A global communications campaign framework to help to combat the threat from substandard and falsified medical products.
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EXECUTIVE SUMMARY

The Member State mechanism has approved a number of prioritized activities related to substandard and falsified medical products. The communication, education and awareness-raising stream was led by MHRA\(^1\) on behalf of the United Kingdom of Great Britain and Northern Ireland and aims to contribute to the *prevent* element of the overarching three-pronged strategy developed by WHO comprising prevention, detection and response.

METHODOLOGY

At the outset of the work in January 2016, the scope and approach of this activity was defined as follows:

Create a working group to develop and leverage existing recommendations for effective risk communication and recommendations for awareness campaigns on SSFFC\(^2\) medical products and related actions, activities and behaviours.

It was agreed that the work should focus on providing practical advice and guidance to Member States and several key elements were identified as useful outputs from the workstream:

- produce samples of hard and soft copy, video and broadcast material
- assess the use of social media for raising awareness
- identify the full range of stakeholders and audiences
- develop key and innovative advocacy material.

During the development of the work programme it became increasingly clear from the social, political and economic perspectives that the impact of communication was growing at an unprecedented pace, making it increasingly difficult to develop guidance and strategies – with a significant risk that they would become irrelevant or outmoded almost as soon as they were published. Meanwhile, considerable computing power and technology growth, coupled with similar software advances, are combining to accelerate the reach, influence and immediacy of communication messaging on a daily basis, but this is happening in very different ways and rates across Member States. From the outset, the communication, education and awareness-raising workstream therefore set out to acknowledge these differences and the very local and contextual nature of communications with different audiences, to ensure all Member State communication environments were represented and reflected in the recommendations developed.

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\(^1\) MHRA – Medicines and Healthcare products Regulatory Agency.

\(^2\) SSFFC – substandard/spurious/falsely labelled/falsified/counterfeit; since 2017, substandard and falsified.
In order to maintain a global perspective for existing and future communications advice, a communications working group\(^1\) was established early in the work programme and invitations to join the group were extended to communications professionals across all six WHO regions. Support and contributions to the workstream were then channelled through the group’s members, acting as a first-level consultative and critical review body.

Beyond the communications working group, the workstream reached out to the broader professional communications community working in Member States, academia and analogous areas of public health, to build a contemporary picture of best practice in communications before developing and testing a bespoke approach to guidance on substandard and falsified medical products.

The proposals set out in this handbook are based on the feedback received, together with the results of a global communications survey and live testing of the framework subsequently developed.

With a clear remit to generate practical guidance for Member States, the communication, education and awareness-raising workstream has focused on contemporary thinking on best practice and campaign implementation to populate its guidance.

BUILDING BLOCKS AND STAGING POSTS

The establishment of a body of knowledge led to a focus on ensuring behaviour change thinking was included as an essential component of communications advice. We need to do more than just provide information to citizens and patients on the risks and dangers associated with substandard and falsified medical products; we also need to engage and motivate them to make positive “considered decisions”, thereby adopting safe behaviour.

Engagement with interested stakeholders showed the extent to which the whole public health community recognized the risks posed by substandard and falsified medical products and the need to develop integrated strategies throughout the supply chain, from manufacture to consumption, and to use communications at key intervention points with relevant audience groups (health care professionals, influencers, citizens).

What we learned from our pilot communications survey in 2016 of communications working group members confirmed our original hypothesis that what was required was practical guidance, particularly on:

- sharing insights and creating assets
- support for success measurement
- showcasing best practice and providing guidance on film, social media and print.

When we took the results and insights from the pilot survey and developed the global communications survey in 2017, we largely found confirmation of our initial work. We also

\(^1\) See Annex 1 for membership of the communications working group.
looked to understand what Member States were currently doing: there was broad consensus on the challenge that this work represented within a wider public health agenda.

- Little original research was being conducted into the use and awareness of substandard and falsified medical products among the public or health care professionals, with informed views suggesting that:
  - for public audiences, social media (or friends and family) were a key channel and were influential;
  - for health care professionals, their professional organizations, government departments and regulators were influential.
- Campaigning was mainly directed at population-wide public audiences.

Furthermore, as might have been expected from feedback from the pilot survey, the global communications survey indicated that Member States were principally looking for guidance on planning, developing and measuring the success of their campaign activities.

Live-testing workshops enabled us to test the validity of the framework with a variety of Member States, most recently in the African Region, South-East Asia Region and European Region, and feedback aggregated from these workshops informed further refinement of our hypothesis, leading to the final version of the communications framework.

In parallel with the design, creation and refinement of the communications framework, we undertook the collection and curation of campaign materials from Member States to best illustrate the scope and range of activity and to generate a digital asset library, in order to inspire new campaigns and serve as templates that could be repurposed or copied for similar communications challenges.

A concurrent review of social media in 2018 gave Member States an overview of this increasingly influential component of communications activity, enabling them to integrate it into their communications planning.

Finally, regular presentations on progress were made at meetings of the Steering Committee of the Member State mechanism and annual Member State mechanism meetings in 2016, 2017 and 2018, providing project updates and giving these forums the opportunity to critique the work to date and provide further direction.

**THE COMMUNICATIONS FRAMEWORK: THE POWER OF IDEAS**

The IDEAS communications framework has been distilled into five key elements to provide clarity and brevity. By adopting the thinking set out in the IDEAS framework, Member States will be able to create compelling communication initiatives to help to combat the threat from substandard and falsified medical products.

The individual framework components are:
I for INSIGHT

- Understanding how and why people (audiences) currently behave the way they do, to inform our communications planning

D for DATA

- Bringing together all the evidence we have on the topic to ensure credible and solid foundations for advice and guidance

E for ENGAGEMENT

- Ensuring a strong connection is made with the target audience(s)

A for ACTION

- Recommending action for people to take to adopt good behaviour and reduce their risk of exposure to substandard and falsified medical products

S for SOLUTIONS

- Measuring the impact of campaigns, and using lessons learned to improve future activity planning

HOW WILL INSIGHT HELP?

- Insight unlocks our understanding of why people are currently behaving the way they are. It is more than just observation; it gives us a picture of behavioural influences: community, cultural, economic, religious, geographical, peer-related, work-based. It helps us to understand how all these influences are working together and gives us clues as to which ones are strongest and how we can address and change them. It helps us to think about where our communications are going to be most effective as a positive intervention and which messages will have the greatest impact.
The importance of understanding audiences

- Effective communications rely on strong insight to develop compelling messages, delivered through relevant communication channels to create behaviour change.
- Segmenting and targeting audiences improves our efficiency.
  - Primary audiences are those we want to directly address with our messages, the people who are directly affected by the problem or best able to address it.
  - Secondary audiences are those who influence a primary audience, either directly or indirectly. They may include family members, friendship groups, community leaders who help to shape social behaviour, health care professionals influencing citizens’ thinking on medical products and treatment practices, or policy-makers who set the public health agenda and infrastructure.

What methods can we use to generate insight? Representative primary audience-based research will help most.

- It gives us an impartial view of people’s current attitudes and behaviours.
- It helps us to build a profile of our most “at-risk” groups, so that we can consider whether we need to segment our audiences and develop custom communications for different groups.
- It gives us strong clues as to what messages will resonate with our audiences.
- It identifies barriers to, and triggers of, change.
- It gives us a better understanding of trusted and scalable communication channels.

If we cannot commission original research, we need to identify sources of independent observation and combine them with comparable evidence from published and other credible sources, such as clinical data, or similar contemporary studies from recognized expert organizations.

How can we find this information?

The following sources could be used:
- reviews of published data;
- structured field work;
- trusted online data sources: WHO, governments, nongovernmental organizations;
- reputable and statistically valid global, regional and locally published research;
- comparable and up-to-date evidence from other countries, regions and districts;
- social media listening.

What should we avoid?

We should avoid the following:
- unverified anecdotal evidence. This will often mask the true picture or give a distorted result;
• self-selection research. This can lead to bias based on the method used to recruit survey participants (for example, online surveys can easily exclude citizens with limited or no online access).

HOW CAN DATA HELP?

Data are very contextual to the topic and the audience, so we need to make sure it is objective, accurate, timely and relevant. What type of data can help?

The following types could be used:
• population and audience size data: determining the size of the task;
• distribution data: understanding where we may need communications to intervene at point of access;
• frequency of use, and clinical and prescribing data: how often we need to communicate;
• data on the intervention of intermediaries (such as the role of health care professionals, pharmacists): where trusted influencers can help;
• adverse reaction data: urgency or geographical focus, or time-pertinent data to use in communications campaigns to alert citizens to the risks involved.

HOW CAN WE SECURE ENGAGEMENT?

Blending what we learn from data and insight will point us towards the creation of engaging and compelling communications. We will know:

• which audiences to target with communications;
• where to reach those audiences;
• which messages they will respond to positively;
• when and how frequently we need to publish communications materials;
• how to generate behaviour change (and feedback where necessary).

WHAT ACTION DO WE WANT PEOPLE TO TAKE?

Effective communication is more than just the provision of information.

• It provides the information and motivation people need to make informed decisions and good choices.
• It provides the stimulus that people need to make such decisions and choices.
• It provides the motivation to take action.
• It provides the support to maintain that action.

Using benchmarks of current behaviour from insight and data collection, we can identify the changes we want people to make.
HOW WILL WE KNOW IF OUR SOLUTIONS HAVE WORKED?

Measuring inputs, outputs, out-takes, outcomes and impacts will help to create connections between the communications we create and the change in behaviour we seek.

- We can measure (or estimate) reach (how many of our target audience saw our communications?) and frequency (how often did they see the campaign?), to start to understand the likely impact. Were we targeting a particular demographic (such as young women) or geographical group (such as urban populations)? What was our penetration of this group?
- We can measure over time how behaviour changes, on the basis of the information we obtained through insight and data collection and by benchmarking existing attitudes and practices and running audit surveys or collecting data from reputable sources (such as registered pharmacies).
- We can investigate in more detail where our communications have had most impact. For example, did our insight lead to messaging that resonated with our audience?
- We can test our activity where the opportunity presents itself. If we have the resources, we can pilot our campaigns to test them in a real-world situation and adjust (if necessary) before wider exposure and expenditure.

Learning from the outcomes of the campaigns we run will lead to improvements in the impact of our future communications, and the building of a useful dataset.

THE FUTURE: 2019 ONWARDS

This communications advice handbook, together with the digital asset library of existing campaigns and the social media review, was made available to all Member States in the first instance on the MedNet platform to coincide with the seventh meeting of the Member State mechanism in November 2018. In the future, any specifically commissioned work from WHO on substandard and falsified medical products communications will also be added to the library.

The dedicated communication, education and awareness-raising workstream of the overall programme was concluded at the seventh meeting of the Member State mechanism, but given that the framework is deliberately practically focused, it is hoped that it will be widely used by Member States and that new campaigns will be added to the digital asset library, so that it can evolve organically and Member States can continue to benefit from the work within a strong guidance framework.
1. INTRODUCTION

In 2012, the Sixty-fifth World Health Assembly established the Member State mechanism to address the issue of substandard/spurious/falsely-labelled/falsified/counterfeit (since 2017, substandard and falsified (SF)) medical products. This mechanism aims at promoting the prevention and control of SF medical products and associated activities, through effective collaboration between Member States and the Secretariat, in order to protect public health and promote access to safe, effective, quality and affordable medical products.

One of the mechanism’s priority activities is to identify major needs and challenges and make policy recommendations, and develop tools in the area of prevention, detection methodologies, and control of SF medical products in order to strengthen national and regional capacities.

The mechanism has approved a number of prioritized activities related to SF medical products. The communication, education and awareness-raising stream was led by MHRA on behalf of the United Kingdom of Great Britain and Northern Ireland and aims to contribute to the prevent element of the overarching three-pronged programme strategy developed by WHO, that is, prevent, detect and respond.

As a descriptive document with no technical content, this handbook was not submitted to Member States for approval, and the information presented has not been endorsed by the Member State mechanism or by WHO. The content of the handbook corresponds to a compilation of information provided by Member States, international organizations and other non-commercial stakeholders with a stated public health remit.

2. METHODOLOGY

At the outset of the work in January 2016, the scope and approach of this activity were defined as follows:

“Create a working group to develop and leverage existing recommendations for effective risk communication and recommendations for awareness campaigns on SSFFC medical products and related actions, activities and behaviours.”

It was agreed that the work should focus on providing practical advice and guidance to Member States and several key elements were identified as useful outputs from the workstream:

- produce samples of hard and soft copy, video and broadcast material
- assess the use of social media for raising awareness
- identify the full range of stakeholders and audiences
- develop key and innovative advocacy material.

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1 See resolution WHA65.19.
2 MHRA – Medicines and Healthcare products Regulatory Agency.
3 SSFFC – substandard/spurious/falsely labelled/falsified/counterfeit; since 2017, substandard and falsified.
During the development of the work programme it became increasingly clear from the social, political and economic perspectives that the impact of communication was growing at an unprecedented pace, making it increasingly difficult to develop guidance and strategies – with a significant risk that they would become irrelevant or outmoded almost as soon as they were published.

Meanwhile, considerable computing power and technology growth, coupled with similar software advances, are combining to accelerate the reach, influence and immediacy of communication messaging on a daily basis, but this is happening in very different ways and rates across Member States.

From the outset, the communication, education and awareness-raising workstream therefore set out to acknowledge these differences and the very local and contextual nature of communications with different audiences, to ensure all Member State communication environments were represented and reflected in the recommendations developed.

In order to maintain a global perspective for existing and future communications advice, a communications working group was established early in the work programme, and invitations to join the group were extended to communications professionals across all six WHO regions. Support and contributions to the workstream were then channelled through the group’s members (see Annex 1), acting as a first-level consultative and critical review body.

Beyond the communications working group, the workstream reached out to the broader professional communications community working in Member States, academia and analogous areas of public health, to build a contemporary picture of best practice in communications before developing and testing a bespoke approach to guidance on substandard and falsified medical products.

The proposals set out in this handbook are based on the feedback received, together with the results of a global communications survey and live testing of the framework subsequently developed. A list of Member States participating in the survey is included in Annex 2.

With a clear remit to generate practical guidance for Member States, the communications workstream has focused on contemporary best practice thinking and campaign implementation to populate its guidance. In essence, the work programme was constituted of 11 elements:

1. establishment of a body of knowledge – gathering examples and theories of current best practice communications activity, focusing on analogous and comparable public health campaigns and activities;
2. engagement with interested stakeholders and attendance at relevant events;
3. aggregation and distillation of understanding applied to communications planning, and ongoing consultation with the communications working group;
4. feedback to inform a pilot communications survey of the working group members;
5. use of the results and insights from the pilot survey to develop and implement a global communications survey, with all Member States invited to participate;
6. use of outputs for the communications framework hypothesis;
7. live testing with Member States at workshops;
8. further refinement from hypothesis to development of the communications framework;
9. concurrent collection and curation of campaign materials from Member States;
10. concurrent review of social media in 2018 to inform better communications;
11. Presentations on progress at meetings of the Steering Committee of the Member State mechanism and annual Member State mechanism meetings in 2016, 2017 and 2018, providing project updates.

3. BUILDING BLOCKS AND STAGING POSTS

Exploring some of the work components in more detail helps us to understand the insights gained from the early stages of the work and how these have been applied to create the communications framework.

The establishment of a body of knowledge led to a focus on ensuring behaviour change thinking was included as an essential component of communications advice. We need to do more than just provide information to citizens and patients on the risks and dangers associated with SF medical products; we also need to engage and motivate them to make positive "considered decisions", thereby adopting safe behaviour.

Engagement with interested stakeholders showed the extent to which the whole public health community recognized the risks posed by SF medical products and the need to develop integrated strategies throughout the supply chain, from manufacture to consumption, and to use communications at key intervention points with relevant audience groups (health care professionals, influencers, citizens).

What we learned from our pilot communications survey of communications working group members confirmed our original hypothesis that what was required was practical guidance, particularly on:

- sharing insights and creating assets
- support for success measurement
- showcasing best practice and providing guidance on film, social media and print.

When we took the results and insights from the pilot survey and developed the global communications survey in 2017, we largely found confirmation of our initial work. We also looked to understand what Member States were currently doing and there was broad consensus on the challenge that this work represented within a wider public health agenda:

- little original research was being conducted into the use and awareness of SF medical products among the public or health care professionals, with informed views suggesting that:
for public audiences, social media (or friends and family) were a key channel and influencer;
for health care professionals, their professional organizations, government departments and regulators were influential;
• campaigning was mainly directed at population-wide public audiences.

Furthermore, as might have been expected from feedback from the pilot survey, the global communications survey indicated that Member States were principally looking for guidance on planning, developing and measuring the success of their campaign activities. This feedback influenced both the structure and content of our communications framework.

Live-testing workshops enabled us to test the validity of our model with a variety of Member States, most recently in the African Region, South-East Asia Region and European Region. In each case, the specific purpose of the workshop was to work with delegates to explore and critique our prototype global communications framework, identify gaps, suggest relevant additions and recommend any additional sources, structures and/or stakeholders.

The format was consistent at each workshop. First, the group was presented with an overview of the role of WHO communications activities in helping to combat the threat from SF medical products, drawing on the feedback received from the global communications survey, which highlighted the areas in which Member States were active and emphasized the topics on which they were looking for support from the communications programme. The specific nature of SF medical products in each country context was then investigated, identifying the influence of key stakeholders and communications in all senses (broadcast, narrowcast, face-to face) in the country of each participating delegate and, where relevant, comparing the relative impacts of the communications.

We then shared the prototype communications framework “IDEAS” and worked through each element in detail, exploring the value that could be added to communication activities by utilizing it. Next the group(s) tackled a hypothetical campaign challenge, adopting the principles from the IDEAS framework to test its validity in a potential real-life situation. In each workshop, delegates contributed enthusiastically and energetically to develop solutions, providing strong endorsement of the communications framework’s value.

Feedback aggregated from these workshops informed further refinement of the prototype, leading to the final version of the communications framework.

In parallel with the design, creation and refinement of the communications framework, we undertook the collection and curation of campaign materials from Member States to best illustrate the scope and range of activity and to generate a digital asset library, in order to inspire new campaigns and serve as templates that could be repurposed or copied for similar communications challenges.

1 WHO regional workshop for Africa on the global surveillance and monitoring system for substandard and falsified medical products, in Lagos, Nigeria, April 2018.
3 4th European Social Marketing Conference and pre-conference social marketing workshops, in Antwerp, Belgium, September 2018.
A concurrent review of social media in 2018 gave Member States an overview of this increasingly influential component of communications activity enabling them to integrate it into their communications planning.

Finally, regular presentations on progress were made at meetings of the Steering Committee of the Member State mechanism and annual Member State mechanism meetings in 2016, 2017 and 2018, providing project updates and giving these forums the opportunity to critique the work to date and provide further direction.

4. THE COMMUNICATIONS FRAMEWORK: THE POWER OF IDEAS

The IDEAS communications framework has been distilled into five key elements to provide clarity and brevity, and to focus on sharing practical advice. Where appropriate or relevant we have included links or references to other sources we believe will helpful to Member States as they develop their own campaign activities, and we have developed guidance on how best to go about using the framework. The framework is designed to cover all steps of campaign planning, from setting the overall objective to implementation, thinking about the required component parts of a strong campaign, how they work together for optimum effect and how they can be best deployed.

In developing this framework, we expect Member States will adopt the SMART\(^1\) approach to objective setting that will dovetail with the elements of the IDEAS model. In brief the SMART approach comprises elements that are:

**Specific**: objectives should be focused, clear and unambiguous. Having specific objectives ensures specific expectations and helps everyone to be in agreement. Specific objectives are easier to measure, too.

**Measurable**: objectives that are measurable allow us to track and report on progress; they help to define success for our key stakeholders, and in addition, having measurable objectives lets us know if efforts need to be adjusted to be more effective.

**Attainable**: objectives that are realistic even when they require a stretch or effort to reach them. The objective should not be out of reach or below what is reasonably achievable. Considering the resources available to develop, implement and monitor the campaign is helpful when thinking about attainable in context.

**Relevant**: relevance means that objectives are aligned with our public health responsibility.

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\(^{1}\) SMART – S: specific, M: measurable, A: attainable, R: relevant, T: time-bound.
**Time-bound** campaigns should have a start and end date to generate focus and urgency in the campaign. Relevant external events should also be considered to provide timeliness to a campaign.

By combining SMART objectives with the methodology set out in the IDEAS framework, we believe Member States will be able to create compelling communication initiatives to help to prevent the public health risks associated with SF medical products.

The individual framework components are:

**I for INSIGHT**

Understanding how and why people (audiences) currently behave the way they do, to inform our communications planning

**D for DATA**

Bringing together all the evidence we have on the topic to ensure credible and solid foundations for advice and guidance

**E for ENGAGEMENT**

Ensuring a strong connection is made with target audience(s)

**A for ACTION**

Recommending action for people to take to adopt good behaviour and reduce their risk of exposure to substandard and falsified medical products

**S for SOLUTIONS**

Measuring the impact of campaigns, and using lessons learned to improve future activity planning
5. HOW WILL INSIGHT HELP?

Insight is the basis of strong communications – it gives us a firm foundation from which to develop campaigns and ensures we are grounded in the real lives of our target audience(s), be they a whole population, or segmented by geography, gender, age, life stage, or more likely a combination of these.

Insight recognizes that peoples’ lives are complicated, that they have many and often conflicting behaviours and influences to reconcile. The issue we are keen to communicate may not be (or may not seem to be) important to them now.

Understanding this context is invaluable if we want people to make good and informed decisions avoiding unnecessary risks to their health – merely presenting information or idealized behaviour may not in itself be sufficiently engaging or motivating to encourage behaviour change.

One of the principle benefits of insight is that it helps to unlock our understanding of why people are currently behaving the way they are. It often surprises us – we think we know why people are adopting a particular behaviour, but it is often only based on limited knowledge or anecdotal evidence that is at best masking the true picture and at worst providing a completely erroneous picture. Acting on that superficial or incorrect evidence can lead to communications that are ignored or resisted.

Worthwhile insight needs to be much more than just observation; it goes deeper to give us a true picture of behavioural influences: community, cultural, economic, geographical, religious, peer-related, work-based.

It helps us to understand how all these influences are working together and gives us clues as to which ones are strongest and how we can address and change them. It also helps us to think about where our communications are going to be most effective as a positive intervention and thus informs the choice of relevant communication channels through which to deliver our messages.

It gives us the opportunity to explore and test existing and new messaging hypotheses to see how these resonate with audiences and enables us to focus our creative development on those that are going to connect most strongly with our audiences.

To improve the efficiency and effectiveness of our campaigns we can also use the outputs from our insight generation to combine with further levels of detail and organization of our audiences through segmentation and communications targeting.

5.1. WHAT METHODS CAN WE USE TO GENERATE INSIGHT?

When we are seeking to influence citizen behaviour, our communications strategy will be informed in two main ways:

1. understanding what our audiences think and feel about SF medical products as a topic;
2. understanding what their actual behaviour is in relation to SF medical products.
Research can provide the answers to these questions but can often be conflicting – people may think or believe they do one thing but in reality, they do not. They may believe, for example, that they check the authenticity of their medicines but may only give them cursory attention and so are vulnerable to the risks associated with SF products. By compiling and then comparing both sets of information we can decide what the focus of our communications should be and whether the changes we would like people to make are related to their perceptions of risk or the actual risk itself.

Gathering information on citizens’ attitudes and beliefs will form the basis of our insight and shape the communications messages and content we develop. Attitudes and behaviours can change very quickly as citizens knowledge, mobility, economic independence and personal circumstances change or they can remain rooted in traditional or ingrained approaches. In either case what we seek to gain through insight is a relevant picture of what is happening now and to set this in the context of likely or potential future changes to enable us to craft messages that will resonate with our audiences and encourage them to adopt safe and considered behaviour.

Representative primary audience-based research will help most to give us this view and commissioning this type of research will also be useful in establishing benchmarks of current behaviour to inform objectives and target setting for campaign activities. It requires appropriate expertise and investment and should be undertaken by a research organization with specialist experience of citizen-based research in the Member State environment.

**What can we expect to learn from original research?**

We will get an impartial view of people’s current attitudes and behaviours, so that we can build a campaign that addresses how they actually think and feel rather than how we may believe they think and feel.

We will be able to build a profile of our key target audiences, so that we can consider whether we need to segment and develop custom communications for different groups, using some of the basic segmentation outlined above, or if we are able to go deeper into demographics and/or psychographics, or perhaps identify a more specific at-risk group, such as mothers, students, retired citizens.

We will get strong clues as to which messages will resonate with our audiences, so that we can focus on making these messages the best they can be.

We will be able to identify barriers to, and triggers of, change, which we may need to address specifically in our messaging, such as exploding myths that prevent good behaviour, or demonstrating the benefits of adopting a different way of doing things.

We will have a much better understanding of which trusted and/or scalable communication channels we should use, as the delivery channel is in itself part of the message – if the message comes through a trusted channel, citizens are more likely to believe the content and act on the recommendations made. Conversely a poor channel selection may undermine the credibility of the message and have an adverse effect of causing mistrust of the message and the recommended action.
Alternatives to original research

Where we are unable to commission original research, we should still aim to gain basic audience insight to inform our communications planning and to ensure our campaigns are relevant and impactful. Methods we can adopt to achieve this include the following.

Community or audience-based consultation and discussions can be helpful when there is insufficient budget to fund research but there may be staff resources available. However, if they are to be used to gather information through forums such as community focus groups or workshops it is vital that staff have received the correct training to undertake citizen-based insight work.¹

From an online perspective social media listening can provide insight into the motivations and behaviours of connected citizens and is essentially the process of monitoring social media channels for mentions of topics relating to SF medical products generally, or specific products if they have been identified as a current risk. The information gleaned has the benefit of being completely up to date and relevant and can then be used to develop actionable insights. Those actions can range from engaging a satisfied stakeholder to shifting the content, tone or targeting of the communications campaign.

It is this actionable element of social media listening that differentiates it from social media monitoring, which is more about compiling data, and gathering information about what has already happened rather than looking forward to determine future actions.

Social media listening looks beyond the numbers at the overall mood behind the social media posts – how people actually feel about medical products generally, whether or not they have considered or encountered SF products and if so their impact on themselves, friends and family, their communities and importantly the role of public health organizations’ regulators and enforcement agencies in tackling them. That mood, also known as social media sentiment, is a key part of social media listening. Effective sentiment analysis can help us to amplify messaging that is receiving positive responses, respond appropriately to anything that has triggered a negative response, and see trends over time that can keep future communication efforts on track. It is often helpful to run social media listening in conjunction with core research approaches, such as focus groups, and then compare insights from both sources, to discover further detail and to understand any differences or nuances. This can then be reflected in messaging through these channels, that is, should we use the same message consistently across all our channels or should the message be crafted differently for specific online audiences?

5.2. WHAT TRAPS SHOULD BE AVOIDED?

There may be a temptation to develop campaigns based on feedback through the supply chain. Such information should always be treated with caution. Unverified anecdotal evidence can often mask the true picture or give a misleading result, which in turn can mean

a campaign has the wrong target audience and/or the wrong message. It is important to verify feedback in the first instance by tracing the information back to source (where feasible) or to substantiate the information independently by informed questioning of reliable sources especially qualified intermediaries, such as health care professionals.

Self-selection research can often be seen as a low- or no-cost method of gaining insight particularly through surveys carried out by one of the many proprietary online providers. Without adequate and thorough qualifying of respondents (that is, determining their eligibility) and the establishment of representative quotas the danger is that although it can be easy to collect data the results will not be necessarily be representative. Bias can easily be introduced, for example, by the method used to recruit survey participants; online surveys by their very nature will exclude citizens with limited or no online access. Also, if time is limited, responses are slow and the survey is closed quickly, results can be distorted by early respondents or a vested interest group who are encouraged to participate through social media.

5.3. APPLYING INSIGHTS TO INFORM AUDIENCE SEGMENTATION

Segmenting audiences enables us to refine our targets and success measurement and generate audience-relevant content that is delivered through appropriate channels. Core segmentation can simply involve thinking about primary and secondary audiences, and their geographical dispersion.

In basic terms primary audiences are those we want to directly address with our messages, the people who are directly affected by the problem or best able to address it. They may include citizens at a population level, patients, or health care professionals responsible for prescribing or distributing medical products.

Secondary audiences are those who influence a primary audience, either directly or indirectly. They may include family members, friendship groups, community leaders who help to shape social behaviour, health care professionals influencing citizens’ thinking on medical products and treatment practices, or policy-makers who set the public health agenda and infrastructure.

Overlaying geographical segmentation can further enhance content generation. For instance, citizens living in urban environments may demonstrate behaviours that diverge from those of citizens living in rural situations. Attitudes to differing medicine types (traditional versus pharmaceutical) and access to and choice of medicines can vary significantly and so will need to be reflected in messages created. Delivery channels chosen may be much more limited in rural settings and we may also need to factor in varying levels of literacy to optimize communication. Radio, for example, often proves an ideal medium to dramatize and communicate to audiences that are hard to reach and/or have low literacy levels. The major benefit of geographical segmentation is that it is straightforward and flexible.

Where appropriate we can add in further levels of segmentation to provide a more sophisticated view of our audiences. These can include:
• demographic segmentation, which divides the audience on the premise that citizens have different attitudes and behaviours according to factors including age, gender, educational attainment, occupation, income and marital status;
• behavioural and psychographic segmentation can be useful to understand and address behaviour that is driven by values, attitudes and opinions and often is strongly influenced by peer groups, leading to attitudes and behaviours that reflect those of a group or community.

When considering the level of segmentation to be undertaken it is important to keep in mind that segments are only valuable if there are communications channels available that will target and connect with the segment identified, and that there is a budget (or other resources, such as face-to-face communications teams) in place that will allow for comprehensive coverage of the chosen segment. Segmentation requires extra effort and resources (for example, time to properly segment audiences, funds and staff time to design separate messages and materials, funds to use additional channels). If the budget does not allow for multiple approaches, we must simply identify the most important audience segment to reach and focus on that segment.

In essence, segmentation is one of the core elements that enables audience targeting to take place. By being able to define our audience more accurately, and to understand their current behaviour, we can generate communications that will address them much more directly and help us to cut through the general noise level of broadcast communications.

When we consider the roles of other stakeholders, particularly health care professionals, our approach should be coherent and consistent and with our citizens communication but should recognize that they are essential influencers in the communications process, and they play an active advisory role in their interactions with citizens. They are trusted advocates, whether that be in primary and secondary health care or pharmacy settings.

If our ambition is for health care professionals to take a proactive role in their interaction with their patients, our task should be to ensure that as well as the clinical advice and guidance they receive we should develop bespoke communications for them with the clear aim to brief them on our campaign plans and materials and the role we would like them to play in the overall activity.

6. HOW CAN DATA HELP?

Data are very contextual to the topic and the audience, so we need to make sure they are objective, accurate, timely and relevant. Each source will provide part of the picture so in an ideal model we aim to capture data from a variety of sources and combine them to give us both a complete picture of the communications landscape and a number of data points that we can use as benchmarks for measuring and reviewing the efficiency of our campaign activity.

So, what type of data is likely to be of most help?
Population and audience size data are essential to understand the size of the task we are undertaking and thus our ability to set sensible campaign objectives. If we are using SMART\(^1\) methodology we need to ensure that our objectives are attainable, so we need to quantify the audience size and consider if it is necessary to prioritize parts of that audience for maximum impact. Even if we need to communicate at a population level, we must still quantify our audience size so that we can measure our expected level of penetration of that audience. Where appropriate, segmentation will help us to divide up audiences into manageable and targetable groups. We will then be able to formulate the key components of how we reach our target audiences through selection of the most suitable communication channels bearing in mind the resources we have at our disposal. An output from this work will be a channel plan describing when and where we are going to deploy our messaging.

In any activity we need to know what will be our campaign reach, that is, how many within the target audience will see or be exposed to our communications, and then frequency, that is, how often and how many times? Thinking about the scale of the task in conjunction with our audience insights will then ensure we set attainable and measurable objectives.

If we are targeting an audience comprising recipients of a specific medicine, such as an antimalarial, not only can we determine the size of the audience segment, but we can also overlay other information such as distribution points. If we are then able to map these points it will help our understanding of where these products are most likely to be prescribed, dispensed and purchased so that we can develop and distribute relevant communications to intervene at these key points of access. We can also take into consideration frequency-of-use data to ensure our messages match how regularly we need to communicate with citizens.

Adding data on interventions of intermediaries (health care professionals, pharmacists) who can support communications and reinforce the credibility and importance of our messaging will supplement campaign impact.

Once again, we should try and quantify these opportunities. How many are intermediaries are there in the health care system, where are they located, how many patient interactions do they have? These numbers may only be estimates, but they will still help in our benchmarking and can be improved over time as we develop and implement further campaigns. By identifying their locations, we can map these against our target audiences to see what level of coverage they give us. If citizens are receiving consistent messages through different sources giving them clear and practical advice, we stand a greater chance of them changing or adopting the appropriate behaviour.

In addition to including information on trusted influencers we can also overlay clinical data where they are available. In these instances, we are looking for evidence from health care settings that may include adverse reaction data: urgency or geographical focus or time-pertinent data to use in communications campaigns to alert citizens to the risks involved.

The ideal dataset will also blend local, regional and national information, depending on the circumstances, but should always try to reflect the “on-the-ground” situation. This could relate to specific types of medical products and whether the risk is likely to be greater from substandard products or from falsified products and an understanding of the groups most at

\(^1\) SMART – S: specific, M: measurable, A: attainable, R: relevant, T: time-bound.
risk. These will likely be directly linked to the medical products identified, such as children’s vaccines. At this stage, if feasible, it will be useful to compare these data with relevant and up-to-date evidence from similar countries, regions and districts.

If we cannot commission original research, we need to identify other sources of independent information, which would require a systematic approach to reviewing published data and studies. We need to identify credible, evidence-based contemporary studies that conform to global research standards and are published by trusted data sources. WHO, government health departments, regulatory authorities and specialist health-based non-governmental organisations may have commissioned their own research on the topic of SF medical products or more broadly on access to medical products.

Studies may also have been published aggregating information from a variety of sources. In each case it will be clear how the final data were collected and interpreted, and the methodology adopted, to ensure objective outputs. The information should be available online from the commissioning organization’s website with clear information identifying how and when it was compiled. By adopting this approach, we can also broaden the search beyond Member States to embrace other reputable and statistically valid global, regional and locally published research.

7. HOW CAN WE SECURE ENGAGEMENT?

Our task at this stage is to blend what we have learned from our insight generation and data collection to create compelling and actionable communications. Trying to cover too many elements can be confusing to our audiences so we should aim to focus on a core truth from our research and bring this to life in words and/or pictures. Articulating this truth in a way that resonates with the audience will help to gain their attention.

So, if we intend to use film or video opening with a real-life situation that our audience recognizes will enable them to relate to the content and follow the narrative through to the advice we are giving. The same applies to audio media such as radio where dramatizing real-life situations will resonate with audiences and lead them into the story or editorial content we have produced. Using animation rather than live actors can both save cost and avoid audiences not relating to the actors chosen.

Short-form social media or online content has to do the same job but in a matter of seconds and so will often rely on animations or GIFs¹ with a simple but direct message. However, in these situations we can often deploy a number of different executions so that we can use a variety and a range of different interpretations of the same core message to connect with audiences.

In print strong visuals will gain the attention of the audience; they can be followed through with explanations and direction, whether that is long-form narrative or simply a headline and recommended route to take.

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¹ GIF – graphics interchange format;
In every piece of communication it is vital that the audience is given a clear “call to action” so that once they have absorbed and understood the message they are quite clear on what they need to do next to protect themselves (or their patients, in the case of health care professionals) from SF medical products.

Production of our media content will be governed by availability of funds and our chosen channel of delivery. Creative work can be undertaken in-house if a team exists to do the work or outsourced to a specialist creative agency. A creative brief may help this process (see Annex 3 for an example). Such agencies can cover all media channels and develop a single core idea that is adapted for each of the channels it is deployed in, or if only a single channel, such as digital, is to be used then a specialist digital creative agency would be more suitable.

Where the budget is limited, reusing or repurposing existing creative campaign material – for example, by changing voiceovers on television or radio advertisements to a local language, or subtitling video content in a local language – can be effective providing the original material is audience relevant and local culturally sensitive. Alternatively, campaigns run in other Member States can act as inspiration for new creative work. A campaign example from Health Sciences Authority (HSA), Singapore, is included in Annex 4. (A digital asset library of Member States’ current creative campaign work is held on MedNet and is available for sharing and download.)

The content of our messaging, however, is only part of the solution to securing engagement. The way we deliver the message and the channel options we take are equally important. Planning the most effective routes to reaching our audiences will help us to focus our messaging on the target groups we know are most at risk of using SF medical products and will thus minimize media wastage.

Planning will primarily be influenced by budgetary considerations. With significant funds we can consider broadcast channels including TV, radio, cinema and mass-reach print platforms such as the press and magazines. Outdoor advertising such as posters and billboards will also have a role to play. The exact mix of the media chosen will be driven by our at-risk audience, taking into consideration some of the variables mentioned earlier relating to demographics and geographical dispersion, and our insight into the behaviour of the members of the audience. To optimize this targeting, it should be undertaken by a competent in-house media planning department or if the organization does not have this facility by an external expert media planning company.

Where there are no funds available for paid media, we will need to rely on our ability to deploy our messaging content through owned and/or earned media channels.

Owned media is essentially a channel or channels that we already control or one(s) we can create. These could include our organization’s website, or our inventory of properties, such as hospitals, clinics and pharmacies, where we can display and distribute our materials.

Earned media is when citizens, patients or mass communication media share our content on SF medical products, or spread it via word of mouth, or otherwise discuss it. In other words, the mentions are “earned”, meaning they are voluntarily given by others.
Generally, we would like to combine owned and earned media for maximum impact and ideally ensure that we have a good distribution of our content in owned environments in place before we seed and stimulate earned channels so that citizens have other recognized and credible sources of content to reinforce (or sometimes correct) the information they have picked up through earned channels. In an increasingly digital communications environment many of the earned comments will be distributed through social media channels.

Engagement will work best when it blends the lessons learned from data and insight and applies them to messaging and channel planning. The combined output will enable us to know:

- which audiences to target with communications
- where to reach those audiences
- what messages they will respond to positively
- when and how frequently we need to publish communications materials.

8. WHAT ACTION DO WE WANT PEOPLE TO TAKE?

Effective communication is more than just the provision of information. It provides the information and motivation people need to make informed decisions and good choices, the stimulus that they need to make such decisions and choices, the motivation to take action and the support to maintain that action over time.

Using benchmarks of current behaviour from insight and data collection, we can identify the changes we want people to make or the new behaviour we want them to adopt and consider how we might best encourage them to take appropriate action.

Our overriding ambition is for citizens to make informed decisions and these will always be contextual. Such decisions will range from ensuring that they take the objective medical advice before accessing medical products, to ensuring these products come from a legitimate and trusted source, to being aware of the dangers of purchasing such products online.

In each case we should be sure that we engage clearly (as described above), and once we have the audience’s attention, we provide them with practical and achievable advice in the form of a clear call to action, such as where to access objective medical advice, where to go for legitimate medical products, and what to do when shopping for such products online.

We also need to provide further advice as a reminder and extended support. This can be a website address, a hotline telephone number or more detailed advice in printed form.

Our aim is always for audiences to make the right decision as a result of the messages we have provided and give them the opportunity to learn more or get further advice if they need it.
Lastly, to distinguish our advice from that of other sources that provide confusing or poor advice and ensure it has legitimacy with our audiences we need to brand the campaigns confidently, ideally with a trusted government department or authority that citizens or intermediaries recognize immediately. (If we have a number from which to choose, we can explore which one would be most appropriate with our key stakeholders at our early insight-gathering stage.)

9. HOW WILL WE KNOW IF OUR SOLUTIONS HAVE WORKED?

Measuring inputs, outputs, outtakes, outcomes and impacts will help to create connections between the communications we create and the change in behaviour we have activated. In order to make sense of a variety of measures it is important at the outset to agree a set of key performance indicators that will show the impact and efficacy of the campaign. These will be defined by our SMART objectives and will be particularly related to the ‘Measurable’ element.

Benchmarking these indicators before running the campaign will establish a baseline that we can then revisit during and after the campaign period to determine its impact and residual benefit. We could expect to see indicators peak during the campaign and then settle after it has concluded. What we will be looking for is long-term improvements from the baseline position.

Clearly the performance indicators we choose will be dependent on the campaign indicators but for the majority of campaigns, understanding how our audience penetration has changed over time, whether or not their awareness, understanding and attitudes towards SF medical products have shifted, and if we can see a concomitant reduction in risk-related behaviour will combine to give a strong view of campaign performance. Specific objectives relating to particular target audience segments or product-specific objectives can be overlaid onto this approach.

Outputs can be helpful to give us a good idea of how comprehensive the campaign has been and how efficiently we have implemented it. The sort of data to capture will include the range of creative assets we were able to deploy based on our insight, the spread of media channels we covered and our efficiency of production, including budget accuracy. These can act as benchmarks and checklists for future campaign activity.

It is when we look at campaign implementation though that we will aim to identify the impact of the communications. We should measure (or estimate) reach (how many of our target audience saw our communications?) and frequency (how often did they see the campaign?), to begin to understand the likely impact. Where we are targeting a particular demographic (such as young women) or a geographical group (such as urban populations) we need to understand our penetration of this group.

For traditional paid media, audit data will tell us this information, be it national or regional broadcast (TV, cinema, radio), press, magazines or outdoor media, that is, billboards and
posters. For digital channels where we are buying online advertising, we will be measuring impressions.¹

Through our owned non-digital channels, such as primary or secondary health care settings, we should be able to estimate our penetration through local feedback or by setting up straightforward reporting surveys (online or by using field workers), or even collecting smartphone pictures of physical materials from practitioners. This valuable information should always be recorded and retained to form the basis of an asset library that can be used to improve materials produced for future campaigns – focusing on improving and reusing what works well, and, importantly, understanding what not to replicate. It will also be helpful to demonstrate on-the-ground activity in workshops or cross-team discussions.

Earned channels measures can include social media where we can see likes and shares and, depending on the platform, take advantage of their bespoke measurement and analytical tools. Monitoring focused on metrics, such as engagement rates, number of mentions, increase in website traffic combined with social media listening focused on sentiment, will help to build a picture of online activity, which can be supplemented by information on traffic directed to the website from partner activity, where the creative assets have been shared with other public health organizations. Data from social monitoring can also be used to test one creative asset against another when we have multiple creative executions, to identify which one has greatest traction with our target audience or, if we are segmenting audiences, it will help us to test and subsequently match specific creative routes with particular target audiences.

We can measure over time how behaviour changes, on the basis of the information we obtained through insight and data collection by benchmarking existing attitudes and practices, and running audit surveys or collecting data from reputable sources (such as registered pharmacies).

We can investigate in more detail where our communications have had most impact. For example, did our insight lead to messaging that resonated with our audience?

We can test our activity where the opportunity presents itself. If we have the resources, we can pilot our campaigns to test them in a real-world situation and adjust (if necessary) before wider exposure and expenditure.

Learning from the outcomes of the campaigns we run will lead to improvements in the impact of our future communications, and the building of a useful dataset.

¹ Impressions are when an advertisement or any other form of digital media appears on a user’s screen. Impressions are not action based and are merely defined by a user potentially seeing the advertisement.
10. THE FUTURE: 2019 ONWARDS

This communications advice handbook, together with the library of existing campaigns and the social media review, was made available to all Member States in the first instance on the MedNet platform to coincide with the seventh meeting of the Member State mechanism in November 2018. In the future, any commissioned work from WHO on communications regarding SF medical products will also be added to the library.

Given the scarcity of original citizen research, and thus few available benchmarking data, it is hoped that WHO will be able to contribute to the insight body of knowledge over time.

The dedicated communication, education and awareness-raising workstream of the overall programme was concluded at the seventh meeting of the Member State mechanism, but given that the model for advice is deliberately practically focused, it is hoped that it will be widely used by Member States and that new campaigns will be added to the digital asset library, so that it can evolve organically and Member States can continue to benefit from the work within a strong guidance framework.
Annex 1

Membership of the communications working group, by WHO region

AFRICA
   Nigeria
   Senegal
   United Republic of Tanzania

THE AMERICAS
   Argentina
   Brazil
   Colombia
   United States of America

SOUTH-EAST ASIA
   Indonesia
   Republic of Korea
   Singapore

EUROPE
   Italy
   Norway
   Sweden
   United Kingdom of Great Britain and Northern Ireland

EASTERN MEDITERRANEAN
   Iran (Islamic Republic of)

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1 There were no contributing countries from the Western Pacific Region.
Annex 2

2017 Global communications survey participants, by WHO region

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Annex 3
Sample creative brief

Creative brief

Date: 
Title of campaign: 
Project name: 
Original author: 

1. The campaign
   - What is the scope of the campaign?
   - When will it happen and for how long?
   - Which media channels will be used?

2. The objectives
   - What are communication objectives of the campaign?

3. The target audience
   - Who is the target audience?
   - How large is the target audience?
   - What insight do we have on the target audience: demographics, geography, values, attitudes or lifestyles, and current purchasing of or access points for medical products?

4. Current mindset
   - What does our target audience think now about substandard and falsified (SF) medical products (or a specific SF medical product)?

5. Personality and tone
   - What tone and manner we should use in our communications?

6. Key target audience’s understanding and behaviour
   - What is the most compelling thing we want the target audience to think after they experience the campaign?
   - What is the most compelling thing we want the target audience to do after they experience the campaign?

7. Timing
   - When is the creative work required to be completed?
   - Will the campaign be launched in all channels at the same time?
Annex 4

IDEAS in action: a campaign example from Health Sciences Authority (HSA), Singapore¹

**Insight:** If you have shopped online you (or someone you know) may have had a bad experience where what you ordered online was not what was delivered.

Medical products ordered online are potentially dangerous. The consequences of substandard and falsified products can be very serious.

**Data:** HSA used real data, real contents of tablets and so real symptoms. This was instantly more credible and believable to the target audience.

**Engagement:** simple animation graphics tell a story and highlight the risks to citizens.

**Action:** a clear call to action that makes sense based on what you have just seen --- what to do, and what not to do.

**Success:** the film was widely shared on social media and resonated with audiences.

- A view-through rate of 39%, or 775 000 views, far exceeded the benchmark average of 15%.
- The view-through rate was highest for individuals aged 18–34 years – the target audience group.

¹ The full film animation is available via MedNet, and can be viewed at https://www.youtube.com/watch?v=dmjl_bSqIgA (accessed 14 June 2019).