Tracey Koehlmoos: How zinc can save 400,000 lives annually

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Tracey Koelhmoos

In the August 17th issue of *Time* magazine, there was an article that discussed the introduction of zinc as a treatment for childhood diarrhoea in Mali. The article has raised international awareness on the lifesaving use of zinc to prevent an estimated 400,000 child lives per year globally. However, two important points were not addressed that should be shared.

One of my projects in Dhaka is the national scale up of zinc in Bangladesh (the SUZY Project). Together with the government and a mix of partners, we are attempting to reach every child between 6 months and 5 years during every episode of diarrhoea with a ten day course of zinc therapy in addition to oral rehydration solution (ORS). So, zinc is a topic that I think about and talk about a great deal – and I am glad that people who never think about diarrhoea as a killer will know a little more about possible solutions.

However, the article, which is available online, presents zinc as a deceptively simple solution. Perhaps for the non-global health crowd, it can best be described as being akin to insecticide treated mosquito nets for preventing malaria – a simple and inexpensive idea fraught with complex realities. Scaling up, which is the incorporation of new treatments into a health system and into the health seeking behavior of a population, is a major undertaking.

In Bangladesh we began the national Scaling Up Zinc Treatment for Diarrhea in Young Children in Bangladesh (The SUZY Project) with a grant from the Bill and Melinda Gates Foundation in 2003. At that time zinc was still a relative unknown among physicians and policy makers, and was untested in the community. My predecessor, Charles Larson, faced accusations of making guinea pigs out of the children of Bangladesh and there were threats that he would be stopped. However, Charles and the Ministry of Health were armed with the knowledge that a successful scale up could save between 30,000-70,000 child lives per year in Bangladesh.

A true partnership developed between the government, public health scientists, and the private sector, which proved essential in bringing awareness and utilization of zinc along with ORS to significantly higher levels – up from around zero. It took five policy changes to make the scale up here possible and different approaches for reaching the poor were tested and tested again.

I imagine that there are contextual factors that would make a scale up very different in a different setting. For example, across South Asia an overwhelming majority of children with diarrhoea receive their care outside of the public sector, which further complicated matters by creating the need to engage the private and the informal sectors (the unlicensed providers and

small drug vendors).

A second problem with the article is that it fails to acknowledge the role of scientists from developing countries in developing zinc as a treatment for childhood diarrhoea and methods for delivering zinc to the people who need it most. Although the efforts of my colleagues at Johns Hopkins are acknowledged, it is an oversight to say that zinc for the treatment of childhood diarrhea is a solution that was developed in the West and handed across as a solution. Rather, zinc was designed and tested and first implemented in countries like Bangladesh, India and Chile, which highlights the fact that given the right working conditions, leading scientists and thinkers from low and middle income countries will opt to stay home and address the issues from the front lines of the war on poverty and disease rather than seeking opportunities in traditional academic centres in the West.

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