That is indeed true of Apac, which has the dubious honor of having the highest recorded malaria rate in the world. "The rates are staggering," says Stone. "People living in the area are bitten by malaria-infected mosquitoes about 1500 times a year."

That means every single day, each person in the district is bitten by at least 4 mosquitoes carrying the parasite that causes malaria.

Mirembe's hopes, though, are slowly dissipating as the impasse continues.

Although the Ugandan government believes nothing but DDT will suffice in trying to control the mosquitoes that transmit malaria, opponents continue to protest its use.

Back in the bustling capital of Kampala, more than 200 worried and angry people have gathered at an anti-malaria protest organized by Ken Lukyamuzi, the leader of the opposition party.

Two smartly dressed businesswomen in their mid-30s hold up a sign on which the words "DDT kills" are scrawled.

"Down with DDT," reads another sign.

Lukyamuzi is far from moderate — he accuses the Ugandan government of poisoning its own people. But he maintains his concern is for people's health and the environment — and not just about politics.

"It is clear that DDT is dangerous to man," he says in Luganda, the local language, gesturing to the crowd. "You can protect yourself. … Get your saw, your machete, your axe! Greet the spraymen at your house."

While few others would counsel such violence, scientists say the environmental concerns of opponents like Lukyamuzi are valid.

"It's important to remember that DDT is persistent organic pollutant, which means that the substance stays in the environment for a very long time. And a lot of our exports to Europe, North America might suffer as a result of having DDT," says Steven Nyanzi, head of the the chemistry department at Makerere University. "All of a sudden we just want to use DDT."

Will such environmental concerns trump the health benefits? For now, no DDT is being sprayed in Uganda but the government's intent is to resume spraying when it can. The question now is: how long will each side hold out? — Katie Lewis, Apac, Uganda

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Dispatch from the medical front

Hard work, harder numbers

Birth is hard work, no matter what part of the planet you call home.

But I learnt that women giving birth in rural South Africa suffer more than others because of one simple fact: numbers (read $).

That's right: debt.

The maternity ward at the Church of Scotland Hospital in Tugela Ferry, where I recently worked, was 30 million rand ($5 million) overbudget in 2007.

That is hard to believe given that we regularly ran out of linens, hand soap, sterile gloves, paper towels, fetal heart monitor ink, paper and belts, chlorihexidine, gauze, amnihooks, KY jelly and proper-sized suture material.

There were definitely no women demanding their epidurals at this hospital (and no midwives pushing them).

You were lucky if you had a cotton sheet to lie on. And I never heard one complaint about the 32 degree Celsius heat in the labour ward (there were no fans or air conditioning).

Certainly the Health Department of Kwa-Zulu Natal has a lot on its plate: take for instance, the province's fight against multi- and extreme-drug-resistant tuberculosis that goes hand in hand with the province's HIV epidemic. In 2004, 40.7% of antenatal clinic attendees in the province of Kwa-Zulu Natal were HIV positive — the highest rate in all of South Africa.

Reuters / Juda Ngwenya

Two-year-old Sifiso is one of the 200 babies who are born HIV-positive every day in South Africa.

Happily, thanks to the Prevention of Mother to Child Transmission Program, close to 100% of the women who delivered at the Church of Scotland Hospital knew their status, and almost all of those who were positive had self-administered nevirapine at the onset of labour, and their babies were given a dose within the first 72 hours of life.

Still, major challenges continue to plague the South African Prevention of Mother to Child Transmission Program. For example, although aiming to provide a 6-month supply of formula to HIV-positive mothers, district hospitals are often out of stock, leading to mixed feeding.

Lack of follow-up of mothers and their HIV-exposed infants results in some babies not receiving nevirapine after birth, and women not receiving the antiretroviral treatment they so desperately need.

Certainly for a woman like Zanele, an HIV-positive 30-year-old mother of 3, who has a young family to raise, a properly funded program would go a long way to ensuring that her children have a mother and an HIV-free childhood. — Lindsay Tabah, Hamilton, Ont.

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CMAJ invites contributions to "Dispatches from the medical front," in which physicians and other health care providers offer eyewitness glimpses of medical frontiers, whether defined by location or intervention. Submissions, which must run a maximum 400 words, should be forwarded to: wayne.kondro@cma.ca