

Taking Therapy to The Doorsteps of the People

A Case Study on BRAC'S Campaign against Diarrhoea

Backdrop

Bangladesh is a deltaic country with some of the biggest rivers like the Padma, the Jamuna, and the Meghna flowing through it. During monsoons, floods are a common occurrence. This annual flooding combined with other factors like high water table, high density of population and low income are factors that inhibit the provision of extensive sanitation facilities and clean potable water to all the people. It is not surprising therefore, that cholera and diarrhoea are rampant in the country and have claimed thousands of lives.

Genesis and Evolution of BRAC

BRAC grew out of Fazle Hasan Abed's zeal to rehabilitate the devastated countryside of Bangladesh following the War of Liberation in 1971. It came into existence as Bangladesh Rehabilitation Assistance Committee (BRAC) in February, 1972. BRAC initiated its work in Sulla region. After the War of Liberation, thousands of refugees had returned from India to the Sulla region and had found village after village completely destroyed. Houses with utensils, tools and implements had been burnt down. Livestock had been killed or eaten. BRAC felt that due to the remoteness of the region the sufferings of its people would not attract much relief assistance therefore it chose to work in this area.

Sulla region is a remote low lying area. For more than six months of a year, the fields in the Sulla region remain under water, leaving fishing as one of the few occupations available. Winter is the only cropping season. Often failure of crops due to early flooding or drought leads to acute hunger.

After the War of Liberation, when most refugees returned to the region, they found only a piece of land. Their belongings had either been looted or destroyed. BRAC, therefore, carried out a quick survey of the area to understand the nature of the inhabitants' immediate needs. Construction of houses, procurement of tools, livestock, food and medical aid emerged as the basic needs of the people. Still in its first year, BRAC provided millions of bamboo pieces to build houses, imported timber to make boats and provided nylon twine to weave fishing nets. Tools such as looms, wheels, hammers, saws and chisels were given to the crafts people to help them resume their respective trades. Over 14,000 houses were built.

However, BRAC was not satisfied with this temporary solution. It was in search of long term solutions that would lead to sustainable development. Therefore, BRAC's name was changed to Bangladesh Rural Advancement Committee, to reflect the transition from rehabilitation to development.

Experiences in Community Development

BRAC's experiences in providing relief assistance helped it to plan and pursue community development initiatives. Most of its early community development programmes were adapted from other experiments or efforts in or outside Bangladesh and applied to the situation in Sulla. Since the inappropriateness of many of the borrowed ideas became increasingly clear, BRAC decided to listen to others but learn from its own experiences. Therefore, making use of its own experiences BRAC developed a new set of programmes. Some of the early interventions of BRAC were:

1. Functional Education

Adult literacy classes were started with men and women with materials borrowed from the Bangladesh Academy of Rural Development (BARD) in Comilla. Since these materials were not relevant to the local people, therefore, based on the conscientization approach advocated by the Brazilian educationist, Paulo Freire and with assistance from World Education, BRAC developed its own functional education materials. The education package was divided into two separate programmes: one on conscientization and numeracy which was compulsory for all BRAC members, and the other on literacy which was optional.

2. Village Group Formation

BRAC's development programmes were organized around the village. There was no special focus on any particular group in the village except women. The two tier cooperative system developed by BARD was adopted. The village was the primary tier with all groups of people having the

opportunity to participate. The *thana* (sub-district) was the second tier from where all the public sector resources such as bank loans and agricultural services were to flow.

3. Agricultural Programme

BRAC workers developed demonstration plots to promote high yielding seeds, fertilizers, compost and insecticides. In some instances, new improved varieties of crops were adopted but the demand for these crops did not increase, thereby resulting in heavy losses. For example, before being introduced by BRAC, radishes were not grown and eaten in Sulla. With the help of BRAC, the farmers in the region produced a bumper crop of radishes. However, the demand for radishes did not increase locally and since they could not be marketed outside the area due to lack of transportation, large amounts of radish had to be discarded.

The Target Group Approach

BRAC in its community development approach considered the village as one entity and tried to address the problems of all villagers under a single programme. However, in the course of its work BRAC realised that there were several groupings within a village based on politics, kinships and economics. Bringing conflicting interest groups under one umbrella of a village cooperative proved to be difficult in solving the problems of the 'disadvantaged' like the landless, fishermen and women. Hence, in 1977, BRAC adopted a 'target group' approach. Under this approach BRAC identified several communities within the same geographical area - rich, poor, men, women, fishermen, farmers, labourers and it worked with the most disadvantaged in these groups.

In 1976, BRAC started a food-for-work programme in Manikganj- a community 40 miles to the west of the capital city, Dhaka. Some of the successful programmes from Sulla such as the 'group formation' were replicated here.

In the same year, BRAC expanded to another area called Jamalpur. At UNICEF's request, a food-for-work programme was initiated in 40 villages for poor and destitute women.

Towards Sustainability

In 1979, BRAC embarked upon a large, potentially sustainable programme for the poor and women of rural Bangladesh. The programme initially known as Rural Credit and Training Project (RCTP) assumed the nomenclature of Rural Development Programme (RDP) in 1986. There are several components of this programme including group formation comprising the poorest of the poor, provision of collateral free credit for gainful economic activities and promotion of technologies in agriculture such as deep tubewells for irrigation, sericulture and poultry rearing.

After three to four years of RDP activities, the BRAC bank is introduced in an area. The BRAC bank is a sustainable endeavour as profit from earned interest meets all lending expenditures. Out of the 240 branches of RDP, half are already self sustaining.

By December 1994, RDP had been operating in nearly 36,000 villages with a membership of nearly 1.2 million (80 percent female). US \$140 million were disbursed as credit to the members with a repayment rate of over 96 percent. The RDP has been able to bring about a marked improvement in the economic status of its

beneficiaries. BRAC organised groups increased their income by more than 25 per cent above those not covered by BRAC.

Children's Education Programme

In 1986, BRAC began a three year basic education programme for 8 to 10 year old children of rural Bangladesh who either never enroll in or drop out of formal primary schools. The programme is designed to give children basic skills in literacy and numeracy and also expose them to other areas such as social studies and environment. Each school has 33 pupils. To bring parity in educational opportunities, girls are given preference during admission. As a result, 70 percent of the pupils are girls. The daily routine of the schools also includes drawing, singing and dancing.

Whereas the drop out rate in formal schools is over 60 per cent, it is less than 2 per cent in BRAC schools. The programme had a modest beginning in 1986, with 22 schools. By December 1994, there were 28,000 such schools. Over 90 percent of children completing the BRAC schools enter the government primary schools in grade 4 or above and perform at par or better than the students of these schools.

Training

The Training and Resource Centre (TARC) is a support service for BRAC's field programmes. It has 16 residential training centres situated in different parts of the country which cater to the needs of BRAC field staff through staff training as well as training of BRAC organised group members, government workers and other NGO employees.

BRAC has also set up a Centre for Development Management. (CDM) to

impart training on different development and management issues to BRAC employees and outside participants.

Research and Evaluation

Research and experimentation have been a part of BRAC since its inception. Action research is carried out by its programme staff in the course of their daily activities. Though this research is not always written in a formal style but the information gained through it is used in management decision making in the field and at higher levels.

The more formal research for BRAC is done by its Research and Evaluation Division (RED) which comprises of over 100 staff with expertise in epidemiology, economics, anthropology, sociology, statistics and gender studies.

The Health Programme

BRAC through its experience has learnt that for lasting impact on the health and nutritional status of a village, the community must develop a health consciousness, look after some of its own health needs, increase its income generating capacities, and develop an ability to utilise and make demands upon the existing health infrastructure.

Training of Paramedics

BRAC did not have the benefit of experience when it initiated its first curative care programme in Sulla region. This programme was adapted from the barefoot doctors programme in China. BRAC provided training to local people to act as paramedics. They were to treat minor illnesses for a small fee and to refer complicated cases to the clinics.

In order to make the system self sustaining, BRAC experimented with a health insurance scheme that required villagers to pay five kilos of paddy (unhusked rice) per person at the time of harvest to obtain medical coverage for the rest of the year. Though the programme was running smoothly, it was discontinued because it was not reaching the poorer villagers who did not find it lucrative to invest in something which provided 'future' benefits. Therefore, it was the richer community which was buying insurance and reaping its benefits.

Moreover, not all paramedics trained by BRAC worked according to its expectations. Some started practicing as village doctors and neither BRAC nor the village cooperative was able to exercise any control over them.

Family Planning Efforts

BRAC trained village based lady family planning organisers (LFPOs) to motivate and provide conventional contraceptives to the villagers. The oral pill was found to be the most popular method. The contraceptive continuation rate in Sulla reached the highest level in Bangladesh in the mid-1970's, with more than 50 percent of the women continually using the pill for 18 months. The other measure of success, the contraceptive prevalence rate, was 20 per cent of fecund couples which was also one of the country's highest.

BRAC's approach was to look at family planning on an individual scale: that is to give the individual the option to plan his or her family.

Training Village Health Workers

Women from poor households belonging to BRAC organised groups were selected to

expensive or too complicated to be dealt with at that time. The decision to invest in diarrhoea control programmes also had much to do with what was happening internationally and what some leading health experts were advising. The International Year of the Child in 1979 also provided an impetus to child centered programmes which could contribute significantly to child survival.

Initially four options for diarrhoea related interventions were brought forward for discussion:

- ❖ a programme to treat all diarrhoea patients by trained personnel;
- ❖ a diarrhoea prevention programme through the provision of safe drinking water and sanitation;
- ❖ a programme to widely market ORS packets through commercial outlets; and
- ❖ a programme to teach mothers how to make ORS at home with easily available ingredients.

The first option of starting a treatment programme with trained personnel was rejected because of non-availability of a health system accessible to all sections of the community, particularly the poor. The preferred treatment method for diarrhoea by village doctors (mostly qualified) was intravenous solution. At that time a bag of normal saline was sold by the village doctor at Taka 100 while the actual price was Taka 25. A severely dehydrated patient would need at least 5 to 10 bags. The average yearly income of a Bangladeshi at that time was Taka 1,500.

The second option of ensuring the supply of safe water and improving sanitation did not

seem feasible to BRAC. Through their past experience the BRAC staff felt that supplying services was not enough unless people were motivated to change. Moreover, it was felt that the effect of such interventions on the incidence of diarrhoea may not be apparent to the population or scientifically possible.

The third choice was a programme to market ORS packets. Many diarrhoea control programmes were using commercial packets, produced on a mass scale. The major advantages of the packet were that it was an easily identified product, it was a complete mix with all the necessary ingredients and could be easily distributed to small shops. However, there were disadvantages too. Bangladesh did not produce even a small proportion of the packets required. If an average Bangladeshi suffered just two episodes of diarrhoea each year and if he or she was given even one packet per episode, the annual production would be over 200 million packets. The health budget could not cope with this level of spending. The packet was slightly expensive for the poor. Moreover, the transportation system made it difficult to get packets to every village and the packets had a limited shelf life. Since the final electrolyte content was still dependent on the volume of water, either a standard container had to be provided or mothers had to be individually instructed on measuring the proper amount.

The choice was clear: mothers had to be taught how to make ORS at home with salt, sugar and water. BRAC decided to go for this option because of its own stated objective of empowerment. Increasing mothers' capacity to take care of their children's diarrhoea without dependence on outside factors was a form of empowerment.

Developing a Formula for ORS

The challenge before BRAC was to take therapy to the doorsteps of the people. ORS was discovered a decade ago but its use was still limited to hospital or clinic situations and controlled by doctors and nurses.

To overcome the problem posed by packets, several people in other parts of the world had been considering ways and means of making ORS easily available at home. Several techniques were being proposed for measuring the salt and sugar. The first was the use of household spoons to measure salt and sugar. Not many poor households had spoons and the size of the spoons varied so much in the rural areas that it was impossible to have a standardized measure for all households. To meet the problem posed by non-standardized spoons, special spoons with one end to measure salt and the other to measure sugar, were developed. Such spoons were foreign to rural homes and could, therefore, increase household dependency. If lost, they would have to be replaced. The spoons had instructions printed on the handle but they were of no use to the illiterate women of Bangladesh who anyway had to be given verbal instructions.

Another issue to be resolved was the type of sugar to be used. In addition to the refined sugar produced from sugar mills, there was another type of local brown sugar called 'gur' which was widely consumed in Bangladesh, particularly in rural areas. Gur is unrefined sugar prepared at home from either sugarcane or date juice. Both types of gur have potassium, which is not present in refined sugar. Three additional benefits of using gur in ORS are (a) it was more easily available in the countryside than commercial sugar; (b) it was less expensive than sugar; and (c) bicarbonate was added to some market gur to lighten its colour.

Church in 1972 had shown that fingers could be used to measure salt and sugar. Following the recommendation made by Church, Mr. Abed, the Executive Director of BRAC did a quick experiment in his kitchen. He used various combinations of local salt (henceafter called 'lobon') and gur in finger measurements and mixed them into half a 'seer' (a local measure equivalent to nearly half a litre) of water separately to make four different types of solutions.

It was found that solutions made with one pinch of lobon and two scoops of gur gave the best solutions with the sodium content closest to that recommended by the WHO. Later a clinical experiment was conducted to test the efficacy of the lobon-gur solution in the management of non-cholera diarrhoea. Fifty adult diarrhoea patients with moderate dehydration were given lobon - gur solution and another fifty received the standard, WHO recommended solution. The outcome was similar for the two groups. Therefore, the study concluded that if the WHO recommended formula for oral diarrhoea solution is not available, everyone should be taught to prepare the best available substitute. In Bangladesh, a solution made of lobon - gur was this substitute.

Planning for the Experiment

The BRAC staff voiced their support for a field trial that would teach the mothers of Sulla oral rehydration therapy for diarrhoea. The idea of a national programme was not yet in their minds. While planning the programme some vital questions emerged:

What would be the contents of the educational message?

The message had to include the method of preparing the lobon gur solution (LGS). If the child survived the episode, the

nutritional status would be the next major issue. Hence, the educational message had to include the nutritional management of diarrhoea. And lastly an appropriate message on prevention was needed.

Who should be the recipients of the message?

In Bangladesh the primary caretaker of the child is the mother, hence, she was made the principal target for education. Since adolescent girls would soon be mothers, they were also targeted. It was decided to teach at least one woman from each household - mothers, daughters or mothers-in-law.

How would the message about diarrhoea be delivered to mothers?

Radio communication was the first choice but it was rejected because only 20 per cent of Bangladesh's households had a radio. Even those who had it used it for listening to music and drama. Moreover, radio communication was likely to be ineffective because for learning ORT preparation, demonstration and practice were essential.

The second option was to deliver the message collectively to all the mothers in a village. Since it was important to teach the method properly to the mothers, it could not be done in a large crowd.

Finally it was decided to teach village mothers individually in their own homes.

Who would teach?

Since women, who were the target group of the programme were forbidden by the local culture to come in front of strange

men, therefore, women were made the front-line workers for disseminating the educational message.

Field trial at Harinagar and Anandapur

Two villages in Sulla thana, Harinagar (95 households) and Anandapur (150 households) were selected for the field trial. Since both the villages were close to BRAC's local offices it was easy for the programme supervisors to receive feedback on the same day.

Two women workers were recruited to teach the message. They were given special training to deliver the message in face-to-face sessions with individual mothers. At the end of each day's work they had a meeting with the programme supervisors to exchange experiences. Strategies needing revision were implemented the following day. A few experts were responsible for monitoring the quality of the teaching. They visited the mothers who had already been taught and asked them to prepare the LGS solution as instructed by the women workers. A sample of these solutions was sent to the Cholera Research Laboratory in Dhaka for electrolyte analysis.

This field trial which continued for three months provided very important lessons for BRAC. It showed that:

- ◆ illiterate rural mothers were capable of comprehending and remembering the messages and reproducing the knowledge to prepare a safe and effective solution;
- ◆ semi-literate, young Bangladeshi female workers could provide education on ORT to rural mothers by visiting them at their homes;

- ❖ a system of monitoring the quality of education in terms of the mothers' acquired ability to prepare ORS could be developed; and
- ❖ a corresponding logistics system could be developed to ship ORS samples to the capital city and receive quick feedback on the quality of programme implementation.

Apart from the above, a tangible outcome of this initial field trial was the drafting of a specific ten-point message for delivery to the mothers which included the definition of diarrhoea, the treatment with LGS and nutritional advice.

Preparing for a National Programme

BRAC's experiences in Harinagar and Anandapur had been encouraging. By 1979, BRAC had already extended its rural development and Women's programmes to Manikganj in central Bangladesh and to Jamalpur in northern Bangladesh. As its experiences grew BRAC discarded the notion that NGOs were only capable of conducting small scale pilot projects and that large scale programming was primarily the government's responsibility.

A Pilot Project

To help solve some of the implementation and management issues that might arise in a greatly expanded programme, a large pilot project called the Oral Therapy Programme (OTP) was started in all six camps under the Sulla thana.

In each camp 3 to 4 Oral Replacement Workers (ORWs) were deputed. They worked under the supervision of their respective camps-in-charge. The teaching in

Sulla thana continued until September, with over 9,000 women being taught the "Ten Points to Remember". Afterwards the pilot programme was extended to include the two neighbouring thanas of Ajmiriganj and Baniyachang. In the expanded programme two teams were formed, each with 15 or 16 ORWs. For six days a week, the ORWs visited one or more villages, with each ORW teaching approximately ten women in a village. Once the ORWs returned from the villages, they had a 'feedback' meeting after dinner which lasted for 2 to 3 hours. In these meetings the day's experiences were discussed including problems encountered and how these could be overcome. Before going to bed each ORW was required to make 10 copies of the "Ten Points to Remember" for distribution in the village the following day (printed copies were not available at that time as the message changed frequently throughout the pilot study).

Incentive Salary System

It was felt that the usual monthly salary system would make the ORWs job-oriented not quality-oriented, particularly when the programme began to expand. Since the overriding consideration was to increase the mothers' knowledge of diarrhoea and ability to prepare lobon-gur solution, a method linking the testing of mothers' capability with ORWs' salary was devised. This was known as the Incentive Salary System.

The system decided the salary of an ORW on the basis of an objective monitoring of her work. Ten percent of the mothers taught by an ORW over the past month were visited by a monitor and asked questions on the ten point message. The mother was also asked to prepare the lobon-gur solution. The responses were graded according to the following criteria:

Grade A: remembered correctly all the ten points as well as prepared the lobon-gur solution (LGS) correctly;

Grade B: remembered correctly between 7 to 9 points as well as prepared the LGS correctly;

Grade C: remembered less than 7 points but prepared the LGS correctly;

Grade D: could not prepare the LGS correctly (no matter how many points were remembered).

From these results the ORWs salaries were calculated. For all mothers graded A, the ORW received Taka 4; for those graded B, she received Taka 2; for those graded C, she received Taka 1; and for those graded D, she received nothing. The emphasis was on ensuring that the mother correctly learned the preparation method of LGS. During the pilot phase, an average ORW received Taka 600 per month (or \$ 40 at the exchange rate of 1980).

The introduction of the incentive system resulted in more attention being given to improving the teaching methods.

The pilot project reached out to over 58,000 mothers in 662 villages. Over 90 percent of mothers scored 'A' or 'B' grades and over three quarters of the solutions prepared by

mothers had a sodium concentration considered 'safe and effective'.

Scaling up of the Programme

Even after a series of detailed pilot projects the ORT programme continued to evolve, initiating new experiments, adding new activities and discarding the less effective elements.

BRAC has always believed that 'Small is beautiful, but big is necessary'. Therefore, the scaling of the ORT programme was consistent with the policies and vision of BRAC.

Scaling up helps sustain the intellectual and physical growth of the organisation. It raises the morale and motivation of the staff and offers better opportunities to them. A large organisation with successful programmes draws the attention of experts, policy makers and the media which in turn increases the credibility of the organisation.

The Oral Therapy Extension Programme (OTEP)

The new expanded programme was named the Oral Therapy Extension Programme (OTEP). This 10 year programme was divided into three phases. Table 1 lists the number of districts and households covered during the different phases.

The Three Phases of OTEP

Phase	Year	No. of district	Households taught (in millions)
Pilot	1979-80	1(part of a district)	0.06
I	1980-83	5	2.5
II	1983-86	8	5.0
III	1986-90	7	4.3
Total	1980-90	20	11.86

Except for the district of the Chittagong Hill tracts all the other 20 districts of the country were covered by the programme. The programme could not be implemented in the Chittagong Hill tracts due to civil unrest in the area.

The OTEP was administered from Dhaka. Although the programme reached 12 million households, the number of women (and children who were onlookers) taught was much higher as in many households more than one woman was instructed.

The programme covered over 75,000 villages in 20 districts. The ORWs and Programme Organisers (POs) visited over 35,000 primary and secondary schools to teach and promote the use of LGS.

The ORWs were the front line workers. They stayed in teams of 14-16 ORWs with one team coordinator - the Programme Organiser (PO) and a cook.

All ORWs worked together in a village, unless the village was small in size. During six days in a week, the ORWs visited the selected village and started working from different corners of the community. They tried to keep themselves as close to each other as possible in the village so that they knew each other's whereabouts. Each ORW moved from household to household and taught a mother in each one. Before leaving she made sure that the other had understood the diarrhoea related message by asking questions on each of the points. She also asked the mother to make the LGS. If the ORW was not satisfied with the level of understanding she repeated the entire session as the degree of learning was directly related to her salary. The mother's name and address was also noted by the ORW. Her day in the field was over when she completed teaching 10 mothers.

The ORW team moved from one union to another and stayed in one location for approximately two weeks. During this period they completed teaching almost all the households in the union. Only those mothers were not taught who were absent from the house at the time that the ORW was teaching.

The team activity was suspended for 15 days every three months of work to allow the ORWs to return to their homes. During this period, the POs drew up field plans for the next three months, with guidance from their supervisors.

Changes in Strategy

Between 1980 and 1990, several changes were made in the programme strategy. The changes were incorporated based on learning by OTEP staff, advice from members of the Technical Advisory Committee (TAC) and other experts, and studies by the Research and Evaluation Division (RED)

Most of these changes were made to either enhance the retention of knowledge or to increase the use of LGS. The following innovations and changes were introduced over the course of the programme:

a) Alteration in the Formula of LGS

Some mothers made errors in preparing LGS thereby increasing the sodium content in some solutions. Therefore, after testing a few other formulas, the formula with a single pinch of salt and single fistful of gur in one half seer was recommended.

To ensure that half a seer of water was measured properly, the ORWs permanently marked a household pot to indicate half a seer.

b) Improvement in the Quality of Teaching

It was observed that the ORWs spoke to the mothers in a 'monotone' and there was hardly any dialogue or conversation between the two. Therefore, flip charts with clear pictures were developed to encourage more interaction between the ORW and the mother.

(c) Reinforcement of knowledge through monitors

The ORWs message was usually given to the mothers only once and there was no reinforcement except through radio and television. Therefore, monitors visited five to ten percent of the mothers a month after they had been taught the message to reinforce it a second time.

(d) Monitoring the Monitors

The monitors were responsible for evaluating the work of the ORWs but there was no formal system of supervising their work except adhoc visits to the field by senior management staff. Therefore, a system was devised to monitor their work. ORWs were asked to record the name of a mother's youngest child. The monitor was also asked to do the same when he interviewed the mother. Afterwards the area manager compared the name as recorded by the ORW with that recorded by the monitor to confirm that the monitor had indeed visited the right mother.

(e) Field Laboratory

Until early 1981, all analysis of LGS for electrolytes and glucose was done at International centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B). In addition, staff from ICDDR, B biochemistry

laboratory occasionally visited the field laboratories to supervise operations.

(f) Revision of Message

The key messages about diarrhoea were revised from time to time depending on the learning in the field. Finally the ten point message was revised to a seven point message.

(g) Increasing Male Involvement in the Programme

Bangladesh has a male dominated society and many decisions at the household level are taken by men, including most on health care. Men were not being reached either through teaching or motivation. It was therefore decided to extend the teaching to male members. Hence, males were contacted and motivated through meetings held in bazaars, mosques, tea shops and schools.

(h) Extending Length of Stay of ORWS at One Place

The length of stay of the ORW team in a union was two weeks. It took a day or less to complete the teaching in one village, with little time available to build rapport. Unless the villagers trusted the ORWs they were less likely to follow their advice. Moreover, due to their short stay, the ORWs were often mistaken as a 'jatra party' or open air rural theatre group. Therefore, the length of time the ORWs spent in each village was increased. An evaluation study found that the usage rates were four to five fold higher here than in villages taught through the earlier system.

(i) Patient Identification and Care

Experience had shown that mothers did not fully trust ORT as the best treatment for

diarrhoea. Therefore, in order to demonstrate the effectiveness of the method, the ORWs started identifying and treating patients with LGS. It was found that the programme performance was better in villages where a large number of patients were treated.

(j) Promotion in School

To increase the use of ORT, students and teachers of primary and secondary schools were also involved in the programme. Students were instructed on the need, benefit and preparation of LGS. With help from teachers, each student was asked to visit ten assigned households daily to identify diarrhoea cases and give LGS if there was a case.

(k) Group Learning

Due to OTEP's radio and TV communication programme the knowledge of LGS was quite high even in areas not covered by the OTEP. It was felt that since LGS was well known outside of OTEP areas, it was no longer necessary to teach mothers individually. Therefore, groups of 4-5 mothers started being taught by the ORWs. Although it was group teaching, hands-on training was still provided with the ORW giving personal attention to all present.

(l) Rice based ORS

Lack of availability of 'gur' and the impression of some mothers that LGS was not very effective in stopping diarrhoea, prompted BRAC to consider ORS made with rice. Though mothers appreciated the rice-ORS more because they thought it shortened the duration of diarrhoea they still preferred the LGS because preparation of rice-ORS was much more complex, time consuming and expensive (due to use of fuel).

(m) Involving Medical Professionals

Since intravenous solution was a major source of income for doctors, they had reservations about prescribing LGS. OTEP started a 'village doctors forum'. In every union, doctors were invited to a meeting where BRAC staff talked about LGS. The meeting held in the presence of influential members of the community asked them to give LGS in addition to what they were already prescribing for diarrhoea.

BRAC started involving government health workers in its programme. These workers spoke publicly about the usefulness of LGS in seminars and meetings, thereby helping to dispel doubts about the programme and lending legitimacy and credibility to it.

ORS Production

Until the early 1980's Bangladesh produced one litre packets of ORS. When BRAC started promoting half a litre packets, the government also switched to half litre packets which is now the size of all packets produced in Bangladesh.

Lessons Learned

❖ NGOs can Implement National Level Programme

A frequent criticism of NGO programmes is that they tend to focus on small, often unrepresentative areas or populations. However, BRAC's experience has shown that demonstration projects conducted by NGOs have the potential to be expanded, even to the level of a national programme.

BRAC envisaged a large scale programme because it had a system that emphasized strong supervision, supervisor accountability and local autonomy. Innovative tools such as

the incentive salary system for ORWs facilitated better management of the programme.

❖ **Upscaling must take into Account the Organisation's Capacity**

When an organisation decides to expand its programme, it should take into account its human resources, support services (logistics, training and research), donor support and the government's attitude. BRAC had all these elements in its favour when it extended its programme coverage.

❖ **Mothers, regardless of their Degree of Literacy, have the Capability to Learn given the Right kind of Training**

BRAC believed right from the beginning that mothers whether literate or illiterate can learn to use ORT and that the key to educating and empowering this group lay in the teaching method. The prevailing opinion was that illiterate women could not learn how to properly mix and administer ORS. BRAC recognised early that in preparing ORS, mothers were simply expanding on their daily tasks of cooking and caring for their children. BRAC however felt that the women should be taught in their community - in their houses using their own implements. Many health education activities were held in clinics - a convenient place for the health staff but a potentially chaotic environment in which to teach.

Since female workers were responsible for teaching the mothers, it led to greater acceptance of the programme.

❖ **In-house Research Plays a Crucial Role in a Programme's Development**

Independent in-house research and evaluation units are invaluable in assisting implementation programmes to continuously

adapt and change to maximise their effectiveness.

Since the programme had a positive attitude towards innovation and change, field workers were encouraged to make suggestions as to how the system might be improved. These ideas often led to research studies that helped to verify field observations. For instance, it was observed that people were reluctant to drink LGS because they thought that it was some type of birth control solution which might cause sterilization. This led workers to suggest that all solutions be tasted by ORWs first to demonstrate that it was perfectly all right to drink ORS.

Research studies also found that people recognised four illnesses all resembling the clinical symptoms of diarrhoea, but the word "diarrhoea" meant only the type that was severe watery diarrhoea. This led to revision in the seven point message on diarrhoea.

❖ **Redefining Target Communities may be necessary to Improve Delivery Mechanisms**

Initially in their health programmes, BRAC tried to reach the whole village but it began its OTEP programme targeting only women. Later new targets were identified as research indicated that men, students, teachers and medical practitioners could significantly increase the use of ORT.

❖ **National and International Support can be obtained if the Process and Information is Shared Openly**

Since BRAC openly shared its strategies and plans it received support and advice from several leading institutions and experts. Moreover, BRAC was never reluctant to accept outside advice and constantly welcomed critical review to upgrade its programmes.

Conclusion

OTEP had certain characteristics that enabled it to transform into a nationwide programme. It dealt with a problem that was present throughout the country. The intervention was relatively simple, requiring no outside assistance once the method was taught. Only a small amount of money was to be spent by the household on the possible purchase of gur or sugar. The message built on home based knowledge and skills (child care and

cooking) was culturally acceptable. The mechanism to measure the progress of the programme was quite effective. Moreover, though the administrative structure of the programme was very large, rigorous supervision was maintained to ensure its smooth functioning. Finally, at the root of its success were the programme's clearly stated goals and objectives that were attainable both programmatically and economically and its total commitment to the process.