

# Where AIDS Efforts Lag

## Shortages of Health Workers Undermine Advances

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President Bush made a historic pledge in his 2003 State of the Union address: to get urgently needed AIDS treatment to 2 million people living with HIV in impoverished countries by 2008. Congress concurred and launched a major initiative to fight AIDS focusing on 15 developing nations. At a U.N. General Assembly conference on AIDS this year, the United States went further and committed, along with other countries, to come as close as possible to universal access to HIV treatment by 2010.

We have come a long way since 2000, when AIDS treatment was available to only the fortunate few. Activists campaigned successfully to drive down the cost of treatment with affordable off-patent AIDS medicines that are now available in most developing countries. After initial objections, the U.S. government became a major purchaser of generic drugs.

But now that donor governments are providing more funding and medicines are becoming available, a new bottleneck threatens the success and sustainability of the effort. People with AIDS in Africa are dying simply because there aren't enough nurses, doctors and pharmacists to administer treatment. Without a new effort to train, retain and support health workers in numbers sufficient to meet basic needs, the United States will not be able to keep the deal it made with Africa in 2003.

It takes years to graduate a new doctor or nurse, and most of them prefer to build a career in a major city with well-equipped hospitals. But with modest investments, donor governments can quickly empower and mobilize an army of health workers made up of the hundreds of thousands of unemployed or underemployed people living in the very settings where HIV's toll is heaviest. Women in particular are often already serving as caregivers at the community level, usually without training or compensation.

Starting in Haiti's central plateau, the organization Partners in Health has trained and employed hundreds of accompagnateurs, or health companions, across the group's projects in five countries, including the United States. Accompagnateurs are paid a stipend to provide a broad range of services, including drug distribution, disease observation and reporting, clinical referrals, and the social support that people with chronic illness so often need. This modest investment is, we believe, one of the chief reasons that adherence to AIDS therapy is so high within our projects -- and why death rates are so low.

Community health workers are lay people on the front lines who provide effective health services and support in countries reeling from AIDS. These nonprofessionals -- often living with HIV themselves -- are rooted in their communities, can be trained quickly and are less likely to emigrate in search of better wages and working conditions. They have deep knowledge of their communities, where they are familiar and trusted neighbors. With continuing training and support, they can rapidly form a strong and active force filling deadly gaps in health personnel and services.

Many programs have sought to rely on "volunteers" and deny these laborers pay for their services -- a model conceived in wealthy countries. But in poor countries this amounts to exploitation of the poorest to treat the sickest. It should be replaced by programs that ensure living wages, continuing training and a career path.

Community health workers cannot succeed alone; they are not an excuse to cut corners. Professional backup from doctors, nurses and medical officers is necessary to provide supervision and to treat referrals. But the pool of available health professionals in many African countries is too small to address basic primary-care needs and far from adequate to supply new donor-sponsored global health programs.

Unintentionally, the laudable U.S. efforts to fight AIDS and malaria in Africa can end up weakening primary health systems that are already crumbling by hiring doctors and nurses away from public clinics and hospitals where they are also desperately needed. When primary public health systems fail, disease-specific initiatives will also fail. The United States must get serious about increasing the overall supply and retention rates for health professionals in sub-Saharan Africa.

According to World Health Organization estimates, the U.S. share of the global cost of training and supporting a healthy workforce sufficient to meet internationally agreed-upon targets in sub-Saharan Africa is roughly \$8 billion over five years.

On this World AIDS Day, we must match the audacity of President Bush's 2003 pledge with a complementary initiative for training and keeping enough new health professionals and community-level workers to fulfill the promises the United States has made.

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