The hottest year I ever spent was my first week in Galaha, in the Afar region of Ethiopia. It was the fall of 2006 and I was on a mission with Médecins Sans Frontières (MSF), an organization known in the U.S. as Doctors Without Borders.

Upon landing in Addis Ababa, I headed for the northeastern desert, home of the Afar people, with whom I was scheduled to work for the next six months. As our Land Cruiser wound its way out of the relatively cool central highlands, the temperature rose with each passing kilometer. I couldn't help but think of the famous quip (apocryphally attributed to Mark Twain) that "the coldest winter I ever spent was a summer in San Francisco." As it happens, I had spent the last five years in San Francisco, and my body, used to its cool summer fogs, was now rebelling.

I was grateful for the two-liter, burlap-wrapped, plastic water bottle between my legs. A local MSF administrator had given me the bottle before I left Addis, promising that it would quickly become my friend. Indeed! It soon went everywhere with me, since 10 to 12 quarts of water a day barely kept me hydrated in midday temperatures that reached 110 to 120 degrees Fahrenheit. It was little consolation when other staff in Galaha would say, as they frequently did, "You should have been here two months ago, during the hot season!"

As we rolled along, I reflected on the news I'd received only a few days before, in Paris, that the MSF project in Galaha would soon close. A dam was being built downstream on the Awash River, and Galaha would be under water within six months. The people in the village would be relocated, but there was no plan to rebuild the MSF clinic, hospital, or TB treatment center.

This word put a whole new perspective on my assignment, and I had a lot of questions and few answers about the continuity of care for the Afar people. The closing of the project would be a huge loss to the region. There were virtually no other primary-care services within a 104,000-square-mile area—the size of Colorado—that was home to about 1.3 million people. Yet I was fretting over matters about which I had little knowledge and no control, I soon realized. So I turned my attention to the stark beauty unfolding around me.

The heat, the harsh terrain, and the isolation were merely discomforts to which adaptation was possible—discomforts that paled by comparison to the suffering I would witness in the ensuing weeks. The Afar, perhaps Ethiopia's oldest ethnic group, have occupied their in-

At right, an early-morning view of the Afar village in Galaha. Smoke rises from cooking fires in the *daboytas*—huts made of straw mats laid over interlaced sticks.

Being Present

By Robert M. Rufsvold, M.D.

Sometimes the suffering in the developing world seems too intractable, too overwhelming, to dispel it, even a small part of it. But far away from home—about as far as he could get, in the Afar region of Ethiopia—one DMS alumnus concludes that just being present, fully present, may be enough.

Even everyday respiratory infections can be life-threatening to a people whose overall health status is so dismal. Two out of five infants don't survive to their fifth birthday, and Afar life expectancy is less than 50 years.

Above, author Bob Rufsvold with a malnourished child in the Galaha Therapeutic Feeding Center. Below, a young woman in traditional dress.

hospitable homeland for at least 2,000 years. Nomadic pastoralists, they suffer from chronic malnutrition, episodic famine, and a list of endemic diseases that could fill an infectious disease textbook. Brucellosis, malaria, meningitis, cholera, schistosomiasis, tuberculosis (TB), and kala azar (a parasitic disease also known as visceral leishmaniasis) are common. HIV/AIDS is taking an as-yet-unknown toll on the populace. Even everyday respiratory infections can be life-threatening to a people whose overall health status is so dismal. Two out of five infants don't survive to their fifth birthday, and Afar life expectancy is less than 50 years.

This is their story. And the story of just one organization among many, just one project among many, seeking to address the growing burden of chronic poverty, disease, food insecurity, and conflict that afflict a majority of the world's people.

Rufsvold is a 1979 graduate of DMS. He practiced family medicine in Lyme, N.H., for 18 years before moving to California in 2001 to be the associate director of the Institute for the Study of Health and Illness and the director of Finding Meaning in Medicine, based at Commonweal, a nonprofit institute in Bolinas. After the trip to Ethiopia about which he writes here, Rufsvold returned to the Upper Valley and is again living in Lyme. He took all the photos included in this article except the larger ones on pages 50 and 53; those were taken by Dr. Nancy Tsai. Rufsvold received permission to take these photos from everyone who is pictured.

The drive north to Galaha was a nine-hour, 350-mile trip. I was tired but couldn't sleep. Not only were we moving into an oven-like climate, the likes of which I'd never felt and at first didn't think survivable, but my excitement about the mission was peaking. Only a few days before I had come through New York and Paris for orientation and training, and now everything I'd only read about or imagined was becoming very real. I wanted to experience all the sights, smells, and sounds of this journey as we passed through large towns, bustling markets, and small villages—each one filled with colorfully dressed, curious people.

As we descended into the northern reaches of the Great Rift Valley, the landscape changed constantly—from fertile, green fields around Addis; to mountainous, volcanic outcroppings and old lava fields; to the more arid but still cultivated region of Oromiya. The farther north we traveled, the more desert we saw—and the fewer people and more camels and goats (plus some cattle). A gang of 40 to 60 baboons greeted us as we neared Afar.

The road to Afar was well-maintained, paved for the most part. But for the last 45 minutes, by then under a full moon, we bounced along a dirt track across the desert—a vast, flat expanse of sand and rock, low scrub, and acacias. As we dipped into a broad depression, our driver, Tesfaye, said, "This is the Mille River." We headed straight for and through a foot or so of water, without mishap. (The crocodiles were not to feast that night!)

It is in this rocky, arid environment that the Afar eke out a subsistence living, relying heavily on milk from their livestock. Sparse grassy patches offer the only grazing ground for their herds. Yet not only had the grass been crowded out in recent years by thorny bushes, but some of the best remaining grazing areas would soon be inundated by the Awash dam project. A further problem was that a few miles to the south and east, the Issa tribe was competing for some historic Afar grazing areas, threatening to rekindle long-standing hostilities. Perhaps this explains the traditional sword, or *gilé*, that most of the young Afar men wear. And the ubiquitous AK-47 rifle that they often strap to their shoulder or carry like a yoke across the back of their neck as they head off with their herds.

The Afar live in domed huts called *daboytas*. Made of interlaced sticks covered with lightweight straw mats, *daboytas* can be easily disassembled and packed on the back of a camel as the Afar follow the rains to find grazing for their herds.

They rely principally on the Karma rains, from mid-July to mid-September, which in recent years have been unpredictable. Persistent drought is now threatening a way of life that has probably not

changed significantly in thousands of years. Weakened by hunger and malnutrition, livestock and people alike are more prone to disease.

Arriving in Galaha, I was greeted by Dr. Nancy Tsai, an American doctor about to leave after a six-month stay. She introduced me to the other expatriate staff and some of the Ethiopian staff and then I was shown to my *tukul*, the hut that would be my home. Built on a platform elevated on three-foot stilts, each *tukul* was a duplex, with two 10-by-10-foot rooms. The *tukul* is constructed of sturdy posts and sticks, covered with a mud and hair plaster on the outside and a sort of stucco on the inside. The roof is thatch over plywood. My room had a straw mat on the floor plus a camp bed made of sticks and strips of hide, latticed like a lawn chair, with a foam pad on top. The amenities also included an insecticide-treated mosquito net and real sheets! Because I was there during the "dry" season, I did not see a single mosquito, but the bed net did keep the bats at bay, or at least a comfortable distance away.

I wondered why the stilts; that question was answered when I heard jackals and hyenas foraging nearby at night. In fact, some of the hide beds and chairs in unoccupied *tukuls* fell prey to their hunger—though the empty bed frames later made excellent posts for a badminton net. There was no electricity in the *tukuls*, but a solar panel and storage batteries provided a little light in the kitchen and dining area, the showers, and the latrines. When the power went out, a headlamp was essential. My alarm clock very early each morning was the bleating of goats and groaning of camels in the Afar village just outside our compound.

The expat staff compound was on a small rise and gave us a little view of the vast plain we occupied, toward some low mountains about 30 miles to the north. We could see dust storms an hour before they arrived—a brown wall, sometimes hundreds of feet high. Though an hour gave us enough time to get the shutters on the *tukuls* closed, the dust still went everywhere.

The sunrises and sunsets were stunning, as was the full moon. With no artificial light for hundreds of miles, the night sky was spectacular. I often found myself humming "Lucy in the Sky With Diamonds"—an especially apt song, since a 3-million-year-old *Australopithecus afarensis* skeleton dubbed Lucy had been found in Hadar, just an hour away.

After less than 48 hours in Galaha, I felt like I'd been transported a thousand years back in time. And I was many thousands of miles outside any

Above, the *tukuls* in which the Galaha medical staff lived. Below, another young woman in the traditional, colorful garb that many Afar still wear.

For a WEB EXTRA about Ethiopia and Galaha, see **dartmed.dartmouth.edu/fall07/html/ethiopia_we.php**.

During my first two weeks in Galaha, four children died —two due to malnutrition and two to illness—more than I'd lost in 20 years of family practice in New Hampshire. But most of the TFC kids attained their target weight.

Above, a group of children in the *daboyta* village near the clinic. Below, a year-old baby who weighed less than six pounds when he came to the TFC.

comfort zone I'd ever before experienced. Between the oppressive heat and the enormity of the medical problems facing the Afar, I felt like a newly anointed intern just out of medical school.

The workdays were tough. They began at 6:00 a.m. and went until 6:00 or 7:00 p.m., with a break between noon and 4:00 p.m. During the break, we all found a place out of the sun and tried to stay as still as possible, to conserve energy and water. We'd work again for two or three hours after the break, once the intense midday heat began to let up. I started each day with rounds in the inpatient department (IPD), seeing as many of the 45 to 50 hospitalized patients as possible. Meanwhile another team, headed by Dr. Paras Valeh, the TB doctor, distributed medications to the TB outpatients.

Our "hospital" compound consisted of several open-ward buildings, plus accessory buildings containing exam rooms, procedure rooms, a nurses' station, an office, a storeroom, a pharmacy, our latrines and kitchen, and a small morgue. The buildings were rudimentary but solid—a concrete slab, block walls, corrugated steel roof covered with thatch, and wooden shutters. Deep, overhanging eaves provided shade where most of the patients spent the day; each had a straw mat, their bed, which they moved around to avoid the sun by day and moved inside the wards at dusk. Only the nurses' station, pharmacy, and clinic rooms had electricity, provided by a diesel generator. The generator had an even more important function—running the pump that filled our water tanks with the only potable water around; it came from a deep drilled well, or bore hole, as a well is called in Africa.

The inpatient roster included about 25 malnourished infants and children in the therapeutic feeding center (TFC). Most were under five years old and had fallen below 70% of the median weight-for-height ratio—due to a protein/calorie deficit, illness, or both. One of my first TFC admissions was quite a shock. Young Mohammed was nearly a year old but weighed only 5 lbs., 12 oz. It was hard for me to accept that he was not a newborn. Some of these kids wouldn't make it—they had come in too late for our medicines and formulas to have an effect. During my first two weeks in Galaha, four children died—two due to malnutrition and two to illness—more than I'd lost in 20 years of family practice in New Hampshire. The good news was that most of the TFC kids attained their target weight and were discharged. Of course, they returned to a tough environment.

About a dozen of the adult inpatients were very sick with TB. The other patients had a variety of acute and chronic illnesses, often compounded by chronic malnutrition, which significantly compromised their ability to heal. We averaged three or four admissions and discharges a day, and one or two deaths a week.

Emergencies came in the form of wounds, soft-tissue infections, broken bones, meningitis, and either sporadic or epidemic "acute watery diarrhea"—usually accompanied by severe dehydration and often due to cholera. Our inability to test for and make specific diagnoses necessitated the use of euphemistic symptom-based diagnoses. Our resources, including the lab and pharmacy, were limited but adequate to provide good basic care.

By mid-morning I would head for the outpatient department (OPD), while Dr. Valeh visited the TB clinic, where she would see each of the TB patients every two to four weeks, depending on their phase of treatment. MSF's primary mission in Galaha was to provide TB treatment to the nomadic Afar. But the lack of primary-care services in the region prompted people with a whole range of other conditions to travel for days to see us. The OPD, which I supervised, saw 50 to 100 patients a day. Two Ethiopian health officers, functioning much as physician assistants do in the U.S., would treat many patients, sending me the sickest or those suspected of having TB. I would evaluate them for pos-

sible admission to the IPD or TFC, begin screening them for TB, or, when possible, treat them and send them home. Since virtually all communication was through translators, the work went slowly.

I was also responsible for the health of all the expat and Ethiopian staff, about 100 in all. The harsh environment and the religious practice of fasting for Ramadan—which fell during my stay, and during which adherents take no food or liquids from sunrise to sunset—took a toll. I saw as many as 10 of the Ethiopian staff every day. Sometimes reassurance and paracetamol, as acetaminophen is known outside the U.S., were enough. Sometimes antibiotics, and occasionally evacuation for more sophisticated evaluation and treatment, were necessary. "Rest" was a frequent prescription for the most common "diagnosis"—generalized body pains—though compliance and resolution of the symptoms were unlikely.

After the midday break, I returned to the OPD, discussed patients with the health officers, saw any staff who needed attention, and then made rounds again on the sickest patients in the IPD and TFC. During the late afternoon, I'd also meet with Dr. Valeh, discuss possible referrals, and, when I had the time, learn more about the treatment of TB in Galaha—a very unique and challenging project.

Tuberculosis—a worldwide scourge until about 50 years ago but nearly forgotten in the second half of the 20th century—is on the rise again, especially in developing countries. Its spread has been hastened by the HIV epidemic, which leaves its victims more susceptible to TB because of their compromised immune systems. Chronic malnutrition and poor living conditions also play a part in the spread of TB. A third of the world's people are infected with the TB bacillus, with 95% of active cases and 98% of deaths (2 million this year) occurring in the developing world. This growing humanitarian crisis, and economic burden on the world's poorest countries, can no longer be ignored.

The Afar suffered dreadfully from TB and could neither find nor afford reliable treatment before the MSF program in Galaha opened in 2001. A survey of the Afar conducted by MSF identified TB as a leading cause of morbidity and mortality. The prevalence of TB among the Afar was related to a number of factors: the presence of the disease in their herds, the fact that unpasteurized milk is one of their daily staples, the chronic malnutrition they suffered, and (since TB is an airborne bacillus) the poor ventilation in their *daboytas*.

The greatest challenge we faced was getting a nomadic people to stay in one place for the sever-

Above, a little boy who represented one of the success stories of the Galaha TFC. Below, another mother whose youngster was doing very well.

Central to the Galaha project was the construction of a "patient village"—a collection of *daboytas* near the hospital. It could hold up to 400 *daboytas*, arranged in three sectors based on patients' contagiousness.

Above, a member of the medical staff making "*daboyta*-DOTS" rounds in the village. Below, local staff preparing the weekly milk rations for the TB patients.

al months of treatment. Other organizations had tried but given up because of the large number of patients who dropped out of treatment before completing the prescribed course of medications. MSF began the Galaha TB project in the hope of demonstrating that Afar TB could be treated comprehensively and successfully. Our primary mission in Galaha was to decrease the TB infection rate and death rate through proper treatment of active tuberculosis cases. Galaha was chosen as the site for the project because it was at a crossroads of traditional Afar migratory routes and offered adequate grazing land and water for their camel and goat herds, since it was at the confluence of the Mille and Awash rivers.

Labhadore is the most common Afar name for TB, a term that literally means "a disease which chooses the strong men." This is an interesting perception, as many of our TB patients were women, children, and older, weaker individuals. Other Afar names for TB relate to specific symptoms, such as *sangalé b-yaak*—"a disease with a hard pain in the chest and weakness," or *mudunta*—"a severe, breath-taking pain after coughing." A newer term, *tash*, comes from the French word *tache*, for the white spots seen on TB patients' x-rays.

The characteristic of *labhadore* accepted by all the Afar is its incurability by *afar dayla*, their traditional medicines, and *daylabeena*, their healers. But by now nearly all the Afar know TB is treatable and curable using *faranji* (foreign) medicine, and most of them knew about the Galaha TB center.

Labhadore is also related to the *jinn* of Islamic belief, supernatural beings also called *ginny* by the Afar. These beings are believed to cause certain diseases that affect behavior or are not curable by traditional means. Often related to the wind, *ginny* are implicated in such diseases as polio, meningitis, and TB. But the Afar attach no stigma to the disease—unlike their Somali cousins, who believe that TB is a punishment for wrongdoing. While Afar TB patients prefer to not reveal their diagnosis outside the family, there seems to be no discrimination against those known to have the disease. Perhaps this is because it is so prevalent among the Afar; even their leaders and strongest warriors are vulnerable to it, as the name implies. That they came to Galaha in such numbers seeking treatment suggests the positive influence that biomedicine and MSF have had in the region, among a people long suspicious of outsiders.

Yet the area's vastness and remoteness make it hard for the Afar to get access to and adhere to the TB treatment regimen. Patients must travel daily to a clinic to be observed taking their medicine. This is part of the World Health Organization strategy to control TB—it's called Directly Observed Treatment Short-course, or DOTS. Caregivers watch patients take their medications both to monitor for side effects of the drugs and to ensure that they're actually taken, since missing a dose can lead to treatment failure and the emergence of drug-resistant strains of TB.

To maximize the chance that our patients would complete their regimens, MSF adapted an approach (called Manyatta) first used successfully in Kenya to treat TB among seminomadic peoples. MSF has learned that nomads are willing to stay in one place for a length of time if effective treatment, food, and housing are available. Central to the Galaha project was the construction of a "patient village"—a collection of *daboytas* near the hospital. It could hold up to 400 *daboytas*, arranged in three sectors based on patients' contagiousness.

Other incentives for TB patients to stay in Galaha for the duration of their treatment were a weekly ration of food (milk, flour, lentils, and oil), clean water, a *daboyta* for each patient and his or her family, and a small mosque. The village became a safe and supportive community. MSF also hired skilled translators who spoke Afar, something lacking in most other health-care facilities in the region.

Every morning at 6:00 a.m., the TB outpatients would visit the TB-DOTS treatment center. They would be checked for jaundice and then observed taking their medicines. For the first four months after their diagnosis, all TB patients received treatment under this close supervision. After that, they were discharged and given a three-month supply of medication to take on their own. They were instructed to return to Galaha after finishing all the drugs for a final TB sputum test. The compliance rate was remarkably high, thanks to frequent classes, especially for newly diagnosed patients, and careful tracing of no-shows and defaulters.

Very ill, hospitalized TB patients received their medications in the IPD. And each day about a dozen patients in the *daboytas* would feel too ill or weak to come to the morning DOTS clinic; a team would make *daboyta*-DOTS rounds to bring such patients their medications.

The success of the Galaha TB program represents a remarkable accomplishment. In an isolated desert setting, we were able to accurately identify and diagnose TB patients and provide six to nine months of effective treatment using multiple drug regimens and a modified WHO DOTS protocol. The cure rate, based on either negative sputum tests at the conclusion of treatment or documented "treatment completed" status for cases of extra-pulmonary TB, was 86% of the 3,000 TB patients seen in the six years the program operated.

Above, TB patients lining up early for the morning DOTS clinic. Below, patients lining up again, after the clinic, to receive their food rations.

Except for emergencies, Sunday was a rest day in Galaha. Or at least part of Sunday. After morning rounds in the IPD, I would enjoy a few hours of R&R, explore the village, read a good book, perhaps walk to the river and look for fossils. One Sunday, though, I stayed in my *tukul* trying to shake a virulent respiratory infection that had laid me low for several days. It was only my third week in Afar, but it seemed like a lifetime and sleep was still not coming easily.

I lay on my bunk and stared absently across the desert, lost in my thoughts. It was nearly noon and the sun was high in the sky; its heat sent ripples through the air as I looked westward toward the river. A few hundred yards away, numerous gray humps on the otherwise flat desert floor marked the area that served as Galaha's cemetery. Three graves were always kept open so any newly deceased patients could be buried before sunset, according to Muslim and Afar tradition.

Suddenly my attention was drawn to a flurry of activity around one of the graves-in-waiting. And my heart sank. An hour before, while trying to steal

I expressed how sorry I was that we had not been able to save Ayisha. He said he knew we'd done everything we could to care for his daughter. She was now in Allah's hands. It was all right. I really wanted to believe him.

Above, the small exam room Rufsvold used in Galaha—featuring one of the only working sinks in the clinic. Below, a "no guns" sign at the clinic entrance.

a little sleep, I had suddenly sensed—in that place between waking and sleeping—that one of my patients, Ayisha, was gone. I'd been afraid her death was imminent, and I hadn't seen her on this morning's rounds because of my own malady. The activity in the cemetery confirmed my fear.

Ayisha had arrived in Galaha with her father on my second day there, and right away we knew this beautiful little girl was in trouble. Five and a half years old, she'd already survived the most vulnerable years and looked well-nourished. She had probably been quite healthy until this illness, but now, after two or three days of travel and high fever, her condition was poor and deteriorating rapidly. Barely conscious and unable to drink anything, she was dehydrated and had had no urine output for some time. Worse, she had classic neck signs of meningeal inflammation and suffered frequent small seizures—tremors that passed briefly but repeatedly through the left side of her body.

A spinal tap had gone smoothly, and we were overjoyed to find that her cerebrospinal fluid was clear. Our lab was limited, but we were able to test for white blood cells and (using an assay called the Pandy test) for protein, which if positive would strongly suggest that she had meningitis. Although both tests were negative, we couldn't ignore her condition; her fever was almost 103 and rising.

So we treated Ayisha for suspected meningitis with our best broad-spectrum antibiotics, worked to control her fever and seizures, and offered every supportive measure, including fluid resuscitation, that we had available. We entertained the possibility that she had TB-related meningoencephalitis, a complex condition more often seen in children than adults.

Over the next two weeks, Ayisha rallied briefly but then deteriorated further. Through it all, her father remained at her bedside—holding her, bathing her, and sponging her down in an effort to cool her fevered body. We explained, and he accepted, everything we were trying to do to save his little daughter. His love for Ayisha needed no translation. I felt privileged to be helping to care for her, then moved to tears when our efforts didn't seem to be enough. In such situations, one grasps for an antidote to the inevitable, gnawing sense of inadequacy. I found my antidote in the love and compassion and acceptance that Ayisha's father exhibited throughout her illness.

And so, on this particular Sunday, I set out for the hospital to find Ayisha's father. I didn't know what I would say, but I just knew that I needed to make contact with him. I found him in the small outbuilding that served as our morgue, where they were washing and preparing Ayisha for burial. One of the Afar-speaking nurses came with me. I greeted Ayisha's father in the traditional Afar way of showing respect, by kissing the back of his hand—a gesture that he reciprocated. Then I kissed his hand yet again.

Strangely, his eyes were filled with joy, a look of peace mixed with exaltation. I believe that he knew exactly what I wanted to say. No sooner had I expressed how sorry I was about his loss, about the fact that we had not been able to save Ayisha, than he offered his own condolences. He said he knew that we'd done everything we could to care for his daughter. She was now in Allah's hands. It was all right. I really wanted to believe him.

We parted, and I later watched Ayisha's funeral from a respectful distance.

As planned, the dam was built. In the interest of "progress," the broad, flat plain between the Mille and Awash Rivers—the site of Afar grazing lands for thousands of years and of the MSF clinic for just over a handful of years—gave way to rising water. However, the irrigation project will not benefit the Afar. Its goal is not food to fill hungry, swollen bellies but sugar cane to distill into ethanol to help fuel a growing military in one of the newest fronts in the war on terror. Once again,

human conflict is at the root of human suffering.

A few days after Ayisha's death, just a month into my scheduled mission, a family medical emergency cut my stay short and I had to return to the U.S. Before leaving Galaha, I prepared a draft plan and timetable for phasing out the project. I regret deeply that I couldn't see it through to its end.

My time there encompassed only a few short-term gains; much loss; and some of the most physically, mentally, and emotionally taxing work I have ever done. The sense of coming up short was pervasive—short of personal, professional, organizational, and governmental resources to do an impossible task in the face of much suffering.

But what I took home from the mission, and continue to learn as I reflect on my experiences there, is that we all face situations where the sense of being or having "not enough" permeates our lives. This is particularly true in medicine, and not just in resource-deprived places.

So perhaps just showing up and being fully present is enough. Perhaps such work, in the words of the 18th-century poet Samuel Johnson, "would in time be finished, though not completed." Perhaps, I have concluded—recalling a poem that I wrote a year before my trip to Ethiopia—poetry is a more appropriate coda than prose for such a saga:

What If . . .

"How do I know when I've done enough?"
You ask the question that perennially
haunts all who serve at that edge
where the pain and suffering of others
threatens to overpower and make us
wish, sometimes, that the gift of empathy
and compassion be lifted from our shoulders,
as if it were a burden we no longer have
the strength to bear.

Why do we add to our suffering so,
tossing and turning and hoping
that we might someday know the unknowable?
What if this is simply a part of the mystery,
just another thought to be held with all
the other unknowables when they
take our attention and entice
us to inaction or, worse, indifference.

Mitakuye oyasin, say the Lakota.
"All beings are my relations."
What if, simply, this is enough?
What if we could simply live this experience,
place our hand on the door,
and before entering say, "Use me.
Help me to do good work today." ■

Above, the Mille River at sunset, before the dam. Below, an Afar man sporting a *gilé* (sword) and AK-47—the reason for the sign on page 56.