support for vaccine access. However, facing funding, supply and distribution constraints COVAX is falling short of both the intended aims and global need. The first COVAX-secured vaccines were delivered to Ghana and Côte d'Ivoire the week of February 24, amounting to 600,000 and 504,000 doses respectively. By mid-2021 countries relying on COVAX

will be able to vaccinate only 3.3% of their population and only 20% by the end of the year, assuming deliveries stay on track. This stands in stark and unacceptable contrast to the rates already experienced in high-income countries with 59% of Israel, 45% of the UK, and 28% of the US already receiving vaccinations.



Furthermore, while COVAX aims to alleviate inequitable vaccine access, it does so through conventional philanthropic models (rich countries donating to poorer ones) while failing to acknowledge or address the systems which produce such inequity. Thus far, COVAX has been silent on the issue of pharmaceutical monopolies, and non-transparent concerning its negotiations with companies and how their vaccine prices are agreed upon. A true move towards equitable access is incompatible with a mechanism that continues enabling steep profits for pharmaceutical companies (such as Pfizer's 80% profit margin gained from a $39 price point for two vaccine doses) and considers tiered pricing models (such as the one that charged South Africa a higher price than the EU).

Scaling up COVID-19 vaccine manufacturing to ensure equitable global access is admittedly not uncomplicated, but it is far from impossible. Manufacturers across the world could be producing more vaccines and their various components (from enzymes to vials), if freed from the constraints of international Intellectual Property (IP) protection and supported with technology transfer and the sharing of technical know-how needed to make vaccines. The systems set in place constraining an equal response to the pandemic are not the inherent facts they sometimes feel to be, fixed in stone since the dawn of time and fated to condemn us forever. The pillar of contemporary IP protection currently protecting pharmaceutical monopolies and standing in the way of increased vaccine production, the World Trade Organization TRIPS agreement, was only brought into being 40 years ago. Before, the intellectual property system looked much different and the idea of patenting essential goods, like medicines or vaccines, was considered unconscionable by many. At the beginning of the WHO smallpox eradication campaign, the WHO estimated expenditures of 10¢ per person with the final average annual cost $23 million across the campaign from 1967-1979. The culmination of this historic campaign was a complete eradication of smallpox in humans. While the diseases and vaccine technologies (and production costs) are not identical, this does illuminate different possibilities than current challenges faced in ending the COVID-19 pandemic.

In the 1972 smallpox outbreak in Yugoslavia (the last major outbreak in all of Europe), the government halted spread of the disease with lockdowns, quarantines and, notably, a mass vaccination campaign that inoculated 18 million out of the country's 20 million residents in just two months. Only 175 people were infected with smallpox and just 35 individuals died. Today the situation looks much different for Bosnia, one of the successors to Yugoslavia and where I am now living, which has been devastated by COVID-19. In a country of 3.3 million, COVID-19 deaths have reached 5,729 since the start of the pandemic; reported daily caseloads are at 1,5000, hospitals are overrun, healthcare workers are exhausted and largely unprotected by vaccines, and resources are running low or are non-existent (such as remdesivir, which being priced out of reach for the country, remains unavailable outside of one region or the black market). The current outlook for rescue by vaccine looks grim. As a self-financing member of COVAX, Bosnia received its first shipment (23,400 Pfizer doses) on March 25th and may be largely reliant on receiving donations from other countries (such as the 52,000 doses given to them by Serbia and Russia and 30,000 donated by Turkey).

These conditions are deeply troubling. Yet hope does remain. Across the globe dedicated individuals, communities, coalitions and organizations are working tirelessly for a People's Vaccine. Last fall India and South Africa, now joined by 100 other countries, called on the World Trade Organization to waive intellectual property rights (enforced by the TRIPS agreement) until global herd immunity is reached. With a TRIPS waiver, manufacturers throughout the world could access the patented information needed to begin making more vaccines for everyone, everywhere. This could also be actualized through the COVID-Technology Access Pool (C-TAP) organized through the WHO, which is a knowledge and IP pool that facilitates the sharing and training needed to scale up global production. By a different tack, Cuba has turned their back on the prevailing system of COVID-19 vaccine monopolies, refusing to make bilateral deals with pharmaceutical companies or even sign up for COVAX. Instead Cuba has leaned into the promise of their own scientific and medical infrastructure – developing what could be their People's Vaccine, Soberana 2, which they would use to vaccinate their whole country by summer's end and ultimately give away to other countries.

Advocates in the People's Vaccine Alliance and others are calling upon governments and pharmaceutical companies to join C-TAP (by entering their IP) and support the TRIPS waiver in order to end the pandemic. On March 11, the anniversary of the WHO pandemic declaration, DGH joined with our allies in this call, participating in a global day of action. In DGH, we know equitable access to COVID-19 vaccines is a human right, that this vaccine should be a global, public good, and that global vaccination also protects us all from variants. Faced with a global pandemic and devastating inequity, we need not a profit vaccine, but a People's Vaccine.

Advocating for Patients and Fighting with the Health System – One Call at a Time

By Patty Medina

As a community health worker in New York City, I advocate for my patients to help them obtain access to medical services, schedule appointments, transportation, contact their health insurance for authorizations, obtain durable medical equipment, medications, identify social determinants of health and connect them to social services to help them stay healthy and safe. I am the first on my team to establish contact with a patient. I work with underrepresented communities that live predominately in the Bronx and Brooklyn, NY. A majority of my patients are non-English speakers, with multiple comorbidities who face the daunting challenge of navigating the complicated automatic messaging system to connect with their provider. As a community health worker, I conduct an assessment to identify barriers that make it difficult for patients to seek medical care and share with them resources to combat food insecurity, housing instability, obtaining their stimulus checks and more. During my interactions, I learn about patient's complex medical needs, the challenges they endure on a daily basis, in addition to trying to survive a pandemic.

I have heard patients' concerns, fears, frustrations and anger as I listen on the other end of the phone. Because of my language skills and ability to establish rapport with my patients, I interact with over 100 patients. I listen to my patients speak to me for five minutes, 30 minutes, one hour, even two hours. On a busy day, I speak with 30 patients. Sometimes I stay past my shift to ensure that I check in with everyone for the day to make sure they are doing well.

"I was appalled that COVID-19 vaccine appointments were dictated by one's access to technology and ease in using the internet."

My patients include children, pregnant women, middle-aged men and women, and the elderly. A 60-year-old man developed a wound infection but was unable to speak with his provider because the line being busy. As a bilingual person, I could quickly skip through the automatic messaging system and connect with a provider within seconds. I called the provider and informed him that the patient was developing a high fever and that his wound was oozing. The staff immediately called the patient and had him transported to the hospital.

A 45-year-old female was silently combatting depression and was desperately trying to find an affordable WI-FI service for her 10-year-old daughter so she could attend her online classes. A 50-year-old male needed to find a specialist to get a procedure done yet his insurance denied him the first time. A 43-year-old female was food insecure and had three small daughters to feed. A 60-year-old male needed transportation to and from his dialysis appointments; and many others.

One story that I will never forget is the 63-year-old male with various underlying health conditions and prior ER hospitalizations. He asked me, "Can you help me make an appointment to get the COVID-19 vaccine?" I immediately replied, "of course!" It was March 3, 2021, and the COVID-19 vaccines were only available to individuals 65 years of age or older – prioritizing those with underlying health conditions – and essential workers.

I searched for the NYC COVID-19 vaccine finder and filled out four forms to different locations to get him on the waiting list. I called a few pharmacies and tried to get him a spot for a vaccine given his high medical risk, but was told that due to his age he did not qualify. I was angry that the vaccine was not being prioritized for patients with underlying health conditions despite the age requirement. I was disappointed at pharmacies for turning away patients when they are supposed to be helping communities stay healthy.

He told me he was grateful that I was helping him find an appointment because he did not know where the vaccine was being offered. He shared that in his neighborhood in the Bronx, appointment slots were full because a lot of people who did not meet the eligibility criteria were getting it before those living there. This was unethical and inequitable. How could it be that those living in a neighborhood with the highest cases of COVID-19 were still not able to get the vaccine? Why were vaccine efforts slow and disorganized? Who determined that scheduling an appointment via telephone and online in English is equitable when 35% of people in NYC do not speak English at home; instead they speak languages such as Spanish, Chinese (Mandarin, Cantonese), Russian, Other Indo-European, Italian, French Creole, Korean, French, Tagalog, Polish, Other Asian, Yiddish, Arabic, African, Hindi, Urdu, Greek, Hebrew and German. I was appalled that COVID-19 vaccine appointments were dictated by one's access to technology and ease in using the internet.

But I was determined to get him the vaccine. I decided to call his insurance to see if they could help. I spoke to a representative who told me that the patient needed to be on the line for authorization. I called my patient and the representative went over HIPAA and asked him if I could speak on his behalf. The patient said he trusted me completely and gave me authorization. The representative told him that he could disconnect as I was now able to speak with him. I told the patient that I would call him after. I informed the representative that my patient had underlying health conditions and needed a COVID-19 vaccine appointment. He said that unfortunately due to his age, he was not eligible yet. I was not ready to accept "No" for an answer. I told the representative that my patient has four underlying health conditions and had been hospitalized over 15 times this year. My frustration got the best of me and I told the representative it was not fair that he could not get the vaccine. I started rambling on about the plethora of medical conditions and the list of medications he was taking until the representative finally gave in and decided to help me. The representative scheduled an appointment for the patient on March 7, 2021, at 9 pm. I thanked the representative and called my patient.

He was very appreciative and told me that

he could not believe I was able to get him an appointment in 3 hours. I was tired but it was worth it when I heard the relief in his voice. It was a big victory for my patient because he had won against a healthcare system that was denying him the opportunity to get the COVID-19 vaccine.

As a future physician, it is important for me to advocate for patients, speak out against injustices within the healthcare system, and combat structural determinants of health. It is not right for a patient to be denied access because of policies that leave the most vulnerable unprotected, the lack of coordination and communication between healthcare entities, and the racism that exists in healthcare institutions. We must stand in solidarity with marginalized communities, our loved ones, friends, neighbors and colleagues in the US and abroad, who have not received the vaccine and advocate for equitable distribution. Together we are strong. Together we will hold governments accountable and ensure that the health and safety of all people are prioritized. Together we will eradicate COVID-19.

FROM LIBERATION TO ABOLITION: A REIMAGINING OF THE WORLD

By Xavier Coughlin

We find ourselves in a world of radical change. The trial of Derek Chauvin, the former police officer who killed George Floyd in a stunning display of police brutality, is ongoing. The wisps of the global uprising against police and state oppression well ingrained in our memories, the consequences of this trial will be felt across the nation. There is a flutter of hope that this global pandemic may be coming to an end at least in the global north countries, but a sinking knowledge that capitalistic and nationalistic shortsightedness will continue to deprive the world of their right to health and a "shot in the arm," thus ensuring the continuation of this plague that ruptures life. And behind it all, the earth sighing in its own turmoil, our only response being to comment "how wild the weather has been."

> "Abolition is a theory of change, it's a theory of social life. It's about making things."

Decades ago, in small oppressed Latin American villages, a theory of liberation was put to words. It was not created then, because what it espoused had been practiced for centuries. It called on those who believe in human rights, who fight for the liberation of the poor, to no longer stand on the sidelines. It simply asked for people to "observe, reflect and act."

We start by observing the world to study it. Then move to reflect or, as other practitioners have stated, to judge what is going on; to see that there is a right and wrong side of history. Then to act based on this belief. Then to continually repeat the process, always being flexible and contemplative of our actions and changing situations. From this theory and the centuries of practice, Liberation Medicine, which is core to DGH's principles, was set into words, offering a way to explain what we had known to be true.

Presently, in a country in turmoil, we find a theory of abolition resurging. For those who may be new to abolition or only have heard debates about the slogan "Abolish the police," it is easy to see an abolitionist policy as being about removing or deconstructing aspects of society, akin to the Abolitionists of the pre-civil war era. But as Ruth Wilson Gilmore argues, "Abolition is a theory of change, it's a theory of social life. It's about making things." While it starts with the carceral state, it expands to include all institutions of life. I argue that a medicine of abolition pulls us beyond Liberation Medicine; that not only must we act in the world, but we must also reimagine the world.

In light of this more expansive definition, what then could an abolitionist medicine look like? As with Liberation Medicine, it calls us to observe the world. A renewed or "people's" history of the United States elucidates the foundations of this country being racism, genocide and patriarchy. The Indigenous of Turtle Island were brutally slaughtered, diseased and removed from land only to have their treaties continually broken. Most of the Founding Fathers were slave owners, and the creation of the nation state was more important than the liberation of slaves, condemning them to a subhuman status. Women and the poor were not even thought to have the capacity for self-governance. The rise of a capitalist system was not some benign progress, but rather a brutal war against workers, the poor, and ultimately the earth itself.

When we look at the police and the carceral state, which is often a starting point for abolitionist theory, we see the historical rise of a police force from slave patrols and forces of colonization. When people say, "The police and the KKK, hand in hand," it is a reference to the documented collaboration between police networks and white supremacist ideology. And recently, history comes back to haunt, as we saw the deliberate collaboration (or grotesque ignorance) of police forces in the January 6th white supremacist insurrection. And lastly, let us gaze at the history of medicine.

Racism and medicine created what is now being called "carceral humanitarianism," whereby plantation owners created a form of "healthcare" for their slaves, not for their ultimate freedom but to maximize their production. Throughout history, we see how Black, Latinx, undocumented and Indigenous populations were forcibly excluded from healthcare, such as a complete denial to bear responsibility for the health of freed slaves or the creation of segregated and grossly underfunded hospital systems in the south and with the Indian Health Service. Or a more sinister use of medicine to further genocidal aims, such as the Tuskegee syphilis experiments and the use of smallpox contaminated blankets "gifted" to Indigenous populations.

Fast forward to today, we have a prison system that seems to surgically target Black and

Latinx populations, a pandemic that "magically" disproportionately kills communities of color, and inmates in NY making hand sanitizer for which they have no access. We may have fought a Civil War, but slavery and racism are alive as ever, a "New Jim Crow."

Liberation Medicine and abolition call us to then "reflect" or "to judge." We must accept, contrary to the recent JAMA podcast, that structural racism in medicine is real, that it exists and it permeates our field of healthcare. We are asked to see that capitalism harms public health that disparity and inequity, nationally and globally are not merely oddities, but are intentionally created through policies and decisions. And finally we are asked to act, to move towards justice. These actions can be broad, working in local/national government to advance policies such as a "Medicare for All," creating free clinics, working to support liberatory movements here and abroad, participating in mass protests to stop extraction, and on and on. So much of the work of DGH is to support such actions, and the list is exhaustive of what would be fruitful action in a liberatory and abolitionist sense.

"And so we ask, "What would an Abolitionist Medicine look like, feel like?" Perhaps access to cutting edge cancer treatments for all, or rather the creation of a world in which our recklessness did not create 'cancer alleys' and an inherent environmental racism."

Abolition and an "Abolitionist Medicine" pulls us forward beyond Liberation Medicine, calling us to finally reimagine the world. Not in contrast but as an expansion, we are called to tear down the institutions of racism, capitalism and patriarchy. At the same time, to build a new world in the ruins of the previous. And so we ask, "What would an Abolitionist Medicine look like, feel like?" Perhaps access to cutting edge cancer treatments for all, or rather the creation of a world in which our recklessness did not create 'cancer alleys' and an inherent environmental racism. Abolitionist medicine calls us to reimagine hospitals and clinics, where hierarchy is ingrained in the fluorescent lights. Rather, let us imagine what a place of healing would feel like, where health, not just disease diagnosis was the priority, where we built community and individual autonomy.

A world where we say yes to a living wage, but also no to a life of mindless work for mere survival. Where society restructures itself to offer purpose to people, not just a life mediated by disconnected work. Let us imagine a world where we don't just pay lip service to the devastation of colonization and chattel slavery, but commit to the hard work of reparations and decolonization.

The list is endless and overwhelming, but our time and our own consciences are demanding that we answer the call. The work of DGH has always been committed to moving towards a world of liberation, to a future of abolition. We are continually grateful to those who have come before us, to those who walk with us, and to those who will come. Join us, as the Zapatistas say, and "walk while questioning."






The smiling faces of children from our partner communities make it easier to reimagine a new world where those smiles will not so easily be wiped away.

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