AIDS in Africa: a personal experience

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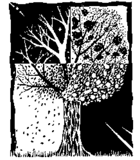

Experience

Expérience

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Recent breakthroughs in the care of patients with HIV and AIDS have finally given physicians reason for optimism. Treatment with the new protease inhibitors often suppresses viral loads to levels below the threshold of detection, with a corresponding decrease in some opportunistic infections. Vertical transmission from mother to child can be reduced by up to two-thirds by the use of antiretroviral drugs.[1]

But these new medications and approaches to treatment have limitations. Perhaps most striking is the fact that, because of the high cost of the new drugs, most people infected with HIV will never have access to them. As of November 1997, more than 20 million of the estimated 30 million people infected were living in sub-Saharan Africa,[2] and it is estimated that the developing countries of Asia and sub-Saharan Africa will be home to nearly 90% of all HIV-infected people by the year 2000.[3] In Africa, AIDS has become the primary cause of death in young adults in some urban areas, and life expectancy has decreased by 20 years in several countries.[4]

Until 2 years ago, the enormity of these statistics was purely academic to me. My experience in the summer of 1996 gave faces to the numbers and impressed upon me the hard realities of AIDS in the developing world.

As a medical student I had visited developing world countries several times, but my first experience working in this setting after graduation came in 1996, when I volunteered for a 3-month placement at the Luisa Guidotti Hospital in Mutoko, Zimbabwe. The Luisa Guidotti is a 140-bed mission hospital providing inpatient and ambulatory care to a rural, largely agrarian population. Its only permanent physician has been there since 1980, and she has seen first-hand the emergence of the AIDS epidemic in Zimbabwe. Despite a recent addition to the hospital, it is frequently impossible to accommodate the immense numbers of patients who come for care. Often, the hospital would have more than 200 inpatients, many of them forced to find space for sleeping under the cots of other patients. At Luisa Guidotti, the annual mortality rate has increased almost 10-fold since 1983, an increase that can be attributed directly to the HIV epidemic.

Although a huge number of people presented with HIV-related illness, some stood out in my mind. One patient, nicknamed Winnie, presented to the outpatient clinic late in the afternoon. I suspected that she already had some idea about her diagnosis. The notes in her outpatient chart informed me of her battle with chronic diarrhea and weight loss. As she sat in front of me, a woman reduced to a cachectic ghost of her former self, she seemed no different from the countless others with which the hospital was filled. (The Luisa Guidotti had a reputation for admitting patients that other hospitals had turned away, so it was not unusual for the sickest patients to arrive there after being denied admission elsewhere.) I told her that her symptoms indicated that she probably had AIDS. As we talked about her illness, Winnie told me about her life, her work as a school teacher, her marriage and her fidelity, and the recent deaths of her father and 2 of her children. It was at that point in our conversation that she stopped and said, "I'm going to die. There's nothing left to do, is there?" It was more of a declaration than a question, spoken with a sense of resignation rather than as a cry for pity. She did not expect an answer. Winnie began to have seizures the next day, slowly lost consciousness and passed away within a week. She was just 29.

The loss of another young life was not unusual at the Luisa Guidotti Hospital,

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The author with a young patient who had pulmonary tuberculosis. The results of this child's HIV test were pending when the author left Africa.

but Winnie's death weighed heavily on my mind. Perhaps it was because it served as testimony to the unfair burden of AIDS on women, who are often infected by their polygamous husbands. Perhaps it was because her death would leave her 2 other children without a mother. In fact, the statistics tell us that for every woman who dies in Africa, 2 children are orphaned.[4] In time, though, I realized that for me the importance of Winnie's death was the emphasis it placed on the personal tragedy of HIV and AIDS. At the hospital where I was working, sickness and death sometimes became uncomfortably routine. The extent of each individual patient's suffering was buffered by the large number of others who were seriously ill. On a busy day it would have been easy to quickly admit Winnie and move on to the next patient. But something about her made me pause. Despite her frail, emaciated frame, her grave condition, she impressed me as being articulate, eloquent and reflective. She put a face to the statistics of HIV. Through Winnie, I saw the lost potential of all those HIV-related deaths. Those 20 million lives lost to HIV in Africa became visible to me as individuals.

Another patient was Tendai, a 12-year-old boy with known rheumatic heart disease who had done reasonably well with medical treatment. Because both his parents had died of AIDS, he lived in a room at the hospital set aside for orphans. He had seen 2 of his siblings die already, and while I was in Zimbabwe his last remaining sibling was admitted with tuberculosis. As his brother's condition improved, the boys would play outside, Tendai watching over his frail sibling, just as one might expect from an older brother. Soon, though, his brother's HIV test came back positive, and it became apparent that Tendai was going to witness the death of yet another family member.

Stories like Winnie's and Tendai's are typical of the AIDS epidemic in Zimbabwe, and they exemplify in particular the effects of HIV on children. For these youngsters, HIV represents a double burden. In addition to the children infected by the virus, many others, such as Tendai, are orphaned because of AIDS. By the year 2000, the number of children who are orphans as a direct result of AIDS could reach 10 million worldwide.[4]

In addition to the overwhelming problems of the patients at a personal level, there were many technical challenges inherent in practising at the Luisa Guidotti Hospital. Only rudimentary lab testing and radiographic services were available for complex clinical presentations. Suspected diagnoses could not be investigated, and patients sometimes died without ever receiving a firm diagnosis. Perhaps the greatest challenge was overcoming the immense sense of futility and impotence that was felt by all of the health care workers at one time or another. The lack of resources made it impossible to meet the high standards of care we are used to in the West. Our role was often reduced to alleviating the suffering of patients who undoubtedly would have had other options had they been living in Canada.

I had been trained to help patients die with dignity, and I value the skills I learned in this area. Yet when I was confronted with the loss of so many very young lives, principles that seemed obvious for an older patient with metastatic cancer or severe congestive heart failure here in Canada just didn't seem as readily applicable. Helping patients to die with dignity was made even more difficult by the lack of medications, investigative techniques and social programs. It was humbling to watch children such as Tendai's brother and realize that little was available to them medically.

I was able to face these challenges, often because the demands of caring for the large number of patients prevented me from stopping and being overwhelmed by feelings of futility. At other times it was the reward of seeing a sick patient improve that compensated for the sense of impotence — the comatose child with cerebral malaria who regained consciousness and strength or the patient with HIV who was discharged after a long stay for treatment of TB.

Since my departure from Africa in the fall of 1996, fears have been expressed that the HIV epidemic may be much worse on that continent than previously anticipated.[2] But despite the economic, physical and social consequences of HIV in Africa, there seem to be reasons for optimism. HIV prevalence rates have recently reached a plateau in some urban settings in Uganda,[3] perhaps reflecting an improvement in HIV control. Recent studies in Tanzania have shown a decrease in the number of new HIV cases coincident with surveillance and treatment of other STDs.[5] A large multicentre clinical trial in Africa is

looking at short-course zidovudine during the perinatal period as an alternative to the longer courses of treatment which are known to be effective but which are too costly.[3]

These are, as yet, only small gains. As we celebrate the legitimate advances in antiretroviral medications, we should not forget the needs of patients in the developing world, patients like Winnie and Tendai's brother. An effective response to the epidemic will be multifactorial. As in North America, conventional social frameworks will have to be challenged, economic infrastructures will have to be rearranged and political organizations will have to give the issue priority. Much of this is already being done. To quote Nelson Mandela, "The AIDS pandemic is getting worse at a rate that makes a collective global effort imperative. When the history of our time is written, it will record the collective efforts of societies responding to a threat that has put in the balance the future of whole nations. Future generations will judge us on the adequacy of our response."[6]

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