ORAL THERAPY EXTENSION PROGRAM

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Introduction

Diarrhea is a major cause of morbidity and mortality in Bangladesh. The Bangladesh Rural Advancement Committee (BRAC) has undertaken a nation-wide program of educating the rural women of how to prepare and administer an oral rehydration fluid for diarrhea. The simple technology using the pinch and scoop measurements has made the method accessible to the rural poor. A three-finger pinch of lobon (common table salt) and a four-finger scoop of gur (molasses) when mixed in a half seer (467 CC) of water gives a fluid which is scientifically close to the recommended preparations. The method of preparation and related nutritional and other knowledge are contained in an educational package called the "Ten Points to Remember". Teams of oral replacement workers (ORW) who are females visit each household in the village and teach atleast one women about the ten points. The male Team Coordinators (TC) take the responsibility of meeting the male-folk and organising a diarrhea control movement in primary and secondary schools. A group of such teams are supervised by an Area Manager (AM). A group of monitors visit ten per cent of the taught households to assess the ORW teaching. Samples of oral rehydration saline prepared by women are collected by the monitors for glucose-electrolyte analyses. The remuneration of ORWs are decided on the basis of the monitoring results. Another independent group evaluate the program in terms of usage and impact on mortality. The program receives the advisory services of an international technical committee (TAC).

The program called the Oral Therapy Extension Program (OTEP) has started in July, 1980. During the first three-year phase of the program, about 2.5 million households in five districts will be covered. Details about the program and its evaluations are available in the publications cited in the reference list. A report on the progress of the program during July 1981-December 1981 is given in the following pages.

it started in July, 1980. Ever since then, a lot of new methodologies were developed and tested and later formed an inseparable part of the program (e.g., the school program). During the six months under consideration also, a number of new innovations were developed to popularise the BRAC method. These are now being included into the program.

a. <u>The Mosque Forum</u>: The people of Bangladesh are basically God-fearing. They have an ardent faith in their own religions. As a consequence, the religious leaders have a commanding influence on their lives. BRAC started to realise these facts and started a new forum of canvassing from the rostrum of the Imam (persons leading the prayer in mosques). As part of this, a TC attends the friday prayer and with prior consultation with the Imam addresses the <u>Musallis</u> about the importance of the program. In this way all the mosque in the areas under operation are being covered.

b. <u>The Hut Forum</u>: The <u>hut</u> is a village market. People from adjoining villages gather there on a particular day of the week for shopping and marketing of produces. It becomes an informal meeting place for people from all walks of life. BRAC has started to utilise this gathering. A TC organises a meeting in the <u>Hut</u> and tells the people about the BRAC program. This is normally done before the arrival of the ORW teams into the locality. This has been found to be useful in dispelling the doubts of the people about the ORWs (e.g. the doubt that the ORWs were from family planning) and in facilitating an easy and convincing operation in the village.

<u>The Quack Workshop</u>: In the virtual absence of trained professionals in our rural areas, the health of the villages are overridingly looked after by the village quacks. They command high faith in health matters. Since the success of the program depends on how the villagers take the program and to what extent they use

it, BRAC recognised the potentiality of these 'bare-foot docs'. BRAC also apprehended a negative attitude from them in view of LGS's cheap and easy availability vis-a-vis the traditional quack medication (allopathy, homeopathy, herbal, etc.). A negative compaign from them was unaffordable for BRAC. Thus a new methodology was developed to take the quacks into confidence. The essential assumption was to assume that the quacks do not become an opposer of the BRAC program. A TC during their visit to an union gets in touch with some known quacks of the area. He personally tries to convince them about the program. Once they are convinced, a senior quack is requested to organise a meeting of all quacks of the union. The TC then explain to them the salient features of the program and seeks their cooperation. This forum is relatively new and the effectiveness is yet to be seen.

The Central School Workshop: To arouse more interest and to reinforce confidence, a central workshop is now arranged at the thana level. The thana education officer (TEO) is requested to arrange a joint meeting of all teachers and elites of the thana. The TEO and some teachers alongwith the elites address these meetings and speak about the usefulness of the BRAC program and tell the audience about their role in this. The TC works only as a facilitator in such a meeting.

IV. Program Evaluations

a. Activity Evaluation: Monitoring the activities of ORWs is an important element of the activity evaluations. The results of the six months under consideration follow a similar pattern as was observed during the previous period. About half of the households taught scored 'A' in each month. More than 95 per cent scored either 'A' or 'B'. Scores in grades 'C' and 'D' were less

than 2 and 1 per cent respectively. More details abot these results are available Appendix 1. Another important aspect of monitoring is the feedback on the quality of the program with respect to the 'safety' of the BRAC method. Samples of oral saline prepared by village women after 15 days of ORW teaching are collected by monitors. Previously these were being analysed for electrolytes and glucose at the Internatinal Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), Dacca. From the middle of 1981, BRAC, at the advice and technical supervisions of ICDDR,B, statted establishing mini-laboratories at the area office for chloride analysis using a simplified method [5]. The analysis of the oral samples are now analysed at the local level. But for quality control, a random 10 per cent of the analysed samples are sent to ICDDR,B for a fresh analysis of chloride using the chloro-counter. The results available on the chloride concentrations are given below:-

Table: ANALYSIS OF CHLORIDE
SUMMARY OF STATISTICS

Area No.	NAME OF AREA	Sample Size n	Mean (mmol/L) X	Standard Deviation Tx
01	HOBIGANJ	200	57.94	18.36
02	JESSORE	2326	71.90	20.08
03	GOPALGONJ	5311	54.67	13.64
04	MOULAVIBAZAR	3662	62.85	19.83
05	BAGERHAT	419	71.80	21.36
06	MADARIPUR	859	59.62	18.0

A graphical repr sentation of these results are available in Appendix 3.

In addition to the monitors, there is a monitor's monitor in each area. His duties are to control the activities of monitors and reinforce the knowledge. He checks a random 10 per cent of the households visited by monitors and also reteaches those households where the chloride concentrations in the ORS prepared by women are found to be too high ($>$120 mmol/L) or too low ($<$30 mmol/L).

b. *Impact Evaluations: The impact evaluation forms an independent* system of the mainstream of OTEP activities. The research and evaluation division of BRAC has started a 3 year prospective study to measure the impact of the program on mortality. The study started in early 1981 is being done in eight thanas of the five districts throught a series of baseline and follow-up retrospective surveys. A large amount of baseline data have already been collected. These data are now being transferred into transcription sheets for onward transfer into computer.

V. Concluding Remarks

The oral therapy extension program of BRAC has travelled quite a long way since July 1980 when it was started. Nearly half a million households have already been visited by the oral replacement workers during the first half of the 3-year phase. Available evaluation results indicate that the program is well under control with respect to the quality of teaching. But the picture about the acceptance by the people or in other words the usage of the method is not very clear. An anthropological study is now being planned to know the reason of low acceptance. In the meantime efforts are being streamlined to increase the acceptance. The formal evaluations are underway. The coming months should be very important for the program.

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A P P E N D I X - I

Table: Month-wise Statistics on Coverage and Monitoring (All Areas)

Month	No. of Areas	No. of Teams	No. of ORWs	No. of ORW Days	Households visited	Cumulative	Monitors Grade (% HHs)				Av.HHs visit per ORW per
							A	B	C	D	
Upto June '81				20,321	187,601	187,601	50.9	46.9	1.5	0.7	9.23
July, '81	3	15	221	2,591	25,509	213,110	50.9	47.1	1.5	0.5	9.85
August, '81	3	16	209	2,766	26,189	239,299	50.5	47.9	1.4	0.2	9.47
September '81	4	20	288	6,164	56,901	296,200	50.6	47.1	1.4	0.9	9.23
October '81	5	23	313	3,742	35,374	331,574	50.5	47.3	1.5	0.7	9.45
November '81	5	26	347	7,077	69,152	400,726	49.0	48.8	1.4	0.8	9.77
December '81	5	27	367	8,055	78,388	479,114	49.5	48.5	1.5	0.5	9.73

APPENDIX - II

Table: Coverage of Sub-divisions, Thanas, Unions & Villages (July - December 1981)

Sub-division (Area)	No. of thanas fully covered	No. of thanas under operation	No. of Unions covered	No. of Villages covered	Remarks
Habiganj	6	..	57	1491	Sub-division fully covered.
Jessore Sadar	3	3	57	805	Under operation
Gopalganj	2	3	50	496	Under operation
M. Bazar	2	3	31	728	Under operation
Bagerhat	-	3	18	251	Under operation
Madaripur	-	3	9	126	Under Operation
Total:-	13	15	222	3,879	