



Newsletter from the Sierra Madre #65

December, 2009



PROJIMO Community Based Rehabilitation Program
run by and for disabled villagers in western Mexico (Coyotitan)

HEALTHWRIGHTS
Workgroup for People's Health and Rights

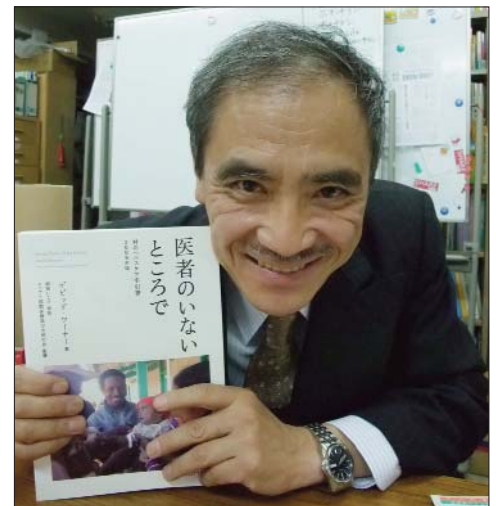
PROJIMO Skills Training and Work Program
run by disabled youth in rural Mexico (Duranguito)

Where There Is No Doctor in Japan by David Werner

In October, 2009, I was invited to Japan for a speaking tour linked to launching the Japanese translation of my book, *Where There Is No Doctor*. At first glimpse, it may seem incongruous that this healthcare handbook—written for marginalized people living in underserved areas of poor countries—be translated into Japanese. After all, modern Japan is reputed to have one of the highest standards of living in the world. It has among the best health statistics in terms of low child and maternal mortality rates and long life expectancy. It also has one of the highest ratios of doctors per capita. Why should there be a

need for this village healthcare handbook in Japanese?

SHARE (Services for Health in the Asia and African Region), the non-government organization (NGO) that arranged my visit, gives three reasons why it translated *Where There Is No Doctor* into Japanese: 1) for community health assistance overseas, 2) for more and better self care in Japan, and 3) for use by and assistance to the growing numbers of destitute people in Japan who lack adequate health services. Let's briefly explore these three uses:



Dr. Toru Honda, the founder of SHARE, holds a copy of the new Japanese translation of *Where There Is No Doctor*, by David Werner. The book will be used not only by Japanese health and development workers in poor countries, but by the growing population of the homeless and destitute in Japan, and by the many local NGOs and "free clinics" offering assistance.



A street person, or "rough sleeper" in Tokyo is ordered to leave. Across the river are tents and shacks of squatters, whose numbers in Japan have been growing rapidly in recent years.

First: Overseas assistance. Japan provides a large amount of "health and development assistance" to poor countries. Its "foreign aid" budget to so-called developing countries is around .28% of its gross national income, as compared to only .22% for the US. The Japanese International Cooperation Agency (JICA), the equivalent of USAID, is very active in the Asian-Pacific region, as well as the Middle East, Africa, and Latin America. During my visit to Japan I spoke—sometimes in Spanish—with beives of enthusiastic health and rehabilitation professionals and students who had worked in disadvantaged communities in Guatemala, Nicaragua, Honduras, Bolivia, Peru, and even Mexico. Many had been volunteers

in the Japanese “Peace Corps,” or gone with NGOs. I was happy to find that many have a humanitarian, politically progressive world view.

Many of these enthusiastic volunteers had used my books—for their personal health-care as well as for teaching tools. They felt having *Where There Is No Doctor* in their own language would be a great asset.

Second: More and better self-care in Japan. Many health activists in Japan feel the population has become over-dependent on doctors and costly medical services. They agree with the basic principle put forth in *Where There Is No Doctor*, that “Ordinary people provided with clear, simple information can prevent and treat most common health problems in their own home—earlier, cheaper, and often better than can doctors.” They see *Where There Is No Doctor* as a valuable and empowering tool, even where doctors are plentiful.

Third: A resource for Japan’s growing indigent population. Japan has a growing marginalized population who can’t afford—or are fearful of asking for—the health services they need. This includes migrants—legal and illegal—from neighboring countries such as China, North Korea, Laos and Thailand. It also includes the swelling ranks of down-and-out Japanese who have lost their jobs and their health insurance, and who live in “flop houses” or homeless shelters. Those who lack any shelter at all—mostly middle-aged or older men—simply “squat” in the



Homeless people along the Sumida River, waiting in line for the distribution of bread.



The “rough sleeper” who was run off by the park guard found a new resting spot under an overpass.

streets or alley-ways. This latter group is referred to as “rough sleepers.”

While walking along a beautiful promenade flanking the Sumida River, which runs through central Tokyo, we saw scores of “rough sleepers.” Like street-people in the US, many use “borrowed” shopping carts to house their few belongings. Some sleep on park benches. Others huddle along the edge of the well-groomed paths. Many suffer from hunger, disease and exposure. From the cold winter nights, some never wake up.

The criminalization of poverty

Poverty and vagrancy are being increasingly outlawed. At one point in the riverside park we watched a grounds-keeper drive his small electric vehicle up to a sickly old man sitting on a tattered comforter, and order him to “move along.” Silently the old man rose, gathered his paltry belongings in his arms, and limped off down the path. Later we spotted him again, settled on his rags under an overpass a few hundred yards down river.

Slightly better-off than the rough sleepers, hundreds of squatters dwell by the river’s edge in tent-like shacks or lean-tos made of plastic tarps stretched over poles. These tiny hovels—tucked among the trees or against the high walls of the city—are at best very transient. Every week a “cleansing patrol” marches down the riverside with big “sweeping machines” and water cannons. As they approach, the squatters hurriedly dismantle their shacks to keep them from being swept away. After the cleansers pass, the squatters quietly rebuild.

Observing with my own eyes this mushrooming underclass, I began to understand why SHARE feels there is such a great need for the new Japanese edition of *Where There Is No Doctor*.

Similar growing inequities in Japan and the US

After its defeat by the United States and the horrendous destruction caused by the nuclear bombing of Hiroshima and Nagasaki, Japan compliantly adopted many of the socioeconomic prescriptions of Uncle Sam. The capitalist economy grew by leaps and bounds—until Japan became one of the world’s strongest and most powerful economies. But, as in the US—where the bottom line of the market system is private profit rather than the common good – bit by bit the traditional social cohesion of Japanese culture has deteriorated. As the gap between rich and poor has continued to widen, the safety nets for the disadvantaged are allowing more and more people to fall between the cracks.

The Japanese health system—largely privatized as in the US

Japan has a complex healthcare system which—although it includes somewhat more public assistance more government regulation than the US—in many ways resembles America’s largely privatized, profit-oriented health insurance system. In Japan everyone is legally required to buy private health insurance—and large employers must help cover the cost for their full-time employees.



Shacks of sheet plastic, set up by homeless squatters along the shore of the Sumida River, in Tokyo.

Traditionally, in Japan, businesses have strong ties to their workers, and vice versa. In some ways the workers are virtually “owned” by the company they work for. But the company in turn assumes a god-fatherly, life-long responsibility for their workers, providing health coverage, retirement pensions, and emergency assistance. It is perhaps this protective role of businesses and the regulatory role of government, combined with the traditional extended family support system, good diet, and other indigenous factors, that help explain Japan’s excellent health statistics—up until now.

Breakdown of safety nets

In recent years these traditional health-promoting patterns have begun to change—largely due to the impact of the free market. After decades of economic growth, during the last few years Japan has experienced an economic downturn—which is now aggravated by the global financial “meltdown” that began in the US. Japan, which relies heavily on manufactured exports and has to import 60% of its food, has been especially vulnerable to the global recession. Huge factories (like Toyota) have had to lay off thousands of workers. When the workers lose their jobs, many lose their health insurance—and sometimes their homes.

Recently big businesses in Japan have been imitating the US by employing increasing numbers of low paid, part-time or temporary workers, to whom they are not required to provide health insurance, job security, or unemployment benefits. Such workers are conveniently dispensable. For example, as the foreign market for automobiles shrank during the current meltdown, giant manufacturers like Toyota—while continuing to retain and protect their inner circle of long-term, full-time employees—has callously laid off vast numbers of low-paid itinerant workers. This swelled the ranks of the homeless and uninsured.

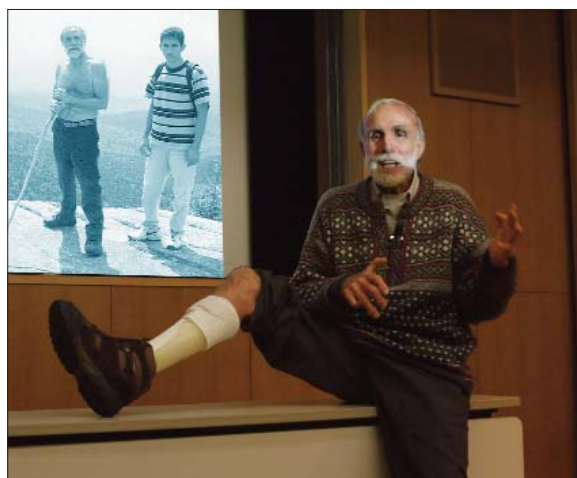
The disadvantaged immigrant population

One population that often falls between the cracks of welfare serv-

ices in Japan are the immigrants, both “registered” and “unregistered.” With its population of 120 million, Japan has nearly two million registered immigrants, mostly poor job-seekers from Southeast Asia. Many came on temporary visas, to fill the need for the menial “dirty work” that the local population avoids. (Sound like the USA?)

Sex workers and HIV

Aggravating the health situation of disadvantaged immigrants is the fact that not long ago a lot of poor women and girls from neighboring countries were brought to Japan as sex workers. Although this pattern has now largely been halted by the state, hoards of the immigrants who come to do other work must resort to selling their bodies when they become unemployed. As a result, the incidence of HIV/AIDS (and TB and Hepatitis C) is higher among these immigrants than in the general population. Sadly, for reasons of shame, prejudice, and fear of deportation, many immigrants avoid testing or treatment—until it’s too late. Although there are lots of community-based HIV educational and treatment programs for immigrants and the destitute—such as those run very humanely by SHARE and AHI—only about 50% of HIV positive migrants get the treatment they need. Many seek treatment only when they are on the edge of death from opportunistic infections.



At a seminar at the Tokyo Children’s Rehabilitation Hospital, David Werner shows the plastic leg brace made for him by Marcelo, a disabled village rehab tech at PROJIMO, in Mexico. The braces worked better than costly ones made by US professionals, because Marcelo worked with David as an equal and partner in the problem-solving process. Behind him is a projected image of David at the top of a mountain he climbed.

Family breakdown and imported wives

As the flow of imported sex-workers has been increasingly curtailed and criminalized, a new pattern has emerged. In rural areas a growing number of girls and young women are leaving their villages and moving to the cities, where they can get better jobs and live more independently. Because of family tradition, however, most young men feel obligated to stay and manage their family farms. As a result, a lucrative business has developed whereby import agencies recruit “wives” from neighboring poor countries and arrange all the paper work for high fees. Under this new arrangement, at least the imported wives tend to be relatively well cared for. Reportedly, many of these “free market” marriages turn out happily.

The aging, shrinking population

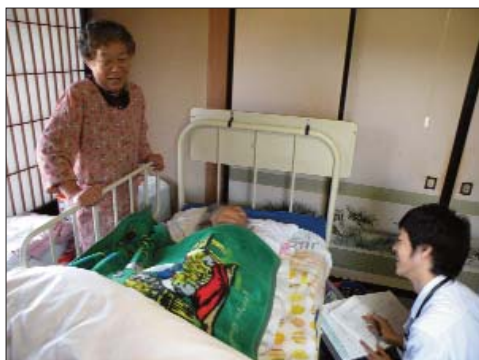
One of the most worrisome official concerns for Japan’s future is its aging population. Today, many young people decide not to marry, and many who do marry choose not to have children—or at most one child. Consequently Japan’s population is decreasing, and the percentage of elderly people is increasing. Rural areas have the most elderly persons due to the exodus of the young to urban areas. In the different provinces, the proportion of people over 60 years old varies from 35 up to 60%!

Adding to the high elderly population is the fact that the Japanese have one of the highest longevity rates on earth, with many people living into their late 80s and 90s. Because these old folks are no longer employed and have larger health needs and costs, the challenge of meeting their needs as the population of younger workers decreases, is daunting.

On a visit to Saku, in the central, mountainous part of the main island in Japan, I accompanied a local doctor on a home visit to a paralyzed woman in her mid-90s, in the rural area. The old woman, who needs continuous care, was fortunate in that she is lovingly cared for by her eldest daughter—who is in her mid-70s. The government provides the daughter with the equivalent of \$120 a month for the round-the-clock care of

her mother. But this doesn't begin to meet the family's needs. The daughter's aging husband is also infirm and retired. He raises a few vegetables behind the house. Life isn't easy.

Despite the economic downturn, in a country as wealthy as Japan one would think a better system could be worked out to help those in need. But the decision makers too often put profit before people.



A doctor from the farm workers community hospital in Saku visits the home of a 93-year-old woman, who is cared for round the clock by her aging daughter.

A proposed solution: bring in more immigrants

One step the Japanese government is reportedly considering, to overcome the disproportionately high number of elderly persons and the shrinking population, is to encourage more immigration from other countries, especially of young people. For all their worry about global warming and other disadvantages of over-population,

the controlling elite in Japan are still wedded to the free-market paradigm of economic growth. Fortunately, however, a growing number of forward-looking activists are questioning the unsustainable free market scripture of growth at all costs. They recognize that their heavily crowded island nation needs to find a way to reduce both its population and its ecological footprint, in order to live in a sustainable balance with its resources and environment.

The health costs of monoculture forests

Japan has been making an effort to achieve a healthier, less polluted environment, especially in urban areas. Tokyo—with an extended metropolis over 30 million people—was becoming dangerously contaminated with smog. But with recent efforts to control exhaust, reduce vehicle size, regulate factory emissions, and clean up waterways, pollution has been visibly reduced. In the rural areas, efforts are underway to protect forests and waterways and prohibit deforestation.

Many problems are still unresolved. One unexpected problem is that extensive forests in the mountains have over the years been replaced by vast monoculture stands of cedar trees, in high demand for timber. The huge cedar forests are closely policed to prevent over cutting. But a serious health problem has arisen: a seasonal pandemic of asthma. In springtime the vast forests of cedar produce a cloud of



Dr. Toru Honda opens the SHARE Seminar in Tokyo titled "Envisioning the Future – 'Is Health for All Possible at All?'" Above to his right is the SHARE logo.

powder-like pollen which the prevailing winds carry all the way to Tokyo and other cities far below. The result is a scourge of hay-fever and asthma, which is taking a serious toll both on people's health, health services, and the economy.

Japan's grassroots movement to build a fairer healthier world

Despite its very different history and culture, since World War II Japan has pursued a free-market economy similar to the US, and this has resulted in an increasingly stratified class system. Its school system, as in most highly stratified societies, tends to teach young people to follow the leader, obey the rules, and fit compliantly into the polarized social order, rather than to think for themselves and work together to build a healthier, fairer world .

Nonetheless, on my recent visit to Japan I was greatly impressed by the numbers and diversity of activists devoted to working for a fairer, more compassionate world. I suppose one reason I met so many like-minded "promoters of change" is that many who attended the seminars were already familiar with my views. No doubt the titles of my talks, such as "Is Health for All possible in a Free-Market Economy," attracted folks who are questioning the unfairness and unsustainability of the status quo. In any case, I found the interaction with so many high-minded souls profoundly encouraging. Among those who most inspired me are the following:

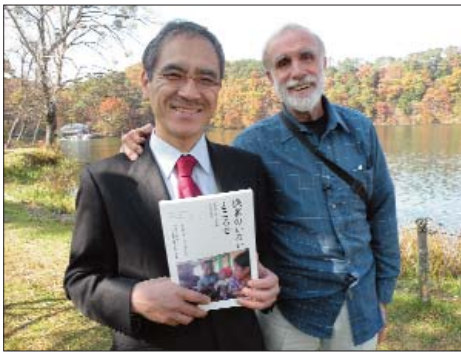


David Werner facilitates the "Chain of Causes" awareness-raising activity with the SHARE team at their Tokyo office. The team learned about this activity from the book *Helping Health Workers Learn*, by Werner and Bower, and has used it in community health education in various countries. At SHARE David added a new link on ENVIRONMENTAL CAUSES—since climate change and environmental destruction are becoming increasingly overriding social determinants of health.

**Toru Honda:
Promotion of
community
health and
social justice**

In his youth Toru Honda was inspired by the work and spirit of the late Dr. Toshikazu Wakatsuki, “the father of community health care” in Japan. After getting his medical degree, Toru has spent his life serving and empowering those in need. In 1983 he helped initiate SHARE: Services for the Health in Asian and African Regions. SHARE has an active community outreach program which provides health services, soup kitchens, and shelter for underserved communities in and near Tokyo. It also is engaged in community health promotion in Cambodia, Thailand, East Timor, and South Africa. SHARE’s mission statement explains that:

By providing medical care, training and advice, SHARE helps people and communities to autonomously overcome their own health problems. We work to promote universal access to health care services with full involvement of the community. Our goal is to achieve a fairer and healthier world through SHARING and working with people.



Visiting a local lake in Saku, Dr. Toru Honda, the founder of SHARE, holds a copy of the new Japanese translation of *Where There Is No Doctor*, by David Werner (on his right).

In Japan SHARE has an active Migrant Health Program. It recognizes that

... non-Japanese persons living in Japan face numerous difficulties when attempting to access health care. The lack of national health service, high medical costs, limited multilingual healthcare staff, and cultural differences are

among the many barriers that may limit access to healthcare. Keeping in mind that healthcare costs increase and outcomes worsen when illness remains undiagnosed and untreated, prevention and early detection are key.

SHARE has helped organize a network of community programs reaching out to migrants and other indigent people. These small non-profit programs work together to help people meet their varied needs. They assist with everything from HIV and TB prevention and treatment services, to soup kitchens, to low cost “flop houses,” to “hospice” nursing facilities for the dying. Toru—now in his 60s—still attends the sick in a free neighborhood clinic in a notorious “ghetto” called Sanyu, from which he makes home visits by bicycle.

It was Toru Honda who spearheaded the translation of *Where There Is No Doctor* and who had urged me to visit Japan. He personally invited me to accompany him on his rounds to the Sanyu Community Clinic and to visit some of his patients.

Toru took me to visit in a makeshift “hospice” in Sanyu—an ancient building where good-hearted volunteers care for homeless persons on their deathbeds. There Toru respectfully introduced me to an elderly man dying of cancer as “the famous Haiku poet from Sanyu.” His name is Izawa Sawao, and



Dr. Toru Honda takes David Werner to a communal hospice to visit the Sanyu Haiku poet, Izawa Sawao, who is dying of cancer, is sheltered.

Toru later printed out for me, in Japanese and in English, one of Izawa-san’s most well-known Haiku:

野宿冬 命の生活 (たつき) アルミ缶
いざわさわ男
(みなせん 2006)

*The harsh winter chill falls on
the shoulder of a rough sleeper;*

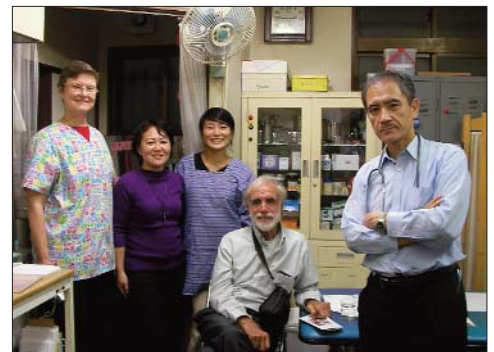
*The only means of survival left
for him*

*Is collecting discarded aluminum
cans on the street.*

When the old street poet felt Toru’s hand on his shoulder, and the good doctor addressed him as an equal, his pale weathered face glowed with pleasure. I’ll never forget the warmth and deep respect that Toru showed this moribund old street person. It made me feel more deeply than ever, what an exceptional and loving human being Toru Honda is.



Local inhabitants of the notorious Sanyu slum help out in the Sanyugai Community Clinic which provides free medical care.



Member of the SHARE team at the Sanyu Clinic, with Sister Rita, a Maryknoll nun, a nurse who is one of its long time supporters and volunteers.

**Congressman
Ryuhei Kawada
and Mika
Tsutsumi:**

*The rights and
dignity of persons
with AIDS*



Two of the most inspiring persons I met in Japan were Congressman Ryuhei Kawada, and his wife, journalist Mika Tsutsumi. Ryuhei

was born with hemophilia, and in his youth he contracted HIV from contaminated clotting factor used in his treatment. (In the 1980s, worldwide, thousands of boys and men with hemophilia became infected with HIV in this way.) But rather than give up, Ryuhei not only fought the two diseases, but also battled discrimination. Little by little he built up a substantial following. Amazingly, as an independent candidate, he succeeded in getting elected to Congress, where he has been a persuasive spokesperson for the rights and universal access to treatment for persons with HIV.

Mika, who married Ryuhei, knowing he had hemophilia and HIV, has joined her husband's campaign for the rights of marginalized people. As a journalist, she has researched and written extensively on the health system of the United States. She has critically analyzed its inequities, rising cost, and the way the US has imposed its costly, inequitable system on other countries, including Japan. Together Ryudei and Mika have done a great deal to raise awareness of the need for health system reform.

**Shoji Nakanishi
and Yukiko
Nakanishi:**

*Founders of the
Independent living
Movement in
Japan*



In Tokyo I took part in a teleconference on “Disability and Development,” organized by JICA (Japanese International Cooperation Agency). Two key participants were a disabled (wheelchair riding) man, Shoji Nakanishi, and wife Yukiko Nakanishi. The couple has devoted their lives to the rights and inclusion of persons with disability, in Japan and other countries. Shoji began the Independent Living Movement in Japan. He set up Tokyo's first IL (independent living) center, the Human Care Association. Today there are 125 centers in Japan which have joined forces in a militant network called Japan Council on IL Centres (JIL). A lot of the changes in laws and building codes in Japan—which have improved accessibility,

public transportation, and education/work opportunities for persons with impairments—are the result of organized action by JIL.

JIL has also been active in promoting the rights and opportunities of disabled persons in neighboring countries. Yukiko spent years in Thailand, introducing Independent Living, and working with JICA to launch a Community Based Rehabilitation (CBR) initiative. She was instrumental in establishing the strong CBR component of ESCAP, the United Nations Economic and Social Development in Asia and the Pacific.

The Independent Living Movement in Japan appears to be more inclusive than in the West. In Europe and the US, IL has tended to be a middle class venture headed by persons with physical disabilities; often it does not include people who are intellectually disabled or are impoverished. By contrast, JIL seems more enlightened and all-inclusive. Perhaps this is due to Yukiko's long involvement with CBR in Thailand. She and Shoji

have advanced an approach to “disability liberation” which incorporates the strengths and avoids typical shortcomings of both IL and CBR. Both Shoji and Yukiko have written extensively on disability rights, and Shoji has authored an informative handbook on Peer Counseling.

The JICA/SHARE teleconference in Tokyo, which Shoji and Yukiko helped organize, was a marvel of communication technology. In addition to the scores of participants in the new space-age JICA auditorium, hundreds of others were present digitally—both visually and vocally—on 7 large video screens behind the podium. On one screen was projected our symposium in Tokyo. On the other six screens we could see the participants from Thailand, Philippines, Malaysia, Kyrgyzstan, Syria, and Egypt. Following my keynote address and responses from Yukiko and Kenji Kuno (JICA's CBR wizard), the “virtual participants” from the other countries took part in a lively digital discussion.

**Yoshinori
Ikesumi:
Organizing a
grassroots
movement to
demilitarize Japan**



I first met Yoshinori Ikesumi—better known as Yoshi—13 years ago, as an activist in the International People's Health Council and an avid promotor of Primary Health Care. In those days Yoshi was a leader of the Asian Health Institute (AHI), based in Nagoya. In 1998 Yoshi coordinated the Japanese translation of David Sanders and my book, *Questioning the Solution: The Politics of Primary Health Care and Child Survival*. At

that time AHI organized a visit by Sanders and me to Japan for the book launching. On my recent visit this November, AHI once again organized a seminar at which I spoke on the Politics of Health in the 21st Century.

From the time we first met, Yoshi and I hit it off well. We have a similar passion for defending the underdog, and for promoting a “subversive” approach to education that encourages people to think and to discover things for themselves rather than merely swallow what they're told.

On my recent visit to Japan I found that Yoshi has become more directly involved with “the politics of peace.” And in doing so he has literally taken a tiger by the tail. He

has mobilized a group of peaceniks who have sued the Japanese government to halt its unconstitutional involvement in the wars in the Middle East. In a Nagoya court, Yoshi made his case that the Japanese government, by sending Japanese soldiers and machinery to take part in the US-led war in Iraq, has been violating its own Constitution. The current Constitution, which was approved following the horrific nuclear genocide at the end of World War II, declares that “Peace is a basic human right,” and forbids Japan to participate in any war of aggression. Yoshi's peace brigade argues that the US-instigated war on Iraq was initiated under the false claim that Iraq had weapons of mass destruction. As such, it is an aggressive war in violation of international law. Japan's

military collaboration in such an offense violates Japan's Constitution.

The federal judge in Nagoya who heard Yoshi's case ruled in his favor, declaring Japan's military participation in the Iraq War unconstitutional. However, the Japanese Government has yet to acknowledge the court's decision. It may never do

so—unless a large sector of the population stands up and demands it.

This "Struggle for Peace" is Yoshi's current endeavor, which he is pursuing with heart and soul. Unless humanity learns soon to "beat its swords into plowshares" by putting our vast military expenditures into ecological renewal and basic human needs, the

prognosis for humanity's future is grim. If the people of Japan—who have suffered the horrors of mass nuclear destruction—can rally behind the call for peace and compassion, perhaps the people of other nations will follow suit. To me, the likelihood of such a peaceful, healthy future seems small. But Yoshi remains hopeful. He is to be commended for his vision and perseverance.

Hope for the Future

It has been said that to be optimistic in today's troubled world is naïve. The enormity of the converging crises facing humanity and the global ecology is mindboggling, and the failure of our world's leaders to take the radical transformative steps necessary is globally genocidal. The theme of my most highly attended talks in Japan was "*Envisioning the future: Is Health for All possible in a Free-Market Economy?*"—to which my considered conclusion was, "almost certainly not!"

But after my visit to Japan I'm a bit more optimistic. Whatever hope there is for humanity on this ailing planet, I've come to believe, lies in an organized groundswell of well-informed, forward-looking people. Admittedly, the obstacles to such grassroots solidarity are intimidating. Given the matrix

of disinformation pushed into everyone's heads by our mass media and school systems, it seems doubtful that enough people will wake up and struggle for the far-reaching structural changes that are so urgently needed.

But during my visit to Japan, I was heartened by the collective energy and compassion of such a large number of people working in different ways for the common good. Japan, after all, is a world power that has religiously followed the US model of exploitive free-market development. If activists in Japan can mobilize a peaceful revolution for the sustainable health of humanity in harmony with the ecology of this beautiful but endangered planet, perhaps our prospects for world health are more hopeful.

NOTICE: David Werner's keynote address,

"Envisioning the future: Is Health for All possible in a Free-Market Economy?"—presented with SHARE in Tokyo and AHI in Nagoya—focuses on "education for transformation:" the need to change our school system from an authoritarian, obedience-training approach to a egalitarian process that helps young people think for themselves, analyze their situation, and work together to build a healthier, more sustainable world. A printed version of this talk, with illustrations, is available through HealthWrights. See the attached publications flyer. A shorter version is on our website: www.politicsofhealth.org.

SHARE in Tokyo is now preparing a DVD—voice-over in English and in Japanese—of several of David Werner's talks in Japan. If you are interested in a copy, let us know. Or keep an eye out under "Publications" on www.healthwrights.org.

Help disabled people earn their living by teaching Spanish

For persons with a disability that greatly limits their physical ability, earning a living is a big challenge, and even more so in the recent economic turndown. At PROJIMO, the rural Community Rehabilitation Program in Sinaloa, Mexico, a number of significantly disabled persons have learned to generate income by teaching Spanish. Their students are often rehabilitation workers from other countries who come to volunteer, but also to learn or improve their Spanish.

The Spanish program is now in its third generation of teachers. Its first teacher was Julio—who is quadriplegic—who learned the basics of teaching from a volunteer, Sarah Werner (David's cousin) who is an ESL teacher in Ohio. Julio, who is a master of turning learning into fun—later taught his teaching skills to

Rigo Delgado, also quadriplegic, and Gabriel Cortez, who has arthrogryposis. Rigo in turn taught Virginia, who has brittle-bone disease, and who has headed the PROJIMO Conversational Spanish Training Program for the last two years.

Rigo, who is now independent from PROJIMO, for the past two years has been studying Community Psychology at the University in Culiacan, the state capital. To help support himself he teaches "distance learning" Spanish by Skype (voice communication by computer)—at US\$10 per hour. He used to have enough students to get by. But with the recent recession, his students are fewer. So Rigo has asked us to send out a notice promoting his Spanish Training by Skype.

INTERESTED IN LEARNING SPANISH? Help Rigo be self-sufficient and finish his



Rigo (top right) and Virginia (with baby), teaching Spanish to North American volunteers at PROJIMO.

university degree: Learn Spanish through one-on-one distance learning by Skype.

Contact Rigoberto Delgado Zavala by email at teacherigo30@hotmail.com.

Alternatively, if you would like to study Spanish en vivo at PROJIMO in Mexico, contact Mari Picos at projimo@gmail.com. See details on the flier. Or see <http://healthwrights.org/spanishtraining.htm>

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December 2009

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Toru Honda helps David Werner—on his recent visit to Japan—facilitate the “Chain of Causes” awareness-raising activity with SHARE (Services for Health in the Asia and African Region).

*What does education often do?
It makes a straight-cut ditch of a free,
meandering brook.*

—Henry David Thoreau

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This issue of *Newsletter from the Sierra Madre* was created by:

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