

# **Dissemination of Information and Method of Successful Communication**

## **Teaching ORT Messages to Millions: The BRAC Case**

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## Summary

This secondary data based paper aimed to familiarise the audiences on BRAC experience in successful interpersonal development communication at grassroots. Starting with some basic conceptual issues of communication the paper focused mainly on the BRAC foregone Oral Therapy Extension Programme (OTEP). Through the OTEP BRAC health workers taught millions of rural women the "Seven Points to Remember" on diarrhoea and its home management. The reason for adopting this strategy among the many options was that most of the rural mothers were illiterate and superstitious. Therefore, to dispel wrong traditional beliefs and values of the learners, face-to-face teaching was proved to be instrumental and effective. Prior to launching the national programme BRAC, however, experimented a pilot in its Sulla project. Based on the pilot experience BRAC developed a concise but comprehensive messages on diarrhoea including homemade therapy for its management. The BRAC trained mobile Oral Rehydration Workers taught at least one woman from each household the "Seven Points to Remember" staying at temporary residences given by the community. Different fora such as meetings in schools, madrashas, mosques, bazaars and villages were conducted to raise awareness of the male population. Apart from these, mass media were used to disseminate messages. Another vital forum was meeting with the village doctors to win their support to the programme. However, a two-tier mechanism was in place for quality control viz; i) ongoing monitoring system, and ii) operations research and evaluation. The paper also delineated some tips for the Pesticide Association of Bangladesh so that by capitalising the BRAC experiences it can launch interventions to raise peoples' critical awareness on the entirety of pesticide to prevent environmental hazards.

## 1. Basic conceptual issues of communication

Communication is a key instrument to bring change for development. It is a continual process to occur. People communicate with others aiming to modify their behaviour towards better survival. Morton et al. (1976) observed, "Communication reflects an attempt to influence another's behaviour to produce physical, social or economic rewards." Communication is also used for making effective decision about what the people think and what they do. Schramm (1964) said:

Without adequate and effective communication, economic and social development will inevitably be retarded, and may be counterproductive. With adequate and effective communication, the pathways to change can be made easier and shorter.

However, there are four types of communication in practice: i) Intrapersonal, ii) Interpersonal, iii) Group, and iv) Mass. All these directly or indirectly effect at intrapersonal level. Different models of communication exist in the domain of communication. Of them, the Convergence Model and the Diffusion Model and/or the combination of both appear to be more effective for development communication. The Convergence Model is defined as a process in which the participants create and share information with one another to arrive at a mutual understanding (Rogers et al. 1981). While the Diffusion Model is concerned with the spread of messages.

Communication, indeed, is a tool for decision-making in partnership. The communicators facilitate the participants to make their own decisions. The participants can make skillful decisions when the communicators and the participants share facts and feelings. Communicators and participants are, therefore, a vital partnership at the centre of communication. However, information about a specific subject reaches the people in many ways (Figure 1).

In a good communication, the communicators and their participants frequently go through a series of interlinked and overlapping steps (Population Reports 1998). These steps can be remembered by the letters in the word "GATHER." The word "GATHER" stands for:

G= Greet: Welcome each participant on arrival

A= Ask: Ask the participants for reason for coming, and encourage them to talk

T= Tell: Start discussion with the participants' preference

H= Help: Help the participants to understand and let them decide

E= Explain: Provide what the participants want

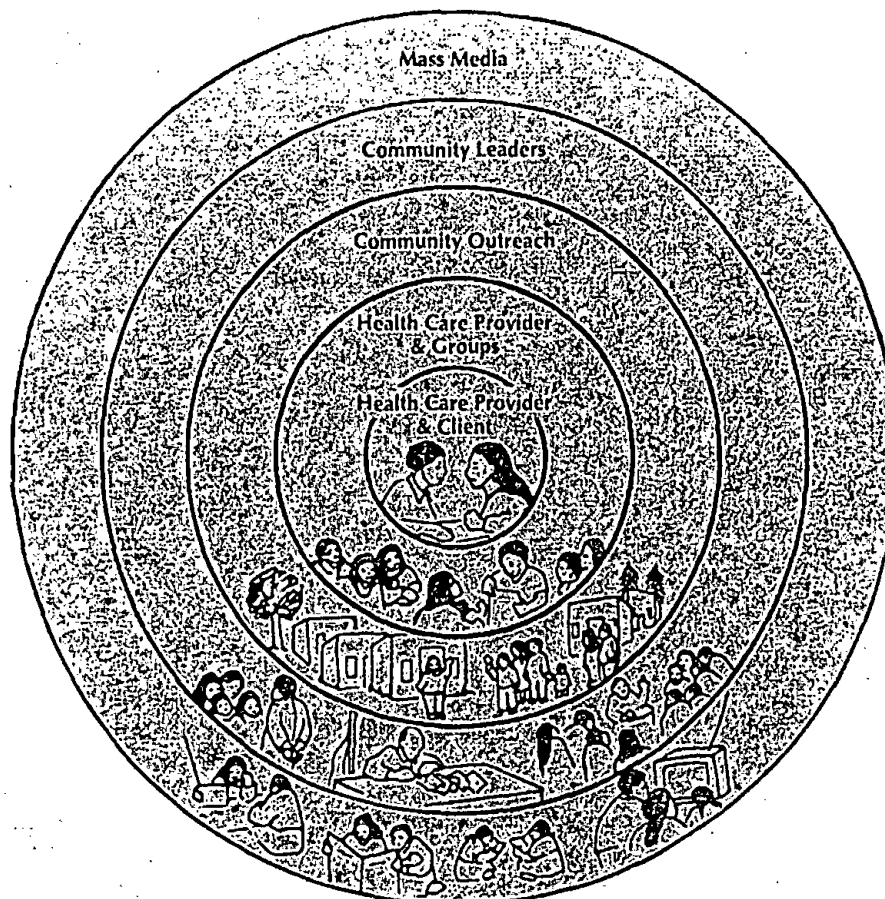
R= Return: Plan the next visit, if needed

For a greater participation of the grassroots, the pattern and flow of the messages should be fashioned in a way that would help the grassroots to have easy access to knowledge and technology through their ordinary channels of communication exist in the rural community (Ouchi 1985). BRAC, one of the largest NGOs in the world proved that even the illiterates could be empowered for development by communicating messages through

appropriate culture-sensitive channel. However, the following section documents the case of BRAC ORT teaching at household level.

Figure 1 Ways of reaching information

**Provider & Client-  
A Vital Partnership  
at the Centre of  
Communication**



Source: Population Reports, December 1998, p.3

## 2. BRAC's Oral Therapy Teaching programme

### 2.1 Introduction

BRAC has diversified approaches to communicate and sensitise the development participants about the overall development. The BRAC communication strategy can be viewed at three levels viz; i) Grassroots level, ii) Training level, and iii) Organisational level (Arif 1996). As an organisation BRAC generates information on development issues and needs by involving the people at various levels, and discusses these at policy level of the organisation. Thus, interventions are designed and implemented. Since the BRAC management structure is a combination of both hierarchical and flat system, it is

relatively easy to communicate decisions to the concerned. However, to implement the development programmes the staff at all tiers are given training in its training centres. Then, they begin work with target people and get involved in continual communication at grassroots. By using the interpersonal communication technique, BRAC successfully reached ORT messages to millions in Bangladesh. The reason for adopting this strategy among the many options was that most of the rural mothers were illiterate and superstitious. Therefore, to dispel wrong traditional beliefs and values of the learners, face-to-face teaching was proved to be instrumental and effective. BRAC's approach was well acclaimed. In the 'Foreword' of the book titled "A simple solution: Teaching millions to treat diarrhoea at home" Jon E. Rohde wrote:

The story of the Oral Therapy Extension Programme, OTEP is a tale of how a medical technology was adapted, revised and presented to an illiterate public through house-to-house health education by a small army of dedicated health workers. Through a decade of persistent work, the entire BRAC organisation initiated this ambitious programme, and in spite of all skepticism from the global public health community, carried the science of oral therapy into every home in Bangladesh. Never before, or since, has a public health effort of this intensity been tried. Never before has health education been provided under such rigorous and cost-effective circumstances with constant monitoring and evaluation, resulting in improved implementation at progressively lower unit cost throughout the decade of the programme.

## 2.2 Development of the BRAC ORT programme

Oral rehydration therapy (ORT) has been a proven cost-effective tool for treating most types of diarrhoea. In the past, many developing countries implemented ORT programmes, some promoted packet oral rehydration solution (ORS) and others home solutions. As mentioned earlier, one of the biggest and widely acclaimed programme was the one run by BRAC in the eighties in Bangladesh.

In the mid seventies, BRAC promoted and distributed packet ORS through community volunteers and BRAC paraprofessionals. But the strategy envisaged many problems particularly in terms of availability and distribution of the packets to the villagers, while cost and management were the other problems (BRAC 1980). BRAC then tried out an alternative. Field research unfolded that a three-finger pinch of *lobon* (common table salt), and one scoop of *gur* (unrefined local sugar) in a half seer drinking water (467 ml) produced a solution having many needful properties of standard ORT. Lobon supplied sodium and chloride, while gur sucrose and some potassium. But the burning question was how to reach the technology to the doorstep of the rural people who need this most? BRAC decided to experiment the process in its Sulla project. The pilot project sought answer to the following critical questions (for details please see Chowdhury et al. 1996):

1. **What would be the contents of the education messages?** Research showed that for home management of diarrhoea BRAC should teach a mother/caretaker about

diarrhoea and its effects, preparation and administration of solution with home ingredients, and dietary advice etc.

**2. Who would be taught the messages?**

Conventionally mothers are the caregivers to the children and other family members. Therefore, they were prime targets for ORT education. While the adolescent girls are would be mothers, they were also targeted for the same.

**3. How would the messages be taught?** Many options were considered such as radio, village level meeting of the mothers, and one-to-one teaching. Since a very few mothers had access to radio, and it was not culturally feasible to assemble the mothers in a common place of a village, the third option i.e., individual teaching approach was adopted.

**4. Who would teach?** Since rural women were the targeted learners, the women were made primary workers for teaching.

Through this trial BRAC also developed a "Seven Points to Remember" which contained a concise but comprehensive messages on the definition of diarrhoea, cause of diarrhoea, preparation and administration of ORT, nutritional advice etc. (Appendix A). Mothers could easily remember these messages and prepared safe ORT when taught. The locally trained female Oral Rehydration Workers (ORW) with 8-10 years of schooling were capable to teach the mothers. However, from July 1980 through December 1990 BRAC health workers visited about 13 million rural households to teach the rural mothers about the BRAC innovated ORT popularly known as lobon-gur saline (LGS).

### **2.3 Operational methods**

**2.3.1 House-to-house teaching:** One woman from each household was taught the core of the "Seven Points to Remember" at home. For this, the ORWs used to travel from temporary residences on foot or by rickshaw or country boat based on the local communication system and season. While visiting home an ORW was to introduce herself to the woman first and engaged in a friendly chat. Thus, she gradually moved to the conversation on the 'Seven Points to Remember.' The ORW ensured two-way communication and invited queries from the woman, and thereby clarified if any. During the teaching session, the ORW also demonstrated how to measure water (half seer) in a household container and put a mark inside the container so that she could measure a half seer water accurately. Then the woman was asked to prepare *LGS* herself. Lastly, the ORW used to review main points of the session to make sure that she fully understood the "Seven Points." During teaching, the ORW used a flip chart containing pictorial illustrations of all the points. At the end of each session, the ORW used to record the village, the *para* (cluster of household), the woman's name and the name of the household head in her diary given by BRAC. This helped identify the woman for post education follow up. Each home visit took 30-35 minutes enabling an ORW to cover 8-10 households a day.

By 1986, about one-third of the rural households was taught through one-to-one teaching method. This helped develop a congenial atmosphere towards female workers' mobility in the villages since news of the programme reached many opinion leaders in the uncovered areas. At this stage, the mode of teaching was changed and instead of one to one teaching at a time, the ORWs started group teaching. The approach created an interactive environment among the participating women for quick learning. Even the learners in the session helped each other to learn. Moreover, the teaching cost reduced by half without affecting the quality of the programme (Chowdhury et al. 1988). An ORW then taught about 20 women a day.

**2.4 Quality control:** A two-tier mechanism was in place for quality control viz; i) ongoing monitoring system, and ii) operations research and evaluation.

**2.4.1 Monitoring-** There was an in-built monitoring system run by the programme itself by involving separate monitor teams. The Area Managers directly supervised these teams. The monitors visited five to ten percent of the households already taught by the ORWs at least one month earlier to assess the core issues of ORT teaching: a) how well the taught women remembered the Seven Points, b) the skill and accuracy of these women in preparing the *LGS*, and c) use of *LGS* in diarrhoea episodes in the last two weeks. The monitor collected a small sample of solution in a screw-cap vial. The samples were analysed for chloride concentrations in the field laboratories and ten percent of them (as analysed in field lab) was analysed for sodium, potassium and glucose at the laboratory of the International Centre for Diarrhoeal Research, Bangladesh (ICDDR,B). Each woman monitored was graded according to her answer on the seven points on a score of ten and her ability to prepare a correct solution. The women who could remember all the seven points and prepare correct *LGS* were given A grade; grade B means that an woman scored 7-9 points and prepared the *LGS* correctly; grade C means that she scored less than 7 points but still could prepare the *LGS* correctly; and grade D means that she failed to make correct *LGS*. Based on this grading, the ORWs received incentive salary (Taka 4 for each visited household in grade A, Taka 2 in grade B, Taka 1 in grade C, and none in grade D). This means that an ORW did not get remuneration if the mothers she taught failed to make the *LGS* correctly. The main purpose of such incentive salary system was to ensure the quality of the teaching programme.

**2.4.2 Operations research and evaluation-** The Research and Evaluation Division (RED), an independent wing within the BRAC continuously conducted a number of studies to improve the programme quality to a further extent. Many research findings were used in programme development. For instance, male contact was introduced to win the support of the male, efforts were made to dispel doubts about ORWs' intentions, seven points were revised to accommodate people's perception on diarrhoea, group teaching was introduced, etceteras.

**2.5 Male contact-** Males play a predominant role in family decision-making in Bangladesh. So unless they are convinced it would be difficult to popularise the ORT. In the early days of the programme the males were not taken into confidence. Therefore, later, BRAC used a number of fora to win the support of the males.

**2.5.1 Village doctor meeting-** Huge village doctors involved in healing practice are very popular to the villagers. To develop their positive attitude towards *LGS*, BRAC workers arranged meetings with them to disseminate the ORT messages.

**2.5.2 School meeting-** BRAC organised meetings in primary and high schools, and madrashas and taught seven points to the teachers and students. Most of them became active promoters of ORT in their own homes.

**2.5.3 Mosque meeting-** Each village has a mosque led by clergies who have influence in moulding people's opinion. BRAC arranged meeting on Friday congregation and got convinced the people by the clergies so that they use *LGS* in diarrhoea.

**2.5.4 Village bazaar-** The BRAC workers organised meetings in different haats/bazaars where people assembled for shopping.

**2.5.5 Patient demonstration meeting-** During teaching ORT at household level, the ORWs and Programme Organisers used to search for diarrhoeal cases and treat them with *LGS*. The POs used to follow up the cases on the following day. They organised meeting in the respective villages along with the cured patients. This directly helped develop people's confidence on the efficacy of *LGS* leading to an increased usage.

**2.5.5 Other fora-** The male workers contacted the people individually wherever possible.

**2.6 Print materials:** BRAC also developed and produced a variety of print materials, which included posters, leaflets, and flip charts. The latter one was used by the ORWs in teaching sessions while the others were distributed in villages.

**2.7 Billboard-** BRAC installed billboards with core messages on ORT in suitable locations of the country.

**2.8 Radio and TV:** BRAC aired a number of messages on diarrhoea and its home management through radio and TV. The most important benefit of this drive was that it gave credibility to what the ORWs and other workers had been trying to tell the villagers through house-to-house visits.

**2.9 Influencing policy:** The Bangladesh government has its own programme on ORS packet promotion, which was to mix in one litre of water. But BRAC one was to mix in a half seer of water. However, to make it uniform the government accepted the standard of half seer for Bangladesh and produced half-a-litre packets. All the commercial producers also followed the standard.

**2.10 Training:** All the workers were properly trained before being sent to the field. Besides, refresher training were organised quarterly.



**2.11 Reinforcement:** The ORWs taught the mothers following the 'reach, teach and leave' method. Later BRAC introduced reinforcement teams who repeated the ORT messages while visiting villages for imparting education on immunisation and vitamin A.

**2.12 Supervision:** A team coordinator who was one of the two male members of the ORW team was responsible for primary supervision. He was accountable to the Area Manager. The Programme Manager from the Headquarters oversaw the whole programme with the help of Regional Managers.

### **3. Some results**

- 3.1 Coverage-** The programme visited about 13 million rural households out of approximately 15 million.
- 3.2 Knowledge retention-** Study carried out in 1993 (Chowdhury et al. 1997) revealed that over 70% of the mothers could prepare a chemically 'safe and effective' ORS. A significant number of these mothers were very young at the time of the mass campaigns using house-to-house teaching, implying an intergenerational transfer of the knowledge on ORT.
- 3.3 Use of ORT in diarrhoea-** Any form of ORT use rate in all types of diarrhoeal episodes was more than 50%. When considered the severe or watery diarrhoea about 83% episodes were treated by ORT (Chowdhury et al. 1997).

### **4. Major lessons learned**

- 4.1 It is very much effective to disseminate messages to the grassroots people through interpersonal communication.
- 4.2 NGOs can implement nationwide programme.
- 4.3 Mothers irrespective of their literacy have ability to learn development information.
- 4.4 Flexibility in planning and implementation improves programme's effectiveness. Such a provision helps redefining the programme target and strategies as and when necessary.
- 4.5 In-house research is useful for programme development.
- 4.6 Peoples' participation in developing messages vis-a-vis methods of communication can play a critical role in programme's success.
- 4.7 Monitoring and follow up are important for a successful communicative programme.

## 5. Some tips for the Pesticide Association of Bangladesh

Capitalising the above experiences, the PAB can launch interventions to raise peoples' critical awareness on the entirety of pesticide so that they can handle the pesticides safely and thereby can prevent environmental hazards. In doing so, the PAB should proceed step by step:

- 5.1 Development of new messages or modification of the existing ones is necessary to accommodate people's perceptions, culture and belief system. The messages should be culture-sensitive, concise but comprehensive, acceptable and easily understandable.
- 5.2 Community trial by involving the villagers is essential in developing messages, and methods for dissemination. Since multiple stakeholders are involved in the mechanism of pesticide delivery and use, uniform messages and method of communication may not be useful.
- 5.2 The community level extension workers of the government and dealers may be used as nucleus for communication with the grassroots people. They should be trained to communicate effectively using different-fora.
- 5.3 Continuous in-built monitoring is a key to the successful dissemination of messages. Moreover, periodic research by third party is essential to track the communication goals.

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## **Appendix A**

### **Seven Points to Remember**

#### **1. What are Dud Haga, Ajirno, Amasha, Daeria or Cholera and their bad effects?**

Dud haga, Ajirno, Amasha, Diarrhoea or Cholera etc. are all characterised by loose motion. With each loose motion salt and water drain out from the body. If this draining out of salt and water continues for sometime, the body becomes dehydrated. Severe dehydrations mostly lead to death. So, necessary steps should be taken in time in the case of Dud haga, Ajirno, Amasha, Daeria and Cholera.

#### **2. Symptoms of dehydration**

In dehydration, patient develops certain signs i.e., sunken eyes, dry tongue, thirst, sunken fontanelle (in the case of a child), severe weakness, reduced urine, etc.

#### **3. Simple management of loose motions**

The simple management of dehydration is the replacement of salt and water lost from the body. Remember, patient dies of dehydration (loss of salt and water). So, whenever a patient gets Dud haga, Ajirno, Amasha, Daeria or Cholera, give oral saline from the very onset of the disease or immediately after the first loose stool.

#### **4. Preparation of oral saline**

Oral saline is prepared with a three finger pinch (upto the first crease) of lobon and one fistful of gur in half a seer of drinking water, well stirred. Care should be taken to mix lobon, water and gur in right proportion. A fistful of (refined) sugar can be used if gur is not available.

#### **5. Administration of oral saline**

Adult patient should take half a seer of oral saline at a time after each loose motion. Children should be given only as much as they want, but at frequent intervals. Once saline is prepared, it may be kept 4-6 hours only.

#### **6. Advice on nutrition**

During Dud haga, Ajirno, Amasha or Daeria, the patient should be given a plenty of water and foodstuffs like rice, curry along with oral saline. In the case of children, breast-milk/normal diet should be continued. Increased amount of food should be given at least for 7 days after recovery. This will prevent malnutrition and weakness of the patient.

#### **7. Prevention**

To save ourselves from this disease, we should drink tubewell water. In case tubewell is not available, water from other sources should be boiled and then cooled before use. Rotten food should never be eaten. All foodstuffs should be covered well so that flies cannot sit on them. Hands and mouth must be washed by soap or safe water before eating. Hands should be washed by soap or ash after return from latrine and even after cleaning the babies after defaecation. Remember that breast-milk is harmless. Children put to breast immediately after birth and breast-fed continuously rarely have Dud haga.