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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
at the opening of the
Third International Conference on Oral Rehydration Therapy (ICORT III)

Washington, D.C.
15 December 1988

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In my remarks yesterday at the opening of this conference, I spoke about the accomplishments in saving children's lives that have emerged as a result of the so-called "simple solution" to the lethal effects of diarrhoeal dehydration - oral rehydration salts (ORS). Broadscale training in the use of oral rehydration therapy (ORT), especially amongst the poorest sectors of a population, has already resulted in saving the lives of one million children in the last 12 months alone. I also spoke yesterday about the possibilities for expanding on such successes; they are vast. The grim reality that 10,000 young children still die each day from this cause attests to the fact that much remains to be done. Nor does this emphasis on continuing mortality reflect the tremendous impact of diarrhoea as a nutritional disease, and thus as a major contributor to malnutrition. Proper diarrhoea management could greatly reduce the nutritional drain of current cases of diarrhoea, to say nothing of the further tremendous nutritional gains if diarrhoea incidence could be sharply reduced.

Exactly how far we go with realizing these potentials depends, to a significant extent, on our deliberations here at ICORT III. But also important to remember, as we turn our attention at this conference to the sustainability of what has been achieved, is the hard reality that there is still much that has not been achieved - as well over half of the world's children in need still do not benefit from ORT. Our efforts to accelerate and extend coverage also require sustainability, and should be an important concern in this conference.

As I stated at the second ICORT in 1985, I have been surprised that the most dramatic advances in Child Survival and Development activities have been made in immunization rather than in control of diarrhoeal diseases (CDD), since the CDD cost is so low and the impact so dramatic with interventions such as oral rehydration therapy. Although many of you are aware of a full range of causes for this phenomenon, I would like to highlight three contributing factors, from which lessons can be learned for ORT.

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First, at the outset, a better, more extensive delivery infrastructure existed for expanded programmes of immunization (EPI) in many countries. CDD is now catching up and this should be accelerated further. Second, immunization is in many ways less complicated than CDD, in which peoples' behaviour must be changed - whether from the use of traditional remedies or from the use of antibiotics and intravenous solutions. Thus, even though immunization requires more of an infrastructure than CDD, CDD has many more obstacles - and even enemies - to overcome, especially within the health care system. We are beginning to recognize more fully that diarrhoea is a largely private sector disease requiring a much heavier involvement of the private sector. Third, immunization efforts have been planned with more clearly quantifiable goals than CDD. Clear and feasible targets - with specific timetables - help tremendously to motivate social mobilization around achievement of the goals. They also make our programmes more understandable and attractive to the political leadership, which is a first requirement for real institutional momentum among governments.

Nonetheless, during the last five years, the commitment to CDD has been growing steadily. Ninety-six countries (with an estimated 98 per cent of the total population in developing countries) now have control of diarrhoeal disease programmes, to at least a modest extent. This expansion has paralleled - and been reinforced by - a growing realization that oral rehydration therapy, if utilized correctly, is one of the most powerful strategies that exists for reducing infant mortality rates in developing countries. In Egypt, for example, the Physicans Association estimates that the sustained, nationwide ORT effort in that country has reduced dehydration-related deaths in some areas by a full 50 per cent. Similar results are reported in Honduras, Bangladesh and Jordan, to name just a few. A critical mass of support - among governments, health professionals, the international community and families themselves - is building for a concerted push toward ensuring that ORT is available to all children who need it by the end of of this decade. Diarrhoeal dehydration remains the biggest killer of children in most developing countries - <u>still</u> taking the lives of some 10,000 young children each day, two decades after the discovery of oral rehydration salts (ORS). The gains of immunization could be wiped out quickly if dehydration continues at current rates.

The very level at which we begin deliberations on CDD at this conference is cause for optimism. In 1983, at ICORT I, the challenge was to garner support for ORT, to convince policy-makers and health professionals that the strategy worked and to encourage the launching of national programmes. At ICORT II, we examined different aspects of ORT programmes and discussed ways to improve communications, distribution, training, monitoring and evaluation. Now, at ICORT III, we have moved to the issue of <u>sustainability</u> - the continued growth and institutionalization of ORT/CDD in the 1990s. The value of ORT is no longer questioned, although inappropriate use of drugs and intravenous treatment persists to some extent in almost every country. The expertise to implement successful programmes is also well established, as demonstrated by the fact that every panelist and resource person at this meeting is from the developing world - a vast change from five years ago, when our colleagues from developing countries were listening to the representatives

of international agencies and Western institutions extoll the virtues of this technique. Today you are the experts, at the forefront of knowledge and advances. We have come a long way since ICORT I!

The challenge now is to ensure the long term impact of efforts already underway and to expand programmes where coverage is insufficient. The WHO Programme for the Control of Diarrhoeal Diseases has specified a number of targets against which progress can be measured. They include:

1. Reducing the number of childhood deaths in developing countries from diarrhoea by 25 percent, or 1.5 million, in 1989;

2. Providing access to oral rehydration salts - meaning access to a trained, regularly-supplied provider of ORS - and information on related child care practices for at least 80 percent of childhood diarrhoea cases in developing countries by 1990. At the end of 1986, 59 percent had been reached, almost three quarters of the original goal;

3. Actually delivering this therapy and information for at least 50 percent of childhood diarrhoea cases in developing countries in 1989. Half this target - 23 percent - had been reached by the end of 1986; and

4. Providing senior and supervisory level management training courses and materials to at least 2,000 appropriate staff from all countries with CDD programmes. As of last year, only 7 percent of this target had been achieved.

The challenge is clear. Can we, as leaders on this vital front, see that all of the steps necessary to go that crucial distance are taken?

The panels in which you will participate today touch on several issues and problems of direct relevance to these targets. The priorities you delineate - the recommendations you make - will directly influence national and global progress for the next ten years.

The first panel - on the practices of mothers and community participation - speaks to the very theme of this meeting, i.e., sustainability. In the final analysis it is mothers or other family members who decide when and how a child with diarrhoea will be treated. No amount of ORS - no number of trained health workers - can compensate for an educated public that is knowledgeable and committed to ORT. UNICEF experience has demonstrated that when a life-saving technique like ORT is explained fully to mothers - and when its effects on improving their children's health are clearly demonstrated - mothers respond quickly, positively and responsibly. Poor families know a cost-effective solution when they see one. Women in developing countries have no time to waste.

One of the biggest challenges is reaching the mothers of children who need ORT. A recent study in India revealed that 80 percent of mothers of children with diarrhoea do not seek help from the formal health sector. Instead, they turn to private practitioners, religious leaders or community elders. Similar

trends are evident in Brazil, Mozambique, Bangladesh and several other countries. We need to broaden our scope on who should be co-opted as sources of information and advice, i.e., on what channels should be used to spread the ORT message. We need to reach beyond government health systems to the private sector, involving the private practitioners who, as a group, care for millions of children with diarrhoea each year. How to improve their practices, change traditional feeding behaviours, sustain community level use of ORT, mobilize communities in the management and prevention of diarrhoea - these are just a few of the issues that will challenge the panel on community participation.

To the targets already accepted concerning CDD, let us add the following: that by 1995 every mother should have the knowledge, support and resources to care appropriately for her child's diarrhoea. Let this goal guide us in our discussions today, as well as in the formulation of recommendations that emerge from this meeting.

The panel on communications strategies must touch upon similar issues, i.e., how to extend the scope and outreach of CDD messages. As in immunization, effective, broad-based social mobilization is essential to programme success. But we cannot adopt the same strategies. CDD messages are more numerous, more complicated and harder to convey than those linked to vaccination days or immunization campaigns. Diarrhoea occurs every day - not just 2 or 3 days a year - and responding to it effectively, either with treatment or preventive measures, requires the application of correct case management, communication with mothers, and changes in deep-seated behaviors of both health workers and mothers. This kind of sustained attention needs sustained promotion, just as maintaining a high market share of soft drink sales demands extensive advertising. Governments - and donors - must prepare themselves for a persistent effort; a quick fix will not work.

Equally important is to broaden our vision as to the people and the channels through which to communicate CDD messages. Village priests, imams, local authorities, school teachers, traditional healers - all these remain largely untapped resources for building sustained, broad-based commitments to CDD. Our new capacity to communicate with families in need - through the growing power of radio, television and other mass media - has created an unprecedented potential to change minds, behaviours and unhealthy practices. The opportunities are limitless; the challenge is to seize them now while the momentum is in our favor.

The panel on health worker training and performance faces a special challenge. This is the area where the least progress has been made, despite the plethora of programmes and materials developed during the last ten years. Why has so little been achieved? Why have so few medical and nursing schools revised their curricula? Why haven't Diarrhoea Training Units - which have been so effective in changing health worker behaviour - been established in every major health facility? We need to identify bottlenecks, propose solutions and provide appropriate support to governments committed to health worker training. Let this be another achievement of ICORT III - that appropriate, broad-based training be recognized as essential to sustainability of ORT in the 1990s.

The panel dealing with production and distribution of ORS has a number of issues to consider. First, local production: UNICEF has provided assistance to over half of the 55 countries now engaged in local production, contributing substantially to further reductions in the already low cost of ORS. Attention is now turning to issues of quality control and the increased efficiency of current operations - and to innovation. Cooperative efforts among organizations are fostering some creative solutions. In Ghana, for instance, an innovative four-way partnership has been forged between the government, UNICEF, USAID (through PATH) and a private firm. The private firm receives technical support and equipment from PATH and raw materials from UNICEF; in return, it provides packets at cost to the Ministry of Health. If successful, this scheme can be replicated in several other countries. The support that USAID has given to private local production of ORS has also made a substantial contribution to its increased availability. Furthermore, where local production is impossible or not yet underway, UNICEF has donated packets or provided them at low cost to governments and other organizations.

The delivery of ORS on a regular basis and at low cost requires that we reach beyond the formal health sector to the small pharmacies and bodegas that low-income families depend on in so many countries. The owners of these stores - like traditional healers - are often more influential than health professionals or local authorities. A recent study in Mexico, for example, suggests that pharmacists are willing to promote ORT if correctly trained and motivated. Their enhanced status in the community as the one who can "cure" diarrhoea can help outweigh low profit margins; use of higher profit margins to motivate retailers while not discouraging use warrants further exploration. Again, these retailers are an untapped ally in the CDD effort.

Increasingly, we must promote cost recovery in the context of CDD programmes. As in other areas, populations can - and should - shoulder some of the burden of health care. Otherwise, services simply cannot be sustained. Parents are willing to purchase millions of dollars worth of anti-diarrhoeal drugs each year, which are both useless and more costly than ORT. Again, past experience in many countries suggests that charging a small amount for ORS increases its perceived value to parents and communities.

It is also important to note that using ORT saves money - and not only for the family. Recent data compiled by WHO from major health facilities in 14 countries indicate a median decrease in the diarrhoea admission rate of 61 per cent following the introduction of ORT. I am sure that those among you who work in planning and finance ministries understand what a savings of that magnitude means for budgets undergoing the trauma of recession and adjustment.

The evaluation and monitoring of CDD programmes need special emphasis in the next few years. We need to know more precisely what works and how successful strategies can be replicated. We need constant, relatively quick feedback to ensure continued progress. More must be done, for instance, to measure more exactly the impact of ORT on infant mortality as well as what is happening to infant mortality. Current attempts to perfect the Brass method and other interview techniques are encouraging. Effective use of ORT (especially the large gaps that persist in knowledge and use levels), the

practices of health professionals, the availability of ORS - all these are areas requiring intensive investigation. Furthermore, ongoing activities must be adjusted to reflect the results of evaluation efforts.

Finally, the panel on linkages with other programmes raises the issue of prevention, i.e., the point at which we move from oral rehydration therapy to control of diarrhoeal disease. ORT treats problems associated with diarrhoea once they occur; it does nothing to prevent the incidence of the disease. In other words, ORT will reduce the duration but not the number of diarrhoea episodes that attack young children each year. Unhealthy environments, poor nutrition, lack of access to clean drinking water - these are the problems we must address to protect children more fully against the deadly combination of diarrhoea and dehydration.

Three of the most effective strategies for reducing the incidence of diarrhoea are the promotion of breastfeeding, the improvement of water supplies and the establishment of sanitation facilities. We have learned through long experience that, if investment in this area is to reach its full potential, the provision of equipment is only one step in a long process of community training and education. In Lesotho, for instance, CDD activities have been fully integrated into a nationwide rural sanitation project. A recent evaluation reveals that children in households with access to latrines have 24 percent less episodes of diarrhoea than those without access. Guinea-Bissau, Rwanda, Botswana, Madagascar and Mauritius are pursuing similar strategies.

Effective prevention of diarrhoea is a long-term, difficult process. It requires intersectoral coordination, high level advocacy, broad-based community participation and constant, tireless support at all levels. But if our goal is sustainable ORT/CDD initiatives in the 1990s, prevention must assume priority status in all programme efforts.

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The prospect of achieving and sustaining global use of ORT whenever the need arises is a formidable challenge. Indeed, what we are really dealing with here is a 10 cent cure for the number one killer of young children. Surely a civilization that can split atoms and send people to the moon and back can ensure that the life of any child threatened by diarrhoeal disease is saved by this simple solution?

As it becomes increasingly undeniable that the capacity to save the lives of so many children, and to improve the health and well-being of so many more, is well within our reach, it becomes increasingly unconscionable not to act on these new possibilities. Never before has the health community been faced with the opportunity - and the challenge - to do so much, for so many, for so little.

The time has surely come to put the mass deaths of children from diarrhoea - and from immunizable diseases and other low-cost preventable causes -

alongside slavery, colonialism, racism and apartheid on the shelf reserved for those things which are simply no longer acceptable to humankind. The time has come to say that it is obscene to let this continue day after day, year after year, as our civilization moves into the 21st century.

It is you - the world's leaders in this health movement - who must take responsibility for making these possibilities into realities throughout the world. I urge you to take even stronger leadership in this peaceful revolution for the health of children, and of all the world's people.