Annexe 1: Literature review

Social marketing for Urban Sanitation

Literature review
(Revised version)

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1. Introduction

The literature review draws on published and ‘grey’ literature on social marketing. As there is limited documented experience in using social marketing within the sanitation sector, much of this literature reviews its application within other spheres. Search terms were put into a variety of databases (including Medline, google, IRCDOC, WSP web page, the cluster of databases accessed through Cambridge Scientific Abstracts) as well of documents held in the WEDC Resource Centre and the libraries at the Loughborough University, London School of Hygiene and Tropical Medicine, and University of California, Davis.

1.1 The context of the research

The Global Water Supply and Sanitation Assessment 2000 Report indicates that 84% of the urban population in Africa has access to an improved form of sanitation (WHO and UNICEF, 2000). The assessment used precise definitions of what constituted improved and unimproved sanitation as shown in box 1 below.

<table>
<thead>
<tr>
<th>Definitions of improved and unimproved sanitation from Global Water and Sanitation Assessment 2000 Report</th>
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<tbody>
<tr>
<td><strong>Improved technologies</strong></td>
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<tr>
<td>Connection to a public sewer</td>
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<tr>
<td>Connection to a septic system</td>
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<tr>
<td>Pour-flush latrine</td>
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<tr>
<td>Simple pit latrine</td>
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<tr>
<td>Ventilated improved pit latrine (VIP)</td>
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<td><strong>Unimproved technologies</strong></td>
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<tr>
<td>Service or bucket latrines (where excreta are manually removed)</td>
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<tr>
<td>Public latrines</td>
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<td>Latrines with an open pit</td>
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*Source: WHO and UNICEF, 2000*

It should be noted that these data were derived from household surveys and thus represent household experience more clearly than previous estimates based on service provider estimates. The figures on access may not, however, directly reflect use and as one of the 'improved' technologies is a shared latrine, the adequacy of service can be questioned.

Although latrines are known to offer substantial health benefits and are often the most affordable and appropriate solution for sanitation in low-income communities, large-scale interventions for latrine construction have on the whole been disappointing with some notable exceptions. Investment in sanitation has fallen to a very low level, and most major donors have reduced their investment in on-site sanitation. For example, the annual external support investment on urban sanitation in Africa from 1990-2000 was US$0.215 billion while the national investment is US$0.195 billion (WHO and UNICEF, 2000).

Various attempts made in the past to increase demand for sanitation have yielded little result, making it necessary to look for alternatives such as using professional marketing approaches. Social marketing uses elements of commercial marketing to encourage as well as promote an activity that benefits both society and individuals. This project investigates how to implement such a strategy and the evidence of the effectiveness of social marketing.
1.2 Why social marketing for sanitation promotion?

The principal cause of diarrhoea is other people’s excreta (Cairncross, 1999). Diarrhoeal disease accounts for deaths of 2.4 million people (WHO, 2000) making it the third largest cause of mortality among children in the middle and low-income countries (WHO, 1999). In Africa, diarrhoea was ranked 5th in the causes of mortality, (WHO, 1999).

Good sanitation, water supply and hygiene could prevent much of this morbidity and mortality. A number of authors such as Cairncross (1999) stress that the installation of a latrine, in conjunction with hygienic behaviour, is one of the major interventions for the prevention of excreta-related diseases (Cairncross, 1999; WELL, 1998). The impacts and risks of a lack of sanitation are more acute in urban communities as these tend to be much more densely populated and there is less space to dispose of excreta and wastewater (UNICEF, 2000)

Although the health implications of inadequate sanitation are often considered the most crucial factor, sanitation is also important for other reasons. Sanitation has gender aspects. These include the necessity of privacy for women when defecating, the dangers of walking to open defecation sites at night, and the lack of school sanitation facilities, which often prevents girls from attending school (Cairncross, 1999). UNICEF (2000) suggests that sanitation is a human rights issue from the perspective of the dignity of having access to a latrine.

Despite the gains made in increasing sanitation coverage during the water and sanitation decade of the 1980s, a large proportion of the urban poor in developing countries lack adequate sanitation facilities (WHO and UNICEF, 2000). It is estimated that 46 million (15%) people living in the urban areas in Africa do not have access to sanitation. This unserved population is primarily located in low-income communities in urban areas.

The relatively poor uptake of sanitation facilities among poor urban residents in the South has highlighted the need for new strategies for promoting latrines. Donor-supported sanitation programmes have failed to produce impressive results in terms of increased levels of uptake and coverage. WELL (1998) suggests that traditional programmes have not taken sufficient account of people’s hygiene and sanitation behaviour, and the goals of such projects have tended to focus quantitatively on the number of latrines constructed or number of people with access, rather than the reasons behind adoption or rejection:

“Hygiene and sanitation programmes have commonly been concerned with the supply’ of education, and materials, rather than with satisfying a ‘demand’ from intended beneficiaries. Demand creation is the main aim of commercial marketing. The social marketing approach is demand led in that it uses a strategic, managed process of assessing and responding to felt needs, creating demand and then setting achievable and measurable goals” (WELL, 1998:203-204).

UNICEF (2000) illustrates the lessons of past and present sanitation projects:

<table>
<thead>
<tr>
<th>works</th>
<th>doesn’t work</th>
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<tr>
<td>political will and strong government role</td>
<td>giving sanitation low priority</td>
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<tr>
<td>Promoting behaviour change</td>
<td>narrow focus on technology</td>
</tr>
<tr>
<td>Reaching schoolchildren</td>
<td>Ignoring family as a whole</td>
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<tr>
<td>Giving families a choice</td>
<td>‘One size fits all’</td>
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<tr>
<td>Community planning and management</td>
<td>Top-down approach</td>
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<tr>
<td>Cost-sharing</td>
<td>Limited access to funds/credit</td>
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Simpson-Hébert and Wood (1998) identify wider factors that also contribute to restricting access to sanitation for the poor:

- lack of political will
- low prestige and recognition
- poor policy at all levels
- poor institutional framework
- inadequate and poorly-used resources
- inappropriate approaches
- failure to accept the disadvantages of conventional excreta management systems
- neglect of consumer preferences
- ineffective promotion and low public awareness
- lowest priority given to women and children
- little effective demand
- cultural taboo and beliefs

Sanitation promotion is defined as “the marketing and promotion of sanitation products and services” (WELL 1998:202). In many circumstances there is little overt demand for sanitation, therefore the key issue is actually the need to create and stimulate demand through sanitation promotion (Sanitation Connection, 2001). It is a process that comprises identifying key target groups to be reached, identifying core messages to be communicated, and gaining awareness of the prevailing socio-cultural framework and understanding what motivates people to invest. WELL advocates social marketing as a strategy to achieve sanitation promotion.

The barriers to the adoption of sanitation are still not well understood, and are likely to include diverse factors such as lack of demand, access, affordability or technical skills. One principal reason for poor levels of uptake that has been highlighted is lack of demand for a latrine on the part of poor households. Social marketing has been identified as an approach that could have the potential to encourage people to install latrines, through marketing messages that emphasise other benefits of latrines that may appeal to them more than the health benefits, such as dignity and aesthetics (WELL, 1998).

This literature review will present a synthesis of social marketing development, practice and theory, with particular emphasis on experiences in developing countries and applicability to sanitation promotion. A review of the literature concerning social marketing history and theory will examine the emergence and development of the approach. The review will also pay attention to the different definitions and conceptualisations of social marketing from both academic and practitioners’ perspectives. The criticisms and ethical concerns raised in response to the emergence of social marketing will also be outlined and considered, along with the distinctions between social marketing and ‘related’ areas such as commercial marketing, health education, social mobilisation.

Following this, the review will examine the practical side of social marketing processes and methodologies proposed. Selected case studies will focus on the application to public health issues in developing countries, presenting both successful and unsuccessful experiences. The discussion section will centre on the applicability of social marketing to sanitation and latrine promotion, and other social/health issues such as birth control and, oral rehydration therapy. The conclusions of the review (the first stage of the research), therefore, will aim to present an idea of how social marketing can be adapted and applied to latrine promotion.
2. Social marketing theory

2.1 Emergence and development

The ‘creation’ of social marketing is generally attributed to American marketing professors Philip Kotler and Gerald Zaltman, whose article “Social Marketing: an approach to planned social change” appeared in the Journal of Marketing in 1971. Although Kotler and Zaltman first coined the phrase “social marketing”, they attribute the birth of the concept of applying commercial tactics to social campaigns to G. D. Wiebe who posed the question “why can’t you sell brotherhood like you sell soap?” in 1952. Wiebe theorised that the more similar a social campaign is to a commercial campaign, the more successful it is likely to be.

Tena (1988) and Ling et al (1992) divide the development of social marketing into three distinct phases:

1. The first phase, from the late 1960s and 1970s, focused on the early theoretical development of social marketing. Tena (1988) refers to this phase as one of confusion, as social marketing suffers from an identity crisis due to its evolution from commercial marketing, and struggles with ethical issues. This phase involved two complementary lines of research: developing theory and studying practice in different areas. It considered the practical mechanisms that are needed to support advertising in order to make it possible for people to move from intention to action. The phase ended with some confusion surrounding the conceptualisation of social marketing, as noted by Fox and Kotler (1980). In this period the first experiences of the practical application of social marketing were underway with issues such as family planning.

2. The second phase, between the late 1970s and 1980s, was one in which theorists turned their attention away from the debate over definition and towards the growing practical experience. A number of successful experiences in the field of family planning were well documented. An example of this is Lefebvre and Flora (1988), who proposed that social marketing is more useful to the field of public health than traditional educational approaches, especially when broad-based campaigns based on successful field experiences, such as the Stanford heart disease study, are used.

Fox and Kotler (1980) outline how social marketing had been applied in practice to issues such as family planning, energy conservation, improved nutrition, antismoking, prevention of alcohol and drug abuse and safer driving, mainly in North America. The authors note that there was increasing questioning of the ethics of social marketing, with the reorientation of Wiebe’s question into “should you be selling brotherhood?”

Tena (1988) observes that, during this phase, social marketing was increasingly accepted by academics and theoretical concepts started to be developed, although critics still did not accept the links with marketing, criticised it for being manipulative and questioned hidden agendas. This phase also included the publication of guidelines for the practitioner, such as those by Kotler and Roberto (1989). Above all, this phase identified the problems with both theory and practice, and set out to address these by trying to bring theory and practice together.

3. The third and current phase, from the late 1980s onwards, is one of increasing acceptance and the beginnings of the establishment of an academic discipline. Nevertheless, there is still confusion with overlapping areas, such as ‘not for profit’ marketing and political marketing. This phase is characterised by the adaptation of theory to practice with continuing conceptual development, but still leaving some
fundamental questions unanswered. Tena (1988) notes that the conceptual development of social marketing has been much less extensive than its practical application, demonstrated by the fact that most studies are specific case studies that are not easily generalised. There is still much debate within the social marketing field over delivery, impact, sustainability, cost-effectiveness, ethical and equity issues.

More recently, other authors, such as Lefebvre (1992), locate social marketing within the framework of a shifting paradigm of public health promotion from a top-down to a people-responsive approach, that is, meeting consumer needs rather than producing products and trying to persuade them to buy them. WELL (1998:201) describes how the “promotion of safer practices will best be achieved by new, promotional community-based social marketing approaches that seek out and use the messages that will motivate change. These must be established and used as the starting point to inspire behavioural change”. Maibach and Holtgrave (1995) note that, in comparison with other public health communication techniques, social marketing is the most developed approach but still has no accepted definition. They believe that this is the case because social marketing has been warmly received due to its progress towards replacing traditional paternalistic approaches with consumer-driven approaches.

2.2 Definitions and conceptualisations of social marketing

Social marketing has been defined in various ways by numerous authors. The first comprehensive definition of social marketing is that it is seen as the framework for planning and implementing social change, Kotler and Zaltman (1971). They defined social marketing as,

“The design, implementation and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution and marketing research. Thus it is the explicit use of marketing skills to help translate present social action efforts into more effectively designed and communicated programs 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 and Zaltman, 1971:5).

The fundamental premise behind Kotler and Zaltman’s (1971) conceptualisation of social marketing is the application of commercial principles to social causes. As opposed to a sales approach, which finds customers for existing products and convinces them to buy them, a marketing orientation seeks to discover the wants of a target audience and then create the goods and services to satisfy them. In this way, the seller recognises that it is easier to create products and services for existing wants than to try to alter wants and attitudes towards existing products.

The concept of exchange is also inherent in Kotler and Zaltman’s original definition: “although planned social change is not often viewed from the client’s point of view, it involves very much an exchange relationship between client and change agent” (Kotler and Zaltman, 1971:4). Some authors point out that the notion of exchange is missing from many definitions and conceptualisations of social marketing. Rothschild (1999) believes that social marketing is now more about education than marketing, as the link with exchange has become increasingly weak. He also emphasises that much social marketing theory has neglected the notion of exchange. Smith (1993) points out that there is often
little marketing in social marketing because practitioners are from health or communication backgrounds.

Tena (1988) notes that a common position is to consider social marketing as a management technique, thus extending and adapting the general principles of marketing. He proposes several key elements: (i) extension of marketing and management principles; (ii) social marketing’s nature as a social process; (iii) emphasis on exchange; (iv) use of the marketing mix.

Other definitions of social marketing emphasise the following concepts,

- **Promotion of social ‘causes’ or ‘ideas’** to products

The definition by Lefebvre & Flora, (1988:300) states that “social marketing is distinguished by its emphasis on so-called ‘non-tangible’ products – ideas, attitudes, and lifestyle changes”.

- **Planned approaches to social change**

Social marketing attempts to persuade a specific audience, mainly through various media, to adopt an idea, a practice, a product, or all three. It is a social change management strategy that translates scientific findings into action programmes (Ling et al, 1992:342).

Social marketing is a systematic approach to public health problems. It goes beyond marketing. It is not motivated by profit alone but is concerned with achieving a social objective. Social marketing is therefore concerned with how the product is used after the sale has been made (WELL, 1998:204).

Other authors focus on the personal changes that social marketing often works towards, bringing social marketing to a more *individual, rather than societal, level*:

A program planning process that promotes the voluntary behaviour of target audiences by offering benefits they want, reducing barriers they are concerned about, and using persuasion to motivate their participation in program activity (Kotler and Roberto, 1989:24).

Developing attitudes and values in people that help them make healthy choices and avoid those bad behaviours (RM and D, 2001).

Critics of social marketing, call for a broader definition by considering the role of social marketing in fostering change not just at the individual level, but also at the higher social and policy level, (Goldberg, 1995:357).

One of the most recent definitions of social marketing is by Weinreich, (1999), who defines social marketing simply as ‘the use of commercial marketing techniques to promote the adoption of a behaviour that will improve the health or well-being of the target audience or of society as a whole’. She mentions the key characteristic that distinguishes social marketing from commercial marketing as ‘its purpose’ – the benefits accrue to the individual or society rather than the marketer’s organisation.

The definition by Weinreich (1999) is more practical and closely related to the social marketing of a sanitation project.
2.3 Theoretical bases and premises

2.3.1 Definition of social marketing situations

Rothschild (1999) sees (social) marketing as one of three strategic tools – law, education and marketing – that can be used to determine people’s behaviour in relation to public health or social issues. He defines these tools as:

Education: Messages that attempt to inform and/or persuade a target to behave voluntarily in a particular manner but do not provide, on their own, direct and/or immediate reward or punishment.

Marketing: Attempts to manage behaviour by offering reinforcing incentives and/or consequences in an environment that invites voluntary exchange.

Law: Use of coercion to achieve behaviour in a non-voluntary manner or to threaten with punishment for non-compliance or inappropriate behaviour.

Similarly, Kotler & Roberto (1989) locate social marketing within a framework of six different types of change strategy:

- Technological: product modification, product substitution; product innovation;
- Economic: subsidies, incentives
- Political/legal: legislation
- Educational
- Social marketing
- Coercive

The use of each tool will be determined by the level of motivation, opportunity or ability of the target audience to comply with goals of the proposed managed behaviour, and whether the desired behaviour change is in the interest of the wider society or predominantly the individual. An issue is of societal concern when the current behaviour has social costs for which other members must pay directly or indirectly (externalities). The decision over which tool to use to control behaviour is a macro policy trade-off between the free choice rights of individuals and the rights of others not to have to bear the resulting externalities. Rothschild (1999) notes that current public behaviour management relies heavily on education and law and neglects marketing and exchange. He believes that marketing has an advantage over education in that it offers specific timely and explicit payback, whereas education can only offer a promise of future potential payback. Similarly, Goldberg (1995) advocates the use of social marketing techniques to address behaviours that are easily changed and where the principal costs are to the individual; but to apply legislation to social issues where it is difficult to achieve individual behaviour change and where the cost is predominantly to society.

There are several different applications of social marketing to social and health issues. Kotler and Zaltman (1971) defined three types of social ‘cause’ to which social marketing can be applied, according to the level of self-interest of the target individual:

- altruistic causes e.g. blood donation
- personal health causes e.g. smoking cessation
- social betterment causes e.g. drink-driving

Fox and Kotler (1980) take a different approach to defining situations for social marketing interventions, basing them on the nature of the activity to be promoted:

- dissemination of information and practices e.g. encouraging people to build and use latrines
- counter-marketing e.g. anti-smoking campaigns and information
- *activation* e.g. turn knowledge for need to exercise into action

Kotler and Roberto (1989) define the opportunities for social marketing into types of campaign:

- **Information and awareness**: provide information and raise awareness of desired goal by bringing about cognitive change e.g. AIDS prevention
- **Act or practice**: persuade a maximum number of individuals to perform a specific act or practice in a given time e.g. vaccination.
- **Personal benefit**: induce people to change some behaviour for their own good e.g. smoking
- **Beliefs and values**: altering deeply felt beliefs or values e.g. birth control

### 2.3.2 Application of marketing theory to social causes

Kotler and Zaltman (1971) were the first authors to attribute the key concepts of marketing to social issues: the classical ‘marketing mix’ or the ‘4 P’s’ (Product, Promotion, Place, Price) to the social marketing process. Kotler and Zaltman (1971) describe that “the marketer’s approach to selling a social product is to consider how the rewards for buying the product can be increased relative to the costs, or the costs reduced relative to the rewards, or trying to find a mix of product, promotion, place and price that will simultaneously increase the rewards and reduce the costs”. They suggest the adaptation of the marketing mix to social causes as follows:

**Product:** *Studying the needs and wants of the target audience and attempting to design products and services that meet their desires.*

Marketers must ‘package’ the social idea in a manner which their target audiences find desirable and are willing to purchase. That is, they must emphasise the positive points of an idea or behaviour.

Many authors have attempted to define the types of products to be using in social marketing. Lefebvre (1992) defines three different types of product:

- message
- tangible product
- service delivery;

Kotler and Roberto (1989) define:

- tangible object (as a tool to accomplish the desired practice);
- social practice (single act or pattern of behaviour);
- beliefs, attitudes and values (belief is a perception held about a factual matter; attitude is an evaluation of a factual matter; value is an idea of right and wrong).

**Promotion:** *Communication-persuasion strategy and tactics that will make the product familiar, acceptable, and even desirable to the audience.*

There is the tendency to think of this as mass media, but promotion is a much larger idea, which includes advertising, personal selling, publicity and sales promotion. Also, promotion should not necessarily be interpreted as hard selling.

**Place:** *Providing adequate and compatible distribution and response channels and arranging for accessible outlets which permit the translation of motivations into actions.*
The target audience should know where the product can be obtained in order to be able to comply with the messages and behaviours promoted. This means that the environment must be shaped to facilitate the behaviour, for instance, providing more exercise facilities to encourage fitness (Goldberg, 1995).

**Price:**  
*Costs that the buyer must accept in order to obtain the product.*

This includes money, opportunity, energy and psychological costs. “In each case, the social marketer must define the change sought, which may be a change in values, beliefs, affects, behaviour, or some mixture. He must meaningfully segment the target markets. He must design social products for each market which are ‘buyable’, and which instrumentally serve the social cause. In some social causes, the most difficult problem will be to innovate appropriate products; in other cases it will be to motivate purchase” (Kotler & Zaltman, 1971). The best price is not necessarily no price: for instance, in Venezuela, some poor patients preferred to pay to see unlicensed practitioners than go to free hospital because it was more convenient, less time-consuming and less patronising. In social marketing, price will be determined by considering that the target audience performs cost-benefit analysis when considering investment of time, money or energy.

Tena (1988) emphasises that there is a great deal of difference of opinion over the definition of the marketing mix. Other authors, such as Kotler and Roberto (1989) and Weinreich (1999) have suggested the addition of extra ‘P’s’ – personnel, presentation, process, publics, partnership, policy and purse strings - specifically to the social marketing process. This can be considered to reflect the increased complexity of applying marketing principles to social, as opposed to commercial, situations that is increasingly recognised by many authors.

Hastings and Haywood (1991, 1994) claim that the original concept of marketing is based on three tenets: *consumer orientation*, *integrated approach* and the *pursuit of profit*. Successful marketing operates by offering optimum satisfaction of customer needs, and for this to occur it is necessary to treat people differently, hence the need to segregate them into smaller groups.

*Consumer orientation:* A consumer-oriented approach sees consumers as active participants and recognises that they have a contribution to make in defining their health needs and how they can be met. Health promoters must understand and empathise with the perceptions, motivations, behaviour and needs of the consumer, and must respect their views even if they do not agree.

*Integrated approach:* Use of the Marketing mix. The 4 P’s should be used in conjunction in order to identify the best combination of variables to offer to the consumer.

*Pursuit of profit:* In commercial marketing, a successful exchange of values is dependent on the marketer making the offering as attractive and accessible as possible. Exchange does not necessarily imply one party getting the better of another; it can also lead to a win-win situation for the marketer and consumer.
2.4 Distinction between social marketing and ‘related’ areas

This section explores the differences and relationships between social marketing and similar approaches. Social marketing is increasingly being promoted and applied to the field of public health, in some instances substituting existing strategies. It is useful, therefore, to briefly consider how social marketing can be distinguished from similar and related approaches, both within and outside the public health arena.

2.4.1 Social communication and social advertising

Social communication is generally regarded to be a broader approach of which social advertising is a component, Fox and Kotler (1980). They consider social advertising to be the root of social marketing, and believe that current social marketing has moved from a narrow advertising approach to a broad social communication and promotion approach.

2.4.3 Entertainment education

Entertainment education refers to the also relatively new strategy of using entertainment methods to convey social or health messages: “a performance which captures the interest or attention of an individual, giving them pleasure, amusement, or gratification while simultaneously helping the individual to develop a skill to achieve a particular end” (Singhal, cited in Maibach & Holtgrave 1995:). This approach is based on the premise that entertainment attracts larger audiences, people are more receptive to the messages if conveyed through entertainment, and that messages conveyed in this way are more likely to exert an influence because of the number of people involved, who in turn influence their peers. This approach is used within social marketing campaigns, and examples have included the promotion of messages and behaviours in television soap operas and popular music.

2.4.5 Social mobilisation and communication for development/development communication

Ling et al (1992) define social mobilisation as a multi-sectoral effort developed by UNICEF to facilitate and exchange the approach to development issues that aims to scale-up interventions from a micro level to national scale, enabling governments and development agencies to move beyond the project phase of development initiatives. It aims to first create political will for constructive change and then to translate that political will into the establishment of viable social service policies and actions to meet basic needs, aiming for a more sustainable approach to development interventions. The umbrella of social mobilisation covers advocacy, marketing, media, training, community education, and grassroots organisation activities. Social marketing can fit within this approach, as it stresses the need to understand people and tailor inputs to the specific requirements of communities.

UNICEF (1999a) has renamed social mobilisation ‘communication for development’, and sees it as a researched and planned process that is crucial for social transformation. UNICEF considers communication for development as an integral part of a wider development strategy that comprises, advocacy to raise resources, social mobilisation for wider participation and programme communication for changes in knowledge, attitude and practice of specific participants.
2.4.6 Health needs assessment

Montazeri (1997) advocates health needs assessment as an alternative to social marketing for public health issues, especially in developing countries. He defines it as a two-fold approach; firstly to identify risk groups, and secondly to identify the groups’ needs. A rapid appraisal approach is used to gauge needs assessment; thus the community evaluates its own health needs. In this way, it is based on the premise that people adopt new behaviours more easily because they themselves have defined the underlying problems.

2.5 The Role of the Mass Media in Social Marketing

Social marketing is inherently linked to the mass media, due to their use in many social marketing campaigns. However, in addition to the wider sociological debate over the influence of the media on behaviour, there is much discussion over the extent to which the use of mass advertising methods in social marketing is effective in conveying messages and influencing behaviour. This debate was already underway in 1971 when Kotler and Zaltman’s pioneering article was published.

Fox & Kotler (1980) consider that the roots of social marketing in fact lie in social advertising due to the apparent effect of advertising on behaviour. Wiebe (1951-52:679, cited in Kotler & Zaltman, 1971:6) agrees with this view, and asserts that the effectiveness of advertising campaigns is determined by five key factors:

- **Force**: the intensity of a person’s motivation toward the goals as a combination of their predisposition prior to the message and the stimulation of the message;
- **Direction**: knowledge of how or where the person might go to accomplish her/his motivation;
- **Mechanism**: the existence of an agency that enables the person to translate her/his motivation into action;
- **Adequacy and compatibility**: the ability and effectiveness of the agency in performing its task;
- **Distance**: the audience member’s estimate of the energy and cost required to consummate the motivation in relation to the reward.

Lazarsfeld and Merton (1952, cited in Kotler & Zaltman, 1971) concord, but define the determinants of influence differently:

- **Monopolisation**: absence of counter-propaganda;
- **Canalisation**: presence of existing attitudinal base for feelings that the social communicators are striving to shape, e.g. influence in terms of brand rather than product;
- **Supplementation**: effort to follow up mass communication campaigns with programs of face-to-face contacts.

With regard to the media-influence debate, Lane (1997) considers the role of information conveyed through entertainment and the use televised dramas that model desirable health behaviour. Theory and research indicate that there is great potential for people to imitate televised behaviours if they are easy to execute and performed by attractive models. Maibach (1993) reflects that the current consensus is that it can have ‘some effects on some individuals under some conditions’. With regard to this, he calls for appropriate and realistic objectives for social marketing. Kotler and Roberto (1989) identify four factors that dilute the impact of the mass media:
- **audience factors**: apathy, defensiveness, cognitive ineptness;
- **message factors**: messages that do not convey benefits in an appropriate manner;
- **media factors**: failure to use appropriate media vehicles at proper time;
- **response-mechanism factors**: failure to provide receptive, motivated citizens with easy/convenient way to respond positively to campaign’s objectives.

Other authors are more sceptical about the use of the mass media for social marketing, even though it may be capable of achieving a certain degree of influence. Wallack (1990) contemplates the debate over whether the role of the media in health promotion should focus on the social-political or personal-individual aspects of public health issues. Ling *et al.* (1992) also point out that, while quality media campaigns can inform, motivate and produce changes, face-to-face communication is needed for skill-building, monitoring and feedback.
3. Social marketing practice

3.1 The social marketing process

The social marketing process is equivalent to what Kotler & Zaltman (1971:4) term ‘marketing management’: “the analysis, planning, implementation, and control of programs designed to bring about desired exchanges with target audiences for the purpose of personal or mutual gain”. This process involves extracting information from consumers and using that information to modify products and concepts that are fed back to the same target audience through messages and packaging or positioning (McKee, 2000).

There have been many attempts to define the process of social marketing. For simplicity, this section is primarily based on the definition of stages of social marketing process in the practical guide by Weinreich (1999) titled ‘Hands-on Social Marketing’ as set out below:

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<thead>
<tr>
<th>1. Planning</th>
<th>Formative research</th>
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<td></td>
<td>Analysis</td>
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<td></td>
<td>Audience segmentation</td>
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<td></td>
<td>Strategy development</td>
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<tr>
<td>2. Message and materials development</td>
<td>Identifying appropriate channels</td>
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<td>Developing effective messages</td>
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<td>Producing creative executions</td>
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<tr>
<td>3. Pre-testing</td>
<td>Conducting the pre-test</td>
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<td></td>
<td>Using the pre-test results</td>
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<tr>
<td>4. Implementation</td>
<td>Developing an implementation plan</td>
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Source: adapted from Weinreich (1999)

i. Planning

**Formative research**

Formative research is generally defined as the research activities conducted prior to the implementation of a social marketing strategy in order to obtain the information needed on which to base the initiative (Maibach, 1993; Weinreich, 1999). Formative research can be considered equivalent to the market and consumer research carried out in the commercial marketing field (Lefebvre & Flora, 1988). Several authors note that commercial marketers invest significant resources in market and consumer research, whereas the tendency in social marketing is to skimp on this activity in order to save resources. Following its importance in the commercial marketing field, many authors conclude that formative research is a crucial and indispensable component of the social marketing process (Lefebvre, 1992).

Maibach (1993) notes that there are many differing opinions as to what exactly constitutes the formative research process, including for instance: the process of data/perceptions collection, the process of pre-testing messages/ideas/methods or determining what works best. Maibach views formative research as a more comprehensive process, which includes the collection of: detailed knowledge of the target audiences’ needs, wants and concerns;
the costs and benefits they perceive from proposed innovations; as well as the language they use, which will be used to inform concept development, message development and message testing.

Weinreich (1999) defines formative research as consisting of the following questions that need to be answered in order to produce the necessary information on which to base the social marketing intervention:

- What is the problem to be addressed?
- What is the context in which the problem exists?
- Who will be the target audience?
- How does the target audience think and behave in relation to the problem?
- What product can be offered that will appeal to the target audience?
- How can the target audience best be reached?
- Which messages and materials work best?
- What is the best social marketing mix?

Some authors, such as Hastings and Haywood (1991), regard problem definition as a separate phase prior to formative research, in order to uncover the nature and extent of the social marketing issue. They believe that formative research should be carried out in consultation with beneficiaries, as their views are likely to be as important, if not moreso, than those of the health professionals. This view is echoed by a number of other authors. Manoff (1997) emphasises the importance of getting a clear picture of the problem from the outset, as practitioners can often misperceive problems. He stresses that knowing the ‘why’ of consumer behaviour can be more important than knowing the ‘what’. For instance, although diarrhoea is the greatest cause of infant mortality in India, parents were more fearful of polio, because the resulting physical disabilities to children represented a greater burden than mortality, due to social stigmas and the burden of care.

McKenzie-Mohr (2000), in his presentation of community-based social marketing, stresses the need to uncover barriers to behaviour. From the identification of these barriers, the social marketing campaign will be better informed to be able to select which behaviours to promote and design the initiative to try to overcome barriers to this behaviour: “an effective social marketing strategy removes barriers to the behaviour to be promoted” (McKenzie-Mohr, 2000:548). In contrast, most other social marketing strategies put forward merely advocate identifying behaviour, on the assumption that the social marketing campaign will later be able to influence and change it. McKenzie-Mohr theorises that identification of barriers is not a common part of social marketing theory or practice because programme planners may believe that barriers are already known. Programmes need to be delivered within a short time frame thus there is little time for identifying barriers, and financial constraints make it difficult to justify identification of barriers.

Formative research can be carried out using primary and secondary research of both a qualitative and quantitative nature. UNICEF (1999b) advocates a systematic approach of qualitative methods including focus groups and participant observation. Goldberg (1995) supports the use of ethnographic methods in order to obtain an understanding of the perspectives of the individual within the social system.
**Analysis**

Market analysis refers to the analysis of the existing market and wider context or environment in which a social marketing initiative will be implemented (Weinreich, 1999). This should focus on the analysis of:

- the problem to be addressed
- the external environment
- the resources available for the initiative

It includes investigating demand, identifying the potential beneficiaries (or consumers/customers), the existence of other competition, reasons for success or failure of previous initiatives and start up costs for the social marketing initiative.

Many authors refer to ‘consumer orientation’ as a component of the social marketing process. This concept is borrowed from commercial marketing, where it refers to sales orientation in response to the expressed needs of consumers, therefore it also has a place in social marketing (Lefebvre & Flora, 1988). Fox (1988) believes that good information about consumers and their preferences is one of the most important characteristics of social marketing. Maibach (1993) notes how a social marketing campaign must reflect its target audience’s orientation in order to effectively reach it, but warns that each individual consumer’s orientation is a composite of many factors.

Hastings and Haywood (1991) believe that consumer orientation goes beyond merely testing understanding of materials, but includes the need to design communications from inception to dissemination with the audience’s needs and perspectives in mind.

Kotler and Roberto (1989) define the social marketing environment as a set of forces that are external to the social change campaign and that impinge on its ability to develop and maintain successful influence on its target adopters. These consist of demographic, economic, physical, technological, political/legal, and socio-cultural factors. Lefebvre (1992) believes that consumer orientation will differ according to whether social marketing managers regard their target audience as passive or active. If they are regarded as passive, the social marketer will seek to understand their wants in order to do something for them, leading to a series of messages, products and services designed to meet their needs but with little direct input from consumers. This approach is unlikely to address external factors. On the other hand, if the audience is considered as active, consumer input to the proposed programme will be a continuing process and not one that occurs at a single point in time, leading to greater empowerment of the intended beneficiaries to address their own situations using social marketing as a stimulus. Goldberg (1995) advocates the identification and assessment of the effects of any discrepancies between the individual’s perspective and observed constraints at this stage of the social marketing process.

**Audience segmentation**

Audience segmentation is another principle adopted from commercial marketing, carried in order to divide the target audience up into ‘similar’ segments to define homogenous subgroups to which to target distribution and communication channel strategies (Lefebvre & Flora, 1988). In commercial marketing, it is used to define sub-markets that are more likely to purchase the product on offer; whereas in social marketing it is used to identify sub-groups of the wider target population according to predefined criteria. In this way, audience segmentation allows the social marketer to target efforts to particular groups, despite the pressure to include everyone (Fox, 1988). Audience segmentation and profiling also serve to establish the starting-point for social marketing by defining who is being asked to change, and from what baseline (Maibach & Holtgrave, 1995). Like formative
research and market research, it is also considered to be a very important part of the social marketing process (Fox, 1988). Maibach (1993) highlights the need to create complete profiles on each segment with primary and secondary data, and warns against the temptation of neglecting or reducing this process in order to save resources.

Weinreich (1999) and Kotler and Roberto (1989) define the following types of data that will be useful in social marketing for segmenting target audiences:

- geographic
- social/demographic
- physical/medical
- psychographic
- attitudinal
- behavioural

Kotler and Roberto (1989) also stress the need to identify influence-holding groups and opponents.

The failure to accurately define target groups can result in the failure of the social marketing initiative. For example, Manoff (1997) notes how a social marketing strategy sought to increase the use of oral contraceptives in Bangladesh by marketing them to women, however, the real barrier to low usage was later discovered to be predominantly due to men’s attitudes towards birth control.

**Strategy development**

Strategy development involves setting goals (i.e. overall change targets) and objectives (i.e. intermediate steps in order to reach goals). This is the stage of the process that involves the application of the social marketing mix: product, price, place and promotion (Weinreich, 1999).

**Product:** Social marketing should seek to offer “product solutions” where possible. These products should be desirable products, and – whether they are tangible products, services, or behaviours - should be tailored to the felt needs of the consumers (Fox, 1988; WELL, 1998).

**Price:** Products or services should be priced so that they are affordable, and, where possible, price should be used as an incentive to increase uptake of the social marketing product (Fox, 1988; WELL, 1998).

**Promotion:** It is important to develop a strategic approach to promote the product, service, or behaviour and improve the adoption of the product, service, or behaviour, and increase the willingness of consumers to contribute something in exchange (WELL, 1998). Kotler and Roberto (1989) believe that the marketing mix must be formulated not only for target adopters but also distribution outlets.

**Place:** Methods for effective distribution should be defined in order that consumers know where and how to get the product, service, or information about it (WELL, 1998).

In addition to the four classical P’s, some authors advocate the inclusion of further ‘P’s’ specifically in the social marketing process. Kotler and Roberto (1989) also include Personnel, Presentation and Process; and Weinreich (1999) also defines Publics, Partnership, Policy and Purse strings. With regard to Purse strings, Kotler and Roberto (1989) believe that all four ‘P’s’ are of equal importance, therefore social marketers must decide how to allocate their budget between them.
Hastings and Haywood (1991) stress that objectives should be set that are both practical – and realistic. Manoff (1997) points out that strategies should be devised from problems (identified at the preliminary problem-definition stage), whereas they are often identified in relation to objectives, because these are much easier to identify. To illustrate this, he cites the example of diarrheal disease in Nicaragua that was identified as a cause to be addressed by social marketing of oral rehydration salts (ORS). Initially, it was envisaged that the remedial strategy was a simple question of administering ORS. However the results were not encouraging as the ORS formula was difficult to remember, the beneficiaries did not perceive diarrhoea as a disease because it was so common, and people perceived ORS as a medicine and deemed it not to have worked when diarrhoea persisted.

ii. Message and materials development

Identifying appropriate channels

Weinreich (1999) identifies a number of channels through which information can be disseminated for social marketing initiatives, which have been adapted here to be more applicable to developing country contexts:

- mass media (television, radio, newspapers, magazines and comics)
- outdoor advertising (billboards)
- brochures, posters and newsletters
- interpersonal communication (such as doctors, pharmacists or health workers)
- music, drama, theatre or traditional folk media
- community events
- computer and internet media

UNICEF (1999a) believes that the most effective strategy is to use mass and traditional media to model recommended behaviours in order to portray model behaviour and to stimulate discussion on the issue being dealt with, on the premise that other people have the most direct influence on the behaviour of others. This could be the reason why many successful interventions have used accepted authorities in their communication campaigns, such as the use of popular actress Karima Mokhtar to promote oral rehydration therapy in Egypt (Lane, 1997). Following the debate over the influence of the mass media on behaviour in the earlier section, McKee (2000) recommends the use of multiple channels and strong community-based programming.

Although the identification of appropriate channels is necessary, the use of each of these channels needs to be analysed for its suitability for particular messages and audiences (Lefebvre and Flora 1988). Fox (1988) further points out that the use and control of existing channels of distribution is a very important consideration, as if this is not possible, it will be difficult to get access to the required media and disseminate through them the desired messages. Hastings and Haywood (1991) emphasise that it is important to make sure that the medium proposed is suitable and used by the target audience.

Developing effective messages

Weinreich (1999) emphasises that effective messages are not just clever slogans but well thought-out communications based on theory and research. She believes that, above all, social marketing messages must consider the main selling points of the project and the ideas the target audience needs to come away with. In order to identify these factors, she suggests a process called ‘consumer-based health communications’. This process poses six questions, the answers to which will form a creative strategy to guide the development of the project strategies:
- Who is the target audience, and what are its characteristics?
- What action does the promoter want the target audience to take as a result of the message?
- What reward should the message promise the consumer?
- How can the promise be made credible?
- What communication openings and vehicles should be used?
- What image should distinguish the action?

Weinreich (1999) believes that the reward should highlight the benefits of the product, reduce barriers to its adoption and portray the consequences of not adopting the product. It should be noted here that this is not the view of all social marketers, such as WELL (1998), some of whom concentrate on focusing only on positive aspects of the message and avoiding any ‘fear-inducing’ tactics. To make messages more credible to the target audience, scientific facts can be used, although there is some debate over whether all target audiences will respect the views of professionals (e.g. UNICEF, 1999a). Another strategy is to use respected individuals, such as celebrities, as described above. In order to be effective, messages must also be delivered at the moments and places when target audiences will be most receptive to them. Images conveyed by messages are a very important aspect, and must be appealing and compatible with the target audience’s perception of itself, as well as clear and decipherable. Language is another important aspect for messages, and this must be appropriate if target audiences are expected to respond (Hastings and Haywood, 1991; Weinreich, 1999).

Effective messages also call for an understanding of behaviour change in order that they may influence the behaviour of the target audience. Maibach and Holtgrave (1995) believe that the role of behavioural theory is important at this stage, as it allows programme planners to understand complex human behaviour and develop effective social marketing strategies that address those behaviours.

Maibach (1993) believes that influence occurs at different levels. At the individual level, he believes that the use of Bandura’s social cognitive theory is especially helpful as it elucidates both the internal and external influences on human behaviour as well as cognitive mechanisms that provide agency to these sources of influence. Maibach believes that status will be an important motivation for people to behave differently, if they anticipate that their contributions will be publicly acknowledged and/or admired by esteemed others. At the network level, theories such as ‘diffusion of innovation’ demonstrate that innovations share similar patterns of adoption within social systems that lead either to acceptance or rejection. At an organisational and a wider societal level, it is important to examine how information diffuses through organisations or groups of individuals. At the societal level, Maibach asserts that public opinion and agenda setting do not necessarily affect what people think, but they do have a large impact on what people think about.

However, Weinreich, (1999) also advises that, at this stage, it is necessary to consider other approaches in addition to communication. This is the point at which attention to structural changes becomes relevant, and these also need to be considered in addition to ‘convincing the audience’.
Producing creative approach

It is necessary to develop creative approaches to social marketing to suit your particular target audience. The way in which the messages are framed and presented is very important for its reception in different situations.

Weinreich (1999) considers that developing a creative approach to the social marketing intervention can be the most difficult part of the process. Social marketing messages, style and presentation must be relevant and meaningful to the target audience, and original so that they stand out and are noticed. Therefore, she recommends that implementers consider the services of an agency for assistance with message development, production and graphic design.

iii. Pretesting

Conducting the pretest

Weinreich (1999) considers pretesting to be a very necessary part of the social marketing process. Pretesting is basically the collection of feedback on the campaign materials from a selected representation of the target audience conducted prior to the pilot test. Pretesting is carried out in order to:

- ensure that the target audience comprehends the message,
- to pick up other unwanted interpretations of the message,
- to catch potentially costly mistakes,
- to realign the campaign with the reality of the situation,
- to make materials more appealing,
- to identify details that subvert the message and to select from other potential approaches.

She identifies the following criteria that should be met in order for the campaign to be adequate: comprehension, relevance, noticeability, memorability, credibility, acceptability, attractiveness, knowledge, attitude and/or belief change, strong and weak points

Weinreich (1999) favours the use of focus groups as the principal method for pretesting, and acknowledges that other alternatives are intercept interviews, self-administered questionnaires, theatre or natural exposure testing, readability testing and expert/gatekeeper review.

Using the pretest results

In order to interpret the results, Weinreich (1999) recommends categorising each suggestion within the information collected as: ‘definitely change’, ‘possibly change’ or ‘do not change’. Aspects of the campaign that fall within the ‘definitely change’ category include factual errors, lack of clarity, changes suggested by a clear majority (if reasonable) and easy changes. After the pretesting and the subsequent changes to materials and methods, the materials can be finalised for the pilot testing stage.
iv. Implementation

Developing an implementation plan

In order to develop an implementation plan, Weinreich (1999) suggests that the following need to be included:

- distribution plan: identify dissemination channels, decide quantity of materials, keep track of inventory, define methods of distribution;
- public relations plan (to attract free coverage): hold kick-off event, organise public relations activities;
- internal readiness plan: make sure everyone in the promoting organisation knows about the campaign and how it will work, and allocate tasks and responsibilities accordingly.

Planning and buying media

Media are usually a necessary, but costly, component of social marketing programmes. The use of paid and free media should be balanced according to those to which the audience is most likely to respond. Aspects that will need to be considered at this stage are how messages will be divided between the print and other media, including billboards for example, and how frequently these media will be used to convey messages (Weinreich, 1999). Adequate financial resources and absence of restrictions on advertising are aspects that must be considered prior to implementation (Fox, 1988).

Generating publicity

The use of public relations strategies can be employed to further the campaign (Weinreich, 1999). Media advocacy may have a role at this stage, in order to sensitise relevant individuals or groups to serve as advocates to attempt to gain media coverage of the issue, the highlighted salience of which may lead to pressure for structural changes at the higher level (Goldberg, 1995; Manoff, 1997; Weinreich, 1999).

Monitoring implementation

Monitoring mechanisms should be in place before implementation begins, in order to retrieve feedback and address any early problems (Weinreich, 1999). Monitoring also serves the following purposes:

- to ensure that the campaign is progressing as planned, and to alter the course if necessary;
- to ensure the quality of the campaign;
- to address any potential problems;
- to keep staff and partners interested;
- for practical reasons, such as knowing when materials need restocking;
- to assess the results.

Process evaluation is used to monitor and measure the response to the campaign, and is carried out through tracking mechanisms, which will be different for different purposes:

- Outreach activities: materials inventory, distribution list, materials placement audit;
- Target audience response: response tracking sheets, activity reports, public diaries;
- Impact of media exposure: television and radio logs, tear sheets, clipping services;
- Management effectiveness: staff surveys, focus groups, partner feedback, timeline, budget assessment;
- Issue monitoring: news/information searches, legislative-tracking systems, attitude surveys.
Evaluation and feedback is necessary to see both what the results were and to identify any improvements that could be made to the design of the project (Weinreich, 1999). This can be done by an external person for impartiality. Whereas commercial organisations devote much attention and resources to impact evaluation, social marketers tend to neglect this in order to reserve financial resources for other activities that are considered more important (Lefebvre & Flora, 1988).

Bertrand et al (1989) stresses the need for evaluation on different dimensions, and the corresponding allocation of funds for this. The authors note that most family planning social marketing programmes (for example in India) have monitored the volume of contraceptive sales but fail to assess whether the overall level of use has increased or whether it had an impact on other components of national family planning strategies (such as clinics or community-based distribution).

**Evaluation design**

Aspects of the social marketing campaign that need to be evaluated are: programme goals and objectives, data to be collected, methodology, data collection instruments, data processing and analysis (Weinreich, 1999).

Strategies for evaluation include:

- **Process tracking:** to provide an integrated and control aspect to the social marketing process, by having in place a system that tracks the on-going activities of the agency (Lefebvre & Flora, 1988).
- **Process evaluation:** to allow planners to monitor progress of messages and products in order to determine the extent to which objectives were achieved (Maibach, 1993).
- **Outcome evaluation:** to measure the effectiveness of the campaign using impact evaluation, causal evaluation, cost-effectiveness evaluation and other appropriate methods (Maibach, 1993).

The following indicators are important in evaluating social marketing programmes (Bertrand et al, 1989):

- Prevalence of product adoption;
- Cognitive indicators (awareness, satisfaction);
- Use-effectiveness (whether the product is being used correctly);
- User profile (whether users belong to the target audience);
- Cost-effectiveness.

**Evaluation methods**

Methods for evaluation include compiling data from existing records, same group pre-test-post-test, comparison to a standard, using control groups and use of evaluation indicators (such as changes in knowledge or attitudes). In order to achieve these, surveys, observation, qualitative (in-depth) interviews, focus groups and anecdotal feedback mechanisms can be used (Weinreich, 1999).

Bertrand et al 1989 advocate the use of quantitative and qualitative methodologies borrowed from commercial marketing based on surveys and analytic techniques:
Surveys:

- **Prevalence surveys:** These are based on large, probabilistic samples of women of reproductive age. Another source of prevalence data has been sample surveys of selected populations.

- **Panel studies:** These consist of a series of interviews or observations of the same units or subjects over an extended period of time. The primary purpose of panels is to measure change and chart trends. The basic characteristic of panel research is that it retains the same (or nearly the same) sample throughout the lifetime of the study, and sample elements are measured at periodic intervals.

- **Omnibus surveys:** These are conducted at regular intervals and usually contain nationally representative samples. Each survey uses a core set of questions to establish basic demographic and socio-economic information. A client pays a fee to have its questions added to the core set. These questions may be used for every round of the survey or for specific surveys only. The client only pays for those surveys in which he/she participated.

- **Tracking studies:** The aim of a tracking study is to monitor product advertising and other promotional activities through periodic measures of audience exposure, message recall, perceived product image, knowledge of methods and brands, and attitudes towards the targeted behaviour. It consists of cross sectional, sample surveys, with new and different samples of respondents interviewed at each wave of data collection.

- **Consumer intercepts:** Here product users are found by intercepting them in the store where they go to buy the target products. The disadvantage of this is that people may start to avoid the stores if they notice that they will be involved in an interview.

- **Mystery shoppers:** In this method, researchers play the role of customers to evaluate the performance of sales staff. This has been widely used in retail marketing.

- **Socio-economic status surveys:** In this approach, a group of experts is used to classify neighbourhoods based on census information; then interviews are conducted in each of the neighbourhoods.

- **Sales data through retail audits:** This has been used to obtain information on the flow of contraceptive products through the distribution channels to end-users. Sales data can be obtained by computing: \( \text{Beginning inventory} + \text{Deliveries} - \text{Ending Inventory} = \text{Sales for period} \).

Analytic techniques:

- Cost-effectiveness analyses,

- Time series analysis,

- Nested logic analysis,

- Discriminant analysis.
The authors suggest the following evaluation methods for project evaluation goals:

- Evaluation of target audience coverage: consumer intercept survey and discriminant analysis;
- Effect of programme on prevalence of product use: before/after survey, consumer intercepts;
- Effect of programme on other projects: prevalence surveys, consumer intercepts, panel study;
- Effective use of products: consumer intercepts, panel study;
- Programme cost-effectiveness: cost-effectiveness analysis, simple cost analysis.

**Using feedback to improve the programme**

Feedback should be integrated throughout the programme, and should not be left until the end of the intervention. In this way, issues can be responded to as and when they arise (Weinreich, 1999).
4. Social Marketing Experiences in Developing Countries

Social marketing has been used for various health problems in the developing countries. Social marketing was first implemented in Asia in the late 1960s, and subsequently replicated to Africa, Latin America and the Arab World, (Ling et al, 1992). The authors attribute its widespread use in these regions to the scale and nature of public health problems that called for both immediate actions and innovative approaches. Furthermore, in developing countries, the mass media are often owned and run by the government, therefore it is easier to use them for social marketing. The most widespread and successful interventions seem to be with contraception. This may be due to the controversial nature of the subject, which makes it necessary to develop innovative communication strategies (Ling et al, 1992).

Aspects of social marketing have also been applied to sanitation in developing countries. This section will present selected practical experiences with social marketing from developing countries, focusing on a variety of social and public health issues but particularly sanitation. Each initiative will be considered in terms of:

- Context and aims
- Approach and methods
- Success/failure
- Conclusions/lessons

4.1 Social Marketing of sanitation

Experience with social marketing of sanitation remains relatively limited. Whilst some aspects of projects referred to (notably the sanitary marts in India and the PADEAR project in Benin) have components that are similar to social marketing, they cannot be said to have applied this systematically.

There are some emerging experiences with social marketing from Asia. WSP (2000a) provides a summary of activities to promote sanitation in Bangladesh by DPHE and UNICEF. Historically sanitation promotion in Bangladesh has used sanitary marts and social mobilisation (e.g. sanitation weeks), with a significant proportion of the hardware being subsidised via grants from donors to Government, (e.g. for buying cement). However, by 2000, it was noted that private sector providers greatly out-numbered sanitation provision centres run by Governments and NGOs and evidence suggested that households preferred private providers because, despite the lack of subsidy, costs were generally lower. The UNICEF/DPHE programme has started to move into a new phase where greater attention is paid to including the private sector and strengthening the marketing ability of the private sector and to ensure that supply of sanitary hardware is closer to the villages. A key component of this strategy is to increase access to local credit institutions. WSP (2000a) notes that there have been some problems in implementing this approach, but if successful this will represent a very significant use of social marketing in sanitation promotion.

WSP (2000b) provides a description of the application of social marketing by WaterAid in rural sanitation projects in India. The project concluded that the major obstacles to increasing sanitation in rural India are the lack of demand, because people do not see the need or feel a desire for sanitation, the promotion of a single high specification design with high construction subsidy by the government. To tackle these problems, WaterAid and its partners focused on demand creation, social marketing (including a shift from health education), providing access to credit and developing a reliable supply of sanitation goods
and services. The programme also developed a more gender-balanced approach to group formation and health promotion. The change of approach was as a result of an evaluation that showed that in one particular area with 100% latrine coverage, only 37% of men were using latrines.

The social marketing approach used by WaterAid and its partners paid great attention to the “4 Ps” of marketing.

**Product:** The product selected was the low-cost pour flush pit latrine

**Price:** A series of latrine designs across a range of prices, which were all cheaper than the models promoted by the government

**Place:** Latrine models were put on permanent display at locally accessible technology and production centres. Small non-profit independent retailers were set up to take orders from customers and working latrine models were constructed and used by village health motivators to demonstrate the technology.

**Promotion:** Household latrines were promoted on the basis of non-health benefits such as privacy, convenience, safety, status and prestige, cost savings, and income generation (building latrines with bath extension and using waste water to grow vegetables). Media used were billboards, painting promotional messages on the walls of houses and sanitary road shows (health workers tour local villages in a bullock cart delivering messages and selling sanitary wares).

As a result of the change in approach, the number of latrines constructed rose from 460 in 1995-96 to 9,793 in 1998-99. The paper concluded that the success of WaterAid in India were attributed to the following:

- It stimulated demand among target communities by marketing the “non health” benefits of sanitation
- It developed a range of latrine designs and options to match household demand
- Installed demonstration latrines at production centres to show the simplicity and ease of construction
- It provided householders with access to credit for latrine construction (by targeting the largest subsidy to poorer families and providing micro credit loans with low interest.
- It built up reliable and effective links between suppliers, manufacturers and consumers.

One reason for success was the availability of high subsidy schemes for the poor. It is uncertain what the level of progress would have been without the subsidies. However, WaterAid seems to have noted this and aims to implement future sanitation projects with zero subsidy.

If the demand created for household latrines is to be realised, there is a need for improved access to credit facilities due to the high capital cost of installing a latrine. Lessons learnt from Cambodia (WSP 2002) indicate that access to credit to assist the poorest families in latrine construction does not necessarily mean providing highly subsidised or free latrines. Development of very low cost latrine designs, allowing poor households to pay over long periods of time (not necessarily in cash), provision of micro-credit schemes to finance latrines, and promotion of shared latrines between several households are some solutions that are possible.

However, it is important to reflect on the relevance of Asian experience in developing similar activities in Africa. Although there is a lack of quantifiable evidence over time for the impact of these approaches in Bangladesh and India, the development of such
approaches (if successful) should provide Africa at least with the evidence of efficacy. Secondly, many of the issues of institutional complexities and reluctance to move from a hardware-focused supply to a software-focused supply are identified as constraints in Asia as well as Africa. Furthermore, the active involvement of small-scale private sector sanitation providers is almost certainly required to achieve improvements in sanitation access, particularly where subsidy-free sanitation policies are in place. The evidence starting to emerge of effective support to the small-scale private sector in Asia may offer important lessons for urban authorities in Africa.

However, it is clear that a certain degree of caution should be taken when trying to apply lessons learnt from Asia to Africa. With particular reference to the example from Bangladesh above, two major points emerge.

1. Access to credit institutions. The ability of small-scale private sector sanitation providers to access credit may well be critical to the economic viability of sanitation as a business. Bangladesh in particular, has a well-established and extremely active credit-providing sector with well-respected banks and NGOs offering a wide range of services and maintaining significant numbers of customers. Of particular importance to note is that many have primarily developed indigenously rather than through establishment by outside agencies. Experience of credit institutions in Africa is far more limited and generally less positive. There simply are not the well-established banks that target smaller businesses and communities. There have also been a number of high-profile failures in the past where such banks were established. Reliance on access to credit therefore appears less feasible in urban Africa.

2. Experience of social provision by the private sector. Although there has been some development within the private sector in providing social goods and services in Africa, these are less well developed than in parts of Asia. For instance, in Bangladesh, the overwhelming majority of tube wells in the country are owned by households, which were sunk by private sector drilling companies (DANIDA, 1999). In a sense therefore, the population in Bangladesh is well attuned to the purchase of some social services and goods from the private sector, which may provide a significantly advanced starting point for private provision for sanitation.

This does not mean that no useful lessons may be learnt from the experience in South Asia, but does perhaps point to the need for careful consideration regarding transferability of those lessons. One important lesson from the case studies is the need to target the poor households through various credit schemes.

Clegbaza (1999) reports on marketing of sanitation undertaken in Benin and states that this led to the construction of 600 family latrines without subsidy. The rural sanitation programme by PADEAR adopted ‘a zero subsidy’ approach. The project in Benin was aimed at increasing sanitation coverage in communities and institutions; fostering hygiene behaviour change through awareness raising and social marketing; and creating a network of qualified masons able to respond to the demand for low-cost sanitation facilities. One of the key aspects of the programme is the ‘zero subsidy’ for building household latrines. The approach adopted by the project to promote household latrine include:

- Providing a wide range of technological options suited to the needs as well as the financial means of the communities and providing access to information to enable informed decision-making.
• Marketing latrines based on community perceptions of the usefulness of latrines (e.g. ‘With latrine, no risk of snakebite’; ‘A latrine is better for receiving visitors). Messages were printed on T-shirts, scarves, and exercise books, and were also broadcasted over the radio and made into songs.

• Promoting the latrine like any other product and providing easy access to quality service by training a network of mason on various low-cost latrines, supporting them in IEC and strengthened social marketing activities

• Developing special schemes to assist the poor householders to build a latrine. This included, getting the masons to agree to be paid in instalments by very poor families who buy materials when there is money and dig their own pits. Masons also targeted groups of households and offered the possibility of one block with two latrines, making it less expensive per household.

The results after 4 years indicated that over 400 household latrines were built without subsidies and over 130 masons were trained in building low-cost latrines and in marketing.

This project is one of the few examples in Africa that appears to have used approaches more closely matching social marketing, but there remained some unanswered questions. Most notably among these are:

1. What background level of construction of household latrines would be expected in the area (i.e. what excess proportion of latrine construction does this represent over usual practice)?
2. Were the 600 family latrines of a different and improved design from those usually available?
3. What impact has 600 latrines had on overall access figures within the region – are we seeing an accelerated increase in access or marginal improvements?

Some important lessons for sanitation promotion also, of relevance to social marketing, emerge from a review of why sanitation promotion had been effective in selected communities in Cambodia, Indonesia and Vietnam (Mukherjee, 2001). Although none of these projects used social marketing (some relied on PHAST and others on more directive promotion activities) many aspects of success were similar to those expected to be delivered by social marketing. The keys for success in all three countries were noted to be:

1. Understanding community preferences and offering a range of options;
2. Peer pressure and collective community responsibility;
3. Using neighbourhood and community networks; and,
4. Development of local enterprise to provide services.

The use of single options was found to be counter-productive to promoting sanitation improvement, particularly when the options did not fit livelihood considerations (for instance use of pour-flush latrines in communities that traditionally use faeces as a fertiliser). Where options did not fully meet expectations (for instance cement water pans for pour-flush latrines that led to problems with smell and blockage) private sector providers in Indonesia were able to change the design and improve the uptake. The experience of neighbours with improved sanitation was also important, as bad experiences in a few households were found to significantly influence whether other households would be willing to acquire improved sanitation.
Mukherjee concludes that a major component for success was effective development of the local private sector to deliver sanitation improvements in the longer-term. More significantly, it was concluded that emphasis should be placed on developing the skills of the private sector and awareness raising rather than subsidising construction. It was noted that where the household had paid for latrines they were better maintained and more hygienic than when projects had supplied the hardware.

Two other key lessons emerge from these case studies. Linkage to water supply emerged as an important driver to the desire to acquire sanitation and most households viewed the acquisition of a household connection as a pre-requisite to acquiring sanitation. This is probably because the technologies promoted were water-borne (pour-flush) although the findings does match broader conclusions drawn by researchers (Briscoe, 1996).

The operation and performance of latrine technologies is seen as vital especially in the long term for continued uptake of the use of household latrines, as shown from the experience in Lesotho, WSP (2002). It concluded that VIP latrines worked well except for pit emptying. The biggest technical and financial problem faced by users was pit emptying. Attempts were made to resolve this by emptying the pits manually, which was problematic in areas with high water table. Imported specialist pit-emptying trucks were also used, which was initially successful but expensive to operate and difficult to maintain. Currently users, especially those in urban areas, are experiencing great difficulties with pit emptying especially as the only alternative is the use of expensive conventional suction tankers. Conventional suction tanker operators are often not very willing to do the job because of the water requirements and the damage caused to their equipment by sharp objects broken bottles, metals, etc) thrown into the pits.

The need to address factors other than health was also important in the promotion of latrines. Although users of latrines noted the importance of health benefits these were typically articulated after acquisition and a period of use, for some time rather than as an initial driver.

The experience from these countries provides support for social marketing even though this was not employed in the projects, as they all emphasise the need to match options to consumer preferences and the importance of local private sector enterprises in meeting demand. In Indonesia in particular, the role of private sector sanitation providers in innovation and improvement in sanitation design indicates that this is important for sustained sanitation delivery. Furthermore, the conclusion that Government and NGO support should focus on developing skills in the private sector and wider promotion also represents an important area to be developed within the current research project.
4.2 Aplication of social marketing to other health and social issues

4.2.1 Social marketing of Safe Water Systems in Zambia (PSI, 2002)

The project on social marketing of safe water systems (SWS) is aimed at promoting clean drinking water in the home. SWS was developed by the Centers for Diseases Control and Prevention (CDC) and the Pan American Health Organisation (PAHO) and is promoted by PSI in Zambia. SWS has 2 basic elements, a disinfectant – chlorine (to treat the water) and a narrow mouthed container (to minimise re-contamination after treatment), (PSI 2002).

In October 1998, PSI started marketing the SWS disinfectant under the brand name (clorin) with the support of USAID and CDC. PSI used local communication channels to encourage the treatment of drinking water with the correct dose of clorin. Trained community members demonstrate and sell clorin door-to-door on a commission basis, while radio and billboard advertising creates awareness of the dangers of unclean water and the importance of using SWS. In response to the cholera outbreak in 1999, PSI and the Zambian Ministry of Health created and aired public service announcements featuring clorin on national television. Over 220,000 units of clorin have been sold to date.

4.2.2 Cost–effective bed nets offer promise for malaria control in Africa (PSI, 2002)

This project used social marketing to promote the use of impregnated mosquito nets in Central African Republic. PSI in conjunction with the Central African Republic’s Ministry of Health implemented the project with the support of USAID and WHO. The project offers 3 components,

- A polyester mosquito net impregnated with permethrin marketed under the brand name of Fa Ngoungou (Kill the mosquitoes!).
- A re-treatment service marketed under the brand name of Zingo Moustiquaire (Come alive, mosquito net!)
- Intensive information, education and communication campaign was conducted by PSI to sensitisise the local population to the causes of malaria, to motivate the use of preventive measures and to encourage immediate and effective treatment.

PSI and the Ministry of Health first conducted baseline formative research on attitudes of the people of Bossembele towards nuisance bites, mosquitoes and malaria. Brand images and concepts were also tested. The results indicated that the inability to sleep well at night due to nuisance and their fear of malaria is their primary concern. They mentioned dissatisfaction with the common methods of preventing insect bite such as spiral coils and leaves. Previous use of mosquito nets in the area was minimal due to their scarcity, inadequate promotion, and high costs of the product, (PSI, 2000).

The research conducted by PSI resulted in the marketing of green, polyester net. According to PSI, Fa Ngoungou was so popular that the initial 12,000 nets were sold out to the 4,000 households in Bossembele. The re-treatment phase is in its early stage but 14% of the target population has already re-treated their nets.
4.2.3 Social marketing of mosquito nets in Kenya (Snow et al, 1999)

This study took a comparative approach to evaluate different delivery strategies of insecticide-impregnated mosquito bed nets in Kenya.

In Kenya, a social marketing approach was employed to introduce cost-recovery into an already-existing programme to expand coverage and use of insecticide-treated bed nets, especially for children, in order to control malaria.

The initial project was carried out as an intervention trial, in which nets were distributed free of charge and accompanied by demonstration and educational activities. Re-impregnation with insecticide was carried out free of charge at various intervals by the project field team visiting villages and houses. Although this approach achieved high levels of coverage and usage, and a consequent fall in malaria in children, it was not sustainable due to the labour and cost intensive approach. The project stopped sending field workers to re-impregnate nets, and instead peoples had to go to ‘dipping stations’ to have their nets reimpregnated.

Although this approach was less expensive, it was also unsustainable, as it contained no mechanism for cost recovery. A social marketing approach was then developed for net re-impregnation in order for people to pay for this service. The social marketing approach tried to establish a ‘product’ around the insecticide rather than the net, and used new delivery channels through the private sector rather than via field workers. Instead, it used independent entrepreneurs, paid on commission, who were encouraged to seek clients by using both dipping stations and door-to-door services. Public meetings were held in villages beforehand to discuss changes in the delivery system and introduce the concept of cost. Intensive promotion was carried out through advertising and sponsorship, including popular events such as football tournaments.

In this case, reimpregnation rates fell dramatically from over 85% between 1993-1995 to 7% in 1997. The overwhelming reason for this fall was financial, as most mothers did not reimpregnate their children’s nets due to the unaffordable cost. A similar experience was recorded in the Gambia.

The authors reflect that during initial trials very high coverage rates were achieved, despite the theory that the provision of free goods and services engenders a passive attitude. They note that, although the majority of mothers stated that they could not afford to reimpregnate the nets, the service itself was not necessarily unaffordable, but not something that the mothers prioritised financially in relation to their other needs, such as food. This is also despite the fact that, during the preliminary community meetings, both Gambian and Kenyan groups had expressed a willingness to pay. It could, therefore, be asserted that a social marketing approach largely failed in this case, as coverage greatly declined. However, the authors further note that condom sales in Kenya started off very slowly and then increased, so net re-treatment rates may possibly increase over time. Interestingly, later changes in the approach, that introduced more flexible payment methods, led to an increased demand of five to six times the previous level.
4.2.4 Social marketing of oral rehydration treatment (ORT) and contraceptives in Egypt (Fox, 1988)

This study is a comparative analysis of two different social marketing programmes in Egypt - in order to assess the effectiveness of social marketing with different issues in the same context. The two programmes studied are the National Control of Diarrhoeal Diseases Project (NCDDP) promoting oral rehydration therapy (ORT) and Family of the Future (FOF) promoting the use of contraceptives.

The NCDDP intervention sought to raise national awareness of diarrhoeal disease and increased use of ORT. The main strategies employed were mass media advertising, subsidised production and distribution of packets of ORT and training for doctors, pharmacists and health workers. Pharmacists were trained to be able to inform customers on correct use of ORS and physicians and health workers on how to administer ORS correctly, and how to teach mothers and other care-givers on the use ORS. The intervention carried out preliminary research but without market segmentation, as the project sought to target a mass audience. The specific media used were television, radio, billboards, posters and pamphlets. The use of television in this intervention is particularly notable, since it used famous and well-liked actress Karima Mokhtar to promote the use of ORT, following research into which actress Egyptians would trust for reliable information (Lane, 1997).

The intervention used a single branded product, with a fixed (affordable) retail price and free distribution through health centres for those who could not pay the retail price. Product distribution was done via wholesalers, retailers and health facilities. In addition, the programme also included an element on raising awareness of diarrhoea prevention.

The NCDDP project produced very positive results, although it encountered some resistance from medical staff on the grounds that ORT was not a sufficiently ‘medical’ treatment for diarrhoea. The project produced substantial increases in awareness, among mothers, of diarrhoea and its treatment. The author notes that this project had a significant impact on the way that health issues are communicated. Lane (1997) describes how the NCDDP was a very carefully researched campaign, and one of most successful social marketing campaigns, describing it as “the ‘Rolls Royce’ of all health interventions” (Lane, 1997:171).

The FOF intervention sought to create awareness and increase demand for contraceptives, especially among lower socio-economic groups. It also sought to establish and maintain a reliable supply mechanism, and to improve operations and services in Cairo and other urban areas. Based on marketing expertise from the United States, a range of products determined by USAID were offered with fixed prices set by the government to be affordable to virtually everyone. The products were branded, and promotion centred on this. Marketing research was minimal, but was based on focus groups. The FOF adopted a strategy of starting in Cairo, where there was a fairly high use of contraceptives, but still unfulfilled demand, and later expanded into other areas characterised by low usage.

The products and accompanying promotion were specifically promoted to ‘healthy, active women’. The key message was the offer of the ability to plan when children will be born. The main promotional strategies used by the FOF were mass media, community meetings, pharmacy visits, and training programmes for doctors and pharmacists. In order to target the specific female audience, women’s magazines, billboards, bus advertisements, radio and television advertisements were used. Television advertising required government permission, but this did not present problems, although the messages had to adhere to the government’s position on family planning. The intervention initially made use of existing...
distributors but, after problems were encountered, FOF itself took over distribution and channelled this through medical establishments.

One of the key lessons of the FOF intervention was the negative connotation of condoms, which were associated by men’s extra-marital affairs. After this was realised, condoms were advertised as a product for the couple, rather than for the man. The project found that urban women were more likely to respond to television messages and advertisements. However, with regard to the intervention goals, this source also found the results difficult to evaluate, as contraceptives are not the only factor that influenced family size. The Islamic leadership of Egypt supports family planning, as it is keen to curb population growth, and has established a favourable policy environment to this end.

Fox identifies the following barriers to the uptake and use of contraceptives, which cumulatively mean that contraceptive social marketing will start off with an ‘uphill struggle’: lack of pre-existing demand; cultural influences determine family size (it is not only the wife/mother’s decision); cultural and religious beliefs (e.g. condoms have negative cultural connotations); benefits not immediate; time/effort/costs may outweigh benefits.

In addition, Fox identifies several factors specific to Egypt that are likely to have influenced the success of these two initiatives. In Egypt, population is relatively concentrated geographically and also the proportion of the population living in urban areas is very high, giving the social marketer the advantage of having a concentration of the target audience for both promotional and distributional purposes. Diarrhoeal disease is a major cause of infant mortality, and thus there is demand for ORT. The relatively high GDP means that Egyptians have good access to health services and pharmacies, and the infrastructure and roads are well developed, facilitating distribution channels. A very high proportion (90%) of the Egyptian population has access to television, and commercial television time is also inexpensive. Other favourable factors include relative political stability, intensive channelling of United States foreign aid, a government move to free-market principles and the existence and acceptance by professionals of appropriate technology.

4.2.5 Social marketing of contraceptives in Colombia (Vernon et al, 1988)

This experimental study undertook a comparative analysis of social marketing of contraceptives (CSM) and the alternative approaches of combined community-based distribution (CBD) and information, education and communication (IEC) in different areas of Colombia. The first stage of the project compared CSM with integrated CBD and IEC.

For the CSM strategy, family planning agencies obtained contraceptives free of charge from donors or wholesale from drug companies and sold them on to commercial outlets, such as pharmacies, at near commercial prices, using the profit to cover costs. Advertising campaigns were used to create demand. These were expensive, but the rationale was that they were cheaper than field staff. The key distinguishing features of the CSM approach as compared with the CBD were that the CSM created marketing organisations or used existing ones according to marketing principles, and that it promoted contraceptives through advertising and market research.

The CBD strategy sought to increase usage in two ways: by satisfying existing demand through increased access to contraception; and by generating fresh demand with IEC, primarily through home visits and community talks. The CBD used community volunteers to distribute contraceptives at subsidised prices, leading to success in rural and peri-urban areas.
Both approaches were effective: the CSM achieved a good level of coverage in urban and peri-urban areas; and the CBD achieved good use-communication rates. However, only the CSM yielded a profit, and the CBD intervention identified the need for more cost-effectiveness, which led to cutbacks including increased product prices and fewer field visits.

The study also investigated external factors that influenced the programme. The main external influence on the programme was the devaluation of the local currency, the Peso, against the dollar. This meant that profit margins were greatly reduced, and, as a direct result of this, pharmaceutical companies started to restrict their supply to the CSM organisations in order to protect their own market share. Therefore, with their supply of reduced-price wholesale contraceptives dried up, the family planning agencies were no longer able to make such high profit margins on the products, and the entire basis of the programme was undermined.

In the light of this experience, the authors concluded that, despite the fact that CSM is in many respects more cost-effective, it appears that family planning agencies would achieve greater stability and acceptable levels of cost-effectiveness by maintaining their field-workers and captive network of distribution posts, enlarging the areas and number of outlets serviced by each instructor, supplying small rural and large urban drugstores (but not other wholesalers), and substantially reducing the amount of time dedicated to IEC activities. In this way, because of their strong sales force, the family planning agency would remain an attractive customer to the local commercial producers rather than a competitor. Thus, the agencies would continue to pursue their social objectives while becoming more financially self-sufficient at the same time, (Vernon et al, 1988:359).

4.2.6 Social marketing of contraceptives in Nepal (Shrestha et al, 1990)

This study describes the approach and results of a social marketing campaign to promote contraceptives by a private non-profit organisation, Nepal Contraceptive Retail Sales Company. The goal was to reach people who had never previously used contraception.

The intervention used mass media advertising via radio, posters, billboards and television.

In this case, the advertising strategies did not prove to be very effective. Only 1% of consumers reported that they had seen the television advertisements, suggesting that the use of television in poorer societies is not appropriate. Distribution was channelled through shop owners and pharmacists at a retail price, or through government sources free of charge.

Although users had substantial knowledge about contraceptive pills, only half actually bought the pills themselves. As 50% of the users do not buy the product themselves, a breakdown in information and communication between them and the information provider was observed. It was also noted that many husbands buy contraceptive pills for their wives. The project thus identified the need to give more information to retailers and pharmacists that could be passed on to the actual users, such as via a newsletter. The most important factor influencing consumers’ decision to buy from private medical shops or pharmacies, as opposed to government sources, was convenience (in terms of proximity to work or home and waiting time), rather than price. Retailers and pharmacists expressed an interest in selling other reproductive health products, such as pregnancy tests. Overall, the intervention highlighted the importance of knowing and meeting the needs and concerns of both consumers and retailers regarding the products.
4.2.7 Social marketing of health services in Cambodia (Stuer, 1988)

This study describes and analyses the adoption of a social marketing approach by the Cambodian Urban Health Care Association (CUHCA). The problem to be addressed by social marketing was identified by project staff as the consumer lacking the necessary knowledge to make good choices in the market for health services.

A marketing approach was adopted following recommendations in the World Development Report, which encourages competition between providers in order to raise the quality of service. The CUCHA centres followed this model, and changed health services to a fee-for-service basis. They found that demand for services on the part of consumers was very low, meaning that the small number of patients could not ensure a reasonable income for staff. After other unsuccessful changes, social marketing was employed to create demand for services, by communicating with the public, establishing personal contact and trying to get a better understanding of the target population. CUCHA now tries to educate consumers and provide good quality services, so consumers can act on the basis of their newly acquired knowledge rather than waiting for the market to supply the kind of services they now want.

In the local culture, it was not acceptable for people to pay for services, only for tangible goods. On this basis, the consultation and product were integrated into a package, for which a single fee was payable. However, the programme found great difficulty in getting the poorest clients to attend, even when they were exempted from payment. The reasons for this were unclear, but the author speculates that they felt stigmatised by not having to pay. Stuer also notes that social marketing principles demonstrate that people value the goods or service if they pay for it.

The author concludes that the original premise that a supply-driven strategy of improving health services by increasing competition (the good would drive the bad out of the market) failed due to the absence of sufficient demand to introduce competition. Where demand is low or non-existent, this first needs to be created. A key lesson identified for other programmes is that the promotion of competition among health care providers works well and it is cost-effective if the goods or service is popular and easy to sell. Where demand needs to be created, or consumers’ attitudes need to be changed, providers first need to try to influence demand. She also suggests that activities need to meet priorities of the public, whereas in the case of CUCHA problems were identified by staff.
4.3 Implications of social marketing experience for sanitation programmes in urban Africa

Much of the experience with social marketing has been focused on promotion of goods that do not require significant capital investment in infrastructure, although many have noted problems in achieving sustained uptake of services requiring ongoing recurrent expenditure.

Sanitation requires significant capital investment at the outset. Ongoing expenditure is often more limited, but occurs in a ‘lumpy’ fashion, often resulting in failures to acquire latrines or failure to continue use beyond the initial working life (for instance failure to empty or dig new pit). This is similar to reasons where there is often limited uptake of household connections to water supplies, although the issues of long-term sustainability are somewhat different. For instance, household connections would typically be to a utility supply and the provider can therefore often provide subsidised initial capital investment costs as these may be recovered through recurrent costs for service provision. Sanitation (apart from sewer connections) does not typically have such options.

However, the evidence from Benin, Vietnam, Bangladesh and India does suggest that households will choose to acquire sanitation facilities provided that the options meet their requirements. The importance of a choice of sanitation facilities and potentials for upgrading is also noted within the research. This suggests that researchers advocating social marketing are right in that this is likely to be an effective approach, although the limited experience to date provides limited documented evidence of efficacy.

Despite the limited evidence presented on direct experience with social marketing as applied to sanitation, it is clear that a number of projects have applied techniques similar to these approaches. Lessons can be drawn, at least in the overall effectiveness of the approach.

The experiences in South Asia, particularly Bangladesh, provide evidence that promotion of sanitation through social marketing can be effective. As noted above, this may in part relate to the presence of an extensive and active small-scale private sector directly engaged in the provision of capital-intensive products and a broader history of private sector involvement in provision of such products (for instance tube wells). The issue of replicability to Africa has been noted, especially the Benin case study. Perhaps the greatest lesson that can be drawn from the Bangladesh and Benin experience is that the development of such private sector agencies is critical to the process. This section will discuss the implications of this for the research project and for social marketing for sanitation more generally.

Although it would be true to say that private sector provision of water and sanitation services is more developed in Asia than Africa, this does not mean that the private sector is either absent from urban Africa or that it cannot be strengthened to deliver services. It is clear that the private sector already actively engage in the provision of services in urban areas of Africa. Pit-diggers and masons ply their trade and meet demands from the local population to deliver sanitation facilities where these are required. However, it is also clear from the initial formative research in Ghana and from the literature that the private sector requires support in becoming a more effective provider of sanitation services and products.

The research to date identifies a number of key issues that require further research if social marketing is to be effective. These are discussed briefly below.
The historical supply-driven, public health-based approach to sanitation has resulted in many cases in a belief among households that sanitation, like other basic services, should be provided by Governments. Thus, whilst households do purchase sanitation services from the private sector, this does not mean that they believe that this is how improved sanitation services should be provided. Governments and the water sector are increasingly moving towards more demand-driven approaches and this is an area where ongoing research has focused (WSP 2002).

There are weaknesses within the small-scale private sector in delivery of services. The products on offer do not necessarily match the preferred options by households and therefore products are either not purchased or seen as interim solutions until Government programmes deliver the improved facilities. A further problem noted is that because small-scale private sector organisations often have limited working capital, delivery of the sanitation products can be a protracted affair. In many situations, the household must supply the materials and they pay the mason or pit-digger a down payment for construction. This process ultimately leads to lengthy disruption in the acquisition process, as households themselves lack access immediately to capital to finance the improvements. Identifying mechanisms by which the small-scale private sector operators can accumulate working capital to be able to deliver products within a short period of time, and hence increase rapidity of payment needs further research.

Identifying strategies to resolve this issue is an important component of this research. It is tempting to advocate for the development of credit schemes for sanitation, either through providing small businesses with grants or loans to allow them to develop working capital and thus speed up the process of sanitation provision. The potential for providing households with low or no-interest loans to acquire sanitation facilities is also attractive. However, the benefits of both these approaches require further consideration. Although there have been cases where credit schemes for small businesses have had some success, in other cases, there have been problems. For instance the collapse of the co-operative bank in Uganda left many small businesses bankrupt. The use of credit schemes and the areas where these should be targeted is an area requiring further research. It is important that short-term access to credit schemes does not result in either proscription in relation to technologies that may be provided nor that it compromises long-term provision by distorting market practices in a way that can be sustained beyond a short period of time. This has particular relevance when considering on-site sanitation provision as long-term maintenance requirements, such as pit emptying, may be compromised.

The ability of the private sector to innovate to meet market demands is one the characteristics that most commentators suggest is its great strength and this was noted in Indonesia for instance (Mukherjee, 2001). Within the field of sanitation, such innovation is not always immediately apparent, often because the private sector has mimicked the standard solutions offer via Government programmes and because of a lack of skill. In part this has reflected that support to the private sector has focused on training of masons in construction of specific types of latrine that they deemed desirable. However, it is clear from Nkawie and other reports, that some degree of innovation is carried out, for instance in the modification of latrine pit designs that incorporate a means for desludging by mechanical means rather than manually. Identifying how the innovative aspects of sanitation design can be developed among the small-scale providers is a key element of this research. Part of this aspect is to work with providers to gain their views on how they could meet changing technological demands from households and deliver these at a cost that is affordable.
A second problem is that the private sector has, in some respects, often also adopted a supply-driven approach. In other words there is limited attempt by sanitation providers to investigate what their potential clients value in a latrine and to adapt designs to suit demands. The experience in Bangladesh and Benin suggests that strengthening the marketing skills of the small-scale private sector can deliver significant improvements in generating interest in sanitation acquisition. It is clear from experience to date that support to improved understanding of market desires and marketing of products is critical to the process of sanitation promotion, (WSP 2002).

4.2.1 Support to the small-scale private sector

The literature review and formative research has identified that a key area of research required is how small business may be supported to improve their overall delivery of sanitation facilities. This includes exploring options for strengthening marketing skills, how innovation can be encouraged and how sanitation providers can develop better business planning.

Means to strengthen marketing ability

This will involve looking at how links can be made to other private sector institutions with skills in marketing and the need and role of intermediaries (whether NGO or Government) in facilitating this process. The purpose of the research will be to clarify the process of option-identification and support mechanisms and to use case studies from the two research sites to assess the effectiveness of these approaches. In particular, the long-term perspective of replication and sustainability beyond project time horizons will be addressed, although this may be difficult to evaluate within the time period. The research will draw on experience from Bangladesh where this approach was used.

To undertake this research, partners in the field study areas will be required to identify appropriate marketing skills within their organisation or bring in such skills as part of their team. This will be supported from the UK research team by a member dealing specifically with support in marketing strategies and small business development. A key mechanism to be tested is the use of demonstration facilities matching the demands of the customers to act as marketing tools. It is proposed to identify a small number of private sector providers and fund the construction of demonstration facilities at their homes and to develop a programme of marketing using the facilities as a tool. It is considered that this may be more viable than constructing such facilities within the broader community as it overcomes most of the problems with selection of appropriate households.

Strengthening technical capacity

This is an area of critical importance to social marketing as one of the key components is the ability of the providers of goods and services to be able to design and deliver products that match the demands of consumers. A particular ‘researchable’ is the degree to which local providers can identify and develop appropriate solutions. In parallel, the UK research team will review options from elsewhere within the countries where field research is undertaken and more broadly to assess whether existing solutions already exist. Within this theme, two areas of research will be addressed.

The first is how can innovation itself be encouraged. This is an important component because the process of innovation does not simply rely on technical skills, but on attitudes of providers. The research will work with private sector providers to develop innovative
attitudes and to discover what roles NGO and Government should play in supporting this process. The second area is technical skills acquisition. There may well be skill deficits identified in relation to construction and provision of sanitation facilities that match community demands. These skill deficits require identification and options for meeting such needs will be reviewed and documented, with recommendations made on how best this can be achieved. Within this area of work, it is clearly necessary to identify the role of NGOs and Governments in supporting the process of skill transfer.

**Business planning**

One critical aspect that emerges from the research to date is that improving the business planning of small private sector sanitation providers is essential to promote more effective delivery of sanitation improvements. In particular, the options that is available to small-scale providers in developing working capital to reduce long disruption in the delivery process and to develop a sustainable client base.

The research will concentrate on identifying such options to assist small private sector providers in gaining access to available credit and other capital in the project sites and also in managing their finances, obtained from the sale of products, to develop working capital. Within the overall time frame of the project it is unlikely that all these options can be evaluated, but it is expected that preferred options will be identified and that some implementation will occur.

**Identifying the role of intermediaries**

This area of research uses the term intermediaries as it is expected that many of these roles could be undertaken by either an NGO or by local or national Government. Some of these areas are referred to in the section above, in particular researching and identifying the options for intermediaries to support the small-scale private sector to improve its marketing ability, innovation and business planning.

Ongoing discussions are being held with local and national government agencies and NGOs in Ghana and similar possibilities will be explored in the second field site. However, one concern is the nature of the influence of these agencies on sanitation provision. For instance, credit becomes available for the construction of specific technologies that do not meet the demands of households; little will be achieved in the long-term. Of particular concern is the long-term maintenance of sanitation and especially, if on-site sanitation is promoted how will emptying be achieved. The possibility of focusing government support on the development of a sustainable system of emptying, which can be operated by the private sector, is an area of particular interest for the research within Ghana.

The research will investigate with local Government and NGO partners the options that are most likely to be supportive of improved sanitation. It is unlikely that within the time constraints of the project that these can be fully evaluated, but it is expected that a short-list of preferred options for support and how these may be implemented will emerge to allow for future testing.
**Communication and promotion of sanitation**

There is also a need to investigate the most effective means of communication about sanitation provision and (promotion of latrine acquisition) within the context of social marketing. These are roles that move beyond the development of marketing skills by private sector sanitation providers. The research will look at the options available for communication strategies and identify those offering greatest potential to support sanitation provision via local private sector providers. Research will be led by the UK team in conjunction with local NGOs and government agencies within the field sites.
5. Concerns regarding social marketing theory

Many authors have criticised the application of marketing principles to the theory and practice of social marketing. Social marketing is criticised by a body of mainstream commercial marketers, who believe that marketing is a business discipline with little application to social causes, as it can only be valid where there are markets, transactions and prices (Fox & Kotler, 1980). According to Fox and Kotler (1980), traditional marketers are also fearful that social marketing will damage the reputation of marketing by promoting unpopular or controversial causes like family planning and influencing people to adopt behaviour that is not in their best interest. The authors respond to these criticisms by emphasising that traditional marketers should not take the view that their discipline has nothing to offer in new territory and asserting that social marketing is more likely to enhance marketing’s image rather than damage it.

Marketing principles cannot be applied to social issues

Some authors emphasise that commercial-marketing principles cannot be applied to social issues. The following are the main points raised:

Marketing theory assumes that society is best served by each individual and each individual company behaving to maximise self interest; as long as ample competition exists among suppliers of goods and services, and given that consumers make economic decisions, social welfare is maximised. This can only apply to economic products and services and not social ideas and causes (Galbraith, 1978, cited in Sirgy et al, 1985).

The driving forces of commercial marketing are supply and demand; but social marketers do not seek to identify and respond to unmet consumer needs or wants, but promote pre-defined ideas and behaviours, (Buchanan et al, 1994:51). Rather than encouraging people to do something, as commercial marketers do, social marketers must often discourage behaviours that may be attractive or deeply ingrained (Buchanan et al, 1994; Ling et al, 1992; Sirgy et al, 1985). Although in the latrine context, social marketing is used to encourage people to build and use latrines.

When social marketing is product-based, there is often no product competition, therefore product use or price is not determined by market dynamics. In true markets, there is much flexibility in the types of products and services that are produced; whereas in the health promotion field, products and services are greatly constrained. Commercial companies often drop a product line when products prove unpopular, whereas it is more difficult to discontinue a needed public health service. Social marketers also wrongly assume that they operate in an environment devoid of competition (Buchanan et al, 1994; Ling et al, 1992; Rothschild, 1999; Sirgy et al, 1985).

Social marketing takes an individualistic rather than a societal view of social issues

A number of authors assert that social marketing addresses social problems by focusing on individuals’ behaviour to the neglect of external social and environmental factors that also have a role in the problems being addressed.

Buchanan et al (1994) assert that social marketing makes an implicit assumption that the social and health problems targeted arise due to people’s lack of information, or because the information has been badly communicated, leading to the theory that health status will improve with more effective communication. This has two principal implications. In the first instance, it questions the influence of information and communication in determining health behaviour. This is already being debated in the context of the social influence of the
mass media, and the general consensus is that information is a necessary component for but not determinant of changing behaviour. Secondly, this assumption implies that people suffer from social problems or poor health principally due to a lack of information, which does not account for other factors that may also play a role in the situation.

**Social marketing is top-down**

Although one of the stages of social marketing is widely recognised to be ‘consumer orientation’, some authors disagree that social marketing involves ascertaining consumers’ felt needs and wants. One key problem with social marketing, expressed by a number of authors, is that the cause being promoted may be widely considered to be in the best interest of the consumer, but ascertaining expressed consumer wants does not generally derive these causes. Montazeri (1997:117) believes that social marketing is inherently top-down because in social marketing there is a tendency to make a choice on matters of health on behalf of the individual. Lane (1997) recognises the philosophical differences about what the goals of health promotion should be, and questions whether social marketers respect people’s health choices if they do not coincide with the behaviours that they are promoting.

**Price and affordability**

In addition to the criticisms of pricing in social marketing from a marketing perspective, Tena (1988) notes how it is difficult to apply marketing to certain public services for which no charge is made. Lefebvre (1992) draws the attention to the further controversy over price in social marketing, in the sense that it is equated with demanding money for products and/or services typically from people who can least afford them. Ling et al (1992) also raise the concern of affordability, as for example, a packet of oral rehydration solution in developing countries can come close to a day’s wage for the poorest. However, price incentives attract the criticism of bribery. Supporters of social marketing would counter-argue that the art of marketing lies as much in communicating effectively the benefits of behaviour change as making the price worth paying.

**Social marketing excludes some groups**

Some authors criticise social marketing for not reaching the groups that may most need the resources offered. Firstly, Ling et al (1992) note that the strategies – especially the mass media – used by social marketing for communicating with the target audience are not inclusive; for instance, the use of television may only reach higher-income urban residents, and the use of billboards and other printed matter is inaccessible by illiterate people. Social marketing strategies may also first target segments of the audience that are most likely to change, which means that social marketing may do little for those most in need of the intervention but having the fewest social, economic, and personal resources to facilitate the change (Wallack 1990). The price of socially marketed products may also exclude some members of the target audience, even if they show willingness to adopt them. Therefore, the audiences not reached are likely to be the poorest and most socially excluded. Ling et al (1992) therefore see social marketing as incompatible with the goals of public health, which typically focuses on the poorest, highest risk and least accessible populations. The authors believe that other approaches may be needed to achieve coverage among groups likely to be excluded from social marketing strategies.
Ethical concerns raised over social marketing

A key issue of debate in the social marketing field is whether the goals targeted by social marketing justify the means used to achieve them. Kotler & Zaltman (1971:8) first raised this issue to justify the application of marketing-oriented methods to social causes: “the issue is not whether a particular approach suits one’s personal taste, but whether it works”. Buchanan et al (1994) observe a shift in the wider health promotion debate from whether certain approaches are morally right to whether or not the benefits are demonstrably compelling. They believe that ends and means in public health are inextricably related and should not be divorced, as in health promotion where the attainment of good health is achieved through the process of treating people with dignity and respect.

Due to its emphasis on marketing and commercial principles, and the use of advertising and mass media, social marketing has attracted widespread criticism for being manipulative, an issue that Kotler and Zaltman (1971) also foresaw.

Fox & Kotler (1980) respond to the criticism that social marketing is manipulative. They object to the use of the term ‘manipulative’, which carries connotations of hidden and unfair ends or means used in the process. The authors believe that if a cause is marketed openly with the purpose of influencing someone to change their behaviour, then the process is no more manipulative than, for instance, a lawyer, religious leader or politician trying to convince others. The authors add that counter marketing can provide an alternative to those promoting certain views.
Conclusions
The literature review indicates that there are practical experiences in the use of social marketing for social health issues including sanitation. Although there have been some criticisms on the social marketing ‘theory’, social marketing has proved effective in many situations with some ‘social products’ including sanitation, safe water systems, contraceptives, bed nets, etc.

Despite recommendations by influential organisations for the use of social marketing to promote latrines, especially in urban areas, there remains limited practical experience in strategic social marketing of sanitation. The existing practical field experiences have used aspects of social marketing but not applied it systematically. In spite of this, various projects have recorded some levels of success in marketing latrines.

There is a common belief that social marketing can be applied more successfully to products of relatively low purchase price and low capital investment. However, there is evidence in the literature to show that aspects of social marketing have been successfully applied to latrines even without subsidies. The experience with bed-nets in Kenya where recurrent costs require infrequent payment of significant prices suggests that the nature of payment may be influential. This was also the indication from the experiences of marketing latrines in Benin and Bangladesh.

In the context of pricing and product delivery, it is clear that payment systems, microfinance, and subsidies may be important. Formative research should provide information about what people want. Sanitation as a product is fundamentally different from other products because of its high capital cost. In urban areas, it should also be noted that expectations of the latrine option will be high, although this does not necessarily equate with the willingness of people to pay for the desired service level. The literature review indicates that providing the target audience with various options, and arranging different types of payment options is key for improving latrine acquisition especially, for the poor.

Some authors have advocated the use of social marketing to stimulate demand for latrines rather than simply to market them. Reiff and Clégbaiza, (1999) promote the use of social marketing to create demand. They indicated that part of the success of the PADEAR sanitation programme in Benin was marketing latrines using messages based on rural communities perceptions of the usefulness of latrines. They gave examples of such messages as ‘With latrines, no risk of snake bite’. The majority of the case studies on marketing sanitation from Asia also support the idea.

Research by Jenkins (1999) in rural Benin concludes that the decision to install a latrine is based on three key conditions,

- The presence of at least one active drive and dissatisfaction with existing situation
- The absence of constraints on adoption
- An influence of life style and village environment.

Although social marketing of sanitation is a fairly new concept, it does not mean that successes have not been recorded in various aspects of its application. The project will adapt successful methodologies used by various sanitation projects in addition to paying careful consideration to the 4 Ps of marketing, (product, price, place and promotion).
References


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