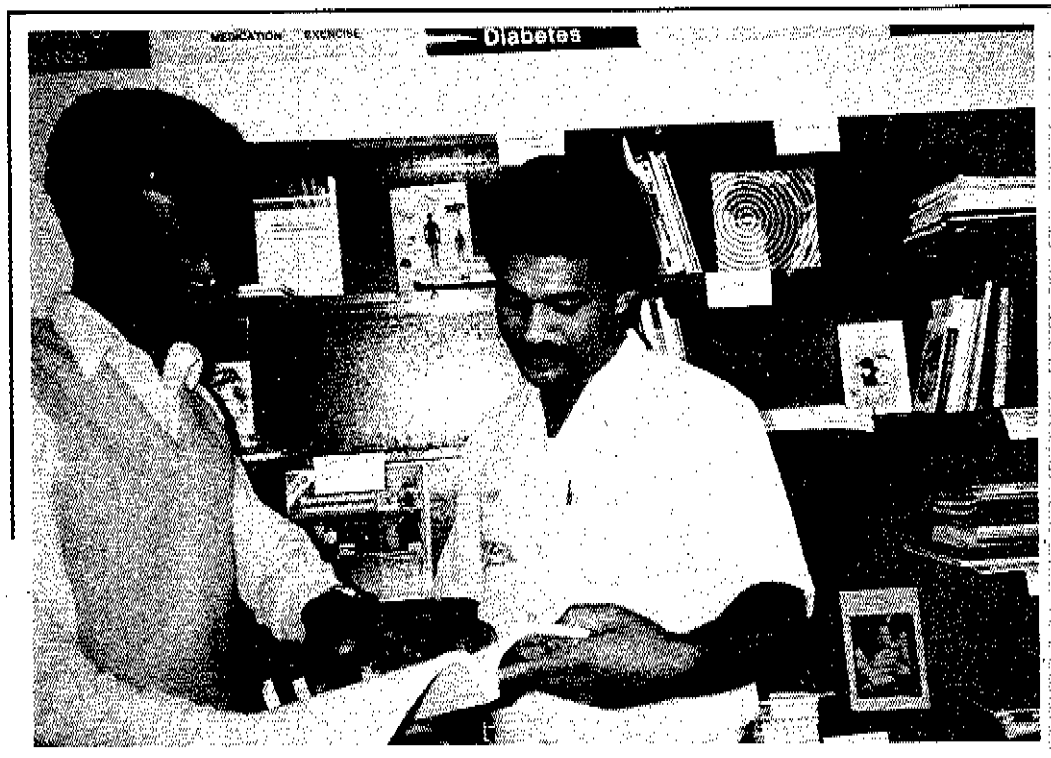


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SOCIAL MARKETING FOR HEALTH

Marie Birkinshaw



WORLD HEALTH ORGANIZATION



An introduction to the large and rapidly expanding field of social marketing of health, with particular reference to its application in health manpower development and health learning materials. This document was drafted in response to a recommendation from participants at the Interregional Meeting on Health Learning Materials, Arusha, 29 February - 5 March 1988 (HMD/88.1):

"to identify and make available to all national research projects appropriate literature on social marketing, and stimulate and assist national staff in applying this approach".

It is not, therefore, intended as a definitive text but rather to assist further reading.

With thanks to Dr Roberta Ritson for technical guidance and to Intern, Kjetil Hustoft, for initial bibliographic research.



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DEFINITION

Social marketing may broadly be defined as the application of marketing techniques to social problems. It covers a wide variety of disciplines including health education, advertising, economics, business management, scientific research, systems analysis, community organization, psychology and epidemiology. Social marketing aims to persuade or motivate people to adopt specific courses of action or behaviour which are generally accepted as being beneficial. It is "the design, implementation and **control** of programmes seeking to increase the acceptability of a social idea or practice in a target **group(s)**" (Kotler 1975). It cannot create the behaviour, it can only help to gain acceptance and a willingness to adopt **the** behaviour. Ward (1986), for example, illustrates the use of social marketing in the prevention and control of diseases, First a vaccine must be produced, then social marketing can be used to help gain acceptance of the need for the vaccine, to make resources available for further development, and to create a willingness of both physicians and the public to use it.

Marketing techniques (audience research, product analysis, message design, distribution, "advertising", evaluation and feedback) can be applied to health by taking into account the interests, values and goals of the consumers, that is individuals and communities and, according to the marketing concept, making the consumer's needs a priority. Social marketing is a tool which may be used in achieving the goal of Health for All by the Year 2000. It includes primary health care and community development.

Social marketing, especially as applied to health, has had a fairly controversial history. This is covered by several of the papers in this field, and in detail in a text devoted to the subject **Social Marketing: a new imperative for public health** by Richard K. Manoff (1985). It gives a thorough overview of the topic and is well illustrated with case studies. This book has been used as source material for much of the current paper.

The term "social marketing of health" was fallen upon by accident, says **Manoff**, during the 1960s as a useful distinction from commercial marketing. It received acclaim in July 1971 when the Journal of Marketing produced an issue on the topic (Kotler, 1971). Its arrival was opportune since it was becoming evident that health professionals should be more responsible for public communications, and social marketing "offered a disciplined approach for public health promotion and communication efforts" (**Manoff**, 1985). Many have tried to narrow the term's application depending upon whether all the marketing components are included. Nevertheless, the approach seems valid provided that most of the essential elements are present. **Manoff** argues that the exact techniques of marketing, for example that there should be a Product, need not be adhered to completely, rather that the usefulness of the strategy be made most appropriate to the situation.

Social marketing emphasizes advance testing of all concepts, messages and materials to obtain feedback. When learning commences, social marketing stresses monitoring of progress towards objectives and adjustment of information to suit the chosen target audience. Intermittent tracking examines the effect of the social marketing programme and provides a systematic mechanism for improvement less dependent on subjective judgement.

Social marketing provides the health educator with a unique opportunity to bridge the communication gaps between the audience and the authorities; between educational assumption and popular perception; educational content and marketplace reality; between dissonant messages from other responsible agencies: the health care system and those who are unmotivated to use the system; and it tackles the competition between curative ~~services~~ and prevention.

Social marketing in public health should not be confused with the marketing activity of new commercial health care and hospital corporations (e.g. Rice, 1981; MacStravic, 1979). The aim of the latter is to market health products and services for the profit of shareholders. The coincident benefits to health are part of the business objective and, it may be argued, need not always be "beneficial" to health. "Health care marketing" has been criticized since costs of health care have increased dramatically and curative health services have become subject to market forces. "Creation of demand seems a dubious strategy when only illness is involved." (Manoff, 1985)

The objective of social marketing is to promote public health, and its goal is improved health for all. Its strategy is therefore predominantly preventive. It could even be seen to be in competition with commercial health care marketing as it seeks to reduce the market for curative services.



The objective of social marketing is to promote public health and its goal is improved health for a31

PRINCIPLES & TECHNIQUES OF SOCIAL MARKETING

This section seeks to give a brief introduction to the approach, terminology and techniques of social marketing. Detail of the marketing strategies is not given and further information should be sought from specific sources.

Ward indicates that, on the whole, people will only alter their behaviour if they are aware of and understand the new behaviour. It must be suitable for their culture and background and not create physical or social barriers. The behaviour should result in a pay-off greater than that for other alternatives. The social marketer must therefore verify that the behaviour which he seeks to promote will be acceptable to the market. A problem-solving approach should be adopted which is appropriate to the particular health need. The health goals should be established and ranked in order of priority.

The health planner or social marketer must consider each of the four marketing elements: product, place, price, promotion. These form the marketing mix. Priority may be given to any one of these elements at a particular time, but all four are important. Special attention must also be paid to the message design, pretesting techniques, and the possible uses and drawbacks of mass media. The social marketer must conform to the market and coordinate his programme effectively.

Product

This may be a service or a material: for example, a therapeutic drug, a clinic, a skills-teaching course, an educational pamphlet. The consumer must know about the product and find it easy to use. The product should be tried out to see if users like it. Good product management concerns branding, packaging, positioning, form, product life cycle and product development. Where there are several products, these should be compatible.

If, for instance, the design of an educational brochure is poor, and the text is difficult to understand, then there is likely to be a poor response to the document. Pretesting will help to reduce some of the difficulties here. Identifying the main components will give the optimum product mix on which the health planner should concentrate his marketing efforts. These are outlined in any good marketing text and are easily adapted to social marketing.

Place

The service or materials should be located where the users are most likely to find them. If the potential users are the elderly, then the optimum location for giving information would be the supermarket, social centres for the elderly, or the church.

Price

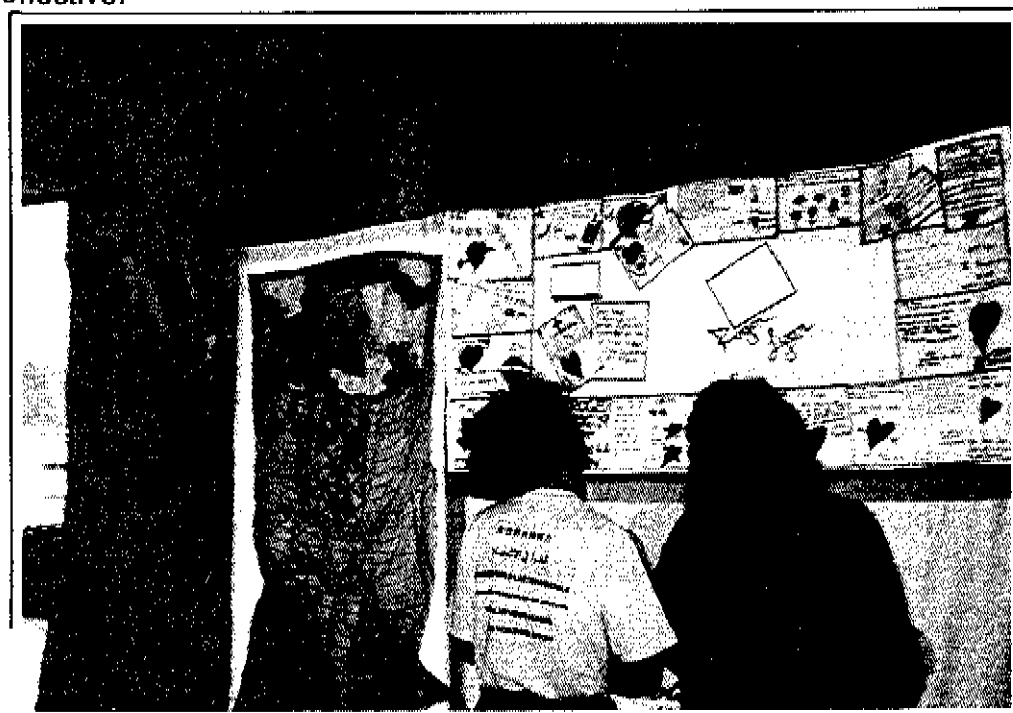
Economic reasons can be put **forward** to help explain why people invest in health (Ward 1986). In life-threatening situations, the cost of health is not at the forefront and the price or person's income has minimal effect on the demand. However, in ordinary curative care, demand is more likely to be affected by the price. If the price is high or personal income is low, then the demand is less. Whereas if the price is low or personal income is high, then demand is increased. Nevertheless, reducing the price alone may not necessarily improve the response to the product; an increase in the perception of the value of the product may also be required.

Social marketing of health has additional costs to take **into** account: these include convenience costs if the individual has to take time off work or lose pay to visit a clinic; and response costs if there is likely to be embarrassment or fear of exposure of a particular problem, or if the individual fears failure in carrying out the behaviour. These costs are more difficult to assess.

Promotion: **visibility** and timing

Visibility reminds the user of the product's existence. Timing is presenting the reminder when the user is most likely to take the required action, since people vary in their readiness to receive information. The message should be promoted when receipt is most desired and in a form that is most readily understood, from a source where the user would most expect to find information of this kind.

In developed economies health information must compete for attention in a crowded information market. In less developed **economies**, however, the mass media are much less common and people are **unaccustomed** to using their various forms. The communication channel must therefore be selected with care and should not distort the information. The chosen channel should be accessible to the health planner and credible to the user. Information channels include television, radio, magazines, newspapers, social and professional organizations, schools, town meetings, drug and medical equipment companies, word of mouth, opinion leaders and so on. The **product** must be planned thoroughly before the promotion takes place (Fine, 1984). Good promotion also needs an element of surprise and novelty to be **effective**.



A novel way to commemorate those who *died* of AIDS, World AIDS Day, 1988, at WHO Geneva

Message design

The message components should be examined to ensure that the target audience will:

- * be made aware of the existence of the problem,
- * understand the problem and solution,
- * be capable of carrying out what is recommended, and
- * know what the benefits of the recommended behaviour will be.

To accomplish this requires up-to-date research (for instance by focus-group or in-depth individual interviews) of the target audience and its perception of the problem and solution.

Message design will depend on sensitivity and creativity rather than on following strict rules. In contrast to commercial marketing, meaningful content and rational presentation are essential in health messages. It is important also to overcome resistance points. These may be cultural and traditional practices which argue against a new behaviour or preconceived images, for instance masculinity. Such psychological, cognitive and emotive factors need to be tackled or the message will be heard but not received. Beliefs are likely to be reinforced by the persons themselves and also by other members of their family and society. Focus group or individual interviews and other attitudinal research will be useful in revealing these. Examination of resistance points usually reveals further message problems for the social marketer and establishing the priority of these will be essential.

An important element of advertising is a short message delivered frequently to a defined target audience. From his experience of message design **Manoff** lists the factors, illustrated in Table I, which need to be accounted for. He expands each fully in his book and gives examples, such as designing and testing a nutrition message in the Philippines.

Table I: GETTING THE MESSAGE RIGHT

<p style="text-align: center;">CONTENT</p> <p>The Problem (can it be understood?) Target audience (is the content believable?) Resistance points (what are the barriers to acceptance?) Solution (can it be understood?) Required actions (what needs to be done?) Authoritative source (does it reinforce credibility?)</p>
<p style="text-align: center;">DESIGN</p> <p>The single idea (is it clear? can it be demonstrated?) Language and cultural relevance (is it suitable to the audience!?) Situation and character identification (are they real?) Distinctive message style (does it have impact?) Low fatigue index (is it boring?)</p>
<p style="text-align: center;">PERSUASION</p> <p>Reason why (dispels doubt) Empathy (gives assurance) Concern arousal (provides incentive) Action capability (can the audience carry out the behaviour?) Believability (is it convincing?) Creativity (is there novelty and imagination?) Benefits (pay-off)</p>
<p style="text-align: center;">MEMORABILITY</p> <p>Idea reinforcement (maximizes awareness) Minimising distractions (maximizes awareness) Reprise (repetition increases impact)</p>

Source: (Manoff, 1985)

Social marketing does not seek to ~~trivialize~~ the intellectual content of a message. It aims to present accurate information in the most appropriate manner. The way the message is conveyed can often cause logistical problems. Health educators rely heavily on interpersonal communication: for example, small group face-to-face delivery. The message is often in printed form or, particularly in developing **countries**, is reliant upon a person to relay it to the audience. It is often difficult to retain the accuracy of the health message. Print media and the use of non-verbal communications also present additional problems, for example illiteracy in the target audience, misunderstanding of symbols, cultural expectation and so colour selection and pre-design research are again imperative. The limitations and difficulties associated with print media are examined in Fusell Communicating with pictures.

Pretesting

Various methods of pretesting are available, both qualitative and quantitative. The former reveal attitudes and perceptions and the latter ascertain their significance. A popular technique within social marketing is the focus-group interview (Heimann-Ratain 1985), which uses an open-ended question guide rather than a questionnaire, to draw out feelings, attitudes and perceptions instead of a purely **yes/no** response. An example of the type of open-ended questions which could be used in a focus-group interview on health learning materials is attached in annex 1 (extract from Knersch). Attention is paid to non-verbal communication, e.g. facial expression, and to extra-verbal characteristics, such as tone of voice, to supplement the information given. The group or individual response leads to further questions rather than following a specified format. The interview session is usually taped so that it can be reviewed later.

Mass Media

The mass media heavily dominate many countries, such as the United States, and their effect is also strongly evident in developing countries. Third World radio may not be reliable, but there are few countries into which radio has not penetrated. Rural **populations** in even the poorest countries have some access to radio, **often** sharing sets between neighbours. A more likely difficulty is obtaining spare parts to maintain the radio sets. The social marketer faces similar problems in both developed and developing countries, in that listening is often fragmented and lacks motivation.

Much research, frequently inconclusive, has been conducted on the influence of mass media upon individual and collective response. This is adequately summarized by **Manoff**. The impact of mass media is powerful but may not be permanent or total, so the social marketer should not rely on it exclusively. It would also be counterproductive to promote a health product on a mass scale if it is not available immediately.

Manoff makes the following comments on mass media communication:

- * it carries special impact and authority;
- * there is fairly thorough control of the message;
- * it has a cumulative impact;
- * it reaches the masses;
- * it can telescope time, which is helpful in an urgent health education objective;
- * it can influence other audiences in addition to the target audience, e.g. politicians, industry and business, teachers, etc.
- it enhances the effect of other educational methods that are employed in health education.

Manoff also examines the effect of technological advances on the influence of mass media and the legislative and other **factors** affecting it, with particular reference to the United States.

When planning a mass media campaign, careful examination must be made of a variety of factors rather than merely choosing the most obvious.

- * **The types** of media chosen must be the most appropriate for the target audience. This can be identified through a "viewing" survey.
- * Message value requirements: obtaining the most visual, audio or literary impact according to the audience's abilities, e.g. instructions, use of colour, media mix, time of impact.
- * Media reach: who could receive the message?
- * Media frequency: how often should the message be repeated through each media?
- * Media weight: who actually receives the message?
- * Continuity: should the message be repeated over a longer duration to wear down resistance points?

- * Cost **efficiency** of all the various aspects of mass media. This is particularly important in developing countries where the cost of media usage fluctuates widely for television and, to some extent, for radio. Print media production costs are more stable. Quality and reliability must be weighed in the cost. Budgeting must distinguish between materials (films, video, pamphlets, posters) and media (the means of delivery, e.g. walls, hoarding, radio, television, cinema, magazines, people). Failure to take these items into account separately in terms of time, money and distribution will lead to problems, especially in developing countries, where trained maintenance staff and resources may be rare and expensive.
- * Each medium has its own variety of **styles**, i.e. type of programme or article, and therefore care must be taken to choose the most appropriate.



*Careful examination of all aspects of a mass media campaign is an essential part of **health** promotion planning*

MARKET DISCIPLINE - A Step approach

- Step 1 Identify the health problem, establish the methods and gain support for marketing the solution.

Social marketing does not follow fixed, predetermined paths: the direction taken will depend upon the knowledge of the problem that is accumulated. It requires market experience rather than theoretical experimentation so that, as far as possible, all factors will be accounted for in advance. Testing the market and the message components is essential.

The more thoroughly the plan is prepared, the more easily it can be implemented. Social marketers must be sensitive to rigid custom and entrenched opinion, rather than seek head-on contention. They should carry out arbitration based on well-informed, strategic decisions. Cooperation with community organizations will be essential, both operationally and politically. The primary goal of such collaboration is consensus building, which will minimize conflicting messages. Where a health product is involved, collaboration will be required with industries and producers. The **decision-makers** in government and the community should be identified in advance, as their cooperation will be essential.

Planning will vary with the organizational level. At national level it will involve policy, priority selection, goals, objectives and strategies; at middle level - management, planning, staffing, training, budgetary expenditure and control, delegation of operating responsibility; at local level - community participation, identification of attributes of the target group, appropriate technical support, implementation of the marketing solution. To achieve consensus at all these levels will require well-researched information, patience and perseverance. It is not a question of making an organization fit into the marketing concept. Rather, marketing techniques should be made to suit the organization's structure. Management needs to operate effectively and to execute decisions carefully.

The information required for marketing healthy behaviour will include traditional health measures, demographic and population studies: for example, prevalence and incidence of morbidity and mortality, the economic impact, the absolute, relative and attributable risks and attack rates. These will help to assess the nature of the health problem. The causes of the problem should be established clearly. In addition, the resources needed and available should be well examined: for instance, research facilities, mass media, marketing expertise, design and production specialties. Solutions to the health problems should be assessed and a marketing technique selected to make the chosen solution most acceptable to the groups of people affected (that is, the consumers).

Step 2 Establish priorities, select affordable efforts and maintain a deferred schedule for other efforts.

organization of priorities saves time, energy and money. This requires discipline. Objective information should be collated as far as possible, within the budget allowance. To do otherwise can lead to false assumptions and subjective judgements which may not be verifiable. The problem and objectives should be defined from the consumer's viewpoint, preferably in quantitative terms. e.g. required input, desired output, time frame. Cost estimates for media materials and media delivery should be differentiated. The size and cost of personnel must be realistically determined in advance, in addition to required support in terms of time, effort and materials. Realistic goals and objectives must be projected, because inadequate budgetary preparation will cripple a project. Once a technique has been adopted, monitoring is essential so that success can be quantified and alternative approaches taken up where necessary.

Step 3 Analyze the distinct **message/marketing** activities needed for **each problem/solution**.

Each component of the social marketing programme should have a specific written strategy which should be regularly evaluated. A number of messages or different styles of message presentation may be required for each component to make the information most appropriate to the particular target group.

Step 4 Pinpoint the target audience for each **message/marketing** component.

The social marketer must find out as accurately as possible who is not doing what they should and who is doing what they should not. This is called market segmentation (Ward 1986). The identification of the target audience is not a clear-cut exercise. The audience must be segmented so that the marketing can be geared to suit each particular section. A health message, for instance, may need to be styled differently to inform a) parents, b) government officials, c) appropriate industries, d) hospitals, e) health services, f) doctors, and so on. Effective market segmentation will allow better management. Detailed statistical knowledge and analysis may be required. For example, Fine (1980) uses the theory of segmentation by objectives to assess the food distribution practices within families in Tamil Nadu, when applying social marketing to malnutrition.

Step 5 Research each **message/marketing** concept to determine current target audience attitudes and uncover any potential resistance points.

Any cultural, social or religious resistance points should be identified. These will differ even within one society, and their relative strengths within each target audience and its segments should be evaluated. Various attitude testing techniques are available to help to isolate beliefs and values. Appropriate strategies to overcome the resistance should then be developed and tested.

Step 6 Establish objectives for each target group and each **message/marketing** component.

Define precisely the proposed behaviour change required in the target group: for example, in dietary practice, use of contraceptives, breast-feeding practice. Ensure that all the necessary information is given according to the abilities and understanding of the target group. Each element of the message should be tested to see if it is understood by the consumers in question.

Step 7 Design the **message/marketing** actions.

Any product or message should be designed to suit the needs and perceptions of the target audience. The most suitable channel of distribution should be researched and chosen.

Step 8 Test the **message/marketing** actions for **acceptability**, implementation, comprehension, **believability**, motivation and conviction.

Prepare draft and prototype materials to be pretested on samples of the target audience for each element above.

Step 9 Revise and **retest** the **message/marketing** actions as necessary.

As knowledge is acquired the whole programme should be reviewed and **reanalyzed** to make it appropriate.

Step 10 Construct the **marketing/distribution** and **message/media** patterns to achieve maximum target audience reach **and** message frequency.

Any production and distribution should be based on planned estimates and quantities to make the most effective use of resources available.

Step 11 **Coordinate** with all ongoing related work.

Liaise with any similar **programme(s)** run by non-governmental organizations, health centres, retailers etc., to reduce the possibility of confusion and dissonance.

Step 12 Track the impact of each **message/marketing** action and modify **it** in accordance with the findings.

Strategy assessment is at two levels. Firstly, to examine and, if necessary, amend each action to maintain effectiveness. Secondly, to monitor and assess whether the programme as a whole is attaining its objectives and cost-effectiveness.

The scope of **social** marketing

In summary, social marketing includes research, product design, distribution, information, communication and possibly, the introduction of a new product, or modification or restriction of consumption of an old product. It promotes change and is essentially educational. The aim of the communication is to affect the attitude of the target audience so that change in behaviour can be brought about and the health problem solved.

*"It is not the diffusion of the famous **cement** slab but the change in attitude toward excreta disposal that may 'force' a person or family to **construct**, use or maintain a pit latrine. It is only when we change people's attitudes that they realize their old methods of disposal are not conducive to good health" (Tuluhungwa, UNICEF 1981, from **Manoff** 1985).*

All components of social marketing are important and failure to make adequate preparation of one area may lead to failure of **the** campaign. For example, a successful **product** alone may be insufficient if support resources are lacking, or if the channels of communication are poor and the message reaches the wrong people.



Social marketing aims to affect attitudes to bring about a change in behaviour to improve health

MARKETING IN A HEALTH CONTEXT

Social marketing takes scientific evidence on health and through the methods of commercial marketing creates education and action programmes. The scope for social marketing is worldwide, though each health education need is particular and varying in urgency. Public service advertising of health messages often yields inconclusive results, whereas using all the techniques of social marketing allows more promise. It is an approach which can be used to help combat many of the major fatal illnesses, especially in children, that can be prevented by vaccination, hygiene or nutrition - measles, whooping cough, diarrhoea - or any other health problems that can be lessened by health education. For instance, illness developed in poverty, in both developed and developing countries, can be reduced by health education. Diet education programmes in the West attempt to lower cholesterol levels, or to reduce salt intake, in an attempt to reduce the risk of serious illness. There are many examples, some due to socioeconomic causes and others to self-induced causes such as smoking, or drinking alcohol. Strategic, controlled education programmes can lessen their effects.

Health education becomes of paramount importance where there are insufficient doctors for the number of patients. Social marketing can assist workers in the field where staffing is very limited. It boosts morale and reinforces the message of the health worker. It can also be refresher training for health staff and can influence public officials, especially when the mass media are utilized. Prevention measures are essential, and using paramedical and community health workers to pass on such information can prove very effective. Typical prevention messages are simple and direct, demanding little technical preparation. They depend equally as much on emotive or persuasive power as on information. They are directed to behavioural and life-style traits of the affluent as much as to the special concerns of the less fortunate. Much information in professional health journals is important for the public and should be disseminated to them in terms they can understand.

Social marketing in Family Planning

A main area where social marketing has been popular is in family planning. Marketing techniques have been used to promote a variety of contraceptives. "Contraceptive social marketing: lessons from experience" (Sherris et al. 1985) gives a thorough review of the field, relating experience acquired and lessons learnt through programmes in thirteen countries over a decade. It also has a very good bibliography on the work covered. The skills of the private and commercial sectors have been used to increase awareness of family planning and to reach a large market. Government and donor support helped to keep the price of contraceptives affordable by low-income couples, whilst still using retail promotion sales, and distribution outlets.

Programmes in Bangladesh, Colombia and Egypt seem to have been particularly successful, others less so. Two aims were paramount: firstly, to make contraceptives more widely available and, secondly, to recover some programme costs. The use of existing retail networks was more convenient for public access and made better use of resources. The first programme began in India in 1973, and since then the number and effectiveness of strategies used has increased over the years. The paper clearly summarizes the lessons acquired concerning management, potential customers, products, pricing, market research, distribution, promotion, and programme costs of contraceptive social marketing.

Social marketing in nutrition

Workshops, seminars and publications of the World Bank, **USAID** and the United Nations have promoted marketing techniques for nutrition. The International Nutrition Communication **Service**, a consortium of three nongovernmental organizations was created by **USAID** to provide technical assistance to developing countries and requests for social marketing aid have continued to grow (**Manoff 1985**). Social marketing is a major instrument in nutrition education improvement (**Manoff 1980**). breast-feeding campaigns (**Matthai 1980**), and several others.

This work often requires the collaboration of professionals, governments, schools, media and industry in addition to health staff, e.g. a margarine company in low cholesterol campaigns (**Manoff 1974, 1977**), a pharmaceutical company in health care advertising (**McKnight 1977**). However, a major drawback is that the mass media and industry tend to concentrate their advertising efforts on affluent audiences and it is left to voluntary organizations and governments to attend to the disadvantaged. Promoting health messages to the poorest communities where resources are severely lacking requires a huge effort to secure and maintain the interest of collaborators. Involving profit-making organizations also risks information **distortion** if, say, a particular industry chooses to make a bias towards one nutritional message over others equally acceptable.



"Getting the message across" Nutritional health education materials produced in Kanqu-Mayombe, Zaire

Social marketing in diarrhoeal disease control

Another area where social marketing has produced useful results is in programmes for diarrhoeal disease control, which promotes oral rehydration therapy (ORT). Fox (1988) details the work carried out by the National Control of Diarrhoeal Diseases Project (NCDDP) in Egypt. Through mass media advertising, subsidized production and distribution of packets of oral rehydration salts, and training programmes for physicians and other health workers, the Project created national awareness and generated wide use of oral rehydration therapy. The project received government and external donor support. Fox critically analyzes the programme of marketing oral rehydration therapy and compares it to the social marketing of contraceptives in Egypt, bringing out essential principles and limitations in both. She isolates eight characteristics which help to make a social marketing programme effective. A programme should possess good information on consumers and their preferences. It should target its limited resources to the most promising and needy groups first, and where possible implement a "product solution" and use price as an incentive. The programme should have adequate money and an absence of restriction on advertising. It requires sound management and effective use of marketing techniques. The organizers should be able to provide hard evidence of the programme's effectiveness for the donors showing quantitative data.

Green (1986) carried out an interesting study in Bangladesh to determine the indigenous perceptions of dehydration and diarrhoea. This type of audience pretesting is of key importance in the social marketing of oral rehydration therapy for it reveals any resistance points or interpretation difficulties. It helps to isolate the **important** respondent groups and their understanding, so that the message can be adapted most suitably to them. It is important too to involve all levels of health practitioner and to gain the support of opinion leaders who may speak against ORT. It also draws attention to the value of particular traditional remedies that could be incorporated into the treatment and shows up harmful practices which would need to be discouraged.

Social Marketing in **AIDS** programmes

"In the absence of a cure or vaccine for acquired immune deficiency syndrome (AIDS), educational and social marketing efforts to reduce the transmission of **HTLV-III/LAC** are currently our best hope for controlling the spread of the disease. With increased understanding about how the virus is transmitted, there is now a growing consensus about what health education messages should be developed for each of several different target groups." (Solomon & DeJong 1986). For many years, public health education on sexually transmitted diseases has involved the promotion of prevention messages using social marketing techniques in an effort to change patient behaviour. Solomon & DeJong examine the usefulness of such techniques in AIDS risk-reduction strategies, pointing out the differences and similarities between them. They show the need for careful advertising and sensitive treatment of specific target groups in a highly emotive area, in addition to the design and testing of a credible message which tackles resistance points and expectations using various educational materials. Their results suggest that innovative programmes focussing on the needs and desires of the target groups, and choosing language, images and techniques which enable identification, can produce positive behavioural, attitudinal and cognitive results.

Social marketing techniques have been used to help combat a very wide range of health problems, in addition to those stated above. These include reducing cigarette smoking (Fox & Kotler 1980/81), lowering blood cholesterol levels (Lefebvre 1988,1986) and "selling good health habits to patients" (Stanton 1985). What is essential in each case is that the market disciplines are followed, that regular monitoring produces effective follow-up and that account is taken of the various limitations of the programmes.

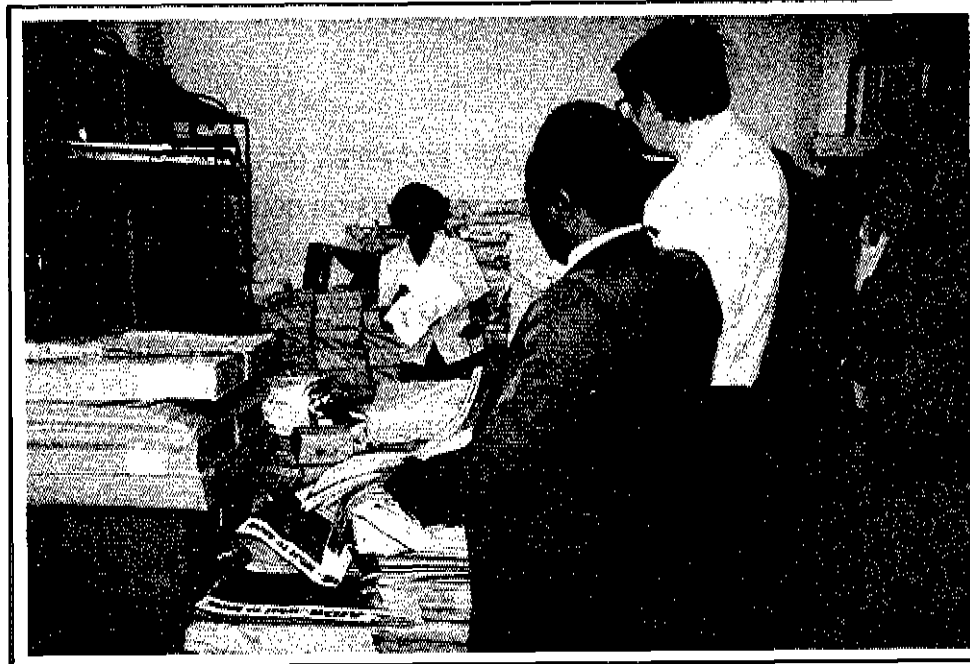
LIMITATIONS OF SOCIAL MARKETING

Social marketing is not the only method of health education and promotion. It is only appropriate in certain circumstances and has limitations (Brieger and Ramakrishna 1987, **Manoff** 1985). These include:

1. **Scale** of intervention: The majority of health education and promotion techniques are based on families, neighbourhoods, villages or institutions, whereas social marketing is aimed at individuals at the city, state, national and even international level.
2. Focus on isolated behaviour or products: Social marketing may lead people with limited resources to perceive a need to choose between the idea which is marketed and other health-promoting behaviour. Traditional health education favours a more integrated approach.
3. Major structural **barriers**: Social marketing is unsuitable where major structural barriers exist against change in individuals. These include poverty, lack of health facilities, political pressure, discrimination. Social marketing is also inappropriate where the effort and resources of the individual alone are inadequate to achieve the desired behaviour. These insuperable problems should be appreciated and careful examination should be made to determine whether or how far a social marketing programme would be appropriate.
4. Decision-making: There are ethical difficulties as to who should make the decisions or on what social behaviours should be promoted, To remain an educational tool rather than a coercive mechanism, social marketing must involve the consumer in decision-making.
5. Funding: Obtaining sufficient funding is always difficult. Social marketing is often labour- and time-intensive. A cost-effective strategy must be drawn up for each case.

6. Lack of support for social marketing programmes: Actual social marketing programmes are sparse due to lack of information, demands on personnel and financial stringencies. Trained social marketers are rare and since the financial rewards are less, commercial marketers are unlikely to be attracted to the area. Social marketing's target population is outside the cash environment and is therefore culturally, socially and psychologically different from profitmaking efforts. Progress is also slow and results more difficult to achieve. Marketed health programmes are frequently of very low priority within official channels and they therefore lack resources and opportunities.

7. Lack of opportunity for educational use of the mass media: Transmission licences often only have a vague reference to public interest, which is often unenforced. Educational programmes may be treated the same as commercial ventures rather than be allowed free-time allocation. Alternatively, the channel or times given for transmission may be poor in quality or ineffective due to inappropriate timing. In addition, the mass media are aimed at those with economic means and are less feasible in developing countries due to financial difficulties.



"Getting the product right" in the Kenya Ministry of Health Education Department

8. Poor management and implementation of a social marketing effort:

Some of the problems that can be encountered by social marketers in decision-making areas are outlined by Bloom and Novelli (1981). The implementation of social marketing creates greater problems than those experienced in the commercial sphere. These include the following:

Market analysis. The social marketer rarely has easy access to available reliable secondary data on their consumers. The consumer research that has been carried out is often weak and simplistic. There are no services that supply reasonably priced data on health behaviour. Health journals can provide useful information but tend to be narrowly focussed. Professional audience researchers have shown little interest in examining social ideas and behaviours.

In primary data collection, the social marketer is often required to ask questions on taboos, for example intimate personal habits and values. Interviewees will often give inaccurate or socially desirable answers rather than their true response. Methodology to obtain greater reliability is extremely time-consuming and expensive.

Social behaviour is complex and relies on more than one variable. For instance, drug therapy depends on self-discipline, family support, drug side-effects, communication between physician and patient; and it is difficult to control any of these. Behaviour reports are often dependent on self observation rather than objective measurement.

In addition, the health planner will **often** experience difficulties in getting funding for research studies or will be hampered by bureaucratic and local difficulties where ethical problems are involved. Social marketers have in the past taken steps to overcome these problems by misusing qualitative research as a substitute for more definitive research, but this only exacerbates the problems and produces misleading results,

Market segmentation. This is fundamental to modern marketing research so that ideas can be targeted to appropriate groups. However, social marketers often face pressure to avoid segmentation because of the discrimination which it implies. The target segments may be those most negatively predisposed to the marketed idea: for example, heavy smokers in a stop-smoking campaign. This is the opposite to the audience response in commercial marketing in most cases.

Product strategy. Shaping the product to meet most closely the needs of the consumer is often difficult in health marketing. Due to custom or political pressure, it may not be possible or expedient to change a social behaviour. So, social marketers will have less flexibility for innovative ideas. The "product" may be a complex behaviour which requires repetition over time, so that defining the exact requirements may be difficult. It may, however, be easier to alter the consumer's perception of the "product", and this will facilitate the marketing programme.

Pricing strategy. Determining the appropriate monetary price of the product is an essential element of commercial marketing. However, the social marketer is not seeking to maximize financial returns, but aims to reduce the barriers of cost that might prevent the consumers from taking the required action. Social marketers have less control over consumer costs, especially those of personal embarrassment or fear for example in an examination for cervical cancer or AIDS.

Channels strategy. This concerns the selection of appropriate channels for distribution of the product. Social marketers often experience difficulty in controlling the intermediary which carries the health message: for example, a doctor or a clinic. The incentives for distribution are often low and difficult to increase. Where the message is not given directly, there is high risk of misinformation.

Communications strategy. Communications options in social marketing are limited since paid advertising is often impractical or impossible (due to the cost or to government restrictions). Social pressure may lead to the corruption of the message. Often a large amount of information needs to be communicated in a health message before behaviour can be changed, which may be difficult to convey clearly and with impact. Pretesting of messages is often financially difficult and may be unreliable.

Organizational design and planning. Health planners often have only limited knowledge of marketing which will lead to only mediocre performance. Those from purely commercial marketing may not fully appreciate the difficulty of the social marketing field. Often health employees are not willing to take the risks that may be necessary to face the pressures against social marketing. In addition, social marketing programmes are often hampered by bureaucratic and funding problems. They will often encounter strong opposition from competing groups, for example tobacco companies in anti-smoking campaigns, food companies in nutrition and dietary programmes. Research will be needed to determine their response in advance.

Evaluation problems. Evaluation is difficult for all areas of marketing but it is especially hard in social marketing. Measuring change in social behaviour and attitudes is complex and it is difficult to know exactly which variable to measure. Estimating the contribution of social marketing to a health education campaign is difficult because it does not lend itself to interpretative monitoring and pre- and post-testing.

Bloom and Novelli make the comment that "social marketing efforts can succeed.. if the problems cited.. are anticipated and dealt with in a creative and logical manner". This requires stamina and ingenuity. It is a difficult but rewarding challenge for marketers. To ensure the programme is comprehensive, Brieger & Ramakrishna advocate that social marketing should be used in combination with other methods of health promotion and education, which will also allow variety in an education programme.



Illustrations and text should be pretested to ensure effective message design

SOCIAL MARKETING IN HEALTH MANPOWER DEVELOPMENT

The application of this discipline within health manpower development may be considered on at least two levels:

- the incorporation of social marketing within training schedules for all levels of medical students and physicians;
- the use of marketing techniques to improve staff performance.

Social Marketing in training Curricula

Manoff advocates the need for public health schools to incorporate social marketing into training programmes. Until this is carried out, he argues, social marketers will be in short supply, since current incentives for following this profession are small. The inclusion of the aims of social marketing, its preventive strategy, its principles of objective **information-gathering**, procedure design and monitoring of results using marketing techniques, could be a useful addition to health training programmes. The limitations, pitfalls and situations where social marketing would be inappropriate would also need to be included to provide a balanced picture.

Staff Performance

The use of marketing techniques to improve staff performance is illustrated by Goldsmith and Leebov (1986). Although this paper is not strictly a social marketing programme due to its commercial setting, it does show how marketing techniques can be used in health manpower development. Similar strategies could be adopted to encourage health staff to adopt more "patient-oriented" approaches to alter their behaviour towards particular health problems (for example, the treatment of AIDS patients or those with mental illness), and to promote a preventive strategy towards health for all amongst health workers.

Goldsmith and Leebov aimed to raise the standard of "hospitality" at all staffing levels of a hospital in Philadelphia. "Hospitality" was defined as "building among employees the knowledge, attitudes, and behaviours reflective of superior service...and commitment to their organization and its future". The programme was designed to motivate very different kinds of people with different roles, background and values, and to minimize resistance as much as possible. The latter was seen to be very important because attempting to train staff in courtesy and politeness could be considered demeaning. As it was impossible to meet the needs of all staff exactly, a best-fit policy was adopted.

The hospital identified that employees did not fully recognize their importance in the quality of care and success of the institution. To meet this need, the training department developed a three-stage programme. Stage one examined, through attitude and focus-group surveys, the organization's position in relation to other similar institutions, both with respect to external public opinion and in-house awareness on the part of patients and staff. Stage two characterized the target populations by isolating attitudes and motivation prevalent within different groups, for example according to type of work, expectation and response to change. Nine segment groups were established. Stage three designed the best-fit strategy. Messages were generated that were suitable for each group according to their willingness to change their behaviour, and each message element was then refined. The planning resulted in a twelve-point scheme.

- * A positive name was given to the department which was organizing the programme.
- Explicit "house-rules" were devised for all employees concerning "hospitable" response to patients.
- * The idea of "hospitality" was incorporated in hospital policy, and infringement led to disciplinary action.
- Job descriptions were revised to encourage "hospitality" specifically within a particular job.

- * "Hospitality" was encouraged within staff appraisal.
- * Such qualities were made important issues in job selection.
- * A suggestion box was installed for staff complaints and ideas.
- * A mandatory workshop was held to inform all staff about the hospital's position and the importance of staff response for the hospital's success and survival.
- * "Hospitality presentations" for physicians.
- * Special training for supervisors.
- * Bi-monthly awareness campaigns, e.g. posters and newsletters.
- * A hospital committee involving representatives from all staff to monitor effects and incorporate new initiatives.

The results of the programme were tested by surveying people's perceptions of the quality of the hospital care before and after the campaign, through questionnaires for patients and employees, and hospital reports. The findings showed a notable improvement in the image of the hospital, and that employees were taking a greater pride in their work and environment.



Social marketing techniques can be used to encourage health staff to adopt a more "patient-oriented" approach

SOCIAL MARKETING IN HEALTH LEARNING MATERIALS

Health learning materials (HLM) are often important components of social marketing programmes in health education and training. They are frequently the medium used to convey the health message and therefore should be designed and tested accordingly to ensure that the health message is suitable for the required target group, can be understood by them, and incorporates all the important elements of effective message design to achieve the optimum impact.

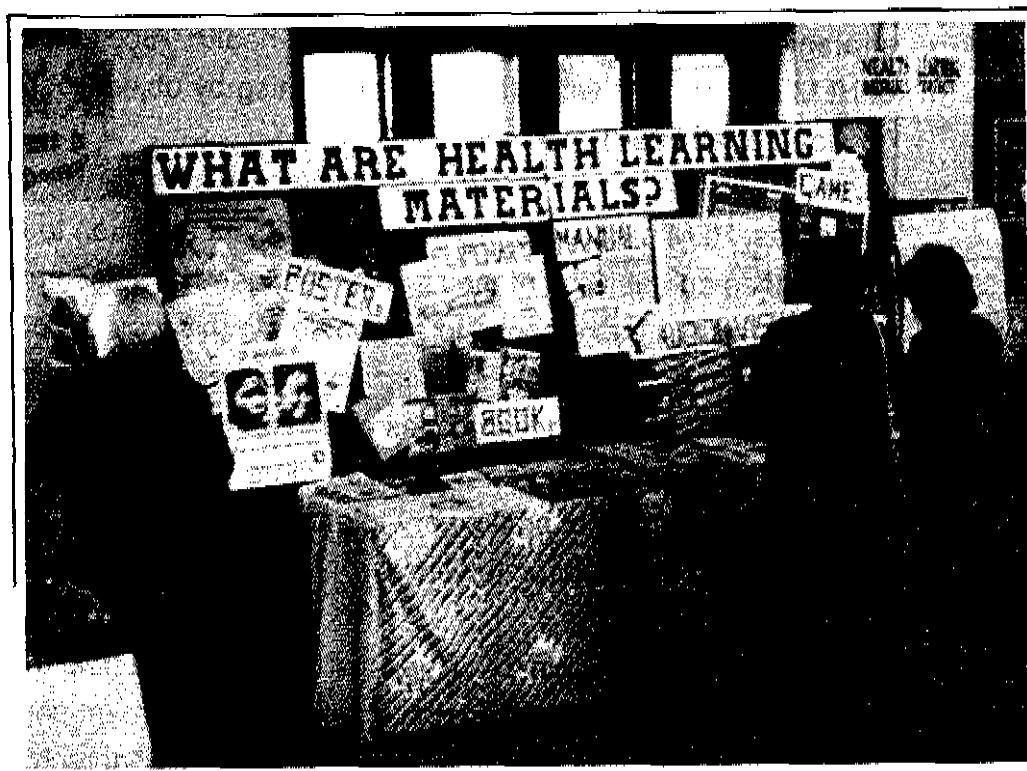
The design and testing methodology used in social marketing ties in closely with usability and field testing of health learning materials and provides a systematic approach for the production of materials with a view to promoting specific health messages. HLM writers, editors and project managers could usefully adopt some of the techniques and disciplines of social marketing when adapting or producing their own documents. Several of the references quoted give examples of the application of objective testing and marketing strategies to HLM within particular areas of health. Social marketing of HLM also fits well with a strategy of learning by objectives (Guilbert et al. 1987).

In the past HLM producers have paid insufficient attention to the preferences and abilities of their audiences, and have assumed that the materials will make sense to all people. In this way, much material has been wasted due to its lack of suitability. Training of HLM staff in field testing techniques and information strategies will help to make production and adaptation more appropriate. Testing for usability is an essential preliminary to production and in the long term makes sound economic sense.

Field testing is applicable to all types of HLM, and will help to improve the quality of the final document. An experiment conducted by the Benin HLM project will serve in brief illustration (Knersch). Field testing was carried out as a means of improving the quality of visual materials and of exploring the perceptive capacities of Village Health Workers (VHWs) in relation to the materials.

The VHWs were categorized according to literacy level and province, and asked to respond to questions on the visual materials. The exercise aimed to establish whether VHWs **could** recognize and interpret drawings presenting various health situations, and whether the drawings conveyed an understandable message. It brought out particular cultural interpretations between the various groups in addition to the effects on understanding due to literacy levels.

It showed that new concepts could not be taught by illustration but that drawings were an effective mechanism for reinforcing health messages using symbols that were recognizable. The findings showed where modifications in colour, design and type of illustration **could** be made to improve understanding of partial and complete pictures. The recommendations were incorporated in the design of a manual for village health workers Volume C, which permitted improvements based on objective findings on the responses of the VHWs themselves, that may not otherwise have been available to the HLM project.



Marketing the concept of health learning materials in Nepal

ANNEX 1:

Testing illustrations in the practical guide for the education, training, and monitoring of Village Health **Workers (VHWs)** - Volume C

Testing will be done by health care personnel who participate in training and monitoring VHWs.

The document will first be made available to the person conducting the test. All comments will be noted and handed to the **HLM** project, where an analysis of the responses will be made.

This is an open test. The document which appears below provides a simple and practical framework for the test, avoiding the need for multiple-choice questions.

Persons to be tested will be given a preliminary introduction to, and explanation of, the images which comprise the first part of the manual. It is, however, important to take note of symbols which are not understood by those being tested.

Testing should be carried out in 2 stages:

1. Analysis of images, using the following method: the person tested will be asked to determine each feature depicted, proceeding step by step, until the image in its entirety has been **analyzed** in sequence.
2. Understanding a complete image or a series of images. Following analysis of each feature separately, the total image may or may not be understood. Recognition of each individual feature may not necessarily indicate comprehension of the entire image.

If the images are not shown in the correct sequence, comprehension of the image as a whole will be hindered. We recognize that images presented in a random manner may not be understood. Features which were not correctly identified when earlier viewed separately could be understood once the image as a whole has been viewed and understood.

Testing of this volume can be conducted on a small group. Those selected may help each other to **analyze** the illustrations.

The key questions given below are intended to serve as a guide during individual testing:

1. What do you see in the picture? What does it mean?
2. What message does the picture seek to convey?
3. Do the people in the picture resemble friends or persons whom you know?
4. Do the landscape and objects look real, or are they different in real life? Name some of the differences.
5. Is there something in the picture which bothers or annoys you?
6. Is there something in the picture which pleases you very much? If so, what is it? Why is it important?
7. Is there something in the picture which is not clear? If so, name it.
8. Is there an important feature which has been left out of the picture? If so, what is it? Why is it important?
9. Is there something unacceptable in the picture? If so, what is it?
10. Do the colours and/or the decorative detail of the native dress please you very much? If so, which ones?
11. Are there colours and/or decorative details in the picture which do not please you? If so, which ones?
12. What can we change in the picture to improve it?

Replies to these questions - and to any other you deem useful for improving the quality of testing - may be transcribed, image by image and page by page, and forwarded to the HLM project for analysis.

Please include the following details in respect of each person tested:

Province:

Commune:

Village Health Unit (location):

Native language spoken:

Age:

Sex:

Profession and position held:

Written skills: French or other native language

Person with no written skills

We wish to thank you in advance for your collaboration in these tests.

Source: V. Knersch (Testing Visual Materials on Target Groups: An Essential Preliminary to Production)

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