Dispatch

In Lesotho

I wake at 6:00 am and drag myself into the orange glow of a southern African sunrise for my morning run. I spend the entire distance — on dirt paths, through open fields, dodging cows, under the shadow of mountains, peeking over river-etched valleys — responding to happy yells of *Hello*, *How are you?*, *Are you training?*, *I will race you* (and she did) from clusters of children walking to school. I am in Lesotho for a one-month locum with the new Ontario Hospital Association-aided Tšepong HIV clinic — a name that means "Place of Hope."

With Canadian team leader Philip Berger, pharmacist Marnie Mitchel, and midwife and nurse Sister Christa Mary Jones, I arrive at the clinic at around 8. We step into the sound of the hauntingly beautiful morning prayer. The hallway is filled with at least 45 patients, many hardly able to stand, using every last ounce of energy and motivation to bring themselves to their feet and engage in a perfect, heartwrenching harmony of prayer for health. My self-absorbed fears wash away as I am swept into the desperation of those pleas.

The morning is spent drawing blood. We see over fifty patients, many with almost imperceptible, dried-out veins that we tap into with little more than bravado and faith. The afternoon is taken up with the unbelievable flow of the sick. I see four people with *Pneumocystis carinii* pneumonia, three with esophageal candidiasis, one with presumed tuberculosis. And these are diagnosed with our only tools — our eyes, ears, hands and stethoscopes.

It is hard to convey the scene. A 36-kg woman panting at fifty-plus breaths per minute, is unable to swallow a banana given to her by a relative because of the pain in her throat. Another, 29 years old, with left-sided paralysis, has a seizure as we try to weigh her. An ox-cart pulls up, carrying a near-comatose woman brought from a village hours away. A 13-month-old child who looks like a 6-month-old is brought in by her grandmother (the child's mother died a month after giving birth). Her grandmother reports she used to crawl but now only lies down and wiggles on her stomach — a regression in developmental milestones that would be responded to quickly and aggressively in Canada. She smiles at me shyly when I tickle her stomach. This child would likely thrive on antiretroviral drugs. The first shipment of pediatric formulations was delivered to our clinic a few days ago, enough for 35 children to be treated for four months. We find ourselves faced with life-and-death judgements: do we treat the sickest, or those who might have the strength to survive longer? Which 35 are to be blessed with a four-month window of hope (a third of this child's lifetime)? We must establish guidelines to choose the lucky few. I cannot promise this grandmother drugs, but I can give her a moment of recognition for her strength. These words provoke a few seconds of tears, a glimpse into her plight; then the child is strapped on her back and she is off.

Our primary measure of each patient's condition, the CD4 count, falls almost uniformly below 200 (the cut-off point for AIDS) and often below 50. We start patients deemed appropriate (according to guidelines developed for this setting) on antiretroviral therapy. In five months the clinic has started over three hundred patients on these life-saving drugs. These patients have an invigorating effect on the team. The clinic's seventh antiretroviral recipient (they are all assigned sequential numbers) returns after three months, having gained 8 kg, his CD4 count having risen from 69 to 196. Another man, after one and a half months, has an unbelievable rise in CD4 from 16 to 265, and in weight from 45 to 60 kg. He bounds in, full of energy, excited to spread word of the clinic and new possibilities for HIV care to the entire country. It is the hope this patient expresses that best captures the impact of this clinic. For the first time, antiretroviral drugs are being provided to the public, giving a sense of future possibility to a country suffering under the yoke of a pandemic beyond comprehension. It is estimated that over 30% of the adult population of Lesotho is infected with HIV. Tens of thousands of children are orphaned, and many thousands suffer from the infection itself.

But this is a country of contrasts. Situated on top of mountains (Lesotho has the highest low point of any country in the world), it is a stunningly beautiful place. One night, Philip calls me and says "Go outside, now!" I am confronted with the greatest light show I have ever seen: huge spears of lightning slicing through the sky, each momentarily lighting up the mountain behind our houses before pitch darkness descends again. It is not hard to find life and beauty amidst the devastation, … like the clinic morning prayer: on the one hand it provides an anchor for hope, on the other it deepens the loss.

Our endeavour is a drop in the bucket, but every drop preserves life. We need physicians, nurses, counsellors, midwives, community support workers, hospital beds, medication distribution systems, public health surveillance systems — an entire health infrastructure to be built overnight and maintained, intact, for decades. In the big picture, it seems impossible. But, as we work with real people, on the ground, we feel the potential to go beyond hope, to create change that is truly profound.

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Information about the OHAfrica initiative is available at www.oha.com.

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