Dedicated to my late Grandfather

Shri K.N Dass.

SOCIAL MARKETING FOR HIV/AIDS PREVENTION IN INDIA : AN EXPLORATORY STUDY

Thesis submitted to Jawaharlal Nehru University in fulfilment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY
(Social Sciences in Health)

MAHUA DAS

CENTRE FOR SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067
INDIA

2006

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
New Delhi - 110 067

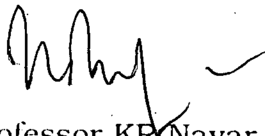
July 27, 2006

CERTIFICATE

This dissertation entitled "Social Marketing for HIV/AIDS Prevention in India:An exploratory Study" is submitted by **Mahua Das** in partial fulfillment of the requirement for the award of the degree of **Master of Philosophy** (Social Sciences in Health) of this university. This work is original and has not been submitted so far, in part or full, for any degree or diploma of this University or any other university.

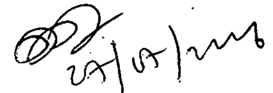
Mahua Das

We recommend that this dissertation be placed before the examiners for evaluation.



Professor KR Nayar
Chairperson and Supervisor

Chairperson
Centre of Social Medicine &
Community Health, SSS
Jawaharlal Nehru University
New Delhi-110067



Dr.Rajib Dasgupta.
Supervisor.

DR RAJIB DASGUPTA
Asstt Professor
CSMCH / SSS
Jawaharlal Nehru University
New Delhi-110067

Tel.: (011) 26704420, 26717676, 26717557 Gram: JAYENU Fax: 91(011) 26717586, 26704420

Acknowledgement

No words can express the gratitude, I have for my supervisor, Dr.Rajib Dasgupta, (Centre of Social Medicine and Community Health, School Of Social Sciences), for his constant guidance, supervision and constructive criticism throughout the course of the study.

I also extend my gratefulness to Dr. KR Nayar, my supervisor and Chairperson of Centre of Social Medicine and Community Health, School of Social Sciences, for his invaluable suggestions and help in clarifying concepts related to the area under study.

My sincere thanks also goes to all office staff, especially Mr.Dinesh, of Centre of Social Medicine and Community Health, School of Social Sciences, for extending their full support and assistance in finishing my work.

I would also like to thank Mr. Debu Sathpathy of the PSI, New Delhi, staffers of PSI Ranchi, who not only fed in important inputs in terms of necessary documents, but also made suggestions which were of immense use in shaping my ideas related to the issue.

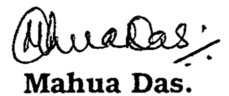
No words are sufficient enough to express my deepest gratitude and indebtedness to my baba (Father) and ma (Mother) without whom I would not have been what I am right now. I also fall short of words in expressing my thankfulness to my grandmamma, my maternal grandma, jethu, jethima, my kaku , kakima and my little cousins Juhi, Mihi, and Abhishek (as stress- busters) for their support and encouragement.

I also extend my heartiest thanks to my friends Doladi, Sanghmitradi, Ranjeetadi, Nandini, Neetudi, Indranidi, Shafkat and Prachin, Dilip, for

standing by my side through thick and thin with positive criticism and constant encouragement.

This acknowledgement is a small expression of my heartfelt gratitude and respect for all those who directly or indirectly helped me accomplish my goal!

And last but not the least, my regards and prostrate pranam to my spiritual guiding light Om Shri Shirdi Sai Baba.



Mahua Das.

27/06/2006.

Abbreviations:

1) ABC: Absistence, Be faithful, Condom use.
2) CSW: Commercial Sex workers.
3) GOI: Government of India
4) HLL: Hindustan Latex Limited.
5) IDU: Intra Venus Drug users.
6) IEC: Information, Education, Communication.
7) IMF: International Monetary Fund.
8) JSACS: Jharkhand AIDS Control Society.
9) KAP: Knowledge, Attitude, Practice.
10) MCH: Mother Child Health.
11) MSM: Men having sex with men
12) NACO: National AIDS Control Programme.
13) NACP: National AIDS Control Programme.
14) NGO: Non Governmental Organization
15) NSS: National Sample Survey
16) PHC: Primary Health Care
17) PSI: Population Services International
18) SACS: State AIDS Control Society.
19) SAP: Structural Adjustment Policy
20) STD: Sexually transmitted Disease.
21) STI: Sexually transmitted Infections.
22) UN: United Nations.
23) VCTC: Voluntary Counselling and testing Centre.
24) VHAI: Voluntary Health Association Of India.

CONTENTS

1. Introduction 1-6

2. Social Marketing: The Theory 7- 41

3. Social Marketing : The Global Experience in HIV/AIDS 42-65

4. Social Marketing Policy Review:India 66-99

5. Analysis and Conclusion 100-122

Bibliography 123-151

Chapter 1

Introduction

Recent literature and debates on the Structural adjustment Policies and related controversies on the introduction of health sector reforms in developing countries, has been a subject of research since many years now. One of the significant impacts of SAP on the health sector was a sharp cut back in the public expenditures during the early nineties. Health services, which are a social asset, are being used as any other economic services.

The beneficiaries of the reform may be about 200 million Indians but the rest over 600 million have to bear the risk born out of these new economic policies. In the present context it is very difficult for the national economies of the developing nations to deny the unequal terms and conditions of power and exploitation which has deep socio-political roots embedded in the structures of our society. It is generally agreed upon that health is a basic need and poor health is not determined by the logics guiding the demand and supply laws of the market. In the field of health planning, the conceptual shift accompanied with its realization, with more and more private players coming into the fray, introduction of the user's fees, cuts introduced in the Public Health, undermining the basic tenets of Primary health care, evokes a lot of concern as part of social responsibility amongst the different sections of the intelligentsia. The crisis has deepened in all ways possible because of the disassociation of notion of health and well being from its socio-economic determinants.(Qadeer,2001)

Rationale of the study

HIV/AIDS affects about 5.1 million individuals in India (NACO, 2006). It is one which ranks very close to Africa, in the global map of the epidemic today. In the absence of a vaccine or a cure, prevention is the most effective strategy for the control of the pandemic: In other words, in this case, the root of transmission has to be attacked by effective ways of interventions, so that that the spread is arrested at its very initial stages. Unsafe sex is the predominant route to its spread, therefore the practice of safe sexual behaviour in various forms, is the key of such a strategy.

With globalization making its inroads in everybody's life, in developing nations like India, the boundaries are getting very nebulous, with structures and values being very fluid, in order to become a part of the global whole. Not only are the institutions changing in terms of policies and reforms, but these changes are reflecting in each one of our lives. Issues like sexuality, sexual preferences, sexual identity and escalating promiscuity, are challenging the existing patterns of social norms and values in the patriarchal set up. The vicious cycle of poverty-malnutrition-unemployment-illiteracy, unhygienic living condition continues to dominate the current socio economic conditions in most of the developing nations including India even today. The interlinkages between poverty and vulnerability are intrinsic. In India the majority of the population still remains unaffected by HIV-AIDS. Therefore it is imperative to continue with intensive communication efforts that will not only raise levels of awareness but also bring out behaviour change in the population.

HIV in India is characterized by a number of concentrated epidemics of varying severity with evidence of diffusion of the virus to low-risk populations. Six states are identified as high prevalence. While others are judged to be medium to low prevalence, many states have districts or locations with substantial high risk groups. While the epidemic appears to have progressed more slowly in India than in parts of Africa, a number of risk factors such as the low level of male circumcision and large-scale intra and inter-state migration imply the necessity of a rapid, targeted, high quality response.

A recent analysis (David Wilson, 2005) of incidence suggests that India's epidemic is driven by groups at highest risk of contracting and spreading the virus, especially providers and clients of commercial sex workers, injecting drug users (IDUs) and men who have sex with men (MSM). In areas where commercial sex, MSM and injecting drug use are evident, where men are uncircumcised and there is a high percentage of people who have multiple, concurrent sexual partners, there exists a confluence of factors which is known to fuel rapid increases in HIV prevalence. If the epidemic can be reversed in

these populations, it will be reversed overall in India. In response, the National AIDS Control Program has confirmed its existing prevention focus on groups at risk and "bridge" populations, those groups whose sexual networks include those at highest risk and others who are not.

At the broader level social marketing comes onto the picture as apart of the package of the health sector reforms and New Public Health management, as a tool of using commercial sales techniques to fulfil social goals. In this case arresting the spread through behaviour change and raised awareness, believing in affordability and accessibility of the product belonging to the "economically active group", who have the ability and the willingness to pay.

Social marketers generally approach behaviours such as high risk sex or injecting drug use with the assumption that people are committed to those behaviours for purposes of economic survival, pleasure, power, prestige, social acceptance or other reasons. They will only give up those behaviours if offered a mix of ideas, products or services that are of greater value to them. It is the social marketer's task then to understand and address effectively the key constraining and supporting forces for adoption of the preferred behaviour.

Social marketing uses educational messaging in much of its work but this differs from purely education-based behaviour change strategies by making essential products and services available, affordable and desirable. It is different from legal-based strategies in that it relies on persuasion and voluntary compliance rather than non-voluntary measures to induce behaviour change..(Chapman, Steven, 2004)

An example would be the training and branding of a voluntary counselling and testing service and the promotion of its use among high risk audiences. Another would be the creation of a drop-in centre for sex workers where they can relax and also receive a regular check-up for STIs. In some countries, marketing approaches have been undertaken successfully to ensure easy, low-cost access by injecting drug users to clean injection equipment.

In India many professionals in the health field associate social marketing only with the subsidized distribution and brand promotion of condoms and oral contraceptives. This is a social marketing approach that is best-known in India. "However, that activity alone is a pale reflection of the full power of the technique in behaviour change for better health. Social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify or abandon behaviour for the benefit of individuals, groups or society as a whole. Social marketers sell behaviour change."(ibid) Social marketers invest in the traditional four P's of marketing--product, place, price and promotion to promote specific safe behaviours among well-identified target audiences. Through their interventions they seek to influence three factors that are known to support changes in behaviour by individuals. These factors are known as an individual's opportunity, ability and motivation (OAM) to behave in the promoted way. In the example from the Avahan program, "Key Clinics" is a network of existing private physicians trained, branded and promoted for their quality STI services. The project is designed to promote these services primarily among clients of sex workers.

Communication through IEC activities has always been a focal area of attention for the policy makers in HIV/AIDS but we see a clear shift of attention from just raising awareness to bringing in behaviour change both in the High risk groups as well as in the "general community", with the emphasis on social marketing expanding in NACP phase III. This study seeks to explore and understand the very concept and theory of social marketing, its application in health as a prevention/intervention strategy, and see the wider implication of its application on the communities paralysed by the new economic reforms.

OBJECTIVES:

1. To review the principle, concepts and the theory of social marketing.
2. To review global application of social marketing in health, with special emphasis on HIV/AIDS.

3. To review and analyse the application of Social marketing at the policy level in Family Planning and HIV/AIDS in India.
4. To critically analyse its application, keeping in mind the larger political economic debates over it.

METHODOLOGY:

As only limited studies have been conducted on this issue, an exploratory research exercise has been undertaken for the study. The methodology comprises primarily of:

- Review of literature and analysis of current concepts, theories and principles.

- Content analyses of government documents and the unpublished reports and articles of the social marketing organizations.

A short exploratory research and rounds of 6 interviews conducted in the Capital of Jharkhand, to see the practical realties vis –a vis as found in the literature review, with the Jharkhand State AIDS Control Society, and its social marketing partner organizations including the Population Services International and Hindustan Latex. Jharkhand was selected as an area of this short exercise as the loop of poverty malnutrition ignorance illiteracy unemployment migration, is omnipresent there. The state got priority as one of the most vulnerable states in the latest NACO survey reports, which made the researcher belonging to the same state, look into the preventive work that is being carried on, in the state.

Sources of Bias:

Sources of bias came in the form of articles and information that were published by Social marketing organizations. These reports spoke highly of the achievements while only those loopholes were talked of that were

marketing /management oriented. The public health perspective was totally ignored.

PROBLEMS FACED:

The researcher faced a lot of problems in citing relevant information and reference material, literature on the issue. There was a dearth of evaluative literature, on terms of socio-economic determinants of behaviour change, and the consistency of such change especially in a particular context like India, to come to a conclusive statement.

LIMITATIONS OF THE STUDY:

Since the study was done primarily on the basis of secondary data, due to lack of adequate primary literature, the need of a close examination of social variables like caste, class, gender and its relationship with the operational social marketing, was realized. This created an urge and a necessity for the researcher to go into the community and evaluate the realty in terms of theory versus practice.

OUTLINE OF THE STUDY:

The study is divided into 6 chapters.
The **first** is the introduction to the study. The **second chapter** discusses the theoretical concepts, theories and principles of social marketing. The **third** contains the review of application of social marketing. **Chapter IV** analyses and discusses the application of social marketing at a policy level in India. The **Vth Chapter** deals with the analysis and the debates over the application of social marketing in Health, in the larger context. It ends with the conclusive remarks on the study undertaken.

Therefore this study on "Social Marketing for HIV/AIDS Prevention in India : An Exploratory Study"

Chapter 2

Social Marketing: The Theory.

Definition:

The term "Social marketing" was coined by Philip Kotler in 1971, a professor of Management at the Northwestern University, and continues as one of the leading proponents and practitioners.

Social marketing was originally defined as "...design, implementation and control of programmes calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communications and marketing research"(Kotler and Zaltman,1971). It has been recognized as an approach which is consumer focused to a question of how to "go to scale" in efforts advance the health status of a population over the past two decades. Synonymous terms might be "social cause marketing", or "public issue marketing". According to Kotler and Zaltman, it is the explicit use of marketing skills to help translate present social action efforts into more effectively designed and communicated programmes that elicit desired audience response. "In other words, marketing techniques are the bridging mechanisms between the simple possession of knowledge and the socially useful implementation of what knowledge allows."(Kotler, Zaltman: 1971).

This term has been used extensively in health literature, where it is looked at, as a powerful tool of segmenting, profiling, and targeting populations: designing, positioning, testing and refining products and services and materializing it into community action and social policy.

History:

The conditions that led to the convergence of the private sector marketing and the public sector grew out of historical trends in the two spheres. In health, the transition from an era of acute infections to an era of chronic disease, heightened awareness of the impact of lifestyle and the environment on the

majority of early, preventable deaths and disabling deaths and injuries. The pendulum in the 1970's and the 80's swung to where there was more and more emphasis given to behaviour changes at the individual level than at the larger level , with new definitions of prevention being acknowledged. In pursuit of this goal, the public health specialists looked to the commercial sector for insights on how gel effective marketing with communication programmes.

The conceptual shift in marketing started much earlier with a much quoted paper in the 1950's by G.D Wiebe posing the provocative question, "why can't brotherhood be sold like soap?" he analyzed four social campaigns and concluded that the society's aspirations can infact be sold through a judicious application of the marketing techniques. This paved the way for a gradual expansion and a further exploration of the marketing domain.(Wiebe: 1952).Marketing can trace its conceptual roots in the "exchange theory", so attention to "quid pro quo what benefit consumers can expect in returns for the cost of they are willing to incur" - is the bedrock for the marketer. The exchange process had a narrow definition: in terms of strict economic exchange of some payment for some tangible products, in the early marketing history. "As American marketing developed increasingly specialized and sophisticated techniques for creating and competing in differentiated mass markets, the marketing functioning industry was broadened from a technical business to product orientation to a much broader social process whose essential task was to identify and meet the psychological and the social needs and wants of the sovereign consumer newly moved to centre stage". These changes in marketing philosophy inspired new ways of conceptualizing the role marketing. (Kotler, Zaltman: 1971).

The assumption behind social marketing was and is that well recognized and demonstrably effective techniques from the commercial business sector can successfully and efficiently be applied to advance social cause. In 1981 Seymour Fine further refined the notions of consumers and producers of intangible products. (S.H Fine, 1981) Three years later the American Marketing Association created a niche for social marketing in the mainstream of marketing

thought by expanding its more than 25 year old of definition of marketing to include the promotion of "ideas".(American Marketing Association, Committee on Terms, Marketing Definitions:1985).

The techniques are in a nutshell, marketing analysis, planning, pricing and control. They include functions like market research, product positioning, conception pricing, physical distribution, advertising and promotion. The social product may be a consumable object (such as a contraceptive) or a practice (a one time act or a more behavioural repertoire), or even an abstract belief, attitude or value.

"Social marketing opened new areas for marketers expertise and intrigued public health advocates, not only did it provide powerful tools, but it had a kind of poetic justice in borrowing from marketers the very discipline that was aggressively promoting such harmful products". (K.F.A Fox and P.Kotler 1980).Early health applications of social marketing emerged as part of the international development effort (under the banner of international communication) and were implemented in the developing countries in the 1960's and the 1970's. Programmes promoting immunization, family planning, various agricultural reforms, nutrition were conducted in numerous countries like Africa, South America, and Asia during the 1970's. These built on some experiences of agricultural development supported by U.S agency for International Development (USAID) as well as on the community –based family planning initiated by the Ford Foundation, Population Council in the late 1960's out of frustration with the slow diffusion of the clinically based family planning services.

Marketing techniques were soon incorporated into International programmes including radio mass media and advertising on a mass scale. For instance Family panning programme designers, began to break out of their clinical mould to experiment to distributing contraceptives via pharmacies and small shops, and ultimately crafted systems of market segmentation, mass communication and product placement to accomplish wider and more efficient

distribution of contraceptives. The first nationwide contraceptive social marketing programme, the Nirodh condom Project in India began in 1967 with the funding from the Ford Foundation. USAID increased its funding of Condom social marketing projects in the 1970's supporting projects in Kenya, Colombia Sri Lanka and Jamaica. In fact, the most important research and development work to understand and the application of social marketing have been in the area of International Family planning field. Some of the programmes used the term social marketing overtly, set out to apply and adapt technology from the business sector while others borrowed a few marketing concepts or approaches without fully embracing the language and the ethos of marketing. To add to it, numerous smoking cessation and prevention programmes over the two decades have experimented with applications of marketing techniques; substance abuse specialists have incorporated elements of Social marketing and public relations more recently in community prevention programmes.

Essential elements of social marketing

Among specialists of social marketing, definitions and disciplinary boundaries seem relatively clear and unambiguous even if the techniques are not always very easy to use in the field. However in the health literature the concept is very elastic and elusive. Often social marketing is used as mass media campaigns or advertising seeking an attitude change, increase in awareness and encourage either the use of certain services or changes in personal or collective behaviour. Social marketers are adamant that their discipline encompasses much more than advertising and mass communication and public affairs although such activities are among its important components.sm had its roots , they say in social advertising and a focus on the messages but has since grown in many directions.

The first expansion called social communication broadened the focus from just the message content to promotion through channels of communication, including personal selling, publicity, and promotional events. With the expansion in social marketing came in market research, attention to

programme development, and the use of incentives and other techniques to facilitate voluntary exchange.(ibid) In some quarters social marketing has been expanded to social mobilization, a term used by UNICEF, to connote a comprehensive planning approach seeing political coalition building and community actions.(J.C Ling etal,1992).

Three broad conceptual principles appear and virtually all descriptions of social marketing and can be irreducible minimum :(ibid)

1. The process is much disciplined with objectives is very clearly stated. A variety of research and management techniques are applied to achieve identified goals, which often than but not include the mass media. A systematic tracking process monitors progress and guides midcourse corrections.

2. "The consumer is heard". Target audiences are segmented along various dimensions. This formative research goes beyond assessing the traditional epidemiological data: it adds measures of value, images, aspirations and concerns of potential clients.

3. Qualitative and quantitative data collection techniques are used to develop an in-depth profile of what reaches and motivates targeted subgroups.

4. The product is responsive, based on "iterative research into consumers' wants and needs". Consumer's responses are solicitated repeatedly for continuous refinement of the fit between product positioning and market reactions.

Beyond these objectives, a well developed series of objectives constitute the disciplined process of Social marketing. Philip Kotler, Richard Manoff, Seymour Fine, William Novelli, Criage Lefebvre, and June Flora have been leaders in codifying these procedures for applications to health.

Theories and models of social marketing

Many different theories (based in economics, marketing and the social and the behavioural sciences) contribute to the conceptual framework of social marketing. Exchange theory from economics addresses the behaviour of the consumers and their decision process in purchasing the product (cost versus benefit of the product). This philosophy guides commercial marketing by helping to describe and predict consumer behaviour. An extension of this concept, the social exchange theory, states that all social activity has rewards and costs associated with it. This concept explains that a social behaviour, such as smoking can be influenced by an individual or a group perception of the rewards and costs of maintaining or changing the behaviour.

In addition social marketing draws on from some theories in public health professionals to design and implement and health promotion programme. For example the social learning theory behaviour as a response to a reinforcement, by another person, especially a peer. These concepts serve as a foundation for social marketing interventions. That can effectively change health behaviour. The various theories used as tandems, form the basis on which social marketing campaigns can be planned and implemented.

Theories of behaviour Change.

The models of behaviour change in public health are usually models based on three theories of Behaviour Change:

The Health Belief Model (Becker: 1974, 1988 Janz and Becker 1984),
The Social Cognitive Learning Theory. (Bandura 1986, 1989)
The Theory of Reasoned Action. (Ajzen and Fishben1980; Fishben 1980; Fishben and Ajzen (1975).

The Health Belief Model was first developed in 1950's to understand low public compliance with screening and other preventive health measures. There are many versions of this model but they all focus on individual perceptions: that is they focus on how individuals perceive their own susceptibility to the illness, the severity to the condition, the potential benefits of responding to recommendations and barriers to health enhancing measures. The models assume that individuals decide how to respond to recommendations made by a health service by reflecting on the costs and benefits of such actions in the context of how threatened they feel.

As formulated by Fishben and Ajzen (1975), the Theory of Reasoned Action has also been used to predict behaviour and it focuses on four different dimensions: affect (attitudes), cognition (belief, opinion), conation (behavioural intentions) and behaviour (observed overt acts).a belief represents the knowledge an individual has about an object, a proposition linking an object to an attribute. An attitude is a general predisposition that is based on beliefs, and that leads to a set of intentions rather than a specific behaviour. Intentions are a special kind of a belief in which the person is the object and the behaviour the attribute. A specific behaviour is "viewed as determined by person's intensions to perform that behaviour. Most social behaviour is assumed to be based on volition and very closely linked to intention to perform that behaviour. The model assumes that the individuals act rationally in evaluating information and are free of outside constraints in taking actions.

The key concepts in Social Learning Theory, as formulated by Bandura are modelling and social reinforcement. Modelling refers to the process of observing and then imitating the behaviour of others as individuals acquire new behaviour by changing their attitudes and beliefs. Social reinforcement implies a distinction between acquiring knowledge about a new behaviour that will only be performed if the environment is favourable. A psychological element that is key to this process is self –efficacy, which involves a perception of ability to perform the behaviour. Such a self appraisal concerns judgments about how well one can execute actions to deal with specific situations.

The theory of culture embedded in theses models treats culture as a set of beliefs ,values and individual goals that pattern behaviour ,a kind of psychological twin to the empiricist sociology of the 1950's.In this view the individuals are constrained by their image of normative action as they seek to conform to the values of the society. Individual attributes and motivations are keys to understanding behaviour. While the role of social and ecological factors is recognized as barriers to health enhancing behaviour, these aspects receive little attention in the explanation of behaviour.

Understanding Social marketing

A social marketing campaign or programme contains the following elements:

- Consumer orientation (Lefebvre and Flora 1988, Lefebvre 1992b, Andresen 1995),
- An exchange (Lefebvre and Flora 1988, Lefebvre 1996, Leathar and Hastings 1987, Smith 1997).
- A long-term planning outlook (Andresen 1995).

Andreasen defines social marketing as a notion of "altruistic marketing". Social marketing is the application of proven concepts and techniques drawn from commercial sector to promote changes in diverse socially important behaviours." Behaviour change is the dependant variable on by four classes of independent variables (1) attractiveness of the behavioural package, (2) Community pressures.

(I) A Consumer Orientation:

The key element of all forms of marketing is consumer orientation, distinguishing it from selling - product - expert-driven approaches (Kotler etal1996). In social marketing, the consumer is assumed to be an active participant in the exchange process. The social marketer seeks to build a relationship with target and consumers over time and their input is sought at

all stages in the development of a programme through formative, process and evaluative research.

(ii) An Exchange:

Social marketing not only shares the basic underlying philosophy of marketing Consumer orientation, but it also its key mechanism, that is exchange (Kotler and Zaltman (1971). While marketing principles can be applied to a new and diverse range of issues- Services, education, high technology, political parties, and social change - each with their own definitions and theories, the basic principle of exchange is at the core of each (Bagozzi 1975). Kotler and Zaltman (1971) argue that: "marketing does not occur unless there are two or more parties, each with something to exchange, and both able to carry out communications and distribution".

Exchange is defined as "an exchange of resources or values between two or more Parties with the expectation of some benefits. The motivation to become involved in an exchange is to satisfy needs". (Houston and Gassenheimer, 1987). Exchange is easily understood as the exchange of goods for money, but can also be conceived in a variety of other ways: Further education in return for fees; a vote in return for lower taxes; or immunization in return for the peace of mind that one's child is protected from rubella. Exchange in social marketing puts a key emphasis on voluntary behaviour. To facilitate voluntary exchanges social marketers have to offer people something that they really want to reduce teenage prevalence of sexually transmitted diseases (STDs) by encouraging Condom use; research with the target finds that they are more concerned with Pregnancy than STDs. The social marketer should consider highlighting the contraceptive benefits of condoms, rather than, or at least as well as, the disease prevention ones. In this way consumer research can identify the benefits which are associated with a particular behaviour change, thereby facilitating the voluntary exchange process.

(iii) Long-term Planning Approach:

Like generic marketing. social marketing should have a long term outlook based on continuing programmes rather than one-off campaigns. It should be strategic rather than tactical. This is why the marketing planning function has been a consistent theme in social marketing definitions, from Kotler in 1971 to Andreasen in 1996, the social marketing planning process is the same as in generic marketing. "It starts and finishes with research, and research is conducted throughout to inform the development of the strategy."(Kotler, 1971) A situational analysis of the internal and external environment and of the consumer is conducted first. This assists in the segmentation of the market and the targeting strategy. Further research is needed to define the problem, to set objectives for the programme and to inform the formulation of the marketing strategy. The elements of the social marketing mix are then developed and pre-tested, before being implemented. Finally, the relative success of the plan is monitored and the outcome evaluated.

(iv) Moving Beyond the Individual Consumer:

Social marketing seeks to influence the behaviour not only of individuals but also of groups, organizations and societies (e.g. Hastings et al 1994c, Lawther & Lowry 1995, Lawther et al 1997, and Murray & Douglas 1988). Levy and Zaltman (1975) suggest a six fold classification of the types of change sought in social marketing, incorporating two dimensions of time (short term and long term) and three dimensions of level in society (micro, group, and macro).

In this way social marketing can influence not just individual consumers, but also the environment in which they operate. Group and macro level change are important because they also impact on health and lifestyle decisions. For example, people's choices about taking up exercise may be limited by their income, local service provision or social mores. Macro-level factors can also have a more direct impact on health: for example, the presence of fluoride in the water (whether natural or artificial) can improve dental health, especially among

Children. This example demonstrates that there are many measures that can be taken to improve people does health without the individual citizen have to do anything at all. Better roads, reduced industrial pollution and improved safety standards on cars are similar example.

The marketing mix – the four Ps

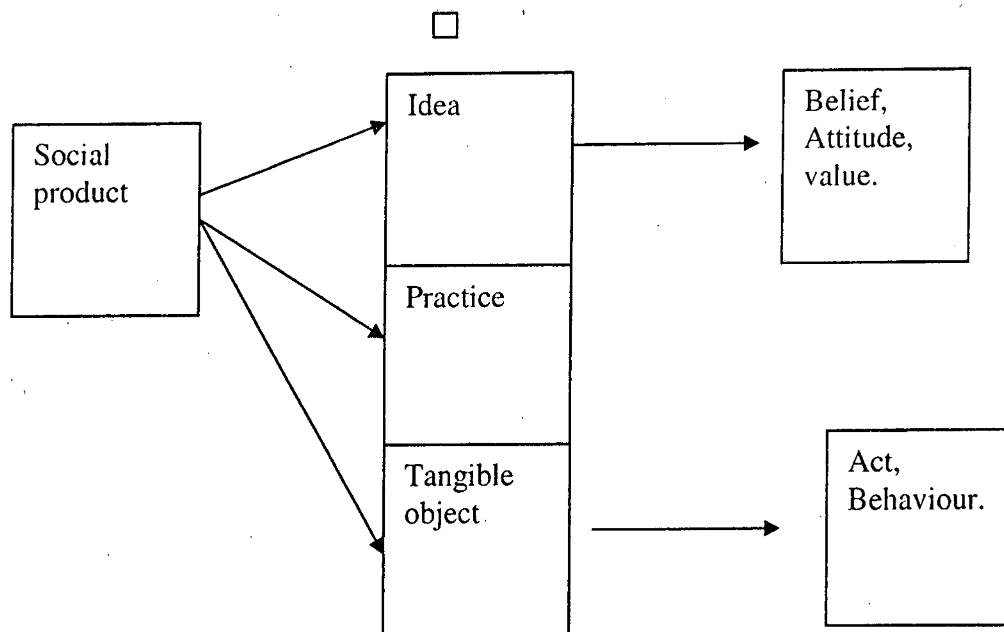
In traditional commercial marketing the 4 P´s (product, price, place and promotion) are called the marketing mix and are the main tools a marketer uses to market their product.

- **Product**

The social marketing product might be very intangible like a belief or behaviour and it is a lot harder to formulate a product concept to such a product than extra soft toilet paper (Bloom and Novelli 1981). People have to feel that they have a problem and that the product offered is a viable solution to that problem (Kline Weinreich 1999). Kotler and Roberto (1989) suggest that that is part of the reason why many social campaigns fail. Because their target group does not perceive a problem, want or need, again stressing the importance of segmentation.

According to Kotler and Roberto (1989) the social product can either represent an idea, a practice or a concrete object. The idea can then be either a belief (breastfeeding is good for my child), an attitude (planned babies are better cared for than babies from accidental pregnancies) or a value (all humans have equal rights). To distinguish these three terms Rockeach suggested that "a person has many beliefs, some attitudes and few values" (Rockeach in Kotler & Roberto1989). The practice can be an act (immunization) and the repeated act turns into behaviour (using a condom). The tangible object could be a condom, soap, oral rehydration formula.

Figure 1
The social product
Adapted from Kotler & Roberto 1989:25



- **Price**

"The real price of everything, what everything really costs to the man who wants to acquire it is the toil and trouble of acquiring it" (Smith, 1776 cited in Kotler & Roberto 1989). Price does not have to be monetary but can also be non-monetary like time, effort, change in life-style. (Kotler & Roberto 1989; Joyce & Morris in Fine 1990; Kleine Weinreich 1999; Kotler et al 2002). Many social programmes such as family planning programmes, health clinics charge a fee (price) for its products and services. Like any other product the price determines who and how many who chooses/have the ability to purchase the product or service. The monetary price serves several functions and Kotler and Roberto (1989) talk about three functions that the social marketer should have in mind when considering the monetary price of their services or products.

1. The accessibility function

The price determines if the product or service will be easy or hard for the people to buy the social product, the lower the price the easier.

2. The Product-positioning function

Price can also be used by the buyer to judge the quality of the product. A high price stands for good quality and low price for poor. As an example; a hospital in a South American City offered a free clinic to the indigent citizens. What the clinic did not realize what that people doubted the quality of the service since it was free and continued to go to the private hospitals until the free clinic announced that a fee would be charged.

3. The de-marketing function

When the demand is excessive or unwanted the price can be used to discourage the usage by raising the price. For example augmentation of price on cigarettes in anti-smoking campaigns).

The non-monetary price

In Social marketing there are many times no monetary prices for the product (Rothschild 1979; Bloom & Novelli 1981; Kleine Weinreich 1999) but the price that is more important might be the non-monetary one. Kotler and Roberto (1989) divide the non-monetary price/cost in two categories; time costs (for example travel time or waiting time) and perceived risks (psychological risks, social risks and physical risk). Social marketers should seek to reduce the prospect's time, energy, and physical cost. Joyce and Morris (in Fine 1990) are less enthusiastic about the use of pricing as a tool for social marketing. They claim that social marketers have little control over non-monetary prices. Many experts state that pricing strategies for social marketing are complex and difficult and that Social Marketers can not use all the tools available for price management in commercial marketing (Joyce and Morris in Fine 1990; Kotler and Roberto 1989).

The complexity of the issue of Social marketing can be seen by the following example. Breastfeeding might be perceived as free but consider the price a mother could be considered paying; time, dealing with sore nipples, the worries of the quality of the milk and the inability to work when breastfeeding. The cost for a woman in Uganda taking her baby to the doctor could be numerous. The time to walk there, the admission fee, shame (the risk to be seen as a mother that can not take care of her child, or not believing in traditional medicine) and the time taken from other duties in the home. Price to use a condom: shame (to buy one, to ask to use one, an act against religion) the monetary price of the condom.

• **Place**

"Place is where and when the target market will perform the desired behaviour, acquire any related tangible objects, and receive any associated services" (Kotler et al 2002). Distribution channel is another word used when talking about place (Alcalay & Bell 2000). The social marketing placing/distribution objective must always be to make that access to the product as convenient as possible for the target group. This could include more and closer location, extended hours, change the appearance of the location and make the performing of the desired behaviour more appealing than the competing (Kotler et al 2002). Distribution channels where to acquire the social product could be health clinics where you go to get immunized, stores that sells condoms or pumps that will provide clean water.

Alcalay and Bell (2000) also talk about the "social availability" for ideas and behaviour meaning that they must be "supported and accepted within the customers' social sphere." One example could be legal rights for lactating women to take breaks to breastfeed or religious leaders supporting the use of condoms for family planning.

• **Promotion**

Communication and promotion often involves persuasion to influence attitudes or/and behaviour. In order to persuade you need to capture the attention of the person you want to persuade in competition of many other sources for example, another person, the radio, the TV, noise etc. (McKenzie-Mohr & Smith 1999). The traditional promotional mix in marketing contains advertising, personal selling, publicity and sales promotion (Zaltman et al 1972). They can be used separately or mixed depending on the communications need of the specific programme. In recent year's popular media such as television series, radio shows, theatre, movies etc have been used to communicate a marketing message (Fraser & Restrepo-Estrada1998).

Additional P's.

In the literature of Social marketing there has been a lot of discussion about adding essential P's to the Social marketing Mix but there seems to be no consensus on how many the P's should be. Hubley (1993) talks about social marketing as focusing on the 4 P´s in the marketing mix while Alcalay and Bell (2000) chooses to explain the social marketing mix as 5 Ps including, Positioning, as the additional P. Other experts suggest the expansion of the 4 P´s to 7. Fine (1990) adds; *Producer* (the marketer or the source of the promotion), *Purchaser* (who is the target and what do they want) and *Probing* (research). Kotler and Roberto (1989) talks about *Personnel* (those who sell or deliver the social product), *Presentation* (the setting in which the product is acquired or used.) and *Process* (the steps the buyer needs to take to acquire the product). Klein Weinberger (1999) adds 4 P´s to her Social marketing mix; *Publics* (internal and external audience), *Partnership*, *Policy* and *Purse* strings (funding agencies)

This is of course the source of confusion among practitioners but looking at the meaning of the different P´s added and the main features of social marketing it

TH-13254

DISS
362.196979200954
D2603 So

TH13254

just seems to be a way for different experts to make a new model with the same ingredients.

Departures from Commercial Marketing

It has been stated that Social marketing is far more complex than commercial marketing (Rothschild 1979; Fine 1990; Kotler et al 2002). Rothschild (1979) argues that it is due to the intangibility of the product, the non-monetary price and problem in segmentation. Kotler and Roberto (1989) talk about the negative demand (get people to wear condoms, stop smoking, drinking) and the sensitivity of the issue (it is easier to talk about toothpaste than your sexual habits. There are some important differences between social and commercial marketing.

Specifically, in social marketing:

- the products tend to be more complex.
- demand is more varied.
- target groups are more challenging to reach.
- consumer involvement is more intense.
- the competition is more subtle and varied.

Table 1.

Similarities and differences between Commercial and Social marketing

Adapted From (Rothschild 1979; Fine 1990; Kotler et al 2002).

Similarities	Differences
• Customer orientation • Exchange theory • Marketing research • Segmentation • Uses the entire marketing mix (4 P's) • Monitoring, feedback and evaluation	• Type of product • The gain/profit • Type of competitors

(i) The Products are more Complex

The marketing product has traditionally been conceived of as something tangible – a Physical good which can be exchanged with the target market for a price and which can be manipulated in terms of characteristics such as packaging, name, and physical attributes, positioning and so on. As marketing has extended its scope beyond Physical goods, marketers have had to grapple with formulating product strategy for less tangible entities such as services (Woodruffe 1995). In social marketing, the product is extended even further from the tangible to encompass ideas, and behaviour change. This complexity makes social marketing products difficult to conceptualize. As a Consequence, social marketers have a bigger task in defining exactly what their product is and the benefits associated with its use.

(ii) Varied Demand

Marketing cannot create needs but commercial marketers do manage to harness needs previously unknown for new product categories such as CDs, catalytic converters and "New" washing powders. Social marketers must not only uncover new demand, but in addition must frequently deal with negative demand when the target group is apathetic about or strongly resistant to a proposed behaviour change. Young recreational drug Users, for instance, may see no problems with their current behaviour (Andreasen1997). In these situations, social marketers must challenge entrenched attitudes and beliefs). Rangun et al (1996) suggests a typology of the benefits associated with behaviour Change. The benefits may be: tangible, intangible, and relevant to the individual or to the society. Demand is easier to generate where the benefits are both tangible and personally relevant. In those situations where the product benefits are intangible and relevant to society rather than the individual, social marketers must work much harder to generate a need for the product. This, they argue, is the hardest type of behaviour change, as the benefits are difficult to personalize and quantify.

(iii) Challenging Target Groups

Social marketers must often target groups who commercial marketers tend to ignore the least accessible, hardest to reach and least likely to change their behaviour. For Example, health agencies charged with improving population health status must, if they are to avoid widening health inequalities further in the general population (Whitehead 1992, Smith 1997), target their efforts those groups with the poorest health and the most in need (Hastings et al 1998b). Far from being the most profitable market segments, these groups often constitute the least attractive ones: hardest to reach, most resistant to changing health behaviour, most lacking in the psychological, social and practical resources necessary to make the change, most unresponsive to interventions to influence their behaviour and so on. This poses considerable challenges for segmentation and targeting.

(iv) Greater Consumer Involvement

Marketing traditionally divides products into high and low involvement categories, with the former comprising purchases for items such as cars or mortgages which are "expensive, bought infrequently, risky and highly self-expressive" (Kotler, 1994) and the latter comprising items such as confectionery or cigarettes which are much more habitual. High involvement products typically command careful consideration by the consumer ('central processing') and demand detailed factual information from the marketer. Low involvement products are consumed much more passively, with very limited (or no) search and evaluation ('peripheral processing'), and simple advertising emphasizing "visual symbols and imagery" (ibid) is called for.

Both the categorization scheme - high and low - and its marketing implications need to be extended in social marketing. Social marketing frequently deals with products with which the consumer is very highly involved (complex lifestyle changes such as changing one's diet fall into this category). While high involvement can result in a motivated and attentive consumer, higher

involvement may be associated with feelings of anxiety, guilt and denial which inhibit attempts to change. At the other extreme, social marketers might seek to stimulate change where there is very low or no involvement.

(V) More Varied Competition

Social marketers, like their commercial counterparts, must be aware of their competition (Andreasen 1995). The most obvious source of competition in social marketing is the consumer's tendency to continue in his or her current behavioural patterns, especially when addiction is involved. Inertia is a very powerful competitor. Other sources of competition involve alternative behaviours. For example, time spent donating blood is time which the consumer could spend doing other more enjoyable, more convenient and more personally beneficial activities. Competitive organizations include other health promoters, educators or government organizations trying to use similar methods to reach their target audiences. Social Marketers must then be innovative and careful not to overwhelm their target audience. Finally, one of the most serious forms of competition comes from commercial marketing where it markets unhealthy or unsocial behaviours. The most obvious examples are the tobacco and alcohol industries.

Common Components of Effective Campaigns

The four categories discussed earlier (product, price, place and promotion) present the basic outline to be included in the development of a social marketing campaign. As the field of social marketing evolved and grew in experience, practitioners gained knowledge and lessons concerning the construction of an effective programme. The following ten elements contribute essential recommendations to the social marketing process.

1) Choose a Specific Target Population

For a social marketing campaign to be most effective, the programme must target specific populations. This permits planners to focus their research and to customize the campaign toward the unique needs, beliefs, values and culture of the defined target groups. "For a public health message to be relevant and effective...it must be highly personal; the receiver must be viewed as a person, not as a population statistic."(Sutton, 1995) Segmenting the target audience based on demographics (age, sex, race, neighbourhood, marital status, etc.) and psychographics (attitudes, behaviours, opinions, etc.) allows for the development of a persuasive and personalized message. (ibid)

2) Create an Audience-Centered Process

The message of a social marketing campaign can be a powerful tool in affecting behaviour change; however, it must be created in coordination with and have strong input from the intended audience. Researchers should use both quantitative and qualitative methods to generate a more complete view of the health issue as seen through the eyes of the target audience. Input from the target population throughout all stages of the process (planning, message development, pre-testing, implementation and evaluation) allows for adjustments that increase the effectiveness of the campaign. (Weinreich, 2003)

3) Build Partnerships with Stakeholders and Gatekeepers

Identifying and involving key stakeholders and community gatekeepers early in the process benefits the community and the lead organization. Partnerships can result in effects such as additional resources sharing of pre-developed materials, assistance with campaign costs and increased access to the intended audience, further expertise and extended community credibility. Engaging gatekeepers also results in an increased likelihood that the local community will assume ownership of the programme. (ibid)

4) The Fifth "P"—Positioning

Practitioners in the social marketing field often incorporate a fifth "p" (Positioning) into the planning process. According to Alcalay (2000) positioning "involves the location of the product relative to other products and activities with which it competes."

Understanding the target audience's views allow the programme planner to position the product in order to maximize the perceived benefits and minimize the perceived costs. For example, a campaign that encourages women to breastfeed would have to position the product (an idea—the value of breastfeeding) to emphasize the positive aspects (healthier for babies, allows mother-child bonding) and provide ways to overcome the barriers (working with a busy schedule, avoiding discomfort). (Weinreich, 2003). In addition, product positioning involves an awareness of how a contrasting product (infant formula) positions itself within the same market. Knowledge concerning that competitor allows a planner to emphasize the positive aspects of their own product (breastfeeding). (ibid)

5) Multiple Forms, Multiple Channels

An essential component to a successful social marketing campaign involves understanding the "openings" in the target audience's life and the vehicles that fit appropriately in those openings. (Sutton, 1995). A study of the intended consumers of a programme supplies information as to the times, places and circumstances when that audience will be most receptive to the message. Once a practitioner has gained insight into these openings, they can utilize variety of creative approaches to reach the specified population approaches to reach the specified population. "Even when the basic ideas may be the same for all audiences- eg. Exercise more, eat less fat, use contraceptives etc-the messages need to be designed and positioned differently for various groups". (Alcalay, 2000)

6) Access to Additional Information

A social marketing campaign should always provide a means for the audience to take the "next step" towards adopting the intended behaviour change. This process requires that all campaign materials contain some method for consumers to access additional information about the product being marketed. This could be one or a combination of such items as a hotline number, a website or a response card. Through these sources the target population would then access additional information or materials, such as booklets, pamphlets or local resources. (Health Canada, 2001)

7) Long-term Investment

For a social marketing campaign to be successful, persistence and a long time frame are essential. "Lessons from cardiovascular risk reduction programmes suggest that it may take up to ten years for the effective diffusion of new ideas and practices to produce measurable and consequential social change." (Walsh, 1993) Theories and models of behaviour change indicate the necessity of a multi-stage process in order to produce valid and enduring change. A strategic social marketing plan may contain a series of objectives to reach the long range outcome of a behaviour change. (DeJong and. Winsten, 1990)

8) Address Policy Issues

Ultimately, a social marketing approach must emphasize the need to create change on a policy level. Environmental adjustments such as supportive legislation, industry cooperation, improved regulations and alterations in public opinion would increase the likelihood of bringing about genuine lifestyle modifications. For example, a programme aimed at reducing teen smoking would be more effective if it addresses policy issues such as:

- Increasing the tobacco excise tax, increasing the regulation of underage smoking and creating smoke-free environments.

- Social marketing campaigns can use media advocacy to "change individual behaviour by cultivating an environment more conducive to health via changes in industrial practices and policy."(Alcalay,2000)

8) Evaluation throughout the Process

Process and outcome evaluations constitute a fundamental factor in any social marketing programme. Evaluation monitors the progress, demonstrates impact and measures the effectiveness of a campaign. While the complexity of social marketing makes it difficult at times to evaluate a programme, methods do exist to assess efficacy. Some of the evaluation tools used in this field include:

1) Tracking studies,
2) Telephone surveys,
3) Personal interviews,
4) time/series modelling,
5) Health indicators and
6) before/after research.

Each of these techniques has positive and negative aspects, including difficulty in specifying the level of change attributable to the campaign versus the numerous other factors that affect attitudes and behaviour. Deciding on how extensive of an evaluation to perform depends largely on the depth and reach of the individual social marketing programme. (DeJong and. Winsten, 1990)

9) Integrate Feedback

Incorporating feedback, obtained through the evaluation process, into the social marketing process produces a campaign that responds to the needs, attitudes, behaviour, and ideas of the target population. Evaluation data, along with information on the consumers' experience of the social marketing product and the dissemination effort, can "drive a process of systematic and regular feedback to guide interim corrections, tactical changes, and sometimes major

- Social marketing campaigns can use media advocacy to "change individual behaviour by cultivating an environment more conducive to health via changes in industrial practices and policy."(Alcalay,2000)

9) Evaluation throughout the Process

Process and outcome evaluations constitute a fundamental factor in any social marketing programme. Evaluation monitors the progress, demonstrates impact and measures the effectiveness of a campaign. While the complexity of social marketing makes it difficult at times to evaluate a programme, methods do exist to assess efficacy. Some of the evaluation tools used in this field include:

1) Tracking studies,
2) Telephone surveys,
3) Personal interviews,
4) time/series modelling,
5) Health indicators and
6) before/after research.

Each of these techniques has positive and negative aspects, including difficulty in specifying the level of change attributable to the campaign versus the numerous other factors that affect attitudes and behaviour. Deciding on how extensive of an evaluation to perform depends largely on the depth and reach of the individual social marketing programme. (DeJong and. Winsten, 1990)

10) Integrate Feedback

Incorporating feedback, obtained through the evaluation process, into the social marketing process produces a campaign that responds to the needs, attitudes, behaviour, and ideas of the target population. Evaluation data, along with information on the consumers' experience of the social marketing product and the dissemination effort, can "drive a process of systematic and regular feedback to guide interim corrections, tactical changes, and sometimes major

rerouting of strategic direction."(Walsh, 1993). Gathering consumer advice, criticism and opinions throughout the entire planning, testing, implementation and evaluation phases:

- improves the programme;
- saves time, energy and money;
- And provides lessons for future or similar campaigns in other locations.

(Weinreich, 2003)

Table 2.

The social marketing process

Adapted From Klein Weinrich 1999:22

1.	Planning	Formative research Analysis Audience segmentation Strategy development
2.	Message and materials development	Identifying appropriate channels Developing effective messages Producing creative executions
3.	Pre-testing	Conducting the pre-test Using the pre-test results
4.	Implementation	Developing an implementation plan Planning and buying media Generating publicity Monitoring implementation
5.	Evaluation and feedback	Evaluating design Evaluation methods Using feedback to improve the programme

Typical Objectives of Social marketing

(DeJong and. Winsten, 1990)

- establish a health issue as a priority concern;
- increase knowledge and change beliefs that impede the adoption of health-promoting attitudes and behaviours;
- motivate change by demonstrating the benefits of the desired behaviour;
- teach new behaviour skills; demonstrate how to overcome barriers to behaviour change; teach self-management techniques for sustaining change;
- And provide supports for maintaining change by stimulating interpersonal communication; the support of opinion leaders, spouses or peers; and broad changes in perceived social norms.

In operational terms social marketing has been described by Israel (1987) as "an analytical and organizational tool for addressing common problems of at-risk behaviour in Public health and nutrition". He takes the examples of the Brazilian Breast feeding campaign, marketing efforts for condoms in Thailand and Bangladesh as cases where social marketing has been used successfully.

Kotler and Roberto (1989) take Israel's description a bit further and make it more detailed; "Social marketing is built around the knowledge gained from business practices: the setting of measurable objectives, research on human needs, targeting products to specialized groups of consumers, the technology of positioning products to fit human needs and wants and effectively communicating their benefits, the constant vigilance to changes in the environment, and the ability to adapt to change."(ibid)

Strategic Model for Social marketing

The Consumer-Based Health Communication (CHC) Model applies six deliberate questions to a specific health topic with the purpose of transforming

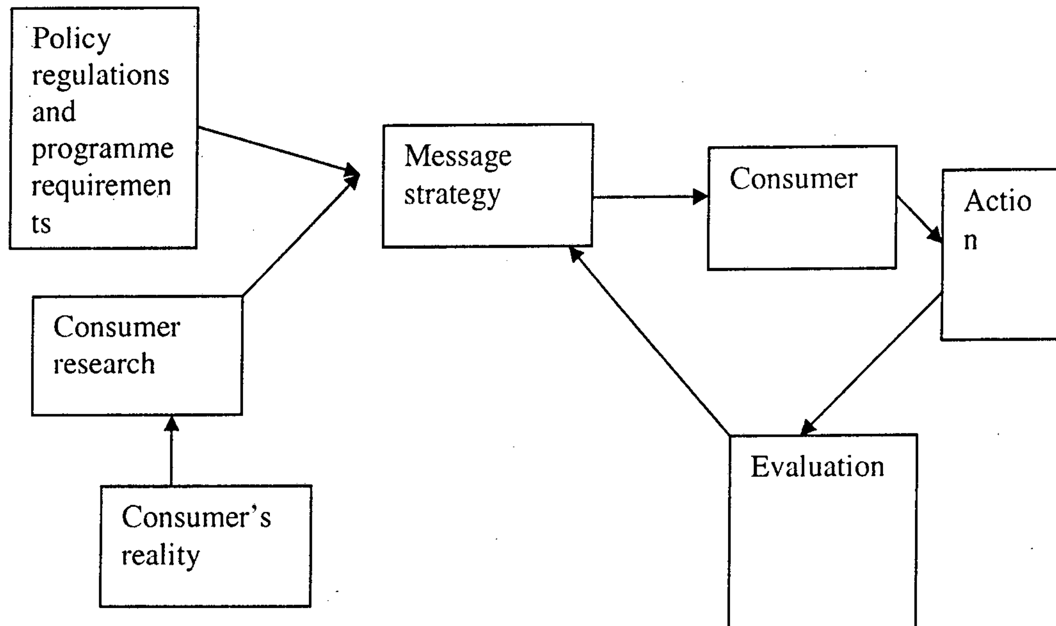
"scientific recommendations for health promotion and disease prevention and treatment into message strategies that are relevant to the target audience." The programme planner uses research techniques including focus groups, commercial databases and personal interviews to understand the realities of the consumer and answer the CHC questions. The six questions used in the CHC Model are:

1) Who will be the target consumers and what are they like?

2) What action should the target person take as a direct result of the communication?
3) What reward should the message promise the consumer?
4) How can the promise be made credible?
5) What communication openings and vehicles should be used?
6) What image should distinguish the action?

The answers to these questions create a strategic approach that supports and strengthens all health communication activities within the social marketing campaign.

Figure 2. Adapted from Sutton, Baich and Lefebvre



What Social marketing is not?

The first definition and the fact that social marketing have influences from many different sciences has caused confusion about what it is. The term Social marketing has also been used to describe activities that have nothing to do with what we talk about here. Abbott (1986) uses the term when describing market sales for the poor population, "Organizing sales so that lower-income or other needy consumers can buy at lower prices than better-off groups".

Social marketing should also be distinguished from terms like "societal marketing", "non-profit organization marketing", "social advertising" and "social communication" (Fox & Kotler 1980; Andreasen 1995; Klein Weinreich 1999).

Societal marketing

Societal marketing does not try to influence people to adopt behaviour but rather just inform them. (Kotler & Roberto 1989).

Non-profit organization marketing

Non-profit organization marketing is about market non-profit organizations, political candidates, and Public institutions. Its goal being to give benefits, goodwill, understanding for the organization and not necessarily especially to the programmes/ideas the organizations implements and stands for (Andreasen 1995).

Social advertising

Social advertising is about using traditional media and mass media to influence change and/or to inform people in society. Social advertising is often used as a component in social marketing but the approach of social marketing is much broader (Andreasen 1995).

Social Communication

Social Communication is a broader approach to social advertising where sales support and PR was added to the mass advertising (Kotler & Fox 1980).

Table 3. The evolution of social marketing
Adapted from Kotler & Fox 1980

Concept	Main dimensions	Differs from prior
Social Advertising	Using mass-media	
Social Communications	Using mass-media, personal selling and PR	Broadened the Promotion aspect when including personal selling and PR
Social marketing	Using commercial marketing techniques and methods	Using all aspects of traditional marketing. Considering all 4 P's not just Promotion

The field is diverse enough that little health related social marketing programmes include all of the elements. Some practioners specialize in or the other of them. Many argue that they need the flexibility to tailor their emphasis on particular steps in the process to the demands of a specific application. But the list of process elements can be used as a template against which to gauge how complete given programmes marketing framework is and to scrutinize the process in finer details.

Problems and challenges

It is important to be aware of the obstacles and challenges that social marketing projects and social marketers face. Below are mentioned some of the areas that can cause problems for a social marketer.

- **Organizational**

Social marketing programmes and social marketers according to Bloom and Novelli (1981) face many challenges and barriers in order to be successful. They must function in environments where marketing activities are vaguely understood, not always appreciated and sometimes inappropriately located. Some organizations especially governmental might be very slow, ineffective and very bad at recording past experiences. Social marketing programmes also need to predict how both friendly and unfriendly competitors will behave in order to be effective.

- **Sustainability**

Andresen (1995) talks about sustainability as one of social marketing biggest challenges. The social marketing programme have limited life and funding and if it is supposed to have long-lasting effect somebody has to continue the work.

- **Lack of marketing skills**

Fraser and Restrepo-Estrada (1998) discusses the lack of resources and knowledge at ministry level to produce effective promotion material such as leaflets and media material and the restraints in budgets that make it difficult to use external resources. This results in failing social marketing programmes in projects that could have been successful if only given the appropriate resources.

- **Top-down approach**

The campaigns many times have a tendency to be top-down still treating the individual as a person to be persuaded and changed according to criteria established by outsiders (Fraser & Restrepo-Estrada 1998; Melkote & Steeves 2001).

- **Failing to address structural issues**

There are discussions that social marketing programmes as such fail to address structural issues and local norms (Fraser & Restrepo-Estrada 1989). For example, in family planning the problem is identified as "too many children "and not as the structural problem that makes family economies difficult without many children. They also think that despite of the fact that the theory of social marketing has extensive analysis of local needs the focus of social marketing interventions are the individual "the consumer". (ibid)

- **Marketing is "the devils work"**

For some people marketing is thought to be commercial and vulgar (Fraser & Restrepo-Estrada 1998) and can't see that it should be put in use for a "good cause". Many see the irony that social marketing is used to repair the damage that commercial marketing has created (in alcohol/cigarette marketing and the extensive marketing of breast milk substitute formula) (Kotler & Roberto 1989).

Fox and Kotler (1980) takes up the issue of social marketing is being perceived as manipulative by people who consider it potentially unethical in giving power to one group in order to influence another.

Ethical concerns in Social marketing

Andreasen (1995) takes the example of family planning to illustrate one of the ethical dilemmas in social marketing. In many developing countries having many children is a security for the parents that somebody will take care of them when they are old. He questions the right for the western organizations to come in and promote contraceptives for family planning when for the individual family that might be the only way to survive. He asks if it is right to intensively promote change and market birth control. Could this be an intrusion in the personal integrity?

Other ethical dilemmas could be the negative impact social marketing can have on the society in the long-term perspective (Salmon 1989). Salmon discusses the impact of social marketing campaigns that lower child mortality in developing countries. The long-term effect will be that there will be more people reaching adult age and he questions the correctness of calling this effective and successful in a society perspective since this could also cause big constrains of resources, high unemployment, poverty and civil disobedience. According to him, it is important to show the indirect and secondary effects that social marketing have on civil society in order for a successful result to be obtained in the long run.

The 1980's outlook for social marketing is one of continued growth and application to an ever widenening range of issues. More and more cause organization and the Government turns to social marketing in search for increased effectiveness. Social marketing can be used as an effective tool to educate audiences, promote healthy attitudes and influence individuals to make real, sustained health behaviour change. A study from the American Journal of Public Health reported in 1992 that social marketing campaigns

using mass media techniques were successful in preventing cigarette smoking in high-risk youth. The possible health topics that could be the focus of a campaign are extremely broad. In addition, social marketing allows for creative and innovative ideas to develop not only from public health practitioners and marketing professionals, but more importantly from the target audiences themselves. Social marketing has the potential to reach a large number of people on a national, regional or local level; yet contain a message that speaks directly to an individual (Kotler.1971).

An effective social marketing campaign begins with a theoretical basis and a programme model. The project should have a foundation in the five "P's": *Product, Price, Place, Promotion* and *Positioning*. In addition, targeting a specific population, centering the process on that audience and incorporating their feedback establish a framework for a successful campaign.

The intended audience also affects which marketing channels are chosen for the project. After confirming the target population, social marketing programmes should bring accepted and engaged stakeholders and gatekeepers into the planning process. A vital part of the social marketing process includes providing consumers with access to additional information, referrals and resources concerning the intended product.

When appropriate, a social marketing campaign will also address policy issues relevant to the targeted health issue. Finally, a thorough developmental process will establish strategic objectives and will build an evaluation plan appropriate to the campaign. "Social marketing campaigns that include these components have the ability to produce positive health outcomes and healthy behaviour changes in individuals and populations". (ibid)

"Social marketing is the application of commercial marketing principles to advance a social cause, issue, behaviour, product, or service. Social marketing has added a framework to social efforts that heretofore lacked organization and has inspired projects that otherwise might never have been initiated". (Lucaire

L.E, "A Focus on the consumer: Social marketing For Change", 1985) In the US, social marketing techniques have been particularly successful in the health field. Although advertising and other communications are central to social marketing, the discipline also depends upon other elements of what is termed the marketing mix: product, price, place, and promotion. Social marketing is a cyclical process involving 6 steps: analysis; planning; development, testing, and refining elements of the plan; implementation; assessment of in-market effectiveness; and feedback. In developing countries, health has similarly been the greatest beneficiary to date of applied social marketing techniques.

Family planning programmes and oral rehydration therapy (ORT) projects have used social marketing techniques effectively in numerous developing countries. Social marketing has been even more widely applied in the sale of contraceptives in developing countries. Contraceptive social marketing (CSM) programmes are well established in Bangladesh, Sri Lanka, India, Thailand, Nepal, Colombia, El Salvador, Jamaica, Mexico, and Egypt. More recently programmes have been established in Honduras, Guatemala, Barbados, St. Vincent, and St. Lucia. SOMARC (Social marketing for Change) is a project funded by the US Agency for International Development (AID) and is working with existing condom social marketing programmes and helping to launch new condom social marketing programmes. Social marketing requires both experience and sensitivity to local conditions. Many developing countries now have their own marketing resources. Local private sector advertising and marketing agencies are helping public and private sector programmes. In countries where local resources are scarce, AID has created several programmes to provide technical assistance in social marketing.

In this chapter we looked at various theories, models and approaches to social marketing. Throughout the discussion it was clearly seen that the very use of the marketing limited the scope of fulfilling the social goals, reducing the whole, to a space where only buyers and sellers interact, health being reduced to a mere saleable commodity. Secondly, it was seen that the social marketers define their target groups as upper/lower/, or lower/middle income groups,

that is to say, consumers with a disposable income. In other words, the social marketing programmes cater to the economically active groups, who have the ability and willingness to pay. Knowing that there is an inseparable inter relationship between poverty and vulnerability, a question that teases our minds, is where do the lowermost and the poorest go, who are not only prone to diseases , but are also handicapped with the no money factor. Target segmentation is one of the major steps involved in designing a successful programme. In that case, there are fair chances of the research being manipulated by the various players and stakeholders in the market, and also the donor agencies, on whom the entire funding of the programme depends. Audience analysis and segmentation is a critical early stage of research. The target audience must be defined, because all populations are heterogeneous and have varying needs and potential responses. Further consumer research is performed through focus groups, surveys, and in-depth interviewing to identify perceived needs and potential barriers to product acceptance.

As pointed out earlier, the social marketing organization's scheme of working, projects a very utilitarian style, where the end gets defined in terms of the number of pieces sold, and not the means or the process matter. "Exchange theory" is central to the social marketing conceptual framework (Lefebvre, Craig, and Flora 1988:302). It suggests that consumers "have resources that they want to exchange or might conceivably exchange, for perceived benefits. . . To be considered marketing transactions, ideas, products or services must be deliberately introduced into the transaction with a buy-and-sell intention." (ibid)

Embedded in this approach is the conversion of citizens into "consumers"; the social marketing literature emphasizes the primacy of identifying and targeting consumer needs. "Creating demand" among "consumers" to become sufficiently "motivated" to purchase some health-related "product" revolutionized approaches to health education, behaviour change, and disease prevention. Social marketing deploys a conceptual framework known in the field as the "four Ps": *product*, *price*, *place*, and *promotion*, which is repeated as a kind of

industry mantra throughout the social marketing literature (Andreasen 1995; Goldberg et al. 1997; Ling et al.1992; Manoff 1985; Walsh et al. 1993). As Walsh and her co-authors point out, the product can be a consumable object (such as a condom), a behaviour, or even an abstract belief or practice. The techniques have taken on a standardized format that is as notable for what it includes as for what is left out (Ling et al. 1992:342).

Product development, packaging, and pricing are then done with the consumer research in mind so that the product correctly targets and motivates the audience segment. Prices are normally set so they provide some profit incentive for participating vendors but remain low enough for the target audience to purchase the product. An advertising message is developed and tested with the target audience, usually with carefully selected focus groups. Communities are systematically examined to identify the best channels for advertising (e.g., radio, billboards, and television) and distribution of the product through private-sector vendors, shops, and other commercial outlets. The best "marketing mix" is achieved by finding the right balance among the four Ps tailored to the specific community (Social marketing 2000:15). Most social marketing campaigns mimic standard advertising campaigns for commercial Products, using catchy packaging and clever slogans to promote strong "Brand identification" in target audiences. Social marketing is now extensively used across the Third World to promote condoms, other contraceptives, oral rehydration solution, mosquito nets, clean water kits, vitamins, antibiotics, and iodized salt

Thus we explore the theoretical encores of "Social Marketing –The Theory', in this chapter, to see the further applications and theoretical as well as practical manifestations of the concept in the following chapters.

Chapter 3

Social Marketing: The Global Experience in HIV/AIDS

Social marketing can refer to the promotion of either a product or an idea. The first approach includes the sale of a socially beneficial product such as condoms or oral rehydration salts. Although the product is generally subsidized to keep costs within the reach of consumers, the actual sale is considered critical because of its role in ensuring consumer motivation, increasing internal efficiency, and facilitating long term self-sufficiency of the program. The second approach stresses the promotion of socially beneficial ideas and practices rather than products, e.g. breastfeeding. The two categories can be called mutually symbiotic, as each works at their own levels of promotion and ensuring the availability of the product /services, reinforcing the working of the other.

Social products differ from commercial products in several important ways: they are more complex, often more controversial, less immediately satisfying to the consumer, require more spectacular results, and are aimed at an audience with fewer resources than most consumers of commercial products. In addition, there are many factors that make social marketing more difficult than marketing in the commercial sector.

Social programs have less control over the delivery system and consumer research is more complicated. Despite these differences, both social and commercial marketing are organized around the same four qualities: product, price, place, and promotion. The product must be configured to maximized consumer acceptance and use. Hidden costs must be considered. There must be an adequate distribution and supply system to ensure easy availability of the product. Finally, the product must be promoted through different communication channels by a wide array of techniques. Attention to these factors can significantly enhance social service delivery of both products and ideas.

History

According to Da Cunha (1991) it was first in the late70's early 80's that Social marketing started to be used in developing countries. Walsh and others (1993)

argues that early health application of social marketing emerged under the banner of "development communication" already during the 60's and 70's. The Nirodh condom project in India began in 1967 and was the first nationwide contraceptive social marketing program. It was the starting point for the increasing support for similar projects in for example Kenya, Colombia, Sri Lanka and Jamaica. There is a belief that much of the development and important research to advance social marketing applications to health has taken place in the international field of family planning (Walsh et al 1993).

Application:

Social marketing in a developing world context is as much discussed and disputed as social marketing in the west maybe more since it also involves the developed world vs. the developing world.

Kindra and Stapenhurst (1998) talks about the difficulty of social marketing programs in developing countries and say that in countries with strong socialist orientation it is even more difficult. They argue that in these countries people have a very negative view of marketing; it is a misunderstood managerial philosophy. The fact that people have none or little marketing training and that the government systems are usually rigid, bureaucratic and sometimes corrupt. This view might also be well guarded by the belief that Marketing and Welfarism can never go hand in hand, and so disjuncture between the two gets expressed, in these socialist countries.

The health sector has applied social marketing more than others have but we now see an increase in other development sectors taking in some of its methods and theories in use. (Fraser & Restrepo-Estrada 1998). US AID was one of many agencies to learn from these experiences and have applied social marketing extensively in their strategies. Other organizations that have applied the social marketing approach are among others UNICEF, the World Bank and WHO. One of the successes of social marketing methods is the Brazilian National Breast-

feeding program described in Fine (1990). The program started with consumer research by asking what mothers should do and why they did not do it. The product was identified as confidence in themselves and the quality of the breast milk. They also analyzed the performance costs involved in breastfeeding and worked out a distribution plan for the product (through health workers, community and different organizations).

A promotion plan was produced and a strategy for dealing with competing products such as commercial formulas and misperceptions of breastfeeding. Social marketing has been widely used globally to promote the distribution, sale and use of condoms by organizations such as UNAIDS and the World Bank and especially to developing countries. Successful examples where condoms did not even exist before the social marketing intervention are Ivory Coast, Uganda and Malaysia. In India, Zambia and Pakistan are places where the usage of condoms increased after the intervention (Fraser & Restrepo-Estrada 1998; Melkote & Steeves 2001).

Application of Social marketing: Condoms in HIV AIDS

With HIV continuing to spread across all regions of the world, effective HIV prevention programmes do need to rapidly scale up to match the scope of the AIDS epidemic. The range and mix of interventions needed vary by country depending on local epidemiology and socio-cultural context. They should include, but not be limited to, education on the 'ABCs' of prevention (abstinence/delayed sexual initiation, being safer by being faithful to one's partner/reducing the number of sexual partners, and correct and consistent condom use), treatment and care of sexually transmitted infections, voluntary counseling and testing services, prevention of mother-to-child transmission, harm reduction, safe blood supplies and medical injections, and addressing discrimination and stigmatization. Condom promotion plays a vital role in HIV prevention. The question is how to position a good public health strategy, within a comprehensive HIV prevention strategy which includes informed, responsible and safe sex behaviour.

A thorough analysis of literature on condoms and HIV prevention and study of experiences from various prevention program show that to achieve the full prevention potential that condoms offer, there are four critical elements to be understood :(UNAIDS, 2000)

- Realizing that there are interactions between condom promotion, including condom social marketing and peer based condom education, and other prevention strategies.
- Understanding and correctly communicating information on the effectiveness of condoms.
- Convincing people to use condoms when they are needed and to do so consistently and correctly.
- Ensure a regular flow or supply of condoms for those who need them.

The use of combinations approaches in HIV prevention is recognized as sound strategy. Multiple interventions complement each other and go with each other to combat the epidemic. For instance, reducing the average number of sex partners in a Population could cut the root of transmission of HIV as much as an increase in the numbers of people using condoms. If both these were achieved simultaneously, the reduction in the rate would likely be more than additive effects of the two interventions on their own. The greater synergistic effective strategies are employed, better would be the impact on the overall result. Programmes in several countries show that positive, interaction among prevention interventions stabilizing or reducing HIV prevalence. "A condom promotion campaign directed at the port workers of Brazil had an unexpectable result of not only increasing condom use in these men but also, decreasing the proportion of men having sex with the Causal partners. Began in the mid 1990's, Senegal's preventive activities led to high levels of condom use with non regular partners, particularly by sex workers and their client. Prevention efforts in the Thailand and Uganda can cited as outstanding examples of effective and comprehensive programmes

leading to HIV transmission. Condom promotion had different roles in these two country's success."(Nelson KE et al., 2002).

The Thai experience:

Condoms played a key role in prevention efforts in the Thai operations .the multi pronged strategy comprised of not only promoting condom use at the brothels and other sex work venues as the core one and also intervened in areas like as health education STI control, HIV testing and also provided supportive clinical care and treatment for the HIV patients. Its success rate can highly be attributed to the strong political commitment and support at all levels, including the health services. Non-governmental organizations, brothel owners and the public in general. Unprotected sex was the driving force of the epidemic in Thailand, and this reason made prevention strategy targeting sex venues absolutely necessary.

Two commendable behavioural changes that happened: there was an increase in condom use in the sex work settings as intended, and the frequency of men visiting these venues fell dramatically to unexpected levels .the proportion of 21-year old men who indicated visiting a sex worker in the past year fell from nearly 60% in 1991 to 8% in 1998. While condom use during transactional commercial sex rose more than 95% of all acts in 1998. (ibid)These outcomes were achieved as a result of great awareness generated condom use programme. The programme's effectiveness was evident in the drop in STI's among men reporting at government clinics in particular, among male military conscripts (a fairly representative sample of men in their late teens since conscription in Thailand is primarily by lottery).

The Ugandan Experience

A different perspective on the role of condom promotion as a prevention strategy was highlighted in the Uganda experience. A multi- sectoral approach, backed

by high commitment, was taken up at all levels, by the country to fight against the epidemic. It involved discussions from all sectors of the society with support from the political leadership. De-stigmatization and open communications were key aspects of the Ugandan response to HIV. Public disclosures of prominent Ugandan's of their HIV status early in the epidemic, active support for counselling and testing from community organization and personal with the HIV positive, made communication much easier, comprehensive and cogent.

The courage and willingness of the Ugandan population to face the challenges of the AIDS crisis were evident in the fact that a greater proportion of Ugandans compared with populations in other African countries personally knew someone with HIV. The government never opposed condoms but nevertheless didn't give it top priority in HIV prevention messages.(UNAIDS,2004) The prevention messages were more focused on delayed sexual debuts amongst young people, being safer by being faithful to their partners and using condoms (the ABC strategy). (Magnani RJ, Karim AM (2002).

Condom promotion wasn't given much importance till the early 1990's. However, widespread debates about condom promotion amongst the political and religious leaders led to open discussions and played a constructive role in directing Uganda's response to HIV-AIDS. Social marketing of condoms got off the ground on large scale in the mid 1990's. The Ugandan Demographic Health services (DHS),conducted in 2000-01 showed that among the 15 -24 year old's in Uganda ,who had co habiting partners,44% of the women and 62% of men used condoms during their most recent sexual encounters.(ibid)

Overall rates of condom use were comparatively low at the time the incidence rates began declining. However, even low levels of condom use in the entire population did make a difference as long as it was high amongst the group practicing "high risk behaviour". (UNAIDS, 2004)

Common elements for success for both Thailand and Uganda were (ibid)

- Responded to the epidemic quickly and decisively.
- Had leadership commitment at all levels.
- Used a multi -sectoral approach and achieved broad public support.
- Avoided stigmatization and included important aspects of care for HIV infected. Developed local responses to locally perceived threats.

The persistent debate on the relevance of condoms in the HIV prevention strategy particularly for young people has generated mixed messages. This tends to the controversy between the two views at two opposite ends i.e. Abstinence at one end and condom use at the other. At the root of this concern is a fear that it would lead to the increased sexual activity and may encourage more number of sexual partners. Effective condom promotion within a combination of prevention strategy involves the equally important and inter-related components of informed choice, empowerment, supportive environment and demand and supply. To meet the needs and the socio economic conditions of all population groups, greater access to, and availability of, condoms should be ensured through diverse channels including free distribution, commercial distribution and Social marketing programs condoms had to be actively promoted between the sexually active populations as well a the group practicing "high risk behaviour" and HIV infected people with their partners. (St. Lawrence JS, Scott CP, 1996)

Studies conducted by Centre for Disease Control and Prevention found that without access to condoms, other prevention strategies lose much of their potentials effectiveness. Evidence has been gathered by the United Nation Population Fund which shows that consistent use of latex condoms is a highly effective method of preventing the HIV transmission. Scientific research by the

US National Institutes of Health and World Health Organization (WHO) found "intact condoms...are essentially impermeable to particles the size of sexually transmitted disease pathogens, including the smallest sexually transmitted virus". (ibid)

Four meta-analyses of condom effectiveness put the range at 69–94%. Conclusive evidence from studies of serodiscordant couples where one partner is HIV-positive and the other shows that using a condom reduces the probability of HIV Transmission during penetrative sex by about 90%. (Weller S, Davis K 2002: Weller SC, 1993)

Thus, the best estimate that may be deduced from all these studies is that condoms used correctly and consistently reduce the risk of transmission by about 90%. With perfect use, effectiveness may be even higher, though not 100%. (Pinkerton SD, Abramson PR, 1997). It is important to clarify that an effectiveness of 90% does not mean that HIV transmission will take place in 10% of sexual acts where condoms are used. In fact, the risk of transmission is much lower. If the risk of sexual transmission is one in 500 without a condom, it would be reduced to one in 5000 when a condom is used. (Davis KR, Weller SC, 1999)

"Social marketing complements and does not replace free access to health services and products". (Population Services international, 1998). Specifically in case of condoms, social marketing does become a source of alternative source of products, information to people for whom it would be difficult to get access to in other conditions. For example, through the Social marketing programs are widely available at in places where people go to very frequently, as opposed to reproductive health clinics giving rise to the anonymity in the commercial transaction, however little it may be, particularly for women an other sexually active groups.

The key support in these kinds of programme comes in the form of Government support without which the success of the social marketing programmes is

impossible. Many governments recognize the important contribution that it makes to improve the reproductive and the sexual health of their low income population, and provide with a financial assistance and a strong political will. In many countries, socially marketed products, frequently condoms are allowed tax exemptions by the local or the national government. Condoms are a case in point, where only a few years back it was rare to find a country where advertising this product was permitted in the mass media, which now is common.(UNAIDS,2002)

Condom social marketing emerged as an effective tool to combat HIV/AIDS in the mid 1980's. Condom social marketing programmes have made condoms more accessible, affordable, and acceptable in many of the world's poorest countries. "In 1997, these distributed about 900 millions male and female condoms. By 1999, at least 71 different social marketing programmes for male and female condoms were active in 59 developing countries". (UNAIDS, 2000)

It has been said (ibid) that incase of condoms, the social marketing approach, has acted as a normaliser, reducing the stigma related to it. Till the recent times, it was difficult not only in terms of the product's accessibility, but also its availability, and generally thought to be more appropriate for use by the commercial sex workers, which was a very false notion. It's reported that as a result of years of social marketing, condoms in many countries are widely available from a variety of outlets, openly discussed in public and media, and seen by the high risk as well as the vulnerable ones, as a common household item.

"The de-stigmatization of condoms in many countries show that how social marketing can help populations to overcome social cultural resistance to practicing effective STD/HIV prevention."(ibid)

The joint United Nations programme on HIV-AIDS (UNAIDS), is the leading advocate for global action on HIV-AIDS. Since its inception in the 1996, it has promoted and supported social marketing and particularly social marketing of

condoms, as a key strategy to combat the epidemic. In countries where social marketing is launched, UNAIDS takes an active role as a fund raiser and a potential provider of technical assistance in collaboration with non-governmental organizations.

Social marketing and its variations:

The traditional model also known as the "own brand model", is the most commonly in use among Social marketing Program in developing countries and is closely associated with organizations like PSI, DKT international organizations that pioneered social marketing in the 1970's and the 1980's. Standard commercial and sales techniques are used for promotion and distribution via a network of wholesale and retail sales point to the mass market.

These social marketing organizations may receive unbranded condoms from international or national donors, or the quality products from the manufacturers, and develop its own brands and techniques for distribution. The ability of operating as effectively as possible in wide variety of ways entails the key element of successful social marketing programs. In most developing countries, low income populations form the great majority and within it there is a frequent need to target specific and, often difficult to access, population groups with specific needs. Social marketing also tends to build in non traditional and informal outlets for distribution to meet the needs of the particular groups/communities.

The potential use of alternative distribution systems is an essential aspect of social marketing. Today in developing countries, socially marketed condoms are to be found in both traditional outlets such as pharmacies, drugstores, and non-traditional points such as bars, coffee shops, brothels, beauty parlours, workplaces ,railway and bus stations. Therefore, other ways of social marketing have been developed and common. These approaches may not be mutually exclusive but a part may be used in one project, or a particular approach used

in some part of the project leading to the strengthening of the "traditional approach".

These models include these possible approaches to Social marketing:

- Community based system of product distribution and product promotion (CBD), where non professional sales agents are recruited from among particular groups in the general population. These individuals receive basic training and in IEC and sales and are usually rewarded financially from small margins on their sales .this approach is increasingly chosen as a means of reaching geographical areas and socio-cultural groups that are Difficult to access. Many programmes incorporate the method to complement more traditional, retail outlet sales.

- An innovative and promising variant of the CBD approach has recently been developed and piloted over two years Chennai, India, by International Family Health and its local partner NGO, the Indian Institute of Community Health. The Community Based Social marketing model recruited sales agents from among the general public as well as the specific communities/groups. In addition from benefiting from the basic training in reproductive health and from commission on their sales, the agents also benefited from recruiting others to act as educational and sales agents. Community Based Social marketing derived from "commercial network" and "multilevel marketing techniques successfully applied in developed countries, have shown potential in rapidly attain community penetration and involvement in reproductive health issues and HIV prevention.

- The "manufacturer model", where the support is provided for the promotion and the distribution of brands developed and owned by a manufacturer or local manufacturer's agents, is frequently an importer of the product. The support usually takes the form of grants directly to the manufacturers and /or their distribution agents so as to reduce their

commercial marketing costs and therefore invest in more key activities. A retail price much lower than the market price, is then the expected result. In contrast to the" traditional model of Community Based Social marketing", the "manufacturer model" is the least common.

- The "target service delivery model" involves planning appropriate social marketing activities, through which the product strives to reach and distribute products to specific target groups, usually high risk, or other priority segments of the general population. These groups are generally inadequately served by other service delivery mechanisms, including standard social marketing programmes. Their identification usually results from market segmentation studies carried out once the basic distribution structure to the mass market is established, so target delivery approach is often a component of programmes mainly structured around the traditional or the commercial model.

Therefore we may see that there are many approaches to the application of the social marketing strategy, at the national, local and at the international levels. Flexibility in planning and implementation are key to successfully meeting the needs for information and products such as condoms in the fight against HIV/AIDS.

Planning and implementing social marketing programs is by no means restricted to large funding agencies. Local initiatives by the private sector and the local NGO's exist in many countries. These can range widely in size and purpose, from small localized projects to training and employment ex-commercial sex-workers in a specific location as sales and IEC agents for condoms, to comprehensive and large scale reproductive health programmes at the national level.

Of particular interest, to local initiatives, is the fact that well managed and adequately supported social marketing projects are among the most cost effective health interventions. The projects can recover large proportion of

costs and revenues from sales which can be invested in other activities, such as capacity building or strengthening the programme itself, if the organization works exclusively in social marketing.

The following examples illustrate the various approaches outlined above. The cases described below are the uses of the approach to social marketing adopted in some countries, by various organizations, focusing on the way of condom distribution and promotion, designed and implemented in differing situations /contexts.

Individuals from the community, trained in IEC and condom promotion and sales is key to the performance of social marketing programmes in several countries of which Haiti and Mozambique are examples. The main reasons adopting this strategy, either on its own or complementing other forms of condom distribution may vary; the various forms it takes may also vary.

CASE STUDIES

(UNAIDS, 2000)

Mozambique and Haiti can be cited as unique examples for its effective CBD in social marketing of condoms which also exhibit various reasons for choices and style of working by condom social marketing programs. It was ensured through social marketing programs in both countries that the rural masses which had moved and migrated had an easy reach to the condoms.

Community locals were used for the job wherein sales persons were appointed with the help of NGOs to address geographical and infrastructural hurdles The existent commercial network for consumer goods was exploited to flaunt the traditional commercial distribution by agents among other things. Though considerable volumes of condom sales are achieved through the community based distributors, traditional distribution were responsible for a majority of the volumes.

In Mozambique where the communication and transportation system had taken a serious beating resulting in a total collapse of commercial economy leading to major problems in standard distribution of products even in urban areas up country commercial distribution also proved to be a major problem. The country hence had a uphill task in first laying a distribution network comprising trained locals for sales and motivation teams. The latter focused mainly on creating a demand among high risk groups through IPC the salesperson was assigned to meet the demand of the retailer since condoms were hitherto an alien product for the country.

Haiti.

Some relevant facts about Haiti: Haiti is the poorest of the Latin American and the Caribbean countries with a population of 8.1 million, around 70% living in the rural areas, and 55% below the age 20.Its GNP estimated by the World Bank, was US$ 250 and the cast majority of the population live on subsistence incomes mainly from agriculture. It ranks 156 on UNDP's Human development Index and life expectancy at birth is estimated at 54 years, much lower than the regional average of 70 years. The prevalence of HIV infection amongst Haitians aged 15-49 years is estimated at 5.17% by the end of 1999, highest in the region, with an estimated 210,000 people living with HIV/ AIDS and 23000 already dying due to AIDS in 1999.the prevalence of STD's is expected to be high, and in 1992 study of male STD clinic patients found that 25% of the patients were tested HIV positive. Population services international has been active in social marketing in reproductive health and reduction in high risk sexual behaviour, since 1989, with a focus on providing accessible and affordable condoms to the low-income groups of the population for STD/HIV prevention. By 1996 the market saw the successful launch of two branded condoms (male and female) as well as reproductive products.

Implementation of a regular product distribution from the commercial wholesaler to the retailer structure was difficult given the topography of Haiti and its economic and political conditions. The masses have little or no

income and are victims of political unrest in their daily lives. Hence in 1990 a supplementary programme for creating a system based on the product sale, mainly male condoms, together with related IEC activities, which was made effective through locally appointed trained individuals, was implemented.

The PSI found the following key advantages in Haiti for promotion and distribution of condoms and other products through CBD:

- Relatives, friends and neighbours enjoyed more credibility than outsider sales persons.
- Availability as CBD'S is usually much accessible at any point of the day or night.
- Privacy and discretion, where condoms can be obtained on a personal basis.
- Sound counselling concerning individual needs, insofar as condoms were concerned ensuring consistent and correct use.

PSI trained 175 members from partner local NGO's, concerning STD's, and HIV/AIDS prevention, social marketing goals and strategies, interpersonal communication and direct sales techniques, condom use demonstration, and basic money management. While initially providing services to low income and target groups by CBDs was a cause for concern, PSI after monitoring the latter's activities found that they were not neglecting their target groups even as they were selling condoms to the rich. As far as educational motives were concerned its neglect was difficult to assess, but the subsequent high increase in sales proved that people were motivated enough to buy and use condoms which again pointed towards the efficiency of the IEC conducted.

"The project was very successful", (PSI, 1998). In a total of all the 3000 condom sales points created throughout Haiti which guaranteed easy availability for Haitians besides traditional markets and commercial sales outlets, bars, salons, hotels both in rural and urban locales also participated in marketing the product. Apart from sales indicators, other evidences were that by end of 1996 between 70-to 95% of sexually active adults, including 85% of adolescent's males, 70% of adolescents females and 95% of commercial sex workers, acknowledged that male condoms helped protect against HIV/AIDS. In 1998, the ratio of those using the condom was 1:5 for protection notwithstanding the success rate surveys showed that there were miles to go insofar as creating awareness and its use was concerned in rural areas and that efforts may be more developed and efficient.

Mozambique

One of the poorest countries in the world with a gross of GNP $80, according to a 1995 World Bank report Mozambique is ranked 166 on UNDP human development index, even as half of the national income is derived from agriculture. By the end of 1999 HIV incidence amongst adults in Mozambique was estimated 13.2%, among the highest in Africa with 12 00 000 living with HIV AIDS and 98,000 deaths due to AIDS in 1999. HIV prevalence by 1996 among anti-natal women tested in different locations in the country was found between 18% and 23%. In addition to this the STD is estimated to be high and by 1995, depending on the location, studies of male STD clinic patients found that between 23%and 40% of those who were tested HIV positive.

Programme:

Communications and Condom Marketing for AIDS Prevention: The Promotion of Safe Sex among the High Risk Individuals in Mozambique.

The return of refugees from other countries where the prevalence of HIV was much higher than Mozambique resulted in the rise of HIV rates in the country following a severe civil unrest. A long era of civil war shattered the existing Government' policy of free distribution of condoms, with no chance of improvement in sight. The government's National AIDS control Progamme invited PSI in 1999 to design and implement a social marketing project in AIDS prevention to promote safe sex behaviour and use of condoms as a component of the NACP's programme.

The project targeted improved health of sexually active men and women and their children, by reducing the transmission of HIV and other STD's. The project implemented in 1995, had two objectives, namely increasing condom use specially in vulnerable groups through introduction, promotion and sale of a condom specifically developed for social marketing in Mozambique (JetitO meaning "flair" or "style" which lends itself to popular slogans such as living with style)- and increasing the demand for condoms through implementation of a behavioural change, communication strategy, promoting safe sex behaviour, especially targeting high risk groups such as commercial workers, long distance truckers, STD clinic attendees, night club patrons, military and police ,people with non regular sex partners ,youth and women. Started as a pilot project limited to urban and peri- urban areas in four provinces, in 1995, it project was taken to the national level by 1996 with sales and motivation teams registering their presence in all ten provinces.

Together the National AIDS Control Programme, from the total of 140 districts in Mozambique, 71 priority districts for AIDS prevention then identified as based on the following criteria:

- High incidence of STD's.
- Common borders with high prevalence countries.
- High volume of trucking
- High urban population density
- High incidence of returning refugees and migrant labourers.

A framework based on six factors necessary for a behavioural change was developed:

- Personal comprehension of being at risk
- Condom Education
- Existence of an enabling, supportive environment
- Easy condom accessibility
- Self efficacy, or sufficient determination and skills for preventive actions.
- Appropriate condom brand positioning.

Activities for affecting all factors collected from different target groups was developed in the project which revolved around a mutually reinforcing media mix emphasizing mass media and promotional materials. "The results have been impressive" (ibid). Around 50,000 peer educators in AIDS/STD sessions were held, which reached out to 1 million members in the target population. 159 traditional healers and trained birth attendants have been trained in promoting the use of condoms with their clients. A KAP survey conducted in 1997 in urban and peri urban areas revealed that 87% of the respondents were aware of the existence of condoms, 31% had used condoms at least once and 78% cited condoms as a means of preventing HIV infection.

More than 3000 condoms sales outlets have been established nationwide , including non-traditional outlets for condoms in Mozambique such as bars and clubs kiosks, gas stations, markets stalls, NGO's, supermarkets, street vendors," traditional healers" and within workplaces. Although sales were fractured by a shortage of subsidized products in 1998, demand for and sales of socially marketed condoms rose dramatically.

Constraints faced In Haiti and Mozambique were:

There was an acute lack of coordination between the NGOs and in Haiti it was easier for sales persons of NGO to sell the products to rich people. In Mozambique there was a shortfall of donor supported condoms in 1998 and PSI was eyed with suspicion.

Key lessons learnt in both countries:

CBD's could make very significant contributions to both condom availability and accessibility and also open new sales that which could be regularly serviced later by the professional sales force. Condom brand promotion could be effective when accompanied not only by mass media IEC but also by interpersonal, community based condom promotion campaigns and supported by government agencies and international agencies. Condom social marketing could be incorporated in the National AIDS Control Programme for prevention in Mozambique and an active community participation in sales and product promotion through peer education and direct sales could be a major boost to the programme.

India

Community based social marketing

A novel approach to social marketing and community based distribution system had been pilot tested for three years in Chennai, India, by IFH and the Indian institute of Community health. The model of "Community based social marketing" was taken from the commercial and the multilevel network of marketing successfully applied in many developed countries in direct, person to person product, promotion and sales. A need was felt to have potential for achieving rapid community penetration in condom promotion and distribution and STD and HIV prevention in general. Condoms and sanitary napkins were socially marketed in Chennai. Apart from the CBSM offer being an effective way for promotion of reproductive health awareness and practices it was also a chance for increased income to many.

Within social marketing one of the proven ways of "community based distribution" of product, including condoms was appointment training sales persons picked up from the common people and target groups. By establishing sales and communication networks the number of sales and IEC agents rose impressively – expectantly leading to a higher demand for information and products. Basic information on sexual and reproductive health, including HIV/AIDS, was disseminated through a "one on one" approach.

Social marketing based on target service delivery in Cameroon:

The Cameroon Social marketing Programme from 1996 to September 1997. PSI's local affiliate, introduced a Young Adult Reproductive Health project in Edea. This project adopted a "target service delivery", which included a social marketing project which distributed products to target groups, priority groups

segments of the public who were ignored by other products and services delivery systems.

Surveys helped in targeting a specific group and along with market segmentation studies are carried out after basic distribution structure to market is established and opportunities are identified. Changes in the behaviour of youth were compared with those in a control city. The concept was based on similar successful PSI projects in Botswana and South Africa. Specific objectives of the project were to target behaviour change in youth through communication and promotion and effect distribution of condoms. The purpose was also to determine the effectiveness of targeted social marketing in addressing the key reproductive health problems of young people. To understand the minds of the youth PMSC staff were trained who deliberated with community leaders and government officials to ensure their support. Research agencies were also recruited to collect information about the target groups.

Three approaches were used

Activities with active community participation and contribution specially of the youth. Extensive use of mass media and IEC campaigns including radio talk shows and distribution of IEC materials on reproductive health, video broadcasts, theatrical sketches and round table discussions, some targeting parents and children. Project results were gauged from condom sales in Edea, and operation research conducted there and a control city. Not only was there a rise in condom sale in Edea and but also a considerable improvement in adolescent male/female understanding of ways and avoiding unwanted pregnancies and HIV/STD infection. There was also a spin off to parents, teachers and community leaders.

Constraints faced in both countries:

In Cameroon a high percentage of men using condoms were not consistent and there was a strong stigma about adolescents carrying/obtaining condoms. In conducting the pilot test, the main constraints that were recognized (UNAIDS, 2000) in India included reluctance of the common man due to a strong cultural barrier and training them in sales techniques was difficult. There were also hurdles in project sustainability since condom prices proved too low necessitating a cross subsidy.

Key lessons learnt

Exposure of the youth to project activities was high in Cameroon. In a comparatively short span, the project had a positive impact on several areas of young people's health beliefs and behaviour. Among young women; there was a greater level of self-efficacy and more contraceptive use. Among men, there was an increase in contraceptive use and an increase in abstinence. Involvement of audience was one of the best ways to ensure the effectiveness of an intervention directed at young people. In India The right mix in product could enable community involvement insofar as public health education was concerned (condoms with less controversial products). There was a need for research and planning in a reproductive and sexual health context. Intensive training and support to community agents could help them overcome hesitance resulting from socio-cultural inhibitions .Those expected to replicate the training were required to be given incentives and women could be effective in selling condoms and sanitary napkins.

The key lessons learned through the various social marketing programmes implemented in different countries can be broadly summarized in the following manner.

1. Increased affordability and accessibility of socially marketed products especially in developing countries.

2. Social marketing seen as a flexible approach as it could be applied in its various forms, depending on the aims, objectives and circumstances.

3. Research was the key to effective social marketing and behaviour change. "Social marketing required comprehensive market and consumer research, and several of the cases. The depth and the scale of the research will of course depend on the amount and quality of available resources, but when resources are scarce, it is possible to collect and analyze reliable information".(UNAIDS,2000)

4. Measure of success of a social marketing programme is much more than the sales achieved, in terms of their impact within the wider socio-reproductive health context. (UNAIDS, 2000).

5. Need for expanded implementation of social marketing programmes in HIV/STD'S campaigns.

In this chapter, we see the global application of social marketing in different realms of health .Experiences with condom programming in countries like Thailand and Uganda; have demonstrated the importance of condoms as a prevention strategy against the epidemic. Case studies in Mozambique, Haiti, India and Cameroon highlight the different approaches to social marketing being applied to these countries. All these interventions were conducted by the Population services International with the help of local set ups, funded by the UNAIDS/USAID.These accounts spoke of high achievement rates in terms of making their products available, accessible and affordable to the member in the community in these poor countries plagued by HIV/AIDS. They also claim to de-stigmatize the epidemic with the help of intense communication activities scaling up awareness and behaviour change. Something that is notable in these case studies is the fact that there was government support at all levels of the

implementation of the social marketing programmes. These programmes boasted of high community participation, involvement of people through the mass media and the mid media. The community resistance was not at all talked about, especially in Mozambique, which later on gets explicated in the following analysis chapter by the researcher. The social marketers believe that the chances of misuse are much less if the product is bought at a subsidized price as offered by social marketing, vis-a vis, one that has been obtained free of cost from the Government machinery. These kinds of ideas which are not only form the basis of the social marketing programmes but also get mentioned in the marketing literature, need to be deeply probed into. When need reckons ,the poor definitely goes on to buy such product for his own protection by keeping his household items on mortgage, takes loans from the local money lender, forcing himself and his family to further go down in their miserable lifestyles.

Chapter 4

Social Marketing Policy Review: India

Social Marketing in India

Social Marketing for Family Planning

Social marketing is a public-private partnership with a long history in India for the promotion of family planning. Working through accredited Social Marketing Organizations began 15 years ago, when the government subsidized contraceptives, making it possible for traders and retailers to obtain an attractive margin despite the low cost of the products. This had the effect of making the product accessible to people who would otherwise not be able to afford it. Promotional and educational campaigns were undertaken to recruit new users, increasing product velocity and profits at the retail level and contributing to sustainable supply at a large scale. Today, half a dozen substantial social marketing organizations retain this partnership with the Government of India like the Population Services International.

The GoI's long term focus on provision of 'opportunity' or the proliferation of recognizable, affordable and attractive brands of contraception were reported to be successful. (PSI, 2005) The Condom Promotion Working Group estimated the private market at 800,000,000 with 2/3 supplied by the social marketing organizations and the remainder from commercial companies. Many social marketing organizations leveraged government support for contraceptives to obtain additional funds to address issues of "ability" and "motivation" in the promotion of contraceptive use. Funding was made available for more intensive communications to promote birth spacing, social franchising operations, rural-based promotion and development of complementary products. Social marketing organization portfolios included such products as oral re-hydration salts, iron folic acid, vitamins, clean delivery kits, water disinfectants, sanitary napkins and pregnancy tests. In some cases, these products enhanced the ability to appeal to parents by addressing health areas beyond family planning. In others, products were intended to cross-subsidize lesser value products,

creating additional funds for communication activities. Janani, the pioneering reproductive health franchise in the state of Bihar supported thousands of rural "Titli" health centers which made contraceptives available and provided referrals to "Surya" clinics for clinical reproductive health services. Vanitha and Saadhan brands identified networks of reproductive health providers in North and South of the country respectively.

Social marketing organizations innovated in order to respond to under-served populations. Rural or community-based projects were funded and social marketing organization explored new partnerships with commercial firms, through establishment of block depots and rural based distributors through the use of ICDS "ration shops" and networks involving rural medical practitioners (and wives), NGOs & Community Based Organizations, Self Help Groups, Anganwadi workers (and husbands), youth volunteers and used innovative communication such as mobile video vans, local folk media, showing presence in local fairs and market places.

These Government of India and donor-funded initiatives developed social marketing organizations in India with scale, strong management, multiple sources of funds and substantial track records in many states of the country. Collectively, social marketing organizations possessed the following core social marketing skills:

- Conducted formative research for the segmentation of populations by health risk, adoption or rejection of promoted behaviour and identification of significant determinants of behaving and non-behaving. This was the foundation of targeted, efficient social marketing.

- Evidence-based communication through inter-personal methods, mid-media and mass media. Communication ranged from the promotion of branded products and services to promotion of generic ideas, skills, educational and motivational messages supportive of promoted behaviours.

- Development and distribution of a broad range of quality products supportive of HIV prevention, including male and female condoms, lubricants and kits for syndromic management of STIs. Increasingly, social marketing organizations were building distribution networks to service high risk locations and rural areas.

- Skills in the support and promotion of private sector services. In addition to a large capacity for support of providers in the areas of reproductive and child health there was a growing capacity among social marketing organization to support services for the delivery of targeted voluntary counselling and testing and improved treatment of sexually-transmitted infections.

- Community-based, structural interventions for sex workers and other marginalized groups. In several states, social marketing agencies played a key role in the development of high quality, community-led programs.

In the strategy paper of the Government of India, the National Population Policy (GOI, 2001) stated that social marketing programmes had "immense potential in expanding outreach and coverage of health care products and services and emphasized the need to formulate and implement social marketing schemes for provisioning products and services, through partnerships between voluntary sector and NGO's the private sector, government and the PRI and the community". It recognized that it would accelerate achievement of the national socio-demographic goals. Accordingly, social marketing for RCH aimed to achieve distribution of commonly needed products at affordable prices to the lesser off (but not necessarily the poorest who could continue to rely solely on distribution by the public health system delivery), segments of the population, through commercial networks and community /NGO based distribution system. The product was priced low to enhance the affordability and increased the outreach and coverage. It was assumed that as the consumer's ability to pay increases, he would graduate "from relying upon the public health network to

the multiple social marketing outlets for the same product, and eventually to the commercially marketed products for meeting their needs."(GOI, 2001).

Accordingly, the strategy of social marketing for RCH aimed to use these channels motivated to stock and sell products on the basis of the financial margins received by them, which ensured provision for health care products through multiple channels. Ideally, the socially marketed products were made available in all pharmacies and other retail outlets in cities, small towns, and rural areas, to enhance availability and visibility in every possible manner. To add to it, the product was priced low to make it more affordable and increase outreach and coverage. It was assumed that as the consumer's ability to pay would increase; he would graduate from relying upon the public health network to the multiple social marketing outlets for the same products, and eventually to commercially marketed products for meeting their needs. Facilitation of this shift was the rationale of the National Strategy on Social Marketing.

India had introduced a brand of condom, known as "Nirodh", in the early 1960s for free supply through government hospitals and primary health centers. Due to lack in number of doctors and para medics, these activities remained concentrated mostly in urban areas. Six to seven years into the programme, it became clear that significantly wider coverage was necessary, if the vast numbers in the rural areas are to be motivated to use the condom, which must be reached out to them. "Exclusive reliance on government machinery was proving inadequate, and clearly, the family planning administered through doctors and clinics could not accomplish this task alone."(ibid)

By 1968, the private sector companies with extensive distribution networks for consumer products were invited to promote 'Nirodh' in the market. "Union Carbide, a manufacturer and distributor of flashlight batteries, Hindustan Lever and Tata Oil Mills, competing manufacturers for cooking oil and bath soap, India Tobacco Company, the premier distributor of cigarettes, and Brooke Bond Tea, the major distributor of tea, were given responsibility for operations within assigned geographic territories. Collectively they covered the entire

country."(ibid). During the eighties, Government launched an oral contraceptive pill called "Mala-D.

The Government initiated massive advertising and awareness campaigns, at the same time. There was a clear shift in the message conveyed through these messages. Till the late 80s, the campaign spoke of "do ya teen bus", highlighting an average family size of five members followed by the 90s, where the message was changed to "hum do hamare do", emphasizing the two child norm.

There was also an active participation from the Non-Government Organizations (NGOs) in the social marketing programme, with funding from Government and also from other organizations. Parivar Sewa Sanstha was the first NGO to introduce its own branded condoms in the market in the year 1978.

By the early 90s however, most of these private firms had withdrawn from the social marketing programme due to lack of adequate media support, for which reason they perceived sales as not becoming stagnant along with the cost of distribution to be very high. The implementation of the programme increasingly was done by the Social Marketing organizations only. These social marketing organizations would in return market their own brand products than the Government ones. Moreover, distribution in the urban areas was easier and more cost-effective. There was intense competition among the social marketing organizations, which began infiltrating into each others' marketing territories, possibly leading to some unethical practices.

Achievements of the Social Marketing Programme in India

1. Since the introduction of the social marketing programme in 1968, awareness regarding condoms and oral contraceptive pills had substantially increased. Current awareness among women of reproductive age was 80% for OCPs and 71% for condoms.

Methodologically flawed: with such high profile IEC campaigns, all this could not and should not be attributed to social marketing.

2. Social marketing products registered large increases in sales since they were launched. Condoms increased from 16 million pieces sold in 1968-69 to 478 million pieces in 1999-2000, and the sales of OCPs increased from 7.24 lakh cycles in 1987-88 to 349 lakh cycles in 1999-2000. The share of social marketing now accounted for one third of all condoms and all oral contraceptives distributed annually in India.

3. This is in part reflected in the quadrupling of the Contraceptive Prevalence Rate (CPR) from 10 % of eligible couples in 1971 to 48% of eligible couples in 1998-1999 (NFHS-2), and in the consequent decline of the Total Fertility Rate (TFR) from an average of 5 children per woman of reproductive age in 1971 to 3.3 in 1997. However, condoms and OCPs only accounted for 10.8% of the current Contraceptive Prevalence Rate.

4. The social marketing programmes helped provide a wider basket of choices and options within each product (condom and the OCP) for the consumer.

5. Numbers of new products, e.g. oral re hydration salts, iron-folic acid tablets, were introduced, and there is a further widening the basket of health care products.

6. Several Area Projects in social marketing, commenced as pilot projects in Madhya Pradesh (by a trust of Hindustan Latex Limited) and in Uttar Pradesh (by the State Innovations in Family Planning Services Agency) clearly demonstrated that there was an unmet need for these products in

rural areas, that could be successfully addressed and even gain immense popularity. 7. Over the years, the Government-owned brand name "Nirodh" (GoI-owned brand) also distributed through Social Marketing, had become a generic name for condoms in India.

Reference: GOI Strategy paper on social marketing in RCH

Challenges that were intended to be addressed in the formal strategy for social marketing included :(ibid) .The Social marketing programme had to ensure that people in India get the products and services that they need for basic and essential health care, in particular in the areas of maternal and child health, family planning, STD / AIDS, and safe abortion, at reasonable cost to themselves, to the Government and also to provide multiple choices, through multiple products and services, at multiple delivery points, so as to optimize outreach. A need to augment the usage and off take of reproductive and child health products being currently marketed was acknowledged. For instance, the combined sales (free supply, social marketing, and commercial sector), of condoms did not exceed 1250 million pieces per year, against the installed indigenous manufacturing capacity of about 2500 million pieces a year.(NSSM) In the past systemic inefficiencies led to frequent stock-outs of contraceptives, and shortfalls in quantities marketed. While these were substantially addressed since 1999- 2000, there was scope for further expansion and improvement.

i. Need for a proper research to tap the potential and segmented market for contraceptives and other relevant products and services, as well as consumer preferences in respect of product attributes.
ii. The programme remained needlessly over-centralized and government directed, with neither appropriately trained human resources nor administrative capacity to provide appropriate direction and management. Decision-making was based on precedents; opportunities for expansion and diversification are lost.
iii. The SMP should not remain confined to the urban and peri - urban areas, but must reach out quickly and massively to rural households. Subsidies should be re-directed accordingly. The following data from the

quinquennial National Family Health Surveys (NFHS) 1992-1993 and in 1998-1999 was revealing

Table 1

Source IIPS 1993, 2000

Rural - Urban Disparities in Contraceptive Usage

(% of reproductive age women using method)	NFHS-1 1992 / 93	NFHS-2 1998 / 99	NFHS-1 1992 / 93	NFHS 2 1998 / 99	NFHS-1 1992 / 93	NFHS 2 1998 / 99
	INDIA	INDIA	URBAN	URBAN	RURAL	RURAL
Condom	2.4	3.1	5.8	7.2	1.2	1.6
IUD	1.9	1.6	3.9	3.5	1.2	1.0
Pill	1.2	2.1	1.9	2.7	0.9	1.9

Clearly, there was an urban–rural divide in the usage of contraceptives. Furthermore, the low percentage increase in usage over the period even in urban areas was also a matter of concern.(reference :GOI strategy paper on RCH)

The objectives that were meant to be sought after through this strategy paper by the GOI in the RCH programme in India were (ibid).

i. To promote the acceptability and adoption of socially beneficial, voluntary health behaviour.
ii. To improve access to, and availability of a wide range of quality health information, products and services with a public health benefit, for the rural, under-served, low-income and vulnerable populations.

iii. To provide more affordable health care products and services, with more equitable distribution so as to reach the low income groups.

iv. To sustain increases in total contraceptive use, especially spacing methods, among all segments of the population.

v. To adequately research the segmented market for contraceptives and other products and services for basic and essential health care, as well as consumer preferences in respect of product attributes.

vi. To decentralize the social marketing programme in the field, and to mainstream the coalition envisaged in the National Population Policy, 2000, for private – NGO - public partnership possibly through a consortium that had the potential to catapult the social marketing programme into a national movement to improve availability, access and affordability of basic health care products.

vii. To simultaneously ensure the strengthening of logistics at state levels to enable an uninterrupted flow of products and services.

viii. The national strategy for social marketing sought to ensure that essential health services reached low income groups and the "economically active" poor people, through an appropriate public - private mix of financing and provisioning so that they did not pay exorbitant sums for quality health care.

Effective communication had been recognized as a key ingredient in any social marketing intervention that sought to encourage the adoption of socially beneficial health seeking behaviour, and to increase the coverage and outreach of products and services. The first step was to promote behaviour change among potential users, more particularly, among priority target groups. Communication approaches based solely on imparting information may not work as well with difficult to reach groups, as for instance, more participatory behaviour change communication that built skills in identification of the problem, articulation of symptoms and problems, and negotiation. Communication that aspired to increase demand must be combined with simultaneous measures to ensure access and availability of the health care product or service sought.

The absence of a comprehensive advertising and promotional campaign addressing (the problems faced earlier) specific concerns about diverse methods of contraception had been a major lacuna in the contraceptive social marketing programme in India. This held true globally, for other products as well. For this reason, the true potential for expanding the market for contraceptives had remained unexplored. "Demand creation as part of social marketing proved extremely effective at increasing the uptake of clearly identifiable products, such as condoms and insecticide treated nets in Tanzania, where increased product supplies were simultaneously ensured."(GoI, 2001)

The strategy paper on social marketing further recognized the strength of social marketing as a behaviour change strategy and that it enhanced access to and demand for goods and services, as a combination of advocacy and communication for health education with the power of commercial brand advertising. "It enabled people to connect the information they received with the easy access and availability of the product, and this enabled them to act upon the information bombarded at them. While IEC promoted health-seeking behaviour, social marketing facilitated the practice of such behaviour by enhancing the affordability and availability of relevant products and services to low income groups."(ibid) For example, while IEC may create a demand for temporary contraceptive methods, social marketing would support this demand by promoting the use of specific brands of condoms or oral pills through advertisement, establishing distribution channels and easily identifiable and accessible sales outlets, and marketing these contraceptives to target groups. In order to ensure comprehensive information sharing in respect of all products included in the social marketing programme, the social marketing programmes should include both brand advertising as well as generic educational campaigns (ibid).

The major focus of the communication component of social marketing aimed at bringing planned and sustainable changes in health seeking behaviour. For this to happen, messages were adapted for each segment targeted, and personal contact promoted wherever mass-media coverage was insufficient. There was a focus on generic campaigns, on the linkages between the proper spacing of

children and reductions in the mortality and morbidity among women and infants. Generic advertising of contraceptives were intended to explain the benefits as well as the limitations of the diverse contraceptive methods, with a view to dispelling myths.

The development of research based communication strategies through multiple channels would further facilitate the process of behavioural change. One of the primary goals of research was also to identify consumer preferences to be addressed in the IEC component as well as program design, in order to stimulate demand and promote use.

The IEC campaigns in different states or nation-wide were planned to be entrusted to qualified professional media agencies, who may be in the private, NGO, or public sectors. Appointments of such media agencies should be based on open competition, involving both technical bids for prescribed performance standards, and financial bids in respect of cost. This was applied to area projects as well.

"The contribution of the private sector had been invaluable in the first two decades of the programme. It was largely through their efforts that the condom (Nirodh) became a household name". (National Strategy on Social Marketing, GOI, 2001) It was now time to ensure the renewed interest and participation of the private sector, in partnership with NGOs and the Government as envisaged in the NPP 2000. The main role envisaged for this coalition is to make available, affordable and accessible a wide range of quality health products and services, at diverse delivery points, as close to rural households as feasible.

The Social Marketing programme as conceived in the strategy for Reproductive Child Health sought to achieve the following:

- Lead to behavioural change among priority target groups of specific target groups using local, innovative and research-based communication strategies.

- Expand the market in rural areas and urban slums, using government rural health infrastructure in addition to private distribution networks.

- Involve the private sector and encourage public-private partnership at all levels.

- Expand the current basket of products.

- Apply commercial franchising techniques to the delivery of standard preventive services.

- Encourage these shifts with government subsidies for the development of new rural markets, better targeting of free distribution towards most vulnerable groups, and funding of specific interventions in specific areas (area-projects).

- Diversify the sources of funding (private corporate sector).

- Set-up a new mechanism for stronger stakeholder involvement in the management of the programme.

- Improve the management of the programme with the development of rational and transparent guidelines for product management, allocation of government funds, monitoring and evaluation.

- Along with its partners, set-up a Code of Ethics for social marketing practices and corresponding sanction measures.

Therefore, we see that in the strategy, the Government of India emphasized the role of the private sector, giving more importance to this half of the sector ignoring the other half, William P. Schellsetede and Robert L Ciszweski, (1984)reported that the since 1975 the family planning program

that advertised and commercially distributed contraceptives products in urban and rural areas throughout the country, managed by Population Services International , performed almost consistently- meeting and exceeded increasingly ambitious distribution goals, serving almost 1 million acceptors per month at an annual cost per couple of less than US$6.50 , including cost of donated contraceptives. The elements of contribution can be summarized in the following way:

- Promotion availability of non clinical contraceptives
- Monetization of the public sector, the vast commercial system is made to contribute in an important way to the National Population objectives. Further more the human and the material resources which went unused were mobilized for an important cause. "By placing a monetary value on the contraceptives, the public began to appreciate the fact of their real worth: their products became valuable and therefore more attractive, increasing the likelihood of its use" (ibid).
- Good acceptance and support by the Bangladesh Government. In many cases governmental support were critical to success as, in gaining access to media for advertising and securing clearances for the products, establishing the "legitimacy of the social marketing programme
- In many countries, social marketing programs were an essential component of the national family planning and HIV prevention programs. At present, large-scale social marketing programs for reproductive health were in operation in over 60 countries worldwide. A growing body of evidence showed that social marketing programs could make an important contribution to the reproductive health of the target population ([future's Group 1999).
- In 2002, social marketing programs in 69 countries sold almost 1.6 billion condoms (DKT, 2003) accounting for more than half of all condoms available from public sources. Total sales of condoms, pills, vaginal foaming tablets and IUDs amounted to over 28 million couple-years of protection (a measure of the number of couples that could be

protected from pregnancy for one year). In these countries (excluding China and Russia) social marketing sales of temporary methods of contraception excluding condoms accounted for almost 10 percent of all use (future's Group 1999).

- Social marketing tended to be a cost-effective approach to achieving widespread access to health products and services.It used private sector incentives and organizations to achieve efficiency and revenues from sales to offset some of the program costs. The total cost of $6 per couple-year of protection compared favourably with costs to implement public sector family planning programs, which were around $15–20 per couple-year of protection (Gillespie etal 1988).

Some programs may eventually become self-sustaining and graduate from donor assistance altogether. Some social marketing programs in low-income countries were now operated by independent local social marketing foundations (e.g., the Ghana Social Marketing Foundation (GSMF) and ADEMAS in Senegal) and in some middle-income countries social marketing sales were continuing well after donor assistance has ended (e.g., condoms in Turkey, oral contraceptives in Morocco, and injectables in Brazil) (Allman, 1998)

T.R Black (1976) pointed out that the issue of social marketing approaches were retrograde in the face of population crisis; that it was not capable of massive expansion and that the high turnover of volunteers made for inefficiencies and intermittency of supply which naturally was undesirable with contraceptives. Critics of the sale of contraceptives maintained that it was commercializing family planning and that however low the selling price was this would deny contraceptives to the extremely poor. Advocates of community based distribution maintained that the implications for family planning went beyond non clinical distribution; saw it as an important step to involving grass root community actually in the process of programming.

Philip.D.Harvey, (1994) in his paper, pointed out that the Nirodh condom in India, the first socially marketed contraceptive, had consistently been sold for less than US 1cent per condom since its introduction in the late 60s. After Nirodh, the second largest brand – Bangladesh's RAJA condom had similarly been priced less than 1US cent each throughout most of the programs 15 year history. Maureen A. Lewis (1986) went on to say that the Government sponsored family planning services in developing countries used free contraceptives supply to the couples who chose contraception. He in his article compared fee for service and free family planning programs and found that that there existed little difference between free and moderately priced services.

Adel .I.EL Ansary and Oscar E.Kramer, Jr, (1973), in his paper, elaborated on how the Louisiana Model of Family planning had been a success which was a result of:

- Adoption of a consumer related philosophy in service delivery as manifested by

a) Defining the services needed by the customer
b) Determining a market target and the use of market segmentation
c) Taking the service to the customer rather than bringing the customer to the service source.
d) Emphasizing the "concept of selling family planning rather than giving a free control birth method." (ibid)

- The recognition of marketing as a process with various participants other than the Family Health Foundation and the customer.
- The recognition of marketing as an integrated effort involving the design of the marketing mix
- The use of a generic "human services" definitions rather than a myopic" family planning definition" of the program's services.

Review of the HIV-AIDS policy.

In reaction to the widespread threat posed by the HIV AIDS pandemic, the Government of India formulated a National AIDS Committee in 1986.On the basis of the recommendations of that Committee, a National AIDS Control Programme was also formulated in 1986. In 1989, a medium term plan for AIDS Control was developed (for three years) with US, $19 million budget to be provided by the external sources. This plan was implemented in 5 states/UTs, namely Maharashtra, Tamil Nadu, West Bengal, Manipur, and Delhi. Initial activities focused on the reinforcement of programme management capacities along with targeted IEC and surveillance activities. It was decided that to change unsafe behaviour, health education through all methods of communication from mass media to inter personal exchanges based on the target groups would be used. For the first time collaboration and co operation of NGO's was also sought. Along with IEC and social mobilization, condom promotion was also aimed at.

It was only after the World Bank gave massive funds for a "strategic plan for prevention and control of AIDS in India", that NACO was established and the NACP was strengthened and consolidated with an allocation of Rs.222.60 crore for the period of 1992-97.

The major components of this strategic plan were the following:

- Programme development
- Surveillance and research
- Behaviour change through Information, Education and communication and the reduction of Impact
- STD Control
- Condom programming
- Blood safety Programme

For an effective AIDS communication programme it was important to know the current stock of knowledge, attitude and practices of the people towards AIDS. For this purpose NACO utilized studies conducted by VHAI, NSS,TISS and some market research firms conducted among youth students, injecting drug users, sex workers and clients of sex workers .

The common findings of these studies were:

- Most individuals did not have accurate information on AIDS.
- The direct link between STD'S and AIDS was not clear to most people.
- STD's were not perceived as serious conditions since they were curable.
- There was a belief that HIV transmission and AIDS was only found in limited groups.
- There was an attitude that AIDS "cannot happen to me", and that in general AIDS was not a problem of major concern for India.

The first phase of the World Bank project for the NACP lasted from 1992-1999. Some of the objectives were well achieved, notably the inflated rates of awareness. The second phase of the programme started in 1999 and till March 2006, during which there was an expansion of the programme at the state level, and greater emphasis on the high risk group and the prevention intervention amongst the general population, with an involvement of the non governmental organizations and other sectors and departments. The Government of India envisaged a complex consultative process including nation wide consultations with various national stake holders, as well as international organizations.

In NACP II the major shift was from a focus on raising awareness to changing behaviour through intervention, participation for groups at high risk of contracting and spreading HIV.

To support decentralization of service delivery to the states and the municipalities and a new facilitating role for the National AIDS Control Organization.

To protect human rights by encouraging voluntary counselling and testing and discouraging mandatory testing.

To support structure and evidence based annual reviews and ongoing operational research.

The key objectives:

A. To reduce the spread of HIV infection in India.

B. Strengthen India's capacity to respond to HIV/AIDS on a long term basis.

Therefore, operationally the project would seek to achieve the following by the end of the project.

- To attain 90% awareness among the youth and the others in the reproductive age groups.
- To achieve condom use of not less than 90% among HRG
- Target intervention for the HRG
- Preventive intervention for the community
- IEC and awareness campaigns complementing all the above mentioned.

Project strategy

A. Delivery of cost effective interventions against HIV/AIDS.

1. Priority targeted intervention for groups at high risk.
2. Preventive intervention for the general community
3. Low cost AIDS care.

B. Strengthen capacity

1. Institutional strengthening
2. Inter-sectoral collaboration.

Achievements:

1. Preventions indicator study showed that there was a rise in awareness levels from 68% to 94% in urban areas, 9% to 35% in rural areas.

Availability of good quality condoms through Social marketing made a significant change.

Social Marketing in NACP I and II

State AIDS Control Societies were not able to provide with adequate funding to cover the Social Marketing Organizations costs of setting up, implementing and monitoring an operation targeted to high risk groups. This was one of the major reasons behind Social marketing been given little emphasis and no investment throughout the years of NACPI and NACPII. It was not a component of either design or even late stage efforts to engage with social marketing agencies to implement targeted condom distribution and communication campaigns.

It was through the support of International donors like Gates Foundation and USAID, that comprehensive work on social marketing approach on prevention against HIV-AIDS had begun, with appropriate support for condom distribution and promotion, in a limited sense. The support came in the form of substantial investments with these social marketing organizations, to deal with intensive, evidence-based communication with high risk audiences, community-led structural interventions, targeted condom distribution and increased availability and quality of key related services, such as treatment for sexually transmitted infections and voluntary counselling and testing. These initiatives were well co-ordinated with close partnerships with the State AIDS Control Society of the respective states.

Despite these investments in absence of a direct emphasis in the NACP, the support for social marketing was diminished largely to the volume based

condom distribution led by the Department of Health and Family Welfare. This approach had a number of severe limitations for the HIV prevention effort:

- The family planning condom program was not likely to reach the right audiences for HIV prevention.

A family planning focused program properly prioritized volume distribution and targets families. The entire general population of fertile couples was at risk of unwanted pregnancy. Therefore, volume sales of contraceptives could be safely assumed to be averting pregnancies. However, in addressing HIV a condom sale was useful to the degree it was purchased and used by a person at risk of contracting or transmitting HIV. There was no mechanism within the Department of Family Welfare's system to assess whether high risk groups were purchasing and using condoms nor was this an objective of that program. Social marketing for HIV prevention needed to be accountable not just for sales but for increased reported use among key target groups.

- High prevalence states had low condom use under the Family Welfare program

The hardest hit states of the South and Northeast did not have strong condom markets for family planning because permanent methods of contraception had long been dominant there (especially in the South). This meant that affordability and ready availability of condoms was an issue that remained largely unaddressed.

- **Missed opportunity.**

With ready social marketing capacity in the country, the NACP missed the power of social marketing to operate at scale on key behaviours in addition to consistent condom use. Further, it left untapped the opportunity to integrate communication with needed products and services for specific high risk groups.

NACP III Social Marketing Strategy.

Under NACP III, social marketing will be used along with legal and education-based strategies as one of three forms of behaviour change programming. It will evolve with sensitivity to the wide district and state-level variation in prevalence levels and risk behaviour in the country. Social marketing projects will be designed for specific at-risk populations and their success will be measured by the achievement of discrete behavioural objectives.

Social Marketing Activities and Target Groups

Under NACP III, Social Marketing may be applied as a lead behaviour change strategy and as a measure supportive of education and law-based approaches where that was more appropriate. Social marketing was a natural lead strategy for the widely dispersed "bridge populations" and was supportive in the efforts with core risk groups such as sex workers. It may also assist with a number of initiatives for the general populations such as ensuring widespread condom supplies and the operation of telephone help lines.

Behavioural indicators to be measured under social marketing programs include (only an illustrative list):

Table I.

(Reference: McLean social marketing proposal; Population Services International, 2005)

Social marketing as a lead strategy	Social marketing as a supportive strategy
• Increase in reported consistent condom use in high risk sex • Improved treatment seeking for STI services • Reported use of VCT and knowledge of HIV status • Increase in reported use of safe injection equipment	• Condom access in places of high risk sex • Referrals from social marketing STI treatment franchises for TB, PMTCT, ARV • Sex workers and clients reported that they were comfortable purchasing condoms • Female condoms and lubricants were regularly available • MSM approved of condom products and STI franchise services

Donor expertise: A number of international donors supported comprehensive social marketing in India and elsewhere providing access to good practice in the design, oversight and evaluation of social marketing programs. Donors were requested to provide technical assistance in the design and management of social marketing interventions or asked to take up the task directly as part of their support of NACP III.

Public sector facilities: There was substantial discussion in the working groups about ways to improve the uptake of VCT, STI and other key services in the public sector. In many cases these were part of the mainstream public service delivery network and were set up within existing structures as that was most cost-efficient. However, these services were rarely convenient, welcoming or sensitive to the stigma and other barriers faced by these audiences. There certainly existed some public facilities which catered effectively to risk groups

and these would serve as good referral points for many of the targeted and social marketing interventions underway. However, where a public medical facility did not serve this essential need, social franchising or direct set-up of mobile or static VCT centers were effective means to fill gaps and capitalize on the existing treatment seeking behaviour of the audiences.

Population Segmentation and Program Design

Segmentation of populations is a technique which assisted social marketers to address effectively the right populations to bring about a change in behaviours and then health status. Under NACP III, the management team would face two key segmentation questions for social marketing.

1. Is the social marketing program responsive to the observed health status or need within the population? In the case of HIV, the disease burden caused by HIV was measured by the level of prevalence in a given district. As our epidemic was driven by groups at high risk, its scale and quality of reach among core risk groups was of paramount importance if we wished to relieve the burden of disease. Therefore, our first level of population segmentation involved estimates of prevalence and levels of risk behaviour. An analytical framework below with both prevalence and risk behaviour would serve as a useful guide for investments in a given district.

FOCUS DISTRICTS

The battle with Indian HIV epidemic would be won or lost in these districts. This called for full scale, integrated social marketing with maximum investment in male and female condom promotion and distribution, funds for multi-media communications, and investment in targeted services through social franchising (STIs) or direct implementation such as mobile VCT. Social marketing for support of IDUs may be developed and piloted for support of clean injecting.

HIGHLY VULNERABLE DISTRICTS

The challenging task at hand was to keep these districts at low prevalence. This put a premium on all preventive social marketing inputs, with an emphasis on consistent male condom use, partner reduction and some associated services such as mobile VCT.

DIFFUSION DISTRICTS

Care, support and treatment are prioritized in these districts which could reflect the activity of bridge populations who travel, engage in high risk behaviour and upon return, infect their regular partners. As levels of risk behaviour were low these locations would have increased in those infected but these districts were not likely to be drivers of the epidemic. Therefore, rather than social marketing, educational approaches to behaviour change were prioritized here to encourage bridge groups (primarily men) to protect their families through condom use and patronize public VCT clinics. As many of those affected were not from stigmatized populations, they would most likely use public VCT services. Where there were gaps, social marketing may play a role in targeted VCT provision and promotion with referral to other facilities for care and support, TB control and other medical services. Support of general condom distribution and promotion was called for.

LOW RISK DISTRICTS

These districts displayed neither the prevalence nor behaviour levels to give rise to major epidemics. The work by the Department of Family Welfare was appropriate here to continue wide distribution and promotion of condoms for family planning. Educational approaches again were important to build or maintain basic awareness. The NACP may advance its agenda through

collaboration with Family Welfare or social marketing agencies to develop further a dual message for condom promotion (protection from unwanted pregnancy and STIs such as HIV/AIDS).

2. Is the program responsive to key target groups in their respective environments? Given India's size and complexity, local conditions would vary widely across states and districts. These conditions such as cultural, linguistic and social norms, urban/rural mix and media access required flexibility in social marketing. There would also be variance in the existence of the promoted behaviour(s), i.e. the number of "behavers" from one place to the next. By implication, the specific approaches required would vary from district to district.

Core and bridge populations under NACP III required high intensity programs involving community support and skill building, repetition of message, ready access to products and services and iterative project design based on evidence of impact. In India, this implied that the NACP managers should be able to tailor social marketing programs to the great variety of situations around the country. The district and state level design and implementation under the NACP III was supportive of good social marketing in this respect. Its success would depend on the discipline with which segmentation of populations was undertaken. The figure below summarizes a manner in which this may be accomplished and it is explained in detail on the ensuing pages.

High Risk Behaviour Districts

Social marketing's main usefulness was in those districts (estimated to be about 200 in number) where risk behaviour was substantial enough to drive an increasing HIV epidemic. For programming purposes, these were best divided into those districts which comprised the key driving forces of the epidemic in

the high prevalence states and those which were "islands" of high risk behaviour in low prevalence states.

Core, Bridge and Low Risk Populations

It was anticipated that community-led structural interventions would take the lead for behaviour change among the core risk groups of sex workers, MSM and IDUs. However, social marketing would play an important supportive role, often in the form of development, supply, promotion and distribution of key products and services such as VCT.

Bridge populations were the natural audience for social marketing. They were a priority due to their typically high power in sexual encounters with core groups and their role in transmitting the virus to low risk populations. These were usually men, a large, dispersed population without any specific socio-demographic or profession.

Low risk groups, those without evident risk behaviours, were not usually targeted through social marketing. Behavioural issues related to their safety were best approached through educational and legal behaviour change strategies.

Behavers and Non-behavers

Quantitative evidence was required systematically on core and bridge target populations to understand how those who were behaving as promoted differed from those who were not. Differences typically emerged at district and state level across indicators of opportunity, ability and motivation. This information then informed program design intended to create more "behaves".

Marketing Activities (the 4 Ps or selective inputs)

Behaviour change among bridge populations in the core and highly vulnerable districts required investment in all of the marketing disciplines while its

supportive roles targeting core risk groups would typically involve opportunity only —establishment, distribution and promotion of branded products and (in some instances) services.

Low Risk Behaviour Districts

Major NACP investments here were anticipated to be in "Diffusion" districts where care and support was the priority. Social marketing for prevention in these districts would be limited to some gap-filling of VCT services and coordination and collaboration with the Department of Family Welfare to ensure general audience condom distribution and dual messaging for pregnancy and disease prevention.

Roles and Responsibilities

Assuming acceptance of recommendations from the program management working group, NACP III would be undertaken with an orientation toward increasing decentralization and a focus on outsourcing of major specialist initiatives such as social marketing.

For social marketing, NACO and SACS would need to play a key role in the following:

- Identification of the core and highly vulnerable districts
- Framing district level target groups for social marketing and identification of behaviours to be addressed
- Resource allocation
- Collaboration with the Department of Family Welfare for access to the required quantity of male condoms

- Develop mechanisms in collaboration with the government or commercial sectors to source other needed commodities or products necessary for the support of social marketing
- Assess and revise social marketing or other policies which required to support the implementation of greater collaboration with private sector providers and other initiatives
- Environmental analysis and development of social marketing scopes of work
- Tendering and contracting for social marketing services
- Supporting and evaluating social marketing projects
- Foster coordination, linkages and exchange among the different social marketing projects and with other program components

Social marketing implementers would take the lead in the following:

- Assess selected target populations and devise program hypotheses on the constraints to adoption of promoted behaviours
- Design and implement a marketing mix and collaborative activities which addressed identified constraints, creating more "behaves"
- Monitor regularly success of activities in bringing about desired behaviour change; modify approach as indicated
- Disseminate results and share lessons learned

Ahavahan, a Population Services International initiative, funded by the Gates Melinda Foundation, the largest running programme in HIV-AIDS, sought to arrest spread of the HIV epidemic that was (through unsafe sexual practices) in states like Andhra Pradesh, Karnataka, Tamil Nadu, and Maharashtra, and the other through (IV drug abusers in states like two NE states).These six states accounted for around 70% of the total HIV cases in India. 90 of these 100 high prevalence districts were in these 6 states.

The strategies they employed to cut down the transmission of the virus through unsafe sexual practices were.

(a) Consistent condom use through rate of partner change and,

(b) STI control through STI treatment

If the incidence was predominantly driven by commercial sex then the arrest of the virus in sexual route states was done through STI control for the commercial workers ,through the Lead agency and the clients of sex workers through the main agency i.e. PSI.

The behaviour of one group reinforces the behaviour of the other group. The target group of Population Services International in HIV-AIDS prevention initiative had been the men clients of the female commercial sex workers, who did not fall under any demographic or geographic segment, with the following behavioural change objectives:

1. Consistent condom use
2. Improve treatment seeking for STI(timely and appropriate treatment)

The behavioural challenge of the male clients of the commercial sex workers comprised of condom use, which would be thereupon facilitated by first the opportunity to use product or services that is to say general availability of condoms in urban areas established , convenient availability in places of sex remains a priority: and second motivation and ability to use product or service so to say low skill, confidence in using a condom ,product related resistance: pleasure, Image of the product, user/buyer.

In the case of STI treatment the opportunity to use product or services would mean client research; low perceived availability of STI services, and provider research: low knowledge and practice of SYNG mgt products. The motivation and ability to use product or service would thereby comprise of the following

1. Misconception related to STI causation

2. Low belief in the severity of STIs'
3. Incorrect treatment seeking practices.

This project therefore intended to serve the high Risk groups, targeting the clients of the commercial sex workers , as summarized above can be called not only a prevention initiative but also an intervention , in the four high prevalence states in India.

The discussions with the key informant were very enlightening as it not only widened my scope of understanding but also added certain new perspectives/dimensions to my study. The meetings with the JSACS authority however indicated that the good work which was being projected was only on paper. Since it was a comparatively new society formed in 2001 after the creation of the state of Jharkhand, there were little or no assessment reports available for study. Though the Society claimed to have done some good work towards prevention along with social marketing organizations surprisingly discussions held. later with these organizations including Population Services International and Hindustan Latex revealed that on the ground precious little had been done to spread awareness on prevention of HIV-AIDS in the state. These organizations which were the leading ones in the social marketing sector not only in the State but also at the global level, talked only about Social Marketing of condoms for family planning while the cause related marketing of HIV-AIDS took a back seat. The organizations also asserted that as part of the condom distribution program, they at times made a passing mention about safety /protection against HIV-AIDS. The complacency of these premier organizations proved the lackadaisical attitude of the government towards the entire cause of VULNERABIITY—PREVENTION. The organizations were focused on High Risk groups, ignoring the realities of the bridging population which was the core of the explosion.

As Prof KK Bhagat (Xavier's Institute of Social Service, Ranchi) complained after completing an assessment study in the Dhanbad district of Jharkhand, "there was no substantial work going on in Jharkhand for HIV-AIDS". It was high time

the State Society tried to materialize their goals, especially in terms of prevention against the Syndrome."

According to what PSI officials reported, the social marketing strategies were primarily used for promoting Family Planning measures which still managed to grab immediate attention. There were intensive levels of communication activities that were conducted at the initial stages of intervention in the target areas to assess the needs or the requirements of the people. Surprisingly this part of research was done by external research organizations. After these baseline surveys were conducted, the entire team got into action and delved into intense communication activities like engaging in the local mass and mid media. There were proper numbers of peer educators who were trained and sent into the community to spread the message .The products were marketed through proper channels of stockiest, retailers and then the small "dhabas", "beetel" shops and other commercial spots for social marketers, the key words being "accessibility and affordability".

After a few assessments and evaluation of this strategy of Social Marketing of Contraceptives, it was found that although there had been a considerable increase in awareness levels there was a huge gap in Knowledge, Attitude and Practice (KAP-GAP). An official from Population Services International, Ranchi along with other social marketers talked about the non- functioning of the government machinery in terms of free distribution of contraceptives and pills, but said that there was no negotiation between the Private and the Public. He said that they promoted and sold the Government subsidized condom. During these sessions of contraceptive distribution and promotion ideally they did not promote brand but safety, i.e. "sell with knowledge". As the PSI officials claimed they promoted the Government brand first and then their own which was according the other researcher, highly questionable.

According to Mr. Jha (HLL, Ranchi) social marketing was all about commercial marketing where "target", captured the centre stage and that all social marketing organizations were vying for achieving their set targets, by hook or

crook. He refuted Mrs. Pushpa Kujur's (JSACS, Ranchi) claim that school intervention program was being held at both the rural and urban levels. Mr. Jha completely denied any possibility of any such program being held in a place like Jharkhand. The fact that the people of the state were still conservative on ideas like sex and sexuality, where even a poster of the HLL brand called "Masti" is torn and thrown also was a major deterrent for the campaign.

The question that came up now was on what terms was the awareness campaigns held if the basic issues of sex and sexuality were not addressed in a given situation where no work was underway on the HIV-AIDS front? He said that they had a reach even in the remotest villages through their network. They accordingly identified Quacks and RMPs who became facilitators for them and many other such "target achievers". He revealed many aspects of the issue and complained against the government which had problems in policy conceptualization which in turn encouraged unhealthy competition. Regarding condoms distributed free he even said that these condoms hardly reached the PHC's but were sent across borders, burnt or, destroyed in a bid to achieve the ultimate "target". The HLL list of activities comprised promotion of birth spacing, health and hygiene through school intervention programs (Sakhi). It's interesting to note that HIV/AIDS did not feature at all in the list. It also emphasized on keywords of the social marketing programmes where access, availability and affordability were important. The undercutting of costs was another deterring factoring the entire process of marketing.

Something that was of real interest to the researcher was the information received from Mr. YK Pandey (PSI, Ranchi) who when asked about price affordability said that one tried to afford the commodities that accounted for safety. When the weekly income of a poor farmer was hardly Rs.10, how could he afford a packet of four condoms at Rs 5? Or how could he spend half his income on buying a pack of something for preventing something which might or might not strike him/her. Secondly, when asked whether the condoms were rightly used and not misutilized he said that it was human psychology to make optimum use of a commodity and not misuse or waste it, if its bought from his

well managed budget. When enquired if people from the poorest segments of society were actually excluded from the target groups, he said that they did exclude them but were supposedly reached by the Government. According to them with purchasing capacities of a consumer on the rise it was not difficult to pay for a condom at Rs 5 for a packet of 4 pieces, where their safety and protection was important. "They even sell their household commodities at times to buy their safety".

Field workers from the Ahavahan Project, (Population Services International, Ranchi) performed on VAT i.e. *Visibility, and Touchability* techniques- at high points on National Highways. Communication activities started off with some orchestra shows conveying HIV-AIDS messages to the truckers (a group exhibiting "high risk behaviour") and their other companions. Stalls were set up for demonstration and promotion of condoms in a comprehensive way. These condoms were distributed at the nearby "dhabas", "pan shops", petrol pumps and other access areas. The target achieved was assessed in terms of number of pieces sold and not in terms of pieces used. These high point areas of NH2 and NH6 had surrounding villages where commercial sex workers were highly active. These field workers did not reach them directly but through their clients (truckers at the high point). Even when they knew that women were equally vulnerable, they were not rendered help or made aware of being shielded from the infection.

Therefore we analyzed how the strategy of social marketing had been applied to attempt in behavioural changes in a community both in Family Planning and to arrest the spread of the HIV virus. It got clear that the support of the Government became very important in the proper implementation of Social marketing. The blurring line between condom being used as a contraceptive and as prevention against HIV/AIDS, adds on to the difficulty, right at the conceptualization of the strategy for an effective solution. Targeting the population was one of the primary tasks of this strategy which would lead to the arrest of the problem.

The emphasis on social marketing in the National AIDS Control Programme has, as mentioned above, had been very little- restricted to condom distribution. Lack of funds had been one of the other reasons which led to an irresponsive prevention strategy. The previous chapters were meant to draw attention to the application of social marketing at a global level, in different countries, in HIV AIDS, with comparable parameters of socio-economic development. This chapter systematically reviewed the strategy of social marketing at the policy level both in Family Planning as well as in HIV in India. This chapter would be followed up by an analysis chapter which would deal not only with analysis of the theory but also the application of social marketing as a strategy in HIV AIDS.

Chapter 5

Analysis and Conclusion

Amidst the ongoing debates related to health sector reforms, we can easily make out that there is clear shift of emphasis from public health care service, to a market driven model where quality, costs and efficiency will be ensured by the competition between providers and informed consumers. This notion of public health, no doubt shrinks the scope of the state's social responsibility, which was once the very basis of public health. State responsibility is no more considered desirable as it hinders the unleashing market forces in the health sector.

The paradigm shift that happened from the all Comprehensive PHC to the packaged one that was implemented ,to the present one, can be clearly seen in the form of varying roles played by the World bank/IMF, not only at the global but also at the national levels .The first and the Second Five year plans in India, gave priority to the building of an appropriate infrastructure ,water supply, sanitation and the MCH, digressing from the attention to be given to the problem of poverty, leaving it to the economic planners, leading to disjuncture.

The Third and the Five Year plans gave less attention not only to the rate of expansion of infrastructure, but there was also a shift from "building peripheral health centers to specializations and Hospitals." There was a complete separation of the vertical techno-centric programs from the general health services. (Qadeer, 2001)

"As population Control remained the priority at the National level, this integration converted FPP into the Black hole of Health Services which sucked into the resources of all other programs"(ibid). The emphasis was shifted to cure rather than one of the most important aspects of Public Health -prevention being ignored. there was evident transfer of power and interest of the ruling class, from the British Military to the Indian ruling class, to the IMF/World

Bank, leading on to adjustments of the Health Services, compromising with the felt need of its own people.

This string of restructures and adjustment didn't stop with the packaged PHC, but it further gave way to the new public health management, in consonance with the World Bank recommendations. This has resulted into the use of terminologies which are rooted into market economics, with an unquestioning acceptance of its guiding principles of demand, supply, choice and cost containment, as the most rational means to reorganize health care throughout the world. Advocates of this view claim that due to the poor economic performance of the Public sector, greater competition in the provision of services is the only means of providing better quality care and improving the efficiency of the Public services (World Bank 1987, 1983).

Due to specific economic and political conditions, in the developing countries, during the 1980's and the 90's, there were variations in the utilization of the public Health care provisions. (Qadeer, 1994).The falling rates of the use of the pubic services due to poor quality of these services was shown as the main indicator, resulting into dissatisfaction and finally being considered as the lead argument for the privatization of the Health services(Mills,1993),guided by the notions of cost containment.(Health Policy Planning 1995,World Bank,1993).A number of authors argued that there has been a shift from the neo-Keynesian outlook of the post war years ,that recognized state responsibility for "basic consumer choice" as a pre-requisites for the organization of services.(Green,1995).

It has been very ironic that while there have been significant reforms proposed for the developing nations with the private sector taking over, the equations are quite the opposite in the developed nations ,where the State is still playing the lead role. (Sen,2001).The fact that public provision ensures redistributive justice, and a growth oriented and market oriented and market led economy, replacing the former, gets restricted in a very econmistic way. This view fails to recognize the global evidence on the widespread acceptance of the socio-

economic origins of the ill health by a majority of policy makers all through the world, to which the Alma Ata declaration too holds a testimony.

The roots of the Structural Adjustment Policies can be traced in the economic crises experienced by many countries during the latter half of the 70's. According to some "... the rich got the loans and the poor got the debts" (Kent 1991).

The World Bank along with the IMF helped the developing countries to pay off the loans, on the condition that the countries adopt economic policies doctored by them for the country's economic growth which was nothing but a strategy to replace the State sector in Public services or to lessen their roles to the minimum, in disguise. (Kanji et al.1991; Lowenson 1993; Werner etal.1996).

The Structural adjustment policies have involved :(ibid)

- Sharp cuts in public spending on health education and others social services
- The removal of subsidies and lifting of price controls on staple foods and basic commodities.
- Freezing of wages
- Shift from the production of food and goods for domestic consumption to production for export.
- Liberalization of trade policies
- Efforts to attract foreign investors by providing them incentives, such as liberal regulatory regimens including fiscal incentives.
- Privatization of public services and the state enterprise
- Devaluation of the local currency.

If we talk about the evidence of effect upon the economy ,there is enough amount of literature to show that the economic policies of lifting price controls, freezing wages, devaluing local currencies, and reducing subsidies on basic essentials such as food and transport have reduced the purchasing power,

further reducing the consumption of nutritional staple foods esp. in the vulnerable groups of children and elderly people and women notable in the countries like Africa, Mexico and Brazil(Watson 1994;Werner etal 1996). Evidence from these countries show that the purchasing capacity of the people to but food, transport, education and health care has been reduced, and also shows that it has not only intensified intra regional inequalities but also aggravated it at the international levels.

Among the changes in the developing countries were:

- Introduction of user fees for specific services
- Introduction of health insurance
- The advocacy for de-centralization
- Introduction of community -based financing
- The location of NGO's as a key reference point in service provision.

The World Development Report 1993, advocated that the public sector should provide only essential services such as 'clinical packages" for the needy whilst the tertiary sector opens up to full global competition (Qadeer 1994, World Bank 1993).There has been very little attempt to define the health sector in developing nations as it might be the interdependency and the complexity within the system which might be ignored, where often the public sector provides much of the basic health care for the majority of the rural population.

As far as the user fees were concerned which are suggested to help increase the insufficient budget for health and inadequate resources for running services, there has been a large body of empirical evidence on a world wide scale on its impact that they enhance inequities, decrease access by the poor and add significantly to their financial hardships [Sen,2001]. In fact, it has been noted that where people are struggling to make ends meet, this is at the very least 27% of India's population (GOI); it is not possible for them to have resources for their sickness. This has led into people not using the Government services at all the overall evidence on the other aspects of reforms, such as decentralization, community financing, reveal and reinforce that under

conditions of gross inequality, the application of market formulae can only act to the advantage of the more wealthy and powerful and strengthen the gradients of poverty and inequality. (Evans 1997).

This now sets a perfect backdrop for us to understand, how far and to what extent the strategy of social marketing and public health go hand in hand, especially in the Indian context with specific reference to HIV-AIDS. This tool of social marketing is used for both prevention and intervention at different levels. People, related to the global pandemic, keeping in mind the goals of "comprehensiveness, universality and equity" (Alma Ata, 1978).

The private sector is taking over from public health services, with private health care, private insurance, provision and finance burgeoning with the advent of the New Public Health Management. Social marketing has been one of the various faces of the same phenomena, introduced for now more than 20years.

Social marketing has emerged as a dominant approach to Health education and behaviour change for more than 20 years now in the developing world, in many instances replacing community outreach, empowerment and participation programs. The social marketing concept, which centers on the use of commercial advertising techniques and private sector distribution of health products to promote "individuals behaviour change", has been institutionalize in many ways .

Condom social marketing has become the centre piece of AIDS education and prevention in many developing countries in Asia and Sub-Saharan African countries. However this successful global diffusion for social marketing techniques for Health promotion has not driven by a thoroughly demonstrated efficacy in improving health by motivating behaviour change.

Infact independent evaluations of the social marketing campaigns are rare in the developing and the developed world, and existing evaluations tend to focus narrowly on the number of units or self reported change of knowledge or

behaviour. (Price, 2001).The widespread promotion of social marketing by Health Ministries and implemented by NGO'S, can be traced more directly to the promotion and privatization of the free market economics in the era of SAP. The celebration of the private sector, the commitment to promoting payment for health products, and the narrow focus on individual behaviour change that define the SM approach provide a tight ideological fit with the broader economic adjustment reform package. Major bilateral and multilateral donors have increasingly channelized much of their Public Health funding into SM campaigns, usually managed by the International NGO's, working on the multiple virtues of the private sectors ability to reach the target communities more efficiently than State services to change the presumably the harmful health behaviours of the people (USAID 2002a,2003a: World Bank 1999).

The concept of social marketing has been under controversy since its very inception. It is believed that its very application ignores the genuine community participation and other structural determinants and constraints on health related behaviour (Wallack, 1993). The use of commercial advertising techniques, the emphasis on the commercial sector, and stress on health products rather than their free distribution in the Public Sector contrasting against the "health for all", elaborated in the Alma Ata in 1978. The last two decades have seen a slow roll back in public sector PHC services led by the SAP that have reduced spending for the Government services. (Kim 2000; Peterson and Swartz 2002; Poku 2002).

As Peter Pilot Director of UNAIDS stated "structural adjustments raises particular problems for Governments because most of the factors which fuel the AIDS pandemic are also those factors that come to play in SAP" (Poku 2002; 538). Social marketing along with the International NGO's and donors approached AIDS prevention with a pre- packaged approach going hand in hand with the economic reforms, with "cost effectiveness as the bottom line."(ibid) The AIDS campaign in Mozambique can be easily used to show the shortcomings of the social marketing programs, where over 20 percent of the adult population in several areas of the country are HIV-positive, and

Mozambique remains one of the poorest countries in the world, with very low literacy levels, strikingly poor health outcomes generally, and few resources to confront the mounting crisis.
The condom social marketing campaign, on the other hand, has developed a central message that not only encourages condom use but is interpreted by many as endorsing "promiscuous" sexuality through its controversial images and suggestive slogans. Further, the campaign arrived in this region of Mozambique just when urban populations were coming to recognize and accept the existence of HIV/AIDS and its transmission through sexual activity. The preliminary research findings suggest that some, and perhaps many, in the community began to associate the promotion of condoms with HIV infection itself, because many believed that condom use promotes promiscuity and that promiscuity causes AIDS.

Reports of significant clashes that can be heated and even violent are found in some agency documents (Thompson and Bennett 1997), and scattered references to religious concerns with condom promotion and attitudes toward AIDS in the developing world can be found in literature (Black 1997; Da Silva and Guimaraes 2000; Freidman 1995; Garner 2000; Greeley 1991; Kagimu et al.1998; agarde et al. 2000; Solomon 1996; Spira et al. 2000; Takyi 2003), but they do not directly examine community responses to condom social marketing campaigns. Clearly, the clash of messages between religious movements and condom social marketers in the developing world is not restricted to Mozambique, but it is widespread and understudied.

As social marketing has become increasingly popular in health promotion both in the developed and developing world, dissenters in public health have challenged the fundamental assumptions behind social marketing and have raised ethical concerns (Buchanan et al. 1994; Minkler 1997; Musham and Trettin 2002; Rothschild 2000; Wallack et al. 1993; Wisner 1987). The literature on SM, and critical responses to it, is substantial; no attempt is made to review the extensive debate here, but key points are identified that help illuminate the problems. Wisner (1987) criticized social marketing's focus on "product" rather

than "process." He saw a one-way communication process, with little genuine community feedback other than focus groups, which provided a "quick fix" in contrast to process oriented approaches that seek to establish dialogue with communities on health problems. He states, "Ministries [of health] that cut back expenditure in such participatory, empowering work because social marketing appears faster or more cost-effective cut the tap root of the newly sprouting community in the increasingly fragmented and class-polarized grassroots" (1987:179).

In a later critique, Buchanan and colleagues provided a more detailed assessment that tackled the underlying social marketing framework (Buchanan et al. 1994; also see response to this critique in Hastings and Haywood 1994).

"The first assumption here is that people become ill because they do not want (Enough) to be healthy. The second assumption is that existing social conditions. Do not present serious (enough) barriers to attaining good health. People just need to get the right message at the right time in the right way and any obstacles can be overcome. . . . In lieu of addressing these factors, social marketing concentrates on communicating messages to individuals liberated from their social context by assumptions of the free market. [1994:52–53]

Wallack and colleagues have provided one of the most substantial critiques of social marketing in their promotion of an alternative approach they call "media advocacy" (Wallack 1994; Wallack and Dorfman 1996; Wallack et al. 1993). Wallack contrasts the "information gap" that social marketing seeks to fill with the "power gap" that underlies most health behaviour problems (Wallack 1994:422). Wallack and co-authors state, "Social marketing tends to reduce serious health problems to individual risk factors and ignore the proven importance of the social and economic environment as major determinants of health". (Wallack et al. 1993:23).

Again, echoing other critiques of social marketing, Wallack suggests that a two-way dialogue is essential to health promotion. He writes, "Traditional public health communication strategies [social marketing] tend to see individuals and

groups as part of an audience to be addressed in a one-way communication. At best, if the 'audience' is included in the planning, it is after major boundaries of the issue have been set" (1994:425). In spite of the considerable debate over the ethics and philosophy of social marketing in public health, and without clear evidence of its efficacy cross-culturally, social marketing has emerged at the beginning of a new century as the preferred health promotion technique in the developing world, especially for family planning and AIDS prevention. Given the elevated status of the approach and the enormous commitment of resources to it by major donors, a renewed skepticism and a reinvigorated debate about its efficacy is urgently needed. Skepticism begins with an exploration of why social marketing has been so widely promoted by key institutional actors in the world of international health, including USAID, the World Bank, and other major donors.

The Political Economy of Social Marketing

Although at least 60 developing countries now have contraceptive marketing programs (Ainsworth 1998), this diffusion of social marketing approaches has been promoted by donors rather than aid recipients; the decisions to channel health funding into social marketing campaigns managed by international NGOs have been driven by broader ideological shifts toward free market promotion and contraction of state services, and have been advanced by a specific constellation of actors in international health dominated by USAID, the World Bank, and several U.S.-based NGOs with an extensive global reach (UNAIDS 2001). The World Bank, which recently became the lead global lender and policymaker in international health, has fully embraced social marketing as the primary method of AIDS education (Ainsworth 1998;World Bank 1999), while USAID has become the leader among bilateral in promoting social marketing in its own funding priorities (USAID 2002a, 2002b). Other key multilaterals such as UNAIDS and the UNFPA have followed suit and embraced social marketing (UNAIDS 2001; UNFPA 2002).

Examination of the institutional literature and promotional material reveals the ideological signposts guiding social marketing promotion. One USAID-funded social marketing newsletter firmly embeds its promotion of social marketing within broader economic adjustment policy and the politics of heightened austerity that it generates:

"For public agencies, working with the private sector is a way to leverage increasingly scarce resources. In many countries, expanding private enterprise is a key component of more comprehensive economic reform or structural adjustment programs, which also include privatizing government-owned or controlled enterprises and generally reducing the government's role in the economy. The goal is to ensure that public spending increasingly targets the most needy, particularly as government budgets are reduced overall". [USAID 1998:1]

The newsletter also clarifies the benefits of social marketing to private sector partners: "The new emphasis [i.e., social marketing] on building commercially sustainable markets for key child-health related products requires more intimate and longer-term partnerships with private firms. This, in turn, represents an opportunity for these firms to develop new markets, expand existing markets, and reposition their products" (USAID 1998:1).

The rationale for channelling donor funds into social marketing parallels the logic used to justify health care privatization more broadly. As USAID's Global Health website states:

"Limited budgets in many developing countries can mean the curtailment or abandonment of publicly subsidized health care. . . . USAID's work in this area involves identifying existing or potential investment opportunities in health and family planning services and providing technical assistance to support the development of private sector interest and capacity to take advantage of these opportunities". [USAID 2003a]

An examination of PSI's own literature indicates the important ideological linkages between promotion of social marketing and broader processes of privatization. PSI's Biennial Report 2001–02 states succinctly that,

"In many developing countries, social marketing fills the critical gap between what over-stretched public sector facilities can provide to the poor and what the commercial sector can provide to a small upper class. In countries where PSI works, that gap is often quite large. . . . Social Marketing harnesses the can-do attitude and bottom-line focus of the commercial sector to improve the plight of the world's poor". [PSI 2002:4]

Social marketing promoters must also justify to a skeptical public health audience why the sale of products is preferable to free provision, even for poor populations. It is presented as axiomatic, and repeated in document after document across agencies, that "When products are given away, the recipient often does not value them or even use them" (PSI 2003a). Nearly identical statements are found in UNAIDS World Bank, DKT International, and USAID documents without cited evidence (UNAIDS, 2001:10; World Bank 1999; Harvey 2003; USAID 2003b). Although there may be research supporting the notion that free health products are often not valued or used by recipients in specific settings, the assumption is cast across a wide range of cultures and societies where it remains untested.

Although major donors provide the financial support for social marketing campaigns, the administration of those activities and funds is nearly always allocated to a handful of well-connected NGOs that maintain close relationships with USAID and other key bilaterals. These include PSI, DKT International, International Planned Parenthood Federation, Marie Stopes International MSI in the United Kingdom, and PROFAMILIA (UNAIDS 2001:18), all of which began as population control or family-planning organizations. DKT and Marie Stopes have shared histories with PSI, interchanging executive board membership and receiving major funding from USAID.

PSI now operates in at least 45 nations in the developing world, usually in close association with USAID (PSI 2002) and has become the largest social marketer in Africa, emerging as a critical player in the swirl of health-related aid activity and funding generated to fight the AIDS pandemic. Having started out in the early 1970s with a focus on population control and provision of contraception, the refocus on AIDS prevention was a natural extension of their ongoing activities in reproductive health. To be sure, AIDS prevention efforts in most African countries, use a blend of approaches that may include youth friendly services, voluntary counselling and testing facilities, school programs, and a variety of other community outreach programs. PSI has more recently branched out into other forms of AIDS prevention and education activities such as voluntary counselling and testing. However, social marketing approaches have increasingly become core educational and prevention strategies, superseding and often negating other community- based approaches. The Mozambique case illustrates PSI's approach to condom social marketing in Africa and raises critical questions not only about campaign efficacy but also about process and unintended consequences of social marketing health promotion.

In India the current epidemiological condition is such that except for the four states of high prevalence most of the other states are ranking high on the vulnerability charts of HIV /AIDS. With high rates of migration, unemployment, poverty, illiteracy and malnutrition, each fallout of the other, reinforce each other paying the casualty to globalization. Poverty and vulnerability are conceptually distinct but are usually linked. This gets clearest in relation to HIV-AIDS, where poverty increases vulnerability both to the disease and the socio-economic impacts of the disease (Mann and Tarantola 1996b).

Social marketing programs can be differentiated according to their objectives and the sustainability strategies which in turn shape the poverty focus on graduating from the dependence upon donors aim to reach financial self-reliance through full cost recovery. Organizations like Population Services International, argue against financial self reliance as an objective in and of itself, and emphasize that ability to demonstrate effectiveness and efficiency is

more important than cost recovery in assuring the long term viability of social marketing. In such cases, it is assumed that the donor funding continues as long as it is needed, on the basis that meeting priority health needs of low income populations, consistent with the principles of public economics and an essential condition for realizing social marketing's social mission.

Impact thus gets defined as the extent to which condom social marketing programme meet the needs of the poor and the vulnerable, demonstrated through behaviour changes likely to benefit the individual's or the wider community's health status, such as increased inter-partner discussion of HIV and condom use, decrease in number of sexual partners, safer sexual practices and increased utilization of services /products promoted and distributed by the condom social marketing programme. The hypotheses therefore being, that behaviour change contributes to the wider development goal of reduction in HIV-AIDS reduction.

In appraising their target population in HIV-AIDS prevention and control program, social marketing organizations, like other agencies focused on HIV/AIDS, need to examine:

1. Which groups are vulnerable to the HIV infection?
2. The behavioural determinants of that vulnerability specifically the local social and economic contexts which shape sexual behaviour–public health interventions aimed at reducing high risk sexual behaviour often fail to address adequately the importance of social identity, vulnerability, marginalization ,and relations of power and control in influencing sexual behaviour(Hawkins and price).
3. Vulnerability in terms of service access, specifically why certain groups are excluded from information and services, and what are the sources of systematic institutional bias that makes policies, systems or programs unresponsive to the needs of realities of the poor and the vulnerable.

4. Whether and how the behavioural, service and institutional determinants of vulnerability and risk are amenable to Condom social marketing programme intervention.

Despite thirty years of history, there has been little learning on the impact and effectiveness, beyond the collection and analysis of aggregate sales and data and the computing of CYP, with a very few of the social marketing programme's collecting data on the socio-economic or vulnerability and the health seeking behaviour. As pointed earlier the condom social marketing programme's have been overlooking the socio-economic contexts that are responsible for shaping behaviour and risk perception. There have been very few published studies that talk about the evaluation and research of the social marketing programme's, which gets really important with these organizations moving into STD treatment and HIV counselling.

Analyzing the impact assessment of these programs, there is data, although limited, to show that that social marketing programme's don't reach the poorest (Price and Hawkins2000), and that making cost recovery a lower priority would enable, social marketing to reach poorer people. The target populations identified –economically active, lower income groups –does reflect the need for the clients to have disposable income. Schellstede and Ciszewski (1984) report that the clients/buyers of the social marketing program cover almost all the socio-economic spectrum in Bangladesh. There have been other studies as well which show that rural and urban users of these socially marketed contraceptives, were middle class, with educational and economic status much higher than that of the general population (Davis etal:pg165), an argument complying to the cross country study which concluded that social marketing programs cater to the higher levels of socio-economic class. The social marketing programs aimed at the HIV-AIDS prevention, are not pro-poor at the initial stages in terms of the distribution of its benefits, but gradually these socio-economic differences diminish with maturity of the Condom social marketing programme and the epidemic. Reductions in the socio-economic inequities are found initially in the supply environment (awareness and access)

and only later in condom use and behaviour change patterns (Stallworthy, 1998).The reason being that in the first half of the interventions although the non poor are likely to be more aware of HIV risk factors because of high education, and promotion to health messages, they are likely to be at high risk to the HIV infection due to various reasons. Data from Rwanda and Cameroon show that there is direct relationship between higher socioeconomic status and number of sexual partners.

It is significant to note that the commercial social marketing programs tend to reach the non poor first because of the formal distribution networks and channels making sales easy in the urban areas where they reside the most, as compared to the poor in the peri urban or the rural areas. Similarly the mass media has wider reach to the middle class clients of these programs whereas most of the communication strategies that are most appropriate for low income groups take longer time to get prepared. An intervention in the non poor group in the early stages of the epidemic has long term benefits for the poor as it will limit the subsequent spread of the HIV-AIDS to the poor who are more vulnerable. (World Bank, 1997). Recent PSI surveys conducted in countries like Nigeria, Mozambique, Rwanda and Zambia (Stallyworthy, 1998), concluded that although the condom social marketing programme are priced at low and affordable prices, the response of the non poor has been much greater than the poor.

Evidence shows that that low health services access is the product of the number of dimensions of poverty and vulnerability, notably.

- Financial :charging user fees affecting the ability of the rural poor specifically ,to consume routine services (Price and Hawkns,2000).the intra household vulnerability also plays a major role in this means that the women ,children and the disabled are most often unable to control their household income .
- Physical: limited to mobility, inadequate geographical coverage and low levels of service outreach.

- Socio-cultural: a key factor in social exclusion from services relates to social identity which shapes the relations between poor and the service providers.

Measuring the success of the social marketing programs in terms of assessing behaviour change, which forms the main qualitative and the quantitative indicators available, for measuring changes in condom use and sexual behaviours can be understood in terms of useful indicators including number of new condom acceptors and correct and consistent use .the sexual behaviour change patterns can be observed through the indicators like decrease in reported number of sexual partners, increased age at first intercourse, decrease in number of unprotected causal sex acts per sexually active male ,reduction in reported incidence of coerced sex and finally increase among women in their ability to negotiate safe and satisfying sexual relationships(for instance, commercial sex workers, and even housewives).The intermediate indicators in terms of the relationship between awareness and behaviour change ,include perceiving personal risk of infection /transmission, discuss IEC messages with friends and discuss HIV risk or condom use with partners.

Measuring access in terms of affordability is important as it is done in a way as what Harvey puts it that the condom social marketing programmes traditionally set out the prices at or below 1% of a household disposable income, following a year's supply. In recognition of the difficulty with the household income data, some of the condom social marketing programme have begun setting product prices of selected household items known as the "basket of goods approach" (Schellestede and Ciszewski, 1984), such as measure of rice, soaps box of matches etc. other indicators include a combination of the following :

1. Clients report that commodity /service price is not a constraint to use.
2. Reduction in the percentage of discontinuers of reporting price in decisions to discontinue.
3. Non or never users report that price is not a reason for non sue.

Monitoring the role of social marketing organizations in effecting behaviour change is fraught with a lot of difficulty, in terms of the attribution in settings where these organizations are not the only one indulging into communication activities. Over a period of time these organizations have developed a strategy to evaluate their generic IEC and behaviour change strategies by inter alia tracking changes in the percentage of respondents who can identify

- o STD/HIV infection risk factors and accurately asses own risk of infection
- o Know how to protect against STD/HIV infection and where to buy condoms from
- o Report receiving messages about safe sex /condom use /HIV and recall related messages.

Therefore, data from around Africa have begun to reveal that condom social marketing in general has not been very successful. As E. C. Green writes,

"After 15+ years of intense condom social marketing in Africa, the result today is an average of only 4.6 condoms available (not necessarily used) per male per year in Africa. That figure was actually a bit higher in the mid-1990s; it has declined somewhat even since then in spite of the explosion of AIDS in southern Africa. The problem seems to be low demand". [2003a:5]

Explanations for "low demand" vary widely, and have triggered a lively debate among anthropologists and public health advocates over what messages should be promoted in light of these difficulties. Some, including Green, have come to embrace the so-called ABC approach: Abstinence, Be faithful, and if not, then use Condoms (Green 2003a, 2003b), arguing that its emphasis on "primary behaviour change" explains Uganda's success in reducing HIV prevalence.

USAID (withdrawn) has more recently embraced the message, and PSI has begun to promote the ABC approach, as well, while continuing its condom

social marketing campaigns (PSI 2003b). Others, however, have argued for a more "sex positive" harm reduction approach to behaviour change and take issue with the ABC explanation for Uganda's success (Feldman 2003; Farmer 2003).

But perhaps the most important aspect of these recent and important debates is that poor target communities are normally left out of the conversation. The ABC message may, in fact, be more palatable to some religious groups, as Green has argued, given its emphasis on abstinence and fidelity, but the focus on message content in these debates obscures a more fundamental shortcoming to the approaches.

As Feldman argues, "the difference is not the message, but how the message was conveyed. In Uganda, beginning in 1986, the government, together with the national media, very aggressively de-stigmatized the disease by discussing the epidemic openly. Public discussion about sex and HIV occurred in schools, public meetings and in the workplace. The wall of denial about AIDS, impenetrable throughout most of the rest of the continent, came tumbling down." [2003:6]

Social marketing's transformation of "citizens" with basic rights to health care, into "consumers" who must exchange something they value to obtain items needed to improve health, has far-reaching consequences for health care provision in poor countries; consequences that have neither been adequately considered nor debated by the international health community. Perhaps the most important "behaviour change" needed for AIDS education and prevention in Mozambique should come within international aid agencies and donors. Influenced by the push to privatize, some have succumbed to the controversial logic of "cost-effectiveness," and, in the process, have alienated many in the communities they seek to help. Social marketing may have a useful role to play in combination with other approaches, and there are certainly instances where it has been successful. But more careful and critical scrutiny of condom social marketing may steer international aid resources away from these strategies

back toward participatory approaches that will both reveal and, it is hoped, begin to address the most important determinants of "risky" behaviour and vulnerability to AIDS: poverty, inequality, lack of public sector safety nets, and declining access to well-funded public sector health services.

Concluding Remarks:

Thomas McKeown, in his famous contribution to the literature of Public Health, presented an outline of the modern rise of population based on the experiences of England and Wales derived from the investigation of population growth in the 18th, 19th centuries in comparison with four other countries i.e., Sweden, Ireland, Hungary and France. McKeon's major contention was to interpret the trends of mortality with respect to the improvements in health status of the population. According to him, there was a decline in the mortality rates, due to, lower mortality from communicable diseases, and hypothesized that the improvement in the living standards, better food supplies and availability, better water supply, housing hygiene and sanitation were responsible for the change. An increase in the real income, with a subsequent increase in food supply, led to a decline in the death rates and hence better health status. Health therefore, we see, is interwoven with the biological, physical, social, economic and political thread. It is a very dynamic concept. Both the health problems and the health practices of a community are deeply embedded within the ever changing social, economic and the political systems. Health services a function of its political system, with power forces playing a dominant role in decision concerning resource allocation, manpower, choice of technology, and the degree to which health services are made available and accessible to different segments of the society, influence the health of the population.

This argument has been followed by certain critics pointing out that Mckeown overestimated the improvement in the health status of the population, and mortality gains from reduction from TB. Public health legislation brought in a decline in the intestinal infections along with significant improvements in water supplies and sewage disposal. He is also criticized on the grounds of lack of

evidence related to better food availability and nutrition. Despite such criticisms, the basic argument about medical interventions and declines in infectious diseases still hold good. (Grundy, 2005).

In the context of privatization and growing inequality in the developing nations, the debate on social marketing captures new spaces in the public health community. Medical anthropologists have an especially important role in moving the examination of social marketing beyond standardized knowledge, attitudes, and practices (KAP) surveys and measurements of product sales toward capturing complex local responses to the controversial images distributed in communities. The health psychology perspective drawing form psychology, anthropology and sociology broadly called a societal perspective examines behaviour by locating disease and the meaning people give to it within a social context. Within this framework primacy is given to people's perceptions, experience, treatment and coping with disease.

The health seeking behaviour is thus, an outcome of a complex process of psychological, social, economic and institutional factors. this model tries to bring together various factors that are independent and influence health seeking behaviour of populations that include the i) severity, intensity and persistence of symptoms, ii) association between the symptoms with a specific disease, iii) the perceived threat of the disease which is determined by how it affects social roles and economic activities, iv) accessibility and availability of health services /rehabilitation/support services and the v) responsiveness of the health services to people's felt needs (Zola:1969). Evidence suggests that the mere knowledge about the disease or higher awareness levels do not necessarily produce desired changes. There is now enough evidence to show that KAP studies have not really helped in providing desired behaviour changes. (Krishhnatray: 2001). Hence, we see that in HIV/AIDS, where the sense of perceived threat is low and the transition from severity, to intensity to persistence may take a long time, or so to say a , chain which begins from awareness to consciousness to action taking may be a long process as the

pandemic might take years to show its symptoms. The distinction between behaviour and social behaviour should also be very carefully studied. Therefore it gets very essential and important for effective research to delve into the health seeking behaviour and the very way of life practiced, including the social prescriptions prevalent in the community under study, to device an effective communication oriented behaviour change programme.

The targeting of the groups practicing High risk further stigmatizes the disease. The vulnerability to HIV AIDS and the effectiveness of AIDS control programmes are both dependent on the general quality of life as well as the capacity of health service systems to provide comprehensive care. Both are outcomes of historical process. The politics of AIDS arises both from its social determinants and from the way the approach to AIDS control is shaped. The paradigm of AIDS action has had two characteristics. One, the isolation of AIDS from other problems affecting people's lives and second the absence of an understanding of the impact of international power equations on national and local perceptions and decision making about actions for AIDS control. The need of the hour is therefore to address the issue with contextual specificity, as universal approaches to AIDS control would not be effective. In a recently published newspaper report (HINDU, June 10, 2006), it was published that in 2005, the National AIDS Control Organization reported a shortfall of $128million in 2006and $170 million in 2007. NACO also reported these findings among its classifieds "most-at risk groups: awareness among sex workers is low at a national level except in Tamil Nadu, Maharashtra, Andhra Pradesh, Goa, and West Bengal: infection from drug use is driving the epidemic in the North East and increasingly elsewhere. Migrant workers have been difficult to track; highly mobile men are reasonably aware of HIV but don't often take action; since homosexuality is illegal in India, the number of men who have sex with men accessing services is very low". As per the report, the 2006 UN Declaration has done little to provide funding outlook or targets upon which NACO will be able to base interventions for vulnerable populations and treatment roll out in the third stage of its programme. These statements issued have a relationship with

the sustainability of the prevention programmes esp. when they are so donor driven.

It can be seen that that although social marketing figured in all the phases of the National AIDS Control Programme, the maximum attention is given to it in Phase III of the programme. The Jharkhand exercise opens questions related to the authenticity of the promised work, on ground. As the Jharkhand State AIDS Control Society, is in its very initial phase, it was not able to provide the researcher, with any assessment studies, that were carried on in the field areas. It was seen that there was almost zilch prevention work going on in the general communities to arrest the spread of the pandemic, despite tall claims by the chairperson of the Society, which later got refuted by the partner social marketing organizations. It can be observed through the information given in this chapter that the condom promotion activities get a little diluted when social marketing for family planning, takes a priority over social marketing for HIV/AIDS, something which was very evident in the short exercise in Jharkhand. Despite ranking high on vulnerability charts in the latest survey reports, there is little or no work going on in Jharkhand especially related to prevention in the general community. Whatever work is going on ,is concentrated at the two high points(NH-2,NH-6) ,on the Groups practicing High Risk behaviour, reflecting a bias of the donors and their obsession with these groups, oblivious of the fact that it would there in the general community where the bomb is rearing to explode.

I would like to conclude the study by pointing out that amidst debates over converting health into a commodity, there is a serious concern over the principles of Primary Health Care " Universality, Equity and Accessibility", getting overshadowed by the market oriented principles of demand, supply, profit and competition. As one of the officials of the Population Services International, India, opines "we need to expand the commercial market, and stop the Government free services, as they don't reach the people but get destroyed and wasted". According to him the poor, who are the target groups of the Government free services, "need food, money, shelter and not condoms." In

such a situation one needs to seriously ponder over the fact that if something like this happens, where would the poorest go? Where would the biblical terms of the famous Alma Ata Declaration stand? This argument forces one to go back to the time when there were such debates and controversies over the concept of selective primary health care and comprehensive primary health care that had baffled the intelligentsia and the public health experts all over the world. Development is a complex process whereby not only the quantity but the quality also matters. With reference to the theories given by McKeown, Snow, McDermott and other exponents of public health, one can clearly understand that it's not about a single silver magic bullet, but a host of socio economic and political factors leading to the balanced path of development, which could be the possible answer towards challenges as deadly as HIV/AIDS.

The quote of Everold Hussein, "if you can sell coke, why not drugs for a disease control programme, in a community", further accentuates the urgency for more insightful research into this area, with proper inquiry into the intricacies of such programmes Vis-a Vis socio-economic determinants of a specific community.

Bibliography

Bibliography

Articles

1. "Making condoms work for HIV prevention: Cutting-edge perspectives Brieger WR et al. (2001) West African youth initiative: outcome of a reproductive health education program". Journal of Adolescent Health, 29:436–446.

2. "Social Marketing." Social Marketing Institute. 24 June 2003

3. "Social Marketing: New Weapon in an Old Struggle." Health Canada. 2001.

4. "The Social Marketing Concept."Novartis Foundation for Sustainable Development. http://foundation.novartis.com/leprosy/social_marketing.html.

5. 2000 Improving Health for the Poor in Mozambique: The Fight Continues. African Region Human Development, Working Paper Series 23789. Washington, DC:

6. 2002 Biennial Report. Washington, DC: PSI.

7. 2002a USAID's Expanded Response to HIV/AIDS: Report to Congress. Washington, DC:

8. 2002b HIV/AIDS in Mozambique: A USAID Brief. Washington, DC: USAID.

9. 2003a Global Health: Private sector Services. Electronic document, http://www.usaid.gov/

10. Grundy, E. (2005) Commentary: The McKeown Debate – Time for Burial. International Journal of Epidemiology, 34: 529-533.]

11. 2003a Profile: What Is Social Marketing? Electronic document, http:// www.psi.org/ resources/pubs/what_is_SM.html.

12. 2003b Global Health: Contraceptive Social Marketing. Electronicdocument, http://www.usaid.gov/pop_health/pop/techareas/ contra social/ index.html.

13. 2003b HIV/AIDS, Electronic document, http:// www.psi.org/our_programs/Abstinence

14. Agha S, Kusanthan T, Longfield K, et al. (2002), "Reasons for non-use of condoms in eight countries in sub-Saharan Africa, Presented at XIV International Conference on AIDS, Barcelona, 7–12 July, 2002: poster WePeD6359.

15. Agha, Sohail (1998), "Sexual Activity and Condom Use in Lusaka, Zambia", International Family Planning Perspectives 24(1):32–37.

16. Agha, Sohail, Andrew Karlyn, and Dominique Meekers (2001), "The Promotion of Condom Use in Non-Regular Sexual Partnerships in Urban Mozambique". Health Policy and Planning 16(2):144–151.

17. Ahmed S et al. (2001) "HIV incidence and sexually transmitted disease prevalence associated with condom use: a population study in Rakai, Uganda". AIDS, 15(16):2171–2179.

18. Ainsworth, Martha (1998), "Setting Government Priorities in Preventing HIV/AIDS". Finance and Development, March: 18–21.

19. Alcalay, Rina, and Robert A. Bell.(2000), "Promoting Nutrition and Physical Activity through Social Marketing: Current Practices and Recommendations." Davis: Center for Advanced Studies in Nutrition and Social Marketing, University of California.

20. Allen A (2002) "Sex change: Uganda v. condoms". The New Republic Online.

21. Allen S et al. (1992) "Effect of serotesting with counseling on condom use and seroconversion among HIV discordant couples in Africa". British Medical Journal, 304:1605–1609.

22. Allen S, Tice J, Van de Perre P, et al. (1992) ", Effect of serotesting with counseling on doncom use and seroconversion among HIV discordant couples in Africa". British Medical Journal 1992; 304: 1605–1609.

23. American Marketing Association, Committee on Terms, Marketing Definitions: A Glossary of Marketing Terms (1985) Chicago: American Marketing Association.

24. Ansary Adel .I.EL and E.Kramer Oscar, Jr, (1973), "Social marketing and the family planning experience", Journal Of Marketing,Vol 37,No 3,1-7

25. B. Dervin, "Audience as Listener and Learner, Teacher and Confidante: The Sense- Making Approach," in Public Communication Campaigns, 67-86.

26. Barberis M, Harvey (1997), "Costs of family planning programmes in fourteen developing countries by method of service delivery". Journal of Biosococial Science.

27. Bhave G et al. (1995) "Impact of an intervention on HIV, sexually transmitted diseases, and condom use among sex workers in Bombay, India". AIDS, 9(Suppl 1):S21–30.

28. Block, Lauren G., Vicki G. Morwitz, William P. Putsis Jr., and Subrata K Sen.92 (2002), "Assessing the Impact of Antidrug Advertising on Adolescent Drug Consumption: Results From a Behavioural Economic Model." American Journal of Public Health: 1346-1351.

29. Bloom, Paul N. and Novelli, William D. (1981) "Problems and challenges in Social Marketing" Journal of Marketing, Vol 45 (Spring) 79-88.

30. Brazilian Health Ministry (2002) "Resposta: experience of the Brazilian AIDS program". Brasilia, Ministry of Health.

31. Brieger, W.R and Ramakrishna, J. (1987) "Health education: social marketing does not have all the answers" World Health Forum, Vol 8, 384–386.

32. Brodie, Mollyann, Ursula Foehr, Vicky Rideout, Neal Baer, Carolyn Miller, Rebecca Flournoy, and Drew Altman.20(2001) "Communicating Health Information through the Entertainment Media." Health Affairs 20 (2001): 192-199.

33. Bruner, Gordon C. "Homan's Theory of Social Exchange (1997)." Southern llinois University.

34. Buchanan, David, Sasiragha Reddy, and Zafar Hossain (1994), "Social Marketing: A Critical Appraisal". Health Promotion International 9(1):49–57.

35. Campbell, Catherine, and Catherine MacPhail Carlisle, Sandra (2000), "Health Promotion, Advocacy and Health Inequalities: A Conceptual Framework". Health Promotion International 15(4):369-376.

36. Celentano DD et al. (1998) "Decreasing incidence of HIV and sexually transmitted diseases in young Thai men: evidence for success of the HIV/AIDS control and prevention program". AIDS, 12(5):F29-36.

37. Chapman, Steven (2004). "Evaluating Social Marketing Interventions," in Evaluating Health Promotion: Practice and methods, 2nd ed., Oxford University Press: New York

38. Ciszewski R, Harvey P (1994), "The Effect of price rice increases on the contraceptives sales programmes in Bangladesh: Journal of Biosocial sciences 26:25-35.

39. D.L. Altman and P.T. Piotrow,(January, 1990) "Social Marketing: Does It Work?" Population Reports: J393-J394.

40. D.S. Solomon, "A Social Marketing Perspective on Communication Campaigns," in Public Communication Campaigns, 103.

41. David Wilson, Presentation the NACP III Team, October 10, 2005

42. Davies J,Agha S (1997), "Ten Years of social marketing in Pakistan :an assessment of management ,output ,effects and output costs and cost efficiency".PSI Research Division Working Paper 7.Washington D.C. Population Services International.

43. Davis KR, Weller SC (1999) "The effectiveness of condoms in reducing heterosexual transmission of HIV". Family Planning Perspective, 31(6):272-279.

44. DeJong, William, and Jay A. Winsten.(1990) "The Use of Mass Media in Substance Abuse Prevention." Health Affairs Summer: 30-46.

45. Deschamps MM et al. (1996) "Heterosexual transmission of HIV in Haiti". Annual International Medicine, 125:324–330.

46. Dnistrian, Steve, Nora Roach, Howard Simon, and Josie Feliz (2002). '"Partnership for a Drug- Free America": Annual Report 2001-2002. New York: PDFA.

47. Family Health International (2003) "Research briefs on the female condom", No. 5. Family Health International, Washington DC.

48. Farmer, Paul (2003), "AIDS: A Biosocial Problem with Social Solutions." Anthropology News 44(6):7.

49. Fauvet, P. (2000), Mozambique: Growth with Poverty, "A Difficult Transition from Prolonged War to Peace and Development". Africa Recovery 14(3):12–19.

50. Feldman, Douglas A. (2003), "Problems with the Uganda Model for HIV/AIDS Prevention". Anthropology News 44(7):6.

51. Flynn, Brian S., John K. Worden, Roger H. Secker-Walker, Gary J. Badger, Berta M. Geller, and Michael C. Costanza.82(1992) "Prevention of Cigarette Smoking through Mass Media Intervention and School Programs." American Journal of Public Health: 827-834.

52. FPAI mobile clinics and community-based distributors in Madhya Pradesh

53. Gantz, Walter, and Nancy Schwartz.(2002) "A Report on Television Content." Shouting to Be Heard: Public Service Advertising in a New Media Age. The Kaiser Family Foundation.

54. Gillespie, D.; Cross, H.; Crowley, J.; Radloff, S. "Financing the Delivery Cost of Contraceptives: The Challenge of the Next Twenty Years. Paper presented at the National Academy of Sciences Meeting on the Demographic and Economic Consequences of Contraceptive Innovations", held in Washington, DC. October 6–7, 1988.

55. Glanz, K., and B. K. Rimer(1995). Theory at a Glance: A Guide for Health Promotion Practice. NIH publication no. 95-3896. Bethesda: National Institutes of Health, National Cancer Institute.

56. Glynn, J.R., Caraël, M., Auvert, B., Kahindo, M., Chege, J., Musonda, R., Kaona, F., & Buvé, A.(2001), "The Study Group on Heterogeneity of HIV Epidemics in African Cities.

57. Greeley, Andrew (1991), "Religion and Attitudes toward AIDS Policy. Sociology and Social Research" 75(3):126–132.

58. Green, Edward C. (2003) a, "New Challenges to the AIDS Prevention Paradigm." Anthropology News 44(6):5.

59. Grulich A (2000) "HIV risk behaviour in gay men: on the rise?" British Medical Journal, 320:1487–1488.

60. Hanenberg RS et al. (1994) "Impact of Thailand's HIV-control program as indicated by the decline of sexually transmitted diseases." Lancet, 344:243–245.

61. Harvey Philip D (1994), "The Impact of Condom Prices on Social Marketing programmes", Studies in Family Planning, Vol 25, No.1, 52-58.

62. Hastings, G. B., and A. J. Haywood (1994), "Social Marketing: A Critical Response". Health Promotion International 9(1):59–63.

63. Hawkins K, Price NL (2000), "the Social Context of Sexual and Reproductive Health: a guide to social analysis and monitoring." Swansea, University of Wales, Centre for Developmental Studies.

64. Hearst N et al. (1999) "Reducing AIDS risk among port workers in Santos, Brazil." American Journal of Public Health, 89(1):76–78.

65. Hessol N et al. (1989) "Prevalence, incidence, and progression of human immunodeficiency virus infection in homosexual and bisexual men in Hepatitis B vaccine trials, 1978–1988". American Journal of Epidemiology, 130(6):1167–1175.

66. Hira SK et al. (1997) "Condom and nonoxynol-9 use and the incidence of HIV infection in serodiscordant couples in Zambia". International Journal of STD AIDS, 8(4):243–250.

67. Hoggs RS et al. (2001) "Increasing incidence of HIV infections among young gay and bisexual men in Vancouver". AIDS, 15:1321–1322.

68. INE (Instituto Nacional de Estatistica) (1998), "Evaluation of the Effectiveness of AIDS Health Education Interventions in the Muslim Community in Uganda". AIDS Education and Prevention 10(3):215–228.

69. J.C. Ling et al.(1992), "Social Marketing: It's Place in Public Health," Annual Review of Public Health 13 (1992): 341-362.

70. J.K. Worden et al.,(1988), "Development of a Smoking Prevention Mass Media Program using Diagnostic and Formative Research," Preventive Medicine 17 (1988): 531-558; L. Donohew, E. Lorch, and P. Palmgreen, "Sensation Seeking and Targeting of Televised Anti-Drug PSAs," in Persuasive Communication and Drug Abuse Prevention, ed. L. Donohew, H. Sypher, and W. Bukoski (Hillsdale, N.J.: Lawrence Erlbaum Associates, 1991), 209-226; and K.E. Bauman et al., "Three Mass Media Programs to Prevent Adolescent Cigarette Smoking," Preventive Medicine 17 (1988): 510-530.

71. Janowitz, B.; Bratt, J.; Fried, D. Investing in the Future: A Report on the Cost of Family Planning in the Year 2000. Research Triangle Park, NC: Family Health International; 1990.

72. K.F.A. Fox and P. Kotler,(1980) ,"The Marketing of Social Causes: The First Ten Years," Journal of Marketing 44 (1980): 24-33.

73. Kotler, Philip and Gerald Zaltman (1971), "Social Marketing: An Approach to Planned Social Change". Journal of Marketing, Vol. 35 (July), 3-12

74. Laga M et al. (1994) "Condom promotion, sexually transmitted diseases treatment, and declining incidence of HIV-1 infection in female Zairian sex workers". Lancet.

75. Lefebvre, C. and Flora, J. (1988) "Social Marketing and Public Health intervention." Health Education Quarterly, 15, 299-315.

76. Lewis Maureen A (1986), "Do Contraceptive prices Affect Demand". Studies in Family Planning, Vol 17, No 3,126-135.

77. M.D. Slater and J.A. Flora (1981), "Health Lifestyles: Audience Segmentation Analysis for Public Health Intervention," Health Education Quarterly 18: 221-233.

78. Magnani RJ, Karim AM (2002) "ABCs: the youth perspective".www.synergyaids.com/Documents/6_Robert_Magnani.pdf

79. Mantell JE et al. (2001) "The acceptability of the female condom: perspectives of family planning providers in New York City, South Africa, and Nigeria". Journal of Urban Health, 78(4):658–668.

80. Meda N et al. (1999) "Low and stable HIV infection rates in Senegal: natural course of the epidemic or evidence for success of prevention?" AIDS, 13(11):1397–1405.

81. Mills S et al. (1997) "HIV risk behavioural surveillance in Bangkok, Thailand: sexual behaviour trends among eight population groups". AIDS, 11(Suppl 1):S43–51.

82. Musham, C., and L. Trettin (2002), "Bringing Health Services to the Poor through Social Marketing: Ethical Issues". Journal of Health Care for the Poor and Underserved 13(3):280–287.

83. Myer, Landon, Catherine Mathews, Francesca Little, and Salim Karim (2001) "The Fate of Free Male Condoms Distributed to the Public in South Africa". AIDS 15: 789–793.

84. Nations, Marilyn (1986), 'Epidemiological Research on Infectious Disease: Quantitative Rigor Or Rigor Mortis? Insights from Ethno medicine". Anthropology and Epidemiology.

85. Nelson KE et al. (2002) "HIV infection in young men in northern Thailand, 1991–1998: increasing role of injection drug use. J Acquire Immune Defic Syndr".

86. Painter, Thomas (2001), "Voluntary Counseling and Testing for Couples: A High Leverage Intervention for HIV/AIDS Prevention in Sub-Saharan Africa". Social Science and Medicine 53:1397–1411.

87. Petersen, Inge, and Leslie Swartz (2002), "Primary Health Care in the Era of HIV/AIDS. Some Implications for Health Systems Reform". Social Science and Medicine 55:1005–1013.

88. Pinkerton SD, Abramson PR (1997) "Effectiveness of condoms in preventing HIV transmission". Social Science and Medicine, 44(9):1303–1312.

89. Poku, Nana (2002), "Poverty, Debt and Africa's HIV/AIDS Crisis". International Affairs 78(3): 531–546.

90. Policy Project (2004). "Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low and Middle Income Countries in 2003". Washington DC.

91. Population Action International (2002), "Condoms count: meeting the need in the era of HIV/AIDS." Population Action International, Washington, DC.

92. Price, Neil (2001), 'The Performance of Social Marketing in Reaching the Poor and Vulnerable in AIDS Control Programmes". Health Policy and Planning 16(3):231-239.

93. PSI (Population Services International) (2001), "Only with Style—Só com Jeito. The Successful Mozambican Condom Social Marketing Project: A Targeted Behaviour Change Strategy for AIDS Prevention".

94. PSI, The creative Edge (1998): Social Marketing for AIDS Prevention.

95. Robinson NJ et al. (1999) "Type of partnership and heterosexual spread of HIV infection in rural Uganda: results from simulation modelling". International Journal of STD AIDS, 10:718-725.

96. Robinson, Les. (2001), "On Making Social Change." Social Change Media.

97. Robinson, Les. (1998), "A 7 Step Social Marketing Approach." Social Change Media.

98. Rothschild, Michael (2000), 'Ethical Considerations in Support of the Marketing of Public Health Issues". American Journal of Health Behaviour 24(1): 26–35.

99. Rothschild, Michael L. (1979) "Marketing Communications in nonbusiness situations, or why is it so hard to sell brotherhood like soap" Journal of Marketing, Vol 43 (spring), 11-20

100. Sampaio M et al. (2002) "Reducing AIDS risk among men who have sex with men in Salvador, Brazil". AIDS Behav, 6(2):173–181.

101. Santos NJS et al. (2002) "HIV-positive women, reproduction and sexuality". Rev. Saude Publica, 36(4 Suppl):12–23.

102. Schellstede W, Ciszewski R (1984), "Social marketing for contraceptives in Bangladesh." Studies in Family Planning 15:30-39.

103. Schellstede William. P, Cizewski Robert L (1984), "Social marketing of contraceptives in Bangladesh", Studies in Family Planning, Vol 15, No.1, 30-39.

104. Serwadda et al (1995). "The social dynamics of HIV transmission as reflected through discordant couples in rural Uganda."

105. Shelton J, Johnston B (2001), "Condom Gap in Africa: evidence from donor agencies and key informants." Br Med J, 323: 139.

106. Smith, William (2000), "Social Marketing: An Evolving Definition". American Journal of Health Behaviour, 24(1):11–17.

107. Solomon, S. (1996), "Religious Beliefs and HIV/AIDS/STD Promotion". AIDS/STD Health Promotion Exchange 2:1–3.

108. Spira, R., E. Largarde, J. Bouyer, K. Seck, C. Enel, N. Kane, J. Piau, I. Ndoye, S. Mboup, and G. Pison (2000), "Prevention Attitudes toward the Threat of AIDS: Process and Determinants in Rural Senegal". AIDS Education and Prevention 12(6):544–556.

109. St. Lawrence JS, Scott CP (1996) "Examination of the relationship between African American adolescents' condom use at sexual onset and later sexual behaviour: implications for condom distribution programs". AIDS Prevention Education, 8(3):258–266.

110. Stallworthy G (1998), "Social Marketing benefit incidence", Draft unpublished paper: London, PSI, Europe.

111. Sutton, Sharyn M., George I. Baich, and R. Craig Lefebvre, (1995) "Strategic Questions for Consumer-Based Health Communications." Public Health Reports 110: 1-13

112. T.R.L Black (1976), "Community Based distribution: The Distributive Potential and Economics of a social marketing Approach to Family Planning". Proceedings of Royal society of London. Series B, Biological Sciences, Vol 195, No 1118. A Discussion on Contraceptives of the Future.

113. Thompson, Randy, and Dee Bennett (1997), "Using Public Relations to Solve a Crisis—When Religious Groups Clash with Social Marketing Programs". SOMARC Occasional Paper No. 20. Washington, DC: The Futures Group International.

114. Ugandan Ministry of Health (2001) "HIV/AIDS Surveillance Report: 13." Ministry of Health, Kampala.

115. UNAIDS (1998), "social marketing: an effective tool in the global response to HIV/AIDS", UNAIDS Best Practices Collection.

116. UNAIDS (1999), Global Directory of Social marketing programmes.

117. UNAIDS (2001), "Global Directory of Condom Social Marketing Projects and Organizations". Geneva: UNAIDS.

118. UNAIDS (2003) "Condoms and HIV Prevention: A Review of the Evidence". UNAIDS, Geneva.

119. UNAIDS and PSI (1999), "Social Marketing: Expanding access to essential products and services".

120. UNDP (United Nations Development Program) (1998), "Mozambique: National Human Development Report". Maputo: UNDP.

121. UNFPA (United Nations Family Planning Agency) (2002), "Preventing HIV/AIDS: UNFPA fact Sheet". New York: UNFPA.

122. UNICEF (2002) "Young people and HIV/AIDS: Opportunity in Crisis". UNICEF, New York.

123. USAID (1998), "Realizing the Promise of a Commercial Approach to Improving Public Health." Social Marketing Matters: A Newsletter for Marketers of Public Health-Recommended Products 1(6):1. USAID.

124. Van Rossem R, Meekers D, Akinyemi Z (2001) "Consistent use with different types of partners: evidence from two Nigerian surveys". AIDS Education Prevention, 13(3):252–267.

125. Van Rossem, Ronan, and Dominique Meekers (2000), "An Evaluation of the Effectiveness of Targeted Social Marketing Top Promote Adolescent and Young Adult Reproductive Health in Cameroon". AIDS Education and Prevention 12(5):383–404.

126. W.J. McGuire,(1983), "Theoretical Foundations of Campaigns," in Public Communication Campaigns (Newbury Park, Calif.: Sage Publications, 1989), 43-65; E. Rogers, Diffusion of Innovations (New York: Free Press, 1983); B.R. Flay, "On Improving the Chances of Mass Media Health Promotion Programs causing Meaningful Changes in Behaviour," in Health Education by Television and Radio, ed. M. Meyer (Munich: Saur, 1981); and B.R.

Flay, D. DiTecco, and R.P. Schlegel, "Mass Media in Health Promotion: An Analysis using an Extended Information-Processing Model," Health Education Quarterly 7 , 127-147.

127. Wallack, Lawrence (1994), "Media Advocacy: A Strategy for Empowering People and Communities". Journal of Public Health Policy (winter):420–436.

128. Wallack, Lawrence, and Lori Dorfman (1996), "Media Advocacy: A Strategy for Advancing Policy and Promoting Health". Health Education Quarterly 23(3):293–317.

129. Wallerstein, N. (1992), "Powerlessness, Empowerment and Health: Implications for Health Promotion Programmes". American Journal of Health Promotion 6:197–205.

130. Walsh, Diana Chapmen, Rima E. Rudd, Barbara A. Moeykens, and Thomas W. Moloney, (1993) "Social Marketing for Public Health." Health Affairs Summer: 104-119.

131. Weinreich, Nedra Kline,(2003). "Building Social Marketing into Your Program." Social- Marketing.Com. 2003. Weinreich Communications.

132. Weinreich, Nedra Kline. "Research in the Social Marketing Process." Social- Marketing.Com. 2003. Weinreich Communications.

133. Weinreich, Nedra Kline. "Social Marketers in the Driver's Seat: Motorsport Sponsorship as a Vehicle for Tobacco Prevention." Social-Marketing.Com. 2003. Weinreich Communications.

134. Weinreich, Nedra Kline. "What is Social Marketing?" Social-Marketing.Com. 2003. Weinreich Communications.

135. Weinreich, Nedra Kline.(2003) "Getting Your Message Out Through the Media." Social- Marketing.Com. 2003. Weinreich Communications.

136. Weinreich, Nedra Kline, (2003) "Integrating Quantitative and Qualitative Methods in Social Marketing Research." Social-Marketing.Com. 2003. Weinreich Communications.

137. Weinreich, Nedra Kline.(2003) "The 'Don't Kid Yourself' Campaign." Social-Marketing.Com. 2003. Weinreich Communications.

138. Weller S, Davis K (2002) "Condom effectiveness in reducing heterosexual HIV transmission". Cochrane Database Syst Rev, 1:CD003255.

139. Weller SC.(1993) "A meta-analysis of condom effectiveness in reducing sexually transmitted HIV". Social Science and Medicine; 369 (12): 1635–1644.

140. Which One Were You? 2003. Kansas Health Foundation.

141. "Why do young women have a much higher prevalence of HIV than young men?" A study in Kisumu, Kenya and Ndola, Zambia. AIDS 15(suppl 4), S51–60.

142. Wiebe, G.D (1951-51)"Merchandising Commodities and Citizenship on Television" Public Cpinion Quarterly, 15 (winter), 679-91.

143. Wisner, Ben (1987) "Doubts about 'social marketing' " Health Policy and Planning (2) 2, 178- 182.

144. Wisner, Ben (1987), "Doubts about Social Marketing". Health Policy and Planning 2(2):178–179.

145. Young, Eric.(2001) "Social Marketing: Where It's Come From; Where It's Going." Health Canada. 2001.

BOOKS:

1. Qadeer I,Sen K, Nayar K,ed (20C1), "Public Health And Poverty Of Reforms: the South Asian Predicament", Sage Publications.

2. Fine, Seymour H. (1990). "Social Marketing -promoting the causes of Public on Nonprofit agencies". Allyn and Bacon, Boston.

3. Goldberg, Marvin, Martin Fishbein, and Susan Middlestadt, eds.(1997), 'Social Marketing: Theoretical and Practical Experiences". Mahwah, NJ: Lawrence Erlbaum Associates.

4. Harvey, Philip (1999), "Let Every Child Be Wanted: How Social Marketing Is Revolutionizing Contraceptive Use around the World". Westport, CT: Auburn House.

5. Kim, J, Y., J. Millen, A. Irwin, and J. Gersham, eds. (2000), "Dying for Growth: Global Inequality and the Health of the Poor". Monroe, ME: Common Courage Press.

6. Klein Weinreich, Nedra (1999) "Hands-on Social Marketing, A step by step guide". Sage Publications, California

7. Kotler, Philip, Roberto, Ned & Lee, Nancy (2002) "Social Marketing, Improving the Quality of Life". SAGE Publications, California.

8. L. Wallack, "Improving Health Promotion: Media Advocacy and Social Marketing Approaches," in Mass Communication and Public Health, ed. C. Atkin and L. Wallack (Newbury Park, Calif.: Sage Publications, 147-163.

9. Mann J,TarantolaD. Ed (1196a), "Vulnerability: personal and programmatic." AIDS in the world II. Pgs-441-3, Oxford University Press.

10. Mann J,TarantolaD. Ed (1196b), "Societal: Vulnerability: Contextual Analysis". AIDS in the world II. Pgs-444-62, Oxford University Press.

11. Manoff, Richard K. (1985) "Social Marketing, New Imperative for Public Health". Praeger Publishers, NY.

12. P. Kotler (1991), "Marketing Management: Analysis, Planning, Implementation, and Control" (Englewood Cliffs, N.J.: Prentice-Hall, Inc.

13. R.K. Manoff,(1985), "Social Marketing: New Imperative for Public Health" (New York: Praeger, 47-48.

14. S.H. Fine,(1981) ,"The Marketing of Ideas and Social Issues" (New York: Praeger, 1981).

15. Turshen, Meredeth (1999), "Privatizing Health Services in Africa. New Brunswick: Rutgers University Press.

16. Wallack, Lawrence, Lori Dorfman, David Jernigan, and Makani Themba (1993), "Media Advocacy and Public Health". Newbury Park, CA: Sage.

17. World Bank (1997), "Confronting AIDS: Public priorities in a global epidemic .Oxford .Oxford University Press.

Jawaharlal Nehru University
Library