The Challenge of AIDS in Africa:
"Treat the Person, Not a Statistic"

by Mark Willis

The face of medicine has changed dramatically in the 15 years that Roger Pacholka, M.D., has been traveling to southern Africa. So has the approach to providing medical care as the spread of AIDS has reached epidemic proportions.

"In the 1980's we talked about curing disease," Dr. Pacholka says. "Now we talk about adding time and quality of life to people's lives there."

A 1985 graduate of Wright State University School of Medicine, Dr. Pacholka first traveled to the southern African nation of Swaziland in 1984 as a fourth-year medical student. His medical education was supported by scholarships from the Montgomery County Medical Society Auxiliary (now the MCMS Alliance). He completed a two-month student rotation at Raleigh Fitkin Memorial Hospital in the Swazi city of Manzini. After completing Wright State's Emergency Medicine Residency, he lived in Manzini for two years with his wife Katy and daughter Laura. Their work as medical missionaries -- he describes it as "a response to a calling we felt very deeply" -- have taken them back to Swaziland seven times. A member of the medical staff at Miami Valley Hospital, Dr. Pacholka is now an assistant clinical professor of emergency medicine at Wright State.

HIV infection was not evident in Swaziland in 1984. The predominant medical problems then were tuberculosis, gastroenteritis, and leprosy. Today, however, an estimated one-third of the reproductive age population in Swaziland is infected with HIV, and both the adult and children's wards of Raleigh Fitkin Memorial Hospital are filled with patients who have AIDS and AIDS-related problems.

"A statistic like 'one-third of the population' doesn't mean that much... until you meet one person who is part of that 'one-third,'" Dr. Pacholka says. "When you look them in the eyes, when you shake their hands, when you meet their children or husband or wife -- you have to see AIDS in Africa on an intimate basis before the full impact of 'one-third of the population' hits you. If you can help one person, that suddenly becomes really important to you. You're treating a person, not a statistic."

Working in collaboration with Swazi officials, Dr. Pacholka is currently organizing the nation's first neonatal AIDS prevention program. Treating HIV-infected women with anti-viral medications such as AZT beginning in the 36th week of pregnancy can reduce transmission of HIV to their babies by as much as 80%. The program will be launched later this spring at Raleigh Fitkin and a hospital in the Swazi capital of Mbabane. The neonatal prophylaxis costs $250 per person, a prohibitive sum where the per capita annual income is $1,000. Dr Pacholka started the program with a grant from the Missionary Emergency Fund in Richmond, Virginia, and he continues to raise funds to sustain it.

"We think we can save as many as ten children a day at the two hospitals," Dr. Pacholka says. "When you think about the magnitude of AIDS in Africa, ten kids a day isn't that many, but we try to keep in mind that if one were your son or daughter, it would be significant. You tackle these problems one person at a time, you do what you can, and you try not to get overwhelmed by the numbers."

In February, two more Wright State medical students followed Dr. Pacholka's path to Swaziland. With his assistance, Megan Baker and Kara Levri arranged a one-month student rotation at Raleigh Fitkin Memorial Hospital. They decided to go to Africa to experience medicine in a completely different context. Along the way they discovered that fundamental lessons about he doctor-patient relationship hold true no matter where you go.

The medical students did their homework first. They consulted travel medicine specialists in preparation for their journey. They had completed Wright State's infectious disease training in Dayton-area hospitals. They were experienced with the use of universal precautions to prevent the accidental transmission of HIV, and they consulted the Post-Exposure Prophylaxis (PEP) hotline (1-888-448-4911) to get the most up-to-date advice about AIDS prophylaxis in Africa. Each of them took a one-month regimen of AZT and 3ZT to Swaziland.

"We struggled with whether or not to bring medications," Kara Levri says. "If you get a needle stick in the

U.S., you begin prophylaxis within an hour. The medications aren't available in Africa unless you bring them yourself.

"We didn't want to feel restricted or scared of the patients," she adds. "We wanted to be ready to sew sutures or deliver babies. If you have any inhibition about doing that because of the threat of HIV, you're not giving your patient quality care. I didn't want that in the back of my mind."

Kara delivered two babies at Raleigh Fitkin, and she and Megan worked frequent shifts in the hospital's emergency room. Neither experienced a needle stick, so they gave their prophylactic medications to other colleagues when they left Swaziland.

With long hours on call and a constant stream of patients needing urgent care, Raleigh Fitkin was "the best preparation for residency that I can imagine," says Megan Baker. She found a significant cultural difference between medical care in Swaziland and here. Swazi people are much more stoic in enduring pain, and doctors there spend less time talking with their patients.

"It was a struggle to get the interpreter to help me take a history," she explains. "It wasn't just a language barrier, but a style barrier. I wanted to ask patients more than three or four cursory questions. One of the nurse's aides finally realized that the patients liked it when medical students asked thorough questions, so she began to take the time to help me.

"For all the differences, I found one important similarity," she continues. "Patients care about their health, regardless of where they are or what cultural system they're used to. They want to know about their health. They're going to do better if you can involve them