Multinational [drug manufacturers] that left out of frustration are coming back."

None of this has made her very popular with the local drug cartels. The sniping incident was only one of several attempts on her life. NAFDAC'S offices have been fire bombed and its personnel attacked by gunmen. No wonder her family wants her not to accept another five-year term when the current one expires next year. But Akunyili, 51, has not made up her mind. "God gave me the opportunity to do something," she says, "and so far, God has been protecting me."

Like many committed health professionals in the developing world, Akunyili brings an almost messianic zeal to her work. "Drug faking or counterfeiting is the greatest evil of our time," she says. "Malaria can be prevented, HIV/AIDS can be avoided and armed robbery may kill a few at a time, but fake drugs kill en masse."

—By Michael D. Lemonick, and Gilbert Da Costa/Lagos

VICKY ALVARADO
HONDURAS

Nutritionist

Well-nourished babies in Honduras look like well-nourished babies everywhere—plump, active, alert. In rural Honduran towns, there's now one more way to identify them: look for a little blue pin next to their names on one of Vicky Alvarado's healthy-eating charts. A child earning one of those is a child getting a fair shot at life.

For too many Honduran children, a fair shot—ensured by a full stomach—has long been out of reach. Up to 40% of the population under age 5 suffers from malnutrition. In the poorest villages, that number jumps to 70%. Honduras is hardly the only country that does such a dreadful job of feeding its babies. What makes it different is that it has the resources to do better. Only 2% of Honduran families are so poor that they

PEDRO ALONSO
MOZAMBIQUE

Malaria Fighter

Even in Africa, the continent most severely affected by a disease that kills more than a million people each year, Mozambique is considered a hot spot. In some parts of the country, 9 out of 10 kids younger than age 5 are infected with the mosquito-borne parasite that causes malaria. That's why Dr. Pedro Alonso, a Spaniard, in 1996 founded the Manhiça Health Research Centre. The terribly impoverished rural town is the last place you would expect to find a sophisticated medical laboratory. But here, working with a team of mostly Mozambican scientists and backed by the Spanish Agency for International Cooperation, Alonso has been studying malaria on the ground and, for the past four years, testing an extraordinarily promising vaccine against the disease. So far, it's only partly effective, but even in this imperfect form, experts say, it could save millions of lives. "We're talking about the first solid demonstration of a malaria vaccine," says Alonso. "This is a breakthrough."

So why hasn't anyone developed a malaria vaccine before now? Part of the problem is that the parasite is so biologically complex that it's difficult to prime the immune system to fight it off. And part is that most of its victims are so poor that drug companies are reluctant to take experimental vaccines out of their lab and into the field for human trials. But an organization called the Malaria Vaccine Initiative, started by the Gates Foundation in 1999 and now supported by a growing list of corporate contributors, is making such trials—including Alonso's—possible.

PETER VAN AGTMAEL—POLARIS FOR TIME

FIELD TRIAL: Alonso screens newborns for a vaccine test

Alonso's trial involves 2,000 children ages 1 to 4 taking a vaccine originally developed by GlaxoSmithKline. The vaccine reduced the risk of clinical (symptomatic) malaria 30%, new infections 45% and new episodes of severe, life-threatening malaria in those already infected an average of 58%. In the children less than 2 years old, it cut the risk of severe malaria 77%. The next step, says Alonso, is to test the vaccine in children younger than a year old. Then trials will be expanded into other countries. "If all goes well," he says, "we should have an approved vaccine by 2010."

That would be deeply satisfying to Alonso, 46, who, with his wife Clara, has been fighting malaria for nearly 20 years. "When you arrive as a young doctor in Africa," he says, "and you walk into a hospital, you're basically confronted with this massive disease that causes so much suffering and death. It is impossible not to become passionate about fighting it." Says the father of three: "Those children in the hospital are looking at us, telling us to put more effort, more resources, more brains, more research, to come out with solutions. They are a constant reminder of all that needs to be done." ***—By Michael D. Lemonick, and Ruth Ansah Ayisi/Manhiça***

can't afford at least some food every day. The rest have it; they just don't know how to make the most of it.

That never sat right with Alvarado. A native Honduran, she graduated with degrees in primary school education and nursing, then traveled to the U.S. to earn her master's in nutrition at the University of Nebraska at Lincoln. All this made her uniquely qualified to tackle the dearth of nutrition education in her home country—something she got a chance to do in 1999.

ANDREW KAUFMAN—CONTACT FOR TIME

FOOD QUEEN: Alvarado teaches the poor how best to feed their kids

That year the Honduran Secretary of Health began a pilot program—partly sponsored by the U.S. Agency for International Development (USAID)—to improve the welfare of children by taking care directly to their villages rather than making them travel for it. Alvarado, who had accepted a job with USAID as a childhood-nutrition consultant, argued that it was imperative that the new program include a comprehensive tutorial in food handling, hygiene and meal planning. She put together her curriculum and dispatched teams of health workers into the countryside to teach it.

The response was electric. Instructors would visit a village, and all the local mothers would turn out. At the next village, not only would the resident families attend, but ones from the surrounding communities would too. Later, when the workers returned for periodic weigh-ins and measurements of the kids, all the same families were there again.

Alvarado doesn't know which nutrition lessons the mothers began practicing in their homes, but it was clear that they were doing something different. "The people in the health clinics started saying 'We don't see so many sick children from those towns,'" reports Alvarado, now 55. "They bring their children in for vaccines or checkups but not for malnutrition sicknesses."

In case the improvement in the children's health didn't motivate the mothers, Alvarado started posting her pin charts in each community. Children who reached their height and weight goals were awarded the blue pins; those who didn't got red ones. "The mothers can see the goal," Alvarado says. "They say, 'I don't want my child to have a red pin; I want him to grow.'"

Growing is precisely what the kids are doing. There are now regular nutrition programs in 2,000 Honduran communities, out of a total of 30,000. But success breeds success, and the program is expanding, thanks to funding from the World Bank, CARE, Save the Children and others. Well-spent aid dollars, it appears, can mean smarter parents. And smarter parents have the tools to save their kids. ***—By Jeffrey Kluger, and Melanie Wetzel/Tegucigalpa***

PETER OKAALET
KENYA

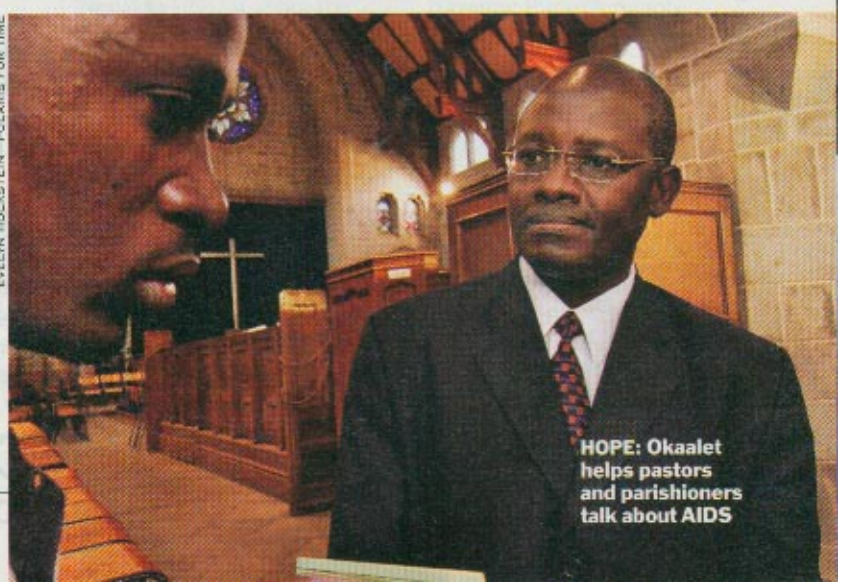
Bridge Builder

When it comes to combatting AIDS, doctors and clergy don't always see eye to eye. Physicians zero in on the virus that causes the scourge. Ministers tend to highlight the moral lapses—from social injustice to sexual behavior—that help spread the disease. They could be allies in combatting the epidemic, particularly in Africa where doctors are few and preachers many, but instead they often seem to work at cross-purposes, divided by mistrust and skeptical of one another's motives.

Enter Peter Okaalet, 52, a physician who decided in the late 1980s to go to seminary in an attempt to bridge the gap. From his base in Nairobi, where he serves as Africa director for a Christian medical-assistance group called MAP International, Okaalet has spent the past 12 years working with ministers—and by extension their congregations—to refine and in some cases redefine their response to AIDS. To that end he has run countless seminars in Kenya and elsewhere and helped establish master's degree programs in pastoral care and HIV/AIDS at 14 seminaries and Bible colleges in eastern and southern Africa.

Why focus so much energy on ministers and churches? "People forget that churches also have hospitals in Africa," Okaalet says. "Most of the mission-based hospitals are in the rural areas where governments cannot reach. Where the road for the four-wheel-drive stops, the pastor gets on his bicycle. Where the bike path stops, the pastor lays it aside and goes on foot."

The path gets rocky at times. Many religious communities, Okaalet finds, progress through four phases in their response to the AIDS crisis: an initial "holier than thou" attitude of condemning others; helpless resignation in the face of the enormity of the epidemic; concern that if they become involved in AIDS issues they will be ostracized; and, ideally, wholehearted involvement. The trick to helping groups out of the early stages,



EVELYN HOCKSTEIN—POLARIS FOR TIME

HOPE: Okaalet helps pastors and parishioners talk about AIDS