There Are No Quick Fixes
A Talk with Dr. Sam Zaramba

Dr. Sam Zaramba is chairman of the executive board of the World Health Organization (WHO) and served as the Director General of Health Services in Uganda. As an early advocate for integrated disease control, Dr. Zaramba is credited with the success of the "Child Health Days Plus" campaign in Uganda, which included a deworming program and vitamin distribution for children. He initiated several other public health related projects including routine immunization, health and hygiene education, and distribution of insecticide soaked nets. Dr. Zaramba has also published a number of articles on neglected tropical diseases, such as river blindness and sleeping sickness. Trained in Uganda as a physician, he retired from his post as the country's top medical officer and now devotes much of his energy to the WHO, the United Nations agency overseeing its global health strategies. He spoke with World Policy Journal *from Geneva, where the WHO has its headquarters.*

***WORLD POLICY JOURNAL*:** You have an interesting take on international health, both from a global and African point of view. From this perspective, I'd like to hear your thoughts on the primary health emergencies facing the world today.

***DR. SAM ZARAMBA*:** There are the age-old challenges—tropical diseases like sleeping sickness and tuberculosis—that have been mostly eliminated in the first world, but continue to plague the developing world. Such diseases have been particularly lethal, especially since the advent of newer viruses like HIV/AIDS, which have led to further health deterioration in at-risk populations. If you look at some African countries, particularly a country like Uganda, we have had the HIV/AIDS crisis alongside the Ebola epidemic—a combination of diseases we never imagined.

***WPJ*:** Do these problems need to be addressed on a local level, country by country, or globally?

***ZARAMBA*:** There is no such thing as a solution that fits all countries. The approach to so many of the diseases we've talked about should be local. The health challenges facing Sub-Saharan Africa are not the same as those facing Southeast Asia, and often we try to provide quick fixes with input that ultimately overlooks the systems in place. Instead, we should be focused on the systems themselves, assessing whether they are capable of managing whatever solutions are offered. This is where the global community is quite often mistaken. It is eager to prescribe solutions and imagine that they will apply universally, but this is not the case.

***WPJ*:** Has the WHO been effective in building competent local health care systems?

***ZARAMBA*:** The principles and guidelines are very clear: the WHO aims to complement countries, while at the same time it doesn't dictate what goes on there. On the other hand, WHO depends on contributions from the member countries and donors. I would say that the WHO has done a lot and it has tried its best, but quite often programs are derailed in one way or another because of the competing priorities and concerns of partners and donors.

***WPJ*:** What do you think needs to be done to build programs that are determined and managed by individual nations?

***ZARAMBA*:** I think we should listen. That is the most important thing. It is important to go into a country, study the situation and analyze what is on the ground. We must also expect countries to contribute to discussions rather than having global decisions imposed upon them, which often has not worked very well.

***WPJ*:** Where should the funding come from for these country-led programs?

***ZARAMBA*:** First of all, I must say, I am disappointed with the response from many developing countries. I think they need to make health a priority. I don't know how much certain countries are influenced, but I believe they're facing pressures from the global community, and as such, have not put health first. The budgeting has been slightly lopsided, which has caused a lot of problems. So developing countries must make health a priority before they can accept contributions from the rest of the world.

***WPJ*:** I have the impression that many diseases and medical issues, particularly in the developing world, are as much societal problems as public health issues.

***ZARAMBA*:** I agree with you. What has happened in the developing world is that the populations' health is left exclusively in the hands of the health sector, forgetting that there are also many other determinants of health. Other sectors could contribute their assistance but they do not.

***WPJ*:** In these countries, how much of a lead should national governments take versus local medical establishments?

***ZARAMBA*:** Change lies in transforming the behavior of the people, both through altering their habits and changing cultural practices. This is something that the health sector cannot do by itself. One example is the issue of sanitation. Sanitation cannot be managed by health care providers alone because it is as much an issue of water as anything else. For this reason, there must be intersectoral collaboration at every level—from the villages and the households to the communities and governments at large. It is rare that other sectors admit they must play a significant role in contributing to health priorities. They forget that their contribution would make a very big difference.

If you look at the U.N.'s Millennium Development Goals in many of the developing countries, the issue of poverty weighs heavily. The poor cannot defend themselves. They will tell you that they are sick because they are poor and they are poor because they are sick. If we are to present a program addressing poverty, it must be all-encompassing. There is no way that a country can develop when its people are perpetually sick.

***WPJ*:** If these problems are systemic, then how does one bring different agencies together to make a concerted effort to improve the public health of a country?

***ZARAMBA*:** It's really a question of convincing the leader of a government to understand and appreciate why this intersectoral collaboration is so important. Policies are developed and agreed upon within a cabinet, so it becomes a question of raising these concerns to the nation's leadership, making sure the issues are addressed, and developing policy in its totality, all geared toward addressing health.

***WPJ*:** Are there countries that have successfully done this?

***ZARAMBA*:** Well, in Uganda we have attempted this, but we still face many challenges. You can look at the strategic plans of places like Ghana, Nigeria, Mozambique, Zambia. They have attempted to make a strategic plan and have created projects that are all-encompassing and are actually apportioning responsibilities to different sectors. But there is always the issue of who is actually guiding these different sectors. As soon as a leader is not convinced of the strategic necessity, the projects tend to derail. But if you look at the strategic plans for the countries I've named, they are really solid. It is now the implementation that stands as the greatest challenge. If you look at the developing world, many of the endemic, often sanitation-related diseases, are killing many more human beings than any potential pandemic.

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***WPJ*:** The first world seems preoccupied with potential pandemics, like H1N1. Are you concerned that we may be bouncing from one crisis to the next without coming to grips with some of the most fundamental health challenges affecting the greatest number of people?

***ZARAMBA*:** The nature of these potential pandemics, and the perception that they can easily spread, scares the global community. They rush in to make sure that these types of diseases do not cross borders. But look at maternal deaths. This is another area that is really an embarrassment to the rest of the world. Women are dying by the day, both during delivery and because they are already afflicted by an underlying chronic illness which is made worse during pregnancy. So when an alarmist disease comes up, somehow we tend to get distracted and don't address the chronic diseases.

***WPJ*:** There has been a big push in the West for philanthropic organizations to counter malaria, a disease widely regarded as preventable. We have seen a lot of money put toward insecticide-covered bed nets, for instance. Do you think that the focus there is the right one?

***ZARAMBA*:** I don't think that the donor organizations are entirely addressing the problem. There has been so much emphasis on these interventions, like the nets, that leave out many of the larger implications of the disease. There needs to be a three- or four-pronged integrated approach to addressing malaria. We have to eradicate the vector, tackle the issue of prompt diagnosis and focus on the system itself. The disease has to be treated immediately, and prevention must be

central to the strategy, using the nets and environmental intervention. What it comes down to ultimately is strengthening the system, analyzing the infrastructure and looking at another crucial element—human resources. If there are not enough trained health care providers, then we should find a way to improvise and teach people who can help us address disease prevention.

***WPJ*:** What is the scarcest resource? Doctors, medicines, funding, infrastructure? What would your priorities be and how would you rank them?

***ZARAMBA*:** My number one priority would be human resources.

***WPJ*:** So, doctors?

***ZARAMBA*:** They don't have to be doctors specifically. We need all different types of health care providers. We need trained physicians of course, but also clinical staff and paramedics, too. Many of the issues and interventions can be handled by paramedics or community volunteers. These people can be trained to advise communities on how to protect themselves, how to properly use a bed net, for instance. Many of the nets are dished out, but they are not used correctly because individuals don't know how. We need to educate community volunteers and workers who can, in turn, help us explain the interventions to their communities.

***WPJ*:** Do you think Western medical institutions have a responsibility to do more to train health care professionals for work in the developing world? At the same time, we often see doctors in North Africa or in East Asia leaving their countries to study medicine abroad. This causes a brain drain where people don't come back to practice in their countries of origin.

***ZARAMBA*:** To begin with, we don't have sufficient manpower the world over. If you're talking about brain drain, there's evidence of it in first world countries, too. There's a vacuum. If the first world had enough health workers and manpower, we wouldn't have this flight going there. So really, we don't have enough human resources anywhere. We need many more people and we need to make health work more attractive. I can give you an example. I am a doctor; I have been a doctor for close to 40 years. I've got three children, but my three children, they would look at me and say, "Daddy, don't bother telling us to become doctors because of what you are going through. Working so hard, putting in so much effort, and at the end of the day, we don't see you reaping what you are supposed to reap." So, we are gradually losing our young people, and they are losing interest in the health profession. There are too few resources, medical professionals are grossly underpaid and doctors don't have job satisfaction. We have not made it a priority in our countries, especially in the developing world, to promote the importance of health workers who provide such an important service. It is crucial that this is addressed. If you are a donor, you can contribute the drugs, but I will always tell you that unless you also assist me in addressing the issue of human resources, health services will always suffer. Developing countries will continue to lose the few trained health workers that they have to this vacuum, and the brain drain is bound to continue unless we address this crucial issue.

***WPJ*:** It seems like insufficient human resources comes back to insufficient funding. If people aren't being paid enough, or there aren't educational systems in place to train a new generation of health care providers, where is the funding going to come from to do this?

***ZARAMBA*:** It's reprioritizing. There will never be enough money in the world, but we need to reprioritize and acknowledge that this is a crucial area that we must address with the few resources that we have.

***WPJ*:** Can you give us an example of where countries spend their money?

***ZARAMBA*:** In Uganda we are currently spending a lot on infrastructure development, projects like road expansion and power generation. The government believes that without these two, we cannot stimulate growth within the country. Although we may get more investors in these areas, at the same time, we are failing to develop our health care infrastructure. We need balance and to make sure that we don't lose focus on the additional importance of human resources as critical priorities.

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***WPJ*:** So where does the initiative come from for funding health care? Who takes the lead on something like this? Is it the United States, with President Obama's Global Health Initiative? Or is it some global group like the WHO or the Gates Foundation?

***ZARAMBA*:** In some ways, the WHO has done its part. We have come out with the documents and strategies to address this issue of human resources. But of course there is still the question of donors. If we could have some of the big donor countries like the United States really coming in, listening to and addressing this issue, I think others would follow suit. There are the big organizations like the World Bank and the International Monetary Fund (IMF), who have always, for some reason or another, believed that we shouldn't spend so much on human resources. I remind them that without the big salaries they receive, they wouldn't be there working in the bank. So really for them to say that we don't have to spend so much on human resources, I think we are all being dishonest with ourselves. In order for health workers to survive, they must be able to look after themselves, they must have their daily needs addressed, and unless these basic standards are met, they won't be able to deliver the services we expect of them.

***WPJ*:** In the West, the private sector—particularly pharmaceutical companies—is often accused of keeping cures from the developing world that are readily available elsewhere. Do you think that private pharmaceutical companies are doing enough in terms of drug development and the licensing of generics to really contribute to the problems of the developing world, especially in Africa and Asia?

***ZARAMBA*:** I don't think that pharmaceutical companies are doing enough. There is so much more they could be doing. On the issue of generics, I think there is no question that the developing world is at a clear disadvantage—their economies cannot afford branded drugs. We need to relax intellectual property law to address the issue of generics radically and rationally.

***WPJ*:** Can you tell us who you think are some of the most at-risk populations in the world, and how best they can be served by the global community? Children, rural populations, urban populations?

***ZARAMBA*:** At-risk populations are spread quite evenly throughout the world. The other day, I was in Baltimore at Johns Hopkins conducting a course and I ended up exploring a bit of the neighboring area. I must say I was very disheartened by what I saw around the university itself. I went on to report in the lecture: "What we are discussing in this course should also be addressed right here in the United States. If

you go into the cities, you will realize that the poorest of the poor actually live within these urban areas." The people in the countryside are sometimes, I would say, slightly better off, because they have a slightly better environment, they can breathe cleaner air, their sanitation—although it may not be good—is definitely not as dangerous as the sanitation situation within urban slums. So at-risk populations are actually distributed between urban and rural areas. It's important to note that rural people usually produce what urban people consume. If I could, I would make sure that the rural communities are better provided for in order to discourage rural-urban migration.

***WPJ*:** If you could persuade world leaders to do more to help the developing world, what would you tell them?

***ZARAMBA*:** The first thing would be to encourage them to look at the entire system. Leaders should forget all about quick fixes, because quick fixes will never solve the most pressing global health challenges. World leaders cannot assume, "Oh, we are providing nets, so the nets are going to solve the entire malaria problem." Quite the opposite: just because the nets are being provided does not mean that they are being used. And therefore, we must listen to whoever would fund the strategies, policies and strategic plans developed within those countries to maximize impact. In Uganda, for instance, we have a forum where we have both the donors and the Ugandan government sitting together agreeing on the priorities. So let us address the priorities of the country together rather than having outside organizations say, "This is what we think is correct, we will dictate it to you, and we expect it to work." I've said many times that this does not work. Whatever health crisis is being addressed must be approached with the understanding that we are living in a global community. We must understand that whatever is happening in one country can easily spread to and affect almost anywhere in a very short period of time. We need to bear in mind that we are not only protecting the people we are providing services to, but we are also protecting ourselves.

***WPJ*:** One final question: what kinds of work are your three children going into, if not medicine?

***ZARAMBA*:** My daughter is a lawyer. She's earning three times what I do. One of my sons is an IT specialist. He is earning almost three times what I do. The other one is a graphics man, and he is earning almost twice as much as I'm earning. And they are okay, they are comfortable. My colleagues who are doctors, the best they can do is either moonlight or cross over to the first world. I can tell you, I had 36 classmates in medical school in Uganda. As we speak I can account for 32 of them, and I believe that only 12 are actually working in Uganda. The rest are in the diaspora: the U.K., South Africa, Saudi Arabia and other places abroad. The reason is innovation and nothing more. There is also the question of political motivation, and doctors fleeing because of political problems. But I think that over the past few years things have been fairly stable in Uganda politically, so many doctors abroad would have come back, but because of their commitments and what they had to go through, they are not returning—they are already naturalized wherever they are. ●