

PN-ABK-097
ISN 74953

FIELD NOTE

**PUBLIC AND PRIVATE SECTOR COLLABORATION
FOR THE MARKETING OF COMMERCIAL ORS IN HONDURAS**

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Sponsored by the
Office of Health and Office of Education
Bureau for Science and Technology
United States Agency for International Development
Academy for Educational Development

University of Pennsylvania, Applied Communications Technology, Needham Porter Novelli, and PATH

Since the late 1970s, the Honduran Ministry of Health (MOH) has advocated the application of social marketing to expand the availability and use of oral rehydration salts (ORS) to control diarrheal disease among children under five. In 1986, a comprehensive program review stimulated interest in extending the local availability of ORS and increasing its use in the home. This review revealed that a significant portion of the population at risk for diarrheal disease was currently not seeking help from either private sector physicians or local Ministry of Health facilities, and thus were not receiving information, treatment, or packets for diarrheal disease. A program was thus launched to examine characteristics of this target audience, what market "place" would be most hospitable to them, and how an ORS product could best be made available to them. The answer was challenging: the most promising market was a small, independent commercial outlet, and the most appropriate producer and distributor of this product was most likely the private sector.

LOOKING AT THOSE OUTSIDE THE SYSTEM

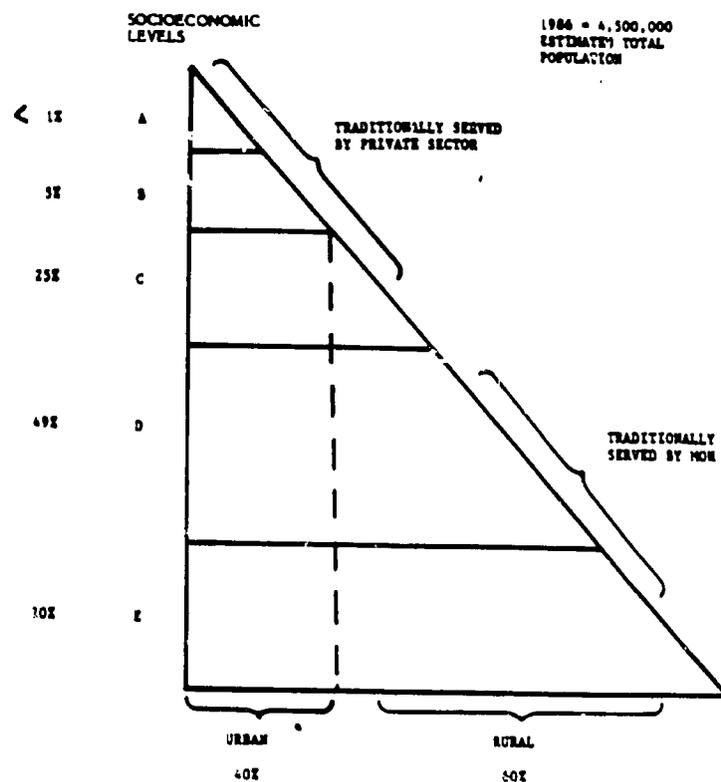
Before looking at those who were "slipping through the system," it should first be mentioned how significantly this system has been improved over the last decade. Under the Ministry of Health's last two five-year health communication plans for child survival (PROCOMSI I and II), enormous strides were made in the promotion and home use of oral rehydration salts. After an initial intensive two-year intervention (1981-1983) in the pilot area, Health Region I, one-third of diarrhea cases were being treated with ORS after its introduction in health centers. About 60 percent of mothers surveyed reported having tried ORS at least once. By 1987, a survey in four health regions revealed that 36 percent of mothers reported using ORS for a child's current case.¹ This degree of success within a short period of time was due in great part to a carefully planned program of integrated mass media, community outreach, and health worker training to promote correct ORS use and related behaviors. However, the Ministry of Health also realized the limits of its capacity to reach all citizens effectively, both in terms of the quantity of ORS needed and the variety of distribution networks. In 1986 the MOH believed it was appropriate to find out exactly who was being missed and how to reach them.

The authors would like to thank Julia Rosenbaum and Renata Seidel (HEALTHCOM/Washington) for finalizing this document.

A rough overview of the Honduran "marketplace" sheds some light on the challenge. Figure 1 shows the general characteristics of the population with regard to health service utilization. In 1986, the total population was estimated to be 4.5 million, with 40 percent of the population living in urban areas and 60 percent residing in rural areas. One-third of the population lives in the capital of Tegucigalpa and industrial center of San Pedro Sula.

The Honduran population can be stratified into five socioeconomic groups. Group A includes approximately one percent of the population and consists of a very small, wealthy group of businessmen and military leaders. Group B includes five percent of the population and is characterized as a wealthy, educated group with easy access to goods and services. Group C includes 25 percent of the population, and would typify Honduras' "middle-class." This group is both urban and rural with mixed educational and income levels. Public employees (civil servants), management, and other professionals of private industries, etc., belong to this grouping. Group D is the largest group, representing 49 percent of the population. The group is primarily rural, although it includes both urban and rural. Income is relatively low and comes from both formal and informal sector employment. Level of schooling is also low with both literate and illiterate individuals. Hondurans in the lowest level, level E, live in extreme poverty, some completely outside of the cash economy. This group is primarily rural and has extremely low levels of literacy, poor sanitation, and suffers high rates of morbidity and mortality.

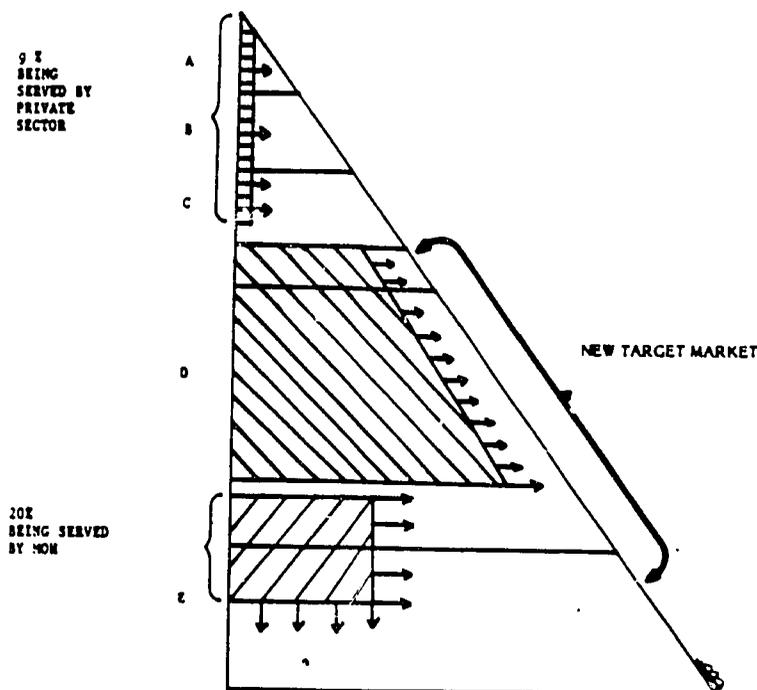
Figure 1
Honduran Health Service Utilization by Socioeconomic Level



Traditionally, the private health sector has served Groups A, B, and a significant portion of Group C since these people are primarily located in urban areas and can afford to pay for medical services. They have access to private physicians and to pharmacies. Approximately 300 pharmacies and other commercial outlets are licensed to sell medicines in Honduras. These establishments are located largely in towns with populations greater than 2,000. Portions of Groups D and E and a percentage of C typically seek services from the Ministry of Health facilities. However, large percentage of Groups D and E live in widely scattered rural areas and their access to health facilities is somewhat limited. According to the government's 1980 health sector assessment, approximately one-third of the population had reasonable access to MOH facilities and one-third had limited access. (Reasonable access was defined as three kilometers, or 45 minutes walking time, from a Ministry facility.) The final third had no access.

It is important to mention that accessibility has improved over the past six years with the addition of new rural health centers, now totalling more that 700. Yet even among those people who have good and/or limited access, a certain portion choose not to avail themselves of MOH services. Figure 2 shows the population in groups C and D and E whose needs related to diarrheal disease control were not being adequately met through either private or public medical services.

Figure 2
ORS Social Marketing Audience Segmentation



Even among those who were not seeking help from private physicians or MOH clinics, however, most mothers whose children had diarrhea did something. They used herbal teas; they went to traditional healers (midwives or masseurs called sobadores); they bought over-the-counter remedies, including antidiarrheals, from small retail outlets (puestos de ventas de medicinas and pulperias) which commonly carry a large line of popular medicines. Indeed, research showed that although this group [?] could not afford expensive prescription, or "ethical" products, (and indeed generally did not even have access to pharmacies), 93 percent were willing to spend an average of U.S. \$1.50 three times month on medicines³ of some kind.

The Ministry therefore came to the conclusion that if the people could not be brought to the product, the product would have to be brought to the people. The most effective distribution system would most likely be the system of small retail shops common in rural and most urban areas. Pulperias are located everywhere (in both rural and urban markets) and sell to all socioeconomic strata. In addition, pulperias are open more days and hours than MOH facilities. The product itself would have to be priced within the reach of the target population. Since it would have to compete with common over-the-counter remedies (such as antidiarrheals) it would require a strong promotional program to support the new product position and distribution. It would also require some sort of training program for distributors so that the store owners would be able to give correct information to purchasers about the commercial ORS product.

ESTABLISHING OBJECTIVES

The Ministry reached these conclusions through a process based upon principles of social marketing. Social marketing is the application of commercial marketing techniques and business practices (market research, product development, pricing, promotion, and distribution) to produce a social benefit. It focuses upon the consumer-- the consumer's perception of his or her needs and the consumer's competing alternatives. Social marketing encourages socially beneficial practices by appealing to people's self interest.

As the Ministry studied the population's needs it was able to refine objectives. It aimed to reach people who were not able to afford high price products available in commercial outlets and who were not being served by or chose not to use MOH institutional services. Overall goals were to:

- produce and package a quality ORS product by a local manufacturer according to the WHO formula;
- distribute the product through existing commercial systems to retail outlets;
- sell the product at a price affordable to mothers;
- support the product with a promotional program designed to stimulate and increase demand for ORS.

The expertise needed for such a program lay in large part beyond the capabilities of the Ministry of Health. The solution appeared to be some form of collaboration with the private commercial sector.

CONSIDERING THE PRIVATE SECTOR

The decision to engage the private sector suggested both new opportunities and new challenges for a national diarrheal disease control effort. From a social marketing perspective, the commercial sector would have much to offer. It could produce and package a quality product. It could distribute this product in a cost efficient fashion and with appropriate frequency to outlets popular among the target audience. It could contribute understanding of and linkages with the retail system in order to help design an appropriate promotion program. On the other side, the public sector had equally important resources to offer. The Ministry had a thorough understanding of the population's health needs and the requirements and attributes of the product. It had extensive experience researching audience perceptions and behaviors and positioning its own ORS product, LITROSOL. Moreover, the Ministry proposed taking on the process of research and development (R&D) for the new product. This cost is normally borne by the pharmaceutical industry itself when it wishes to introduce a new product or enter a new market, and the cost is factored into the final purchase price. With the Ministry taking on this activity, the company(ies) who participated could pass on the savings to the consumers.

However, such partnerships between the private and public sectors in Honduras--indeed in most countries--are rare. In this case, neither side had successful models of collaboration to build upon, and lack of experience working together would compound any

any potential problems. A series of questions needed to be answered before involving the private sector: Would the private sector be interested in the social marketing of ORS? Would nontraditional outlets be willing to sell ORS? Would existing distribution systems carry the product? Could the product be sold at a low enough price to be affordable to the target population but at a high enough price to provide sufficient incentives to the private sector (manufacturers, distributors, wholesalers, and retailers)? Would a private sector program complement or compete with that of the Ministry? And, perhaps most importantly, could two such different structures--with varying management systems, goals, and perspectives--be able to work smoothly and productively together towards a common aim?

Only careful research and negotiation would determine whether such a partnership would be advantageous to both sides and whether it would ultimately be beneficial to the target audience. This field note covers a period of approximately two years. One of the overriding themes of this experience has been that such collaboration takes time, patience, and mutual planning. One of the benefits, however, is that both sectors gain more than just a new "product" and a new "market." The learning process can be institutionalized. In this case, the initial effort began with middle management levels within the MOH and ended as a priority at the level of the Director General. For the target audience, the rewards of this partnership should continue to multiply.

THREE STAGES OF RESEARCH AND PLANNING

The process of looking into partnership possibilities itself began as a cooperative venture. The Ministry of Health, with the assistance of the HEALTHCOM Project, Aragon y Asociados (a local subcontractor), and with the support of Management Sciences for Health/Honduras, took the first steps and coordinated efforts. The initial team consisted only of the authors of this document: a member of the Epidemiology Unit within the Ministry, two members of the Science and Technology Research Unit, a consultant funded by the U.S. Agency for International Development through AED and a resident technical advisor. Our backgrounds were highly complementary--balancing the medical, research, and social marketing perspectives. Together, we anticipated the potential and the challenges confronting this project.

The team embarked on a three-staged research effort. The first stage, a "prefeasibility study," took place over four weeks. One objective of the study was to review and analyze existing data and literature on several subjects: the geo-socio-demographic and health characteristics of the country; the status of diarrheal disease and

government efforts to control the problem; the community infrastructure and local practices related to diarrheal disease; and the range of products currently available on the commercial market. A second objective of the study was to analyze the capabilities of the Ministry of Health infrastructure (in terms of financing, supplies, production, distribution) and to suggest alternative models for administering an ORS social marketing program including promotional activities at the national level. We presented the results of this review to the Ministry of Health together with a work plan for the next phases of research.

Phase II consisted of a detailed look at the market. The work took place over seven months. We solicited bids and contracted a private sector market research company, Aragon y Asociados, to carry out a series of marketing research studies among consumers, pharmacists, physicians, and retailers. The studies included:

- a trade overview of pharmacies, puestos de ventas de medicinas (small stores providing over-the-counter drugs), and pulperías (small general stores);
- a study of physicians' knowledge, attitudes, and practices with regard to diarrhea and ORS;
- a study of users' knowledge, attitudes, and practices with regard to diarrhea and ORS;
- a consumer ORS product home use panel.

The studies were designed to help provide a ground plan for partnership with the private sector, and also to provide a baseline for measuring future variations in the market as a consequence of the product launch.

This phase constituted the basic "R&D" which a commercial company generally carries out before introducing a new product or entering a new market. It supplied a wealth of information about how the potential outlets for the product work, what the potential "competition" is for consumers willing to spend a certain amount of money on a diarrheal remedy at those outlets, and what forces could influence the successful promotion of this product. It examined what products are sold and in what volume by local commercial outlets, how those retailers "diagnose" diarrhea and dehydration, and

what they recommend to their consumers. (In Honduras, pharmacists as well as proprietors of small general stores often assume the role of medical advisors to their local customers.) Therefore, the data, both quantitative and qualitative, also gave us an understanding of how the new product might best be positioned as a popular medicine in order to appeal to our intended consumers.

Phase III, a "feasibility study" for the Director General, presented and analyzed the research results, summarized the methodology used, provided criteria for selecting private sector collaborators, and provided an assessment of several potential commercial partners. These companies fell into a number of categories (described under "Three Models" below) according to whether they produced ethical or popular medicines and the nature of their distribution networks. The feasibility study made multiple recommendations to the Ministry of Health in order to provide maximum flexibility in working towards agreements with one or more of the companies.

This last stage was important not only to establish the context of future efforts, but also to establish working relationships within different parts of the Ministry of Health. When the feasibility study was completed, a one-day meeting was held for senior level personnel throughout the Ministry to explain the overall project strategy, the key findings, and to provide an opportunity for questions. At this time, all major departments were invited to express their concerns and to offer suggestions. The meeting laid the basis for senior management consensus within the bureaucracy. At this time, a committee was also set up to handle the process of forming an agreement with a selected private sector company(ies). The committee included representatives from several departments, including those of finance and administration.

FINDING COMPLEMENTARY INTERESTS

What is not apparent in this description of the three-staged program is the extensive learning and negotiating process which took place over the two year period. During this time members of the public and private sectors met continuously with each other to gather data but also to study formally and learn informally how the other worked, and to build relationships. This process was as complex and as important to the success of the program as any single aspect of the research or planning.

Initial internal discussions focused on what would motivate the two sectors to work cooperatively together. There were, after all, reasons why this sort of partnership did not form frequently and with ease. Within the Ministry, a better understanding of the private sector was needed--its driving forces, what factors it considered important, and

how it viewed the public sector. We also needed to analyze these same areas with regard to the public sector. We began by trying to step back and objectively examine the respective goals and views of the private and public sectors in relation to a health issue such as diarrheal disease control. We identified the following points:

Public Sector Goals are to:

- improve the quality of life for sectors of the population in need;
- control and reduce public health problems;
- ensure access to service, treatment, and education for those who cannot afford to pay for private services;
- maintain cost effectiveness.

Private Sector Goals are to:

- provide a quality product or service;
- obtain a profit or return.

Questions asked by the public sector before taking on a new initiative include:

- Would this service or treatment help to improve the quality of life?
- Does this service or treatment address an important health problem?
- Is this compatible with the national health policy? With national programs and plans? With available resources?
- How much will it cost?
- What will the benefits be?

Questions asked by the private sector include:

- Is there a demand for the product?
- Can a profit be made?
- Who would use it?
- Is it a high quality product?
- Does this product fit in our existing product line?
- If not, do we want to expand our product line?
- Will it enhance our image?
- What, if any, is the role of the government?

As this process of considering the goals and views of the two sectors unfolded, we also began to uncover a number of negative perceptions which the public sector held regarding the private sector, and vice versa. Whether the perceptions were true or not was not the issue--but the fact that they existed would affect if and how the two sectors would be able to work together. Briefly, we came up with the following.

Perceptions of the public sector about the private sector are that:

- The private sector has different goals;
- It provides services and products that are not essential;
- It serves different segments of the population;
- It wants primarily to make a profit rather than to help people;
- It enjoys high salaries and many incentives;
- It cannot be trusted; it is corrupt.

Perceptions of the private sector about the public sector are that:

- In the public sector, staff are not motivated to get work done;
- The public sector has numerous rules and procedures which interfere with progress;
- It lacks a system of performance-based incentives;
- It is only influenced by politics;
- It has limited resources;
- It is corrupt, inefficient, and dictatorial.

Articulating and understanding these concerns was the first step in developing the foundation of new alliances between the public and private sectors. To ignore or deny them might have led to false expectations and blocked the collaborative effort; to recognize them meant we would be able to offer reassurances and explanations to a concerned party. Government commitment to the program was important, and to build confidence we needed to establish a realistic basis upon which to conduct negotiations.

COMBINING STRENGTHS

When we went into the field we were armed with an understanding of the basic modus operandi and potential prejudices of both sides. The perspective proved invaluable as we met with representatives of this quite different section of the health economy. In conducting the trade studies under Phase II of the research, the team traveled frequently to manufacturing plants (both ethical and popular medicine producers), to distributors, pharmacies, and rural outlets. We conducted both surveys and observations. We

exchanged views on the needs of consumers and the difficulties of marketing health products. This face-to-face interaction was the first step in consensus building and negotiation between the two sectors.

Within the MOH we then agreed upon two primary principles as a basis for cooperation. The most fundamental of these was the understanding that "a good deal" is one in which both parties benefit--each party has something to offer that the other wants. The second principle was to operate according to the strengths of the two parties--to build upon institutional capabilities. We summarized the strengths of the two sectors as follows.

Public sector strengths include:

- the ability to develop policy and programs that meet the health needs of the country;
- many years of experience in programs for the control of diarrheal diseases;
- knowledge of the complexity of marketing ORS to mothers and understanding of the components of an effective demand creation program.

Private sector strengths include:

- the ability to produce and distribute a quality ORS product;
- ability to distribute the product to commercial outlets with the required frequency and cost-effectiveness;
- ability to reach a segment of the population not served by the Ministry;
- ability to respond rapidly to changes in the marketplace.

Although these strengths were in a sense "self evident" to both groups concerned, enumerating and discussing them helped us focus on what each side had to offer and how we could make the most of differences.

We also analyzed several factors which would influence the design of the program. These related to production of ORS, distribution of ORS, and the nature of the consumers who would be targeted. A few of these considerations are described below.

Considerations regarding production:

- The capacity for producing a quality ORS product exists in the public and private sector in Honduras;
- The cost of producing ORS is less in the private sector than in the public sector.

Considerations regarding distribution:

- There are more retail outlets for medicines than there are MOH facilities;
- Increasing the number and type of outlets will increase availability of ORS;
- Commercial systems renew their stocks of supplies more frequently than do the MOH facilities;
- Commercial distribution systems are efficient since each tier makes a small profit on items distributed.

Considerations regarding consumers:

- People are willing to pay something for medicines;
- People often place more value on items they pay for than on those they receive free of charge;
- Consumers in Groups C, D, and E may not be able to afford products currently available in pharmacies.

This analysis helped us propose alternative strategies for engaging the private sector in producing and distributing ORS to our target audience.

CRITERIA FOR COOPERATION

Before entering Phase III of the project, we developed a list of criteria for selecting a private sector collaborator. Briefly, the ideal company would:

- be able to produce and package ORS in aluminum sachets using the WHO formula;
- have adequate staff, procedures, and systems for quality control;
- have ability to carry out quality control procedures on all ORS produced;

- be willing to acquire equipment and, as necessary, to modify the existing facilities to produce ORS;
- have the ability to market to rural areas directly or to sell to a company which distributes to rural retail outlets;
- be willing to position the product as a popular medicine that can be sold in pulperias, pharmacies, and puestos de venta de medicinas;
- have the ability to promote ORS to C, D, and E socioeconomic levels and produce a demand creation program;
- have the ability to provide incentives to its sale agents and to retailers;
- have the ability to make the product affordable;
- be willing to focus on high volume production.

We were willing to look at companies which were familiar with producing either (or both) ethical or popular medical products. However, ethical and popular products make different demands on both production and distribution systems. Our choice of company would have broad implications for the program. First, ethical products (those that are name brand or imported) must be registered with the Colegio de Quimica de Farmaceutica and the contents must undergo a chemical analysis before initiation of any sales activity. Manufacturers of ethical products are therefore likely to have sophisticated quality control procedures. Second, the sale of ethical products is restricted to pharmacies, sales outlets for pharmaceuticals, and hospitals and theoretically requires a prescription for purchase. The number of outlets authorized to sell ethical products is also substantially lower than the number of general merchandise stores where popular medicines might be sold. A distributor of these products will therefore have similarly restricted sales networks. Third, profit margins for ethical products is legally controlled, but they are not controlled for popular medicines. Producers of these different products are therefore likely to have different expectations regarding profits. Fourth, a typical firm dealing with ethical products has a staff of medical "detailers" who make special visits to physicians to promote their products.

THREE MODELS FOR COLLABORATION

Given our agreed-upon criteria and in consideration of the types of companies in operating in Honduras and their respective strengths, we developed three possible models for our program.

Model A: Manufacturer and distributor are the same organization.

In the first model, one organization would carry out both the manufacturing and distribution activities. This model can be divided into two distinct subgroups. Model A(1) consists of a firm which carries a line of ethical products. Model A(2) consists of a company which focuses on popular medicines.

In general, such companies might produce name brand products under license with an international manufacturer, might import finished products, or might develop their own products. The marketing process (product positioning, promotional message content and materials, bonus and incentive plans or special offerings) of these companies varies according to the type of product and the manufacturer. When the product is produced under license or imported as a finished good, the international manufacturer may supervise the activities of the local firm and provide marketing support.

Resources available within the organization vary according to size of the firm, the number and type of products carried, and the length of time the firm has been in business. These firms may have the capacity to import raw materials and to register products (name brand, package, price) with the Colegio de Quimica de Farmaceutica. They may have sales personnel, distributors, production personnel, and other administrative staff, as well as facilities for storage, production, packaging, and shipping.

Both types of firms accept orders and deliver or sell products directly to retailers and wholesalers. Credit is frequently provided to retail outlets with which they have established relationships. Other sales are made on a cash-on-delivery basis.

Model B: Manufacturer and distributor are not the same organization.

Model B is based upon cooperation between two different firms. One is the manufacturer; the other is the distributor. The two firms might deal either with ethical products or popular medicines. In Model B, for example, the manufacturer might be a producer of ethical products which sells to a manufacturer or distributor of popular

medicines. In this model, a concern for quality control during production is balanced by the need to obtain a widespread and deep penetration into the market in rural areas by tapping into resources of two different types of companies.

Model C: The manufacturer distributes a portion of the product to one market and a second company distributes the balance to another market.

Model C is a combination of Models A and B. It consists of one firm which manufactures and distributes ethical products. The firm would manufacture the new product and market it to its usual ethical outlets, but also sell the product to a distributor of popular medicines or consumer goods.

In all of these models, the Ministry and the private sector are looking for similar outcomes. The Ministry wants the private sector to produce a quality pharmaceutical and to distribute this product to sales outlets in rural areas where the target population is located. The private sector wants to produce and distribute the ORS product, to make a reasonable profit, and to be assured of government support.

RESULTS OF THE SEARCH

After analyzing the marketing research, meeting with numerous manufacturers of pharmaceuticals, popular medicines, and other consumer products, and various types of distribution and packaging firms, the Ministry began negotiations with a private manufacturer and distributor of pharmaceutical products. Laboratorio Quimifar was selected initially because of its capacity to produce a quality ORS product according to the WHO formula and its willingness to do so in sufficient quantities to meet the projected need. In fact, they had already been considering producing a new prescription ORS product and distributing it to pharmacies. After extensive discussions with the Ministry, the firm agreed to produce a second product as well and to market it as a popular medicine at a price affordable to the target population.

Quimifar will market the ethical through its standard distribution system. However, it does not have the experience or the networks to market the popular product to retail outlets in extensive rural areas. They agreed therefore to contract with a second company which has this capacity. The Ministry has left management of this process to Quimifar partly because it will be easier for the private sector firms to work together and partly because it is clearly in Quimifar's interest to provide good oversight in order to increase their own profits on the popular product.

In principal, this arrangement follows model C above, in which one firm manufactures a product and then arranges for distribution both through its own system and through another company. However, in this case the firm will produce two ORS products, appropriate to two different markets.

FUTURE DIRECTIONS

Work still remains to be done before the new product is brought successfully to the target audience in need. Most of this work will consist of bringing the product to the attention of consumers and in assuring that they understand its proper use. Marketing will be the responsibility of the producer and its chosen distributor. This chapter in the story will be a challenging one. The MOH will be able to assist the producer in the marketing of their product by sharing their experience with formative research and product testing.

Because there are two different products, there will have to be two different promotional strategies. And because there are two different distribution networks, there will have to be two different training systems. Such a system is already in place for ethical products. Pharmaceutical companies traditionally use detailmen to bring new products to the attention of pharmacists and to inform them of their proper use.

Assuring distribution in the rural areas will provide a real challenge to Quimifar and their distributors. Providing effective information to rural retailers will require careful planning and innovative approaches. In the rural commercial system, the middleman who moves the product from the wholesale distributor to the retail sales outlet is an independent link in the chain. Training and motivation will therefore have to focus on both the middle and the final target. The Ministry has taken the best available approach to assuring that this challenge will be met. It is relying upon those within the commercial system to know how that system works and to design methods for communicating information.

The Ministry in Honduras has taken on the unique role for a public sector institution of examining the marketplace, assessing needs, determining market potential, and studying the costs of infrastructure and other similar costs of this product. The Ministry has also made a major investment in promoting the expansion of the ORS market in the country. The private sector is interested in doing what it does well--producing and selling a product. Reaching agreement between these two sectors to combine strengths and commitments required lengthy study and negotiation. It also required a basic willingness to come to terms with and make the most of differences. All

parties await the outcomes of this innovative approach to reaching a new market segment. This unlikely marriage of public and private sector may provide a unique solution to the problem of reaching more Honduran mothers with effective and low-cost prevention for diarrheal dehydration.

NOTES

1. The HEALTHCOM Resurvey of Oral Rehydration Therapy Practices in The Gambia, by Jeff McDowell and Judith McDivitt. Applied Communication Technology. December 7, 1990.
2. Honduras ORS Private Sector Marketing Feasibility Study III, p. 15.