# ORT And The Credibility Gap

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Late 1982 and early 1983 saw the launching of massive publicity on the theme of oral rehydration therapy (ORT), timed with the release of the UNICEF report on the **State of the World's Children** (1983). Since then the press has been flooded with news items and feature articles on ORT the 'miracle cure' for preventing dehydration and diarrhoea deaths, with potential to revolutionise the child health scene. The print media continue to give coverage to ORT, faithfully quoting the statements of WHO, UNICEF, ICMR etc., as well as reporting on various conferences, seminars and workshops across the world where ORT is being talked about with enthusiasm. UNICEF's 1984 report on the world's children has re-emphasised the ORT angle.

So why, one might well ask, one more 'paper' on ORT? Is there anything left to say about ORT that has not been said already, and continues to be said at regular intervals in various forums?

This counterfact is **not** about 'ORT the miracle cure'. It will instead attempt to list the reasons why the miracle has so far failed to take off on quite the scale expected of it. Clear proof of this is seen in the innumerable news items on the continued and unabated occurrence of deaths due to diarrhoea, gastroenteritis and cholera. These news items appear with the same unfailing regularity as the items on ORT workshops and seminars. It is not that ORT does not work. But it is undeniable that **ORT is not being made to work.** (See Box A and B). The dysentery toll in West Bengal this year is the most eloquent proof that ORT theory has not yet become large-scale practice.

What inhibits the miracle from being put into use? What are the lessons from the field? What are the controversies and politics which hamper ORT promotion? This counterfact seeks to compile relevant, available information on these aspects, with an appeal to health and consumer groups to lobby for action on these specific issues. (The precise physiological details of glucose-induced sodium absorption, the mechanics of ORT, how the sugar-and-salt drink is prepared etc., will not be described here. There is no need at this stage to explain ORT or prove it works.)

In 1981 an article in **The Lancet** (September 19) on 'Oral Therapy for Acute Diarrhoea' began by referring to the first controlled clinical trials of ORT which had demonstrated its efficacy. These trials had been done **as long ago as 1967.** Which means an almost sixteen-year gap between the discovery of ORT and its eventual 'newsworthiness'. Admittedly the WHO has been recommending ORT for diarrhoea management since the late seventies but who, to put it very mildly, reads WHO documents? If the time lag between the discovery of a miracle and

its large-scale publicity is remarkable, even more amazing is the still persisting lag between theory and practice. Or perhaps, not so amazing after all, when one views the ORT issue against the politics of health care, attitude of both doctors and patients, the role of the drug companies, and the apathy of governments.

UNICEF's 1984 report on the **State of the World's Children** stresses at the very beginning the need for a 'social breakthrough' if ORT potential is to be achieved :

"Oral rehydration therapy (ORT), for example, can in **theory** save the lives of most of those five million children who now die every year from diarrhoea-induced dehydration. But if only 10-20% of children are in contact with modern health services, then many other channels will have to be used to put the ORT breakthrough at the disposal of the majority. And the fact is that ORT — which **The Lancet** describes as **potentially the most important medical breakthrough this century** — will **not** reach more than a small proportion of the children who need it, unless it is also promoted through primary schools and colleges; through the churches and the temples; through the women's nutrition classes and the work-place; through the water engineers and the extension workers; through the transistor radio and the press; through the television and the video recorder; through the centres of culture and entertainment; and through every other channel which can reach out to link present knowledge to people's needs."

In other words, UNICEF has called for the sort of media blitz which the Indian government at present reserves only for pushing the family planning message.

The UNICEF report quotes several examples from Latin America and the Carribean which used intensive radio, television and press campaigns combined with door-to-door and face-to-face counselling, successfully promoting ORT in the same hard-sell fashion normally associated with commercial products. And yet, other examples in the same report have shown that if media and educational efforts are not actively supported by persuasive advocacy from senior health professionals, such campaigns will not carry conviction. In one instance in Egypt, an ORT promotion drive failed precisely because the young women recruited to teach ORT 'lacked credibility'. Evaluation of the campaign further revealed that local doctors took no part in spreading the ORT message.

Thus, although ORT may be the simplest technology in medical history, ORT promotion is a complex issue with many facets which need to be understood individually as well as viewed in totality. Some of the questions involved are discussed below .

## Do Doctors Believe in ORT?

Commenting on the WB dysentery epidemic this summer, the Drug Action Network newsletter (Voluntary Health Association of India) quotes Dr Sameer Chowdhury of the Child-in-Need Institute, Calcutta. Dr Chowdhury, who assisted the state government in organising the health education

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BOX A

## No access to ORT

About 1.5 million children under five years old die each year in India as a result of diarrhoea, according to a UNICEF report released this September, entitled **An Analysis of the Situation of Children in India.** The report expresses shock at the fact that 60 to 70 per cent of deaths due to diarrhoea are caused by dehydration which can be avoided by prompt and adequate rehydration at an early stage. That access to this simple remedy is limited is clear from the fact that an estimated 2,500 children in the country die of dehydration each day.

The packets of oral rehydration salts distributed by the government through its network of hospitals, primary health centres and village health guides are inadequate to meet the need. A study by a team of scientists of the Christian Medical College of Vellore has shown that the composition of the ORS packs does not conform to the standard prescribed by WHO and UNICEF.

(From a news report in **The Hindu,** Sept 14, 1984)

BOX B

## Selling the ORT message

"Why is this not a sensation?" asked Liv Ullman recently of the oral rehydrations salts which restore the body's essential fluids and electrolytes to people critically dehydrated by diarrhoea. Speaking on behalf of UNICEF, the actress said : "ORS is simple. It is cheap and can save thousands of lives each day. Why is it not on all the front pages? Why are all the people involved in this not Nobel Laureates? If this had been a cure for cancer, for something rich people suffer from, my God there would be nothing else on TV!" (Quoted by the VHAI newsletter from **World Development Forum,** January 31, 1984.)

To this may be added a suggestion made in all seriousness by a medical scientist formerly associated with an ICMR institute : "Instead of all the money now being spent on organising ORT seminars, one short film featuring, say, Hema Malini, making the rehydration drink for an Amitabh Bachchan suffering from a stomach upset would not only reach out to the masses, but effectively sell the message."

aspect during the epidemic, "was asked repeatedly by unconvinced doctors to give medical proof about the efficacy of ORT." He found medical professionals **the most resistant** regarding use of ORT. The newsletter comments : "Ignorance among medical professionals about one of the simplest yet most important medical technologies is inexcusable." There is a poignant irony in the fact that West Bengal is one state with ready access to three premier institutes where many an ORT seminar must have been organised in the recent past : the All India Institute of Hygiene and Public Health, the National Institute of Cholera and Enteric Diseases, and the School of Tropical Medicine. Across the border in Dhaka is the International Centre for Diarrhoeal Disease Research. And ORT theory seems to remain within these ivory towers of knowledge.

The **Pune Journal of Continuing Health Education** has been repeatedly focussing on ORT to persuade doctors to adopt the therapy in diarrhoea management. Here is a quote from the editorial of issue No. 64 (November 1983) :

"Indian children are really unfortunate as far as the disease diarrhoea is concerned. They are not receiving rational and scientific treatment from pediatricians and general practitioners. We have screened several hundred prescriptions from various parts of the country and have come to this conclusion. Instead of using ORT as a basic treatment, they are unnecessarily preferring gun shot therapy of antibiotics, kaolin, pectin, I.V. fluids. Lomotil etc. This increases the cost of medication and delays the cure."

The same issue of the Pune journal has a letter from two medico-social workers engaged in promoting ORT in the villages around Pune, who write of the "strange paradox" they are facing. On the one hand they have been exposed to a great deal of WHO and UNICEF literature on ORT, and have tried persuading local health workers to adopt ORT in diarrhoea management. However, the health workers point out that when the diarrhoea cases go to the local doctors the latter make no mention of ORT. When the health worker's advice is not backed by the higher-ups in the medical hierarchy, the credibility of ORT efficacy is seriously undermined.

One reason for the neglect of ORT by doctors is attributed to the lack of emphasis on ORT in medical curricula. Dianna Melrose's example from Bangladesh (**Bitter Pills : Medicines and the Third World Poor,** Oxfam 1982) appears to be appreciably true of India. Quoting Dr K.M.S. Aziz of the International Centre for Diarrhoeal Disease Research on the subject of medical education and ORT, Melrose writes : "Throughout five years' training not a single lecture is devoted to appropriate non-drug treatments for diarrhoea although diarrhoeal diseases account for one-half of the country's illness. It is hardly surprising that these doctors prescribe expensive anti-diarrhoeal drugs and rarely encourage oral rehydration."

Which brings us logically to the next question.

## ORT Vs. Irrational Antidiarrhoeals

It follows inevitably from the above facts that no educational ORT drive can succeed unless preceded by the education of doctors. Nor can ORT promotion make much headway without a simultaneous campaign aimed at both doctors and the general public on the irrationality of drug treatment for the most common viral diarrhoeas.

The eighties have seen spirited campaigns by health and consumer groups in many countries against the use of harmful drugs as antidiarrhoeals. They have stressed the dangerous side-effects of some of these drugs as well as the fact that these drugs have **not** been shown to be effective except in some specific diarrhoeas caused by bacteria or certain other parasites. The message they have tried to spread is that the common viral diarrhoeas don't need drugs, they only need ORT; even cases which need drug therapy, primarily need ORT for fluid replacement with drug therapy initiated only after stool examination has confirmed the causative factor. However, activist groups can neither reach out to the vast majority, nor can they carry conviction in the face of the ominous silence on this issue from the medical Establishment. (See also Box C).

Clearly, any strong public statement on irrational antidiarrhoeal drugs will meet with stiff opposition from the powerful drug industry. One seriously wonders if this is the reason why WHO, UNICEF and other major rational medical bodies, which are vocal on ORT, make no reference to irrational drug therapy when they talk about ORT. And yet, it is not as though WHO advocates drug therapy. It just doesn't condemn it as publicly as it calls for ORT promotion.

The April 1982 issue of **World Health**, the WHO journal, has an article on 'Traveller's Diarrhoea', which strongly advocates oral rehydration : "In most cases maintaining a high fluid intake, preferably with an oral rehydration mixture, is all that is needed until the diarrhoea stops. There is no evidence that drugs play much part in curing travellers' diarrhoea except under specific conditions. This is a rather controversial area, since a vast number of commercially available 'anti-diarrhoeal agents' are on the market. It is doubtful whether any of these really cure diarrhoea although they may temporarily reduce its severity and relieve symptoms. Antibiotics are of value only in cholera, frank dysentery due to shigellosis or amoebiasis. There is also a specific drug for giardiasis. There is little evidence that any other preparations or combinations are useful." WHO's message to travellers is clear : keep oral rehydration packs handy. This is because when people are travelling and eating out, diarrhoea is an unpleasant possibility and so they tend to keep anti-diarrhoeal drugs handy. (Ciba-Geigy's hoarding in Lagos was specifically promoting Enterovioform as a 'must' for travellers — an example of a strictly restricted prescription drug in the West being advertised to the general public in an African country) (**South**, August 1982).

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BOX C

## Politics of oral rehydration

"Sudan's National Health Programme estimated the cost of oral rehydration fluids needed for 1984 at £529,800. The cost of an equal volume of intravenous fluids was a massive £53.3 million. One estimate suggests that the cost of providing sufficient rehydration mix for treating all cases of diarrhoea in the world's 1,000 million children under five years old would be $300 million. This may seem high but it is scarcely half of one per cent of the world's spending on pharmaceuticals. It is difficult to imagine a more efficient medicine, nor one that has waited so long to be found ... A huge leap has to be made between developing an efficient, efficacious remedy and seeing it applied where it is needed. Oral rehydration mix is no exception. One problem, particularly for those who want to see the mix used by parents at home rather than dispensed by health workers in clinics (where children often arrive too late to be helped) is that parents in poor communities do not regard diarrhoea as anything abnormal. But there are others who see that the drug-and-intravenous-needle-oriented education of the doctors who decide policy on these matters as the main obstacles to its use. In too many communities, oral rehydration mix is just one more remedy competing in the market with Lomotil and Entero-Vioform and the rest. It will be tough competition because no one stands to gain by selling the mix. No one except those 1,000 million children."

From **The Health of Nations : A North-South Investigation** by Mike Muller, Faber and Faber, 1982

The question is : how many members of the lay public have access to the impeccable information in **World Health**? Why aren't these facts disseminated by WHO through the mass media along with the press releases on ORT?

In 1982 the Medico Friend Circle launched an anti-diarrhoea campaign, promoting ORT and publicising a study by Dr Shirish Datar who found that of the 48 drugs listed as antidiarrhoeals in the prescribers' guide, **The Monthly Index of Medical Specialities** (MIMS), only four are scientifically justified for use in certain specific instances only. The campaign also stressed its finding that the commercially sold brand-name ORT packs do not conform to the WHO formula and are exorbitantly priced (On this, more later.)

To this I may add a little postscript : if you look up these brand-name ORT packs in the November 1983 issue of **MIMS**, you will find that they are not even listed in the section containing "anti-diarrhoeals," but are tucked away in the 'Nutrition' section among the 'tonics and mineral additives' !

In June 1983, the MFC and four other health groups wrote to the Drug Controller of India that their efforts at ORT promotion were being seriously thwarted by the continued reliance on drug treatment by both doctors and patients. (Over-the-counter sale of anti-diarrhoeals is widespread.) The activists had two demands : 1) A ban on all irrational and harmful drugs being sold as anti-diarrhoeals, beginning with the many brands containing a combination of chloramphenicol with streptomycin. 2) A statutory recommendation printed on **all** products sold as anti-diarrhoeals to the effect that ORT is a must in all diarrhoea cases, with pictorial instructions in regional languages on how to prepare the rehydration drink. So far there has not been any response to the demands. It is high time the authorities recognised that promotion of ORT and publicising of the irrationality of drug treatment in diarrhoea are two sides of the same coin.

## Do Patients Believe in ORT?

Doctors who do try to promote ORT report that lack of confidence among patients in non-drug therapy is a major problem. For example, one young doctor says he can get his patients to try ORT only if he also gives them a placebo in the form of a vitamin pill. Another doctor feels that patients appear to accept the packaged ORT salts more readily than the pinch-of-salt-and-scoop-of-sugar, the former having an aura of 'sophistication' akin to packaged medicine while the latter seems too simple — a first-aid home remedy rather than 'modern' medicine. Inevitably it becomes convenient for many doctors to blame patients for not accepting ORT and to continue prescribing irrational drugs on the excuse of giving patients 'what they want'.

ORT acceptance by patients calls for unflagging commitment on the part of doctors. Dr A.R. Patwardhan of the Arogya Dakshata Mandal writing in the Pune journal (June 1984) says that over the past four years, after reading much about ORT he has been implementing it in his general practice. He explains that when he first tells patients that he will not give any medicine for diarrhoea but will only prescribe ORT, they find it hard to accept. Initially they are not receptive to his explanation that most anti-diarrhoeal drugs are useless while some are positively harmful. It takes effort to convince them and get them to co-operate in administering ORT to their babies. When they see for themselves that it works they begin to have faith in the therapy. But without 'patience and motivation' on the part of the doctor, patients may not be willing to give ORT a try.

## Home-Remedy or Packaged ORT?

The debate on this continues with much to be said on both sides (Box D). However, it is argued that in many Third World villages even basic ORT ingredients like sugar or jaggery are beyond the reach of the poorest sections. (The efficacy of rice water as a substitute for the sugar-and-salt solution needs to be known more widely (Box E). However, according to a joint WHO/UNICEF) statement (1983), the number of ORT packs currently produced round the world is only enough for about 2% of all episodes of diarrhoea. It has therefore been stressed that the correct and early use of the home remedy should be taught whenever the packaged salts are not available. Further, even if the packs are available people need to know they must start the home remedy

as soon as diarrhoea strikes and not wait until they can procure the packs from the health centre. Thus, great flexibility is needed in deciding the content of ORT campaigns, the challenge being to identify correctly which option is appropriate in a given situation and to promote the more feasible remedy. (Box F).

## ORT And The Elite

One fall-out from the current media focus is the widely prevalent notion linking ORT with 'poverty' and 'childhood'. Because it has been publicised as the miracle which will revolutionise child health in poor societies it is being assumed that ORT is a poor-man's-remedy for dealing with children's diarrhoea. This is a sub-conscious concept even though it has nowhere been stated that ORT is not appropriate for adults or that it is not good enough for the rich. However, the consequence to this is the attitude that those who can pay the costs of 'sophisticated' medicine need not adopt ORT ... implying thereby that ORT is a sort of second-best cure meant for those who can afford nothing else. Such an attitude cuts both ways. It makes the rich cling to irrational drug therapy while stimulating the poor to emulate the rich.

Mike Muller puts it well in **The Health of Nations** (1982) : "In this two-tier world, the extravagance of the uncontrolled market for the rich would be a permanent advertisement for the multinationals, a goal to which the poor might aspire. The poor peasant farmer will not believe that the basic drugs he gets from the health centre are as good as or better than the expensive vitamin tonic which the prosperous village shopkeeper claims is the source of his well-being. The washerwoman from the squatter shanty town will not believe that her child's diarrhoea is best treated with sugar and salt when the family for whom she works in the suburbs gives three different tablets to their children when they are ill."

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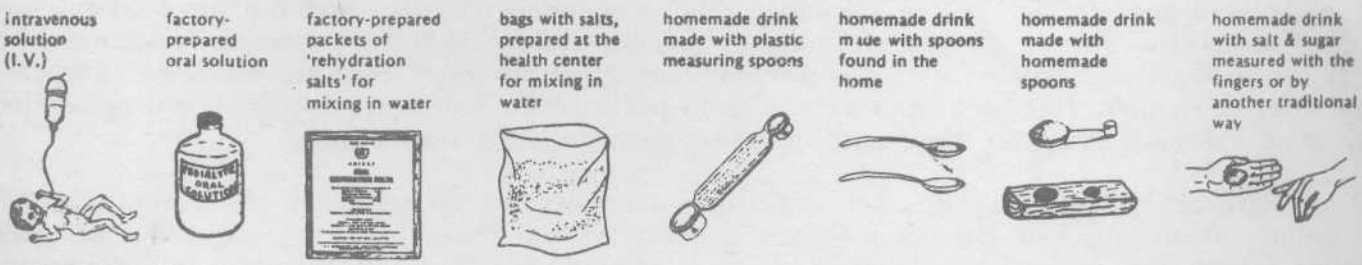
BOX D

## Dependence vs. self-reliance

### A RANGE OF REHYDRATION METHODS FOR CHILDREN WITH DIARRHEA




**MORE DEPENDENCY** — control in the hands of institutions and professionals

**MORE SELF-SUFFICIENCY** — control in the hands of the family

#### ADVANTAGES AND DISADVANTAGES

- Control and responsibility mainly in the hands of professionals, institutions, and drug companies
- Measurements more precise and 'controlled' (at least in theory)
- More magical; acceptance may be quicker but with less understanding
- More dependency—on high technology, on outside resources, on centralized services, and on local and international politics
- More expensive
- Easier to gather data on, and prepare statistics about
- Reaches fewer people; supply often uncertain and inadequate
- Sometimes causes delay in treatment, because special materials have to be obtained; effect is more curative than preventive
- Focus is on materials and supply (so cost goes up each year)
- May give better (safer) results for individuals treated in time, but has worse results overall since many children never receive the liquid, or are given it too late

#### ADVANTAGES AND DISADVANTAGES

- Control and responsibility mostly in the hands of the family
- Measurements less precise, less 'controlled'
- More practical and easier to understand
- More self-sufficiency; uses local resources (whatever is available in the home or in stores)
- Cheaper
- Harder to gather data on, and prepare statistics about
- Reaches more people; supply is local and almost always available
- Treatment can begin at the first sign of diarrhea; more preventive than curative
- Focus is on people and on education, so the people's capacity for self-care increases over the years (cost goes down)
- May be less safe in individual cases due to the possibility of errors in preparing or giving it, but it probably saves many more lives—since it reaches more children more quickly

Source: 'Helping Health Workers Learn by David Werner and Bill Bower

BOX E

## Life-giving rice water

"Probably the best thing that has happened regarding ORS is the acceptance of the findings of Prof. Wong Hock Boon, a pediatrician from Singapore who has been advocating the use of rice water (kanji) for rehydration of babies.

The stopping of diarrhoea could be because the starch-sugar in the rice water draws out less fluid into the gut-lumen as compared to glucose. The other reason could be that the starch in the rice water is more easily digested by babies than simple sugars. A little salt may be added to take care of sodium losses. Studies done by the International Centre for Diarrhoeal Disease Research, Bangladesh, have also indicated the therapeutic value of rice water for effective rehydration of diarrhoea cases.

For rice-eating communities this would be a real boon specially with the ever-increasing price of sugar and difficulty in obtaining cleanly prepared, unadulterated jaggery. A point to be noted is that for ages, illiterate mothers in many areas have been giving rice water to their children with diarrhoea. According to David Werner (author of **Where There is No Doctor**), women in Mexico have been giving rice water to children with diarrhoea. This is even when rice is neither the staple diet of Mexicans nor even one of the cereals commonly used.

Rice is the staple food of 60% of the world's population, hence the availability and acceptance problem is easily overcome. Since rice is cooked at least twice a day, the rice water obtained from it costs no additional money to buy ORT constituents. Since it is already boiled, no extra effort or fuel is required. Since it is boiled for a length of time it is safe from contamination."

From **Health for the Millions,** October 1982

## MNCs And ORT

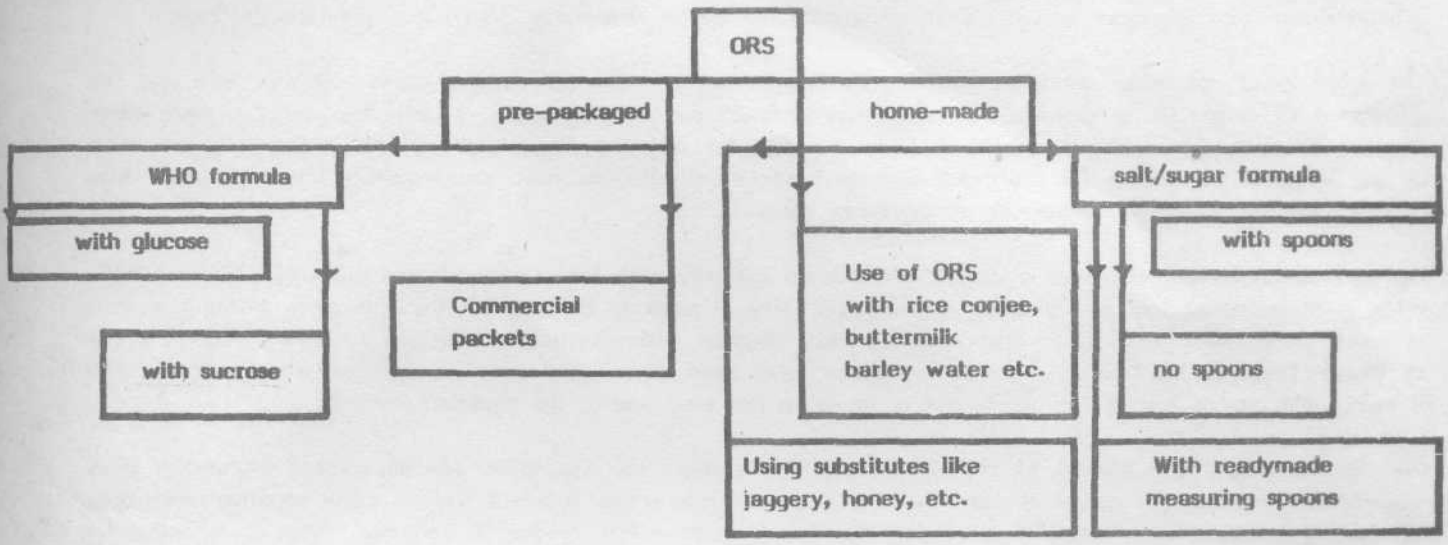
It has already been pointed out that commercial brand-name ORT packs are exorbitantly priced and also do not conform to the simple basic WHO formula. In India there is evidence that these brand-name 'electrolyte' packs are being consumed by the middle-class for 'providing stamina' on hot thirsty days when profuse perspiration causes a feeling of fatigue. Dianna Melrose's example of Searle's promotion of **Rehidrat** sachets in Sierra Leone offers an important lesson of what could be in store if hard-sell of brand-name packs begins in this country. The lushly packaged product is advertised as containing a 'special granule' to preserve its 'lemon-lime flavour'. It contains more glucose than necessary to make it 'more palatable'. The price of the product is about **16 times** the cost of preparing the standard WHO formula from basic ingredients. An obvious danger is that elite preference for 'lime 'n' lemoni' MNC brands could well result in the same pernicious effect as the present preference of the elite for irrational drug treatment rather than adopt the humble sugar-and-salt therapy.

Another related point is that WHO and UNICEF packs are mainly distributed through the health care system. If the general public, including the elite and the middle-class, is to be encouraged to accept straightforward ORT without any lemony frills, they too should have access to retail sale of standard ORT packs conforming to WHO formula and available at reasonable prices. Public sector production of 'generic' ORT packs seems to be the only safeguard against 'consumerisation' of ORT by MNCs. (See also Box G).

Some of the salient features of the ORT issue have been enumerated above to show that a dynamic multi-pronged effort alone can make some headway in spreading ORT practice. A number of informative 'lessons from the field' have been compiled in the next section from the quarterly journal, **Diarrhoea Dialogue.** Since 1980 the Appropriate Health Resources and Technologies Action Group (AHRTAG) has been publishing this journal from London with support from WHO, UNICEF and SIDA (Swedish International Development Authority.) This eight-page newsletter not only compiles the latest information on ORT and diarrhoeal disease but acts as a forum for ORT activists to share their experiences. Considerable light is thus shed on the factors which hamper ORT promotion as well as ideas on how to overcome them.

BOX F

## ORT Options




BOX G

## "Generic Packs": no simple answers

One of the major controversies surrounding ORT relates to the use of prepackaged ORS (oral rehydration salt) packets, prepared commercially or by organisations like the WHO ... Multinational companies have already been involved in the supply of ORS packs to UNICEF, WHO and USAID-funded programmes. With their large economies of scale they have been able to supply them at lower prices, inhibiting internal production and sales in Third World countries by national producers. This has been some source of embarrassment for governments as well as the international agencies. In Bangladesh, the offer by Gonoshasthya Pharmaceuticals to UNICEF for the production and distribution of ORS packets with adequate quality control was refused. Closer home, IDPL and other public sector enterprises are unable to supply adequate number of packets.

Hence if the decision is to be made in favour of the prepackaged formula, one has to fall back on one or more of a variety of unsatisfactory answers :

* Continue to buy from the multinationals, through international organisations like WHO.

* Ensure that national public or private drug companies produce ORS packets at reasonable prices in adequate quantities.

* Allow hospitals, health centres and community health programmes to produce low-cost packets locally.

In any case, without the motivation to ensure the use of oral rehydration the mere pressure of ORS packets on the market shelf would not mean much ... Switching over from doctor-drug-dispensary dependence to home-based ORT is a simple inexpensive first step towards revolutionary changes in social behaviour. A simple salt and sugar solution in the hands of a mother with continuous health education, backed by a balanced electrolyte solution in the hands of the health care provider is a viable and most effective way of reducing child mortality."

From 'Controversies in ORT', **Health for the Millions**, Oct/Dec 1983, special issue on diarrhoea

## Home-truths About ORT

The following collage of quotes from **Diarrhoea Dialogue** present an 'identikit' picture of the ORT scene :

** ***Science and Tradition :*** *Two health activists in North Yemen have found that mothers are more receptive to ORT when it is explained to them in terms of 'cleaning the stomach', since salt in that country has been traditionally associated with 'cleansing' properties. 'Scientific' description of 'fluid replacement' etc., does not evoke the same empathy. The activists point out that the basic objective is to inspire confidence in ORT and that the underlying reason for its acceptance is of secondary importance.*

** ***ORT Jingle :*** *In a mass media project in Honduras, ORT radio spots were broadcast to compete with other catchy jingles for commercials products. The ORT jingle, a 60-second song, became a nationally popular tune.*

** ***In the Rich World too :*** *Since 1979 the health care system in the German Democratic Republic has adopted ORT as a routine treatment for diarrhoea cases. Bulk production of a standard ORT pack has been introduced and is part of the official list of 'medicines'. A professor from a child health institute in GDR points out that his country's shift to ORT illustrates how "a practical treatment, developed to solve a problem in the Third World, can also be used very effectively elsewhere."*

** ***Apathy to ORT :*** *Commenting on the lack of emphasis on ORT in medical education and the absence of refresher courses for doctors unfamiliar with ORT, a doctor from Kenya writes that it often seems easier to set up an intravenous drip than explain patiently to a mother how the rehydration solution is made and given. Sometimes even if spoons are available it seems less of a bother to explain ORT in terms of pinches and scoops rather than the precise measurements. "This sort of experience with many medical workers explains our failures with ORT."*

** ***Setting an Example :*** *A letter from Uganda describes how confidence in ORT was promoted by an enthusiastic professor in a teaching hospital. Mothers in the wards were taught ORT through vigorous demonstrations at health education sessions. Not only the mothers benefitted, "but also another very important target group — junior doctors and medical students." Through the campaign they learnt that people's participation as well as active involvement by doctors are necessary for ORT acceptance.*

** ***For Adults Too :*** *To a query from a doctor in the Fiji Islands on whether ORT is appropriate for adults, the editors reply : "This letter demonstrates the need to spread the ORT message more widely and more clearly. Anyone who has diarrhoea needs early oral rehydration therapy regardless of age or size. Because dangerous dehydration occurs so quickly in small children they must be the first to benefit from the special UNICEF packets. The formula also works for adults but they can, as an alternative, be advised to drink large amounts of water to which glucose or sugar and a little salt has been added."*

** ***Danger of Complacency :*** *There is a very distinct danger that enthusiasm over ORT may detract attention from the more fundamental objective of* ***preventing*** *diarrhoeal infection. A* ***DD*** *editorial sounds a timely warning : "Rehydration therapy alone is not enough. Getting fluids into people, especially children, early enough will save lives but will not stop diarrhoea recurring unless the causes of the problem are looked for and dealt with appropriately." (Sanitation, safe water supply and public hygiene were three measures which controlled the incidence of diarrhoea in the developed nations long before ORT was discovered. Dr Ashok Mitra's comment on the WB dysentry toll is significant (See Box H)*

** ***Tailpiece :*** *The editorial in the August 1983 issue of* ***DD*** *comments : "It is a sobering thought that fizzy drinks and cigarettes seem to reach the remote places when letters to* ***DD*** *suggest that packets of oral rehydration solution or even simple home ingredients for home-made oral rehydration fluids are not always readily available." To which a WHO official replies in the February 1984 issue : "Maybe the producers of 'fizzy drinks and cigarettes' could be asked to help in the distribution of ORT packs as part of their contribution to Health for All by the Year 2000."*

BOX H

# News from a health centre

Bleaching Powder, oral rehydration packets, halogen tablets, ionzol, oral hydrate powder. It is a simple list of medicines and preventive accessories. If you happen to be in charge of a primary health centre or clinic in an area suddenly visited by bacillary dysentry, you know what your responsibilities are. You want adequate stocks to be sent to you, pronto.

But suppose the supplies do not arrive, or do not arrive in time. Transport is bad, communications are difficult it takes you a full week to inform the nearest district centre of the outbreak of the virus. The district centre in turn will take perhaps another three to four days to let the State headquarters know. It is a highly centralised arrangement and you are not always left with enough funds for such a contingency.

Meanwhile the epidemic spreads. In the course of a single week there are nearly two thousand cases of attack, of which as many as fifteen hundred concern children below the age of three. Your clinic can accommodate only six patients at a time. The district hospital is some 25 miles away, its capacity does not exceed sixty and the demand on its facilities comes not just from your area.

So what do you do as you wait for an ample supply of drugs and medicines and preventive detergents? You have one pharmacist and one nurse to assist you and a bicycle to pedal on. As the patients begin to come in, you pile two to each bed. Often you arrange for three kids to be next to each other sidewise along the narrow hospital cot. But however much you stretch your facilities you cannot accommodate at any given time more than fifteen. In the course of the week five of them die.

The area has been affected by drought for three successive years. As a result the water level has gone down precariously. The tube-wells have run dry. The villagers cannot afford to be choosey. They drink water from the ponds which also serve as lavatory and laundry. And this year the bacillus shegilla has butted in, dysentry has assumed a virulent form and contamination has spread rapidly.

Even as you wait desperately for the bleaching powder and the rehydration and halogen tables to arrive, you drop by on the villagers. You advise them to wash their hands and cleanse their face before meals. You advise them to boil the water they drink. Sound advice, impeccable advice. But you know and the folksy villagers know the futility of such advice. Not one in a hundred households can afford to use either toilet or washing soaps. And pray, how are they supposed to boil the water? They need fuel. Fuel is scarcer than food grains. Boiling the water is yet another luxury the villagers cannot afford.

This defines the human conditions for millions of South Asians spread over perhaps a dozen countries. The doctor at the primary health centre is of a non-philosophical bent of mind. He cannot arrange for the boiling of the water. He himself boil inside. He knows it takes another four or five days for the bleaching powder and re-hydration tablets to arrive. He pushes out the cots from the health centre, piles them in a corner, creates extra space and makes his patients, whose number now exceed thirty, occupy the makeshift beds on the floor itself. Even as another patient dies, he leafs through the worn out glossy American magazine and reads of the donation of a further 500 million dollars foundation grant for medical research to a New York hospital. The news excites him no end.

- Ashok Mitra,
From **The New Internationalist,** July 1984

The CED health cell specializes in documentation and dissemination on health issues. Earlier issues include: Abuse Of Female Hormone Drugs, Bleeding For Profit, Injectables: Immaculate Contraception?, Health And The Work-Place, Asbestos - The Dust That Kills, Health Sans Multinationals: The Bangladesh Crusade and Pills For All.

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