Health and Social Services

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Social Marketing of Bednets in Tanzania

Rose Nathan, Hadji Mponda, Hassan Mshinda

Malaria is still a devastating disease in sub-Saharan Africa where it kills at least one million people every year (UNICEF 2003). Children are most vulnerable to malaria attacks, which kill more than 3,000 children every day, largely in Africa. At least 100 Tanzanian children die daily because of the disease. Another high-risk group is pregnant women. However, all other adults are also exposed to substantial risk of malaria. In Tanzania, control and care of malaria puts a huge burden on financial and economic costs both at micro and macro levels, thus translating into enormous poverty implications. As such, malaria has a potential in slowing down the achievement of the MDGs in countries where it is endemic as is the case in many parts of Tanzania.

Many efforts and resources have been invested in search of effective malaria control strategies. Among few of the strategies that have shown effectiveness are insecticide-treated nets (ITN). Such nets have been proven to be effective, feasible intervention for reducing malaria morbidity and mortality.

At the African Summit on Roll Back Malaria, African leaders signed the Abuja Declaration, with the commitment to protect 60 percent of African children with a treated net by the year 2005 (RBM 2000).

The issue of how the nets should be effectively delivered to the poor communities has been a subject of debate. Formulating effective and sustainable mechanisms that guarantee access to ITNs by the most vulnerable has been a challenge. Social marketing programs offer a way to increase demand through promotion at the same time supplying nets at subsidized prices.

The concept

Social marketing is an approach where the experience of commercial marketing is applied to a product which has a social benefit, with the main motivation being social improvement rather than financial gain to the marketer (Andreason, 1995).

Largely Population Service International (PSI) and Ifakara Health Research and Development Centre (IHRDC) have implemented social marketing of insecticide-treated nets in Tanzania. Here, we describe a specific social marketing program, known as KINET, for...
insecticide-treated nets in two rural districts of Tanzania, Kilombero and Ulanga, implemented by IHRDC. The program aimed at achieving substantial and sustainable use of insecticide-treated nets in young children and pregnant women. The purpose of the program was well in line with the philosophy of social marketing; it was therefore envisaged as the most appropriate technique to reach the target population with the insecticide-treated nets as a malaria control intervention.

**Setting up the program**

The program implemented delivery of treated nets in five phases. By the end of the third year of the program implementation, a population of about five hundred thousand people in 112 villages had been covered. Phase one of the implementation covered the area with a demographic surveillance system (DSS).

Community participation was made central right from the designing stage of the program. Community members were given a primary role in shaping the implementation activities. The research team in partnership with district health management team held sensitization meetings with village leaders. The meetings, in a form of open discussions included general health issues, prevention of malaria sustainability and cost-recovery. Community preference studies were conducted to identify size, quality and color of their choice. Through local market research a brand name “ZUIA MBU” (a KiSwahili phrase which means prevent mosquitoes) was identified for treated nets and insecticide.

**Marketing package**

**Product**

The nets were dark green high quality polyester in two sizes: (100 x 180 x 150 cm and 130 x 180 x 150 cm). The sizes were suitable for the local sleeping places. Insecticide water-based formulation of lambdacyhalothrin (ICON TM) was packed in 6 ml sachet.

**Promotion**

Formative research was conducted at baseline to explore community perceptions of severe childhood disease. In collaboration with District Health Management Team results of the research were used to develop a range of promotional materials. Promotional materials included: billboards posted along main roads, posters, leaflets, exercise books used at primary schools, T-shirts, umbrellas, caps, and point-of-sale stickers and flags.

Information Education and Communication (IEC) seminars were held for the sales agents, and groups of specially recruited village resource people once in every six months. The resource people included village leaders, village health workers, primary school teachers and Maternal and Child Health (MCH) aides.

**The distribution system**

The distribution network of the insecticide-treated nets included retail agents in each village and wholesalers in each division. The retailers were chosen jointly by project staff and community members; they included private shopkeepers, community leaders, health workers and priests. A reward system was used for retailers and wholesalers for reaching certain sales targets. Over time, inactive retailers were replaced. Insecticide retailers, in the initial distribution area were provided with bicycles to be able to offer door-to-door treatment services. As the area expanded, the insecticide was sold as a dip-it-yourself kit containing a pair of gloves and instructions. The kits were sold through shops (often were the same shops that sold treated nets).

The program relied on collaboration with public entities such as the district health management team and Ministry of Health, the private sector such as international and local suppliers, local businessmen, and other non-governmental organizations involved in health.

**Price**

Price was based on what the community indicated they were willing to pay and experience from previous net projects. The prices were near to cost recovery—consumer prices were set at TZS 3000 (US$ 5.00 in 1997) for a net, and TZS 250 (US$ 0.42 in 1997) for a sachet of insecticide.

**Targeting**

The program aimed at targeting the most-at-risk group, pregnant women and young children. To
achieve that, a discount system was developed. The system was based on a simple paper vouchers issued through the MCH clinics. The vouchers were given to pregnant women when they visited MCH clinics for antenatal care as well as to mothers of children under five years of age. The voucher was worth TZS 500 (approx. US$ 0.5); therefore it allowed the beneficiary to purchase a Zuia Mbu net from a retailer at a reduced price of TZS 2,500 (instead of TZS 3000). The retailers were reimbursed on their next order with an addition of TZS 50 for each voucher as a handling charge. Implementation of voucher scheme reflected a successful public private mix.

Reach the poor

KINET program had several features which qualified it as a pro-poor initiative. Those included:

- Adoption of social marketing as a strategy to deliver the insecticide-treated nets - by default SM has no motive of financial profit.
- Use of discount system facilitated access to pregnant women and young children without excluding the poorest.
- The remotest rural settlements where the poorest are concentrated were reached with the insecticide-treated nets through the established delivery system.

The program assessed the extent to which it reached the poorest in the served population. This was done through annual household coverage surveys within the DSS area. Each household was asked whether they owned a net and a similar question for other specified assets.

Using the reported ownership of assets, quality of houses, and occupation of the head of household, a statistical analysis (Principal Component Analysis) was done to categorize the households into five wealth quintiles. The survey and the analysis were done for the year of the start of the program, 1997, and three years after, 2000.

The coverage, measured by percent of households with at least one net, improved from 37 per cent in 1997 to 73 per cent at the end of 2000. Coverage among the households categorized as poorest improved from 20 per cent to 54 per cent, while among the least poor (rich) households it increased from 63 per cent to 92 per cent. The poorest/least poor ratio of the coverage increased from 0.3 to 0.6 over the three-year period (Nathan et al., 2004).

Conclusion

Social marketing was associated with rapid overall improvements in net coverage, and the pace of change was higher among the poorest than the least poor. It should however, be noted that this success happened in the presence of two enabling factors: the existing demand for mosquito nets, which was extremely high probably because of perceived mosquito nuisance, and the existing active private sector for nets (Nathan et al 2004).

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Rose Nathan and Hadji Mponda work for the Ifakara Research and Development Center in Tanzania, and Hassan Mshinda is the Director of the Ifakara Health Research and Development Center.

References


