The Risky Business of HIV Work Abroad

Safety threats include security hazards from political unrest—and traffic accidents.

November 3, 2013 By Benjamin Ryan

Two weeks from delivering her first child, Elif Yavuz, 33, had recently received her doctorate in public health from Harvard and was working on behalf of the Clinton Global Initiative as a senior vaccines researcher in Africa when she was among the more than 60 people tragically killed in the September militant attack on the mall in Nairobi, Kenya. Also killed was her partner, Ross Langdon, 32, an architect who had designed a Kenyan AIDS hospital and was in the midst of finishing another HIV/AIDS clinic in Uganda.

In a statement expressing their grief, the Clinton family noted that "Elif devoted her life to helping others, particularly in developing countries suffering from malaria and HIV/AIDS."

While the young couple's death highlights the risks researchers and aid workers face when working abroad, particularly in areas of political unrest and war, it probably comes as a surprise to most that such security hazards do not actually pose the greatest threat to safety.

The biggest peril comes from traffic accidents—the single greatest cause of death and injury for healthy Americans traveling abroad.

According to the World Health Organization, the global toll of traffic fatalities stands at 1.24 million people a year, with 91 percent of these deaths occurring in low- and middle-income nations. Without significant action, the impact is expected to rise to 1.9 million annual deaths by the end of the decade, jumping three spots—past AIDS, malaria and tuberculosis—to become the fifth leading cause of death worldwide.

Most of these deaths aren't even among car drivers; the majority of victims are pedestrians, bicyclists or motorcyclists.

The region with the highest rate of road traffic fatality is sub-Saharan Africa, where much of HIV research and humanitarian efforts are also focused. According to the Pulitzer Center's interactive "roads kill" map, South Africa and Nigeria each have a traffic fatality rate of over 30 deaths per 100,000 people, compared with the United States' rate of 11.4, Canada's 6.8, the United Kingdom's 3.7 or Sweden's 3. Most of the other sub-Saharan nations have a death rate in the mid-20s.

Compounding the dangerous roads is a lack of proper trauma response systems in Africa. A recent New York Times op-ed written by Ola Orekunrin, the founder of West Africa's first indigenous air ambulance program, decried the fact that in Nigeria injured people are often transported to a hospital not in an ambulance, but by car or minibus, or even by motorcycle, only to reach a hospital that may lack proper equipment or skilled clinicians. A seriously injured person most likely bleeds to death, Orekunrin writes in her critique of the "silent epidemic" of trauma—the collateral damage of a region whose rapid industrialization far outpaces its ability to enact effective safety precautions or to create proper transportation infrastructure.

With the preface that "anything we're subjected to is nothing compared to the local people," Edward Mills, PhD, an associate professor at the Interdisciplinary School of Health Sciences at the University of Ottawa who has worked extensively in Africa, says that the streets in that part of the world are harrowing for foreigners such as himself. The roads lack sidewalks, putting at risk pedestrians traveling by foot or perhaps waiting for public transportation. Many of the cars, bicycles and motorbikes don't use a headlamp, nor are there widespread streetlamps. The drivers of unregulated minivans and busses have high rates of alcohol use on the job and typically drive rapidly because they are paid according to the number of riders they can pick up. And then there are the conflicting cultures of high-speed driving and of not stopping in the event of an accident.

"I used to go jogging, and I tried to go jogging on the roads," Mills says. "It's terrifying."

While he is able to protect his own safety through the use of a hired driver and a sturdy Land Rover, Mills says the brunt of the risk in the HIV research field falls onto younger, more naive graduate students. A combination of youthful heedlessness, a lack of understanding about the risks on the road, a desire to save money and an inclination to join in with local customs can be a deadly mix.

"Collectively, my colleagues and myself have lost a number of students from traffic accidents where kids are on the backs of these bodabodas," Mills says, referring to a type of motorbike taxi a ride on which often doesn't include a helmet.

"I actually blame the institutions," Mills says. "Because [the universities] know better, or we should know better. But this rise of global health means that institutions that don't have a history of global health, that don't have people with a lot of experience in it, are implementing global health programs anyway and sending these kids abroad."

According to Margie Peden, PhD, coordinator of unintentional injury prevention at the World Health Organization, most United Nations divisions and other large humanitarian organizations have safety policies governing transportation. At WHO, all workers must pass a safety course every two years that includes preparation for potential perils on the road.

"We encourage people not to drive themselves," Peden says.

Thomas Dougherty, MPH, executive director of the global health and human rights organization

HealthRight International, says of the teams his group sends abroad as well as the staff the organization works with on the ground, “We certainly are pretty strict about telling people that they need to follow the guidelines for safety, and certainly make things available to do that. But when there, it can seem really inconvenient, but obviously safety comes first.”

One major group seeking to combat the potentially fatal lack of road safety preparation among universities is the Association for Safe International Road Travel. Its president, Rochelle Sobel, founded the organization in 1995, just two months after her son was killed on a bus in Turkey during his final rotation in medical school. ASIRT provides a manual to prepare university students for road safety abroad, and it has also created a dossier of detailed road travel reports on over 160 countries. In addition to educating corporations about safety, the group is also working on the ground in specific countries, with local governments, non-governmental organizations and the tourism industry, to promote greater safety.

“Humanitarian deaths are a real concern to us,” Sobel says. “Because the people who do that really are in the grassroots area and they are taking the local traffic.”

Compared with the billions of dollars spent fighting HIV/AIDS, malaria and TB each year, the global financial investment in combatting traffic injuries and fatalities is, in the words of WHO’s Margie Peden, “a drop in the ocean.” The biggest financial player in the field is Bloomberg Philanthropies, outgoing New York City mayor Michael Bloomberg’s charitable foundation, which in 2010 committed $125 million over five years toward road safety initiatives.

Funneled through WHO and other global collectives, with ASIRT among them, the funding supports the promotion of practical and proven safety interventions—including increasing helmet and seatbelt use, decreasing driving speeds and trying to prevent drunken driving—as well as efforts to improve road infrastructure and to develop sustainable urban transport in 10 countries that make up half of annual traffic fatalities.

“We see a real opportunity, because for road safety we know what works, and we know how we can reduce fatalities and injuries,” says Kelly Larson, MPH, who directs the Bloomberg global road safety program. “It’s not really rocket science, because we have the science behind us to implement these interventions and to really save lives.”

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