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Communication strategies for the control of diarrhoeal diseases (CDD) in Africa

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Abstract

It is estimated that 50 percent of all deaths among children under 5 years in Africa result directly or indirectly from diarrhoeal diseases. The mortality associated with childhood diarrhoea is often as a result of poor case management by mothers, childcare takers and health workers. It is therefore essential to teach mothers, child care givers and health workers that when a child has diarrhoea, it is essential to keep feeding and give plenty of fluids (breast milk, soups, water), including oral rehydration therapy (ORT) and the use of oral rehydration salts (sachets) to remedy the dehydration in the child. The knowledge needed to save our children from dying from diarrhoea dehydration already exists. The essential part of that knowledge is not highly technical. Making that health knowledge available to all parents, health workers and communities is the core of the control of diarrhoeal disease programme in Africa. New alliances must be forged to provide the necessary input for action at the family, health facility, community and policy levels. It requires a public private sector initiative. The mass media especially radio and television have been used successfully in several countries to bring regular messages on oral rehydration therapy , breastfeeding and advocate for policy support for CDD programmes. The possibility for reducing infant mortality resulting from diarrhoea resides on a well informed parent, because diarrhoea can be prevented through breast feeding, use of latrines, access to portable water and personal hygiene.

Keywords: Diarrhoeal Diseases in Africa, Communication Strategies

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1. Introduction

Diarrhoeal diseases are the leading killers of children under age five, with between three to nine episodes per year (Kone, 1993:33). An estimated 4 million children die each year of diarrhoeal diseases brought on by the parasites, viruses and bacteria that thrive in unsanitary environments, exacerbated by poor nutrition, respiratory infection and other diseases (USAID, 1990:24). It is estimated that children in Africa and the developing world suffer more than one billion episodes of diarrhoea each year. About 60 to 70 percent are acute cases; characterized by watery stools often accompanied by vomiting and fever. In some cases, the loss of fluids and imbalances in essential chemicals is so severe that the child dies in a matter of hours (USAID, 1990:24).

The incidence of persistent diarrhoea in Africa varies from 3 episodes per year in Niger, Senegal and Mali to 5 episodes in Namibia (HFS Namibia, 1996). In Malawi, bloody diarrhoea is a common cause of hospital visits at the end of the year, resulting in changes in nutritional status, an elevated risk of mortality and inadequate management by health workers (Manirankanda et al., 1993). Age groups most affected by diarrhoea vary from country to country, 7 to 24 months in Nigeria, 13 to 24 months in Mali and 12 to 23 months in Namibia (Kone, 1993:33). Among the risk factors are drought and increased food insecurity (M'manga, 1993) that lead to increasing early supplementation. Others, include traditional beliefs and practices, varied diet, unsanitary conditions and poor food, water and personal hygiene (M'manga, 1993:32).

Until the late I960s, drugs and intravenous fluids were the accepted treatment for dehydration due to diarrhoea requiring modern medical facilities, equipment, supplies and skilled personnel, all in short supply in Africa (USAID, 1990:24). This therapy was expensive and inaccessible to most African children. Research conducted at the International Centre for Diarrhoeal Disease Research, Bangladesh, contributed to the discovery that a simple solution of essential salts, glucose and water, together with bicarbonate or trisodium citrate, can reverse dehydration within a few hours. Furthermore, the solution could be made from inexpensive ingredients and given orally to children by their mothers or by health workers with limited training. Today, oral rehydration salts (ORS) are available in premeasured packets to 40 percent of families worldwide. Rehydration solutions can also be made from ingredients found in all but some of the poorest households; water, sugar and salt. However, the oral rehydration solution is not a vaccine nor is it a solution to the basic causes of diarrhoea. It is rather, a remedy in addition to other diarrhoea preventive measures such as protection of sources of water supply, hygiene education and adequate sanitation (USAID, 1990:21). ORS is not a prevention for repeated episodes of diarrhoea, nor can it provide a cure for cholera, the most severe form of diarrhoea disease, and rotavirus, the most common form of diarrhoea.

2. Control of diarrhoeal diseases (CDD) programme in Africa

As a matter of policy, many countries in Africa have put in place a National Control of Diarrhoeal Diseases (CDD) programme that is anchored on four main strategies, namely: (i) Empowerment of mothers/caretakers with children (0-5 years) with knowledge, skills and attitudes to make them capable of

taking preventive measures against diarrhoea; (ii) Capacity building of health workers in all health facilities to enable them provide correct case management for children (0-5 years) presenting with diarrhoea; (iii) Support to ensure that children with diarrhoea have access to oral rehydration salts (ORS) sachets and receive proper feeding and home based fluids during diarrhoea episode, and (iv) Establishment of ORT corners in all health facilities. To ensure that mothers/caretakers and communities are empowered, information and educational materials on preventive measures and on how to mix and administer ORS were developed and distributed to mothers at the health facility level in addition to radio and television messages. At the regional and local levels, health workers, especially, community health workers were trained to promote prevention of diarrhoea and advise mothers on Oral Rehydration Therapy (ORT). To ensure that health workers possessed adequate knowledge and skills to provide quality services, they were trained on how to prevent and treat diarrhoea in children, based on the National CDD policy guidelines, which were developed and distributed to all health facilities. A World Health Organisation (WHO) chart on management of diarrhoea was also produced in English and some local languages, as a support material for health workers in Anglophone and French in Francophone countries in Africa. In order to improve the level of accessibility of ORS to children (0-5 years) with diarrhoea, and educate mothers/caretakers on the importance of Oral Rehydration Therapy (ORT), national governments established ORT corners in health facilities and provided ORS sachets to all health facilities with support from the World Health Organization and UNICEF. At the community level, community based health workers were trained to promote the use of ORS as well as home based fluids in the management of diarrhoea.

3. Oral rehydration therapy

When a child has diarrhoea, he or she loses a lot of liquid and body salt. As a result, the child suffers from dehydration which can result in death if not properly managed through the use of oral rehydration therapy (ORT).

Oral rehydration therapy is based on the discovery that the dehydration caused by diarrhoea can be prevented and treated not by withholding food and fluids but by giving plenty of liquids, including breastfeeding, gruels, soups, rice, water and even weak tea or clean water (UNICEF, 1994). An important part of the therapy is continued feeding during diarrhoea. ORT is effective in more than 90% of cases of diarrhoeal disease promoted by WHO and UNICEF. Some forms of ORT has now reached more than 40% of families worldwide. In Africa, the use of ORT varies from 90 percent in Zambia to 13 percent in Morocco (UNICEF, 1994:15).

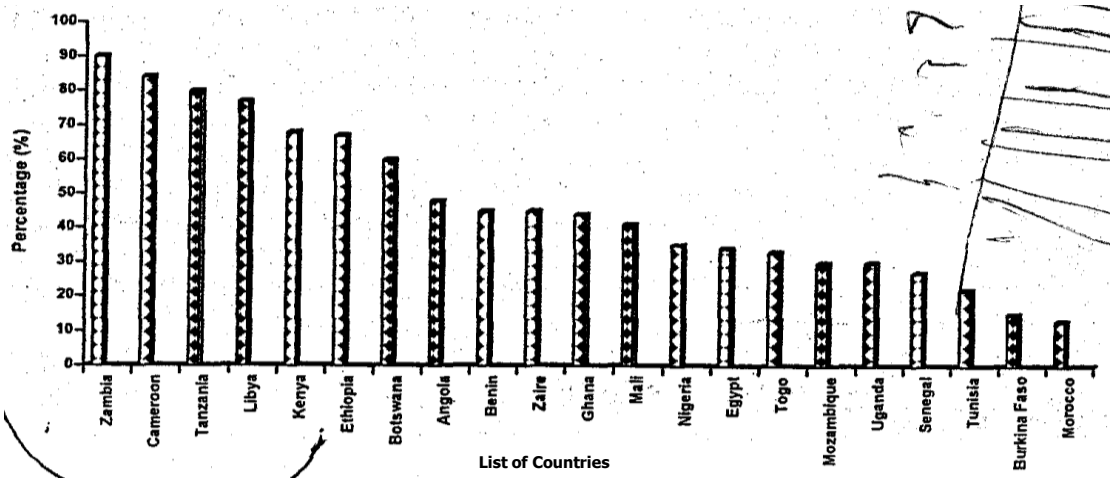

Figure 1. ORT use in Africa (UNICEF, 1994, p.4)

4. Programme review

Since the inception of the CDD programme, the communication component has lagged behind the operational aspects, with the result that only a few of the health facilities that have established ORT corners, used these corners to educate mothers on ORT and to rehydrate children who were dehydrated before sending them home (Namibia, Mid Term Review 1994) A Health facility Survey involving mothers in Namibia (Imoh, 1999) revealed that only 57.3% of the mothers/caretakers attending health facilities, said that they received information and education on diarrhoea prevention and home care from health workers. About 6.8% said they were dissatisfied with the treatment they received at the health facility from health workers, and that their expectations were not met as a result of poor interpersonal communication by health workers, wrong information given, inaccessibility of services and lost opportunities for health education of mothers on diarrhoea prevention, ORS mixing and home management. For instance, only 7.9% of those interviewed said that they were advised by health workers to give more food to the child with diarrhoea while only 0.9% were advised by health workers to give more food to the child with diarrhoea while 0.9% were advised to continue to breastfeed and give more fluids (Namibia Health Facility Quality Survey, 1997): These findings confirm earlier reports in 1994 that only 33% of health workers in the North west region of Namibia know the preventive measures in the control of diarrhoea (MTR, 1994) while 90% and 80% in the North west and North east regions respectively could demonstrate how to mix ORS. About 49.6% of mothers/caretakers in the survey (1997) did not know how to mix ORS, invariably because only 46.6% of them received health education and demonstration on ORS mixing (Namibia Health Facility Survey, 1997). For instance, only 34.9% of the respondents in the survey claimed that they know what to do to prevent diarrhoea, and 77.7% said they will do nothing to protect and prepare drinking water to make it safe before drinking no matter its source. The survey also showed that ORT corners are not functioning properly and that health workers do

not follow the CDD guidelines on ORS distribution, promotion and demonstration of use. There was no noticeable systematic procedure for clinic or community based health education of mothers on home management of diarrhoea including feeding, fluids intake and personal hygiene. Not all health workers have been given orientation on the CDD Policy and Guidelines and as a result there are no standard procedures on who to give ORS sachets and how many sachets to give. It was also found that health workers lack motivation to give health education on ORS mixing, home management, child nutrition and diarrhoea prevention (Namibia, Health Facility Survey, 1996). This is because health workers have been adequately trained to provide health education on the control of diarrhoea disease. The few visible educational materials on CDD, target only health workers, not mothers or child care takers, who constitute the primary target group for CDD messages. Most CDD activities are limited to the health facility level, leaving out the community where the people live, and where the predisposing environmental and behavioural risk factors can be found in abundance.

5. Statement of the problem

Diarrhoeal diseases still remain one of the major childhood killer diseases in Africa. Effectiveness of programme interventions in Africa have been constrained by deficiencies some of which lie within the community and childcare takers while others lie within health workers and the health system.

5.1. Gaps in community behaviour, beliefs and practices relating to diarrhoea

According to UNICEF Report (1997), there were certain community behavioural risk factors that drive the diarrhoea epidemic. These include:

i. Traditional beliefs that breast milk alone is not an adequate diet for young infants has led to poor feeding practices, especially early food supplementation and weaning foods prepared under unhygienic conditions which predispose children to diarrhoea.

ii. Even though 75.7% of households have heard of ORS as a means of diarrhoea management, only 25.9% have ORS available in the household.

iii. Inappropriate use of home fluids by mothers. Only 61.3% of all under five are given ORC during a diarrhoea episode, but food intake is mostly restricted. According to the survey, 85.2% of the children with diarrhoea are given the same or less to eat, while 75.9% are given same or less to drink during the episode.

iv. Poor health seeking behaviour of mothers. Only I out of 3 children with diarrhoea are taken to the clinic for treatment. We need to know what triggers mothers to start seeking help when their children have diarrhoea.

v. Mothers in rural areas use a sophisticated classification scheme for treatment which is often inconsistent with the biomedical model of diarrhoea. Those diarrhea with sexual origin, taboos and

transgression are often referred to grandparents and traditional healers. Mothers often set aside ORS and give home traditional remedies, enemas and herbal portions considered as more efficacious.

vi. Only when the child does not get better that she goes to the clinic. Once the mother believes in traditional approach to treatment, ORS is noncommittal (Namibia, 1997 MTR). The practice of cutting mothers in the anal and vaginal areas when their children suffer from persistent diarrhoea complicated by under nutrition does not have any beneficial effects either on the child or the mother's motivation to seek medical treatment (Lumpkin, 1992) and

vii. Knowledge of causes, signs and symptoms, prevention and treatment of diarrhoea has not been extended to all mothers in both rural and urban communities. There have also been some elements of selective access to ORS sachets in various communities.

6. Deficiencies in the health delivery system

Diarrhoea control interventions are unlikely to be sustained until there is a critical mass of technical personnel to support them. Many health facilities especially those at the peripheral level are understaffed and are managed by one health worker compared to the magnitude of their multiple responsibilities to all Primary Health Care Programmes (Imoh, 1999). Where there is staff, logistics and transportation constraints, community based outreach activities become difficult. This also affects supervision and monitoring of activities for compliance. The private sector serves a large segment of the African population and has a role to play in the Control of Diarrhoeal Diseases (CDD). Unfortunately, the private sector input has not been documented Currently, there are different brands and contents of oral Rehydration salts (ORS). There is need to standardize ORS and emphasize to mothers and health workers, the appropriate one to use. The management of diarrhoea emphasizes Oral Rehydration Therapy. Oral Rehydration Therapy includes in addition to ORS, fluids intake, local foods and breast feeding. However, it is the practice of health workers to give only ORS (Imoh, 1999). A UNICEF Report (1997) showed that many doctors and nurses, especially those involved in child care have not been trained or orientated to the new CDD policy and guidelines. This affects their compliance with recommended regimen. For example, only 21% of health workers could explain correctly how to manage a child with diarrhoea. At the district/local level, it was found that some health workers lack faith in the CDD policy. About 88% of health facilities sampled had ORT corners which were not functional. Even though there were charts on management of diarrhoea in 99% of these clinics, these charts were not used in the assessment of children with diarrhea as health workers prescribed antibiotics for watery diarrhoea contrary to CDD guidelines.

Other constraints to the success of the CDD programme at the national and local levels include the following:

- Religious, cultural and regional differences in the acceptance and use of ORS and home based fluids has affected the outcome of home management of diarrhoea.

- Infrastructural weakness resulting in poor service delivery. Low management capacity, including poorly defined roles and responsibilities of clinic staff, supervision of that staff and the monitoring of the quality of service delivery have negatively affected the programme, and
- Regulatory and medical barriers to the local production and sale of oral rehydration salts (ORS) affect access to ORS sachets.

7. Theoretical framework

Research experience and theoretical work in the behavioural and social sciences have increased our understanding and knowledge of how to motivate new practices, attitudes and actions in individuals, institutions and communities. Manoncourt (2002) identifies three theories that are useful in explaining human behaviour in relation to adoption or rejection of ideas, services or technological innovations, such as the Oral Rehydration Salts (ORS). These are the (i) Health Belief Model, (ii) Social Cognitive Theory and (iii) Social Network, and Social Support Theory. Collectively, these theories on individual health behaviour have established links between predisposing and enabling factors (beliefs, skills, social support or knowledge), reinforcing factors (personal benefits, rewards, positive support, etc) and behavioural intentions (Hubley, 1988 cited in Imoh, 2006:38). These theories point to the fact that the people's perception, attitudes and beliefs about the Oral Rehydration Therapy, combined with their beliefs about the efficacy and effectiveness of ORS will determine their intent and desire to use ORS. They suggest that individuals may intend to do something, such as using ORS, but may not actually do so due to lack of certain enabling factors such as time, money, knowledge, skills, access to and availability of the product (ORS) when demanded (Imoh, 2006:38). The models of development communication that inform our communication strategies for diarrhoea control consist of the communication for development model, the instructional design model and the social marketing approach.

7.1. Communication for development model

The communication for development model (Mckee, 1992; Okoro, 2005) is a researched and planned process of social transformation which uses a number of communication strategies to help people towards group consensus, to help people to acquire the knowledge and skills they need to improve their conditions and that of society and to improve the effectiveness of institutions (Imoh, 2007:23).

The model includes advocacy for financial and policy support and commitment of the government at all levels to a plan of action. It also includes social mobilization of the community in human and financial terms in support of the CDD/ORT programme, and lastly, it means changing the knowledge, attitudes and behaviours of mothers, health workers and policy/decision makers in health and other sectors; through training, information giving, and motivational activities, using multisetting, multimedia and multiple languages to spread the ORT messages.

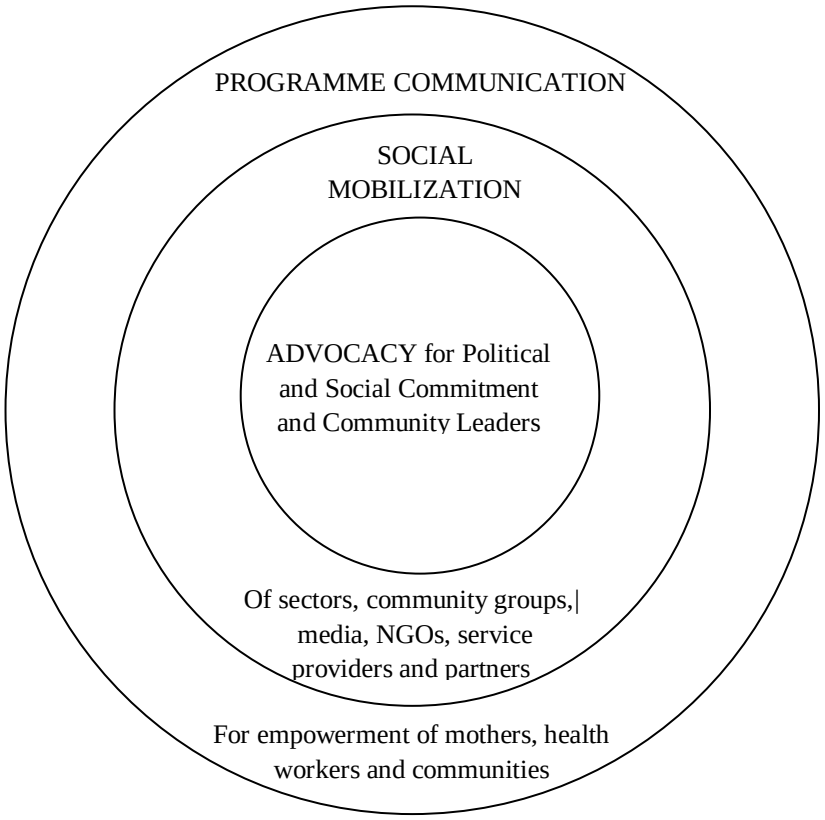

Figure 2. Communication for Development Model (Source: UNICEF, 2002)

7.2. Instructional design model

The instructional design model (AED, 1985:7) focuses on individual learning and the collection of information on different audiences (health workers, women, fathers, policy/decision makers) to know their perception of the problem and the behaviours being advocated; the resources available and the most effective media and channels to reach the different audiences (Imoh, 2007:31). Messages designed are disseminated through appropriate channels with adequate organizational, managerial, technical and communication support, to ensure reinforcement or constancy of opinion among the people. This model has a monitoring and evaluation component that allows for sampling of the impact and outcome of the programme, spot socio-cultural, behavioural and technical obstacles and modify programme content, methodologies and strategies (Hornik, 1985).

7.3. The social marketing approach

The social marketing approach is a generic concept of marketing applied to non-commercial transactions such as control of diarrhoeal diseases and marketing of oral rehydration salts. Philip Kotler (1982) described social marketing as the use of marketing principles and techniques to advance a social cause, idea or

behavour for the purpose of increasing the acceptability. It utilizes the concepts of target audiences, segmentation, audience research, communication facilitation, incentives and exchange theory. Social marketing is made up of five elements "5Ps" viz; product, price, promotion, place and positioning. The approach recognizes that there are different audiences, with different cultural backgrounds and media use. The audience is seen as active catalyst whose needs, constraints and vocabulary orient and propel the communication component (AED, 1985:35). In order to reach all segments of the target population, social marketing incorporates the use of channels provided by non-governmental organizations, civil society organizations and the private sector, employing a multisectoral approach to programme planning and implementation in order to gain more channels for diarrhoeal disease control messages (Imoh, 2007:28).

8. Programmatic challenges: Limits to overcome

A wide spectrum of motivational and enabling factors are implicated in mothers/child caretakers' decision concerning the use of ORS, child supplementary feeding, type and amount of fluids to be given during diarrhoea episodes, including health seeking behaviour. Some of these factors include:

i. Mothers/caretakers knowledge and beliefs about diarrhoea, its causes, prevention and management.

ii. Mothers/caretakers knowledge or lack of knowledge of ORS and its efficacy in the management of diarrhoea.

iii. Mothers' perception of diarrhoea, e.g. the classification of diarrhoea, may determine course of treatment, traditional or modern;

iv. The quality of health education or instruction received, how the information was organized, mothers expectations vis-à-vis mothers interaction with health providers when her child had diarrhoea.

v. i. The influence of significant others; husbands, family members, community leaders, community workers on mothers decision to use ORS.

vi. The product ORS, its availability, accessibility, distribution outlets and community and home delivery system,

vii. Traditional beliefs and practices relating to child supplementary feeding, type and amount of fluids to be given for home case management of diarrhoea. In the African setting, the heath seeking behaviour and decision making concerning the course of treatment for a child with diarrhoea may not be exclusive to the mother. For instance, health education on CDD often target health workers and mothers in the clinic. There is therefore the need to look at the role of significant others in mothers/caretakers decision making as 60% of mothers/caretakers visit the traditional healer first before coming to the health facility (Namibia MTR, 1997).

viii. Mothers expect that ORS will stop the diarrhoea in their children. When this does not happen, they feel disillusioned. We need to verify the expectations of mothers so that health workers can acknowledge them in their interaction with mothers/caretakers (Lumpkin, 1992).

ix. ORS sachets are not being given out to mothers and caretakers with children under five years of age according to the CDD Policy. In the peripheral communities, health facilities may be several kilometers away. When a child has diarrhoea, transport to the nearest clinic may be problematic. Under these circumstances, mothers may prefer traditional medicine because it is close, cheap and available. The CDD Policy advocates the use of ORS both in the health facility and at home. At present, however, ORS distribution is done only at the health facility level and this poses a problem of accessibility, availability and use. There is also the need to look at the available household cups or containers that are equivalent to use for ORS besides what health workers tell them. In addition, there are limited ways of promoting ORT and the use of ORS in the community outside the health facility.

x. The ecology of food and nutrition in child food supplementation and in the home case management of diarrhoea has biomedical implications for the outcome of Oral Rehydration Therapy (ORT). There is the need to identify and evaluate child weaning practices and the use of appropriate fluids or cereal based remedies that are available with a view to assessing their potentials in Oral Rehydration Therapy.

xi. It is not clear what health workers perception of the CDD policy and guidelines are. In some health facilities, there is no compliance. We need to know if doctors, nurses and primary health care supervisors understand the policy and are willing to comply and enforce it at the service delivery level.

Below are some communication challenges in the campaign to reduce infant mortality resulting from Diarrhea.

8.1. Reaching mothers with ORT messages

The communication challenge is to increase mothers' knowledge of Oral Rehydration Therapy (ORT) so that they can effectively treat dehydration resulting from diarrhoea at home. First, we need to reach health workers with information on diarrhoea, oral rehydration therapy, its causes, symptoms, prevention and management so that they can educate mothers at the clinic and in the communities through community based outreach programmes (USAID, 1990:27). Programmes reaching mothers in remote villages with information on oral dehydration therapy have increased mothers knowledge about ORT and their ability to intervene in cases of diarrhoea (USAID, 1990:27). Most of these successful projects used small group discussions or focus groups to gather information about local customs and knowledge about diarrhoea disease, in order to fashion culturally appropriate messages, promoting ORT. They reached mothers using a combination of clinic based education and counselling, radio messages, television programmes, posters, charts and other interpersonal and group channels (Oramedia, sports festival, market days, churches and mosques, labour unions, women groups, etc) to urge mothers to seek medical care sooner in cases of serious diarrhoea and to make oral rehydration therapy and salt sugar solution (SSS) their preferred method of treatment.

8.2. Conducting socio-behavioural and biomedical research

There is need to develop and promote inexpensive weaning foods from local ingredients and teach mothers how to counter the varied adverse nutritional consequences of diarrhoea. Research is also needed on possible vaccines against cholera and other preventive behavioural and environment strategies so as to identity the best way to produce, package and distribute the oral rehydration salts (ORS) at the national and local level, in such a way that the commodity is accessible, available and affordable to all. Above all, research is needed on community perception of management of diarrhoea, the oral rehydration therapy and health services provided. This way, the system can provide services based on those perceptions. The oral rehydration therapy is a technologically mediated intervention that requires both knowledge and skills on the part of both mothers and health workers, to work effectively. Research is needed on the best communication strategies to reach mothers and health workers, the primary and secondary target groups for diarrhoeal messages.

8.3. Reaching health workers through training to improve quality of care

Many health providers lack skills in interpersonal communication and counselling, including referrals. Some lack user friendly and interactional skills and these attitudes discourage clients' enthusiasm. The success or failure of the control of diarrhoeal diseases programmes in Africa depend on the health workers, whose knowledge and enthusiasm can influence the knowledge and behaviours of mothers, child care givers and the entire community (USAID, 1990:27). It is therefore important to devote time and resources to build support for ORT among health workers, through in-service training, study tours, short courses, workshops etc. Research findings in Namibia (Imoh, 1999) showed that mothers did not have adequate knowledge about ORT and therefore could not give mothers adequate health education and information regarding management of diarrhoea. In Niger and Senegal, reports indicated that the quality of services and care given by health workers was often poor and inconsistent (USAID, 1990:27). In several countries, capacity building of the health workers have produced good results. This was achieved through the integration of diarrhoea information and education into the training curricula of nurses, doctors, pharmacists, CHOs and other categories of primary health workers. In Pakistan, PRITECH in collaboration with the World Health Organization (WHO) have established a Diarrhoea Training Unit in teaching hospitals in the country and this has seen an improvement in the treatment of diarrhoea and the education of mothers has improved (USAID, 1990:27).

8.4. Promoting the use of oral rehydration therapy

The effective management of diarrhoea requires rehydration therapy which consists of Oral Rehydration Salts (ORS), in addition to increased fluids intake, continued feeding with local foods, including breast feeding and timely referral. This requires that health workers be trained so that they can educate mothers on management of diarrhoea (Imoh, 1999:12).

8.5. Using a multisectoral, decentralized and integrated approach

Diarrhoeal diseases should not be seen as purely a health problem. All sectors of society are affected, the causes of diarrhoea are multifaceted. It therefore needs for its prevention and control a multisectoral approach that encourages public and private sector partnership and collaboration. The ministries of health, agriculture, education, information and communication, women, environment, water resources, rural development, together with social organizations, women groups, school children, market women, professional groups, mass media, religious organizations, traditional healers, traders, youth groups, etc should integrate diarrhoea information and education into their plans and activities in order to achieve a multiplier effect. Certain line ministries such as education, health, information and agriculture can help to educate their publics, while the ministries of environment and water resources, put in place actions that can ensure adequate supply of portable water, adequate environmental sanitation and building of pit latrines. Mothers with children under five years of age who come in contact with Primary Health Care services should be informed about prevention of diarrhoea, ORT and use of Oral Rehydration Salts (ORS). To have a multiplier effect, officers in the Ministries of Education, Youth, Local Government, Housing, Environment, Agriculture, Water and Rural Development, Women Affairs, Information, Labour and Culture should be given orientation on the control of diarrhoea, oral rehydration solution and food and personal hygiene.

8.6. Ensuring community involvement and participation

Key members within the community should be selected and trained on the ORT rationale. Those trained can serve as depot holders and community based workers who will mobilize the community for preventive measures against diarrhoea (Imoh, 1999:9).

8.7. Promoting child spacing through breast feeding

When a child is born too soon after the birth of a sibling, its risk of dying before its first birthday increases significantly (USAID, 1990:32). A child born to a family that already has four or more young children or to a mother outside her prime child bearing years is more likely to have diarrhoea. The influence on a child who is under one or two years, when her mother is pregnant with another child can lead to kwashiorkor or severe malnutrition.

Exclusive breast feeding promotes the delay of the onset of fertility and enhances child spacing. Policies that encourage baby friendly practices by service providers should be put in place, to encourage women of reproductive age to take advantage of family planning services available in their communities and embrace exclusive breast feeding.

8.8. Promoting public-private sector partnership

The programme will fail if private doctors, private health institutions and the organized private sector do not participate. It is necessary to target professional associations, religious groups, and other maternal and child

health services. Through orientation of the private sector on the policy on diarrhoea, they can be used as conduits for reaching service providers and mothers (Imoh, 1999:10).

8.9. Establishment of Monitoring and Evaluation System

An active field staff, armed with transport and communication support to monitor field activities is necessary to ensure that there is compliance with policy guidelines at the level of implementation.

9. Summary and conclusion

The goal of any intervention strategy on Diarrhea prevention is to reduce death due to diarrhoeal dehydration. The programme strategy to be effective must focus on removing constraints to the use of ORS by addressing cultural barriers, weak ORS delivery institutions and poor access to ORS and diarrhoeal management services. It should also focus on increasing information on prevention, recognition and management of diarrhoeal diseases, through multimedia and multisetting approaches. This will require the institutionalization of information, education and communication skills and capabilities within the Primary Health Care System so that health workers can carry out community and facility based education and counselling of mothers. It also requires the institutional development and capacity building of key managers and decision makers in information, education, agriculture, local government and women sectors as partners in the control of diarrhoeal diseases (CDD). Increasing demand for and use of ORS sachets by mothers and child care givers also require an increase in the availability of ORS sachets in health facilities and in homes. Political will in support of policy on CDD should be demonstrated by African governments, through the establishment of an effective system for public sector distribution of ORS sachets, the development of community based distribution systems and the orientation of private sector conduits for clients.

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