

# MEDICINE WITHOUT DOCTORS



In Africa, just 2 percent of people with AIDS get the treatment they need. But drugs are cheap, access to them is improving and a new grass-roots effort gives reason to hope.

BY GEOFFREY COWLEY

**T**HE FIRST PART OF NOZUKO MAVUKA'S STORY IS NOTHING unusual in sub-Saharan Africa. A young woman comes down with aches and diarrhea, and her strong limbs wither into twigs. As she grows too weak to gather firewood for her family, she makes her way to a provincial hospital, where she is promptly diagnosed with tuberculosis and AIDS. Six weeks of treatment will cure the TB, a medical officer explains, but there is little to be done for her HIV infection. It is destroying her immune system and will soon take her life. Mavuka becomes a pariah as word of her condition gets around the community. Reviled by her

parents and ridiculed by her neighbors, she flees with her children to a shack in the weeds beyond the village, where she settles down to die.

In the usual version of this tragedy, the young mother perishes at 35, leaving her kids to beg or steal. But Mavuka's story doesn't end that way. While waiting to die last year, she started visiting a two-room clinic in Mpoza, a scruffy village near her home in South Africa's rural Eastern Cape. Health activists were setting up support groups for HIV-positive villagers, and Médecins sans Frontières (also known as MSF or Doctors Without Borders) was spearheading a plan to bring lifesaving AIDS drugs to a dozen villages around the impoverished Lusikisiki district. Mavuka could hardly swallow water by the time she got her first dose of anti-HIV medicine in late January. But when I

met her at the same clinic in May, I couldn't tell she had ever been sick. The clinic itself felt more like a social club than a medical facility. Patients from the surrounding hills had packed the place for an afternoon meeting, and their spirits and voices were soaring. As they stomped and clapped and sang about hope and survival, Mavuka thumbed through her treatment diary to show me how faithfully she'd taken the medicine and how much it had done for her. Her weight had shot from 104 pounds to 124, and her energy was high. "I feel strong," she said, eyes beaming. "I can fetch water, wash clothes—everything. My sons are glad to see me well again. My parents no longer shun me. I would like to find a job."

It would be rash to call Nozuko Mavuka the new face of AIDS in Africa. The disease killed more





**HIV**  
**POSITIVE**  
**TAZ - LUSIKISIKI**  
**JUNE 16**  
**YOUTH DAY**

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**ROCKIN':** In Lusikisiki, treatment is something to sing about

than 2 million people on the continent last year, and it could kill 20 million more by the end of the decade. The treatments that have made HIV survivable in wealthier parts of the world still reach fewer than 2 percent of the Africans who need them. Yet mass salvation is no longer a fool's dream. The cost of antiretroviral (ARV) drugs has fallen by 98 percent in the past few years, with the result that a life can be saved for less than a dollar a day. The Bush administration and the Geneva-based Global Fund to Fight AIDS, TB and Malaria are financing large international treatment initiatives, and the World Health Organization is orchestrating a global effort to get 3 million people onto ARVs by the end of 2005—an ambition on the scale of smallpox eradication. What will it take to make this hope a reality? Raising more money and buying more drugs are only first steps. The greater challenge is to mobilize millions of people to seek out testing and treatment, and to build health systems capable of delivering it. Those systems don't exist at the moment, and they won't be built in a year. But as I discovered on a recent journey through southern Africa, there's more than one way to get medicine to people who need it. This crisis may require a whole new approach—a grass-roots effort led not by doctors in high-tech hospitals but by nurses and peasants on bicycles.

Until recently, mainstream health experts despaired at the thought of treating AIDS in Africa. The drugs seemed too costly, the regimens too hard to manage. Unlike meningitis or malaria, which can be cured with a short course of strong medicine, HIV stays with you. A three-drug cocktail can suppress the virus and protect the immune system—but only if you take the medicine on schedule, every day, for life. Used haphazardly, the drugs foster less treatable strains of HIV, which can then spread. Strict adherence is a challenge even in rich countries, the experts reasoned, and it might prove impossible in poor ones. In light of the dangers, prevention seemed a more appropriate strategy.

Caregivers working on the front lines represented the idea that anyone should die for having the wrong address. So they set out to prove that treatment could work in tough settings, and by 2001 they'd succeeded. In a project led by Dr. Paul Farmer of Harvard, two physicians and a small army of community outreach workers introduced ARVs into 60 villages near the Haitian town of Cange. Around the same time, MSF teamed up with South Africa's

Treatment Action Campaign to make the drugs available in an urban slum called Khayelitsha. The upstarts simplified the drug regimens and dialed back on lab tests, and most of the patients were monitored by nurses or outreach workers instead of physicians. But none of this made treatment less effective. The cocktails worked as well in the slums as they did in San Francisco—and the patients were often *more* steadfast than Americans about taking their pills. The obstacle to treatment was not a lack of infrastructure, the activists proclaimed. It was a lack of political will.

The climate has changed since then. Yesterday's unacceptable risk is today's moral imperative, and the world's highest-ranking health authorities are pushing hard to realize it. "We still believe in prevention," the WHO's director-general, Dr. Jongwook Lee, told me during an interview in Geneva this spring. "But 25 million HIV-positive Africans are facing certain death. If

we fail to help them, it can't be because we didn't try." Since Lee took office last year, staffers in the agency's HIV/AIDS department have worked at a furious pace to devise a global treatment strategy and help besieged countries design programs that the Global Fund will pay for. Proposals are rolling in, and the fund is responding favorably. Grants approved so far could finance treatment for 1.6 million people over the next five years.

**T**HE TROUBLE IS, FEW OF THE countries winning those grants are ready to absorb them. Their health systems have withered under austerity plans imposed by foreign creditors. Doctors and nurses have left in droves to take private-sector jobs or work in wealthier countries. And those left behind are overwhelmed and exhausted. While traveling in Zambia, I visited Lusaka's Uni-



Geoffrey Cowley will host a Live Talk on curbing AIDS, July 15, at noon, ET, at [Newsweek.com](http://Newsweek.com) on MSNBC



**'A NEW DISPENSATION':** Nothabile Noggotho (left) at home in the Eastern Cape, Mavuka (above) near the Mpoza clinic, Reuter (below) with participants in the Lusikisiki project



tivists used what they found—a struggling hospital and a dozen small day clinics—to start a movement. A small team led by Dr. Hermann Reuter, a veteran of the Khayelitsha project, set up a voluntary testing center at each site, organized support groups for positive people and emboldened them to stand up to stigma. Before long, people like Mavuka were donning HIV-POSITIVE T shirts, singing about the virtue of condoms and quizzing each other on the difference between a nucleoside-analogue reverse transcriptase inhibitor and a *non*-nucleoside-analogue reverse transcriptase inhibitor.

By the time the first drugs arrived last fall, people in the support groups were poised not to receive treatment but to *claim* it. They shared an almost religious commitment to adherence, and some had become counselors and pharmacy assistants. Twenty-eight-year-old Akona Siziwe was as sick as Mavuka when she joined a support group in Lusikisiki last year. Weary of her husband's incessant criticism (he didn't like the way she limped), she had packed up her 7-year-old son and her HIV-positive toddler and gone home to die with her mom. But her health returned quickly when she started treatment in December, and she went to work as a community organizer. She now runs workshops and counsels patients in three villages. "What's a good CD4 count?" she asks. "The nurses don't have time to explain, but people want to know. When I share information that can help them, they're grateful and happy and full of praise. I can't even sleep because they are knocking on my door! They want testing and treatment tonight!"

The Lusikisiki project has only two nurses and two full-time doctors, but it was treating 255 patients when I visited in May, and people from the villages were flocking to the clinics as the good news spread. Many of them show up expecting a quick test and a jar of pills, but as the program's head nurse, Nozie Ntuli, likes to say, "Giving out pills is the final step in the process." First the patient has to join a support group and get treated for secondary infections such as thrush and TB. A counselor then conducts a home study to make sure the person is ready for a long-term commitment. When the supports are all in place, the counselor takes the patient's case to a community-based selection committee. And everyone shares the joy when a patient succeeds. "I see people transformed every day," Ntuli says. "It is a new dispensation."

This isn't the first time village volunteers have launched a successful health initiative. "Home-based care" is a tradition throughout southern Africa, and a cornerstone of countless successful programs. In rural Malawi,

versity Teaching Hospital, the 1,600-bed facility at the forefront of the country's two-year-old treatment program. Dr. Peter Mwaba, the hospital's stout, vigorous chief of medicine, detailed the country's strategy for treating 100,000 people (50 times the current number) by the end of next year. Yet his own facility was half abandoned. In 1990 the hospital had 42 nurses for every shift. Today it has 24—and the patients are sicker. "I've been here for 30 years," Violet Nsemiwe, the hospital's grandmotherly head nurse, confided as we walked the dim corridors. "It has never been this bad."

In an ideal world, the clock would stop while countries in this predicament trained tens of thousands of health professionals, quintupled their salaries and dispatched them to underserved areas. But the clock is ticking at a rate of 56,000 deaths a week, so the WHO is embracing a different approach—one rooted in the populism of Cange and Khayelitsha. "AIDS care, as we

practice it in the North, is about elite specialists using costly tests to monitor individual patients," says Dr. Charles Gilks, the English physician coordinating the WHO's "3 by 5" treatment initiative. "I've done that and it's great. But it's irrelevant in a place like Uganda, where there is one physician for every 18,000 people and that physician is busy at the moment. If we're going to make a difference in Africa, we've got to simplify the regimens and expand the pool of people who can administer them."

That's precisely the agenda that activists are pursuing in Lusikisiki, the remote South African district where Nozuko Mavuka got her life back. When MSF and the Treatment Action Campaign launched their project there last year, the local hospital was performing the occasional HIV test but had little to offer people who were positive—a population that includes 30 percent of pregnant women. Lusikisiki is the poorest part of the poorest province in South Africa, but the ac-

minimally trained community volunteers manage everything from pregnancy to cholera. They work with TB patients to ensure adherence, and they supply vitamins, aspirin and antibiotics to people living with HIV/AIDS. When Malawi's Health Ministry starts distributing antiretrovirals through a national program this fall, the volunteers will help administer those, too.

They'll play an especially important role in Thyolo, a desperately poor district surrounded by tall mountains and jade green tea plantations. Roughly 50,000 of Thyolo's half-million residents are HIV-positive, and 8,000 have reached advanced stages of illness. When I visited Thyolo this spring, MSF was treating several hundred of them at the local district hospital, a converted colonial-era country club run by nurses and clinical officers (non-M.D.s with four years of training). But the hospital was in no position to handle thousands more, even if the government provided the drugs. Its two-person AIDS staff was struggling just to keep up with the MSF program. Many of the untreated patients lived too far away to trek in for routine visits anyway.

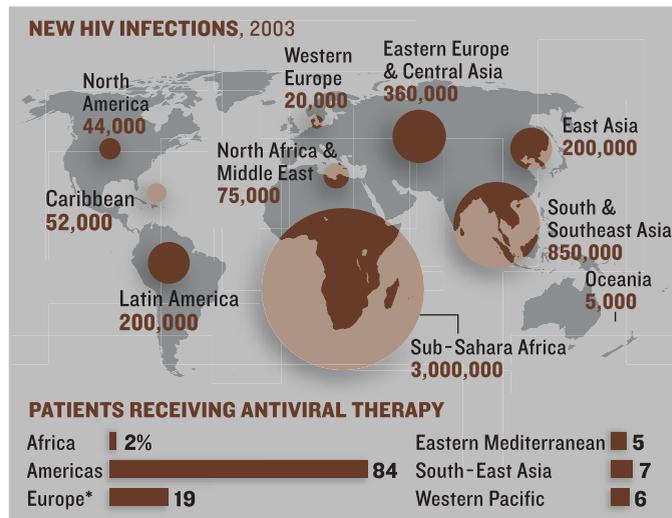
Dr. Roger Teck, a fiftyish Belgian physician who runs MSF's Thyolo program, described the predicament during a bumpy jeep ride from the hospital to the outlying village of Kapichi, where 20 volunteers were waiting for us in a freshly painted one-room community center. Some were as young as 20, others as old as 70. After an hour of prayers and introductions and soulful choral chants, the group's leader, 49-year-old Kingsley Mathado, peppered us with facts about the 30 villages in his area (3,000 people living with HIV, 500 in need of treatment) and described the volunteers' program for supporting them. When the government drugs reach Thyolo district hospital, the patients will still have to walk a half day to queue up for an exam and an initial two-week supply. They'll also have to return for their first few refills so that a nurse or doctor can see how they're responding. But the volunteers will take over as soon as patients are stable, refilling prescriptions from a village-based pharmacy and charting adherence and side effects.



**ON CALL:**  
Ntuli  
attends to  
a patient

## New Patterns of a Global Plague

Africa remains hardest hit by AIDS. But infections are booming in Asia and Eastern Europe. And most patients go without adequate therapy.



Could this strategy work on a grand scale? Lay health workers are already a mainstay of large-scale TB initiatives, and the Malawian government has assigned them a big role in AIDS treatment as well. The country's nascent ARV program uses a regimen simple enough for anyone to administer after a week of intensive training (three generic drugs in one pill—no substitutions). Physicians from Malawi's Ministry of Health are now traveling the country to conduct training courses for lay health workers. The first drugs should arrive in the fall. "We've taken a radical leap to ensure real access," says Dr. William Aldis, the WHO's Malawi representative and one of the plan's many architects. "We're either going to win a Nobel Prize or get shot."

Malawi's challenge is to foster the kind

of engagement that has made treatment so effective in places like Cange, Khayelitsha and Lusikisiki. If 25 years of HIV/AIDS has taught us anything, it's that grass-roots involvement is critical. "One set of characteristics runs through nearly all of the success stories," the London-based Panos Institute concludes in a 2003 report on the pandemic: "ownership, participation and a politicized civil society." No one denies the need for trained experts to manage programs and handle medical emergencies. But people from affected communities are often better than experts at raising awareness, shattering stigmas and motivating people to take charge of their health. Reuter, the Lusikisiki project's director, recalls an experiment in which doctors teamed up with activists to extend a hospital-based ARV program into community clinics in the Cape Town slum of Gugulethu, where access would be easier and peer counselors could play a bigger role. The ghetto-based patients achieved 93 percent adherence during the first year. The hospital's program had never topped 63 percent—a rate Reuter dismisses as "American-style adherence."

With access to treatment, millions of dying people could soon recover as dramatically as Nozuko Mavuka did in Mpoza—and their salvation could revive farms, schools and economies as well as families.

But there are hazards, too, and drug resistance isn't the only one. Successful ARV therapy expands the pool of infected people simply by keeping people alive. Unless the survivors can reduce transmission, the epidemic will grow until the demand for treatment is unmanageable. "We can't focus blindly on treatment," Teck mused as our jeep lurched away from Kapichi. "If we don't reduce the infection rate, we're going to end up in a nightmare situation." The patients and counselors in the clinics I visited weren't singing and stomping only about pills. They were celebrating a shared commitment to ending what is already a nightmare. The rest of the world needs to lock arms with them.

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