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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
at the
"Celebrating 25 Years of ORT"
Conference

"ORT – Celebration and Challenge"

PAHO, Washington, D.C.
2 March 1994

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"ORT -- Celebration and Challenge"

It is not every day that we in the development community get together to celebrate. But here we are -- distinguished government representatives, international agency colleagues, public health experts, and many old friends -- celebrating the 25th anniversary of the discovery of oral rehydration therapy. ORT, a breakthrough described by The Lancet as "potentially the most important medical advance of this century." Faced as we usually are with so many formidable problems, many of which seem to defy solution, I think it won't hurt us too much if we revel a bit in this genuine success story that is now saving the lives of over a million children a year in the developing world.

Diarrhoea isn't something people worry about very much anymore in the United States. There is even an aura of taboo around the subject. Not long ago a colleague of mine reported getting strange stares from some of his fellow-commuters on the train to work one morning. It took him a while to figure out why, but then he realized it was simply because he was reading **Dialogue on Diarrhoea**, that excellent newsletter published out of London. Many feel it's a topic that isn't fit for "polite society". I myself have the unusual distinction of having been admonished by a Crown Prince for waxing eloquent over the potential of ORT at a State dinner.

Actually, we pay a high price for such attitudes. Complacency and ignorance about diarrhoea have led to unnecessary illness, widespread mistreatment, high costs to families and health systems in the rich countries, and, most tragically, the deaths of some 50 million children since 1980. Even in the U.S., it is estimated that children under five experience over 20 million episodes of diarrhoea a year, and between 300 and 500 of them die. Most of

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these deaths could be prevented, if timely rehydration were given at home and appropriate care made available at health facilities. The disease accounts for 3 million doctor visits and over 200,000 hospitalizations a year, or almost 10 per cent of all hospitalizations of children under five. The cost per treatment with IV is about $2,300, and many of these weakened children come down with other hospital-borne diseases. The annual price tag for not using ORT in this country comes to well over one billion dollars a year.

You may ask why ORT is so slow in gaining legitimacy outside of leading hospitals and paediatricians. Let me share an anecdote with you. At a luncheon before the opening of the first ICORT meeting, in June 1983, I remember that then-U.S. Surgeon-General C. Everett Koop told me it would take about 25 years for ORT to catch on fully in the States among hospitals and doctors, due principally to the traditional slowness of change in the medical field. Educating new doctors about the treatment, getting it into the medical journals and textbooks, changing practice in hospitals, clinics and pharmacies, all would take a long time -- far too long for the US to be a role model for the developing world. He remarked, however, that ORT could be popularized far more quickly if a magazine like Reader's Digest -- widely read by doctors and parents alike -- published an article about it just once a year for five years. And it's true: there's nothing like demand from below to shake things up and gets things moving. (And someone else commented at the time that ORT would catch on even faster if a paediatrician were successfully sued for malpractice after the death -- from another disease -- of a hospitalized diarrhoea patient who could have been readily treated with ORT at home.)

Something about ORT and its history satisfies the mind:

* First, the **simplicity** of the solution -- combining water, salt and sugar -- is matched only by the sophistication of the scientific knowledge that went into learning how the body best replaces lost fluids and absorbs nutrients.

* Second, there is something wonderful about a quest in which the hero travels the world over only to learn that the Holy Grail was back home, right under his nose, all the time: after all, the **ingredients of ORT can be found in most homes** -- not all, but most -- waiting to be combined to slay the dragon of diarrhoea.

* Third those of us with an appreciation of symmetry and a sense that history moves in cycles just love it that ORT was discovered by modern scientists in 1968 in Bangladesh and India, where something very close to ORT had been used as a highly-prized remedy in households at least **2500 years before**!

* Fourth there has to be some justice in the world when the solution to a major social problem turns out to **cost next to nothing.**

* And lastly, in our democratic era, what could be more democratic than ordinary people having the knowledge and the means to **take care of their own health**, and that of their babies?

In short, ORT is a brew that celebrates simplicity, traditional wisdom, modern science, cost-effectiveness, and the democratic impulse -- all at once. Now if that doesn't describe a miracle -- or at least a "miracle in the making" -- I don't know what does...

Back in the early and mid-1980s, when we were launching the Child Survival and Development Revolution based on GOBI, I was sure that because of all the advantages I've just enumerated, it would be the "O" in GOBI -- oral rehydration -- and not the "I" -- immunization -- that would quickly catch on and take off. After all, ORT didn't require the production of large quantities of fragile vaccine or the creation of long cold chains reaching into the hinterlands of the developing world. All it required, it seemed, was doing a good job of spreading the word about the remarkable efficacy of ORT, and soon, mass deaths from diarrhoea would begin to be a thing of the past.

But it didn't turn out that way. It was immunization that caught on and took off, and in less than a decade coverage went from under 20 per cent to fully 80 per cent of the world's children. And yes, that was the occasion for another rare celebration -- on 8 October 1991 -- when Dr. Nakajima and I certified to the Secretary-General of the United Nations that the UCI goal had been reached. The greatest global peacetime collaboration had been a success. It was UCI that demonstrated, conclusively, the potential for reaching every last human being with the benefits of modern science and medicine.

Though it has been slow to catch on, ORT has not been a disappointment; not at all. From almost zero per cent usage in 1980, it is now being used in 38 per cent of cases of diarrhoea in young children. As I said before, it is saving more than a million young lives every year -- and thus, diarrhoea is no longer the leading global cause of death among under-fives, as is has been for centuries. So, we certainly do have a lot to cheer about on the ORT front.

But some 3 million children continue dying of diarrhoeal disease every year and we are having to fight every step of the way to increase coverage. It is clear that my intuition back in the mid-80s was wrong. The simplicity and elegance of the ORT solution disguised the complexities of its widespread application. I -- and

many others -- underestimated the difficulties we'd come up against, and the stubbornness with which people would stick to old behaviours.

In promoting ORT, we have had to contend with resistance from those you'd least expect to object. First, many physicians and medical Establishments have tended to look down on ORT as a "home remedy", a second-class treatment when compared to the greater sophistication of IVs. And as a result, industrial country hospitals and doctors all too often have been poor role models. Second, in most developing countries, it is usually diarrhoea that first brings babies into contact with doctors and the health system. ORT administered properly at home would, therefore, deny paediatricians and many hospitals a substantial part of their income. Third, to pharmacists, widespread ORT use would mean a significant loss of sales of antibiotics and anti-diarrhoeals. Fourth, we have come up against the profit voracity of some major pharmaceutical companies that find it far more profitable to push unnecessary and potentially harmful anti-diarrhoeals down babies' throats than actively promote far cheaper, far more effective ORT.

Lastly, there's the resistance on the part of ordinary people. Why is it, for example, that in Bangladesh -- where ORT was discovered in antiquity and rediscovered a quarter century ago -- a decade of promotion has made 93 per cent of the population aware of ORT, while actual use remains at only 25 per cent -- in a country where, on current trends, one and a half million children are expected to die of diarrhoea by the end of the century?

Why this enormous gap between the knowledge of ORT and its actual application? It's not as if ingredients for the life-saving solution are not available in virtually every home. And ORS packet availability is also widespread, at low cost or no cost to those who need it. So once more I ask, what is the problem with the solution? Is it perhaps too simple?

Although ORT itself may be simple, I suspect that programme designs in the past have been too simplistic to deal effectively with the complexities of human behaviour. Myths about withholding food and liquids from infants with diarrhoea have proven difficult to dispel. People need to know that children with diarrhoea require a greater volume of fluids and continued intake of food. Many parents still feel they are doing the right thing for their sick child when they ask the doctor for an antibiotic or the pharmacist for the anti-diarrhoeal they've seen everywhere in advertisements.

Clearly, we have underestimated what it takes to empower families at the household level to take advantage of this simple solution. Today we recognize that we need to know more about the perceptions, preferences and practices of parents in order to effectively promote ORT. We need to project this "simple solution" and position it as a first class, scientific treatment, not as a home remedy for the poor. Dehydration needs to be recognized as the dreadful killer and debilitator it really is -- public education is key. We need to make greater investments on the communication front to motivate behavioural change. More impact requires more input.

Underestimating the problems we'd encounter caused me to lose a bet about the prospects for GOBI that I made with Bob McNamara back in 1983. I predicted more rapid success for ORT than for UCI. McNamara thought the opposite, arguing that the systems of monitoring and accountability that were being built around immunization would be harder to establish in the case of ORT. As we know, in the UCI effort presidents and prime ministers are able to hold governors accountable for immunization levels in their areas and governors are able to hold mayors accountable, and so too along the chain of authority in the health system. Immunization statistics are relatively easy to keep. But because ORT is, first and foremost, a home remedy, it is more difficult to measure its use and build accountability into the promotion effort. Not impossible, but more difficult.

Let us take a leaf -- let us take **several** leaves -- from the success of the UCI programme. If there is one great lesson we have learnt from the achievements of UCI, it is that no single agency or organization can sustain a successful project for long. Sustained success requires a combination of social mobilization and visible, high level political commitment and leadership; partnerships and alliances with a great variety of social groups are also critical, along with the creation of enduring networks and infrastructure to institutionalize the new behaviour we seek at the grassroots level.

Let us be frank: defeating lethal diarrhoea will require more than these packets I always keep in my pockets. It will also require a health movement -- or even an anti-poverty movement, because if we are clear about one thing it is that diarrhoea largely kills where poverty has already done its terrible stunting and wasting of the life force. In fact, it is precisely because diarrhoea is primarily life-threatening only to the poor that ORT was described as "potentially" the greatest medical breakthrough of the century; if it cured a disease that primarily affected the better-off, like cancer, you can be sure that within a few years it would be in use everywhere, not just in 38 per cent of cases!

Our efforts with ORT need to take all these factors into account, and we must not be deterred by the evident difficulties we face.

In our favour is the vastly greater attention being given children by political leaders in the 1990s. Thanks to the Convention on the Rights of the Child, the World Summit for Children, and the achievement of UCI -- to mention just three of the milestones of 1990 -- we have a combination of legal obligations, political commitments, concrete goals and timetables based on demonstrated capability to radically improve children's lives -- something that has never existed before! There is a real momentum of progress on the ground that needs to be more widely publicized. And it needs to be better supported by the rich nations -- as a high-yield investment in global stability and future prosperity.

In the case of ORT, in spite of the difficulties I have mentioned, we are seeing real progress from Bangladesh to Mexico, from Tanzania to Peru -- a growing number of nations have accelerated programmes to make this technology a family habit. New partners are coming on board to help make this happen -- 25 million Boy Scouts, the Hunger Project, the Jaycees, and so many others.

The world community has now set itself the challenge to reach the goal of 80 per cent ORT use by end 1995. I am convinced that the goal can be reached, and that more than an additional one million lives can be saved each year. But how do we get there?

* We need more active **high-level political leadership** -- I am convinced it can be found. President Salinas of Mexico is now waving ORS packets around almost as much as I do. President Clinton has shown great interest in ORT, as well as immunization. Prime Minister Zia of Bangladesh recently presided over a highly-publicized commemoration of the ORT anniversary. King Hassan of Morocco is providing national leadership for ORT. But far more of such leadership is needed, as we experienced in UCI, and this should be possible since a majority of the developing world's presidents and prime ministers have endorsed the mid-decade goal.

* We need to **strengthen monitoring and accountability.** Household, clinic and hospital surveys can shed light on ORT usage and greater accountability for levels achieved can be instilled both in the health system and the political structure. This is possibly the greatest deficiency that needs to be overcome.

* The effort must be **multi-sectoral and decentralized.** It is not just a job for the health ministry. The entire fabric of society needs to be mobilized, including the media. This underlines the desirability of head of state leadership and the need for decentralized implementation. Sub-national programmes of action -- at the provincial and local levels -- are critical for success.

* **Steady infrastructure-building, combined with regular social mobilization**, are needed and we must not neglect one or the other. While building up the health infrastructure over time, high-profile days and weeks of nationwide efforts for ORT can keep the momentum of progress going.

* In order to accelerate progress, we need to **integrate and "piggy-back" programmes**, so that schools as well as clinics, community centres as well as hospitals, further our efforts. There is no reason we can't distribute ORS packets when we immunize, along with vitamin A capsules and information about breastfeeding, family planning and the importance of using iodized salt.

* We need to use the remarkable **power of the marketplace** to advertise, motivate, and distribute ORS. The private sector needs to be heavily involved. Where voluntary action does not produce results, government regulation should protect the public from harmful and unnecessary anti-diarrhoeals.

* And we need the **medical community**, with all its well-deserved prestige and influence, to strongly advocate -- and prescribe -- use of ORT as the "state of the art" treatment for almost all cases of diarrhoea.

Seldom do we have in our hands the means to improve the lives of so many in such a short time, at such a low cost! Seldom have health ministers had such potential for a supportive national and international environment! Let us all work together to realize the full potential of ORT.

In closing, allow me to say a few words about the central role of USAID in ORT for more than 25 years. I do not think it is an exaggeration to say that a majority of the 1 million children whose lives are saved each year thanks to ORT, owe their lives -- directly or indirectly -- to the US Agency for International Development. USAID largely financed the brilliant multi-year research that led to the discovery of ORT at what would become the International Centre for Diarrhoeal Disease Research in Bangladesh -- and it is still the largest funder of the ICDDR,B today. Its role was publicly recognized by an award to USAID from the Prime Minister of Bangladesh just one month ago. USAID took the lead in involving UNICEF, WHO and other UN partners in sponsorship of the series of ICORT meetings, beginning in 1983, that legitimated ORT and won converts on a global scale. And, most importantly, USAID has pioneered international support for its widespread application, beginning with the extraordinary nationwide success in Egypt in 1985 and continuing today in many countries. It certainly took vision and courage for USAID to embrace ORT the way it did, often in the face of incredulity from elsewhere in the bureaucracy and skepticism from taxpayers unaware of the impact of diarrhoea around the world.

USAID's support for ORT -- and the entire Child Survival and Development Revolution -- has been more than exemplary, and let me say for the record that many of the kudos that have gone to UNICEF and others over the years rightfully belong to USAID and its dedicated leaders and staff.

Our heartfelt gratitude also goes out to WHO, UNDP, the ICDDR,B, health ministries and other strategic partners -- including particularly NGOs -- in this noble undertaking. Working together, we can continue to make a difference for development and the children of the world. Thank you.