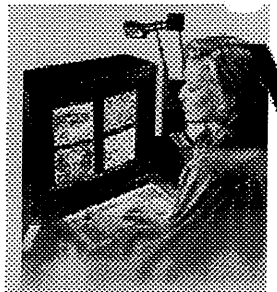

Minnesota Medicine

EDITOR'S NOTE

Bringing Africa Closer

Africa is a long way from Minnesota—geographically, climatically, culturally, and medically. It takes 21 hours flying time to cover the 8,500 miles between Minneapolis and Nairobi, Kenya. Today's predicted high for Minneapolis is 12 F; for Nairobi, it's 82 F. Minnesota is a financially healthy state in a wealthy nation; Kenya is an economically struggling country on a hurting continent. Minnesota's health care system usually runs smoothly; Kenya's, and all of Africa's, health care system is on the verge of collapse. Yet Africa is closer than we think. This month's Minnesota Medicine brings it closer.

We hear from Minnesotans Tony Pfaff and Mark Jacobson about their personal experiences with AIDS in Zimbabwe and Tanzania (see stories pages 14 and 19). We learn what AIDS has done to the continent in Jonathan Sellman and Alan Lifson's "AIDS in Africa: A Global Responsibility." We see the appalling carnage of Sierra Leone's civil war in David Parker's photographic essay. Even so, Africa can seem far away.

What links Minnesota's medical community to Africa?

We're connected through people. Minnesotans like Mark Jacobson, sponsored by local churches and foundations, devote their lives to battling poverty and disease in Africa. Other Minnesotans work in Africa for weeks or months. Their stories tell of despair and destitution; their actions promise hope and redemption. The suffering that is daily African life is human. Although emotional bonds to millions of people thousands of miles from here seem virtual, the Sierra Leone children in David Parker's pictures are intensely real. Their eyes tell stories that bring our hearts closer to Africa.

We're connected increasingly by technology. Daily, planes take passengers from Minneapolis-St.Paul International Airport to African cities. Phone calls to Africa connect promptly (with a bit of good luck). E-mail arrives in microseconds and is packed with news. Stories from Africa are as close as the nearest computer.

And we're connected by AIDS. Theories vary, but most scientists contend that AIDS started in Africa. It has stayed there and thrived. Although AIDS has a slightly different "profile" in Africa, with predominantly heterosexual transmission, African victims get pneumocystis, tuberculosis, and other infections just as Americans do. But they die faster. Weakened by pre-existing nutritional deficiencies, dependent on 19th-century medical care, and unable to get life-prolonging protease inhibitors like their American counterparts, African patients with AIDS linger only briefly and leave orphaned children and ruptured families. Read the astounding statistics in Sellman and Lifson's piece. AIDS has cost the United States a lot of money and lives; it may cost Africa an entire civilization. Stories of AIDS in Africa are overwhelming.

Ten years ago I heard Michael Osterholm, former Minnesota state epidemiologist, say that late 20th- and early 21st-century medicine will be judged by how it responds to the AIDS crisis. Although the statement was a bit of a rhetorical flourish, it contains great truth. For years, Americans and American medicine marginalized AIDS and its victims, hampering a prompt, sensible reaction to the epidemic. Now that the expansion of AIDS in the United States has slowed, we're in danger of distancing Africa and its AIDS victims and letting that

continent implode. Africa and its people are just around the corner, and the stories of their pain are insistent and ominous. We need to listen.

–Charles R. Meyer, M.D., Editor-in-Chief
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