FIRST LADY HILLARY RODHAM CLINTON
VIDEO MESSAGE FOR 25TH ANNIVERSARY CELEBRATION:
ORAL REHYDRATION THERAPY IN THE UNITED STATES
NOVEMBER 14, 1996

Good afternoon. Last March, I was delighted to accept an invitation to be Honorary Chair of this important conference. I am sorry I can't be with you today as you launch your nationwide campaign to promote oral rehydration therapy. I would particularly like to thank the Johns Hopkins School of Public Health for spearheading this initiative.

On my trip to Bangladesh two years ago, I visited a center supported by Johns Hopkins and USAID where doctors have saved millions of lives through their pioneering use of oral rehydration therapy. I also watched mothers and fathers and sisters and brothers administer this therapy to family members seriously ill with diarrhea. I saw a simple yet effective treatment give health and hope to children and families.

While I was in Bangladesh, I met a doctor from Louisiana who had come to learn about oral rehydration therapy. He told me that back home he was seeing increasing numbers of children hospitalized and dangerously ill because of diarrhea. So he had travelled to a country that we think of as less developed to learn a basic, cost-effective method to treat our children.

This simple therapy, costing only cents a dose, now saves the lives of millions of infants around the world every year. The therapy was developed in this country and has been proven safe and effective for use here, but we have failed to teach health care providers and families to use it as the first line of treatment for diarrhea.

Today, 300 to 400 babies in the United States die each year from diarrheal dehydration. At least 200,000 children are hospitalized. And our failure to use oral rehydration therapy costs more than $1 billion each year.

As we mark the 25th anniversary of the introduction of oral rehydration therapy in the United States, it is so important that we educate and reach out to health care professionals and parents in our own country about the use of one of the best and most basic tools to prevent disease and death. Twenty-five years ago, the White Mountain Apache Tribe had the foresight to enter into a partnership with Johns Hopkins to use oral rehydration therapy, and they reduced deaths from diarrheal dehydration to zero. Every community in America can and should follow in their footsteps.

The campaign you are launching today will mean that doctors in our country will no longer travel thousands of miles to learn about a therapy that was developed right here. Because of your determination and expertise, we can look forward to the end of unnecessary suffering, disease and death from diarrheal disease and dehydration.

Thank you and best of luck.

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First Lady Hillary Rodham Clinton
Honorary Chair, ORT Symposium
Draft Video Message
November 14, 1996, 2:25 pm
The Johns University School of Public Health

Good afternoon.

Last March I was delighted to accept Johns Hopkins' invitation to be Honorary Chair of this important conference. We are here to celebrate one of the best and most basic tools known in the world today to prevent disease and premature death.

Today we gather to mark the 25th Anniversary of the introduction of the WHO-recommended Oral Rehydration Solution in the United States and to increase its use among our medical practitioners and families. This simple therapy, costing only a few cents a dose, now saves the lives of millions of infants around the world every year. While the therapy was developed by US scientists, and proven effective for children in the U.S., we have failed to teach our parents to use it.... or our medical students to apply it as the first line of treatment for common diarrhea. Today, three hundred to four hundred U.S. babies die a year from diarrheal dehydration. At least 200,000 children are hospitalized. Twenty-six hundred (2,600) elderly die. Added to this toll of human suffering, our failure to promote ORT wastes more than 1 billion health care dollars per year.

You who have gathered here today have the determination and know-how to stop this

intolerable waste of lives and resources.

When I was in Bangladesh 2 years ago, I saw little babies who would have died from diarrhea being saved by this miracle solution -- ORS. There is no reason why our own children should not benefit from this simple technology.

I am delighted that you who are international experts have met over the last two days to formulate a plan to stop the unnecessary death and suffering from diarrheal disease and dehydration. The nation awaits your wisdom and strategies.

In closing, I must commend the foresight and courage of the White Mountain Apache Tribe, who 25 years ago, entered into a partnership with Johns Hopkins to measure the effectiveness of ORS among their children. It was at a time when no other medical or lay community was willing to test this solution, given the alternative of "high tech"--*and high cost*--intravenous care.

I also add my personal congratulations to Johns Hopkins School of Public Health, and the conference coordinator, Dr. Mathu Santosham, for spearheading this initiative to prevent unnecessary death and suffering among our most vulenerable populations. Be assured that the Clinton Administration will do its part to continue to support humane, accessible, effective and affordable medical treatments like ORS, treatments that save lives, and improve the quality of life for all citizens of the U.S.

Thank you and best of luck.

Transcript

FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO NATIONAL LESSONS WITHOUT BORDERS CONFERENCE
BALTIMORE, MARYLAND
SEPTEMBER 16, 1996

Thank you. Thank you very much. I want to start by apologizing for the delay. It took a lot longer in the rain to get here than anyone had planned and I'm very, very sorry that anyone had to wait and I hope you've not been inconvenienced.

But I am delighted to be here and I'm especially pleased because as I look out in the audience, I see that we have both those who are participating in the Lessons Without Borders Conference, who themselves are development experts who are working both abroad and here at home and dealing with the most pressing human needs that we face around the world, but I'll also note that there are younger students and faculty from Johns Hopkins who may not be as familiar with what this conference is about. And so I'm delighted that you have both those involved in it and those who are interested in these lessons, and I look forward to sharing some of my impressions with all of you.

I particularly want to thank Mayor Schmoke and his wife Dr. Schmoke who are here for their friendship and support but also more particularly, Baltimore was the first city that really embraced the idea that the work that the United States had been doing abroad for decades might possibly have something to teach us here at home. And under Mayor Schmoke's leadership those lessons have been taken to heart and put into effect.

We're also always pleased to be anywhere with your United States Senator Paul Sarbanes and his wife Christine Sarbanes. I'm particularly pleased though, on this occasion, that Mr. Sarbanes has been a consistent, reasonable voice on behalf of American involvement around the world in the area of development.

Congressman Cummings is here as well and our Ambassador to Bangladesh, David Zamiro (phonetic). I also want to thank Johns Hopkins. Once again I must say I love coming and Dr. Brody is always such a delight for me to read about and learn about what this great university is doing, and I want to thank you for hosting this. But more that for the role that Johns Hopkins has played in development work and in particularly the work of USAID for many years.

And then finally I need to thank Brian Atwood, the administrator of USAID, who has brought a new sense of energy and urgency and common sense to the agency and has really made a difference under his leadership, not only in making our work abroad more effective but beginning to explain to those of us who pay for it, the American taxpayer, why it is a good investment to be doing what we are doing around the world in helping people to become self-sufficient, understand what democracy means, what the requirements

of citizenship are.

So all in all, it is a great pleasure to be here and thank all of you who are involved in this conference for bringing so much energy, faith and commitment to the partnership that is represented by the USAID experience abroad and in our communities here at home.

Since Brian Atwood launched the USAID initiative "Lessons Without Borders" two years ago, I've been following its progress with great interest. And I've been extremely pleased to see that the program has already helped improve the lives of thousands of American children and families.

Now let me just explain to those of who are not development experts what we're talking about, and I'll do it by giving you a few examples of what has happened abroad that the United States has helped fund and provide technical assistance for, and what we have learned which we then have brought home.

For example, here in Baltimore we have seen how grassroots strategies pioneered in Nairobi, Kenya, can also improve childhood immunization rates and encourage economic development in America. As you may know, Baltimore has increased its childhood immunization rates from 62 percent to over 95 percent by adopting a simple strategy of replacing complicated jargon and brochures that people didn't read with a door-to-door, person-to-person initiative, so that people in the neighborhoods where the largest numbers of children not being immunized would find a knock on the door and a neighborhood worker standing there to say, "Have you gotten your baby immunized?" If not, "Why not?" and "How can I help you get that done?"

I'd often wondered in the years during which I was involved in trying to increase the immunization rates of American children why, for example in this hemisphere, the United States would have the third or fourth worst rate of immunization, while so many countries that were poor and had a high rate of illiteracy were doing a better job than we. What were we not doing?

It really boiled down that in many other countries USAID was helping those countries create infrastructure that would reach out to families to persuade them to bring their babies in for their shots. And often times it would be a worker who would go up across the mountains of Peru or through the rain forests of Central America or out into the savannahs of places like Kenya, finding families and helping them overcome the obstacles of knowledge and awareness, or transportation or fear or whatever else might stand in the way to be sure that their children would be immunized.

So when we look at what we have done as a country abroad, I thought it was just common sense that under Brian Atwood's leadership USAID, which cannot fund programs here in the United States, that is not its mission, would though be able to share its expertise and acquired experience with cities like Baltimore.

For decades, USAID has supported efforts in developing countries to address the debilitating problems of poverty: Poor nutrition, poor pre-natal care, disease, illiteracy, and unemployment. USAID workers and their partners abroad have seen firsthand what is practical. So how then can we profit from that?

Well that is what this conference is all about. We are bringing together the people who have done the work on behalf of you and me, through our development efforts with people who are working in our cities and our rural places here at home.

Over the past four years I have seen firsthand many programs around the world that really work. I have become somewhat of a cheerleader for USAID and development efforts because I, like perhaps many of you, am not very knowledgeable about what we actually do in foreign aid, and many people in our country have an idea that we spend a huge percentage of our budget on foreign aid. In fact often times in public polls when citizens are asked, "How much do you think the United States spends on foreign aid?", the answers range from 15 to 25 percent of the United States budget. And often times then the person asking the question will follow up and say "Well how much do you think we should spend to try and deal with problems in other countries, both to help the people there and to stop the spread of several problems to make the world safer for American interests?", and people scratch their heads and say "Well maybe ten percent."

Well of course the fact is we spend less than one percent on foreign aid, on the kind of work that is done not only to keep our embassies going abroad, to take care of you when you travel and might need some help, but to do this kind of work as well. And I have seen and became somewhat of a witness about how effective the relatively small amounts of money so many of our programs abroad rely on are.

We've already heard reference to a dinner that is being held later this evening in honoring an institution called the International Center for Health and Population Research in Bangladesh. That center has had lots of help from Johns Hopkins as well as from USAID. The doctors there have saved millions of young lives through their pioneering use of something called Oral Rehydration Therapy. That is a method of treating serious cases of diarrhea with a basic salt-and-sugar mixture. Now I brought up this packet with me to show those of you who are students here at Johns Hopkins what I'm talking about, because the others who are working in this field know very well that inside this packet is a mixture, a combination of salt and sugar that when dissolved in clean water and administered to a person with diarrhea, particularly a child is most likely the one to be afflicted with perhaps fatal diarrhea, that child's life can be saved. It doesn't even have to be in a hospital or intravenous fluid going through the veins if this is administered over a long enough period of time.

I walked along the beds in this center in Bangladesh and I've seen mothers and fathers and sisters and brothers administering this combination of salt and sugar to a person seriously ill with diarrhea. My visit there was meant to highlight the USAID presence and American support for this pioneering effort.

But while I was there, I met a doctor from Louisiana who had come to study at the center for about six months. And I asked him why he had chosen that center, and he told me that at the time I had this conversation with him, a very large number of children in Louisiana were uninsured children, they were very poor but not poor enough to qualify for the state's level of Medicaid, and their families did not have jobs that provided health insurance, and that he was seeing increasing numbers of children hospitalized who were dangerously ill because of diarrhea. So he had gone all the way across the world, to a country we think of as a less developed country, to learn a cost-effective, simple method for helping save children's lives which he then could bring back to Louisiana. It's that kind of interchange and learning of lessons this conference is meant to promote.

Some of you who know the work of Jim Grant and others of you I'm sure have heard of UNICEF understand how he took simple ideas like this little packet and preached, to many of us it seems as though he would never stop, about how these simple interventions that don't cost a lot of money could really save children's lives. And that's what we're seeing here in the United States. Oral Rehydration Therapy can be a more accessible, more effective, and less costly alternative to hospitalization: It costs just $7 a day, it can be administered at home, compared to the $800 a day it costs to administer intravenous drug treatments in American hospitals.

The lessons we can learn go beyond health. They also apply to our challenges from economic self-sufficiency to effective family planning.

Last fall, I visited a poor area of Santiago, Chile, where the schools are open on weekends to accommodate parents' work schedules. And I met a lot of parents who are trying to become more involved in their children's lives and to know what to do, how to take care of their children more effectively. I see in this country similar kinds of parenting programs, some of them borrowing lessons from what we are seeing what works in other countries.

One of the most exciting programs that we have brought home at the national level here as well as locally is what is called microenterprise. That means lending small amounts of money to very poor people for them to start their own businesses, for them to buy certain products that they need to re-sell so that they can try to become more economically self-sufficient.

That is happening here in Baltimore. With microenterprise lending, small loans are given to start very small microbusinesses. I've seen the difference that can make in the lives of people from India to Nicaragua. I have stood in some of the poorest places in the world and have listened as women told me how their lives had changed because somebody had believed in them enough to see them as credit-worthy. When all of a sudden they had some resources which they used to create a business.

As we begin to implement welfare reform, I think one of the most important aspects of our efforts will have to include a very large-scale commitment to microenterprise. Because if we intend to not only help people get off welfare, but to change the

environments and communities in which people have become economically trapped, there has to be more economic activity. If we think that is a challenge, then imagine how it must have seemed to the very first person in the world to devise the idea of microenterprise.

His name is Dr. Muhammad Yunus, he is also from Bangladesh, he was trained in the United States as an economist and when he returned home he looked for ways to try to take the ideas he learned about the economy and put them into practice in his own country. He realized that although the millions and millions of very poor people in Bangladesh had skills, those skills were not considered economic skills. They weren't considered market-worthy. And yet he could see how with a little bit of investment, those skills could create entrepreneurs and businesses that would create economic activity, that would help lift not only individuals but whole communities out of poverty.

I visited one of the villages where the bank that got these started, the Grameen Bank, is working. And I looked at this village, it was a Hindu village that was a village of untouchables. My schedule was such that I could only go to one village, and the people arranging it wanted me very much to go to a Muslim village, as Bangladesh is a predominantly Muslim country. But we couldn't work it out and so the Muslim women, and all the borrowers were women, came from their village to the Hindu village where we had a big meeting, where the women stood up and told me how their lives had changed.

One woman had stood up and told me that she borrowed the money to buy a milk cow. With that one milk cow she was able to produce enough milk which she then sold so she could buy another milk cow. And then as a proud owner of two milk cows she was able to take the money that she made and buy a rickshaw for her husband, so that he could begin to try to be a taxi driver in the village where they lived.

I went into a home that had been built because of the Grameen bank's lending policy, and I saw firsthand how the entire village had been transformed and as importantly, how the lives of these women who were borrowers had changed from destitution to inspiration, not only for themselves but importantly for their children and the rest of us.

I visited a similar microenterprise effort at a community-based bank in Managua, Nicaragua, one of the poorest areas of that city that has seen civil war, earthquakes and many different kinds of challenges. At the FINCA Village Bank, "Mothers United," a group of women located in that neighborhood, had borrowed money and had worked with each other by creating a unit of borrowers who supported each other's economic activity. I heard how those very small sums had started businesses that were sewing and selling clothes or baking bread and pastries, selling auto parts door to door, mosquito netting. The kinds of things that were needed in the community but would otherwise, perhaps, not be available.

And finally, on my visit to Santiago, Chile, I met a seamstress who told me that for years she could barely make a living. She had an old, beat up sewing machine that was always breaking down. With a small loan she got a brand new, fast-speed sewing machine, and she told me "I felt like I had been released like a bird from a cage." She got that

sewing machine and began to kiss it over and over again because she knew what a difference it would make in her life.

We have seen in our travels so many instances of how USAID, with a little bit of money, has been able to spawn a great deal of local support and community effort and has been able to, with technical assistance, train people in the local areas to carry on the work. So as we look at the lessons that have been learned from our work overseas, I'm convinced that many of those lessons can be learned and applied here.

One of the most important areas is in family planning and prenatal care for children. And particularly for at-risk children and their mothers because we still have a very high rate of infant mortality and maternal mortality around the world. And in some of our inner cities our rates of infant mortality are as high as some third world countries.

In Indonesia I saw how the whole community had come together to support families in their choice of family planning and in the care of their children. In Brazil I met very courageous health officers who had committed themselves to family planning efforts because the hospital where I visited with them has an admission rate that is 50 percent women giving birth and 50 percent women who are appearing at the hospital after self-induced abortion with serious physical problems. And those health officers knew that sensible family planning access had always been available to the rich women in Brazil, but not available to poor women.

Certainly many of the problems that we see around the world are exacerbated by incredible population pressures, and one of the things that I would hope is that when our Congress looks at USAID's work, they would understand how important family planning is internationally. That American assistance to try to help countries deal with their population pressures is in America's interest economically, environmentally, politically and every other way I can think of.

So these are the kinds of issues that we have brought home with us and this is what this conference is all about. There are many more examples that will be discussed at this conference, from the hospital that I saw in Manila where one day-old babies are being taught to drink from cups because they cannot be taught to breastfeed, so they cut down on infection from bottles that can't be sterilized in slums, to the kind of work that I saw in Central and Eastern Europe that are teaching people what democracy really is, what a free press is. All of it is part of America's commitment to take our own ideals and give other people the chance to learn how to live democratic, free enterprise lives in this complicated, new challenging world.

Now in the grand scheme of things America's investments in social development abroad are minuscule. But the differences that they have made in our global economy, in world peace and prosperity and the lives of men, women and children are immeasurable.

America's ideals and interests cannot be worse than the political, economic and social... (inaudible). As this conference demonstrates, our engagement represents

opportunities for ourselves at home, not just obligations abroad. I would hope that every American who hears about this conference will understand that it is a two-way street. The money being invested in social development abroad is being brought home in the sense that we are learning what works and applying to solve our own problems here.

These lessons, I believe, are valuable and will more than pay for themselves. They are proof that this country, the strongest nation on Earth, cares about the smallest child, the littlest problem, because we understand how interconnected we are today. And we understand that ultimately, the kinds of futures those of you who are students at Johns Hopkins now can look forward to will in some measure depend upon what we do to take care of the last and the least among us. What we do to solve our own problems in Baltimore or Boston, and what we do to help solve problems in Bangladesh.

Because as we look toward the 21st century, as we understand how each of us is going to have to work and be educated to fulfill our own potential, we also, I hope, understand that our potential will be enhanced the better educated and the better the economy is in places very far from here, and that at its heart, America's interests lie in making sure that not only our own people but many of the people on this earth go to bed looking forward to waking up in the morning, because they're going to have some control over their own destiny.

So Lessons Without Borders is a way of saying we have learned from what we have done and we want to continue leading the world, and showing the way to how our problems can be solved so that we can build a better future for everyone.

Thank you. Thank you very much.

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JOHNS HOPKINS
UNIVERSITY

School of Hygiene and Public Health
Department of International Health
615 North Wolfe Street
Baltimore MD 21205
(410) 955-6931 / FAX (410) 955-2010

Center for American Indian and Alaskan Native Health

MEMORANDUM

To: Sabrina Corlette
From: Allison Barlow Bova
Subject: ORT Information
Date: October 24, 1996

Please find attached information to explain the thrust and purpose of the *25th Anniversary Celebration of the use of Oral Rehydration Therapy in the United States.*

Mrs. Clinton's video message will be shown at a large Public Forum (250-500 attendees) on November 14 at approximately 2:25 pm. It will be introduced by Alfred Sommer, MD, MHS, Dean of the Johns Hopkins School of Public Health. A draft script for the video message is attached. Stapled to it is the agenda for the Public Forum. In addition, I have attached a 30 second script for a PSA that would be sent to all major networks, local stations in DC, MD, VA, and if funds permit, the nine major media markets throughout the US.

Additional background information I have attached for you and Brenda Costello includes:

- Overview of the purpose of the event
- Information about ORT (fact sheet)
- Agenda for the symposium culminating with the public forum
- Draft of consensus statement to be read at the Public Forum
- List of symposium participants
- Invitation to public forum

Thank you for your help and interest. We can only imagine what a busy time this is for the White House staff, and we are grateful for you time. If we can answer additional questions, please do not hesitate to contact me (410-614-2072) or Liz Pettengill, Division of Public Affairs (410-955-6878).

List of invitees to Oral Rehydration Therapy 25th Anniversary Celebration:

- World experts in ORT, Pediatrics, Health Care Economics and Policy
- Representatives from USAID, UNICEF, WHO, American Academy of Pediatrics, US Health and Human Services and the Indian Health Service
- Symposium Participants
- Johns Hopkins Medical Institutions
- Faculty, staff and students, University of Maryland Medical System
- Faculty, staff and students, Pediatric Infectious Disease and GI departments in medical schools in New York, New Jersey, Virginia, DC, West Virginia
- Representatives of manufacturers of ORT: Wyeth-Ayerst, Ross, CERA, etc.
- Officers and CEO's, managed Care and Health Maintenance Organizations, nationwide

In the United States, **300-400 children die** each year due to dehydration from diarrheal disease. While diarrheal disease in this country, compared with that affecting children in developing countries, is mild, it accounts for **4.5-5.5 million outpatient and emergency room visits**, and an excess of **$1 billion hospital costs.** Oral Rehydration Therapy (ORT), in use in developing nations for the past twenty-five years, saves children's lives as well as health care dollars. Using ORT instead of an IV to rehydrate a child with diarrheal dehydration is both humane and cost-efficient, and parents can be trained to recognize the signs of dehydration and initiate treatment in the home, before a child becomes moribund.

In November, 1996, at Johns Hopkins School of Public Health in Baltimore, leaders in public health, pediatrics, managed care, preventive medicine and the insurance industry will come together to inaugurate a nation-wide campaign to promote ORT as first-line treatment of diarrheal disease and dehydration in the US medicine. A public ceremony on November 14, 1996, with appropriate significant media coverage, will launch an intense public effort to alter the practice of using high-tech, high cost medical procedures, when simpler treatments are as effective, less expensive and less traumatic, particularly to children.

As stated in the ORT Consensus statement, to be signed by representatives of the American Academy of Pediatrics, the World Health Organization, UNICEF, Centers for Disease Control, and pediatric infectious disease faculty from across the country at the November 14 event, the **proximate goal is to reduce diarrheal mortality and hospitalizations in the US by 50% in the next four years -- by the Year 2000.**

These goals can be accomplished by:

1. Encouraging the use of ORT promptly to correct dehydration from diarrhea
2. Distributing guidelines set forth by the AAP (3/96); ORT should be used as **first line therapy for all children with mild-to-moderate dehydration.**
3. Making sure that medical facilities treating children have Oral Rehydration Solution readily available.
4. Teaching new parents about the use of ORT.
5. Providing all pediatric practitioners with continuing education opportunities regarding management of diarrhea.
6. Utilizing well-baby visits to educate parents about the management of diarrhea and the use of ORT.
7. Educating the general public about the use of ORT and management of diarrheal disease by developing and widely circulating appropriate materials.
8. Developing regional ORT demonstration and training centers throughout the country.

Dr. Mathuram Santosham, Professor of Pediatrics and International Health at Johns Hopkins, and Director of the Center for American Indian and Alaskan Native Health, is the co-ordinator of the Anniversary Celebration. A quarter century ago, Dr. Santosham was a researcher on the White Mountain Apache Reservation in east central Arizona. Infant mortality rates due to diarrheal disease on the reservation rivaled those in the Third World. Introduction of ORT to the community through the use of "fieldworkers" resulted in an almost immediate reduction of death due to diarrheal dehydration to zero. The White Mountain Apache Chairman, Ronnie Lupe, will offer an opening blessing at the public portion of the 25th Anniversary Celebration, and, on behalf of the tribe, accept an award recognizing the contribution that Indian people played in confirming the importance of ORT in US medicine.

Dr. Santosham will act as facilitator of the the scientific symposium and welcome participants and guests to Johns Hopkins for the celebration. A recognized world authority on ORT and diarrheal disease, Dr. Santosham is responsible for much of the interest in the medical community in altering current treatment of diarrheal disease.

ORT FACTSHEET

There are more than 20 million episodes of diarrhea in American children each year. Each year 4.5-5 million children are seen in emergency rooms and outpatient settings for diarrheal dehydration. Of those children seen, 180,000 -200,000 are hospitalized. Between 300-400 children die each year in the United States because of diarrheal disease and dehydration. It costs $1 billion each year to treat diarrhea and dehydration in American children using the current protocol of intravenous therapy.

- Childhood diarrhea accounts for 20% of acute care visits in city hospitals in the United States.

- Diarrhea is responsible for approximately 10 percent of preventable deaths of children in the United States.

- Fewer than 25 percent of children in the United States receive the benefits of ORT when ill with diarrhea.

- Antibiotics and antidiarrheal drugs have little role to play in combatting childhood diarrhea. They are ineffective and may have damaging side effects on small children.

- ORT is labor intensive: small amounts of rehydrating solution are fed to children over a period of several hours to days. It is not a "quick fix", but it is as effective as IV therapy, less invasive, and far less expensive.

- The technique for the administration of ORT can be taught to those with no medical background.

ORT can and should be made the first line treatment of diarrheal disease and dehydration

National Symposium
Celebrating 25 Years of ORT Use in the United States

ORT: We have the Solution. What is the Problem?

November 13-14, 1996

Hosted by The Johns Hopkins School of Public Health
Baltimore, MD

Goals:

- **Review current status of ORS globally**
- **Review diarrhea morbidity and mortality and economic impact in US**
- **Review ORS knowledge and attitudes among US health care**
- **Review ORS use rates**
- **Make recommendations for increased ORT rates in the US**

Sponsors:

Ross Products Division, Abbott Laboratories
World Health Organization
Wyeth-Ayerst Laboratories
American Academy of Pediatrics
US Agency for International Development
UNICEF

Scientific Symposium
Day 1
November 13, 1996

12:00-1:15 pm	Welcome and Opening Remarks	Mathuram Santosham, JHSPH Robert E. Black, JHSPH
	Special Guest Speaker	
	LUNCHEON	
1:15-1:45 pm	Development of ORS: Physiologic Basis and Early Studies	Bradley Sack, JHSPH
1:45-2:15 pm	First use of WHO-recommended ORS in USA: Apache Studies	Bert Hirschhorn, University of Minnesota
2:15-2:45 pm	Current Status of ORS and New, Improved Formulations	Jim Tulloch, WHO Olivier Fontaine, WHO
2:45-3:15 pm	Clinical Trials of ORS in the United States	Chris Duggan Children's Hospital, Boston
3:15-3:30 pm	BREAK	
3:30-4:00 pm	Morbidity and Mortality from Diarrhea in the United States	Roger Glass, CDC
4:00-4:30 pm	Feeding Issues in Diarrhea	Ronald E. Kleinman Massachusetts General Hospital
4:30-5:00 pm	Problems with Diarrhea in AIDS Patients and the Elderly: Use of ORS in Special Populations	William Greenough, JHH
5:00 pm	Distribution of Draft Consensus Statement	

Scientific Symposium
Day 2
November 14, 1996

8:00-8:30 am	BREAKFAST	
8:30-9:30 am	Adoption of Consensus Statement	
9:30-10:00 am	Physicians and Parents: Knowledge, Attitudes and Behaviors Toward ORS	John Snyder UCSF
10:00-10:30 am	Parent Compliance with Provider Recommendations for Treatment In Pediatric Diarrhea	Anita Chawla MEDSTAT
10:30-10:45 am	BREAK	
10:45-11:15 am	Implementation of ORT Program In Pediatric Clinics and Emergency Rooms In the United States	Julius Goepp, JHH
11:15-11:45 pm	Economic Impact of Diarrheal Disease In the United States	Gerard Anderson, JHSPH
11:45-12:15 pm	General Discussion Concluding Remarks for Symposium	Mathuram Santosham, JHSPH
12:15-1:30 pm	LUNCHEON	

The Scientific Symposium is funded by a grant from Ross Laboratories, Columbus, Ohio and the World Health Organization.

25th Anniversary Celebration:
Oral Rehydration Therapy in the United States

Public Forum and Campaign Launch

November 14, 1996

2:00-2:10 pm	Introduction and Welcome	Mathuram Santosham, M.D.
2:10-2:30 pm	Blessing Ceremony	Ronnie Lupe, Chairman White Mountain Apache Tribe
	Presentation of Recognition Award to White Mountain Apache Tribe	Everett R. Rhoades, M.D. Former Director, Indian Health Service
	Special Message from the Honorary Chair	First Lady Hillary Clinton
2:30-2:50 pm	Keynote Address	J. Brian Atwood, Administrator USAID
2:50-3:00 pm	Reading of Consensus Statement	Antonia Novello, M.D., M.P.H.
3:00-3:30 pm	Panel Discussion	David Brandling-Bennett M.D. WHO Denis Broun, M.D. UNICEF Edward Keenan, M.D. AAP
3:30-3:45 pm	Concluding Remarks	Mathuram Santosham, M.D.
3:45-5:45 pm	RECEPTION	

List of Scientific Symposium Attendees

Gerard Anderson - JHU
Susan Baker - University of South Carolina
Richard Cash - Harvard University
Anita Chawla - MEDSTAT Group
Robert Clay - USAID
Larry Croll - IHS
Chris Duggan - Harvard Medical School
Olivier Fontaine - WHO
Stephan Foster - IHS
Steve Garrett - IHS
Mark Gilger - Texas Children's Hospital
Roger Glass - CDC
Julius Goepp - JHU
William Greenough - JHU
Joyce Harper - MD State Health Department
Norbert Hirschhorn - Minnesota Department of Health
Maurice Keenan - AAP
Ron Kleinman - Harvard Medical School
William Klish - Texas Children's Hospital
Alan Lake - JHU
Alan Myers - Boston City Hospital
Caryn Miller - USAID
David Nalin - Merck Research Laboratories
Antonia Novella - NIH
David Oot - USAID
Robert Parker - Washington County Health Department
Nate Pierce - JHU
John Ryan - Health Officer, Talbot County
Bradley Sack - JHU
David Sack - JHU
John Snyder - University of California
Jim Tulloch - WHO
Ron Waldman - BASICS

Consensus Statement

Oral Rehydration Therapy (ORT) is a well established form of therapy for the treatment of dehydration due to diarrhea. The principles of ORT are: early adequate rehydration therapy using an appropriate oral rehydration solution (ORS), replacement of ongoing stool losses with ORS, and frequent feeding of appropriate foods as soon as dehydration is corrected.

Diarrhea is a major cause of morbidity and an important cause of mortality in the US. Each year, approximately 300 to 400 children die as a result of diarrhea and 180,000 to 200, 000 are hospitalized. Among the elderly (60^{+} years of age), there are approximatley 2,600 diarrheal deaths per year. There are 4.5 to 5 million clinic visits for diarrhea resulting in a total estimated cost of more than one billion dollars for children alone.

The effective use of ORT has saved millions of lives around the world. However, in the US, ORT is often not used optimally. Contrary to the recommendations of the American Academy of Pediatrics (AAP), pediatric practitioners overuse IV hydration, prolong rehydration therapy, delay re-introduction of feeding, and inappropriately withhold ORT especially in children who are vomiting. The experts gathered at the Scientific Symposium on November 13,1996 would like to propose the following measures that could reduce diarrhea mortality by 25% and reduce hospitalizations by 50% in the next 5 years:

I. Implementation of AAP guidelines:

a) The guidelines published by the AAP in March 1996 that recommend **ORT** as the **first line of therapy** for all children with mild to moderate dehydration secondary to diarrhea should be widely distributed.

b) All general pediatric and emergency departments, clinics and pediatrician offices should have ORS readily available and implement its use according to the AAP guidelines.

c) Parents of infants seeking medical care for diarrhea should be provided education about the use of ORS and early feeding.

II. Prevention of dehydration:

a) Educational material about the prevention and treatment of diarrhea, emphasizing the importance of early hydration with home available fluids and ORS, should be developed and widely distributed.

b) All providers should be encouraged to educate and provide materials to parents during well-baby visits about the management of diarrhea, particularly the appropriate use of ORS. Families should be encouraged to have ORS available at home.

III. Training of Providers:

a) Continuing education opportunities regarding the management of diarrhea, should be provided to all pediatric practitioners, nurses and health care providers to infants.

b) Regional ORT demonstration and training centers should be established at several sites around the country, to act as training centers and for ongoing development of strategies and skills to implement ORT programs.

4. **Third party payment for services:**

a) All third party payers should be encouraged to reimburse physicians and hospitals appropriately when ORS is used for the treatment of diarrhea.

List of Scientific Symposium Attendees

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