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# SOCIAL MARKETING
# ORAL REHYDRATION THERAPY/SOLUTION
# A WORKSHOP

NOVEMBER 1-2, 1984

ARLINGTON, VIRGINIA

**PRITECH**

Technologies for Primary Health Care

Management Sciences for Health
1655 North Fort Myer Drive, Suite 700
Arlington, Virginia 22209

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## PREFACE

Recent trends in overseas economic development have led to an interest in "marketing" certain technologies in developing countries with the goal of making them self-supporting and self-sustaining over the long term.

In November 1984 the AID Office of Health through the PRITECH project sponsored a workshop which explored the potential of marketing oral rehydration therapy/salts for the treatment of childhood and infant diarrheal dehydration.

The workshop was held in Arlington, Virginia and brought together specialists in oral rehydration, marketing specialists from universities and private industry and those with marketing experience in developing countries (for the workshop agenda and a list of participants, see Appendices A and B). The workshop consisted of presentations by the specialists and small working groups dealing with certain aspects of the marketing process as they apply to developing countries. The conclusions and recommendations resulting from these working groups were then reported to the group at large and later to selected participants invited from AID. Following is a review and summary of the workshop proceedings.

# CHAPTER 1

## INTRODUCTION

### Oral Rehydration Therapy

"Beginning in the mid-1940s, diarrhea research centers in Dhaka, Calcutta, Manila, Cairo, Baltimore, and Taipei proved that intravenous solutions containing sodium chloride, potassium chloride, sodium bicarbonate (or lactate or acetate) in a well-determined combination could be given rapidly [to children suffering from severe and often fatal diarrheal dehydration] so that [they] could, Lazurus-like, be resuscitated within two to four hours."*

It was later discovered that in most cases administering the solution orally was just as effective if not more so and that in fact no other treatment was needed with the exception of supplementing the diet of recovering patients. This discovery is considered potentially one of the great medical breakthroughs of recent times (Lancet), and subsequently oral rehydration therapy (ORT) has been used quite successfully for the treatment of all types of diarrhea in developed as well as developing countries around the world.

Diarrhea is implicated in most illnesses of infants and small children in developing countries and indeed is considered a major killer in many countries (where in some instances fewer than one of four children reach their fifth birthdays).

According to Dr. Robert Black of the University of Maryland, diarrhea accounts for 20 to 30 percent of all deaths among children under the age of five in developing countries. There are approximately one billion cases a year and between three to five million deaths a year as a result. Death can occur within 24 hours of the onset of severe diarrhea. Oral rehydration therapy has the potential of reducing the number of severe cases of dehydration (i.e. those requiring intravenous treatment) to four percent of all diarrhea cases seen in health clinics.

In addition diarrhea contributes directly to malnutrition, and retarded growth is very clearly perceived in association with diarrhea. In sum, diarrhea is a major contributor to mortality and morbidity and to malnutrition among children and as such is a severe drain on scarce resources.

There is now a major effort among multinational development groups, bilateral donors, including the U.S. Agency for International Development (AID), and private and voluntary organizations not only to produce and distribute the premixed dry packets of salts for preparing the oral rehydration solution (ORS), but also to promote its use and the method for making a homemade solution. (The homemade solution may consist of table sugar and

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* Dr. Norbert Hirschhorn, "Oral Rehydration Therapy: The Scientific and Technical Basis," Proceedings of the International Conference on Oral Rehydration Therapy, June 7-10, 1983, Washington, D.C., sponsored by the Agency for International Development in Cooperation with ICDDR/B, UNICEF and WHO.

salt dissolved in water and may be administered with a cup and spoon. Other home treatment methods can include rice water, coconut water, carrot soup, or fruit juices).

Oral rehydration of a child with diarrhea should begin at the first sign of loose stools and feeding should be continued (including the breastfeeding of infants) to make up for the nutrients lost through the diarrhea. The quantity of the solution to be given ideally should be equal to the quantity of the fluid lost through the diarrhea. A rule of thumb has been to give a cup of the solution administered with a spoon each time the child has a loose bowel movement. Continued feeding is of the utmost importance, and if the child does not improve within two days of home treatment, he/she should be taken to the nearest health center.

Given the simplicity of the technology, its low cost, and its effectiveness, it would appear to be an ideal "appropriate technology" for addressing high child mortality rates.

Though it would appear simple at first glance to market such a product, the concept is fraught with pitfalls and problems. In most developing countries where most people have little or no access to modern health facilities, where rural health posts, if they exist, are staffed by semi-literate paramedics and where there is little or no radio or other mass media, what is the best method for marketing ORT? How does one mount a campaign to teach the mixing of a product which, if not mixed properly, can cause rather than cure illness? How are physicians and other health providers persuaded that such a simple remedy is more effective and more health giving than antibiotics and other antidiarrheal drugs? How does one deal with mothers who traditionally have withheld food from children with diarrhea in the belief that they are giving the system a "rest"? Or overcome the belief that exists in one place that diarrhea is healthy and makes children beautiful? How is a product sold for use at home at the first signs of diarrhea if a loose bowel movement is not perceived as such or where money is spent on children's health only if they are perceived as being severely ill?

## Social Marketing: Two Ways to Improve Health Delivery*

*"If you can sell toothpaste, why can't you sell good health?"*

This simple and somewhat disquieting question lies at the heart of social marketing and reflects its origin in the commercial world. Commercial marketing represents a powerful technology for selecting, producing, distributing, promoting, and selling an enormous array of goods and services to a wide variety of people in every possible political, social, and economic context. Even those who resent the slick superficiality of some modern advertising or decry the ever-increasing array of seemingly useless gadgets must accept the fact that marketing works. It creates products (most of which are useful); it makes the products available and affordable to particular consumer segments; and it motivates consumers to buy and use a product by illuminating its benefits.

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* By William A. Smith, Academy for Educational Development.

Social marketing applies this approach to problems such as cancer detection, forest fire prevention, dental hygiene, automobile accidents, alcoholism, child abuse, family planning, and infant diarrhea. Internationally, the term is used in two ways. The first emphasizes selling a product; the second selling an idea.

The first view of social marketing necessarily includes the sale of some socially beneficial product, such as condoms, birth control pills, or oral rehydration salts. Typically, these products are subsidized to ensure that the consumer cost is low enough to reach those unable to pay commercial prices, but the actual sale of the product is considered critical because it contributes in four ways to marketing effectiveness. First, it helps to ensure consumer motivation. Some argue that if hard-earned cash is used to pay for a product, then the person really wants it and will use it. Second, marketing increases internal efficiency. Sales are a simple and clear-cut measure of program success. Poor sales are a motivation to examine the program itself and change what is wrong. Advocates also argue that the sale of a product stimulates the entrepreneurial instincts of program managers; it provides an internal stimulus to succeed which makes these programs more efficient than public sector bureaucracies whose incentives are often independent of program performance. Finally, sales contribute, although not fully, toward cost recovery and increase the potential for long-term self-sufficiency.

The second view of social marketing uses the same systems approach as the first, but emphasizes the promotion of socially beneficial ideas and practices, as well as products. There is no object to sell, no transfer of money, but rather an articulate reshaping of traditional educational strategy to reflect a consumer orientation and a marketing context. "Eat less salt," "use seatbelts," "immunize your child before age one," "keep breastfeeding your infant during bouts of diarrhea" are examples of socially beneficial practices which can be marketed almost like Coca Cola, support hose, and condoms.

But social products are different from commercial ones in important ways. William Novelli, President of Needham Porter Novelli, has outlined some important differences between the marketing of commercial and social products. For example:

## Social Products Are More Complex than Commercial Ones

It is one thing for a consumer to choose between Coca Cola and Pepsi Cola, but quite another for a rural woman to learn a new formula for making a diarrhea medicine at home, remembering how much salt and sugar to use, and then giving enough of that solution to a fitful and sick child.

## Social Products Often Are More Controversial than Commercial Ones

Again, it is one thing to sell a new perfume and quite another to motivate a young African man, whose status in his community depends upon having children, to use modern contraception.

## Social Products Are Less Immediately Satisfying to the Consumer

It is not much fun to walk several hours, wait in line several more to receive a vaccination and have your husband complain the next morning because your child was crying all night. Nor is it gratifying to go for a breast examination and discover you have breast cancer. In contrast, you drink Coca Cola and it immediately tastes sweet and pleasant.

## Our Audiences Have Fewer Resources than Most Consumers

The "poorest of the poor" are rarely an explicit audience for commercial marketers. But social marketers are committed to reaching precisely those people with the least time, status and mobility; people who are often illiterate, isolated, sick, discouraged and left out.

## Social Programs Require Spectacular Results

Ministries of Health want a 30 to 50 percent reduction in infant mortality. Changes of two or three percent are simply not acceptable. Any major manufacturer of support hose, however, would be delighted with a two or three percent increase in market share after six months of advertising.

There are many other differences:

1. there is greater resistance to audience research and audience segmentation in social programs;

2. governments are rarely able to maintain continuity and support long-term marketing efforts;

3. social programs have much less control over the delivery system (government intermediaries are not motivated by sales incentives);

4. social marketers are asked to teach many things at once, not just focus on the single most important benefit of a new suntan lotion, for example;

5. consumer research is difficult because of the very nature of social products. How, after all, do you really verify consumers are using contraceptive products properly?

6. competition often comes from colleagues in other social ministries so we find ourselves defending "health" as more important than "food" in order to compete for scarce government resources.

These and many more factors make the job of social marketing substantially more difficult than that of the traditional commercial sector.

## CHAPTER 2

## SOCIAL MARKETING

### Social Marketing: An Overview

After introductory remarks by John Alden, Director of PRITECH, an overview of marketing was presented by Barnett Parker of the University of North Carolina, who defined "marketing" according to Phillip Kotler.

> *Marketing is the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational/programmatic objectives. It relies heavily on designing the organization's offering(s), i.e., products and/or services, in terms of the target markets' needs and desires, and on using effective pricing, communication, and distribution to inform, motivate, and service the markets.*

Kotler's definition of "social marketing" was given as "the design, implementation and control of programs seeking to increase the acceptability of a social idea or practice in a target group. It utilizes concepts of market segmentation, consumer research, idea configuration, communication, facilitation, incentives, and exchange theory to maximize target group response" (Kotler, 1975).

Within this framework, the importance of consumer attitudes cannot be overemphasized and viewing the whole process as "marketing" rather than "selling" in order to bring about an "exchange of values" is the key. "Marketing is a decision problem involving the determination of the 'best' marketing mix, i.e., that blend of controllable marketing variables through which the organization/program can best achieve its objective(s) in a specified target." There are four accepted variables within marketing which must be examined and they include product, price, place, and promotion (the four "Ps") and each of them is actually a "class of decision variables". (All of the aspects of the four Ps and their relationship to each other which result in the appropriate "marketing mix" are shown in Figure 1.)

In applying the social marketing concept to the design of an oral rehydration therapy/solution, it would be useful to consider Weibe's five factors for effectiveness of social campaigns:

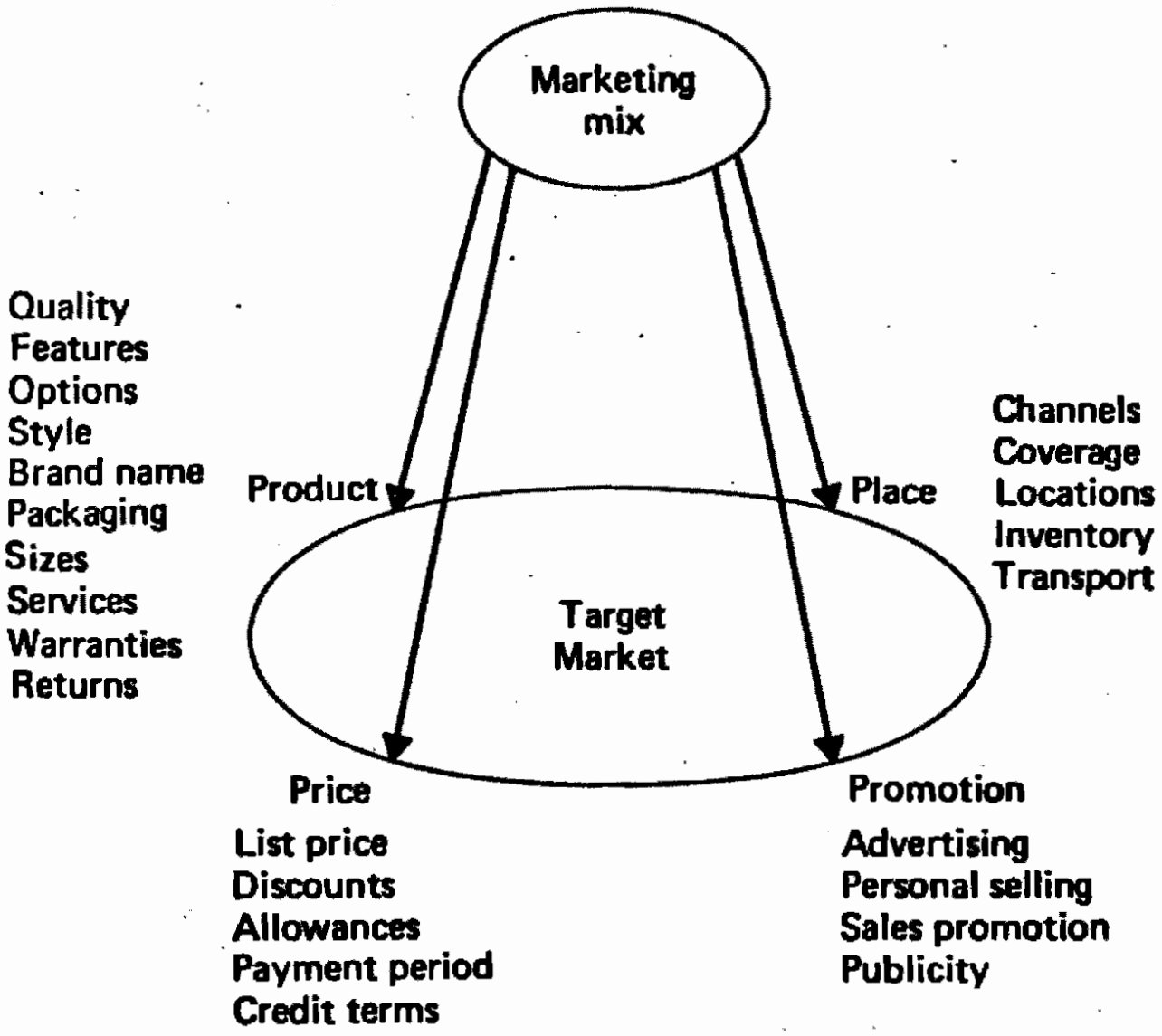
| EXPERIMENTAL DIMENSION OF AUDIENCE (MARKET) MEMBERS | ROUGH 4 P'S COUNTERPART |
|---|---|
| 1. The Force. The intensity of the person's motivation toward the goal as a combination of his/her predisposition prior to the message and the stimulation of the message. | PROMOTION |
| 2. The Direction. Knowledge of how or where the person might go to consummate his/her motivation(s). | PLACE |
| 3. The Mechanism. The existence of an agency that enables the person to translate his/her motivation(s) into action. | PRODUCT AND PLACE |
| 4. Adequacy and Compatibility. The ability and effectiveness of the agency in performing its task(s). | PLACE AND PRICE |
| 5. Distance. The audience member's estimate of the energy and cost required to consummate the motivation in relation to the reward(s) or benefits. | PRICE |

## Issues in Social Marketing

John Farley opened the discussion of social marketing issues by saying that if there are one billion cases a year of childhood diarrhea in developing countries that is, by marketing standards, a huge market with the implication that some selection would be necessary in choosing which markets to enter. The place to begin looking is at those countries most likely to yield success, and social marketing works best among those with concessionary income, access to a distribution system, and who can process information.

In the case of oral rehydration, continued Farley, it is known that the consumer is not the customer and that in most instances the customer literacy level requires that promotion be non-written. One also needs to know how much potential customers can afford to pay for ORS or how close they are to a distribution system.

Rajeev Batra (Columbia University) who has substantial commercial marketing experience in India, discussed marketing ORS from a "product management perspective" (for his model, see appendix C). The starting point must be the study of consumer/customer behavior. Then it would be necessary to identify market segments and develop a strategy for each segment based on the four "Ps". It is important that the product/price/distribution system be developed as a whole package and that it all "hang together."

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For a product, does the customer want powder, tablet, liquid, color, flavor, effervescence? Do they want "modern" or traditional remedies? In regard to packaging, do they want sachets in paper like tea? Prices may be kept low if there is more than one manufacturing site and if ORS is locally produced because distribution costs are kept to a minimum.* In addition, wholesalers are required to have far-reaching outlets so retailers do not need to stock large quantities.

Alan Andreasen (UCLA) cautioned against 1) the danger of believing there is a foolproof set of techniques and 2) the danger of marketing/selling from a provider's point of view and reiterated the importance of the consumer's perspective. Because social marketers often have a preconceived idea of what clients need and/or want, they often develop campaigns without determining what the clients perceive their needs to be. When such campaigns fail, the failure is blamed on the clients when in fact the fault lies with the "seller." It is perceived as a persuasion problem with an emphasis on motivation. Often among marketers the need for research is not perceived and the goal is to get the message out. Experience has shown, however, that it is absolutely essential to see marketing as a process which sets in motion exchanges--money for toothpaste, changed behavior for changed health or what consumers see as costs and benefits (for a background paper prepared for this workshop by Alan Andreasen, see Appendix D).

Santiago Plada (Profamilia, Colombia) spoke of the relative success of marketing good cheap oral contraceptives and condoms in Colombia and of the limited success of selling ORS which is available at cooperatives and in stores. This is attributed to the fact that diarrhea is not perceived as a problem. It has been in Colombia "forever", bouts of it don't last, and the death of children, although tragic, is not considered unusual, whereas contraception is seen as an immediate benefit.

## Organization Models for Social Marketing in Developing Countries

Steven Samuel, an attorney, with considerable experience in developing countries, presented the following organizational models for the social marketing of contraceptives:

1. Semi-autonomous programs run by a board of directors some members of which are government officials (as in Bangladesh and Egypt).

2. The nearly autonomous programs of private voluntary organizations which offer other services in addition to family planning and which usually have a tenuous relationship with government units such as those in the Caribbean, Colombia, Ecuador, El Salvador, Mexico, Sri Lanka and Thailand.

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* For a discussion of problems and the potentially higher costs of locally manufactured ORS, see Elliott, V., Oral Rehydration Salts: An Analysis of AID's Options, September 1984. Prepared for Westinghouse Electric Corporation under contract to the U.S. Agency for International Development.

3. Contraceptive social marketing programs within governments such as in India, Jamaica and Nepal.

The legal and jurisdictional complications of such programs are indicated by the numbers of organizations and individuals involved including those within donor agencies, government units, private voluntary organizations, the commercial sector, the medical community, and political interest groups. There are many administrative and service functions which such individuals and entities are responsible for and sometimes share. The legal issues which characterize such programs are many and varied including host country import duties and restrictions, commercial activities of non-profit organizations, registration of drugs and other health products, registration of brand names, packaging requirements, limits on maximum and minimum profit margins, advertising restrictions, distribution restrictions, competitor grievances, sub-contractor guidelines, flow of funds between organizations, taxes, and continuity, etc. Samuel's recommendations included:

1. Hire legal advice at the very beginning of a project. For instance, food and drug products often need registering and this can take months and perhaps delay the start-up of a program which is otherwise ready.

2. Recruit support for the program in the country. If it is not forthcoming, it might be the wrong country and it would be wise to move on.

3. Get a lawyer on the marketing board.

4. Try to get into and stay in the private sector. Bottlenecks are not in the marketing sector, but in government.

5. Sell ORS as food in grocery stores. Avoid competition with other "drugs".

6. As a contractor, do not let donors impose an inappropriate model.

## CHAPTER 3

## LESSONS LEARNED IN THE FIELD

### Bangladesh

William Shellstede of Population Services International described a three-month test marketing in Bangladesh of oral rehydration salts called Orasaline. The cost of a packet of powder to mix 500 cc. of solution was the local equivalent of US $0.20 which was substantially higher than the cost of another locally produced product. The sale of Orasaline was promoted by the Social Marketing Program (SMP) medical representatives to medical and pharmaceutical outlets, namely pharmacies. There was no advertising and no use of mass media, and no credit was extended to retailers. In addition there was a limit on the amount which could be stocked. Apparently there was little need to explain what ORS was as the concept was widely known already among health providers and pharmacists.

During the three months of the test, of the entire amount sold, 36 percent was through restocking--which was considered very good product movement especially in the absence of advertising. Familiarity and use of ORS among consumers varied directly with their socioeconomic status, and it has been concluded that to reach the lower social and economic groups in Bangladesh, a mass communications campaign will be necessary. It was also learned during the test that:

1. The pharmacists can to a significant degree play the role of educator--even to the literate half of the consumers who bought the product. Even among them fewer than 10 percent read the package insert.

2. Great care must be taken to convey even the simplest message (one mother, for instance, used substantially less water than called for because she believed her small baby would not take a half liter of liquid but she wanted it to have all the salts).

3. Orasaline is believed by consumers to be superior to other products and its flavor was preferred by mothers.

It was concluded that Orasaline is a good product even at a price which is perceived as high by the trade. It can be sold on its own and it can be self-sustaining at current prices for more prosperous segments of the population. Orasaline, however, will remain "irrelevant" in affecting public health or in meeting the huge need for rehydration therapy. Therefore, a donor must be found to subsidize the price of Orasaline and/or help finance a communications campaign. (For a fuller description of the Bangladesh test and an analysis of results, see Appendix E).

### Egypt

Farag Elkamel (John Snow Public Health Group) described the large scale mass media communications ORS program in Egypt using radio and television "commercials" to market a packet of ORS salts which cost the equivalent of

US $0.45 for ten packets (enough to make two liters of solution). There were six commercials using conversations between mother and daughter about baby, between mother and doctor, and mother and others based on:

1. Awareness that dehydration rather than the diarrhea itself is the danger;

2. Awareness that gaffaf (dryness) can be prevented using ORS and continued feeding;

3. ORS is highly effective and medically approved;

4. Effectiveness of ORS is dependent on proper mixing and administration;

5. Diarrhea can be prevented.

Surveys have shown that in May of 1983 only 32 percent of the survey population knew about the dangers of dehydration whereas by February 1984, after the campaign, 87.2 percent knew. Knowledge of ORS grew from 1.5 percent in the sample population from May 1983 to 87.4 percent in February 1984 to 90.3 percent in October 1984. Those who used ORS went from one percent to 30 percent to 82 percent for the same three points in time. The impact of oral rehydration therapy on mortality in Alexandria was demonstrated by a reduction in diarrhea-related death rates among children under one year old from 32 percent in 1980 to three percent in 1984 and among children one to five from 20 percent in 1980 to one percent in 1984.

In Egypt the lessons learned included:

1. The necessity of familiarizing government officials with social marketing and its methods and effectiveness.

2. The necessity for social marketers to be politicians as well as marketers ("committees can kill you").

3. Doctors are not trained communicators.

4. A clear ORT-specific campaign must consider who buys ORS and not just how much.

5. A general public message is different than one directed at the elite.

6. Themes and characters must be familiar to the target audience.

7. Mass media can change behavior.

8. Social marketing is different than advertising on radio and television. They must be integrated.

9. Care must be taken using professional actors. Mothers are best.

10. Even mass media is not enough if other parts of the campaign are not in place--i.e., if health professionals are not convinced of product effectiveness or the product is not perceived as suitable by the target audience or readily available.

## Honduras and The Gambia

William Smith of the Academy for Educational Development described the Mass Media and Health Practices Project which attempted to apply a public communication approach to the problem of diarrheal disease control in Honduras and The Gambia. In both The Gambia and Honduras, the "persuasion model" was used rather than "behavior modification."

In Honduras the rural target population consisted of relatively homogeneous cultural groups living, however, in often isolated single homesteads. In The Gambia, by contrast, there were striking linguistic and cultural differences among more than five major ethnic groups, but rural people lived in villages of clustered compounds.

The Gambian health system had severely limited central resources but, as a small country with a relatively extensive network of rural health posts, it had the potential for reaching the rural population. Honduras had substantial central resources but a relatively limited rural outreach capability.

In Honduras, the Project promoted a locally produced packet of oral rehydration salts (LITROSOL) for use at both home and clinic levels. In The Gambia, a simple sugar-salt solution was promoted for home preparation, and the UNICEF packets were saved for use in health centers.

The Gambia's single government broadcast channel reached only two-thirds of the country in contrast to Honduras's multi-channel commercial broadcast system, which afforded excellent broadcast coverage. Rural Gambian women had a literacy rate dramatically lower than Honduran women--only about three percent--and print media were practically nonexistent at the village level.

The same communication planning methodology, however, was applied in each country to identify and implement effective, appropriate strategies. The key elements are:

- Clear measurable behavioral objectives;
- The investigation of existing knowledge, attitudes, and practices among target audiences;
- The integration of mass media (radio, print/graphic materials) and face-to-face channels (such as health workers);
- A systematic process of materials development and their pretesting to ensure they are accurate, comprehensible, attractive, and culturally appropriate; and
- Monitoring and formative evaluation to determine if and how the campaign is working and what changes, if any, need to be made.

Preliminary results indicate that in Honduras:

- After one year, 48 percent of women reported having used LITROSOL to treat diarrhea at least once;
- During the same period, recognition of LITROSOL as a diarrheal remedy rose from zero percent to 93 percent of the population;
- Of those using LITROSOL over 90 percent could mix it properly and 60 percent gave the correct recommended daily amount; and
- Diarrhea-related mortality in children under two dropped by 40 percent within 18 months.

In The Gambia:

- After eight months of the campaign, 66 percent of mothers knew the correct homemade ORS formula being promoted;
- 47 percent of mothers reported having used the home formula to treat their children;
- During an intensive four week period in October 1982, 11,000 rural women attended 72 village sugar/salt mixing contests; 6,500 women actually mixed the solution during these contests; and
- Following a 1983 mini-campaign on feeding during diarrhea, more than 50 percent of mothers reported giving solid foods to their child during diarrhea, a four-fold increase from the previous year.

**Lessons Learned:** In Honduras a survey of infant and child morbidity and mortality before and after the campaign showed that there had been no drop in childhood mortality overall but that there had been a drop in mortality from diarrhea. This is a strong indication that control of diarrheal disease alone cannot affect the overall health status of young children in developing countries and that what is needed is an effective immunization program as well as growth monitoring and nutrition programs in addition to diarrhea control programs.

Mass communications and social marketing, with its audience oriented approach as opposed to physician or product orientation, is novel to most ministries of health in developing countries. Some of the obstacles to this approach often reside within the ministries themselves. In the case of Honduras it was learned by the project staff that one manifestation of diarrhea was referred to locally as "impacho" or "a knot" or "hardness". When it was proposed that the campaign promote ORT as a remedy for this condition among others and call it by name, i.e. "impacho", Ministry officials would not permit it because technically "there is no such condition" and they did not want to reinforce a false concept. Therefore it was necessary to describe all the symptoms for which ORT was an appropriate treatment and let the audience determine for themselves that "impacho" was one of them.

## Nepal

James Messick spoke next about his experience with the Contraceptive Retail Sales (CRS) Project in Nepal which markets oral contraceptives, condoms, and vaginal foam tablets. When he arrived there in 1976 there were no local resources--no advertising, no local manufacturing or packaging of contraceptives, no marketing researchers, no trained sales representatives, and no commercial distribution system. Forced to start from scratch to create an autonomous promotional, marketing, and distribution system, Messick said that "institutionalization" is a 22 month word. Not only was there no system for distribution, but the product was highly taboo laden, and even some of the bright young recruits chosen for training as sales representatives did not know what condoms were and how they were used. However, within several years, there was a full-fledged, though infant, contraceptive retail sales project working on its own complete with logo, attractively packaged products, billboard panelled jeep, public address system, and pricing incentives for retailers (namely pharmacists, tea shops, and food outlets). Initially there was some reluctance on the part of these retailers to display the dispenser with condoms--they were kept under the counter and out of sight. Only when a contest was started with a substantial cash prize and it was explained that family planning was "good for Nepal" did the dispensers come out of hiding and did the condoms begin to be sold.

**Lessons Learned:** It is believed that initially the price of the condoms was too low--that is, the market could have borne a higher price and often the perception of a "cheap" product is that it is not effective. It is essential to determine pricing both by surveys among consumers and also by testing different prices with different products in different places and among different population segments.

Messick also said that such social marketing projects must be in the private sector and be perceived as commercial. The "exchange of values" notion is very important. It might be necessary to work out a contract with a national government to the effect that such a project must be autonomous, must be capable of eventual self-support and self-sustainability, and have a minimum of oversight by the public sector. If such a contract cannot be negotiated, then look for other places in which to develop social marketing projects.

Where such an agreement is reached, count on a long and involved start-up process of negotiation with government and donors, training of sales representatives, etc.

And finally, Messick said that the social marketing model is not the only method of introducing change but is only a guide, and it is not likely to fit each country situation.

## Discussion

The wrap-up discussion on the second morning included the issue of capitalization for such projects and whether AID provides this initial type of support. It was determined that it did but did not work hard enough to get such projects established. In general, service providers are not adept mar-

keters. If such service providers are given the funds to promote such programs, they are often not able to market their services effectively.

Robert Hogan, a health planner with the World Health Organization, said his concern was how to get oral rehydration therapy used, that there was already a basic product and it was available. WHO has plans in 80 countries already (60 being implemented and 20 under consideration). The WHO Control of Diarrheal Diseases Program is training oriented and has trained 60 senior program managers in seven countries and plans to train 1,500 more. With this discussion of marketing ORS, Hogan said he was afraid that a demand would be created which could not be met. He said that all activities related to ORT should be coordinated, that WHO and UNICEF were already in the field and would be there probably long after other programs had come and gone and therefore a need for collaboration was essential. Hogan said further that message definition was critical in any marketing attempts, that it should not just stress ORS and diarrhea but should also instruct mothers to get children to health centers if they do not improve after two days and that the use of ORS should be just one part of overall child health promotion.

Steven Joseph of UNICEF asked the workshop participants not to worry about defining social marketing. What is needed now is a "package" including a set of appropriate technologies which are available and affordable and community mobilization efforts using mass communications to get the technologies to the communities and to the children and child care providers where they are needed. He said, echoing Alan Andreasen's earlier remarks, there are too many in UNICEF with the attitude "we've got a great product, and if people really knew how great it is, they'd buy it." It is necessary to build alliances with communities, to develop projects which become the communities' own. UNICEF efforts in fact become community efforts. He ended by saying that there was a need for an international network of social marketers with experience in developing countries whether they be based in industrial countries or in the developing countries themselves.

## CHAPTER 4

## WORKING GROUP RESULTS

Each of the six working groups was assigned one of the following topics for discussion:

- Potential target markets and market research
- Products and packaging
- Distribution and sales
- Pricing and pretesting
- Information, education, communication, and advertising
- Evaluation

### Working Group 1: Potential Target Markets and Market Research

The target markets quite naturally included children under five, their mothers, and other child care providers. In addition, the family as a whole is a logical target because of shared responsibility within the household. Other important target populations to serve as channels for information about ORT are certain segments of the educational system (teachers in primary and secondary schools and extension workers, etc. etc.). A most important segment of the population for the success of ORT programs is of course the health infrastructure ranging from ministry of health officials to physicians and community health workers and other potential distributors of ORS/ORT such as pharmacists.

A large part of the health establishment might have to be given considerable information and might really need to be "sold" on the idea of ORT in many parts of the developing world because of their traditional dependence upon antibiotics and other antidiarrheal drugs.

As for research on the target populations, what holds for one region, group, or country would quite possibly be different than that for another region, group or country. Each campaign, therefore, will need its own target population research. Furthermore, it was suggested that even within a given region perceptions and values might vary among groups with different income levels or with other differentiating characteristics.

Of the types of perceptions which are significant for the sale of oral rehydration salts, is the fact that they do not cure diarrhea but prevent dehydration. Therefore, "there might be increased wellness but continued diarrhea." If a mother is looking for a cure for diarrhea and has used antibiotics or other antidiarrheal drugs in the past, she might be disappointed in ORS and therefore stop using it. "These physical outcomes represent constraints to the marketing effort that must be addressed in the marketing mix design."

Another problem in the case of ORT is that the product is more or less fixed. Therefore, the ability of marketers to control the outcome is less than it would be if they could, say, manufacture the product on their own in response to perceptions and beliefs that were found among the target population (though local adaptions are possible in the packaging design).

The other issue is the ethical one. Should messages be based on local beliefs even though these beliefs are not scientifically sound or should there be an attempt to give a simplified explanation of the technical reasons why the product is effective? The example was given of a latrine building project in Africa where the local people were persuaded to use the latrines because their feces would be covered and inaccessible to anyone wishing to use them for purposes of casting spells. The message was effective and led to program objectives, but it was based on falsehood. What is the dividing line between adapting a message to the perceptions of the potential users and using the understanding of those perceptions to deceive, albeit with the best of intentions?

## Working Group 2: Products and Packaging

Although this group realized there were many oral rehydration products on the market, they decided that for purposes of distribution and promotion, the most appropriate and suitable product would be the current WHO dry powder regardless of who manufactures it, packaged in the simplest way possible (in foil, if necessary, to keep it from disintegrating on the shelf*) with instructions given graphically for a non-literate audience. The size packet, however, should conform to the most common sized container used in a given area, be it a bottle, jar, cup, or tumbler. In addition, a built-in quality control of such packets was recommended as they moved through the "pipeline" to ensure that they are still good when they reached the customer. This was decided because, in view of the vast need and the perceived limited resources of both customers and donors to reach the poor, the cheapest and most effective product available would be the logical one to distribute.

The larger group did not agree with this focus on a single product in a single form. From the floor came suggestions for variety in packaging and a premixed liquid or tablets in addition to powder, and consideration of products with added flavor, color, and effervescence to address the range of consumer demands including convenience and availability. The discussion was ended with a plea to get the product out in the market place as soon as possible in a form or forms acceptable to potential customers and to offer a wide range of packaging and presentation that would be as creative and diverse as possible. If one has a range of products, the expensive ones could pay for themselves if they appeal to wealthier segments of the market, and the profit from these products could in fact be used to subsidize the cost of producing three or four types of products including a cheap one for the poorer segments of the community. What is wanted among marketers is the

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* The issue of foil packaging might be moot because a new formula with a citrate base does not deteriorate and therefore could be packaged less expensively in polyethylene packets, although the shiny aluminum might make the product more attractive to consumers and might be necessary for overseas transport or in climates with high humidity.

attitude on the part of the customer, "Yes, I'll take the product and I'll try it." This is far more likely to happen if the customer has a choice.

This scattershot approach raised the issue of safe use of the product. However, there is a range between which the mixture is "safe", that is between 50 to 110 meqs. of sodium as long as there is also glucose or sucrose. With the upper ranges of sodium content, however, it would be wise to give the solution in conjunction with other fluids--including breast milk-- which are low in sodium. It was therefore concluded that regardless of who makes the product, if the formula is in the above range, it should be encouraged, whether it has citrate or bicarbonate in it, or whether it is in liquid or tablet form, flavored, or effervescent. At the same time that a variety of products was recommended, caution was also urged with regard to a campaign promoting many products which might confuse the audience.

## Working Group 3: Distribution and Sales

The first point made was that the wide array of products (more than 50) on the market to treat diarrhea (including antibiotics, antimotility drugs, kaolin, and others) have substantial implications for not only distribution but also for product and package selection and the information to be communicated to a wide audience. For example, the impact of the oral rehydration solution is not visibly different in an immediate sense from antibiotics or narcotics. Furthermore, these latter products are more expensive and have a substantial profit margin and therefore are more attractive from the pharmacists' point of view. How can a pharmacist be expected to sell a product with a profit of a nickel or dime when he has other products on which he can make fifty cents or a dollar? Furthermore, this same pharmacist would at least initially have to explain to the customer why ORS is superior and how to use it. So in addition to making less money, it would require more time for him to sell the product. This is indeed, from a marketer's point of view, a very hard sell!

Now, on the other hand, ORS could perhaps be sold to pharmacists with an approach something like the following: "You've got people coming into your shop with an infant with diarrhea or dehydration who cannot afford antibiotics or some of the other drugs. We have a product that you can sell to them that does substantially the same thing and is in fact better for them and which they can afford."

The one real difference between social and commercial marketing is to whom social marketers try to deliver products, services, and information. They are usually the group that is not in the commercial market or not in it as intensely. They don't have enough purchasing power. This has implications for distribution.

This points up the complexity of the "social marketing" mission. The inference is that not only is there an attempt to distribute a product, but that the product is in some way going to be subsidized. Someone is losing money or not making enough money, and the difference is going to be partially made up by an outside source. In addition, the distribution of the product will depend upon social motivation at every level of the program.

Another consideration in distribution is who is the first person turned to when a child is ill? Who is the "gatekeeper?" Is it an old auntie, a community health care worker, a family planning worker, a pharmacist, or a physician? It would seem that these individuals, once they have been identified, are the keys to the success of a distribution system.

There was a discussion of the advantages of distributing ORS in food/grocery stores rather than pharmacies (sometimes they are both the same and the grocery store may be the only place that distributes the only available medications). This would remove ORS from competition with other drugs and place it where rapid turnover with low margins is the norm further aiding its sale to consumers.*

There was also a discussion of teas, herbs, and purges that are used to deal with diarrheas and other digestive problems--another potential field of competition for ORS. It was then suggested that ORS should perhaps be pushed as a tonic rather than a medicine for diarrhea--a tonic to strengthen a child further strengthening the argument that it should be made available at a grocery store rather than pharmacies.

A discussion also arose about those products which are very harmful, and those which are harmless but ineffective and about the fact that whereas antidiarrheals stop the diarrhea, ORS doesn't. Some buyers of ORS will want kaolin along with it, or some medical professionals will continue with antibiotics--and it has nothing to do with profit. The ethical question arose again about tampering with local beliefs and whether to discourage the sale of some products which are not harmful. (Obviously those products which are harmful must be absolutely discouraged.) Why not ask traditional practioners to stock and use ORS along with the other items in their pharmacoepia rather than attempt to get them to stop selling or using these items. The safety issue can't be dismissed but many traditional remedies are harmless, and both the distributors and the consumers are reluctant to given them up. Better to push ORS alongside them.

## Working Group 4: Pricing and Pretesting

This discussion opened with a quotation from an article by Lincoln Chen to the effect that as logical and potentially effective as the notion of social marketing is, "Caution...should be exercised in banding together the profit and social motives into an effective instrument of improving health." This was followed by the question "What is our mission?" "What are our objectives?" Is the target market one which will sustain and support an oral rehydration line of products or is it one which cannot afford oral rehydration salts at any price or at a very low price? If the product does require a price, then how does one go about establishing it? What does the product cost to manufacture, distribute, and promote? Is the cost of advertising to

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* In a later session, John Farley referred to the relatively efficient postal system in Sri Lanka and said that "it would not be the worst idea in the world to mail every registered baby three packets of ORS" because the basic cost of the salts is so low relative to the cost of hospitalization of children for diarrhea. He estimated that it could be done for around $100,000.

be included in the price of the product, and how much of an incentive must the retailer have to carry the product? Related to these costs is product type. It is possible that effervescent tablets would be more expensive to produce. These questions require an investigation of what the market will bear (including the disposable income of the target audience) and the desirability of the product or a variety of products. If consumers are willing to pay a high price, say, for a tablet, fine, go right ahead and price the product.

In addition, with regard to price, if working through a commercial distribution system, most countries have regulations regarding margins. Sometimes they are fixed by law and in other cases they must be negotiated. Other considerations are price controls in the country in question. And, of course, the major question is, are consumers prepared to pay X amount of money for such and such a service or treatment or are they not concerned that the child has diarrhea? Or will they go to the diarrhea center later without having to pay?

The question also arises of self-sufficiency. Where there are local manufacturing facilities or capabilities within a country, there is usually at least an attempt made by donors to have them become self-sustaining. Beyond the manufacturing level, is the objective of the program self-sufficiency or cost-effectiveness? In social marketing as a rule the product price is not set to create revenues but to get the product out and used. These will all affect the pricing of the product.

Another issue is the need for different products at different prices for different segments of the population. One product is not going to serve everyone. With variety in the market, one has a good price for the consumer and one creates revenues to help pay for program costs. In addition, profit margins help the product move in the commercial sector.

Another way to determine the prices is to look at other social marketing programs and the differences between their product prices, other similar product prices, and the price of the next higher product and relate what those percentages or ratios say about how to place ORS.

And finally, everything should be pretested to the greatest extent possible and that means every component, including price, product and campaign. Prices can be tested through questionnaires, by comparing the price with other similar products on the market, and by putting different prices on different products in different places among different market segments. From experience in Nepal where there has been a restriction on raising the price of the condoms distributed by the CRS program, it was suggested that increases in the price be planned at the beginning and introduced over time so that they keep pace with other commodities in the market.

Compared to contraceptive social marketing campaigns, the oral rehydration effort is flexible. With contraceptives, there was a fixed product or products, and it was the mission of social marketers to go out and market them without any consideration of meeting needs as perceived by the consumers. With ORS there are several forms of the product, and pretests can be run to determine which among them is preferred by customers.

## Working Group 5: Information, Education, Communications and Advertising

Alan Andreasen set out the objectives of an ORT social marketing program as follows:

- everyone uses ORT
- they use it when necessary
- they use it correctly

If these are the objectives, what are the necessary conditions for arriving at them? They are probably as follows:

1. The target population has to understand that dehydration is life threatening.
2. They need to know that ORT cures dehydration.
3. They have to see that the benefit exceeds the cost for using ORT or ORS.
4. They have to know where to get it.
5. They have to have the funds to acquire it.
6. They have to know how to use it.
7. They have to be satisfied with the results.
8. They might have to have the support of others such as relatives or health workers to use it.

Given this array of necessary conditions, which is the responsibility of social marketing? Item one above is probably really the responsibility of health education programs with perhaps some stimulation from marketers. It is probably neither practical nor appropriate for social marketing to change some basic underlying traditional beliefs and practices. In the case of family planning for instance, this would include fundamental attitudes toward family size. That is the business of other "communications" techniques, not marketing. In which case, looking at item two onward, the next assumption is that the market will be those people who have a level of education as well as at a level of income to be candidates for the things that are being offered. This does not include everyone. It is setting boundaries on the tasks facing the social marketers of ORS. And it is necessary to focus on the customers--or the "marketing deciders" and the "buyers"--as well as the distributors, physicians and other health care people, educators, extension workers, and "gatekeepers" as discussed.

It is probably necessary to use a "persuasion" model of selling rather than behavior modification, although the role of behavior modification and its relationship to marketing should not be ruled out. Behavior modification might be more efficient, but it is not marketing. Setting the boundaries of the role of social marketing, however, does not mean just focusing on selling products to pharmacies and convincing people through advertising. At the

same time, social marketers should not be in the behavior modification business.

From the remaining necessary conditions above, Number Five, "available money to pay for ORS," is certainly not the marketer's responsibility. Number seven, "satisfaction with results", might be supported by a communications program.* The last item, "support of other institutions and programs" is only partly the responsibility of social marketing.

## Working Group No. 6: Evaluation

It is obvious that evaluation procedures would be different for programs promoting a premixed powder and those promoting the homemade oral rehydration solution. The absolute measures, however, would most likely remain the same, i.e., what impact has the program had on infant mortality and morbidity and on the number of cases of childhood diarrhea admitted to hospitals and/or clinics?

If the program is promoting a commercially available premixed packet of salts, further evaluation would be based on:

- the percentage of people in the target market who have been made aware of ORT as a result of the marketing campaign--the existence of ORS, how it can be used and whether and where it is available.
- the percentage of people with a favorable attitude, and, most importantly,
- the percentage of people who report using it correctly.

The same data are needed with regard to health workers and hospitals. How many are aware of it? Are their attitudes favorable? Are they using it correctly?

In addition to consumer information, a complete evaluation of a marketing program would require an analysis of trade data, whether from food stores or pharmacies, depending upon the outlets supplying ORS. This would include:

- the percentage of merchants aware of the availability of ORS
- the percentage who stock the product
- the percentage who have a favorable attitude toward it
- the percentage who know how to mix it

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* This could be done, for instance, by emphasizing the importance of rehyration in messages and the relative unimportance of short-term but continuing diarrhea. What has become absolutely essential is to find a rationale among mothers and other child care providers for their use of ORS whether it is to strengthen the child, "prevent dryness," or revive the child.

- the percentage who are willing to communicate information about it to consumers.

In addition an inventory tracking system is necessary to learn what percentage of merchants are stocking ORS and how shipments are proceeding from factory to warehouse and beyond. If stock movement is sluggish retailers will not be satisfied with profit margins and promotion efforts will be in vain.

Finally, the costs of the program will be evaluated in two ways. The first requires a cost management tracking system to determine whether manufacturing and overhead costs are under control. And the second requires a method of estimating the cost effectiveness of the program, i.e. the costs per death averted.

It can be anticipated that there would be greater cost effectiveness among those easy-to-reach parts of the population in the urban areas with more education and, therefore, one assumes more willingness to try ORS/ORT. However, a principle of diminishing returns will most likely apply in the cost effectiveness of reaching those farthest away, both in geographic and socioeconomic terms.

## CHAPTER 5

## CONCLUSIONS

The general conclusions of the workshop were summarized in the remarks of John Farley on Friday afternoon and are paraphrased below.

First, marketing is not a be-all and end-all in the area of oral rehydration therapy any more than it is anywhere else. It could be part of a bigger picture, and it has a role to play, but it is not going to take over the entire job, and it is not necessarily going to do the toughest part of the job. Secondly, the pilot testing which has already been done and which was described in this workshop, especially in Egypt and Bangladesh, are plusses and will make future efforts easier. It would appear that the basic idea will work. Thirdly, it must be remembered that marketing environments vary enormously from place to place and from group to group, and it is very important where the first experiments are carried out. The toughest environments are not necessarily the best places to run the first marketing tests. They may be the neediest places, but they are probably not the best places to start. For an example, the contraceptive social marketing program has been relatively successful because it had the good fortune to start in Jamaica--where it could be tested with relatively good opportunity for success.

Two main concerns in an ORS marketing program will be where the inventory resides. How accessible is it when it is needed quickly? Chances are such sources of salts will be only part of the health services program or a subset of the population. The second problem is determining target populations. There will most likely be a clash between people interested in health administration and those interested in marketing. The former will perceive the "universe" as the target market and the latter only a segment of that universe. In reality, marketers do not provide universal service. This fact will influence every other consideration when exploring the marketing of oral rehydration or any other product or service for that matter. This reality brings us to the following considerations:

1. From the perspective of targeting, it is very important to choose carefully the national environment in which to begin a program. There is a tendency to go to the place where the most good can be done. These places are ordinarily the places that are the most difficult to deal with--they have neither the political commitment nor the information, health education, promotion, or private sector infrastructures to carry out such programs.

2. Unfortunately, marketing works best when people have some money to spend and works worst with people who do not. In determining population segments for focussing marketing efforts, unless there is a continuous flow of subsidies, segmentation will require elimination of those who are most in need of services. Access to effective communications is a necessity for running an effective marketing program and such communications most of the time do not reach very deeply into rural areas.

3. Finally, literacy levels or the ability to process information among the target population is key to the success of marketing programs. Unfortunately, the "poorest of the poor" are the least likely to have the ability to absorb media messages.

It is essential in making decisions about ORS social marketing programs to establish key features of consumer behavior. There is a fair amount of epidemiological information, but very, very little of the behavioral kind. It is absolutely necessary to know consumer perceptions regarding illness and treatment, what is done, by whom and why. In addition, market research should include pretesting of products and/or concepts. And finally what are the responses to those in the distribution channel?

When all of the above conditions have been met, then it is necessary to make decisions as follows:

1. What are we going to sell? Will it be the ORS package mix or the instructions on how to make it at home? It would appear that the package mix will be the easiest to sell. However, this does not rule out the other. In any case, something clear has to be decided and the simpler the implied message the better.

2. How much will it cost? Will it be subsidized to reach those who need it most? Or will it be strictly a marketing effort and eventually become self-supporting? It has been estimated that a full cost recovery price depending upon the size of the package would be from US$0.15 to US$0.30 per package including the cost of manufacturing, distribution, and promotion. This makes it an "upscale" or at least a middle scale product. In any case, a decision must be made as to how "commercial" the program will be.

3. It is estimated that about 75 percent of the success of any marketing program depends upon distribution. "It is possible to sell rotten products with no support at all, priced outrageously if there is a strong distribution system, but a weak distribution system simply will not support a good marketing program." In developing countries, the development of distribution systems is even more important and, in fact, marketing and distribution are for all practical purposes synonymous.

4. Finally, after all of the above are in place, implementation of advertising and promotion can begin. (Planning of advertising and promotion must naturally be included at the first stages of a project. This is especially true for advertising research.) While they are important, and the messages are important, it must always be remembered that they are part of a package which includes production, pricing, distribution, and the other components of a marketing program.

# CHAPTER 6

## RECOMMENDATIONS

### Program Recommendations

- Recognize the limitations of social marketing.
- Perceive the process as "marketing" rather than "selling."
- Be prepared for a long lead time in launching an ORS marketing campaign.
- Operate a social marketing campaign like a business.
- Operate social marketing programs only in countries where there is a commitment to program autonomy and a minimum of public sector interference.
- Introduce social marketing programs only in countries where there is at least a basic marketing infrastructure including public relations/advertising firms, established distribution systems, market research firms, relatively wide public access to media, and a population segment with a certain degree of literacy and some disposable income.
- In those countries without the above, use another approach (i.e. mass media, health education, extension and health workers) to promote ORT.
- Recruit a legal consultant to study the implications of marketing a health product in any given country and to help move the product through the regulatory system if necessary.
- Assume products/services promoted through social marketing will reach limited target populations, i.e. those able to process and use information, are motivated to follow instructions and/or can afford to buy the product if a product is being promoted.
- Assume at the start that nothing is known about target population perceptions, attitudes, and behavior related to diarrhea.
- Assume that a campaign will fail unless target audience perceptions are studied and marketing messages are based on consumer perceptions and tested before general dissemination.

- Ensure that all parts of the marketing system are in place (i.e. product, supply lines, outlets, pricing, health education, etc.) before launching a media or advertising campaign.

- Be flexible and be prepared to change program elements after the campaign is under way.

General Recommendation for AID:

- Establish a global network of social marketers who will be accessible to health program professionals around the world.

# APPENDICES

APPENDIX A

## AGENDA

PRITECH SOCIAL MARKETING/ORT WORKSHOP

November 1 and 2, 1984

Westpark Hotel, Rosslyn, Virginia

**Thursday, November 1, 1984**

| | |
|---|---|
| 9:00 a.m. - 9:15 a.m. | INTRODUCTORY REMARKS - John Alden, PRITECH, and Anne Tinker, S&T/Health |
| 9:15 a.m. - 9:45 a.m. | AN OVERVIEW OF MARKETING - Barnett Parker, University of North Carolina |
| 9:45 a.m. - 10:15 a.m. | EPIDEMIOLOGY OF DIARRHEA AND TREATMENT WITH ORS - Robert Black, University of Maryland |
| 10:15 a.m. - 10:30 a.m. | BREAK |
| 10:30 a.m. - 11:45 a.m. | ISSUES IN SOCIAL MARKETING<br>Moderator: John Farley, Columbia University<br>• Alan Andreasen, UCLA<br>• Santiago Plada, Bogota, Colombia<br>• Rajeev Battra, Columbia University |
| 11:45 a.m. - 12:00 p.m. | INTRODUCTION TO WORKING GROUPS |
| 12:00 p.m. - 1:15 p.m. | LUNCH |
| 1:15 p.m. - 3:15 p.m. | ISSUES CENTERED WORKING GROUPS<br>(Concurrent Sessions)<br>a. Potential Target Markets & Market Research<br>b. Products and Packaging<br>c. Distribution and Sales<br>d. Pricing and Prestesting<br>e. IEC, Advertising<br>f. Evaluation |
| 3:15 p.m. - 3:30 p.m. | BREAK |
| 3:30 p.m. - 5:30 p.m. | WORKING GROUPS REPORT TO PLENARY SESSION |
| 5:30 p.m. - 7:30 p.m. | Reception - Hosted by PRITECH |

Friday, November 2, 1984

| | |
|---|---|
| 9:00 a.m. - 10:30 a.m. | LESSONS LEARNED FROM SOCIAL MARKETING IN THE FIELD<br>Moderator: Alan Andreasen, UCLA<br><br>a. Bangladesh<br>• Bill Schellstede, Population Services International<br><br>b. Egypt<br>• Farag Elkamel, John Snow, Inc.<br><br>c. Gambia & Honduras<br>• Bill Smith, Academy for Educational Development<br><br>d. Nepal<br>• Jim Messick, John Short & Associates |
| 10:30 a.m. - 10:45 a.m. | BREAK |
| 10:45 a.m. - 11:30 a.m. | ORGANIZATIONAL MODELS FOR SOCIAL MARKETING PROGRAMS - Steve Samuel, Samuel and Ott |
| 11:30 a.m. - 1:00 p.m. | LUNCH |
| AID Mini-Workshop | |
| 1:00 p.m. - 1:30 p.m. | MARKETING OVERVIEW - Barnett Parker, University of North Carolina |
| 1:30 p.m. - 2:00 p.m. | ISSUES IN SOCIAL MARKETING: A Summary<br>John Farley, Columbia University |
| 2:30 p.m. - 3:00 p.m. | SUMMARY OF GROUP DISCUSSIONS - Group Leaders |
| 3:00 p.m. - 3:15 p.m. | BREAK |
| 3:15 p.m. - 3:45 p.m. | SUMMARY OF GROUP DISCUSSIONS cont. - Group Leaders |
| 3:45 p.m. - 4:30 p.m. | WHAT NEXT FOR AID AND PRITECH? |
| 4:30 p.m. - 5:00 p.m. | CLOSING REMARKS - Ann Tinker, S&T/Health and John Alden, PRITECH |

## APPENDIX B

## Social Marketing and ORT Workshop

### Participants

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18. Mr. Joel Lamstein
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# APPENDIX C

## MARKETING ORS/ORT: A PRODUCT MANAGEMENT PERSPECTIVE

by Rajeev Batra, Columbia University

## CONSUMER BEHAVIOR

- STARTING POINT MUST BE STUDY OF APPROPRIATE CONSUMER BEHAVIOR:

CONSUMER BEHAVIOR

IDENTIFY MARKET SEGMENTS, DEVELOP "STRATEGY" FOR EACH

DEVELOP APPROPRIATE MARKETING PROGRAM FOR EACH

(PRODUCT, PRICE DISTRIBUTION, PROMOTION)

- CONSUMER BEHAVIOR WILL DIFFER ACROSS MARKETS, BUT IN GENERAL THE ISSUES MIGHT BE AS FOLLOWS:

FROM A CONSUMERS PERSPECTIVE:

- HOW DO THEY RECOGNIZE SYMPTOMS? ARE ALL DIARRHEAS PERCEIVED AS THE SAME?
- WHAT IS USED NOW? WHAT WILL ORT DISPLACE?

  HOME REMEDIES
- WHAT ARE THE BARRIERS TO USING ORT? ATTITUDES TO "MODERN" MEDICINES?

  (GENERAL ATTITUDES FAVORABLE, SPECIFIC KNOWLEDGE POOR?)
- HOW DO CONSUMERS MEASURE EFFECTIVENESS? I.E. SOAP TO BE EFFECTIVE MUST HAVE SUDS; SOME DRUGS RELIEVE PAIN
- WHAT OTHER PRODUCTS ARE BOUGHT FOR THESE INFANTS?

FROM A TRADE POINT OF VIEW, RETAILERS SELLING ORS WILL HAVE LOW MARGINS AND HIGH TURNOVER.

FROM A HEALTH PROVIDER POINT OF VIEW, ONE CAN EXPECT RESISTANCE BECAUSE THEY PREFER COMPLEXITY, WHAT IS "MODERN".

## MARKET SEGMENTS

CONSUMERS

URBAN, HIGH EDUCATION, AND HIGH INCOME SEGMENTS:

- WANT MODERN MEDICINE?
- PHARMACY DISTRIBUTION?
- TO RECOVER COST?

RURAL, LOW EDUCATION, AND LOW INCOME SEGMENTS:

- WANT TRADITIONAL PRODUCT?
- FOOD/GROCERY DISTRIBUTION
- LOW PRICE?

HEALTH CHANNELS

- MAY NEED SEPARATE PRODUCT/NAME, PACKAGING, MESSAGE, MEDIA

RETAILERS WILL NEED

- INCENTIVES TO STOCK, DISPLAY PRODUCTS
- CREDIT TERMS
- MARGINS
- MIXING INSTRUCTIONS (ESPECIALLY FOOD OR GROCERY SHOPS)

## PRODUCT

- HOME-MIX VS. PRE-MIX:
  - PRO: COST: AVAILABILITY
  - CON: WRONG MIX DANGEROUS, LOW FAITH?

    PRE-MIX (OR FOOL-PROOF HOME-MIX PACKAGING)

- FORM:
  - POWDER? TABLETS? LIQUID? OTHER?
  - COLOR? EFFERVESCENT? FRAGRANCE (COST)?
  - INERT ADDITIVES?

- LINK TO POSITIONING:
  - STERILE TABLETS FOR URBAN MODERN?
  - EFFERVESCENCE TO "CLEAR SYSTEM?"
  - COLORS/ADDITIVES TO MIMIC TRADITIONAL REMEDIES?
  - ONE VS. MANY? IF MANY, COLOR CODE?

- PRODUCT + POSITION MUST "FIT IN" MAXIMIMALLY WITH CURRENT USAGE/BELIEF PATTERNS

- PACKAGING AND PRODUCT FORM CRUCIAL TO COMMUNICATE POSITIONING (COLOR, SHAPE, ETC.)

  PAPER PACK = INVIGORATIVE?

  TABLETS = MODERN MEDICINE?

  BOTTLED COLORED POWDER = TRADITIONAL HERBAL?

## PRICE

- USE PRICE POINTS PER UNIT, NOT PER CARTON

- KEEP COSTS LOW
  - DISTRIBUTED MANUFACTURING
  - GOOD INVENTORY MANAGEMENT
  - LOW DISTRIBUTION OVERHEADS
  - FAST SYSTEM THROUGHPUT FOR LOW TRADE MARGINS

- COST RECOVERY DECISION HAS CRUCIAL SEGMENTING IMPACT - SEGMENT BY INCOME/GEOGRAPHIC LOCATION, FOR "MODERN" PRODUCT?

- PRICE-QUALITY RELATIONSHIPS MAY BE CRUCIAL IN INFANT PRODUCTS. HOW MUCH DO TRADITIONAL REMEDIES COST?

## DISTRIBUTION

- HEALTH VS. COMMERCIAL

  HIGH RESISTANCE: LOW "REACH"; HIGHER OVERHEADS?

- COMMERCIAL: PHARMACEUTICAL VS. FOOD/GROCERY

  PHARMACIES: LOW REACH, HIGH MARGINS

  BETTER MIX ADVICE, FOR "MODERN" IMAGE?

  FOOD/GROCERIES: LOW MARGINS (3%, 10%)

  CAN PIGGYBACK ON TEA, MATCHES, FUEL, SOAP

- SEASONALITY IN DISEASE ONSET: MUST FORCE STOCK-UP PRIOR TO "DIARRHEA SEASON"

  USE INCENTIVES

- MUST ENSURE FAST RETAIL TURNOVER, HIGH RETURN ON LOW MARGINS:
  - WIDE WHOLESALE REACH, FREQUENT VISITS
  - WHOLESALER/MANUFACTURER FINANCING OF SYSTEM
  - PIGGYBACK ORS ON EXISTING FOOD/GROCERY PRODUCTS
  - USE CONTESTS, TRADE PROMOTIONS

- TRAINING FOR RETAILERS IN MIXING INSTRUCTIONS

## END-USER PROMOTION

ROLE OF ADS

- PIGGYBACK TRIAL PACK "IN-PACK"?
- DON'T OVERPROMOTE: DISTRIBUTION ADEQUATE?

POSITIONING

AS PRODUCT WHICH

- "CLEARS SYSTEM"
- "FIGHTS DRYNESS"
- "RESTORES APPETITE: TONIC"
- IS "MODERN" VS. "TRADITIONAL"

MESSAGE

- "UMBRELLA" THEME AND BEING MARKETED WITH OTHER GOOD/SERVICES LIKE CONTRACEPTIVES?

  IF THERE ARE FEWER BARRIERS TO USE OF ORT THAN TO OTHER ITEMS PROMOTED, MAY HURT PROMOTION OF ORT.

  IF TARGET POPULATION SHARES COMMON "INNOVATIVE" TRAIT, MAY HELP (WILL CLUTTER AND MAY CONFUSE MESSAGE).
- INCLUDE ADDED SENSE OF GRATIFICATION
- INCLUDE SPECIFICS ON MIXING, AVAILABILITY
- LINK TO OTHER FEEDING
- TONE: USE CREDIBILITY (RESEARCH) WITHOUT BEING BUREAUCRATIC/PEDANTIC

MEDIA

- RADIO, OUTDOOR, CINEMA
- POINT OF PURCHASE
- FLAG OTHER COMPLEMENTARY PRODUCTS (ORS IN-PACK INSTRUCTIONS?)
- SEASONALITY CONSIDERATIONS

## CONCLUSION

- SPECIFICS HAVE TO COME FROM LOCAL RESEARCH

- DON'T TAKE ANYTHING AS "GIVEN" - EVEN PRODUCT FORM - TILL YOU'VE STUDIED CONSUMER BELIEFS AND USAGE PATTERNS SEPARATELY BY SEGMENT

- DEVELOP A LINKING "POSITION" CONCEPT BASED ON THIS RESEARCH, THEN TAILOR EVERYTHING ELSE (PRODUCT, PRICE DISTRIBUTION, PROMOTION) TO THIS CONCEPT - BY SEGMENT.

APPENDIX D

# SOME NOTES ON

# MARKETING ORAL REHYDRATION THERAPY

Alan R. Andreasen
Visiting Professor
UCLA

Background Paper presented to:

Social Marketing and ORT Workshop

Washington, D.C.

November 1-2, 1984

# SOME NOTES ON

# MARKETING ORAL REHYDRATION THERAPY

Marketing has come to be seen as something of a knight in shining armor for a wide range of social programs. It has been looked to as the potential savior of the National High Blood Pressure Education program, the National Cancer Institute's Smoking and Breast Cancer programs, and even the marketing of the two-dollar bill. And, of course, it has seen growing application in contraceptive programs in a range of developing countries. It has been proposed that marketing can materially aid the adoption of oral rehydration therapy (ORT). So that potential sponsors and users understand what social marketing can and cannot do, it will be useful to understand some of its basic elements. This paper offers a few brief notes introducing an approach I have found useful in designing effective marketing programs in a wide range of profit and non-profit contexts. These notes may prove useful as a framework for discussing concrete problems involved in marketing ORT at the present workshop.

## Defining Social Marketing

First, it is necessary to define marketing and then social marketing. Marketing may be defined as:

> the analysis, planning and implementation of strategies designed to effect exchanges with target audiences so as to maximize the marketing organization's objectives.

Social marketing then can be defined as simply a subset of marketing where the organization's objectives in the particular program are primarily to improve the welfare of the society rather than its own well being. In most cases, such as with ORT and contraception, project success requires responses at the individual level with individual benefits. In some cases, however, such as driving 55 mph or saving energy, social marketing requires individual responses but the benefits are primarily at the societal level. Indeed, often the latter may involve net costs to the individual.

## Marketing Building Blocks

What then, are the essential building blocks of a marketing program consistent with the above definition?

1. Consumer Behavior. Basically, any organization undertaking a marketing program wants the individual to give up things. These can be concrete things like cash payments or contributions of money, time, blood donations and so on. Or the things one must give up can be abstract things like old habits or old ideas. To get the individual to give up things the marketer in return has to offer benefits. These, too, can be concrete like products or services or they can be abstract and subtle like good health, a feeling of doing good, increased self-esteem, a sense of participation and so forth.

2. Exchanges are not simple. In most cases, what the target consumer will be evaluating is a bundle of benefits to be exchanged for a bundle of costs.

3. Increasing the number of exchanges means changing the ratio of costs to benefits as seen by the target consumers. Improving the ratio can mean reducing the cost, for example by making it easier or less frightening to act or to change ways of thinking. Or it can mean increasing the benefits like offering giveaway incentives or providing a clearer picture of how one's health will improve after a certain change of life style. It can mean both.

4. Since success is, in the first instance, dependent upon the target customers' perceptions of the cost/benefit ratio inherent in the exchange, development of any marketing strategy must begin with (a) the target consumer and (b) an understanding of how they initially perceive the exchange and its potential costs and benefits. (That is, the best marketing projects must begin with some kind of customer research).

5. Target customers will vary in both their perceptions of the costs and benefits involved in potential exchanges) and their likely responsiveness to strategies and tactics the marketer might adopt. As a consequence marketing analysis and planning should always consider segmenting consumers into different sub-populations who would subsequently receive different marketing treatments.

6. Since the task of changing complex perceived cost/benefit ratios can be difficult--especially when, as in social marketing programs, the costs are often seen by the target consumer to be very, very high--complex strategies will be needed to effect the exchanges. And to insure that the tactics involved in these complex strategies are mutually reinforcing and not counterproductive, they must be carefully coordinated (e.g. so that, for example, tactic A enhances the effect of tactic B and does not counter the effect of tactic C).

Since marketing strategies are only effective if they achieve organizational (e.g. societal) objectives, decisions about individual tactics and overall success must be dependent upon (a) careful definition--preferably quantification--of objectives; (b) careful testing of program strategies and tactics to see whether they are likely to achieve short run program objectives and (c) careful monitoring of program accomplishments to see whether they are achieving longer run objectives.

## Pseudo Marketing

What, then is marketing not?

1. Marketing is not trying to effect exchanges the marketer wants, but what the consumer wants.

2. Marketing is not assuming one knows customer perceptions in advance.

3. Marketing is not trying to force target customers to perceive costs and benefits as the marketer perceives them.

4. Marketing is not treating all customers alike (unless there is sound research evidence for doing so).

5. Marketing is not relying on just one or two elements of the marketing mix such as advertising or public relations or distribution.

6. Marketing is not assuming that achieving interim goals (e.g. number of posters put up, rallies held) that are supposed to lead to longer run goals (e.g. behavior change) will in fact lead to long run success.

## What ORT Societal Marketing Should Be

If ORT programs are to adopt the best of marketing practice, they must adopt the principles outlined above. This means:

a. Adopting a customer not an organization starting point for strategizing.

b. Conducting a substantial amount of consumer level research before beginning a program and following up with a consistent program of consumer monitoring as one goes. (This is particularly critical for programs in developing countries where marketers may have ethnocentric perspectives different from target consumers.)

c. Carefully investigating what kind of segmentation in the market is possible and desirable.

d. Testing elements of the marketing mix before using them and then monitoring after the fact whether they've worked.

e. Thinking constantly about using all of the elements of the marketing mix and making sure that they are complementary and not conflicting. This may require considerable imaginativeness in infrastructures that are only weakly developed.

f. Finally, remembering that the end result is the exchange and that the basic strategy must be based on a full understanding of the core nature of the exchange as seen by consumers. The ultimate goal of ORT programs (as Meyer and Boni have pointed out[1]) is behavior, specifically correct, continual usage. To achieve this, Foote Snyder and Spain noted that:

> "the target audience[s] must have access to the channels, must be exposed to messages from the campaign, [and] must have the information or skills being taught..."[2]

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1 Anthony J. Meyer and Anthony F. Boni, "CRS and ORT: A.I.D.'s Alphabet for Social Marketing," working paper, A.I.D., February 1984. Privately circulated.

2 Dennis R. Foote, Leslie Snyder and Peter Spain, Executive Summary of Findings from the First Year of Evolution of the Mass Media and Health Practices Project in "The Gambia," working paper, Institute for Communication Research, Stanford University, December 1983.

This is a complex task made all the more difficult by the poor infrastructure in many developing countries, the abstract nature of the benefits to be communicated, and the seriousness of the costs to consumers inherent in giving up old habits and ideas.

Achieving the goals in such projects is therefore immensely difficult. Marketing can help considerably. But, as this brief note has sought to point out, expectations as to the usefulness of marketing will most likely be met if program managers adhere closely to principles distinguishing between what marketing can and cannot do.

APPENDIX E

# SOCIAL MARKETING PROJECT

# TEST MARKETING OF ORASALINE

# OCTOBER - DECEMBER 1983

William P. Schellstede
Vice President
Population Services International

# POPULATION SERVICES INTERNATIONAL

## Social Marketing Project

## Test Marketing of Orasaline

## October - December 1983

In the last three months of 1983, the Social Marketing Project (SMP) undertook the test marketing of some 50,000 packets of its branded oral rehydration preparation, Orasaline. The primary concern of the test market was to gauge the potential for a well packaged, attractively presented product placed at a price that would allow the full cost of its production, promotion, and distribution to be recovered from the consumers. This price was Tk. 5.00 (U.S. $.20) for a 500 cc equivalent sachet, a price substantially higher than a comparable product put on the market by an indigenous PVO, Gonoshastra Kendro, which seems to have received outside funding for its product; this price is similar to that of an ORS produced and marketed by a local commerical pharmaceutical house, Pioneer.

The test market was carried out by SMP Medical Representatives (MR's) in eight locations; viz, the four districts of Sylhet, Barisal, Mymensingh, and Rajshahi; and the four sub-divisions of Munshiganj, Bagerhat, Lalmanirhat, and Lakhipur.

No mass media promotion was used, and only medical and quasi-medical outlets (pharmacies) were eligible for purchase. No credit was extended for purchase of ORS. Neither wholesalers nor stockists were involved, and an upper limit to the quantity sold per outlet against cash per visit was strictly enforced (to prevent over-stocking and hording). The test market was not carried out during the peak diarrhea season.

The basic results from the test market are given in Table I.

| Dist./ Sub D | Outlet Visited | Outlets Sold | % Refusal | Amt. Sold | Sold/ Outlet | % Outlets Resold |
|---|---|---|---|---|---|---|
| Barisal | 667 | 324 | 52% | 7,140 | 22 | 64% |
| Sulhet | 220 | 112 | 49% | 9,040 | 81 | 46% |
| Mymensingh | 257 | 169 | 34% | 9,460 | 56 | 52% |
| Rajshahi | 204 | 137 | 33% | 6,840 | 50 | 42% |
| Lalmonirhat | 61 | 46 | 25% | 1,560 | 34 | 28% |
| Bagerhat | 191 | 130 | 32% | 2,400 | 18 | 27% |
| Munshiganj | 113 | 62 | 45% | 2,060 | 33 | 82% |
| Lakhipur | 144 | 111 | 23% | 4,380 | 39 | 22% |
| AVERAGE | | | 37% | | 42 | 45% |

Particular attention was given to the refusals to stock Orasaline. It is extremely encouraging that in no case was the refusal based in an ignorance of oral rehydration therapy. The most frequent reason for the refusals was that the price was perceived as too high - compared to that of the Gonoshastra product as well as the NORP, UNICEF, and ICDDR,B product also found in the market, all at much lower price. The other reasons given can also, for the most part, be traced back to the factors which were imposed on the test market: little brand awareness in the absence of promotion; credit not extended; and low current incidence of diarrhea. And, in any event, an average refusal rate of 37 percent would be quite acceptable even after a longer period of marketing.

Of the entire amount sold during the test market, some 36 percent was sold through re-stocking. In a marketing period of only three months duration, that percentage is encuraging as it suggests that product movement from the shelf was beginning to be significant, even without consumer advertising. It also lends further credance to the notion that there is already substantial awareness of the use of a rehydration product and that wider availability and more intensive distribution - even in the absence of big education and promotion campaigns - will lead to more frequent use of the product.

However, a comparison of the performance in urban and rural areas seems to confirm what was assumed: that familiarity with - and therefore use of - rehydration product vary directly with socio-economic status. Thus, while it may be true that sales will increase substantially even in the absence of a communications campaign, in order to increase its use in the lower socio-economic groups, where dehydration probably poses a more genuinely mortal threat, such a communications campaign is absolutely required.

To supplement the sales data generated in the test market, a small survey of consumers was also conducted. Perhaps most significantly, it was found that the pharmacists to whom the SMP Medical Reps. had sold the Orasaline were the source of information and motivation concerning rehydration therapy. That is to say, the pharmacists can to a significant degree play the role of educator with regard to ORS. The potential for this role seems, at this time, greater than is the case with contraceptives, possibly because sickness is more easily or more routinely discussed by pharmacist and client than is sex or family planning. The pharmacist seemed to have conveyed the information on how to use Orasaline even to the half of the consumers who were educated and who presumably could have gotten such information from the package insert. (The other half of the consumers was illiterate.) Less than 10 percent of the entire sample went through the insert at all.

The survy confirmed that no matter what channels of communications are used, great care is required to convey even the simplest messages. Two mothers used one liter of water per packet, possibly confusing the Orasaline instructions with those of Ganoshastra. One mother used substantially less water than called for: she believed that her small baby would not have been able to take as much liquid as a half-liter, and yet she wanted the baby to have all the contents.

...

Orasaline was said by both suppliers and consumers to be superior to the other available brands. Some attributed the superiority explicitly to the flavor. The opinion of both pharmacists and mothers was that the children took the flavored ORS more readily; whether this opinion is true in fact is less important than the preference the flavored product enjoyed, leading to the clear presumption that flavor will increase sales.

Conclusions and Recommendations:

1. Orasaline is a good product with considerable sales potential. Even at a price that is perceived as high by the trade and by consumers, SMP can anticipate sales in the following magnitudes:

| | No. Med. Rep. | Outlets | Sales | Pkt/Out | | Total Pkt. |
|---|---|---|---|---|---|---|
| 1st Quarter | 22 | 250 | 65% | 60 | = | 215,000 |
| 2nd Quarter | | | | | = | 236,000 |
| 3rd Quarter | Add 10%/Quar for natural increase | | | | = | 259,000 |
| 4th Quarter | | | | | = | 284,000 |
| 1st Year | | | | | = | 994,000 |

Thus, even at present price and with little additional promotion or education, sales in the magnitude of 1,000,000 sachets would seem easily achieved.

In the present absence of any donor willing and able to subsidize the price, SMP should immediately take steps to procure Orasaline on its own and sell it at a self-sustaining price in order to maintain its market presence.

2. The potential for ORS sales is tremendous. With a low cost, attractive, flavored Orasaline, supported by an agressive mass media motivation and education campaign, the sales projections above would quickly be surpassed. Furthermore, it seems unlikely that Orasaline sold at a self-sustaining price would ever move in quantities significant in a public health sense. In other words, Orasaline at TK. 5.00 would probably remain irrelevant to meeting the huge need for rehydration therapy.

Therefore, an intense effort must be made to locate and persuade a donor to subsidize the price of Orasaline and/or to help finance a communications campaign.

...

## ORASALINE SALES

(January - April 1984)

| | Jan. | Feb. | March | April | Total | Balance Stock |
|---|---|---|---|---|---|---|
| Barisal | 2860 | X | X | 1260 | 4120 | Nil |
| Mymensingh | 540 | X | 500 | 1500 | 2540 | 1425 |
| Sylhet | 960 | X | X | 1440 | 2400 | 750 |
| Rajshahi | X | X | 580 | 820 | 1400 | 1180 |
| Bagerhat | 460 | 300 | 640 | X | 1400 | 1725 |
| Laxmipur | X | 480 | 80 | 300 | 860 | 2010 |
| Lalmonirhut | 194 | 90 | 115 | 420 | 819 | 240 |
| Munshiganj | X | 180 | X | 360 | 540 | 400 |
| | 5014 | 1050 | 1915 | 1600 | 14079 | 7730 |
| Dhaka H.O. | | | | | | 4000 |

APPENDIX F

NATIONAL CONTROL OF DIARRHEAL DISEASES PROJECT (NCDDP)

MASS MEDIA DEPARTMENT

EGYPT

# CAMPAIGN UPDATE

No. 2 AUGUST 30 1984

The National Control of Diarrheal Diseases Project is about to launch its television informational campaign for 1984-85. The campaign will focus on five important concepts related to diarrhea and dehydration:-

1- Awareness that gaffaf, rather than the diarrhea itself, is the danger.

2- Awareness that gaffaf can be prevented by using oral rehydration therapy (ORS + nutrition).

3- ORS is a highly effective, medically approved treatment.

4- The effectiveness of ORS is dependent on proper mixing and administration.

5- Diarrhea can be prevented.

In developing this approach, the five concepts were identified by the NCDDP as important and an outline of the message content was then circulated to medical and social experts, and modified based on their comments. The outline or "writer's guide" was subjected to an expert review by eminent pediatricians at two conferences - the WHO Review Committee Meeting and the Ismailia Conference for Professors of Pediatrics. Before production of the commercials, the scripts and narration of the television commercials were also pretested among samples of the target audience - mothers of children under three years of age, particularly those of low socioeconomic status. This issue of Campaign Update contains the final scripts of commercials which will be on TV in a few days.

Other interesting features of the new ORT commercials are:-

- It is the first time a famous actress appears in a commercial on Egyptian Television.

- Breastfeeding is emphasized, both as preventive and nutritional, in three of the six commercials.

- Half the commercials talk about baby boys and the other half about baby girls. This is done purposefully, because of the tendency, found in several studies, to give more attention to boys than girls.



For more information call Dr. Farag Elkamel, tel 28281

Six different commercials were derived from the five basic concepts described before:-

- Commercial one : Awareness of dehydration and its signs.
- Commercial two : Management of diarrhea and prevention of dehydration.
- Commercial three : Song - ORS - breastfeeding and nutrition - the way to avoid dehydration and live healthy.
- Commercial four : Advantages of ORS, medical approval, and more on mixing.
- Commercial five : Mixing and administration of ORS.
- Commercial six : Prevention of diarrhea.

---

COMMERCIAL ONE

Hania knocks hard on door - Karima opens

| | | |
|---|---|---|
| Karima | : | what's wrong? |
| Hania | : | I'm going to lose my daughter. For the last two hours she hasn't stopped having diarrhea.<br><br>maybe she's teething? |
| Karima | : | Teething, not teething, thank God you didn't waste time, because diarrhea can cause gafaf |
| Hania | : | Is this gafaf dangerous? |
| Karima | : | Dangerous? It drains out all the liquids in the child's body and leaves him like a squeezed lemon |
| Hania | : | Oh my dear daughter. And how can I tell if she has gafaf |
| Karima | : | Gafaf begins when the child has watery diarrhea, and after that his eyes become sunken and his skin gets wrinkled. He has no appetite and has temperature and is exhausted, dying to drink |
| Hania | : | if gafaf happens, what should I do? |
| Karima | : | run to the hospital. The doctor will prescribe Mahloul Moalget El Gafaf, how to mix it, how to give it to your child. |
| Karima | : | and a word to put in your ear like an earring: Gafaf can be prevented if the child takes MMG |

COMMERCIAL TWO

Hania drops tea cups on table - looks worried and tense

| | | |
|---|---|---|
| Karima | : | what is wrong with you, Hania? |
| Hania | : | nothing,but from the time I heard that diarrhea can cause gafaf to the child, I'm at a complete loss |
| Karima | : | Diarrhea is indeed the greatest enemy of your child, but you can protect your child from it |
| Hania | : | How? |
| Karima | : | with nutrition and plenty of liquids he has defenses against the disease and replaces what his body is losing |
| Hania | : | liquids like what? |
| Karima | : | Lemonade, Karawy, Helba, Yansoun, and don't forget soup |
| Hania | : | and solid foods? |
| Karima | : | Yougart and boiled food, rice, vegetables or potatoes. And what hydrates and satisfies and nourishes the child and protects against illness, truly, is his mother's milk. |
| | | A word to put in your ear like an earring: With liquids and nutritious foods and before them mahloul moalget el gafaf, you cross with your child to safety shore. |

---

COMMERCIAL THREE (Song) - General

To protect from gafaf
Give him (Mahloul)
In 200 cc
And nursing continues!
And by the permission of God
His life will lengthen
And why be afraid
I still say
To protect from gaffaf
Give him Mahloul
In 200 cc

And nourishment continues
And by the permission of God
His life will lengthen
And why be afraid
I still say
To protect from gaffaf
Give him Mahloul
In 200 cc
And nourishment continues

Comment : Mahloul with nourishment and liquids prevent from getting gafaf.

---

COMMERCIAL FOUR

| | | |
|---|---|---|
| Karima | : | my dear son<br>my dear son who is precious to me<br>he was going to die from me |
| Doctor | : | and his diarrhea was like water |
| Karima | : | God keep the Mahloul<br>the strongest medicine and there's nothing like it |
| Doctor | : | its price is low in the pharmacies<br>it restores his appetite and you nourish him |
| Karima | : | .... and I nourish him |
| Doctor | : | Mahloul Moalget el gafaf |
| Karima | : | Energized his body and left him good. I made it at home with no problem |
| Jingle | : | Of course this package, sister<br>You'll get it<br>And here is the 200 cc of water<br>Pour it in, mix it<br>Because you love your son, cure him<br>All of that of course while nourishing him |

---

COMMERCIAL FIVE

Karima and a friend in a living room. They look at a picture album. The little boy, Khaled holds on to the album.

| | | |
|---|---|---|
| Karima | : | Oh Khaled<br>you see, it's his picture when he was small |
| Friend | : : | God bless him, he was beautiful like the moon |
| Karima | : | Ah, but you didn't see him when he almost got gaffaf |
| Friend | : | almost got gaffaf? How? |
| Karima | : | he had watery diarrea, and looked really tired and lathargic |
| Friend | : | and what did you do? |
| Karima | : | God bless the doctor. He instructed me to use MMG |
| Friend | : | MMG? |
| Karima | : | yes you bring a box from any pharmacy, it contains ten sachets. And it's possible to get it for free from the hospital or health center -<br>you take a sachet out and stir it into 200 cc of water |
| Friend | : | two hundred cc of water? How do I measure it? |
| Karima | : | I was like you, but they told me that the small soft drink bottle filled with water equals 200 cc water. That's if you don't find the special cup that is sold with MMG.<br><br>Add 200 cc of water, take the package, empty it into cup, and stir with a clean spoon.<br><br>And don't add anything else or you'll spoil it. Then you give the child a spoonful every minute. |
| Friend | : | suppose he vomits? |
| Karima | : | wait five minutes and then give it to him again And when the package is finished, make another one, and a third, and a fourth until he goes back to normal.<br><br>MMG can save the life of the child. Always keep it in your house |

COMMERCIAL SIX

A boy washes his hands with soap and water - His older sister cheers him.

| | | |
|---|---|---|
| Karima (laughing) | : | Oh, girl |
| Girl | : | Karim washed his hands with soap and water like I taught him |
| Karima | : | and did he wash his hands before eating? |
| Girl | : | of course mother |
| Karima | : | Ok darling - can you take this to your Aunt's house |
| Girl | : | yes mother |
| Karima | : | do you remember what to tell her |
| Girl | : | yes... to prepare her daughter's food freshly each time she feeds her |
| Karima | : | right |
| Girl | : | and to cover food from flies |
| Karima | : | because it causes diarrhea which is more common these days |
| girl | : | and utensils, dishes, and her hands, |
| Karima | : | she should wash with soap and clean water |
| girl | : | before she prepares the baby's food |
| Karima | : | good for you, good bye now (girl comes back) |
| Karima | : | what else, |
| girl | : | should I tell her to wash the baby's hands with soap and water |
| Karima | : | good girl I forget to tell you that. But you too forgot something |
| girl | : | what? |
| Karima | : | that nothing satisfies or norishes the child and protects him from illness as much as his mother's breast milk. |

22/10/84

# NCDDP CATALOG OF

# INFORMATION, EDUCATION, COMMUNICATION AND TRAINING MATERIALS

# ON DIARRHEA AND DEHYDRATION

## General

1-001 This is the National Control of Diarrheal Diseases Project is a 30-slide set depicting the range of activities of the NCDDP. It is accompanied by a written script which elaborates on each activity. Approximately 30 minutes. It is intended for program planners, decision-makers and public figures, both in Egypt and abroad.

1-002 Guidelines for Establishing and Operating a Rehydration Center is a practical guide to establishing and operating on-site rehydration services in established medical facilities. It covers site selection and preparation, equipment, staffing, organization of services, patient managmement, and education. Language: English. Currently in draft form, highlighting hospital-based services. The final version, expected to be published in April 1985, will be expanded to cover health center-based services as well.

1-003 Lapel Button pictures the project logo, the Aware Mother. Intended to be worn by dehydration center staff or others to show their support for and knowledge of oral rehydration therapy.

1-004 Every Living Thing Depends on Water is a 40 x 60 cm. poster that adds Koranic confirmation to the concept of rehydration. Also available as smaller window stickers. Language: Arabic.

1-005 1985 Appointment Calendar conveys messages about the NCDDP and oral rehydration therapy. Available in both desk diary and appointment book formats. Language: Arabic.

## For Physicians

2-001 Pediatricians' Roundtable is a videotape featuring four of Egypt's top pediatriac specialists and is aimed at convincing physicians of the merits of ORT. The experts discuss ORS as a scientific breakthrough and describe the national implications for the adoption of ORT nationwide. 20 minutes in length. Language: Arabic. Available in U-matic; Betamax Home Video, and; VHS (SECAM).

2-002 Introduction to Diarrheal Disease Management is a resource kit to assist professors and other discussion leaders in giving a 30-45 minute introductory lecture on diarrheal diseases to physicians and other health professionals. It contains 35 slides and a set of teaching notes. Script language: English.

2-003 Rapid Rehydration with ORS - I is a 5-slide sequence of a moderately to severely dehydrated child being rehydrated with ORS. Time is noted on each slide. The set is intended to highlight the rapidity and effectiveness of ORS.

2-004 Rapid Rehydration with ORS - II is a 7-slide sequence of a second moderately to severely dehydrated child being rehydrated with ORS. Time is noted on each slide. The set is intended to highlight the rapidity and effectiveness of ORS.

2-005 Schedule for the Treatment of Diarrhea in Children is a wall chart (70 x 100 cm) which summarizes the clinical signs and appropriate treatment for mild, moderate and severe dehydration as well as for diarrhea without dehydration. Language: Arabic or English.

2-006 The Most Important Discovery Since the Introduction of of Penicillin (Doctors' Version) is a 16-page pamphlet covering a range of clinical topics from the pathophysiology of diarrhea to the management of dehydration. Language: English.

2-007 Introduction to Oral Rehydration Therapy: A Training Package.

This is a multimedia training package intended to introduce physicians and High Institute-level nurses to oral rehydration therapy and to convince them of the merits of ORT. It contains:

a. Scientific Breakthroughs in the Treatment of Acute Infantile Diarrhea is a 30-minute video/film intended to heighten physicians' awareness of the effectiveness of ORT and to stimulate their interest

in it as the primary treatment for dehydration by elaborating on the underlying scientific facts. Language: English or dubbed Arabic. It is available in video (VHS or Beta (SECAM); VHS (NTSC)) and film (16 mm.)

b. Discussion Guide for Scientific Breakthroughs in the Treatment of Acute Infantile Diarrhea will assist the instructor in leaing a discussion following the videa/film presentation by pointing out important areas for further discussion. Language: English

c. Journal Article: I.W. Booth and W.A.M. Cutting. Current concepts in the management of acute diarrhoea in children. Postgraduate Doctor-Middle East. July 1984 summarizes the major points brought out in the video/film, Scientific Breakthroughs in the Treatment of Acute Infantile Diarrhea. A master copy of important article is provided so that copies can be made and distributed to the trainees for future reference. Language: English.

d. Patient Management Guide in the Treatment of Acute Infantile Diarrhea is a basic reference for the diagnosis and treatment of dehydration due to diarrhea. Language: English.

This training package will be available January 1985.

2-008 Diarrhea Control Newsletter, No. 1, Fall 1983 introduces the National Control of Diarrheal Diseases Project and presents the findings from a variety of diarrhea research projects conducted in Egypt. Language: English

2-009 Diarrhea Control Newsletter, No. 2, Summer 1984 includes the research findings of studies on the effectiveness of ORT, nutrition during diarrhea, the failure of drug therapy for vomiting, and the effectiveness of health education via mass media, and presents strategies for service delivery, education of mothers and diarrhea prevention. Language: English and Arabic.

2-010 Diarrhea Control Newsletter, No. 3, Winter 1984 includes research finding on the impact of ORT on overall deaths and case fatality, chronic diarrhea, and the effect of diarrhea on nutrition. Articles also describe project activities in training and mass media, and highlight future directions. Language: English and Arabic.

## For Nurses

3-001 Treatment of Infant Diarrhea is a 7-page booklet which summarizes the clinical signs and appropriate treatment for mild, moderate and severe dehydration as well as for diarrhea without dehydration. A growth chart is included to highlight the relationship between diarrhea and malnutrition. Language: Arabic.

3-002 Management of Diarrheal Disease: A Self-Instructional Manual is designed to enable nurses to learn the basics of oral rehydration therapy and diarrhea prevention through a program of self-study. Each informational section is followed by self-testing questions, the answers to which are found elsewhere in the manual. Language: Arabic or English.

3-003 The Angel of Mercy is a 4-page booklet emphasizing the the importance of the role of the nurse in the treatment of dehydration from diarrhea. It discusses the dangers of dehydration and describes its signs and treatments. Language: Arabic.

## For Pharmacists

4-001 The Problem and the Solution is a 4-page introductory flyer for pharmacists which provides expert testimonials about the effectiveness of ORS and describes its composition, its dosage, its mode of administration, and precautions to be taken. Language: English.

4-002 The Most Important Discovery Since the Introducation of Penicillin (Pharmacists' Version) is an 8-page technical pamphlet for pharmacists. It discusses the scope of the diarrhea problem in Egypt and describes the appropriate treatment. Language: English.

4-003 Mahloul Moalget Al Geffaf (ORS) - The Elixir of Life if Your Child Has Diarrhea is a protruding metal sign (23 x 30 cm) that can be mounted over the cash register, at the door or elsewhere in the pharmacy and describes the correct way to mix and administer the ORS. Language: Arabic.

## For the General Public

9-001 An Overview of Diarrhea: Its Prevention and Treatment in Egypt is a videotaped interview with five eminent physicians about all aspects of the problem of diarrhea. It is intended to heighten the awareness of the general public. Videotape in two 15-minute segments. Format:

SECAM only. Language: Egyptian Colloquial Arabic.

9-002 El Om El Waayya (The Aware Mother) is a collection 90 15-minute episodes on audiotape of the 1983 radio series aired in Alexandria. It includes dramas, songs, interviews with mothers and doctors and public appearances by Fuad El Mohandis to create awareness of dehydration, and let mothers know how to care for their children during diarrhea and where they can go for help. Written scripts also available. Language: Egyptian Colloquial Arabic.

9-003 Health and Your Family is a series of audio tapes of 1984 radio broadcasts using drama and interviews to convey messages about diarrhea and dehydration especially the importance of ORS and correct mixing. Language: Egyptian Colloquial Arabic.

9-004 Ya Om Es-Sughayyar (Mother of the Little One) is a 20-minute audio tape variety show including drama and songs, featuring commedian and social commentator Fuad El Mohandis. Language: Egyptian Colloquial Arabic.

9-005 Fuad El Mohandis: Beware of Geffaf is a videotape of 4 one to two minute television spots in which Fuad El Mohandis introduces the concept of "geffaf" (dehydration), its dangers and its cure with ORT. Also available as audio tape. Format: SECAM only. Language: Egyptian Colloquial Arabic.

9-006 Messages from Karima Mokhtar is a video tape including six 45-80 second television spots. This much-loved Egyptian actress gives counsel on diarrhea prevention, and the use of ORS and food to fight dehydration. Also available as audio tape. Format: SECAM only. Language: Egyptian Colloquial Arabic.

9-007 1984 Television Excerpts is a 2-hour videotape of highlights of Egyptian television programs sponsored by the NCDDP. Format: SECAM only. Language: Egyptian Colloquial Arabic.

9-008 Dalil El Om El Waaya (A Guide for Aware Mothers) is a 7-page booklet for mothers describing the seriousness of diarrhea, concept of dehydration, use of ORS and the proper way to mix it, nutrition during diarrhea emphasizing breastfeeding, and a schedule for childhood immunization. Language: Arabic.

9-009 Aware Mother Poster (40 x 60 cm), for use in clinics and pharmacies, is intended to familiarize mothers with ORS and gives instructions for proper mixing and administration. Language: Arabic.

## Other NCDDP Resources Available

NCDDP Library is located on the 3rd floor at 20A Gamal El Din Abou Mahasen Street in Garden City. It contains books and articles on mass media, training, marketing and research techniques as well as the clinical and epidemiological aspects of diarrhea. Sunday through Thursday 8 AM-4 PM.

NCDDP Information Service for Professionals screens journals for important new articles related to diarrhea and circulates them to its mailing list.

NCDDP Information Service for the General Public makes available photocopies of articles on diarrhea and dehydration that have appeared in newpapers and magazines.

## APPENDIX G

## ORAL REHYDRATION
## MARKETING WORKSHOP
## DRAFT ISSUES FOR WORKING GROUPS

### First Afternoon

It is assumed that the following issues will vary from country to country and region to region given various levels of development around the world and the production and media resources available in each country.

1. Potential Target Markets and Market Research

   - o Who is the target audience(s)? (Children under five, their parents, other child care providers, etc.)
   - o What is known about the target group(s)? Size? Age? Location? Literacy? Income? Access to media? Radio? Television? Access to health care?
   - o Who needs ORT?
   - o Can they afford it?
   - o What are the local perceptions and beliefs regarding diarrhea in general and childhood diarrhea in particular?
   - o Perceptions of physicians and other health care providers?

2. Products and Packaging

   - o Is there already an ORT product on the market?
   - o Is it satisfactory and/or is there a need for another one?
   - o Is there a local capacity to produce and package ORS? From scratch?
   - o Should ingredients be imported and combined locally?
   - o What size packet is most appropriate for home use? For clinic use?
   - o What about a logo and tradename and an attractive packet which is easy to open and yet moisture proof?
   - o How can quality be controlled? (A wrong combination of ingredients could cause more problems than ORT solves.)

3. Distribution and Sales

- What already exists on the market for the treatment of diarrhea?
- What distribution networks exist already, public and private? Urban and rural?
- Warehousing facilities?
- Do "sales representatives" have to be recruited and trained?
- Is there a group of merchants, i.e. pharmacists, throughout the country which distributes drugs and other health related items? Distributors of traditional medicines? Are they a feasible distribution channel? What would it take to train them in the sale and use of ORS?

4. Pretesting and pricing (pretest what? product? market? price? all three?)

- What are parents willing to spend for treatment of their children?
- Can ORS be produced at that price? Will it need to be subsidized?
- What is the difference in the price if ORS is imported? Manufactured locally? Component parts are imported and combined and packaged locally?
- Will the product pay for itself on the market? Only in urban areas? Only among the middle and upper economic groups? Can the price be subsidized for the poor? How wide a distribution will the product need so a company can break even? Make a profit?
- What incentive is their for retailers to handle ORS? Will a commercially attractive product be within the reach of most of those who need it?
- Will ORS compete with other products already on the market? How?

5. Information, Education, Communication, and Advertising

- Are there any public relations, advertising or other media-oriented commercial firms in the country?
- What is the nature of current health messages?
- Through whom or what are they channelled?

- Does any type of local folk entertainment lend itself to information dissemination?

6. Evaluation

- Of what? Product? Campaign? IEC?
- How to measure? Product consumption? Number of cases of diarrhea reported in clinics compared with former number? Changes in childhood morbidity? Mortality?

APPENDIX H

FACT SHEET

AID ORAL REHYDRATION MARKETING ACTIVITIES BY REGION AND COUNTRY

## AFRICA

Kenya: A joint study of the impact of marketing oral rehydration salts (ORS) is just beginning in Kenya sponsored by the Government of Kenya, a Kenyan NGO, Ciba-Geigy Pharmaceutical Company and AID (see case study).

Swaziland: The AID sponsored Mass Media and Health Practices Project (MMHP) has launched a one-year ORT project in Swaziland which includes training, radio, posters, and pamphlets (see case study). The cost to AID is approximately $200,000.

Gambia: Under the AID-sponsored MMHP Program, the Gambia executed a full-fledged public education program promoting homemade ORS from 1981 to 1984 (see case study attached). The local costs (excluding AID's costs) of the initial two-year project was approximately $41,000 per year.

## ASIA

Bangladesh: There has been a pilot test of the commercial marketing of oral rehydration salts in Bangladesh as an adjunct to the marketing of contraceptives. Currently plans are under way to test market Ciba-Geigy salts packaged for the Bengali market focussed on the poorer segments of the population and priced accordingly. A mass media and advertising campaign is planned based on an analysis of the market and behavioral research.

Indonesia: There is currently a proposal in AID to evaluate the marketing of locally produced oral rehydration salts in several regions of Indonesia.

Philippines: AID plans to support a substantial marketing/mass media component to promote both the homemade ORT solution and a locally produced packet in working with a local research and development firm.

Nepal: Investigations have begun on the feasibility of marketing ORS in Nepal through CRS which is a commercial distributor of contraceptives.

## LATIN AMERICA

Ecuador: Under the MMPH project there is a large mass media campaign for ORT under way in Ecuador.

Peru: There is a large mass media project promoting ORT and other health related activities in Peru under the MMHP program (see case study).

Honduras: Under the MMHP program there has been a large and on-going ORT program in Honduras (see case study). The local cost for the initial three years of the program was approximately $135,000 per year, not including the costs of foreign technical assistance.

## NEAR EAST

Egypt: In Egypt there is a large mass media campaign in support of the Control of Diarrheal Diseases Program in Egypt (see case study). The cost for radio and television broadcasting over a period of five years is $145,000.

Jordan: As part of a health education project in Jordan, there has been a pilot mass media program with emphasis on the use of oral rehydration therapy including presentations at health and community centers in schools, radio and television messages, and newpaper coverage.

# APPENDIX I

## CASE STUDIES: AID ORAL REHYDRATION MARKETING ACTIVITIES

- Peru
- Swaziland
- Kenya
- Honduras
- Egypt

## CASE STUDY

## THE PERU HEALTH LITERACY CAMPAIGN (ON-GOING)

**Question:** Can themes like ORT, Family Planning and Immunization successfully interact in a single social marketing program?

**Objective:** Increase demand for and improve the use of ORS, contraceptives, and immunizations through an umbrella campaign which links all three themes to "responsible parenthood."

**Target:** ORS for all children under three-years-old. Immunization for urban and semiurban children under one year of age. Family planning for 1.5 million couples of childbearing age who do not wish to have more children and are not using contraceptives or who do not want to have more children but are using "traditional" methods such as herbs, teas, and rhythm.

**Strategy:** Strategy is to mount a Health Literacy Campaign, including broadcast, print, and interpersonal support on key messages in each area, held together by an umbrella theme of "responsible parenthood." Family planning messages stress that modern methods really work and congratulate couples using modern family planning methods. ORT Messages stress that ORS is good for all diarrheas and provide both a mixing container (plastic bag) and clear instructions on how to mix and give the litre packets. Immunization messages focus on popularization of an immunization card and calendar which health workers fill in and give to mothers as an explicit reminder of when to return for next immunization.

Printed materials for mothers are packaged as a "Health Bag" -- a colorful envelope containing the EPI card, the ORS plastic bag and two packets, and two illustrated booklets on ORT and Family Planning methods. The calendar is printed on outside of "Health Bag." These are distributed by health workers at all levels of the systems. Radio and TV broadcasts are sequenced and pulsed to coincide with diarrhea season, to promote three intense immunization sweeps at three month intervals, and to provide regular family planning promotion intensified at intervals between other two programs. Special attention was given to decision-maker support including newspaper articles and a national press conference.

**Production of ORS:** For the first year the campaign is targeted primarily at people in urban and semi-urban areas where services are now available, permitting the MOH to strengthen their ability to meet demand in the rural areas. Local pharmaceutical production of packets of ORS to be distributed free under the name SALVA-ORAL by the Ministry of Health and sold under the name SALVADORA by commercial pharmacists. Name similarity deliberate effort to associate positive consumer reputation of commercial product with new government product and to improve the accuracy of mixing and administration of commercial product through widespread dissemination of correct instructions with government product.

**Vaccine Supplies:** Inadequate for National program -- initial promotion limited to Lima which constitutes one-third of total population.

**Contraceptives:** Stocks are provided largely by U.S. and are presently adequate. Concern about health system personnel willingness to distribute.

**Marketing and Promotion:** Joint program of public and private sectors. MOH contracts local advertising and market research firms to develop promotion strategy which benefits both private and public sector products. Market research reveals 1) key family planning audience includes couples who want no more children but who use only traditional methods or resist all methods due to fear of effectiveness and safety; 2) primary ORS problem included a lack of adequate mixing and administration knowledge despite widespread availability of commercial ORS product and inadequate health system marketing of its own ORS product; 3) belief that ORS is good for only <u>some</u> diarrheas, and 4) lack of immunization services serious constraints to national program, but even where service is available biggest problem is lack of explicit information to mothers on when to return for next immunization, and mothers' concern with side effects.

**Results:** Actual campaign began in September 1984 and continues through April 1985. Impact data being collected but not yet available.

Within MOH establishment of ORT, EPI and Family Planning as priority programs, reducing from 12 to 3 the number of primary targets for 1984-5. Development and analysis of high quality consumer research on these health problems in Peru. Initial model of public-private collaboration in health areas developed and tested.

**Problems:**

- How to provide face-to-face support through a public sector mechanism (MOH) plagued with strikes and work stoppages.
- Need to ensure that communication program does not promote services more rapidly than they are available.
- How to influence health professionals to support program.
- How to segment campaign to provide for different levels of program development among the three themes.

**Lessons Learned:**

- Importance of explicit preparation of public and private sector institutions to work together.
- Fundamental necessity of pretesting as means to correct significant design errors.
- Importance of understanding existing consumer attitudes toward diarrhea as means of developing effective message strategy.

CASE STUDY

# PREVENTION AND TREATMENT OF ACUTE DIARRHEA IN SWAZILAND

This Mass Media and Health Practices Project (MMPH) activity is part of the Rural Water Borne Disease Control program in Swaziland and part of a three pronged health program which includes immunization and malaria control and prevention.

OBJECTIVES:

1. To promote oral rehydration therapy (ORT).
2. To strengthen the health education system's ability to design and produce systematic mass communications campaigns.
3. To produce a radio series on selected health themes.

PLANNED OUTPUTS:

1. A national implementation plan for the campaign.
2. A poster/certificate on oral rehydration solution (ORS) for traditional healers.
3. An instructional flyer for mothers on the use of ORS.
4. Instructional posters for health professionals
5. An educational pamphlet on ORS for use in schools.
6. A nine-month radio campaign on prevention and treatment of infant diarrhea using oral rehydration solution and the five key activities which prevent diarrhea.
7. One to two-day courses for at least half of the existing health care workers.
8. One day of training for a significant percentage of traditional healers on ORS, the danger of purges for children with diarrhea, and the importance of feeding during diarrhea.
9. A national medical seminar on infant mortality including ORT, immunizations and malaria.
10. A series of short radio programs on the importance of the measles vaccine for children at nine months of age.

11. A regular malaria program discussing the importance of malaria and including interviews with spraying team and community members.

PLANNED OUTCOMES:

- A 50 percent increase in the number of mothers who have used ORS in the home.
- A 30 percent increase in the number of health facilities regularly using ORT.

This campaign began in mid-September which is the beginning of the "diarrhea" or rainy season.

ACTIVITIES TO DATE:

Considerable behavioral and clinical "market research" has been completed and based on the research:

- A treatment strategy has been developed for the Ministry of Health including training and distribution of ORS packets.
- An MOH policy statement has been developed as a health workers manual.
- A "diet for diarrhea" poster and an instructional poster for health workers has been developed.
- A photonovel for use in secondary schools has been developed.
- Radio messages are being broadcast which
  - promote the early use of homebased ORS treatment
  - clarify mixing instructions
  - emphasize the need to restore "balanace" of fluids (based on a traditional concept)
  - explicitly discourage purges
  - direct parents to take a child to the clinic if diarrhea persists into the second day
  - promote personal hygiene, domestic environmental sanitation, and the protection of water supplies.

Evaluation of the program will be based on self-reported behavior of mothers and on the number of cases and the status of cases seen at clinics.

CASE STUDY

# A COMPARATIVE STUDY OF THE EFFECTS ON CHILDHOOD DIARRHEA OF PUBLIC SECTOR AND COMMERCIAL DISTRIBUTION OF ORAL REHYDRATION SALTS IN A RURAL AREA OF KENYA

## OBJECTIVE:

To test alternative programs for distibuting ORS salts and their impact on reducing preschool mortality from diarrheal disease among rural families.

## METHODOLOGY:

This study will compare two areas in the rural district of Kakamega 400 kms. west of Nairobi (comprising 3,558 square kms. and a population of over one million people) for the effect of oral rehydration therapy on mortality and morbidity among children. In this district mortality among children under two years of age is 143/1000 and for those under five 109/1000.

In the control area, free sachets of unflavored rehydration salts will be available from health centers where health personnel will be trained in their use. "Minimal messages" will be given to child caretakers and health center staff including signs and symptoms of dehydration, criteria for self care and referrals, the importance of breastfeeding during diarrhea, and instructions on preparing the solution at home.

In the comparison area the health centers will have the same unflavored salts, and staff and parents will be given the same information regarding its use. In addition, however, there will be the commercial distribution of flavored Ciba-Geigy salts and an advertising campaign to promote them.

Baseline data for monitoring and evaluating the campaign will include information on consumer price elasticity, household KAP surveys, and morbidity and mortality. Flavored sachets are to be sold and distributed along with Aspro, the Ciba-Geigy aspirin. An experienced local advertising firm (Orro Marketing Ltd.) will do a market analysis on which they will base the package design and the advertising material, media mix, and health education material. It is planned to use sound trucks, film, billboards, and market demonstrations for the campaign.

## MONITORING AND EVALUATION:

Effectiveness will be measured at mid-project through
- analysis of mortality surveillance data from clinics
- verbal autopsy reports from clinics, and
- clinic treatment and referral records

Final evaluation will be based on KAP studies, mortality and morbidity surveys, and a "recensus."

## CASE STUDY

## ORT IN HONDURAS

## SOCIAL MARKETING IN THE PUBLIC SECTOR

**Question:** Can the principles of Social Marketing, independent of product sales, contribute significantly to improved public sector health delivery?

**Objective:** Develop 1) proper diarrheal management in the home including widespread and correct home use of locally produced ORS for early response to diarrhea in children under 5, and continued feeding during bouts, and 2) proper clinical management of dehydration in the health center, clinics and hospitals stressing ORT as preferred therapy in most cases of moderate and severe dehydration.

**Strategy:** Strategy integrated radio, specialized print materials, and health worker training to promote proper home use of ORS packets. Packets produced locally by government pharmaceutical company and distributed through health system as well as through a special cadre of "red flag depots" which were highly publicized on radio.

The basic messages stressed throughout the campaign were 1) how to mix and administer ORT salts correctly; 2) continue feeding and breastfeeding during diarrheal episodes; and 3) seek help if the child gets worse.

About 900 health care workers (HCWs) received four to eight hours of ORT training. The training focused on performance: mixing and administering ORT salts and teaching village assistants to do likewise. The HCWs then trained selected mothers in ORT and in a number of behaviors associated with breastfeeding, infant food preparation, and personal hygiene. Red flags were flown over the homes of these mothers so that others would know where to go for advice and/or further instruction.

Print materials and radio were used to reinforce the instruction given by the health care workers. Posters, a printed instructional flyer, packet labels, and flipcharts were used to illustrate mixing directions for the ORT solution and to carry supporting messages.

Some 39,000 30-60 second radio spots, many of them featuring a fictitious Dr. Salustiano, were broadcast the first year. Jingles, slogans, and songs were also incorporated. The announcements covered child care during diarrhea and encouraged the administration of "Litrosol" — the name of locally packaged ORS.

A significant investigation of the medical problem, consumer research, and media usage was conducted before the project was implemented. Significant traditional beliefs uncovered during research were incorporated.

The tone of the campaign was serious and straightforward. It sought to promote a mother-craft concept which supports what mothers are

already doing and adds several components to "being a good mother." ORT was presented as the latest achievement of modern science: as an aid for lost appetite and quick recovery. ORT was not presented as a remedy for diarrhea.

**Results:** Data was collected on 750 families randomly selected from 20 communities by Stanford University. Within a year, 93 percent of the mothers knew that the radio campaign was promoting Litrosol; 71 percent could recite the radio jingle stressing the administration of liquid during diarrhea; 42 percent knew that Litrosol prevented dehydration; and 49 percent had used Litrosol. Of those who had used Litrosol, 94 percent knew the correct mixing volume and 96 percent knew to use the entire package. Sixteen months into the campaign, 39 percent of all cases of diarrhea within the previous two weeks among the sample households were being treated with Litrosol. Mortality of children under five years of age in the study communities showed a drop in the proportion of deaths attributed to diarrhea from 47.5 percent in 1981 to 25 percent in 1982.

**Problems:**

- Timing of all in-puts -- distribution, training and promotion to coincide.
- Medical community resistance to private-sector involvement and to supplemental distribution systems.
- Local production and supplies which had to be supplemented by UNICEF imports.

**Lessons Learned:**

- Importance of understanding and reflecting existing village views of diarrhea in promotion strategy.
- Importance of regular monitoring and mid-course correction to keep program responsive.
- Key role that radio can play in teaching mixing skills, not only publicizing the availability of and usefulness of ORS.

## CASE STUDY

### The Egypt National Control of Diarrheal Diseases Project (1981-1987) Marketing Strategy for ORS/ORT

Objective: Improve the treatment of diarrhea in children through the use of ORT by all health practitioners, through widening the knowledge and practice of ORT among mothers, and by increasing access to ORT throughout Egypt.

Target: The 4.8 million children under three years of age in Egypt among whom 20 percent will have serious bouts of diarrhea (and will be seen in clinics and hospitals this year) and among whom 30 percent will have non-serious cases and will ideally be treated at home.

Strategy: Production of ORS:

The local production of 20 million 5.5 packets of ORT (that required to make 200 cc. of oral rehydration solution) for distribution on the mass market in addition to the use of 27.5 gram packets (for one liter of solution) in hospitals and clinics.

Marketing and Promotion:
Market research had two major thrusts: 1) to determine the substance of folk entertainment and the media entertainment habits of rural and urban low-income people; and 2) their access to television and radio. Two thirds of all Egyptians own or have access to television. However, the really poor in upper Egypt do not have such access. Ninety percent of all Egyptians have access to radio although large percentages (from one fifth to one half depending upon socioeconomic status) never listen.

Based on research results a large radio and television campaign is being developed to familiarize families with the use and proper mixing of the solution using, among other message techniques, a dialogue based on questions and answers between an interviewer and a woman physician and reinforced with repetitious jingles and musical lyrics.

Printed materials have been prepared including textbooks, newsletters, pamphlets, and leaflets. Samples of the salts with cup and spoon have been distributed, and conferences and mobile teams organized.

Project representative visits to private doctors and pharmacists in an effort to "sell" oral rehydration therapy and salts. The representatives were given salesmanship training. Pharmacists were asked to stock the 5.5 gram packets and for every 10 they sell they can sell for 5 piastres the plastic cup and spoon for mixing the solution at home. The pharmacists receive the cup and spoon free. The profit margin is estimated at 30 percent, and is favorable compared to other antidiarrheal products.

**Results:** By midproject (1984) there are nearly 200 centers providing ORT to thousands of children and hundreds of physicians and nurses have been trained in latest methods of the treatment of diarrhea. Although the use of mass media is so far limited, the awareness among the general public of ORT and its use in dehydration has increased substantially in many parts of the country.

**Problems:**

- How to get mothers and others to mix the solution correctly.
- How to reach and teach mothers, physicians and nurses.
- How to change the attitudes of medical staff.
- How to stop the use of antidiarrheal drugs.