WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean

منظمة الصحة العالمية
المكتب الإقليمي لشرق البحر المتوسط

ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Méditerranée orientale

EM/5th.MTG.RSWG.DDR/7

REGIONAL SCIENTIFIC WORKING GROUP
ON DIARRHOEAL DISEASES RESEARCH

Alexandria, 15 to 16 July 1984

SELF-HELP IN DIARRHOEAL DISEASES CONTROL

People and Health

Every community has its own "health culture" with a definite rationale behind their health beliefs and practices, their therapy seeking behaviour and perception of their own health problems.

Health to the people, has clear determinants which are socially and culturally defined and is a state of being which is actively sought through numerous daily practices. Though some of these practices may be harmful to health, these communities have rich traditions of local practices that promote health, which are fundamental to traditional life-style. These traditional notions of preventive medicine can be regarded as the basis for ultimate self-care.

Though medical care may be always available, the essence of "health" is personal life-style, not treatment by specialists. Moreover, knowledge of how to achieve health has not been the monopoly of formally trained healers but held by ordinary people. Women, in particular, are active promoters of the health of their families.

Primary Health Care, Health for All and Self-help

The Declaration of Alma Ata adopted in 1978, gives a place of prime importance to health education in promoting individual and community self-reliance and in developing people's ability to become full partners in health promotion and care. More than one element of the primary health care approach deal directly with diarrhoeal disease control, such as appropriate treatment of common diseases, environmental sanitation and safe water supply.

The global strategy for the achievement of Health for All by the Year 2000 depends largely on mobilization of community resources both human and material, and in the participation of the people, families and communities in action for health.

The need to increase "individual and community capabilities for involvement and self-reliance in health and to promote healthy behaviour, particularly regarding family health and nutrition, environmental health, healthy life-styles and disease prevention and control" are emphasized as essential approaches in this direction.

The Executive Board, in its Meeting last January 1984 stated that without adequate understanding and sustained motivation on the part of individuals, families and communities in dealing with their own health matters (self-help), the goal of Health for All is not likely to be achieved.

Health Services Delivery and Self-Help

To achieve this much sought after self-reliance, people need to be suitably prepared through educational activities to enable them to cope with pressing health problems. This calls for a thorough understanding by the health care providers of the people's perception of their health needs and their acceptance and utilization of different health care technologies - influenced as those are by socio-cultural and economic factors. Communication channels between the communities and the health care providers whereby they can voice their needs and express their opinions thus establishing positive interaction between them, helps identify common areas where both share the same views on health problems and health needs. Appropriate solutions, identified jointly are an essential guarantee for self-care activities to develop in the right direction.

Renewed awareness of the contribution that lay people can make to health care is slowly developing under the new importance given to self-help and self-reliance in Health for All strategies. For this self-reliance to materialize and take shape, an effort must be made to help the people overcome the growing dependence on the health services developed over the past years. This can be counteracted by giving them back their confidence, by helping them develop their skills in making the right choices and by a change in the attitude of the health professionals themselves, who should recognize people's right for decision making with regard to their health problems.

Life-Styles and Diarrhoeal Diseases Control

Life-styles are developed over the years by individuals and groups to cope with the requirements and contradictions of their social environment. Diarrhoeal diseases, where social and environmental causes contribute to their incidence, are therefore directly affected by lifestyles. These comprise a variety of behavioural patterns that are influenced by several factors including shared values, traditions, typical forms of communication and interaction.

Health education efforts aiming to promote health enhancing behaviour should therefore address the general life-style of an individual and not focus on a single isolated trait if positive impact for motivation of self-help is sought.

In diarrhoeal disease control this implies the use of a health education model based on a sound knowledge of human ecology, and taking into consideration the interaction between the biological and environmental factors both physical and social. Such a model can promote behavioural changes necessary to create barriers to transmission of a wide variety of micro-organisms and to promote appropriate management of the diarrhoeal episode. It is recognized that conditions of life in several countries of the Region render prevention an extremely complex and difficult task.

Factors Facilitating Self-help Efforts

1. The already existing notions of prevention and self-care practices in communities and among individuals in countries of the Region.
2. Recognition of the responsibility of the people for their own health and helping them regain it.
3. Dynamic interaction between the communities and the health professionals.
4. Basing health education activities on a sound knowledge of human ecology, taking into consideration interaction between all social and environmental factors.
5. Use of people oriented technologies, built on existing knowledge and indigenous health practices.

All the above considerations need to come into play if self-reliance is to be promoted for the control of diarrhoeal disease.

Why Self-Care in Diarrhoeal Disease Control (CDD)

Self-care needs to become an important component of CDD programmes because of:

1. The commonness of the problem or the high incidence of diarrhoeal episodes.
2. The need to encourage correct and early use of home-made oral solutions to prevent dehydration as the current production of ORS around the world is estimated to satisfy only a small percentage of all episodes of diarrhoea
3. The fact that home measures nearly always precede consultation of the health professionals for treatment of diarrhoeal attacks and commonly modify the outcome.
4. appropriate feeding (self-care) during and after the attack is needed for complete recovery from a diarrhoeal episode.
5. The need for preventive measures in the home and the community to prevent infection and recurrences.

Self-help in National CDD Programmes

Reviewing some reports of national diarrhoeal disease control programmes with regard to the self-help component, it was found that though self-help was recognized as an essential component for the success of CDD programme activities needing intensive health education to enlist its support, it was mainly sought for the preparation and early administration of ORT, whether home made ORT solution or reconstituted from packaged ORS.

While continuation of breast feeding was commonly stressed, the home dietary management (for other foods) during and after the diarrhoeal attack was often not given enough attention or follow up during the diarrhoeal attack. The dietary mismanagement (by mothers) of cases in the control groups not receiving ORT was often due to incorrect directions given by the treating professionals.

Generally, the health education programmes were managed in an outward and downward fashion, with the people - as "receivers" - presented with information and technologies that are considered good and desirable with the assumption that they (the people) should be made to accept it.

The credibility of the source and the quality of instruction to communities was questioned in some reports. Both are key elements in an educational interaction promoting self-reliance.

Generally, this "selling" of ORT without much consideration given to the coummunities concerned is contrary to principles of self-help expounded earlier and the approaches will have to be modified if self-help in CDD programmes is the target.

Research Issues in Self-help

Levels of action for "self-help" in CDD programmes

Self-help in CDD is expected to be active at four levels of "intervention":.

A. In altering the incidence of diarrhoeal disease by changing the conditions that generate it and creating barriers to transmission of the infective agents.

B. In reducing mortality by early ORT and appropriate feeding.

C. In altering the outcome of the diarrhoeal episode and preventing the onset of malnutrition/infection cycle by adequate feeding especially during the period of increased metabolic activity and nutrient uptake immediately following the attack.

D. In preventing recurrences.

Research Areas Identified by The Regional Scientific Working Group on Diarrhoeal Disease Research

Priority areas for research identified as early as 1981 include:-

(i) Nutritional management of cases with acute diarrhoea giving simple and feasible dietary recommendations;

(ii) Studies on simple effective environmental interactions to reduce disease transmissions;

(iii) studies on the role of health education in the prevention and control of diarrhoeal disease;

In order to support the contribution of self-help to CDD, research in these same areas identified above needs to be designed with due consideration given to factors facilitating self-help mentioned earlier. Consideration should also be given to the many interacting variables in the life-styles of the people concerned. Two other research areas are now being pursued in Egypt, namely:

(iv) Investigation of common home remedies used for oral rehydration including ways and containers used in their preparation;

(v) Investigation of what people do in their daily life that can be identified as health enhancing behaviour or health lowering behaviour whether deliberate or non-deliberate. Appropriate solutions or interventions to reduce disease transmission within the home and in the community are thus identified.

Information gained from all the research priority areas designated above will need to be fed into the "intensive" health education component of CDD programmes. This information is also necessary for identification of areas of common thinking and interest in diarrhoeal disease management and control between the communities and the health professionals, vital for the positive interaction and guidance of the former towards appropriate self-help.

It may not be feasible or possible to compile information on the above for all the different regions in a country, and suggestion is made to encourage research aiming at the following practical issues:

- to develop and field test a simple procedure and checklist for rapid and easy investigation and recording of possible disease transmission routes and related behaviour inside the homes and in the communities for use by health workers;
- recording of home remedies for diarrhoea;
- recording of food restrictions or abstiances enforced during diarrhoeal attacks;
- local weaning habits;
- simple methods for evaluation of community participation and impact of health education activities.

Such "working tools" for use by the health worker will help him or her to adopt the holistic approach in the management of diarrhoeal disease with full awareness of the complex interaction of aetiological factors.

Research is also needed to develop and test a simple model for monitoring and evaluation of CDD programmes to be conducted with the active participation of the people themselves. This will further motivate the self-help efforts and their contribution to the diarrhoeal disease control programme.

* * * * *

Multidisciplinary research in support of self-help needs to recognize the complex interaction of variables affecting life-styles of people and the effect of these life-styles on the incidence, management and outcome of diarrhoeal disease. It is only with such knowledge that appropriate intensive health education/community motivated programmes can be designed enlisting people's contribution to diarrhoeal disease control through self-help. Participation of individuals and communities in monitoring and evaluation of their local diarrhoeal disease control programme is considered as a positive incentive for self-care.