The Oral Therapy Extension Programme

A micro-study of beliefs and practices.

The BRAC Oral Therapy Extension Program (OTEP) has now been underway for about two and a half years and has covered over 1.5 million households. This reflects a stage in the first phase where the mobilization of staff and facilities has reached full strength and where coverage of another 1.5 million households is anticipated by the end of the phase in nine months time. At this point a number of questions are being posed that will have great significance over the eventual impact of the program. The program, as presently conceived, requires three goals at different levels to be achieved before its objectives can be successfully met. At the most immediate level there is the need to organize staff and implement a program which will effectively convey the health message to a pre-identified target group (in this case, at least one member of all households within the program areas). At the next level this retained, passive knowledge must be converted into active knowledge and actual usage of the therapy must take place within these households during episodes of diarrhoea. The desired goal at the third level, then, would be an impact of this usage on mortality and morbidity rates. The criteria for success in achieving the goals will differ from level to level . At the first level it is necessary to achieve very high degrees of success. That is, the program coverage must be extremely thorough and it must be ensured that retention of the correct way of preparing the labon-gur solution (LGS) is high. This is necessary because an incorrect preparation, particularly an over-concentration of salt in the LGS, would open up unaceptable risks for those who are drinking the solution. At the second level the criteria may be relaxed slightly since a usage rate of only 65% or above could lead to

a significant impact. At the third level the criteria are least stringent since even a partial impact of the usage of LGS on diarrhoea induced mortality and morbidity rates could lead to the saving of enormous numbers of lives, particularly in the 1 - 4 years age group. Needless to say, the greater the success at any one level the greater will be the impact on the subsequent level. The BRAC program is commendable in that all three levels have been identified as crucial for a successful outcome of the program and arrangements have been built into the program to attempt measurements of success at each of these levels.

At the first level, the program has an automatic monitoring system which is designed to ensure that nearly all households in an area are visited by the Oral Rehydration Workers (ORWs) and whether the households remember the 7-points of OTEP.
For the second level there is a Usage Servey conducted by the monitoring team which not only identifies the level of usage of the LGS during diarrhoeal episodes but also collects samples of the solution prepared by the householders in order to test the composition. The impact on mortality is being undertaken as a large, separate study known as the Evaluation of BRAC's Oral Therapy Extension Program (EVABO). This study is collecting data in eight unions located in the five districts where phase I of the program is being conducted.
These studies show so far that the coverage and retention are indeed very high. Moreover, the composition of the samples of LGS prepared by the householders have been shown to be well within acceptable limits and this is so even in those cases where the samples have been made six months after the program was conducted in the area. Thus, the primary level goals of the program are being successfully achieved. At the usage level however, the results are still open to different interpretations. In general, it seems that usage levels do not exceed 20% . That is, of those households who have been covered by the program,

less than $\frac{1}{5}$ th actually use the LGS when there is an occurrence of diarrhoea. This is a problematic result and its implication is that the diarrhoea related mortality and morbidity are not being significantly reduced. Preliminary results from EVABO seem to confirm this. This result has been of concern to the OTEP and some steps have already been taken to alleviate this situation. This particular study was undertaken in the light of the above-mentioned problems as part of an attempt to understand why usage rates remain low despite high program-coverage and retention rates. One of the areas where the EVABO mortality study is being conducted was chosen as the study area. This is a remote, famine-prone area in Faridpur district where land transport is poor and medical facilities are scarce. The name of the village chosen for observations is Nagerpara in Goshairhat Thana of Madaripur Sub-Division. A sample of about 50 households were identified in which at least one diarrhoeal case had occurred within the fortnight prior to the study. This sample was selected in such a way that around 30% of the households should be LGS users.

It was presumed that a lack of usage in the face of high retention rates was due to problems of confidence and belief, and that the study should attempt to explore these areas. Thus, it was decided that the most important aspect of the data-collection exercise should be in the form of long and detailed discussions with householders rather than through pre-arranged questionnaires. The final form of the data-collection consisted of some information collected through a simple questionnaire and other information gained through long interviews. For this a check-list was produced in which all the possible areas of relevance with regard to non-use of LGS were enumerated. These check-lists acted as a guide to the interviewers and a reminder to them in case an important aspect had been left out of their discussions. The questionnaire used were very simple and collected some basic

demographic and economic data on the household as well as some data on the nature of treatment used during the diarrhoeal episodes . In the check-list were a number of points that could be identified as possible contributors to the non-use of LGS, covering the areas of belief and world-view, the area of decision-making within the household, the question of vested interests in the village and the question of program short-comings. The actual interviews with the households were conducted by teams of two consisting of one member of the research section and one member of a usage survey team. The researchers involved were present in order to facilitate the interview to ensure that all the improtant topics were covered and to record the results while the usage survey team member, who was female, carried on the actual discussion. The interviewers were usually the wives of the householdheads, thus it was necessary to have a female interviewer present to ensure an easy and informal flow of information. It should be pointed out here that the method of information-collection used, through proping interviews, is an extremely difficult exercise requiring great presence of mind, penetrative interviewing skills, the ability to follow leads in interviewees' responses and constant attention in keeping the conversation focused on relevant topics. At the same time there is a need to maintain rapport, spontaneity and informality so that the interviewees may be encouraged to speak freely and with minimal gaurdedness. To achieve the correct balance requires a great deal of experience , patience and good judgement and is a skill that is acquired over many years. In these circumstances, the interviewers , most of whom had limited higher education, little formal training or previous exposure to such techniques, rose to the occassion and turned in admirable performances. Naturally some of the interviewing may not have been as incisive as desired but, under the circumstances, this cannot be considered as unexpected . The point to be [illegible]

is that the interviewers were at all able to collect useful, illuminating information and for this we must give them credit. Before we can interpret the revealed data in a potentially useful way there are certain background ideas that should be clarified and elucidated. These are to do with the ideology of illness and curing and have a tradition and hold on human societies which are far older and more deep-seated than our present-day "rationalism" usually permits us to acknowledge. Such perspectives have opened up in investingations of the newly-developing sub-field of medical anthropology and here we shall mention only some of the more general findings.

Illness is a state of being in an individual's health where he is in an abnormal condition, that is, he is in a state which is altered from his normal, everyday state or condition. The point at which an alteration in the condition of his health shades over into actual illness is socially defined, that is, it is a matter of common agreement among the in-group that subscribes to this or that particular definition of illness. This agreeing in-group is usually a social unit in the sense that they share a common set of other cultural beliefs as well. Thus, the agreed-upon point where health turns to illness is a part of that shared culture: illness is culturally defined and is a cultural category. This may be hard to accept at first sight since we are all far too accustomed to thinking of illness as something which has a precise objective reality that can be exactly defined through scientific (modern medical) investigation. This is more the fault of the common man's misconceptions of what " scientific knowledge" is rather than any over-exaggerated claims on the part of practising scientists/medical researchers. Suffice it to say that the marriage of science and medicine is a comparatively recent phenomenon whereas medicine, in its more general sense of the ideology of illness and curing,

has existed from very much earlier times than the advent of what we call scientific reasoning.

So medicine has a deep social grounding in the sense that it is a product of a very old socializing process. It also shares another very important function in common with other social features. It becomes a means by which norms are delimited, it points out where a zone of "normality" ends and where the zone of "abnormality" begins, and it has this in common with almost all kinds of social regulation. This distinction is then given moral accentuation by ascribing opposed values to the opposed sides of the distinction. Thus the zone of the normal is also the zone of the acceptable and desirable while the zone of the abnormal becomes the zone of the unacceptable and undesirable. Again, a process with very close parallels to all types of social regulation. In the end we find ourselves dealing with "conformity", the supreme social imperative, and perhaps this is a little surprising when applied to the notion of health and ill-ness. The suggestion is that he who is in a (socially defined) normal state of health is conforming with social requirements while he who is in a (socially-defined) abnormal state of health is transgressing the social requirement. This will seem less surprising, however, as soon as we consider the extremely widely prevalent view that illness is a result of the wrath of the gods, or is a result of prior misdeeds on the part of the victim, that it is a form of nemesis or the result of too much pride or over-confidence or some other socially unacceptable transgression. Illness is visible punishment and as such it brings not only physical sufferin but it also inflicts on the victim a certain degree of guilt and shame. And however much we moderns may consider ourselves believers in rationalism and objective etiologies, it is very difficult indeed to shake off those last vestiges of embarrasment at having to admit that we are today, yes, not feeling upto scratch.

We can now turn our attention briefly to the "curer". It is clear that this person is dealing not only with physical symptoms but also with symbolic transformations - he is the expert brought in to deal with a specialized area of knowledge. He is also delving into taboo by crossing over with the patient into the forbidden zone and effecting the necessary changes and ritual acts that will help the patient return to an allowed zone. He is the intermediary who, through his specialist knowledge and position, is able to intervene, examine, judge, prescribe and, where necessary, intercede with powerful agents both physical and spiritual. The one attribute that he possesses most glaringly is authority. His possession of certain knowledge, whether acquired through various means or naturally endowed, gives him the power to heal and the fact that this knowledge is specialist, that is, it is not available to the uninitiate, gives him power in the social structure. It is important to realize that this element of exclusiveness in the knowledge is a very vital part of its curative function and lends it its authority. Since very ancient times the medical profession has always been identified as a brotherhood with its own territory of secret knowledge which it guards against any encroachment from the laity and which is entered only under oath. The point to be emphasized here is that the curer is regarded in society as a man of specialized knowledge and authority (note that the term "authority" refers both to power in the political sense as well as to command over a particular field of knowledge) and that he is able to perform tasks that cannot be performed by ordinary persons.

Having established the backgrownd context against which the OTEP program is progressing, let us now consider some of the results of our survey. The observation most consistently reported by the interviewers was the fact that there is a mismatch in the set of illness categories being used by CHW's and by the village women themselves. Although steps have been taken by the program staff in the last few

months to try to minimise this discrepency, this is still an area of great significance and interest in understanding the successes or failures of the program. The first question that is raised is: "at what point does a health condition exist which may be called an illness requiring treatment?" his point varies not only from individual to individual but also from society to society depending on the conditions under which it exists. In other words, is the first loose motion a case for treatment? Well, that depends on who you are and where you live. The answer to the question may seem like an obvious "no", no matter what conditions you live in, but the answer becomes much more contingent if the question were posed in this way: "are five loose motions in one day a case needing some sort of treatment?". The point is that a diagnostic judgement, which is a very difficult, technical, socially - influenced decision, has to be made somewhere along the line. To avoide this difficulty the safety rule adopted by the BRAC health message is that LGS administration must begin at the very first episode of loose motion. Yet this rule is almost never followed, and the above discussion easily helps us to show why. In fact, our investigation shows that LGS administration begins, if at all, after an average of at least 5-6 episodes. Nowhere does treatment begin with the first episode of diarrhoea and both experience as well as statistical investigation amply justify this approach. So there arises the first doubt in the minds of the village householders: when do we <u>really</u> use the LGS?

This difficulty is compounded by terminology. In the early part of the program the ORW's introduced the notion of LGS use to the households as an effective agent to be used for diarrhoea. Now, the term "diarrhoea" carries connotations for the villagers which are quite different from those it carries for medical and health workers. Whereas "diarrhoea" is a very general term for medical staff signifying a wide range of diseases involving watery stool, in the world-view of the villagers it is a term used exclusively to denote the

more severe cases involving acute symptoms reminiscent of cholera. Of course, this results in serious problems for the use of LGS because it is not a "medication" for severe diarrhoea, in fact, it is not a "medication" at all. Thus, there is a real problem with regard to the timing of LGS use. That is, the villagers are not clear as to <u>when</u> to use LGS. There is no tendency to use any treatment at the early stages, neither LGS nor any other form of treatment. If it is the mild self-limiting type of diarrhoea, which is by far the commonest type, treatment is missed out altogether. If it does not recede and shows signs of turning into a more serious situation, perhaps cholera, then the villagers have little confidence in LGS as a cure, and quite rightly so, since LGS is not meant to cure anything. In fact, the villagers are not really clear as to what <u>role</u> LGS has to paly and if its role is not "curing" then there is no other role which the villagers are familiar with which can be compared to LGS, except perhaps the intake of food (nutrients) which, in effect, is what LGS is. Those few who do take LGS under the misconception that it is a cure soon find out that it is not effective, particularly in the severe cases, and this adds fuel to their scepticism. It also reinforces all the "folk reasoning" that tends to show that LGS <u>could</u> not work. We now consider some of these.

Let us consider first the local etiology of diarrhoea. There is a very sketchy and occassional appreciation of the germ theory of disease but this is considered with a degree of suspicion and scepticism. Alongside this there is a parallel etiology which is more attuned to the local belief system where the causative agents are either "dirt" or other factors which do not have a tangible or directly observable existence. Even this system of causation is imperfectly or vaguely expressed and does not have much conceptual elaboration. Thus, little children often get diarrhoea as a result of being exposed to a "bad wind" (batash laga). This is sometimes transmitted from the mother's breast via her breast-milk. Adults,

on the other hand, usually get loose motions because they have eaten "dirty, contaminated" food. Cholera, a dreaded illness, particularly when epidemic, is the definite work of evil spirits and is, as such, very difficult to deal with effectively. All these diarrhoeal diseases are of a "hot" nature. This last observation has implications for the use of LGS since salt, which is one of the components of LGS, is also considered a "hot" element. This is interpreted in two ways, however as it is not clear whether a "hot" disease should be combatted by another "hot" element or should be neutralized by a "cold" element. At least one informant claimed that LGS was appropriate to diarrhoeal illnesses because it was itself a "hot" solution while many claimed the opposite, that the "hot" salt in LGS would further exacerbate the problem. It is clear, of course, that these respondents were talking in terms of LGS as a cure rather than as a replacement agent. Again and again we found this confusion between LGS as a curing agent and as a replacement agent even among those households where they were able to remember from the CRW's visit that LGS was a solution that was meant to replace the water and salts lost from the body.

We must consider also some of the confusion surrounding the type of molasses to be used in the LGS. There seem to be three distinct types of molasses used: Molasses derived from sugarcane, from the juice of the date-palm and from the juice of the palmyra tree. Of these only the sugarcane molasses were used during the CRW's demonstrations. This led to the misconception that only this type of molasses could be used and subsidiary arguments were developed in support of this idea. For instance, sugarcane molasses were thought to be "cold", therefore appropriate, while date molasses were said to cause heart burn and indigestion (ambal pitta) and palmyra molasses were said to cause stomach worms. There was also the case of one mother who felt that it was wrong to give a water-based solution to her child when his body was actually ejecting water (in the form of watery stool). She felt that the correct thing would be to

deprive him of fluids until his body had stopped rejecting it.

We have reviewed a number of individual criticisms of the LGS and the general trend of the comments seems to be one of rationalizations for a deeper, unspoken dissatisfaction. It is to this that we must now turn and attempt to see what lies below the surface.

Let us try to imagine ourselves experiencing the arrival of ORW's at a household..The chances are that they come completely unannounced and they never explain clearly exactly who they represent. They are usually fairly young(around 20-25 years), female and have some education- unfortunately they thus closely resemble the village Family Planning workers. They announce that they wish to draw attention to the problems of diarrhoea, particularly among children. They then proceed to carry out a discussion that includes a demonstration of how the LGS should be prepared. The LGS is extremely simple in nature and made of the commonest of ingredients. After this brief interlude the ORW's leave and the women of the households resume their arduous, normal life. Now it is easy to see that from the point of view of the household women the experience of the interaction is short-lived, fragmentary and very much a passing phenomenon. With no other reinforcement the memory of the experience recedes to a passive state, lying there capable of being recalled through active stimulation but otherwise not obtruding itself into consciousness. Part of the reason for this, of course, is that it does not "fit" easily into the commonsense expectations of the villager's world-view. It is rather like an anomolous, free-floating piece of knowledge that does not mesh in with the conceptual systems that the villager uses to construct his reality and make sense of the world around him. In a sense it almost appears "zany" to him. Moreover, the ingredients used for he LGS are not normally thought of as having any medicinal value. They are thought of as everyday substances which add flavour and taste to foods so that it really is difficult for the villagers to think of them as having any curative effect. Again, we must note that there is no clear distinction between LGS as replacement solution as opposed to LGS as

a cure for diarrhoeal problems. Hence its rejection as a possible cure means also its likely rejection from any other kind of consideration.

What all these individual reviews add up to, finally, is a single, major theme: in the perceptions of the villagers, the ORW message lacks authority. Neither in its mode of dissemination (through young, female workers), nor in its form of treatment (as a non-curing replacement solution), nor in the ingredients used does it have the trappings of authoritativeness. Those who belong to the hierarchy of local medical authority (the health officials, the local doctors, the herbal and spiritual medicine practitioners, the retailers of medicines) have little interest in lending their authority to this technique. Particularly because the technique is completely external to their body of practice and, in some cases, a threat to their established position. Although they may not actively criticize the technique, their indifference is usually sufficient to discredit it in the eyes of their clientele.

It should, however, be pointed out that most of the aspects uncovered in the previous discussions have been felt already by those who are managing the CTE Program. Moreover, many steps have been taken to overcome these problems. The program now lays great emphasis in involving the male population as well as the local health practitioners to support the use of LGS. Broadcast media as well as visuals are also used to re-inforce the message and to give it greater currency. It remains to be seen whether this stamp of authority will lead to greater usage. However, it may be prudent to remind ourselves of another dilemma that this may bring.

It is essential not to forget that the "authority" we have been talking about emanates from the same sources which are responsible for much of the inequity and exploitation that run through rural society. The people of authority on medical matters belong to the same group of people who wield this authority to control and subjugate. As development workers committed to the curtailing of this

self-interested authority, we face an ethical consideration of whether it is acceptable to resort to this authority to support particular goals no matter how laudable these goals may be. This reverts to the age-old means/ends dilemma to which there are no easy answers. There are some who believe that the strengths and weaknesses of a system may legitimately be turned-in on the system to transform it. Others hold that the use of any element of a system inevitably commits one to the upholding of that system. In their respective senses both views are true and so all that remains is for individuals to guide their actions within their own ethical limits.

It would be wrong to end this report on a pessimistice note because that would reflect unfairly on the achievements of OTEP. On the contrary, there are, despite all the difficulties discussed above, strong grounds for optimism. In fact, the 20% usage rate is itself a cause for encouragement. Given the restraints and obstacles that are bound to be evoked by a novel approach like oral rehydration, it is significant that even 20% of the households came forward and used it. This is a reflection not only of a very devoted effort on the part of the program staff but also a demonstration of the tremendous tenacity of the rural people of Bangladesh. That, after innumerable years of being given false starts, broken promises, shabby experiments and dehumanizing treatment, the rural poor are still willing to listen with patience and give a strange, new idea even a 20% effort is, in the opinion of this writer at least, a testament of their heroism.

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