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SOCIAL MARKETING FOR CSDR

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GOING TO SCALE WITH CSDR

CSDR objectives are clear. UNICEF knows where it "wants to go". CSDR strategies are also clear. UNICEF knows how it intends "to get there" -

- Through country health systems.
- Endorsed by inter-agency, inter-ministerial agreement.
- With the involvement of NGOs.
- With cooperation of the private sector.
- With free supplies of ORS.
- Plus subsidized ORS supplies marketed commercially.
- (And free contraceptives and subsidized retail sales).
- Linked with an EPI cold chain.
- With proper breast-feeding instruction.
- And timely weaning food introduction.
- With scales in place for monthly weighing.
- And growth charts to monitor infant development.

Given an ideal situation with all this in place, could it be possible not to achieve CSDR objectives? The answer is yes. The program could miss in almost every respect.

It could miss in the health centers when there are not enough of them. But it could miss even where they exist because they are usually underutilized. People who need them most use them least.

It could miss in the private sector. Stores may stock ORS and contraceptives. But if there is little demand the stores will de-list the items. Even people who want them will be unable to buy.

It could miss with ORS because availability does not guarantee utilization.

It could miss with contraceptives because availability does not guarantee practice.

It could miss with EPI because accessibility does not insure immunization.

It could miss with breast-feeding because if supply were the answer then breast-feeding would not be in crisis.

It could miss with timely, nutritious weaning because of too much of the wrong foods too soon, or too little of the right ones too late.

It could miss with weighing even if the scales are there but the children are not in them.

And it could miss with growth charts for every child if every child's mother does not want one.

Supply and availability of products and accessibility to services are clearly not enough. If people are indifferent, do not understand, are burdened by conflicting cultural and psychological resistances - if people do not want, do not demand them, then even limited supplies and services can prove to be superfluous. The critical fraction of supply/demand must equal unity. Less than unity could mean unsatisfied demand. More than unity probably signifies underutilization. Neither is desirable. Effective planning takes both into consideration. Supply is often restricted by fiscal and personnel constraints. But demand is a matter of far less costly interventions of public education and motivation. Nonetheless, it has often been neglected or poorly dealt with in public health programs of the past. Tarzie Vittachi has said it eloquently:

> "The 'demand' for basic services benefitting children must be consciously and pervasively present for a health revolution to succeed. The supply approach - making pure water, vaccines, ORS packets, etc. available is only a means of responding to what, in the Foundationese of the 60s, was called Felt Needs - the result of people internalizing the prospect of some real gain for the family. The preoccupation with the indispensable but far from sufficient supply approach retarded the population limitation movement for many years. The population 'mafia' failed to realise that people would adopt the habit of contraception only when they recognised the need for it, when a change of habit was seen and felt to be advantageous to them as a family and not just because the gadgetry of control was available or just because it was policy. It has not yet been widely enough realised that the population 'problem' will not be solved in the uterus but in the human mind.
>
> We in UNICEF have to learn this lesson if we are to avoid making the same mistake in trying to assist countries to stimulate and implement a children's

> health revolution. The brunt of the lesson for our purposes is that the Child Survival and Development Revolution is even more an information and communications revolution than an improvement on the supply side of government services, important as that is. Information here means education and advocacy programmes designed to reach the government and the general public so that a climate of concern and a demand for CSFDR action is created nationally as the State of the World's Children Report has done globally."*

Past programs have been "hardware" oriented, concentrating on the supply factor - institution-building (and not always the right kind) - on the assumption that demand is automatically appeased by supply. Now that we know differently, we have still to accept that real demand is often dormant and may have to be aroused.

This creation of demand is a frequently missing factor in public health programs. When acknowledged, it is as an afterthought, a begrudging recognition of the need for "education", "educational materials" and support communications. Even the nomenclature suggests a hierarchical bias: once program decisions are concluded, then communications "support" is invited.

But future demand is not always inherent in a program or its products, services and institutional links. The means of creating it must be factored in from the start. We did not always know how to do this. It takes inquisitive minds with

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* Vittachi, T. CSDR Going to Scale. Draft IV, 2917G, pp. 12-13, UNICEF, New York, 1984.

adventurous inclinations to find the way. The apple may have been the source of wordly wisdom for Adam and Eve. In communications, however, it may very well have been the orange.

IN THE BEGINNING WAS THE ORANGE

For countless generations an orange was an orange was an orange. But almost a century ago one unconventional California orange grower was impelled to question this received wisdom. What was an orange <u>really</u>? Was its place properly in the family fruit bowl? What do people think about the orange? Who buys it? How do they consume it? Why?

Long before Alma-Ata he went out into the community to find out. He knew the secrets of orange <u>supply</u>. What he needed to uncover was the magic of its <u>demand</u>. His reaching into the community helped re-define the nature of the orange - from a fruit to be peeled and eaten to a fruit to be cut open, squeezed and drunk.

"Drink an Orange for Breakfast!" he then proclaimed to a vast untapped market. His effort even inspired this paean of praise from an aspiring bard.

Accolade to the Ordinary Orange

God's lofty aim o'er looked in the common fruit bowl
Till inspiration siezed upon an inventive soul
Who discerned in the orange a far nobler use
Than peeling for eating - yes! squeezing for juice.

The orange was never to be the same, nor breakfast, nor consumer behavior. Had the grower continued the historical focus on the fruit bowl - pursuing a supply strategy - his communications would have had limited effect on the disposition of his supply. But by adopting a demand strategy he shifted his communications focus from the product to the consumer. He no longer was selling a fruit. He was marketing a consumer want or need for which his fruit could ideally be positioned. He had discovered a new strategic objective: not merely to sell supply but to satisfy demand. Orange marmalade, orange drinks, orange sherbets were inevitable.

This insight, multiplied a thousand times, changed for all time the process of moving products, services and ideas to the consuming public. Thus, if among the people were to be discovered the insights to new market opportunities then innovative techniques were needed to penetrate the hard crust of consumer resistance to the rich subsoil of consumer desire and motivation. Messages would no longer offer only the facts about a product, a service or a behavior and expect that the consumer demand would logically follow. Now the message could be "positioned" with a new sensitivity toward the consumer. Communications would be more than a support logistic for supply but a demand strategy resolving resistance points and prodding latent motivation to action. But communications planning would then have to begin at the beginning - in the community and among the people.

ALMA-ATA: NO MORE HAND-ME DOWN PROGRAMS

Alma-Ata in 1978, some years later, ordained the same new responsibility for communications in primary health care. Communicators could no longer accept hand-me-down programs. They were obliged to participate in the design. Communications development had become a two-way process: to communicate with the people in order to ascertain how to communicate to them. It established the preeminence of feed-forward over feedback - to listen and learn from the people in advance so that program design might benefit from that input. This became a communications responsibility as surely as message design and delivery. It was not to replace feedback but simply to assure that "feedback-shock" - the discovery of preventable error after a program is running - would be minimized.

This kinship between commercial marketing and primary health care inevitably led to a sharing of technology. The focus group interview is a case in point. This development of commercial marketing was an effort to reach beyond the limitations of the traditional quantitative research in which pre-structured questionnaires confine people to a respondent role. The focus group empowers them as participants in the search, volunteers of unsolicited information, initiators of questions unimagined by the program planners.

This innovation of the commercial marketer has since been seized on by social planners but there was much more they were to share - disciplines of message design, ingenious uses of modern media techniques and in-process uses of evaluation. They came to employ a common vocabulary - target audience identification, target audience segmentation, community-based planning, formative evaluation, concept testing, media planning, message design, message testing, evaluation.

This explains the emergence of the new discipline we have come to call Social Marketing. But we have not come all the way to understanding the same values with these words - almost, but not quite. An experience from Indonesia serves to illustrate.

THE INDONESIAN NUTRITION EDUCATION PILOT PROJECT

In operation since 1974, the Indonesian Government's Nutrition Improvement Program (UPGK) "targeted primarily at children under five and pregnant and lactating women is based on the premise that the home and community are the most appropriate and effective points of entry for influencing behavioral changes which can best effect improvement in nutritional status."*

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* UNICEF (Indonesia), The Situation of Children and Women in Indonesia, Draft Report, 1/5/84.

In 1977 a special Nutrition Education and Behavior Change Pilot Project (NE)* was introduced by the Health Education Directorate of the MOH in five sub-districts of three provinces of Central Java and South Sumatra. The purpose was to determine whether a different approach to nutrition education could positively affect the behavior change goals of the underlying UPGK program.

Four years later, in 1981, the evaluation was conducted by a team from Tufts University among households in the NE pilot project areas compared to households in nearby UPGK areas. How did they compare? Here are highlights of the findings:

Key Foods: NE project children consumed more of the recommended foods.

Nutrient Intake: NE breast-feeding mothers and children had significantly higher protein and calorie intake.

Nutritional Status: NE children grew significantly better after five months of age. NE children never fell below the normal zone whereas the mean values for non-NE children dropped below the normal zone after the 13th month of life. At the end of the second year, 20% more of the NE children were well nourished. Among children with normal growth, 20% of the NE children had better growth status. Thus, at least 40% of the NE children had better nutritional status.

At 23 months the mean weight of NE children was one and one-half kilos higher.

* Manoff International served as Social Marketing consultants to this project.

Impact on Mothers: NE women with less formal schooling had a nutritional knowledge score equal to those with more education - a special objective of the NE Pilot Project. This was reflected in the nutritional status of their children.

Impact on Kaders: 20% more NE kaders taught nutrition concepts to mothers. They taught and trained 12% more mothers. They reached 15% more children with the weighing program. Their sessions had a 10% higher monthly attendance rate. Thirty-one percent more of the NE kaders made home visits and made 5.7 more visits per kader per month. They spent an average of more than 6.9 more hours at nutrition work.

What made the difference?

After all, both sets of communities were matched demographically.

They were organized along the same lines.

They had the same priority nutrition problems.

They had formulated the same nutrition education content to deal with them.

They had trained similar corps of volunteer nutrition workers - the kaders gizi - to transmit the education.

They had the same weighing programs.

They had the same growth charts.

The only operational difference was in the approach taken to the nutrition education objectives:

- The way target audiences were identified, analyzed and segmented.
- The way villagers were embraced in the preparatory inquiries into health and nutrition problems, proposed solutions and the necessary behavior changes.
- The way villagers were enabled to participate in shaping the decisions about concepts, messages, media and media materials.
- The way messages were designed and media strategies were planned and executed.
- The way the kaders were trained to focus on priority issues, to maximize their understanding, enhance morale and to minimize the time required.
- The way the program was monitored.

The difference was in the social marketing approach to nutrition education: the observance of social marketing disciplines in the planning, development and execution of all the component tasks especially message and media strategies and concentration on the priority nutrition problems that had been identified by project management through nutrition and health surveillance activities:

- Protein-calorie malnutrition in children 0-4 months of age (probable cause: mothers' lactation practices)
- Protein-calorie malnutrition in children 5-8 months of age (probable cause: delayed and/or inadequate supplementation)
- Protein-calorie malnutrition in children 9-24 months of age (probable cause: inadequate total food intake/protein-calorie depletion from morbidity)
- Infant diarrhea
- Undernutrition of the pregnant woman
- Undernutrition of the lactating mother

There were other problems - Vitamin A deficiency and goiter, for example - but these were not included because of pending programs for Vitamin A capsule distribution and the iodization of salt.

Now was the time to take these problems to the community for essential inputs from members of the target audience: their perceptions of these problems (if, in fact, they perceived them as problems); how these perceptions had implications for target audience differentiation, for the proposed solutions (concepts), for message design, media strategy and media materials.

Traditional quantitative research would not suffice for this household investigation. Instead, a carefully structured open-ended qualitative technique was fashioned - a kind of portable version of the focus group model. It was a community-based process of preparatory actions:

- A community-conducted "self-survey" in which all children were weighed and their weights charted on a single community graph.

- A community meeting at which the results of the "self-survey" were announced and discussed so that mothers and village leaders had the chance to discuss the problems, the optional solutions, to discuss them and to offer suggestions. It was also the forum for winning village leaders' endorsement of the plan for the household investigations.

- A household investigations guide - a set of key questions for discussion with mothers of the problems, solutions and suggestions gathered from the community meeting. The guide, unlike a quantitative research questionnaire, was designed to stimulate discussion and exchange, not merely to elicit response to pre-coded questions. Example: in exploring the formulation of an enriched weaning food, the guide listed suggestions for locally available ingredients to satisfy nutritional requirement, yet be within the means of impoverished families. It also provided for examining local food preparation patterns and mothers' preferences from among the suitable ingredients mentioned at the community meeting.

- Recruitment of the investigation team from among women with children of their own. They were trained in simple qualitative research and participant observation techniques. They were required to live in each village to which they were assigned for the investigation.

- Selection of the target-audience sample with the assistance of village volunteers: pregnant women, nursing mothers, mothers of malnourished children or those with diarrhea. Malnourishment was confirmed by weighing.

- Conduct of the interviews during which investigators sought to assess dietary intake of mother and child for the previous 24 hours. Interviews were taped. Investigators used an innovative dietary recall analysis worksheet (DRAW) to calculate instantly nutritional deficiency. The worksheet also provided the basis for recommending foods to make up for it. The choice was left with the mother.

- Weaning food recipe worked out together from ingredients on hand and in accord with the mother's food preparation pattern. The new food was served to the child immediately so that the mother and investigator could witness together and discuss it. Having agreed on the regimen to be followed, the investigator promised a return visit in 3-4 days. (A similar investigation pattern was followed with respect to <u>all</u> identified priority problems, but no more than three such problems were covered with any mother).

- The return investigation was an opportunity to review the mother's experience since the first visit. This opportunity for the mother's participation in "product development" is one of the critical elements of the social marketing methodology for this phase of the formative evaluation. It is another adaptation of the commercial marketer's method of involving the consumer in product formulation and then testing for acceptability, modification and intent-to-buy (retrial).

The investigations produced subtle insights into mothers' enlarged views of the weighing session as an educational opportunity: if an infant's weight proved poor then it motivated the mother to want to know why.

"I learned," one mother said, "that at five months my Atik needed more food than rice and water. Even my mother's eyes opened."

Other mothers made similar comments. These changed the planners' concept of the weighing session; it was more than a growth monitoring strategy. It was also a strategy for education.

This had profound implications for target audience differentiation and for message design. Now we could see how our focussed investigations had brought into sharper light the differentiations among our ostensibly homogeneous target audience of mothers.

The mothers were segmented by their differing concerns which shifted with each change in their own status - pregnancy, childbirth. After childbirth, their concerns changed with each advance in the age/related dietary need of their infants.

There were seven distinct concerns, seven distinct objectives and, therefore, seven focused messages to deliver to the five sharply delineated segments of the target population.

The concept of the weighing session as also an educational opportunity made it ideal for the precise delivery of the precise message to the precise mother at the precise time of her precise need for the instruction. This is social marketing's primary tactic: focus on priority need when, where and for whom it is essential and minimize all extraneous factors.

Thus, the appropriate objectives and messages for each target audience segment coalesced like this:

Target Audience Segment	Objective/Message
. Pregnant Women (P/W)	Each day eat four plates of food, eat green vegetables four times and take an iron pill.
. Lactating Women (L/W)	Same as above, plus drink eight glasses of liquid per day.
. Infants 0-4 months (M/0-4)	Breast-feed only and use both breasts at each feeding.
. Infants 5-8 months (M/5-8)	Breast-feed, using both breasts. Feed the baby bubur campur (enriched rice porridge) four times per day. Introduce this supplementary food patiently. (Recipes for bubur campur vary by region).
. Infants 9-24 months (M/9-24)	Give the child adult food four times per day, including tahu, tempe, or fish and green vegetables. Offer snacks between meals. Continue to breast-feed.
. All Mothers: When Children Have Diarrhea	Give the child LGG, an oral rehydration mixture made with a two-finger pinch of salt, a tablespoon of sugar and a glass of water or tea. Continue to feed the child soft foods. (This message has special versions for cholera and non-cholera areas).
. All Mothers: Weighing of Children Under 5 Years Old	Take the child for weighing every month. If the weight does not increase, s/he is not healthy: seek advice and give her/him more food. Ask your kader, midwife or the health center staff for nutrition advice.

As we can see: (1) two objectives/messages (weighing) (ORS) were addressed to all audience segments at the same time; and (2) for every woman, only one other message she needed at a specific stage of her life or her infant's.

MESSAGES

Target Audience	P/W	L/W	M/0-4	M/5-8	M/9-24	M/CD	M/5
P/W	X					X	X
L/W		X				X	X
M/0-4			X			X	X
M/5-8				X		X	X
M/9-24					X	X	X

Knowing this much more about our audiences and their perceptions also produced insights for our messages. For example: the widely reported prejudice against colostrum was not firmly held in the project areas. It was not a resistance point that had to be dealt with.

Other findings were even more surprising. Mothers' complaints of crying infants under four months of age, whose hunger they could not appease with breast milk alone, were probed for other underlying causes because premature supplementation was widespread. Discussion among the mothers revealed that use of the right breast almost to the exclusion of the left was common. (In South Sumatra the pattern reversed: the left breast was used

primarily). Several hypotheses were advanced by authorities: popular women's blouses unbuttoned from one side; the taboo against the left hand ("left hand is for toilet; right hand, for food", seemingly unreconciled to South Sumatra); a belief that the left breast (in Java) is for "food" and the right for "water", but this is possibly the effect of the left-hand taboo, i.e. reduced suckling of the right breast would reduce milk flow and lead to the misperception.

ORT messages current at the time were found to be flawed by reference to the use of a "teaspoon" which is rarely found in village homes. Mothers' recommendations for revising the messages were adopted: the universally available "tablespoon" was referred to for measuring sugar; a "two-finger pinch" for the salt.

Differing food preparation customs from area to area were found to be significant, particularly for the addition of a fat source to the Bubur Campur, the enriched weaning food: (1) frying the tahu or tempe before mashing in the porridge; (2) in another area, the addition of a few drops of coconut oil to the cooked rice; or (3) in yet another, cooking all the ingredients in coconut milk. The Bubur Campur messages were adapted by area to accommodate these differences.

The qualitative investigations also yielded important information about village mothers' sources of information, the impact of

the mass media and patterns of use. For example, mothers' radio listening in Java was found "lighter" than had been anticipated from the available data on ownership of working radios. The extent of radio listenership did not have its normal correlation to radio set ownership. Reasons appeared to be that the government service was simply not popular and commercial stations did not penetrate beyond peri-urban areas.

Having planned a more significant role for radio, it became necessary to find ways to compensate for radio's shortcomings and the additional possibility that the government stations might not deliver on even their limited voluntary commitment. The medium of the kader network would have to be relied on to a greater extent than planned. This placed an additional burden on their training and the materials they were to use: these had to be designed for a more intrusive effect on their target audience in terms of message impact and the frequency with which they could be made to register their messages.

The seven individual messages were translated into scripts for radio and posters for the kaders to teach from and distribute to mothers. The radio scripts were short message, mini-dramas. But the posters were a radical departure from traditional poster design to meet the new media requirements of intrusive impact and message frequency. The response to this creative media and message challenge was the action-poster which produced a new dimension of audience involvement with the poster medium several

times a day in much the same way that radio intrudes into audience awareness simply by message repetition. An example of one of the seven action-posters appears on page 22.

This action-poster was used by kaders to instruct mothers of infants 5-8 months of age on proper feeding: breast-feeding on demand from both breasts and Bubur Campur (enriched weaning food) at least four times daily. The boxes beneath the illustrations are a "scorecard" for the mother to mark or pierce each prescribed feeding. The 30 lines of boxes provides for the 30 days between monthly weighings. The concept behind the action-poster is that the "scorecard" feature makes the traditional poster more involving for the mother, provoking a deeper sense of obligation to the recommended dietary practices whether or not she actually "scores" each feeding. The expectation, borne out in practice, is that each food intake experience during the day will actually recall her "scorecard" obligation, thus serving as a "reminder" of the message and raising the frequency of its exposure - its <u>frequency</u>. Six other action-posters were designed for the other priority messages of the NE Pilot Project.

The training of kaders was similarly organized. They were trained in 3-4 days with the same messages they were eventually to use in educating mothers. They were taught how the action-posters were to be used: in conjunction with the weighing and the keeping of the growth charts and why only those action-posters were to be given to each mother that were relevant to

her circumstance or the age of her child. They were instructed also in proper weighing procedure, in growth chart comprehension and maintenance and in the conduct of home visits.

This priority focus in the training of the kaders is credited with the superior level of their performance as compared to their counterparts in non-program areas. Also, the principle of using for their training the same materials that were to employ with their future "clients" accelerated their adeptness and shortened training time. It also insured message consistency and may have contributed to the kaders' sense of security and morale.

Almost all these decisions were made possible by the insights gained from the "feed-forward" approach of social marketing to formative evaluation in communications research. And these by no means represent the entirety of what was uncovered. Message design was inestimably aided by insights about language and idiom, cultural practice, etc., garnered from a verbatim review of the tapings of the investigations.

The difference that social marketing made to the NE Pilot Project has been acknowledged by the World Bank whose loan funded the project:

> The low-cost nutrition education as practiced in Indonesia looks particularly attractive. That it was cheaper than programs requiring food commodities comes as no surprise; the question is whether it is effective. The evidence has shown that nutrition education alone <u>can</u> make a difference in improving nutritional status. Nutritionists

> have long held out the promise of this possibility; the Indonesian experience is the first time it has been demonstrated in an operational setting.*

The cost per beneficiary in this project was the lowest of six interventions in nutrition projects assisted by the World Bank.** To analyze the NE Project, actual expenditures were used to calculate the initiation phase costs, then estimates for an expansion phase were made with the actual figures. The distinction between non-recurrent costs (vehicle and equipment purchases, consulting service, one-time training and message and materials design, etc.) and recurrent costs (supervision, salaries, materials production, etc.) was maintained in the analysis of each phase of the project. Ho calculated that the annual cost per project beneficiary (children 0 to 24 months old and pregnant and lactating women) was $3.94 during the pilot project stage, but that if the project were to be expanded to more areas in the country, the annual cost per beneficiary would be reduced to $2.05. Based on Ho's project cost estimates and the finding that 40% of the NE children were growing better by 24 months of age than children in the comparison sample, the cost per child with nutritional status improvement was $9.85 per year for the pilot project and would be approximately $5.13 per year for an expanded program.

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* World Bank Department of Population, Health and Nutrition. Nutrition Review. Washington, D.C.: World Bank, 1984.

** Ho, T. J. Economic Issues in Assessing Nutrition Projects: Costs, Affordability and Cost Effectiveness. Staff technical report. Washington, D.C.: World Bank, 1984.

But behind this account of the social marketing approach to the Indonesian NE Pilot Project is a social marketing system of disciplined steps. The process has been mapped on the following page in Figure A.

Now, what does all this mean to UNICEF? For one thing, UNICEF has a significant opportunity for CSDR in Indonesia and provides important support to the Government's health and nutrition programs.

For another, the Indonesian NE Pilot Project dealt with the essential elements of CSDR - growth monitoring, oral rehydration, breast-feeding and the special dietary concerns of the pregnant woman, the lactating mother and of her infant through all the vital growth stages. While it did not embrace immunization - or, directly, FF - it could have, and will, when infrastructural circumstances and program requirements demand them.

SEEING UNICEF COUNTRY PROGRAMS THROUGH SOCIAL MARKETING EYES

Thus, it is relevant to CSDR activity at any level of UNICEF in-country support. This becomes readily apparent when we examine on a random basis specific references from typical UNICEF reports of country program plans and activities. Recent UNICEF Indonesia reports offer good examples. They are heavily detailed, highly informative documents. Let us begin.

FIGURE A

PROCESS FOR DEVELOPING SOCIAL MARKETING PROGRAM *

DEVELOP STRATEGY

A. ACTIVITIES:

Given	Identification of Objectives/ Definition of Strategy Components	Strategy Formulation
General Goals	The problem	Develop specific strategies for each component:
	Objectives	- Messages - Target groups - Research (method of tracking success of program)
General Target Groups	Target groups (segments)	
	The proposed behavior change	
	Resistance points	
	Media systems	Media: Delivery systems for information for each objective for each target group
	The product	Product: Characteristics, benefits, name, pricing, packaging, promotion
	Distribution systems - Messages - Products	Distribution: Integration with health clinics, pharmacies, public and private service and commodity distribution centers, retailers

B. RESOURCES:

Review:
- existing studies
- feedback from ongoing programs

Conduct: qualitative investigation followed by quantitative studies

Analyze: all data and information for written situation review

IMPLEMENT STRATEGY

A. ACTIVITIES:

Production of Draft Materials	Testing Messages, Concepts & Materials	Inaugurate Program
Messages for different materials and media	Authorities	Finalize social marketing plan
	Target Audiences	Produce materials
		Execute media plan (reach, frequency, continuity, coverage area)
		Coordinate with other programs
		Train field personnel
Product packaging, promotion and sales materials	Target Audiences	Execute sales and distribution plan (sales training, meetings)

B. RESOURCES:

In-house production

Advertising agencies

Contract out; other arrangements

Groups or "in-depth" individual interviews to test -
- Messages: for comprehension, cultural, relevance, practicality, emotional appeal, memorability
- Product: for performance, packaging, pricing, name

ASSESS STRATEGY

A. ACTIVITIES:

Periodic Evaluation
Feed results back to project managers
Determine strengths and weaknesses
Revise program accordingly
Assess cost-effectiveness
Product sales

B. RESOURCES:

- Tracking Studies (KAP) - qualitative and quantitative
- Observation by supervisor.
- Reporting by field worker
- Monitoring of media
- Wholesale and retail audits of product sales

* This process is reproduced from "Social Marketing: New Imperative for Public Health", a forthcoming book by Richard K. Manoff to be published by Praeger Publishers, New York, in February 1985.

> "Improvement of people's health will be carried out through preventive and curative efforts by bringing the health services closer to the people ... [through] information on the people's health to popularize a healthy way of life to be started at the earliest possible age in childhood."* (p. 4)

A worthwhile objective not to be debated. But how are health services to be brought closer to the people? How are "information" activities to be designed, messages and media strategies to be devised? On an ad hoc traditional basis or in accordance with necessary disciplines like those intrinsic to the social marketing approach?

> "By the middle of Repelita III several weaknesses in the programme had become apparent: the attitudinal changes expected ... had not materialized, the PSMs (community social workers) did not have the skills to carry out needs assessments ... PSM training was not fully appropriate for their tasks." (Ibid, p. 10).

Was it possible to have learned this in advance through "feed-forward" inquiries of formative evaluation as employed in social marketing? The "feedback" reported here is too costly in lost momentum and mistakes. "Feed-forward" helps cut down on waste, reducing the need for post-mortem insights of "feedback" after valuable time has elapsed.

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* Child Survival and Development Strategy. (Working Draft), GOI/UNICEF Cooperation, 1985-1989, 4/24/84.

> "In addition to supporting programmes at the national level, a major thrust of the Country Programme will be ... to strengthen regional and area administration and communication capabilities ..." (Ibid, p. 12)

Again, the question is not whether this should be done but <u>how</u> and by whom and with what approach.

> "Communication support will therefore be an essential element within the framework of GOI/UNICEF cooperation." (Ibid, p. 16)

At what point will it become essential? Will it be deemed essential to the program planning process or not until the program is ready for launch?

> "... [one] of the continuing problems contributing to the situation [is] ... low coverage of immunization, though the services are available in over 80% of all sub-districts (one out of three infant deaths can be prevented by immunization) ..." (Ibid, p. 18)

Here is the hint of danger: accessibility does not guarantee utilization; information and education (cognition) may not be enough. Advocacy - the creation of demand - is clearly indicated. Will social marketing be called upon?

> "While the national leaders are genuinely desirous of strengthening the process of a bottom-up approach to development, sub-national administrations often lack the necessary technical skills and management capacity to make the approach effective." (Ibid, p. 18)

Given a specific problem, the best training for local administrators is in the planning and implementation of activity. The assurance of a "bottom-up approach" is to be found in <u>taking</u> such an approach, not merely "talking" it in isolated

"talking" it in isolated training sessions.

> "It is expected that this integration (of the UPGK and EPI programs) will not only improve coverage ... but improving the knowledge and skill of village volunteers will enhance performance ..."* (p. 5)

"Improving" administration requires more than a re-shuffling of the boxes of an organization chart. At its heart is a revised substance of the administrative tasks and objectives. If the knowledge and skills of village volunteers are to be improved, more fundamental changes are called for in the substance, method and focus of their training. It is not only a "hardware" (administration) problem but also a "software" (program) concern.

The litany goes on ...

> "The distribution of ORS and an education programme for ORT have been integrated into the UPGK programme since 1976 ... UNICEF will support this programme ..." (Ibid, p. 7)

> "This community worker awareness programme will be ... supported by education and training materials ..." (Ibid, p. 8)

> "The (UPGK) nutrition education component is a critical element and could be strengthened by emphasizing this activity at weighing sessions ..." (Ibid, p. 9)

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* Program Strategy for GOI/UNICEF Cooperation. Draft Working Paper, Components IA and B: Health and Nutrition, 4/19/84. (This is the second section of the aforementioned report).

> "A number of support activities (for the Water and Environmental Sanitation Component) have also been undertaken. These included Health Education and Project Support Communications activities ..."* (p. 2, the third section of the report)

But the real need behind these matter-of-fact statements is revealed in a more urgent statement one page later:

> "... improved sanitation is not a recognized need in most communities. What is required therefore is the inducement of change in long-established patterns of behaviour. It appears that the conventional approach to health education has not been very effective and a fundamentally different approach to the community is required." (Ibid, p. 3)

Need more be said? Yet, soon after come these words of, is it, resignation or, could it be, despair?

> "Educate the community to improve the knowledge, awareness and practice in respect of water supply and environmental sanitation ... the primary target groups ... being women and children..." (Ibid, p. 4)

> "[One of] the major outputs for GOI/UNICEF cooperation ... would be visual aids and educational materials for health education activities ..." (Ibid, p. 6)

But what will be used - the conventional approach or a "fundamentally different approach to the community"? Will the effort be dissipated on old ways or steered in a new <u>proved-effective</u> direction?

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* <u>Water and Environmental Sanitation Component</u>. Programme Strategy for GOI/UNICEF Cooperation, 1985-1990, April 1984.

These questions are particularly relevant to women's status.

> "The problem here is not the lack of legal protection but the ignorance of many women of their rights and the lack of consistent enforcement of laws and regulations relating to working conditions and employment benefits."* (p. 5)

Is this a delicate issue? If so, can it be deftly handled through existing message delivery systems - NGOs, the mass media, etc.? A social marketing assessment would produce the answer - and the appropriate response to countering the ignorance that obstructs women's exercise of their lawful rights. The "resistance points" to be uncovered are fascinating to contemplate - among women, (fear, perhaps) employers (greed) and perhaps even public officials (political "hot potato"). Regardless, some way can be found to deal with them.

> "A key feature of the current health infrastructure is the Puskesmas (community health center) which is ... the primary source of public education and information about health, nutrition and sanitation ... (but) only 60% of them have adequate supporting staff."** (Ibid, p. 4)

Recruiting staff or building its morale are clear-cut tasks for social marketing. Why is staff hard to recruit, to keep? Why is morale low? The problem is not unique. More than 40% of the mid-wife jobs in Turkey's health centers remain unfilled at any one time. Other countries report the same problem. The quality

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* The Situation of Children and Women in Indonesia. UNICEF Outline Draft, Part II, 1/5/84.

** Ibid. Part III.

of the training, its relevance to priority health problems at the health center level could be a contributing factor. The criteria for selecting candidates might be another. Moreover, there are ways to make up for such staff shortages.

> "... a parallel strategy has been adopted to encourage greater public participation in the health delivery system ... During Repelita III some 20,400 village health promotors and 172,000 nutrition volunteers were trained as part of the Village Health Improvement Scheme in addition to 400,000 trained to conduct weighing and other activities (UPGK). The health manpower projection ... calls for about 500,000 ... by the year 2000." (Ibid, p. 8)

This recalls the NE Pilot Project case history. The pertinent question is: how will these volunteers be trained? Along the lines proved more effective under the NE project - or not? But personnel shortages are only one facet of the crisis in health care delivery.

> "An unacceptably high proportion of currently available services and facilities are seriously underutilized." (Ibid, p. 11) ... "Apparently 26% of the population who are ill do not seek assistance at all and of those who do only about 50% use health centers and hospitals while the rest use traditional methods or private care ... the Puskesmas reach less than 42% of the babies born and less than 11% of the under-fives." (Quoted from the World Bank on p. 13)... "Only 21% of those using the Puskesmas came from the lowest economic class ... the Puskesmas serves primarily the middle and upper income groups ..." (Ibid, p. 14)

So it cannot be the quality of service that discourages the poor but some combination of other circumstances. This would indicate the need for two lines of inquiry: (1) why don't disadvantaged groups make greater use of the system? (2) how can they be

motivated to do so? The evidence that such motivation can be aroused is to be found in the Indonesian family planning program whose

> "... success ... is largely attributable to the extensive outreach and promotional efforts ..." (Ibid, p. 16)

A comparable success eludes the government insofar as immunization is concerned:

> "The Government estimates that more than 80% of the deaths of children under the age of five could be prevented with appropriate (immunization) intervention." (Ibid, p. 22)

But -

> "... with the programme introduced in over 60% of all sub-districts only eight to 33% of surveyed children receiving two DPT and one BCG immunization ... the evaluation identified (as a major issue) ... low public demand for immunization." (Ibid, p. 26)

And when it comes to basic food and nutrition concerns

> "at least one study found that malnutrition rates among young children were no better in 'food adequate' households that in 'food deficient' households, which suggests that child feeding practices may be an important factor ..."* (p. 2)

And given the goiter problem,

> "There have been problems in marketing and distributing iodized salt partly because it is more expensive ... (and from competition) with many small 'people's salt' producers ... also due in large part to the poor understanding by the public of the importance of iodine in the diet." (Ibid, p. 14)

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* Ibid. Part III C.

Could there be more compelling reasons for considering social marketing? No wonder that

> "Implementation of support programmes including health education maintenance, trials in community participation has been less than successful." (Ibid, p. 11)

The problem with "less than successful" results starts long before the implementation stage. Poor results are commonly attributed to administrative failures when they should more appropriately be charged to errors in program conception and design leading inevitably to skewed directions and unsuitable educational materials and training. There is no way a poorly conceived program can be effectively administered. In fact, poor program conception foredooms the possibility of good management and corrodes the morale and initiative of even the best of administrators. This underscores the necessity of planning input from those who are later to be called on to implement the demand strategy with educational, informational and advocacy tasks.

THE TANZANIA EXAMPLE

This is more the exception than the rule as we may infer from the Joint WHO/UNICEF JNSP plan for Tanzania. This is an impressive program. However,

> "At its first meeting a Project Preparatory Team (PPT) with five full-time members was appointed. The members represented the fields of health, human nutrition, food science and agriculture, community development and nutrition planning."*

* WHO/UNICEF. Programme Plan of Operation and Plans of Action. 1982-1987, Joint WHO/UNICEF Support for the Improvement of Nutrition in the Republic of Tanzania. May 1983, p. 5. (underlining ours)

Where is the communications/education representation on this Project Preparatory Team? Of course, there was such representation in the preparatory meetings and consultations but why not also in the planning body since communications/education is so vital a part of the eventual effort? Education, Training and Project Support Communications, combined, rank third among the 12 operational components of the program in terms of dollar investment. This alone would warrant initial planning input from these sectors. But even had communications/education representation been arranged for on the PPT, what assurance is there that it would have adopted a new, different approach to education, training and communications planning? It might very well have continued to employ past approaches rather than a demand strategy. Yet, in demonstrating the workings of its conceptual framework, the plan suggests the possibility of

> "Measures to improve infant and young child feeding, including the protection and promotion of breast-feeding ... the use of ORT ... the expansion of the immunization programme ... the development of P.S.C. activities for advocacy on the socioeconomic causes of malnutrition." (Ibid, p. 14)

So it is obvious that the need for significant communications involvement at several levels is well acknowledged. Yet, this failure to reflect it in the organization for the planning process is a manifestation of the tenacity with which we cling to the traditional approach to health and nutrition program planning despite an awareness of the need for innovative change.

Interestingly, we find that, by contrast, communications has been assigned an advocacy role at the policy-making level - recognition of the importance of levelling the political barriers that impede official sanction of vital social programs. What of the cultural and psychological barriers that thwart consumer adoption of these same programs? We have entered upon a new era in health and nutrition program planning with the realization that advocacy has a similar role to play at the community level. One lesson learned from the past is that information and education (cognition) are not enough that persuasion - the demand creation - is essential and is impossible to provide for without a social marketing approach to the very first stages of the program planning effort.

We have learned that the distinction between program and communications is mythical, that communications is as vital a part of the program as service delivery though its financial requirement is perceptibly less. But money is not a reliable measure of value. The difference between success and failure of a service delivery system may be in its social marketing approach. This is significant - perhaps, predominant - value added.

The traditional view of the communications role leads to an artificial separation of "education" from "training". They are interrelated, interdependent, mutually reliant on the same messages. The training of trainers should be done with the same basic materials that the trainers will eventually use in the

training of the public. Their training should be kept as close to the site and substance of and interface with the community as possible. Otherwise, we create the danger of a "communications gap" between trainers and trainees which more often than not lends to the situation where

> "... health facilities ... are within 5 km of 70% of the population ... (but) ... the utilization of health services is much lower. A recent survey of immunization coverage, for example, showed that only about 20% of the eligible population had been immunized." (Ibid, p. 36)

Any question as to the importance ascribed to communications and education is conclusively resolved by an examination of the most important constraints "as regards the four most important nutrition-related diseases." These are:

"Diarrheal Disease. (Of the four constraints, two are:)

- Inadequate oral rehydration and dietary therapy during diarrhea episodes

- Lack of health education on the prevention of diarrheal disease

Measles. (Of the three constraints, one is:)

- Ineffective implementation of the immunization programme

Malaria. (Of the four constraints, one is:)

- Lack of health education on vector control measures that can be undertaken at household or community level

Respiratory Infections. (Of the three constraints, two are:)

- Lack of health information on proper home care including dietary therapy

- Ineffective immunization against tuberculosis." (Ibid, pp. 36-37)

In effect, of the 14 constraints to dealing with these four most critical diseases, at least six are directly or indirectly related to education/communications. Certainly, this would warrant re-evaluation of traditional methods and techniques in favor of the alternative social marketing approach. Were that to have taken place in Tanzania, the situation analysis would not have found that

> "Nutrition education has ... concentrated almost entirely on the promotion of the 'balanced diets', with emphasis on the use of protein-rich ingredients like meat, milk, and eggs. Since these items are not available in most of the poorer households, the people concerned do not - and cannot be expected to - identify themselves as being in a position to adopt the dietary improvements exhorted by the nutrition educators ... Therefore education in nutrition should be oriented in such a way that its understanding and recognition of hidden hunger identifies the ways in which it can be eliminated using household resources." (Ibid,. p. 43)

"Oriented in such a way" can only mean the necessity of employing a social marketing approach so that audiences will be able "to identify themselves" with its messages and concepts.

> "Another problem in the past has been that nutrition education has been treated separately - and in different ways - by the different sectors with the net result that some of the nutrition 'messages' have been inconsistent ..." (Ibid, p. 54)

This is to be expected from the "vertical" conceptualization of nutrition education programs when, in the era before PHC, individual ministries pursued their independent strategies. The resulting message dissonance is one of the critical circumstances that has made the social marketing approach inevitable.

But the report, itself, so astute in its observations of the gaps and flaws of past efforts illustrates a lesser capacity for assessing the "information and communications" opportunities of the future. While recognizing that

> "One of the most important communications channels is the system of functional literacy classes," (Ibid, p. 53)

its appreciation of the totality of modern communications media is regrettably circumscribed.

> "In addition there is a monthly zonal newspaper, Nuru Yetu ... a circulation of 8,000 (that) ... cannot cover even all the functional literacy classes and discussion groups in Iringa ...
>
> "Some four years ago the Iringa Region started its own magazine, Ukombozi ... the number of readers is not known, but it is likely that it is greater than the 10,000 circulation ...
>
> "There are 114 libraries in Iringa Region of which 111 are in villages but these are underutilized partly because the number of titles available is very limited ..." (Ibid, pp. 53-54)

The notion that a library can serve as a major medium for urgent programs on health and nutrition priorities ignores the time frame and demand creation imperatives involved. Libraries

primarily serve the already motivated. For the unmotivated, the underserved, they represent a social marketing problem of their own: how to get more people (even among the literate) to use the facilities. Given even that possibility, what assurance have we that the program messages will be delivered? The library is a center whose intrinsic feature is the freedom of the individual to select material. What we look for in nutrition education are media for "directed education", for guaranteed delivery of much-needed instruction. The same problem is implicit when

> "Some cultural activities are used as communication media. These include songs, ngonjera (a form of drama) and ngoma (music and dance) ... any of them can be used by any combination of members of the community as and when the inspiration takes them." (Ibid, p. 54)

But the problem is not how to employ the inspiration of "members of the community" but to inspire them in behalf of program objectives.

> "At least one cinema van is available in Iringa Region for adult eductation activities ... (but) ... the coverage that one cinema van can achieve is limited and the maintenance problems involved should not be underestimated." (Ibid, p. 54)

A very realistic appraisal of a medium with restricted reach. Other "media" possibilities are identified within the government.

> "The institutional structures of the Party and the Government in Tanzania are two important communications channels ... they maintain a three-way communication channel: top-down, bottom-up and horizontal ... Regular village meetings are one of the most popular forums for exchanging information and participation in development in Tanzania as a whole and Iringa is no exception ... seminars on specific subjects ...

> discussions about agriculture, health, community development and education." (Ibid, p. 54)

Finally, the report gets to the mass media.

> "Idhaa ya Taifa (National Programme) the national mass education radio channel broadcasts every day between ... 6 a.m. and midnight ... Both the educational channels and commercial services include programmes with specific regional focus ... the exact number of radio receivers ... is not known ... nor is the number of regular listeners." (Ibid, p. 54)

But such information is important and is possible to develop as the discipline of the social marketing approach insists. The fact that radio can be helpful to the program is implicit in the caution that

> "An important point to bear in mind when considering the use of radio as a communications channel of the nutrition Programme is in Tanzania it has been found that radio programmes followed up with discussion groups are far more effective than broadcasts alone." (Ibid, p. 54)

There is much more to know about the use of radio that no communications/educational plan should proceed without.

This, in summary, is the extent of the discussion of "communications channels". Missing are suggestions for explorations of further possibilities inherent in disciplined (rather than sentimental) media materials design. The gap is particularly noticeable when we consider the four Programme Impact Objectives:

"1. Reduction of infant and young child mortality and morbidity.

2. Better child growth and development.

3. Improvement of maternal nutrition.

4. Improvement of the capabilities at all levels of a society to assess and to analyse nutrition problems and to design appropriate actions." (Ibid. p. 56)

These objectives give clear indications of the need for a demand strategy to effectuate the behavior changes required to realize objectives 1-3 and the need for a social marketing approach to community participation in the formative evaluation process of program development in objective 4.

When it proceeds to detail its excellent Plans of Action, the report is very clear about what the program intends to accomplish and the strategies to be employed. The need for a social marketing approach is implicit in virtually every project.

Project 1 - Health Sector Support - declares that

"The health status of an individual is a result of many underlying factors: environmental sanitation, water utilization, health services and education are some of the important ones ... This project aims at improving the health services of the people especially mothers and children ... the coverage ... in Iringa ... is ... better than ... 70% ... The utilization ... is, however, much smaller ... Because the population not covered ... is ... in ... smaller villages ... emphasis has been given to improve ... MCH services ... and expand ... the new Village Health Worker's Programme ..."

Sub-Project 1.2 Expansion and Improvement of MCH Services:

> "The goals for MCH services were to reach 90% of eligible women and to immunize 90% of the people in the vulnerable age group."

How will this be possible without the kind of preparatory community-involved formative evaluation and a demand strategy for message and media executions?

Sub-Project 1.3 Expanded Programme on Immunization makes the need even more explicit.

> "The main problem is that the services are provided only for the parents who come to the health institution with their children ... In order to achieve universal coverage of immunization ... a mobile unit will be established initially by the programme."

Iringa Region covers a total area of 57,000 km^2 with a population of 925,000. The program covers 279.500 of this population (seven divisions of the five districts of the Iringa Region which includes 42,300 under-fives.) (Ibid, p. 61) The task assigned to the mobile van is formidable and in no way can substitute for a strategy designed to motivate parents to bring their children to the MCH centers. The mobile van ("the maintenance problems involved should not be underestimated" to quote the report, earlier) is merely another (portable) expression of a supply strategy that cannot be a sufficient response to the greater need of a social marketing effort to promote immunization from its main supply sources, the MCHs. Even the mobile van will find

itself underutilized by many of those it seeks to serve if they are not motivated to accept it. Many may choose to ignore the mobile van for the same reasons that impel them to stay away from the MCH center. What are those reasons and how can they be dealt with in effectively designed and delivered messages? Social marketing approach is needed to provide the answers and the actions.

Sub-Project 1.4 Diarrheal Disease Control:

> "In Tanzania the strategy has been to teach the health worker to teach the mother how to prepare an OR solution. It has however become increasingly clear that most often the necessary ingredients are lacking in the homes of the mothers ... Oral rehydration salts (packets) will be provided through the Essential Drug Supply Programme."

But health workers should be supported by a public motivational (demand creation) program about ORT so that their direct efforts are aided by the "pre-selling" of ORT in advance. Moreover, as we have elaborated before, the availability of the ORS packets in the EDSP will not insure demand any more than the availability of immunization facilities assures utilization.

Sub-Project 1.5 Village Health Worker's Programme is intended to improve on the unsuccessful effort with Village Health Posts in the past:

> "The main reason for this failure was that young people were selected for the jobs but after some training left for other jobs partly because of lack of remuneration. A new strategy has now been worked out in which two permanent residents, one

> male and one female, of the village will be selected as VHWs ... The training will take place in three steps. Regional trainers ... trained in a National Training Center. District trainers ... by the Regional Trainers ... VHWs in the district."

Should the process perhaps be reversed? Should the local people selected as VHW candidates first meet with Regional trainers for insights into local attitudes on critical health matters? Then should Regional trainers provide the same input to the people at the National Training Center - all this, before the actual training curriculum is carved in stone? This could possibly insure greater "bottom-up" input by reflecting the realities of village life while also instilling in the VHWs a sense of participation in the training process. In effect, this is a formative evaluation (social marketing) approach to development training communications. Should we not strive for community participation in all the aspects of communications whether for the "outside job" of communicating with the public or the "inside job" of training health workers?

Sub-Project-1.6 Malaria Control seeks

> "Reduction of specific mortality by teaching those who have malaria to treat themselves ... (also since) ... at risk groups ... pregnant and lactating mothers, and infants and children are given antimalarials prophylactically ... the effort needs to be coupled with education of consumers since drug compliance is behavioural."

Project 2 Environmental Health Hazard Control

> "will concentrate on the rural sanitation aspect of environmental health hazard control in particular the construction of latrines and health education."

How does one get people to construct latrines except to cultivate demand, thus supporting the direct efforts of the health workers in "selling" the concept, distributing the proper supplies and providing instruction. The latrine is, in fact, a key element of Sub Project 2.1 Rural Sanitation whose specific aims are

> "to promote the construction and use of improved pit latrines and to intensify health education in the area."

The determination of Project 3 Education and Training in the Assessment, Analysis and Design of Nutrition Interventions is

> "... to spread education to the masses and (to capitalize on) the very positive attitude to education and training that most people in Tanzania have ... In order to 're-think' development work in terms of nutrition impact there is a need for training and re-training at all levels ... the programme of training will also provide good opportunities for projects communication ..."

All of Project 4 Child Care and Development is even more insistent on these inputs as would be expected by all who are familiar with the heavy behavioral demands it represents.

Additional comment on the other projects (there are 11 in all, not counting the sub-projects) would merely repeat the social marketing litany. But Project 8 Programme Support Communications

deserves special mention. Its thrust comes as close to social marketing thinking as possible without deliberately describing social marketing, itself.

> "... it is now increasingly recognized that these (village) people have a wealth of knowledge about their own environment and that it should be not only respected but also tapped as a resource for the formulation of effective development strategies ... many projects have been designed with communications only as a cosmetic extra rather than as an essential and dynamic lubricant to the whole machinery of the prouject. At the same time more attention has often been given to the hardware rather than the software aspects of communication - often with the result that the use of sophisticated technology and machinery is imposed on the 'target group' and the message is conceived according to the values, concepts and language of the communicator. This renders both the message and the medium irrelevant and inappropriate."

Yet its own Programme Support Communications, "three sub-projects" are planned:

> Project News ... a constant flow of information will ... be transmitted through existing communication channels both at regional and national levels with cooperation, material inputs and contributions from the organizations concerned ... one new communication ... will be ... a quarterly newsletter for Party functionaries and extension workers at all levels ... the initial communications efforts will be focussed on ... providing news and information about the Programme.
>
> Project Information Exchange ... based on the rationale that nutrition problems are related to the functions of society as a whole and that their solution lies in sustained nutrition-oriented action at all appropriate levels ... in order to participate, the people require information as well as the means to produce and exchange information ... articles in Nipe Habari (the newsletter) ... the back page of Nuru Yetu (the newspaper) ... and Lishe (the quarterly journal of the Tanzania Food and Nutritional Centre) ... Ukombozi (the Regional

> magazine) ... All materials ... will be distributed (through) libraries. However it is said that the libraries are under-utilized ... (underlining ours)
>
> Production of Films ... to support the implementation of the Programme ... to inform concerned parties inside and outside Tanzania about the progress and impact of the Programme."

What we have here is seemingly a communications focus on administrative and operational target audiences. Its relevance to the problems and objectives analyzed in the project descriptions is unclear. Motivation, education and demand creation will apparently be left almost entirely to the Village Health Workers. Also unclear is the nature of the materials they will employ in conveying their messages to the public and, in fact, what the content of those messages will be.

If "message and medium" are not to be "inappropriate and irrelevant", to quote the report, then the strategies to guide their use must be fastidiously formulated. Then, the execution of those strategies must be rooted in community input (formative evaluation) to maximize their potential for motivating audiences to adopt - to demand - the available health services, the assistance and guidance of VHWs, and the new behaviors conceived and proved acceptable to these audiences in the "feed-forward" obtained in advance of program implementation.

In short: a typical opportunity for the employment of the social marketing approach.

TURKEY: A PROPOSED DEMONSTRATION FOR SOCIAL MARKETING

The situation in Turkey is not qualitatively different from either Indonesia or Tanzania. The health care system of Turkey, though conceived on a sound theoretical basis, has a long way to go to fulfill its design. The number of health centers and health houses is inadequate; an estimated 40% of the midwife positions remain unfilled at any one time (which means that a far larger number may be vacant for some portion of the year); equipment is short (scales, immunization facilities, etc.) and personnel is inadequately trained to deal with the priority problems of a CSDR program.

Under such circumstances, other means to supplement the services of the health care system are needed especially in connection with education of the public and training of health system personnel. A social marketing approach could help immeasurably in adding extra dimensions to the traditional (and limited) means employed. Moreover, social marketing could also assist where actual CSDR products are involved (i.e. ORS packets, contraceptives) in enlisting the private sector to complement the government distribution system.

In effect, the social marketing component can: (1) create greater awareness of the causes of infant disease and death; (2) educate target populations on how to deal with these; (3) promote existing MOH facilities and services and motivate

wider use of them; (4) motivate health system personnel; (5) develop opportunities with the private sector to broaden distribution of CSDR products.

All in all, a comparable situation to those we have examined thus far and to those that exist in most of the countries UNICEF deals with. After all, the comparability of problems is precisely the underlying premise for the universal applicability of CSDR.

1. The IMR was reported in 1973 to have ranged between 150-155. It is estimated to have fallen to 120 today, still extremely high.

2. The IMR in rural areas is higher than for peri-urban or urban areas. The rural late-neonatal IMR is almost double that of semiurban areas.

3. Infant deaths in first four weeks of life amount to over 30% of the total; in the first 11 months, 69.7% of the total.

4. The greater the distance from the health center, the higher the IMR.

5. Pneumonia accounts for more than 43%, gastro-enteritis for more than 16% of all infant deaths. Or, together, they account for almost 60% of all the infant deaths. Prematurity accounts for

almost 10%; other infectious diseases, 7%; immunizeable diseases, accidents and all other causes about 24%.

6. The main social causes for death and infectious diseases are universally reported to be ignorance, indifference or lack of motivation of parents. Other causes: delay in seeking help, transport problems, disbelief.

7. Preventability estimates are more than 80% for pneumonia; 84% for gastroenteritis; 40% for other infectious diseases - or almost 50% of all infant deaths. The derivation of these estimates are not described except that they are based on multifactoral influences - nutrition, breast-feeding, ORT, etc.

8. 91% of all deaths of infants 0 to 4 years of age occur in the first year; 63%, in the first six months of life. Some of the numbers conflict on this issue from report to report but there's no doubt that there is universal agreement on the severity of the condition.

What all of this boils down to is a classic situation for CSDR intervention. Malnutrition is rife largely because of poor feeding practices from the earliest weeks of an infant's life. Breast-feeding, though universally practiced, is handicapped by

premature supplementation during the first 0-4 months of life and inadequate supplementation after. Diarrhea is epidemic. Family planning (birth spacing) is sparsely practiced. Monitoring of growth is the exception. Even in a major city like Ankara, almost one out of four children is not immunized and even more fail to complete the cycle. And, consequently, pneumonia and other infectious diseases are rampant.

The Messages of the Program

On the assumption that the foregoing problems will be identified by the government for attack through CSDR "packages", there are at least 12 distinct social marketing messages that need to be developed:

1. Maternal nutrition

   (a) the feeding of the pregnant woman

   (b) the feeding of the lactating woman

2. Infant feeding

   (a) how to feed the infant 0 to 4/6 months - exclusive breast-feeding

   (b) how to feed the infant 5 to 9 months - an enriched supplemental food

   (c) how to feed the infant after 9 months - the introduction of grown-up foods

3. Diarrhea

   (a) ORS - motivating use of the packet in areas of free and/or commercial distribution

   (b) ORS - educating the home preparation method in all areas

   (c) proper feeding during diarrhea - soft foods and continuation of breast-feeding

4. Growth monitoring

   (a) monthly weighing

   (b) awareness of value of growth chart

5. Immunization

   (a) promoting its adoption and availability from health center, other sources

6. Pneumonia

   (a) arousing concern and educating as to symptoms and action to take

7. Family planning

   (a) promoting contraceptive use and sources of free and/or commercial supply

These would be individual messages developed specifically for identified target audiences and in accordance with social marketing disciplines that put emphasis on perceptions and inputs of the target audience rather than on the beliefs and opinions of the medical establishment. Content of these messages (a combination of instruction from health authorities and inputs from the target audience) are meant to be the basis as well for messages and materials for all other networks - the school system, all government agencies - in order to maximize message harmony.

All messages would have certain motivational mandatories: (1) go to the health center; (2) consult the midwife (and other health personnel as designated); (3) consult the doctor. The purpose of these mandatories is to familiarize the public with these officials and at the same time reinforce their authority (and morale). Other mandatories may become clear during the course of the message development process.

Delivering the Messages

CSDR calls for a combination of all current health system educational (face-to-face) methodologies as well as use of the mass media - particularly radio and television - and to approach this task on a social marketing basis - to use the mass media reach-and-frequency (short message) technique.

The mass media situation in Turkey, though restricted, is effective and affords deep penetration of the population to almost all areas of the country. TV penetration, according to TRT, is 7.5 million sets - virtually 100% of the population considering an average family size of 7 or 8. Official figures in the private sector give a somewhat lower estimate of close to 6 million sets of which something over 4 million are licensed. These latter figures give an effective penetration of 67% nationally, 83% urban and 53% rural.

There is only one television channel and it is operated by the government. Regular viewing on television is said to be 68% of those with sets; on radio, 81%. Both television and radio audiences are equally divided among men and women.

Radio set ownership is uniformly estimated to be over 7 million sets with an effective penetration of 87% nationally, 92% in urban areas and 70% in rural. There are 11 radio stations offering combined national and regional services. There are 3 national radio services, only one of which is used for commercial purposes. Information is available on viewing and listening habits: frequency of listening and viewing; most recent listenership; channels listened to on radio; listenership by day of week; location of listening to radio and TV (at home or elsewhere); audiences by quarter hour each day; favorite television programs, etc. This will prove extremely helpful in more sharply targeting messages to audiences. In

effect, we have an unusual opportunity for major penetration campaigns through radio and TV.

There are 356 cinemas in Turkey, 310 of which are in the three largest cities. There are 11 dailies of any importance with an average circulation of 2,200,000 daily and 21 magazines with a monthly circulation of 1,285,000. Use of these media will be limited.

Obviously, because of the lack of regional TV originations, certain CSDR messages will not be possible by television - ORT packet promotion, immunization (because of cold-chain limitations) growth monitoring (because of personnel and equipment shortages), etc. However, breast-feeding promotion, home preparation of ORS, proper feeding of mothers and infants at various age breaks, child spacing, etc., can be handled on a national basis.

If limited areas were to be selected as "demonstration" sites where necessary infrastructures will be established, regional radio could be the primary medium to support those programs. Appropriate telecast and broadcast schedules could be set up so as to "flight" messages at appropriate times, i.e. saturation for ORT promotion during the summer months, "pulsing" immunization messages by monthly cycles to coincide with the bi-monthly pattern of immunization administration, etc.

All schedules could be calculated on the basis of potential audience accumulation so as to make the CSDR program a major presence in these media.

Intersectoral Coordination

This would require a major effort on the part of program planners. For example, though breast-milk substitutes are not in major distribution in Turkey, it took one visit with the private sector in Istanbul to uncover the fact that government regulations had been relaxed six months ago on that score. Nestle is starting distribution with its usual promotional onslaught, even if confined to missionary work with the medical establishment. Others also are coming in.

Media: Cooperation has already been solicited and appears to be promising. In meetings with TRT officials like Professor Toksay and Leyla Elbruz (State Planning Organization and member of the High Council of TRT) and Selim Egeli (special media adviser to the Prime Minister), outright commitments of support were forthcoming.

Other cooperation would be available. Banks have been restricted in their advertising and may now sponsor public service announcements and receive an on-air credit. The Health Ministry has an allocation of time on a yearly basis from TRT to be used on any two days of the week on both radio

and television. A comment by Dr. Toksay, head ot TRT: "But messages are most important. Health Ministry programs are run like school lessons and people don't listen."

Advertising agencies have indicated their availability to work with the social marketing program. The premise would be to obtain as much time free on television and radio as possible, if not all, and simply to pay a basic minimum fee for the services of agencies in the preparation of material and the monitoring of broadcast and telecast schedules.

Training: So that all organizations involved in the CSDR are well coordinated, "an inside" communications job would be necessary to harmonize inter-agency understanding and performance. Various ministries, especially the Ministry of the Interior with its direct responsibility for provincial government, as well as key elements of the private sector - pharmacies and food stores, for example - and the NGOs would need to be reached and given orientation on the program. The aim is to minimize message dissonance in the course of their service to the public.

Thus, an audio-video presentation would be advisable for upper level government officials and provincial administrations on the entire program with explicit reference to the health problems, the messages, the full range of MOH interventions. This should in turn be converted to slide or video presentations

for: (1) lower administrative levels; (2) for health care personnel. In addition, appropriate materials for schools; and posters and information give-aways for pharmacies should be developed.

The Social Marketing Plan for CSDR

Once the government has selected its "demonstration" areas and identified the objectives applicable to each area, the development of the social marketing plan can be speedily undertaken. Certain basic assumptions underlie the Work Plan:

1. Inter-ministerial coordination is an absolute pre-requisite to the successful implementation of the program. In this regard the Coordinator of the MOH would be responsible for effectuating the desired support and necessary approvals from the inter-ministerial committee.

2. The Work Plan envisions constant, close cooperation with the various NGOs conducting programs in the relevant areas:

   (a) To learn from their experience, to profit from their lessons learned, and to utilize this knowledge in the strategy formulation phase of this project.

(b) To enhance the effectiveness of their activities by offering assistance in the areas of staff training, program management and organization.

(c) To ensure a single-mindedness of purpose between their programs and the UNICEF effort, to avoid the problems of message dissonance among the target audiences.

3. An effort would be made to secure the support of the medical profession, who may be expected to take an antagonistic view of the UNICEF program(s). Where a medical infrastructure currently exists, the objective must be to gain acceptance of the Social Marketing component; where the medical infrastructure is presently inadequate, the task will be to convince the medical profession of the indispensability of Social Marketing as a necessary complement to the existing delivery system. These tasks will be accomplished through orientation meetings or seminars, and by a constant stream of communications to the medical profession informing them of current and planned activities, achievements and lessons learned.

4. The formative and evaluative research studies proposed as integral parts of the Work Plan are all relatively inexpensive, action-oriented

projects.

No large-scale quantitative studies of the KAP-type would be contemplated; however, these can be integrated into the final Work Plan if required by the Government of Turkey or any donor agency that may become involved in the project.

5. Most of the activities would be carried out by local public and private sector organizations. UNICEF's principal function vis-a-vis these organizations would be in the area of transferring appropriate technologies, (training management and staff in the disciplines required for effective social marketing efforts) and in setting up and monitoring high standards of quality, performance and cost-efficiency.

6. The entire range of activities - from the formative research through the periodic evaluation studies - is based on close involvement with the various target audience groups. Social Marketing dictates soliciting insights and responding to the needs and aspirations of the community as these are reflected by its members and not necessarily as they are perceived by institutions or authorities.

Proposed Work Plan

The sequential steps for the social marketing communications programs can be grouped under three broad headings:

I. Strategy development

II. Strategy implementation

III. Strategy assessment

I. Strategy Development

1. Identification of Objectives and Definition of Strategy Components.

Purpose:

(a) To develop specific objectives of what the communications program is intended to accomplish.

(b) To identify and describe the primary, secondary and tertiary target audiences and their respective sub-segments.

(c) To uncover the "resistance points" that appear to militate against the adoption of the desired behavior.

(d) To identify positive facilitators that would enhance credibility and foster adoption of the desired behavior (for example, authority figures).

(e) To determine media exposure habits of the target groups.

Resources:

(a) Review of existing studies and consultation with appropriate authorities.

(b) Thorough review of ongoing programs being conducted by the government and NGOs for the purpose of determining the strengths and weaknesses of these programs, and identifying the various target audiences and their sub-segments.

(c) Formative research consisting of focus group interviews among samples of the target audience(s), or other forms of qualitative, small-sample research. The research would be carried out by local research organizations, especially trained in non-directive research techniques.

2. Strategy Formulation

Purpose:

To develop specific strategies for each component of the communications campaign:

- Target Groups
- Messages
- Media
- Research (method of tracking progress of program)

Resources:

Written strategy statements will be formulated and reviewed with appropriate officials for their approval. Only when the strategic issues have been completely resolved and accepted by all parties concerned, will the production of materials begin.

II. Strategy Implementation

1. Production of draft materials

Purpose:

Prepare prototype messages for each target audience, for each medium.

Resources:

Local advertising agencies, working under the direction of UNICEF staff and consultants.

2. Pre-testing of draft materials, concepts and messages

Purpose:

To ensure that materials are comprehended, are culturally relevant, practical, capable of motivating the recipient, emotionally appealing, memorable and free of negatives.

Resources:

Focus group or individual in-depth interviews among samples of the target audience. Presentation to appropriate governmental authorities to ensure acceptability.

3. Preparation of Media Plan

Purposes:

(a) To coordinate the scheduling of the various formal and informal media activities, establishing the necessary media objectives for target audience reach and frequency, flight duration and

scheduling, coverage areas, etc.

(b) In the case of radio and TV, to establish which programs require national or regional scope, and to develop plans for both situations.

Resources:

Local advertising agencies, working under the direction of UNICEF staff and consultants.

4. Preparation of Promotion/Publicity Plan

Purpose:

To enhance the effectiveness of the mass media communications program at the local community level by marshalling all available resources, including the participation of public sector officials.

Resources:

Local advertising agencies and appropriate government officials.

5. Preparation of a Product Marketing Plan

Note: This step applies to any intervention program involving the social marketing of a product (such as ORS packets or non-clinical contraceptives).

Purpose:

To develop specific strategies for product packaging, pricing, distribution channels, promotion, and other marketing activities.

Resources:

Local private sector firms and their advertising agencies, working under the direction of UNICEF staff and consultants.

6. Program Inauguration

(a) Finalize social marketing plan for each intervention program

(b) Produce final materials and arrange for sales and distribution of necessary product intervention (i.e. ORS)

(c) Execute media plan

(d) Train field personnel and private sector sales organization (sales meetings)

(e) Develop presentation materials to explain programs to government authorities, NGOs and community-based groups whose support

and supplementary activities will be sought to strengthen the impact of the campaign (women's groups, religious organizations, etc.)

III. Strategy Assessment

1. Periodic Evalulation

Purpose:

To determine strengths and weaknesses of each component in the programs so that necessary changes can be effected while the program is still in progress.

Resources:

A series of monitoring research studies will be designed to provide program managers with the necessary feed-back mechanism. The research will be carried out by indigenous, private sector research organizations working under proper direction.

If a product is involved as part of the intervention program, the periodic evaluation would consist of sales audits at the wholesaler and retailer levels.

File RT 25/10

In 1977 an Indonesian Nutrition Education pilot project was initiated which incorporated social marketing. In a report describing the project, entitled "Nutrition Education and Behavior Change Component; Indonesian Nutrition Improvement Program", the claim was made that "the results of the project are positive, reinforcing the approach used here." (p.3) But while the pilot project has been judged a success, the implication that social marketing can be credited is open to contention. Social marketing was only one of four stages, encompassing kader training, a weighing program, and subsequent evaluation.

The discussion which follows examines two issues emanating from the reputed credit due social marketing.

I) It is beyond dispute that there is a plethora of ill-conceived health education messages which indicate the need for more culturally sensitive message design. But is the social marketing technique necessarily the only and/or best approach to redress these flaws in health education?

II) Programmes that have been evaluated favorably have been used as evidence in support of social marketing. But how much of the credit should be accorded this approach?

I. Borrowed from commercial advertising, social marketing seeks to deliver a persuasive message made compelling because it is based on market research into audience attitudes. The actual message development is preceded by extensive research conducted during what is called the concept testing phase followed by a pretesting phase. The report identifies the following steps as indispensible to the research phase before the message can be developed and pretested.

Concept Testing Phase

1) Selection of topics for investigation based on amenability to health education
2) Selection of sample
3) Self survey (weighing and charting) by sample communities
4) Community meeting to introduce investigation and provide forum for mothers
5) Question guide devised by staff for subsequent interviews
6) Training of investigative team
7) Selection of families for interview
8) Behavior trial stage; interview, observation, and preparation and use of weaning food
9) Investigators returned to homes, more product development
10) Information from households analyzed and behavioral objectives created

As will become apparent, although internally logical, the concept testing phase is inordinately involved and may not be justifiable on several grounds. The argument favoring this market research process maintains that there is a high yield in benefits that is unique to this approach. Yet an examination of the purported "insights" gleaned

from this stage shows that other means could have been employed that are preferable to the social marketing scheme.

Among the information uncovered was the practice of favoring one breast to the exclusion of the other during feeding. This knowledge lead to the development of a message emphasizing the use of both breasts. But while implied to be attributable to the concept testing phase, the hypothesis for the practice was noted to have "slipped our during a focus group interview with some Javanese health workers." (p.12) This aside is notable for it underscores a potentially relevant but overlooked method of gaining knowledge of the cultural attitudes and practices that social marketing underrates, group participation and use of existent health workers.

Derived from the advertising practices in a commercial market characterized by individual consumerism, the concept testing phase fails to adequately utilize the community meeting as much else than a chance to acquaint villagers with the upcoming investigation and gain endorsement from village leaders. Why not instead use this community forum to uncover local practices thereby eliminating a considerable number of steps (training investigative team, and conducting one-on-one interviews) and encouraging community participation at the group level?

But this community emphasis is at odds with the tendency of social marketing to mimic commercial advertising by focusing on individuals in spite of its claims to be participation oriented. Social marketing favors individual as opposed to community participation, subverting the total programme in this direction. While not specifically addressing social marketing, the "Synopsis of a Research/Training Project on Mobilization of Human Resources" recognizes this issue in its warning that "an approach based on the extreme individualism of Western society has frequently alienating effects on traditional societies with strong communal values. Attempts to change the behavior of individuals for the purpose of social transformation seem mistaken in communities which traditionally solve social problems through a process of consensus making."(1.4)

Another revelation attributed to the extensive investigative process was the discovery that households did not have the teaspoons that had been referred to in national ORT messages. It is truly amazing that with all of the international discussion of tailoring ORT to local needs it would take such a sophisticated interview process to recognize this oversight. This raises the question of who is involved in message development. The kaders, if they are carefully selected, should be cognizant of such local realities even if the "deskbound bureaucrats" (p.1) are not. It was unclear as to why the kaders were not considered to be adequate informants as to the typical behavior of their communities. Even regional cooking styles were cited as discoveries in the concept testing phase, affecting weaning food preparation messages. But again it is hard to believe that the kaders themselves or individuals in a group setting couldn't have revealed this information. One would have to scrutinize a project that needed such elaborate means to uncover these basic cultural norms.

Although certainly advo i the development of cultura ' ısitive messages, it seems that it should be possible to circumvent some of the steps recommended here without loss of quality by using the kaders as a resource in combination with village meetings. Using the kaders as information sources and tapping the community communally would improve on the concept testing phase by;

1) cutting the time and cost of the concept testing phase as described in the 10 steps (and allowing the pretest to elicit inconsistencies as it was designed to do)
2) redirecting the strategy to be better oriented to community participation by de-emphasizing individual interviews
3) Taking advantage of the knowledgeability of the kaders.

II. The social marketing technique which produced and delivered the nutrition messages claims itself to have been responsible for the successes of the pilot project. Yet a number of points are alluded to in the report which indicate that this claim is exaggerated.

Even assuming that the radio programmes were soundly conceived it is mentioned that "even on the government owned radio stations, air time was minimal, and the spots did not receive the desired amount of exposure." Moreover, "the radio in this case was principally a reinforcement for the interpersonal communication, which occured when the kaders distributed the poster, visited homes, or weighed the children." (p.20) This admission raises a crucial point which tends to discount the importance of the social marketing component. It is implied that it was not the content of the messages per se, which received minimal exposure time anyway, but the encouragement to the audience to seek advice from the kaders. The actual learning took place through interpersonal communication encounters with the kaders. Thus the relevance of social marketing was not so much with the content of the messages, for which so much time was alloted during concept testing, but with the ability of the material, posters and radio messages, to stimulate face to face oral interactions with the kaders.

Hence when the evaluation* of the project reveals findings indicating that "the Nutrition Education program participants followed the advice offered in the messages to a much greater degree than the non-participants" it is open to question as to whether the advice was absorbed from the message itself as offered on the radio or in posters or from oral contact with the kader, a factor not entirely attributable to social marketing. Not enough background information is available from this project report about the comparison group. The presence of various nutrition education messages in the comparison group is alluded to but not elaborated on, implying it was superiority of the message design resulting from social marketing that accounted for the impact. However, it is equally possible to conjecture that the critical factor of success had to do with the level and quality of activity of the kaders rather than the specific nature of the messages. If this is the case then the training and utilization of kader

both falling somewhat o[illegible] of the purview of social [illegible]ng may be more responible for the project's impact. Support to the kaders who "were encouraged to make as many home visits as possible" (p.20) may have been the ingredient to programme success rather than the strict adherence to the principles of social marketing.

The decision to use and train kaders was made apart from social marketing and accomplished during stage one so it is questionable to assign social marketing such a large share of the credit. If , as it appears, the oral eyeball to eyeball kader contact was the critical success dimension then training of kaders should get the acclaim and the social marketing scheme lauded only insofar as it trained and encouraged kaders.

Overall the social marketing scheme is to be commended for its encouragement of home visits by kaders, willingness to link ORT with nutrition, acknowledgement but less than perfect involvement of the community and its sincere attention to the development of relevant messages. However, the costly and time consuming social marketing technique of concept testing could be improved upon in the ways already suggested. The research methods of social marketing fail to foster true community participation through action research but instead owing to its origins focuses on individuals in market analysis to the detriment of the rest of the project (i.e. not involving kaders earlier). The lengthy hiatus before pretesting is unjustified and reflects faulty reasoning on how to gather culturally useful data. The research money from the concept testing phase could be better spent on kader training since they are the backbone of the project. And finally, social marketing is not the panacea it is claiming to be. Much of the project's credit should go to the kaders who conveyed messages through personal encounters. Social marketing played a supportive but by no means a starring role, and should be viewed as a component of the programme, not <u>the</u> programme.

* assessment of the evaluation technique would entail analysis beyond the scope of this paper

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