



Doctors for Global Health Reporter

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DGH PROFILE: DR. LANNY SMITH

By Monica Sanchez

His given name is Clyde Lanford Smith, but his friends, co-workers, students, patients, even his acquaintances, would not recognize him by that name. To the world he is just "Lanny." That simple fact reveals the essence of the man who, at 36 years of age, has already helped improve the lives of over 40,000 people in southeastern El Salvador and been the driving force behind the founding of DGH. He is an intelligent, talented physician, dedicated to fighting for the health and human rights of those less fortunate, who has accomplished what many warned him was impossible; and he has done it with humility, a warm smile, a contagious sense of humor and a genuine interest in everyone who crosses his path. "I met Lanny when I was training to be a health promoter. We were discussing women's rights and machismo and he made a joke and I knew right away he was a good person and I would like working with him," recalls Etelvina Umana, a native of El Rodeo, who joined the project in 1996, "He has been a good example to us all. He knows how to share with others. He always wants us to feel equal to him and share with others what we know and learn."

“We see him as one of us here in the campo, which is not always easy to achieve. Lanny’s work touched everything here, down to the smallest grain of sand.”

Lanny grew up in a loving suburban home in Atlanta, Georgia, the oldest of three boys. His parents, Clyde and Renée Smith, influenced the path he has chosen. "My concern with community as a whole started when I was little," he explains, "My parents worked with kids in the poor section of town, mostly black kids, and I didn't understand why they did it. Sometimes I even resented them for doing it. But looking back, that's a memory that has touched me as something very important in my life." The Smiths also stood up for their strong belief in the equal rights of all human beings. "My dad always fought for people, like women in his office who were being discriminated against," Lanny remembers with pride.

An avid reader since he first learned his ABCs, Lanny wanted to study English Literature and become a writer. Upon graduating from high school, he entered Davidson College in Davidson, North Carolina. His other love, the great outdoors, led him to join the long-distance track team, frequently competing in the 10K race—a physical stamina that would serve him well as he routinely worked 20-hours a day, seven days a week in El Salvador. In recognition of such hard work, Lanny was honored by his alma mater this year, which presented him with the John Kuykendall Award for Community Service.

It was this desire to serve the community that made him



Dr. Lanny Smith with community members in Morazán, El Salvador.

question his career path. Between his sophomore and junior year, Lanny says he realized that though he loved literature, he needed a more concrete way to help people. Becoming a doctor seemed the best way to fulfill both his goals. “I thought I could make a good doctor and that being able to listen to people’s stories would be good training as a writer too,” admits Lanny, “What I didn’t count on was liking being a doctor as much as I do. It was a very nice surprise.”

He graduated with a major in English Literature in 1985 and was set to start at the Medical College of Georgia in the Fall, when he decided to volunteer with Habitat for Humanity building houses in Nicaragua for the Summer. That eye-opening experience changed the course of his life. “I lived with a campesino family and started seeing that there are people in the world who have really terrible, terrible lives. The family I lived with had no running water. There was a well in the middle of the corral, and rain water (with excrement) ran into it, and then we drank that water everyday. There was no latrine. People were just terribly poor and yet struggling to make their lives better. That’s when I decided that I wanted to work with people who didn’t have the opportunities I did and yet had a desire to improve their own lives.”

While he completed his medical training,

Lanny continued to visit Nicaragua, which he has come to think of as his second birth place. After medical school he moved to Boston to do his internship and residency at Boston City Hospital, a non-profit, public hospital, serving Boston’s poorer South End. There his interest in international medicine found many outlets, all of which paved the way to El Salvador.

In 1992, Lanny was in his last year of training in Internal Medicine, working as Senior Resident at Boston City Hospital. He had applied and been accepted to the Harvard School of Public Health (HSPH), but was torn about his next step, “I thought I would get more out of Public Health School if I worked abroad for a year. Dr. Jonathan Mann, who was at Harvard then, sug-

“He always came without anything, just with his body and soul and his words and decisions and richness in genuine desire to help.”

gested I consider working for a year with MDM and offered to write me a recommendation.” Earlier that year, the Peace Accords were signed in El Salvador. Lanny learned MDM had a project there, which they were planning to dismantle by the end of the year, and thought it would be wonderful to bring the groups that had just recently been at war with each other together under the common goal of promoting health.

“I made an exploratory trip to El Salvador in July of 1992 to find out if the *Health as Reconciliation* project I had in mind seemed reasonable,” explains Lanny, “The three MDM International Volunteers living in El Salvador agreed it did and the more than twenty other institutions I spoke with concurred. The site I decided on—isolated, war-torn and minimally organized Morazán—was new to the MDM Volunteers, but that did not deter them. They agreed to have their last project serve as a bridge for the community-based initiative I wanted to implement.” In October of 1992—having worked-out credit for his year abroad as an Affiliate Student at HSPH under Dr. Mann, as well as getting a practicum year credit for a Preventive Medicine Residency and a Community Oriented Primary Care Fellowship at the Center for Community Responsive Care—he moved to El Salvador and began training Health Promoters with the MDM Volunteers.

One of the things that surprised Lanny most upon his arrival was how open the Salvadoran people were to a ‘Gringo.’ He had feared that after suffering through a 12-year civil war largely financed by US military aid, they would be resistant to him. “They seemed to understand that the policies of a government do not necessarily reflect the feelings of its people. After all, theirs certainly didn’t reflect their own,” marvels Lanny, who at 6-feet, with light blond-hair and a very fair complexion, had little chance of just blending in.

If the project was going to succeed, Lanny had to build on that openness and create trust and enthusiasm among the communities. He immediately met with members of ADECOSAL, a community development association formed by many of the villages in Morazán, the area where

he wanted to work. “I went with each of them into their home community. Being invited and accompanied by someone from there gave me a certain legitimacy,” explains Lanny, “I told them that I had been invited to explore a health project for MDM and wanted to know what they would like to see in it. One thing that I made very clear was that I had no funding. I was there to help them come up with ideas and after that I would help look for money, but that didn’t mean we would ever get money.”

Maria Isabel Martinez, a Mental Health Promoter who teaches in the project’s Center for Integral Child Development (CIDI) of La Presa, remembers this well, “He came and held a meeting to see the things that were needed by the commu-

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Dr. Lanny Smith (center) participating in a small group discussion at the Second Annual DGH General Assembly, which was held at Panola Mountain State Park, Georgia, in August 1997.

DGH SUPPORTS THE MEXICO SOLIDARITY NETWORK


By Jonathan Harris

When DGH Board member Shirley Novak learned last April that concerned activists were coming together in Washington, D.C. to discuss events occurring in Mexico, she knew she wanted to be a part of it. "It was a day filled with speakers, small and large group strategy sessions and music," Novak recalls of the energy-charged gathering of nearly 300 people, "Out of it came the decision to form a group to look at long and short term needs in Chiapas." That day, the Mexico Solidarity Network (MSN) was born.

"MSN has sent thousands of dollars to Chiapas for refugee relief, coordinated delegations, and has now increased to two paid staff members," raves Novak, who lives in Syracuse, New York. Another important aspect of MSN's work is lobbying Congress and promoting speaking tours to raise awareness and money for human rights groups in Chiapas. "I'm personally excited because I just booked a May date for a dynamic young Zapatista I met through MSN to come speak in Syracuse," Novak added.

MSN organized its first Tri-National Friendship Delegation to Chiapas last July, bringing in nearly 100 delegates from the US and Canada. Novak was among them. The delegation visited thirty-four communities at the invitation of indigenous groups.

Today MSN enjoys the support of almost 60 non-profit groups—including founding sponsor DGH—which have helped the organization evaluate the area's needs and funnel aid to the region. Non-profits as different as the North American Neighborhood Association and the Colectivo Apoyo Latinoamericano support MSN's work.

Novak currently represents DGH on the Network's council, which plans another visit to the region this year. For more information you can visit MSN's web page at www.mexicosolidarity.org or e-mail them at msn@mexicosolidarity.org. 

When DGH Board member Shirley Novak learned last April that concerned activists were coming



Acronym Glossary

- ▶ **DGH** is *Doctors for Global Health*.
- ▶ **MDS** is the Salvadoran association, *Médicos por El Derecho a La Salud* (Doctors for the Right to Health), founded in 1995. MDS currently works in conjunction with the mission of MDM-France in El Salvador and is DGH's partner organization. MDS is currently training personnel and raising funds as it prepares to assume full responsibility for the MDM project in El Salvador.
- ▶ **MDM-France** is the headquarters of *Médecins du Monde* (Physicians of the World), the French international relief organization through which the project in El Salvador was first organized in 1992.
- ▶ **CIDIs** are Centers for Integral Child Development (Centros Integrales de Desarrollo Integral) that provide early educational, nutritional and mental health intervention to over 180 children in six villages in Morazán.

A Day's Life . . .

I have spent most of my time working on the "Improving Women's Reproductive Health and Human Rights in South-Eastern Morazán" campaign. Steve and Irma worked out the details of the project so that when I arrived we were practically ready to begin. In a two day training session we taught MDM Health Promoters, Health Promoters from the Ministry of Health and local midwives, basic information about female anatomy, STDs, gynecological cancers and human rights. This training prepared participants to give a brief talk at the beginning of each of our scheduled community visits. During these two days, I grasped what the reality is for many of these women: They have to live in a society where women are not valued nearly as much as men. The machismo begins at birth—a midwife receives a considerably higher fee for delivering a baby boy than a baby girl. Many of the women are not permitted to leave their homes to go to the clinic,

while the men may roam the streets at night and have relations with different women. One notes the discrepancy even in the children's play: There always seem to be little boys playing soccer in the street while the little girls are at home helping their mothers in the kitchen or watching their smaller brothers and sisters.

After writing and revising the 34-page-long project, we jumped right into the first phase of community visits. The project covers a two-year time span (I would be able to participate only in the first phase, but I would love to return for the later phases). Each day began with the construction of the exam rooms using sheets and hammocks as walls. Following that the health promoters gave an interactive lecture on human rights, breast and cervical cancer, the vaginal exam and STDs. Then we took data and finally performed the examinations. Steve looked at samples for trichomonas [parasite that causes a common STD], candidiasis [yeast infection] and bacterial vaginosis [vaginal infection] in our ambulatory lab and

we sent other samples to the Department of Microbiology at the National University of El Salvador for further analysis. All of the activity made for a very full day, everyday.

The work was always a challenge—providing a mobile gynecology clinic in rural El Salvador is not an easy task—and each community offered a different surprise in coordinating efforts. In Babilonia we had to carry the tables and equipment for a fifteen-minute walk down an impassable road and a few days later back up again. A few members of the community helped us out—one man carried a table, the generator and a large box on his back! In Matapalo, the community was incredible. When we arrived they were already sweeping the school and had divided the room into two, then they hung our hammocks. The two days of the actual project at least 11 community members helped throughout the day. The community's participation is essential in projects such as these.

—Wendy Hobson, MD, March 1995

REPORT FROM THE FIELD: DGH IN CHIAPAS

By Linnea Capps, MD

I recently returned to the US after spending a year as a DGH volunteer in Mexico. I worked in Hospital San Carlos, a small Catholic hospital in Altamirano, a town of about 10,000, in the highlands of Chiapas, a beautiful area of mountains and pine forests.

The hospital has been there since the 1960's and is run by the Daughters of Charity. It has 60 inpatient beds and a busy outpatient clinic. It also has a large program to train auxiliary nurses. These young women are almost all indigenous and are the ones who do almost all of the nursing work in the hospital and also serve as translators.

Patients come with every imaginable type of medical problem. There is a small medical staff comprised of a mixture of Mexican physicians and foreign volunteers. There are presently no surgeons or obstetricians and anything complicated has to be transferred to

a hospital in the state capital, which is about four hours away by car. Also, the diagnostic testing capacity is fairly limited. There is a very basic laboratory, X-ray and ultrasound equipment, but nothing else. Working there as a physician was an experience in using basic doctoring skills without the high-tech testing we always rely on in the US.

I have been interested in health and human rights since my days in medical school. During my residency in Internal Medicine at Harlem Hospital, I participated in the movement to keep the public health care system in New York City accessible to the most vulnerable patients. I continued to work in Harlem after training to pay back a National Health Service Corps scholarship.

“Working there as a physician was an experience in using basic doctoring skills without the high-tech testing we always rely on in the US...I found myself relying a lot more on intuition than I would have at home.”

In 1984, while studying public health, I became acquainted with a small humanitarian organization, Aesculapius International Medicine, which was just starting a project (along with the Catholic Archdiocese of San Salvador) to train rural health promoters in an area where many people lacked basic health care due to the civil war. I lived and worked in Chalatenango from 1985 to 1987.

After returning to New York, I continued to work on health and human rights in El Salvador, where I met MDS volunteers recruited by DGH and visited the project in Morazán. When DGH began looking for a volunteer to work in Chiapas, I decided to try to devote a year to working at Hospital San Carlos and exploring how DGH could support community-based health care there. I was fortunate to be able to arrange a one-year leave of absence from my work at Harlem Hospital and Columbia University. I went to Chiapas in January of 1998.

It was a wonderful experience, which I found very rewarding although sometimes frustrating. Working in a completely different culture—with patients whose understanding of illness and treatment is profoundly different from the concepts of “Western” medicine—is sometimes

DGH in the Peruvian Amazons

By Jonathan Harris

As Dr. Richard Witzig prepared recently for a month-long trip to Peru, he packed away a new laptop computer and printer in a padded carrying case. In just weeks Witzig hopes to be booting up and printing in the remote wilds of the Amazon rain-forest, where the new electronic equipment will run on solar energy and be an instrumental part of creating a health database of some of the world's most isolated people. A \$25,000 grant from a New York-based foundation, which DGH channeled to Witzig's initiative, is making the Amazonian Indigenous People's Health Project possible. “DGH has contributed an immense amount to this project,” Dr. Witzig said.

Witzig plans to transport the computer equipment on a small boat amid drums of gasoline, provisions and medical supplies on a forty-eight hour river trek from Iquitos, in Peru's north-eastern Loreto Province, to its eventual destination in the heart

of the rain forest. There, Witzig hopes to continue his work among the Urarina, an indigenous group that has lived in the area for at least half a millennium. Dr. Witzig, or Ritchie as his English-speaking friends call him, is affectionately known by another name in the Chambira river basin where the Urarina live. “They call me Big White Monkey,” he said before his trip, smiling.

Witzig has worked in the region since 1992, studying and treating increasingly drug-resistant strains of Malaria. There were 150,000 recorded cases of malaria in the Rhode Island-sized jungle province

last year, many of them fatal. New strains of malaria are just one of several invaders threatening the survival of the Urarina, who traditionally have moved deeper into the jungle when danger has approached. Some of the people Witzig hopes to examine for the medical database live so deep in the jungle that he may be the first outsider they've ever seen. “These people are quite remarkable,” Witzig said, “They are ecologically very flexible. They can live in the



Dr. Richard Witzig conducting a malaria survey of the Urarina, an indigenous group living for centuries in the Peruvian Amazons.

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difficult. The vast majority of the patients are Mayan Indians. Doing a medical history and physical exam can be a slow process because of the need for translation and the cultural differences in describing the symptoms and course of an illness. Although the majority of the patients are from the Tzeltal group, many are from one of three other ethnic groups: Tojolabal, Tzotzil or Chol. They don't understand each other's languages, so just finding the right translator can be time consuming. And it can be almost impossible to get what we think of as an adequate history, especially when there is a chronic symptom like abdominal pain (a very common one), in which the diagnosis often relies heavily on the history. The auxiliary nurses are really good workers, but they are not professional nurses, nor do they have any real training in medical translation. I often found myself relying a lot more on physical findings (or lack thereof) and "intuition" than I would have in the US.

Many of the medical problems seen in the hospital are diseases of poverty and the lack of the most basic housing, nutrition, clean water and sanitation. We saw epidemics of several infectious diseases during my year there. At the beginning of the rainy season in May and June, there were dozens of cases of typhoid fever (or at least that's the best diagnosis we could make without blood cultures). It seems that typhoid is a common seasonal problem, which isn't confined to any one region. Most small rural communities don't have running water and, since many less serious cases never get treated, there are probably many infected people with no symptoms, which leads to a lot of contamination of the environment.

Tuberculosis (TB) is another problem. At one point in June there were 10 cases in the hospital's 30-bed adult inpatient ward. There are usually at least one or two patients hospitalized with TB and the hospital diagnoses a new case about once a week. Many patients arrive with severe symptoms and one or both lungs already partially destroyed by the infection. Most never complete their treatment because they live in very isolated areas where there is no follow-up care. The hospital gives them a two-month supply of medicine, but some can't even come for an appointment every two months since it is such a long trip and/or they don't have money for bus fare. During the latter half of the year, there was also an epidemic of whooping cough due to the low rate of childhood vaccinations in most communities. Two young infants died in the hospital.

To make matters even more difficult, the hospital is plagued from time to time by electricity shortages, which means sometimes having to do without radiology, which makes diagnosing TB particularly difficult. In addition, the hospital lives on a shoestring budget. They occasionally run out of certain medications and other supplies, due to both the tight budget and the distance from the larger cities where the supplies can be purchased. The most essential medicines are usually available, however, and that is more than can be said of some of the government hospitals, where the patients' families have to go out and buy medicines out of their own pocket before they can be administered.

In spite of all these difficulties, the rewards of my time there were immeasurable. It's hard to forget some of the individual patients and their stories. There were a few amazing successes. One was Elena, a young teacher whose family brought her to the hospital in a coma. She was so emaciated we doubted we could save her. They told us she had gotten sick a few weeks earlier. They had taken her to other clinics and hospitals, but no one could help her. We admitted her, gave her intravenous fluids and tried to correct her serious dehydration and electrolyte problems. We performed what few diagnostic tests we had available, but could find no specific cause for her illness. Her parents and siblings stayed with her many days. Just when we were about to give up, she woke up. Gradually she regained her ability to communicate and to walk. Later, she told us



The hospital tries its best to accommodate the special needs of its patients. Since most have to come from very far away and are very poor, the hospital allows family members to stay in the room with their sick relative.

“The only real problem for me personally during my stay in Chiapas was the continuous scrutiny of foreigners by Mexican immigration authorities.”

that her illness had begun with what, from her description, sounded like the mumps. She explained that she kept getting weaker until she was unable to get out of bed or eat. The best diagnosis we could come to was that she had some type of viral encephalitis [an inflammatory infection of the brain] and that she had recovered because of the supportive care she received from us and her family.

Others may face more difficulties. Patients with chronic diseases sometimes find it impossible to keep taking their medications. I remember a three-year-old diabetic boy who came to the hospital active and well, but would clearly need insulin every day for the rest of his life. His parents were very poor, living in an isolated village with no electricity, and couldn't read, write or speak Spanish. We spent a great deal of time trying to explain the concept of diabetes and the need for life-long medication. They left with a month's supply of insulin. We knew it would be very hard for them to keep the insulin without refrigeration and that it would be very hard for them to bring the child back for the necessary frequent follow-up appointments. I often wonder what has happened to him.

One of DGH's goals in sending a volunteer to Chiapas was to work toward supporting the work Hospital San Carlos had started in community-based health care, which would allow us to follow-up with patients like that child. In recent years, this work has

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Poetry Contest Winners

Last year DGH sponsored a poetry contest to commemorate the 50th anniversary of the *Universal Declaration on Human Rights*, as well as to draw attention to the still ardent need to fulfill its promise. All entries had to be based on the theme of "Promoting health and human rights with those who have no voice." We received many wonderful poems, making choosing the winners a difficult task for our distinguished panel of judges. Our thanks to all who shared their verse with us and our congratulations to the 14 winners, listed below.

FIRST PLACE:

- ▶ Sandra Farkouh, Chapel Hill, NC
Casos Especiales

SECOND PLACE:

- ▶ Jeph Harrin, Atlanta, GA
Sauteurs
- ▶ Jessica L. Bloom, Swarthmore, PA
Puncture
- ▶ Meena Ramakrishnan, Boston, MA
En Silencio

THIRD PLACE:

- ▶ Meena Ramakrishnan, Boston, MA
Pleas
- ▶ Patricia Grace King, Atlanta, GA
I Go To Pick My Own Strawberries
- ▶ Meena Ramakrishnan, Boston, MA
When The Fires Engulf Your Body
- ▶ Meena Ramakrishnan, Boston, MA
Lullaby Of The Landless Laborer
- ▶ Meena Ramakrishnan, Boston, MA
The Journey

FOURTH PLACE:

- ▶ Meena Ramakrishnan, Boston, MA
I Told Him Not To Come To Me
- ▶ Sue Sun Yom, San Francisco, CA
Reconciling Anger
- ▶ Sue Sun Yom, San Francisco, CA
What The Water Said
- ▶ Jessica L. Bloom, Swarthmore, PA
Kennet Square Clinic
- ▶ Jeanne Marie Garcia, Washington, DC
Bridges Between

Human Rights

At DGH we believe there is an intrinsic relationship between art, health, education and Human Rights. Art, in its various forms, inspires our daily work. Every Spring we'll share some of the books, movies and music that have touched us. We invite you to recommend some works that have moved and enlightened you. Send suggestions to Monica Sanchez at P.O. Box 1761, Decatur, GA, 30031, U.S.A., or e-mail it to newsletter@dghonline.org.



In Print

IN THE TIME OF THE BUTTERFLIES, By Julia Alvarez, Algonquin Books, 1994, Fiction, ISBN 1-565120-38-8. Set during the waning days of the Trujillo dictatorship in the Dominican Republic in 1960, this extraordinary novel retells the true story of the Mirabal sisters, three young wives and mothers who were assassinated after visiting their jailed husbands. Only a fourth sister, the youngest, survived to tell this moving tale.

AT PLAY IN THE FIELDS OF THE LORD, By Peter Matthiessen, Vintage Books, 1991, Fiction, ISBN 0-679737-41-3. Don't be put off by the mediocre film version of a few years back. This 1965 classic is worth the read. No liberation theology here. This is an old-fashioned battle for the souls of the heathens, but who's saving who?

BREATH, EYES, MEMORY, By Edwidge Danticat, Random House, 1998, Fiction, ISBN 0-375705-04-X. The tale of a Haitian girl haunted by her family's traumatic past and the violence of her native country. *The New York Times Book Review* raved, "Ms. Danticat's clarity of vision takes on the resonance of folk art. Extraordinarily ambitious, extraordinarily successful."

FREEDOMLAND, By Richard Price, Broadway Books, 1998, Fiction, ISBN 0-767900-24-3. A searing novel of racial injustice in two New Jersey cities. Imagine Dostoevsky writing a crime novel set in a housing project in a down-and-out American city and you'll have an idea of this book's power and complexity.

THE WAR OF DON EMMANUEL'S NETHER PARTS, By Louis de Bernières,

Vintage Books, 1997, Fiction, ISBN 0-375700-13-7. An English author with a French name writing about Latin America? Don't worry, he does it very well, drawing upon his time living in rural Colombia to tell this entertaining story. It is a brilliant caricature of life, love and politics.

OUR AMERICA, by Lealan Jones and Lloyd Newman with David Isay, Washington Square Press, 1998, Non-Fiction, ISBN 0-671004-64-6. Unflinching journalism from two teenagers living in Chicago's Ida B. Wells Homes—one of the most dangerous housing projects in America. Their voices emerge from a part of the world that most have forgotten, or chosen to ignore, to ignite our conscience and rekindle our sense of justice.

DO THEY HEAR YOU WHEN YOU CRY, by Fauziya Kassindja and Layli Miller Bashir, Delta, 1999, Non-Fiction, ISBN 0-385319-94-0. At age 17, Fauziya Kassindja fled Africa to escape the tribal ritual *kaika* (female genital mutilation) in preparation for



In the Arts

an arranged marriage. Smuggled to the airport on the eve of the procedure, fleeing without passport or hope of safe return, Fauziya arrived in Newark Airport. There, when she was imprisoned for illegal entry, is where her struggle truly began.

A HOPE IN THE UNSEEN, By Ron Suskind, **Broadway Books**, 1998, **Non-Fiction**, ISBN 0-767901-25-8. This work, which recounts the struggle of Cedric Jennings, a bright but poor ghetto-kid trying to make it in the Ivy League, reminds us that human rights begin at home.

EL NIÑO CAMPESINO DESHABILITADO, By David Werner, **The Hesperian Foundation**, 1990, **Non-Fiction**, ISBN 0-942364-07-4. Excellent book of ideas and practice also available in English, for working creatively with children who have disabilities.

MEDICINA LIBERADORA: TEORIA, METODO Y PRACTICA, By Agustín Sanginés, MD, **Programa de Formación en la Acción y la Investigación Social, A.C.**, 1989, **Non-Fiction**. This book, published in Spanish, is an exploration of medicine as a liberating agent.

NOT ALL OF US ARE SAINTS: A DOC-

TOR'S JOURNEY WITH THE POOR, By David Hilfiker, MD, **Hill and Wang**, 1994, **Non-Fiction**, ISBN 0-8090-3921-4. A doctor wrestles with "poverty medicine" and the experience of practicing and living with the poor in inner-city Washington, DC. This book is both disturbing and inspiring.



MEN WITH GUNS, Directed by John Sales, **Starring Federico Luppi and Mandy Patinkin**, **Spanish with English subtitles**, 1997. After retiring from his profitable private practice, a distinguished South American physician sets off on a quest to locate his former health care students, whom he trained to work in remote, disease-ridden villages. Once he steps outside his comfortable milieu, he is confronted by the reality to which he has been so willfully blind: the violence and despair in which the majority of his fellow citizens must eke out a miserable living.

ROMERO, 1989 USA movie directed by John Duigan; **Starring Raul Julia**. This compelling film tells the story of El Salvador's Archbishop Oscar Romero, who was assassinated in 1980. It follows his awakening to the plight of his people and his stance against the violence and poverty under which they toil.

THE VICTIMS OF THE WAR IN CHIAPAS, Directed by Carlos Martinez, 1998. This 28-minute video was filmed just before and after

viewed just two days before the massacre. The video costs \$35 and is distributed by the non-profit organization Cloudforest Initiatives, PO Box 13149, Minneapolis, MN, 55414.

I AM CUBA, Directed by Mikhail Kalatozov, **Cinematography by Sergei Urusevsky**, **Script by Yevgeny Yevtushenko and Enrique Pineda Barnet**. Francis Ford Coppola and Martin Scorsese present this black and white, 1994 Milestone Film release in Spanish and Russian with English subtitles. This film by the great Russian director is an epic poem to Communist kitsch, giving the viewer a bird's eye view of the decadence of Batista's Havana and the poverty and oppression of the Cuban people. The rise of the revolution is shown in four main stories in this restored 1964 film.

THE BAD HARVEST, **Chiapas Media Project**. This 17-minute video documents the severe food shortages in indigenous communities in Chiapas, Mexico. It is a co-production of indigenous youth, who are learning video skills through the Chiapas Media Project (www.chiapasmediaproject.org), and professional video producers from Mexico and the US. The story of crushing poverty is portrayed through first-hand testimony from several indigenous communities and the various causes of hunger in Chiapas are explored, including droughts and floods, burning of the mountains, lack of agricultural expertise and the militarization of the area. Contact the group at 4834 N. Springfield, Chicago, IL 60625, 773-583-7728, 773-583-7738 (fax).



WE ONLY WANT THE WORLD: SOUNDS OF REVOLUTION FROM AROUND THE GLOBE, **Compiled and produced by A World to Win**, 1990. This collection, combining mainly new material with some songs from the world's revolutionary heritage, was made possible thanks to the efforts of a great many artists and friends on the same side of the barricades in the fight against imperialism and reaction. BCM World to Win, 27 Old Gloucester St., London, WC1N3XX, U.K. Fax: 44-71-831-94-89 (ref. W6787).

LEFT: Portrait of the Aztec Goddess of rain, Chalchihuitlicue, who carries the sun during the 4th prehistoric age known. Seeing much injustice in the world, she created a bridge to the 5th world for those whom she favored.

RIGHT: Portrait of the Japanese Sun Goddess, Amaterasu. Disgusted with her brother because of his violence towards women, she enclosed herself in a cave and refused to come out. The snake, draped on her arm, holds the sword of her brother, which she broke into three pieces that became Goddesses.

Reproduced here with permission of the artist, Sandra Stanton, from her series on ancient goddesses.



LIBERATION MEDICINE: HEALTH & JUSTICE

By Lanny Smith, MD, with Ken Hilsbos, MD

I was searching for an adequate definition for the kind of medicine we had been practicing in El Salvador for a presentation at the Second International Conference on Health and Human Rights to be held in September of 1996. I also wanted to include the larger component of local and international education and solidarity that our work had come to involve. The defining word came to me while reading Father Ignacio Martin-Baro's book, *Writings for a Liberation Psychology*. While ostensibly about psychology, I found the book's message applicable to medicine as a whole. Fr. Martin-Baro wrote, "In our case more than anyone else's, the principle holds that the concern of the social scientist should not be so much to explain the world as to change it."

In his book, Martin-Baro urged that Liberation Psychology explore new horizons, a new way of seeking knowledge, and a new way of acting. As an example of what needed to be done to accomplish this, he referenced Paulo Freire, the Brazilian who developed a method of teaching literacy for impoverished adults based on dialogue and sought to break "the chains of personal oppression as much as the chains of social oppression."

It seemed to me that Martin-Baro was describing the kind of medicine we had been attempting to pursue in Morazán. Thus came the definition of Liberation Medicine that we at DGH have been using: "The conscious, conscientious use of medicine to promote human dignity and social justice."

This definition was the springboard for two group discussions in the Fall of 1996, which led to the creation of the Liberation Medicine Working Group, a group of health professionals dedicated to exploring and pursuing this concept. The first discussion was held in a workshop setting at the Conference that had spurred my search, which took place at the François-Xavier Bagnoud Center for Health and Human Rights of the Harvard

School of Public Health. The second group discussion on the subject was in a non-official workshop two months later, as described in the following vignette by Dr. Ken Hilsbos: "I first heard of Liberation Medicine when I saw a hand-written sign taped up on a fancy glass case outside a meeting room at the 1996 American Public Health Association (APHA) meeting in New York City. The sign announced a workshop on Liberation Medicine. Twenty or so people attended. We rearranged our chairs to form a circle. The process and the content were very democratic. Lanny gave his definition of Liberation Medicine. Each of us talked about what we thought Liberation Medicine might be about and how the idea related to our experiences. I introduced my short essay *Caring, Compassion and Humility: A Proposed New Model for Medicine Closer to the Heart*, which I had brought: 'Compassion means empathy and kindness. Caring is fundamental to good medicine. Humility is the most difficult, especially for doctors, but can best be described as a radical equality with those whom we accompany. In other words, the person seeking my help might have a third grade education, or Down's syndrome, or an annoying lack of access to

“What we in DGH are looking to do with Liberation Medicine is forge a path for hope.”

soap and water, but they don't really understand any less than I do the mystery of death, or of birth, or the other great mysteries.' The group agreed that these three values, so little found in clinical medicine and medical teaching, are essential to the practice of Liberation Medicine."

Liberation Medicine immediately brings to mind Liberation Theology, the movement that interpreted Jesus' teaching as a radical call for the equality of all people and to caring for one another, which began in the 1960's within the Catholic Church after Vatican II and the Bishops' Conference in Medellin, Colombia. Martin-Baro was greatly influenced by the Liberation Theology movement and pointed to it as his inspiration for Liberation Psychology. A useful methodology with or without the religious angle, Liberation Theology calls for observation, reflection and action. Whenever possible this process should be done through accompaniment of the disempowered, those whom Archbishop Romero (the Salvadoran clergyman who was assassinated soon after calling on soldiers to stop killing their brothers and sisters), referred to as the "voiceless."

Of course, people have been practicing Liberation Medicine for a long time without necessarily calling it that. One example is the Jankhed project in India, ongoing for 28 years now, led by Drs. Raj and Mabele Arole. The humility they describe in sitting together in a circle to eat and the equality they promote with the untouchable women as Health Promoters, is Liberation Medicine in action. Just as is the social medicine tradition of Chile, continued in another form in Cuba, and the accompaniment of Charlie Clements, MD, MPH, in his book *Witness to War*, where he documents the suffering reality of the Salvadoran people. Another example of Liberation Medicine under a different name is what David Hilfiker, MD, describes as "poverty medicine" in *Not All of Us Are Saints: A Doctor's Journey With the Poor*. Responding to a physician in a conference who asked, "I can only applaud your commitment to the poor, Dr. Hilfiker, but don't you think it's a waste of your professional education?" Dr. Hilfiker wrote, "It takes all the medical judgement we possess to discern when to let go and when to press a homeless patient. It takes every bit of our medical authority to get such patients into the health care system. It takes as much medical knowledge as we can muster to diagnose across cultural barriers. But—since our work is so different from a doctor's standard routine—it is easy, from the medical point of view, to mistake it for no work at all...Medical practice in a community of poor people often seems a solitary specialty without research, common cause or shared experience."

One of the goals of DGH in promoting the concept of Liberation Medicine is to address and remove the isolation described by Dr. Hilfiker. Drawing on his example, and aware that we must walk with humility in this endeavor, we would like to help people see the inter-relatedness of life and the need to address the issues of the poorest if we are to have full lives ourselves. As Rev. Martin Luther King, Jr. once put it, "As long as there is poverty in this world I can never be rich, even if I have a billion dollars. As long as diseases are rampant and millions of people in this world

cannot expect to live more than twenty-eight or thirty years, I can never be totally healthy even if I just got a good check-up at the Mayo Clinic. I can never be what I ought to be until you are what you ought to be. This is the way our world is made. No individual or nation can stand out boasting of being independent. We are interdependent.”

Of course, this means that we must strive to work within the context of community, for liberation is a community exercise as well as an individual one. In *The Virtues in Medical Practice*, Edmund Pellegrino, MD and David Tomasma, PhD, present the concept of medicine as a moral community, “These three things—the nature of illness, the non-proprietary character of medical knowledge, and the oath of fidelity to the patient’s interests—generate a strong moral bond and a collective responsibility...Medicine cannot, and should not, undertake all of this alone. It can join with other health professionals, concerned people and legislators.”

In addition to the many examples of Liberation Medicine that do not define themselves as such, we have also found some references to liberation and medicine together. In *Liberating Medicine*, David Seedhouse asks physicians to enable their patients’ potentials, help them to overcome obstacles and honor their oath to “First, do no harm.” He also seeks a new definition of “health” as optimal patient autonomy, and the reform of medical education to embrace what he terms the “rings of uncertainty” theory—a call for humility in medical training and practice.

Similarly, a Mexican physician, Agustín Sangines, in *Medicina Liberadora*, applies a Marxist interpretation to elucidate the social causes of disease and explore what he calls “oppression medicine.” A home-grown example of oppression medicine is California’s Proposition 187, which would have required health professionals to report “illegal” immigrants to the Immigration Service—as if any human could be illegal. Another less overt but more appalling look at oppression medicine—including the role of physicians as torturers—can be found in the British Medical Association’s *Medicine Betrayed*.

The Father of Liberation Theology: Gustavo Gutiérrez

Reverend Gustavo Gutiérrez, a Peruvian theologian who lectures in theology and social sciences at the Catholic University of Lima, is considered the father of Liberation Theology by many scholars. Best known for his 1971 groundbreaking book, *A Theology of Liberation* (published in Spanish and English), Gutiérrez drew international attention to the plight of the poor in Latin America when he challenged his church to work for liberation and justice by identifying and changing the social, political and economic structures that create and perpetuate oppression.

His theology of liberation—later termed Liberation Theology—influenced religious scholars around the world and became one of the most influential movements in contemporary theology. After calling the world’s attention to the oppressive structures that victimize the poor in Latin America, theologians began applying Liberation Theology to

liberation movements for women, for developing countries, for African-Americans and other oppressed groups.

Born in Lima, Peru, in 1928, Gutiérrez grew up among the poor. After studying in both Rome and France, he returned to Peru to teach at the University of Lima, but chose to live in the slums of the city rather than the more comfortable neighborhood surrounding the university.

Gutiérrez received The Marianist Award from the University of Dayton in 1997 for outstanding scholarship by a Catholic. The University’s chancellor, Rev. James L. Heft, said, “It is significant that Father Gutiérrez’s thought has never been criticized by the Vatican, I believe, because his thought is so clearly rooted in the Gospel. He has taught us that the Gospel should never be reduced to politics, but that the Gospel, fully lived, always has political consequences.”

Likewise, *Health as Liberation: Medicine, Theology and the Quest for Justice*, by Professor Alastair Campbell, defines health as freedom. Outlining his plan in the book, Professor Campbell writes, “First, in every chapter I will introduce some of the ‘voices of the oppressed’ and try to give these a normative place in determining how health may be more richly understood. Second, I acknowledge that hearing these voices demands a critical stance toward the social structures within which the oppression occurs. When we are willing to listen to the experience of the oppressed, we begin to see how injustice has become institutionalized in those very social structures that claim to be concerned only with human well-being.” Despite such a brutally honest vision, Professor Campbell offers hope in the form of a quest: “Here, I think, we must try to distinguish between dreams of utopia and a hope based on a refusal to accept that we have no power to change things...One thing is for sure: if we do not take such risks, our attempts at health care will be little more than the echoes of our own ill-founded complacency.”

What we in DGH are looking to do with Liberation Medicine is forge a path for hope, a way to build upon the energy found in the people of Morazán and around the world who, despite suffering horrible injustice, have the strength to rebuild and the vitality to believe that they can. Like the hope found in Paulo Freire’s *Pedagogy of the Oppressed*, “The dehumanization resulting from an unjust order is not a cause for despair but for hope, leading to the incessant pursuit of the humanity denied by injustice. Hope, however, does not consist in crossing one’s arms and waiting.” This quest is put most eloquently by Dr. Nancy Scheper-Hughes in *Death Without Weeping: The Violence of Everyday Life in Brazil*: “Medicine, the hospital, and the clinic can be isolated, closed off, from the experiential world of patients. Or, they can provide a space where new ways of addressing and responding to human misery are worked out...We might conclude by asking what medicine might become if, beyond the humanitarian goals it espouses, it could see in the suffering that enters the clinic an expression of the tragic experience of the world. We might have the basis for a Liberation Medicine, a new medicine, like a new theology, fashioned out of hope.”



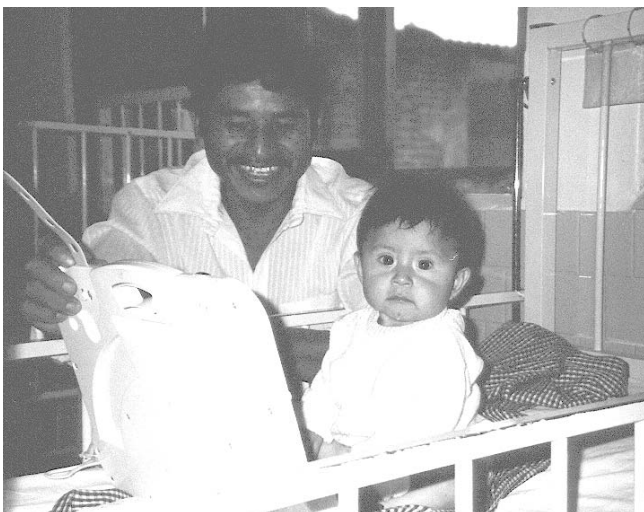
DGH IN CHIAPAS

(Continued from page 4)

been difficult to maintain due to the political tensions in the area and, related to these, a severe shortage of the personnel and financial resources needed to maintain the hospital and its community-based programs. I couldn't do much traveling to communities because of the government restrictions on foreigners, but I did have the chance to observe a little of the work and begin to help plan how to strengthen it. Shortly before I left this past December, I was able, for the first time, to attend a meeting of health promoters with the Mexican physician who works in community health.

The promoters come from one of the "autonomous municipalities" (indigenous communities trying to set up their own governance structure and not depend on the Mexican government). They were in the midst of learning how to do a survey of vaccine coverage in their communities. They reported that it was very poor—as many as one-third of children under five hadn't received any vaccines and very few were completely up to date. In some of the communities this is because there is so much distrust of the government, people won't even accept vaccines from public health workers.

The promoters were all enthusiastic participants in the class and seemed eager to learn. The education process can be slow, however, since many of them have very little



A father tries to keep his infant son entertained and preoccupied in the pediatric ward of Hospital San Carlos in Altamirano, Chiapas, Mexico.

DGH IN THE PERUVIAN AMAZONS

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jungle or along rivers." That adaptive ability has served the Urarina well as oil companies and colonists have penetrated farther into the Amazon wilderness, bringing diseases such as cholera, whooping cough and drug-resistant malaria to this once isolated part of the world.

The growing health problems generated by encroaching outsiders prompted Witzig to work with the Peruvian government in an attempt to bring organized medical care to the region. "We're running a completely functional health clinic on the river, but we want the government to put in a full blown health post," he said. To give the government the necessary information, though, Witzig must first catalog the inhabitants of the region and their health needs. "The census is key," Witzig explained, "Everything will be computerized and analyzed so we can show the Peruvian government what is needed."

Witzig hopes the census can help the Urarina with another life and death issue, this one a legal matter: retaining the rights to the land they live on, which is threatened by oil exploration and a PetroPeru pipeline. Retention of enough rain forest to hunt in is central to their survival. "If they don't have access to their land," warns Witzig, "They're going to die."

Dr. Witzig is a DGH Advisory Council member and the coordinator of the Amazonian Indigenous People's Health Project. For more information, you can read an online article he wrote about his work among the Urarina: www.nativeweb.org/saiic/ayn/urarina.html.

formal education and Spanish is not their first language. Although all of them speak Spanish well, they are more comfortable in their native indigenous languages, of which there are two distinct ones in this group of 12 promoters. Occasionally, they had to pause so one of them could explain a point better to the others in one of their languages.

The only real problem for me personally during my stay in Chiapas was the continuous scrutiny of foreigners by Mexican immigration authorities. Earlier in the year there was lots of talk blaming foreign agitators for all the problems and that Mexico doesn't need any observers or outside help of any kind. There are immigration posts at all entrances into the jungle areas that are strongholds of the rebel Zapatista army and immigration agents question anyone who looks like a foreigner whom they find in an area that is off the usual tourist routes. This has meant that it has been very difficult to travel to and from Altamirano and it has also meant that I have never really been able to do any community health work since the army and immigration authorities have made it very difficult for foreigners to travel to many of the more isolated places in the "conflict" zone. I was hoping to be able to travel to more of the communities and work with health promoters in the rural areas, but that proved impossible.

Conditions remain very difficult for many people living in Chiapas. There are still tens of thousands of Mexican Army troops stationed in many areas of the state and many of the indigenous communities feel very intimidated by their presence. Peace talks have been stalled for months. No one knows what to expect next, but there remain many people in the indigenous communities and people from various humanitarian organizations (Mexican and international) who persevere in looking for a peaceful way to end the conflict.

DGH plans to continue to work in the area by supporting and strengthening the community health work that is already being done. Primarily, DGH has begun by paying the salary of the Mexican physician who is currently in charge of the community health program since Hospital San Carlos didn't have the resources to keep him on staff. DGH members experienced in setting up community-based primary health projects will visit Altamirano to help fine-tune the program. DGH will also be actively recruiting volunteers and gathering material support for Hospital San Carlos.

DGH PROFILE: DR. LANNY SMITH

(Continued from page 2)

nity. We decided that they were health care and education. We had nobody to guide us in our work and he seemed like a good guide because he had good ideas. Lanny never promised anything, but rather encouraged our ideas. He always came without anything, just with his body and soul and his words and decisions and richness in genuine desire to help. Once we started acting on our ideas he was behind us all the way.”

Following up with the money was harder than Lanny had anticipated: “The biggest challenge was just to put together sufficient financial resources to do some semblance of what the people in the communities had prioritized.” MDM-France came through with some minimal backing and promised to take the project before the European Union (EU) for funding, but the process was drawn out and full of pit falls. “About one year into the project it became clear that EU funding wasn’t going to come overnight. It was also clear that people trusted me, both in Morazán and in MDM-France, as well as in other potential funding sources,” he says, explaining his decision to stay one more year, which eventually turned into five more, “I just basically realized that it wouldn’t be right for me to leave El Salvador and the project until I felt I had sufficient funding and sufficient resources in terms of people to keep things going.”

Lanny has no intention of sounding like a martyr, however. “It may sound like a sacrifice to people, but really it’s a great privilege,” he asserts, “I was quite clear that I was in the right place, at the right time, doing the right thing and, to top it all off, I was having fun doing it.” He emphasizes that every day was filled with moments that reinforced this conviction, like the laughter evoked by the plays put on by the health promoters to educate the communities about important health topics. “Men, who just a few years before had been soldiers in the FMLN, would dress up as women to promote the importance of breast milk. It was hilarious and people in the village were just very, very appreciative,” recalls Lanny with a smile.

After more than six years of accompanying the people of Morazán, Lanny left El Salvador this past December. “In community work, knowing when to leave becomes a key part of the process. If one leaves too early, then the work will fall apart because one did not prepare others sufficiently to continue. If one stays too long, then the others, who were once ready to take over, have left instead in frustration, or have never been encouraged to take control,” he explains.

Lanny’s immediate plans include a year of academic study. MDM awarded him a scholarship to attend the London School of Hygiene and Tropical Medicine from January to April of this year, where he received a Diploma in Tropical Medicine and Hygiene, and in September he will finally be going back for his Masters in Public Health at Harvard. “During that time I will evaluate where the best place is for me to act in the future,” declares Lanny, “Since some of the most obvious human suffering in the world (in terms of preventable disease) occurs in Africa, I am leaning toward working in a community there. With that in mind, over the Summer I will be visiting Uganda for a short time to teach in a medical school and then taking an intensive French course in France before starting school in the Fall.” As the Volunteer president of DGH, Lanny also plans to work with the other DGH Volunteers to continue supporting the work in El Salvador, Chiapas, Honduras and Peru, as well as helping the organization grow and become sustainable without depending on any one person. “I intend to be very involved until there is human dignity and social justice for persons all around the world,” assures Lanny.

Bustling plans for the future aside, leaving El Salvador has been difficult for Lanny. “Personally I’m sad because I’ve grown to love being in El Salvador, living with the people there, and it is very tough knowing that is not a daily part of my life anymore,” he admits, “But I also have a lot to be happy about: the work is going to continue, the Salvadoran people whom I have worked with for years have taken charge through MDS, and there are three more years of assured funding and a lot of commitment by the people in the communities.”

“It may sound like a sacrifice to people, but really it’s a great privilege. I was quite clear that I was in the right place, at the right time.”

In addition to seeing a bright future for the project in El Salvador, Lanny is pleased to be able to look back on all that they have accomplished over the years. Two CIDs have been built as well as a clinic, a pharmacy and the bridge over the Rio Chiquito. Health Promoters, some of whom never attended a year of school in their lives, have all gone through grade school equivalency and are finishing high school. Some of them have even started college. And many student volunteers from El Salvador, the US and other countries, have had their vision changed about what their role is in the world. “I think we also helped reinforce hope within a lot of people in these communities,” adds Lanny, “Made them feel there are people who think about them, who care about them and, in some ways, inspired them to care about their own lives. I’ve been incredibly privileged in my time there to work with an incredible people. People who have taught me a lot about suffering and not complaining; about having a positive attitude even when your family has been killed; about not giving up.”

Those same people feel just as strongly about him. Eulalia Perez, one of the health promoters says, “Lanny has been a true friend of the community. He is a good person who lived in solidarity with us.” Ms. Martinez concurs, “He is a true friend. We have a lot of trust in him. The way he behaves is just like a Salvadoran. We see him as one of us here in the *campo*, which is not always easy to achieve. Lanny’s work touched everything here, down to the smallest grain of sand.”

DGH Reporter

**Edited and designed by Monica Sanchez.
Mail suggestions to P.O. Box 1761,
Decatur, GA, 30031, U.S.A., or e-mail it to
newsletter@dghonline.org.**

DGH is administered by a volunteer Board of Directors whose members have volunteered with DGH a minimum of three years and are elected by DGH Voting Members. The Board is assisted by an Advisory Council composed of 100 physicians, students, retirees, artists, nurses, business people and others. A diverse group of volunteers provides the vital core of DGH’s resources, including this newsletter. There are no paid employees. DGH is incorporated in the state of Georgia as a 501(c)3 organization. Donations are tax deductible.

DGH Announcements

► **Volunteers Needed in Uganda.** Lanny Smith, the DGH President, recently visited Mbarara University of Science and Technology School of Medicine in Uganda, a small country in Eastern Africa surrounded by the much larger nations of Sudan, Ethiopia and the Democratic Republic of Congo (formerly Zaire). This initial contact raised enthusiastic interest on both sides, which share similar values and goals. In fact, Mbarara University was founded ten years ago with the express purpose of promoting community health. Medical School officials have asked DGH to accompany them in looking for qualified Volunteers. Located in Mbarara, Uganda, the School is in need of physician and basic science teachers. They are in particularly urgent need of a psychiatrist to head the Department of Psychiatry and would welcome teachers in most disciplines (classes are taught in English). Volunteers will need to cover their own transportation and food expenses, and be able to stay a

minimum of one month (the University will provide housing). Present international faculty (none yet recruited through DGH) include a former pediatrics professor at Harvard Medical School and an internist from Texas, as well as professionals from Cuba, Canada and England. If you are interested in Volunteering, send your curriculum vitae and a brief letter to the DGH office, attention of Dr. Wendy Hobson.

► **Grupo Morazán to Perform in the US.**

This group of massacre survivors from El Salvador tell their people's story through song in the tradition of oppressed peoples throughout the ages. Most group members were between the ages of 3 and 8 when their families fled El Salvador in the 1980's and settled in refugee camps in Honduras. During this flight, children were forced to be silent—no tears, no laughter, no conversation—so that the military would not see them fleeing through the underbrush. Only through music were they able to start expressing the trauma of their experiences and echo what they were hearing from the adults. They did this instinctively,

without knowing how integral a part of their refugee community's healing it would become.

Texas Presbyterian Churches have provided seed money to allow *Grupo Morazán* to perform in North Texas in April. Their \$500 grant will cover expenses relating to obtaining visas and passports and paying exit fees. Student Groups at Austin College in Texas have already started gathering donations for airline tickets and other groups throughout the United States are raising funds and making plans for concerts throughout the country. The concert tour will end as *Grupo Morazán* joins a School of the Americas Watch Action in front of the White House on May 1st.

You can purchase a CD or cassette of the group's music from Cat Garlit Bucher at 903-868-2783 (who also has copies of their last recording). *Grupo Morazán* is also ready to put out a new album. If you have any resources, expertise or contacts that could help them record a new CD and/or cassette, please contact the person above or Henry H. Bucher, Jr., at 903-813-2460; e-mail: hbucher@austinc.edu.



DOCTORS FOR GLOBAL HEALTH

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