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**A MODEL FOR MARKET RESEARCH
IN CONTRACEPTIVE SOCIAL MARKETING**

Prepared for the
International Contraceptive Social Marketing Project
The Futures Group
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TABLE OF CONTENTS

	<u>Page</u>
<u>CHAPTER 1. THE MARKETING PROCESS</u>	1
I. BACKGROUND	2
II. CONCEPTS AND DEFINITIONS OF MARKETING	3
III. THE MARKETING PROCESS	5
The First Stage--Analysis	6
The Second Stage--Planning	12
The Third Stage--Development, Testing and Refinement of Plan Elements	16
The Fourth Stage--Implementation	23
The Fifth Stage--Assess In-Market Effectiveness	24
The Sixth Stage--Feedback to Stage 1	26
<u>CHAPTER 2. MARKET RESEARCH--METHODS AND APPLICATIONS TO CSM PROGRAMS</u>	28
I. INTRODUCTION	29
II. PRIMARY vs. SECONDARY RESEARCH	29
A. Secondary Research: Uses and Sources	30
B. Primary Sources: Qualitative vs. Quantitative	32

	<u>Page</u>
III. QUALITATIVE MARKET RESEARCH METHODS	34
A. Uses of Qualitative Research	34
B. Focus Group Interviews	37
C. Individual In-Depth Interviews	41
IV. QUANTITATIVE MARKET RESEARCH METHODS	43
A. Survey Research	43
1. Personal Interviews	44
2. Telephone Interviews	47
3. Mail Surveys	48
B. Survey Sampling	51
C. Steps in Conducting a Survey	54
V. SEMI-QUANTITATIVE MARKET RESEARCH	57
A. Central Location Intercept Interviews	57
B. Panels (Consumer and Retail)	59
C. Field Tests (Pilot Studies)	62
<u>CHAPTER 3. CONSTRAINTS AND CONSIDERATIONS</u>	66
A. Lack of Market Research Resources	67
B. Communication and Cultural Barriers	68
C. Integrating Market Research into the CSM Organization	69
<u>CHAPTER 4. CONCLUSIONS AND RECOMMENDATIONS</u>	71
<u>BIBLIOGRAPHY</u>	74

APPENDICES

1. Sample Communication Strategy for Condoms
2. Contraceptive Prevalence Survey--Model Questionnaire
3. Sample Questionnaires for Testing
4. Standard Comprehension and Diagnostic Questions for Pretesting Radio and TV Advertisements
5. Sample Focus Group Moderator's Guideline

Chapter 1

THE MARKETING PROCESS

I. BACKGROUND

Contraceptive social marketing (CSM) programs in developing countries are now entering their second decade. These programs have taken different organizational forms, depending on the countries and cultures in which they have taken root.

CSM programs are not easily described. They have been called a hybrid — public health-oriented social action programs grafted onto commercial distribution and marketing systems. The common goal shared by all CSM programs is to generate strong consumer demand for contraceptives which are then subsidized so that they may be sold at the lowest feasible prices.

Eight steps have been identified which are said to characterize CSM programs:

1. Establishing management and operating procedures.
2. Selecting the products to be marketed.
3. Identifying the consumer population.
4. Deciding on brand names and packaging.
5. Setting an appropriate price.
6. Recruiting sales outlets.
7. Arranging and maintaining a distribution system.
8. Carrying out promotion.

These eight steps are integral to the process of marketing — an established discipline in the business sector, but relatively new among social and health organizations. The CSM programs — hybrids that they are — must reconcile social goals with commercial entrepreneurial approaches. But there is no doubt that the basic means of stimulating, maintaining, satisfying and measuring consumer demand are marketing issues.

The purpose of this paper is to describe these marketing means, to order them into a process for taking action, and to explain the role, methods and tools of market research as essential to decision-making.

II. CONCEPTS AND DEFINITIONS OF MARKETING

A useful working definition of marketing is given below. This definition is then broken down into its component parts, with specific application to CSM.

Marketing is the (1.) analysis, planning, implementation, and control of (2.) carefully formulated actions designed to bring about (3.) voluntary exchanges of values with (4.) target markets for the (5.) purpose of achieving organizational objectives. It relies heavily on (6.) designing the organization's offering in terms of the target markets' needs and desires, and on (7.) using effective pricing, communication and distribution to inform, motivate and service the markets (Kotler, 1982).

1. Marketing is a managerial process. It requires skilled persons to analyze, plan, implement and control the marketing organization and its actions. Management training through on-site technical assistance, conferences, training programs and written materials have long been a part of CSM.
2. Marketing does not consist of random or "seat-of-the-pants" trials and errors. It seeks to achieve market response through carefully formulated actions. For example, a CSM program would not make up a series of cinema commercials on the basis of intuitive views about what consumers want to hear. Rather, the concepts which underlie the messages and the messages themselves would be pretested and then later evaluation would be conducted to further assess audience response.
3. The key to marketing is the process of exchange between an organization and its "customers" or target audience members.
 - A woman may exchange money for a cycle of oral contraceptives.
 - A retailer exchanges valuable counter space for an attractive CSM display unit.
 - A physician exchanges time and effort for knowledge and skills in IUD insertion.The exchange must be studied, so that the CSM manager can facilitate and improve this exchange process.
4. A distinguishing feature of marketing is its attention to target markets. A CSM program's offerings will not be equally attractive, or equally in demand, to all consumers. It is necessary to divide up,

- or "segment" consumers by attributes, such as benefits sought, risk of pregnancy, or predisposition to contraceptives.
5. Marketing has a definite organizational purpose. For a business sector organization, this objective may be profit maximization. For a CSM program, objectives may require a balance of:
 - sales maximization -- to increase contraceptive usage as widely as possible.
 - market penetration -- to reach C and D levels of socioeconomic strata.
 - revenue enhancement -- to increase revenues for possible self-sufficiency of operations.
 6. Effective marketing designs the organization's products (sometimes called offerings) in terms of the target markets' needs, desires and expectations. It is necessary to consider the "customers," or target markets first, in order to offer products which can be of value to them. This can apply to the method of contraception offered, and also to packaging and name, usage instructions and display and other promotion materials for retailers.
 7. Marketing utilizes what is termed the "marketing mix." The set of tools in this mix are product design, pricing, communication and distribution.
 - o Product design -- Includes performance characteristics (e.g., low dose orals, size of condom) and perception characteristics (e.g., taste, color, package design).
 - o Pricing -- Practically speaking, price setting (and price changing) strategies are usually tied to cost, demand levels and competition. In addition to monetary price, target markets may also have to expend time and effort, and perhaps pay a "psychic" price (e.g., the embarrassment of a woman asking for condoms in a pharmacy or a man purchasing a cycle of oral pills).
 - o Communication -- CSM programs can choose from many channels to promote their programs and products, including advertising (e.g., radio, TV, cinema, newspapers), publicity/public relations (e.g., talk shows, news programs, articles in magazines), personal contact (e.g., rallies, village demonstrations, physician training), and promotion (retail materials, calendars, T-shirts, boat sails).

- o Distribution — The channels by which products flow to the marketplace (e.g., commercial wholesalers, CSM employees, other "middlemen") and the place at which they are offered (e.g., physicians' offices, pharmacies, kiosks) are the essential elements of distribution planning and administration.

III. THE MARKETING PROCESS

Marketing is a process for solving problems and achieving organizational objectives. It provides a framework for moving in an orderly, disciplined, data-based fashion from problem to solution.

Essential to the marketing process is marketing research — systematic data collection and analysis. Marketing strategies rely on an understanding of marketplace changes, customer behavior and competitive factors. This information must be collected and interpreted to contribute to meaningful decision-making:

- o to provide useful data for formulating marketing strategies;
- o to help avoid mistakes and increase the likelihood of effective choices; and
- o to increase the overall efficiency of the CSM marketing effort by contributing to the allocation of scarce marketing resources.

The application of marketing research in CSM program development is not new. In a presentation at the 1979 International Conference on the Commercial Retail Sales of Contraceptives in the Philippines, Manila, John U. Farley, Graduate School of Business, Columbia University, N.Y., noted that a common element CSM programs have shared is a dependence on market research for data to support a number of key decisions as well as for overall program design and evaluation (Farley, 1979).

His examples of research applications included:

Pre-launch activities — establishing specifics of target markets (e.g., socio-demographic profiles, knowledge, attitude and practice studies), developing and testing specific program elements (e.g., price, brand names, packaging, advertising) and assessing reactions of retailers and other program participants.

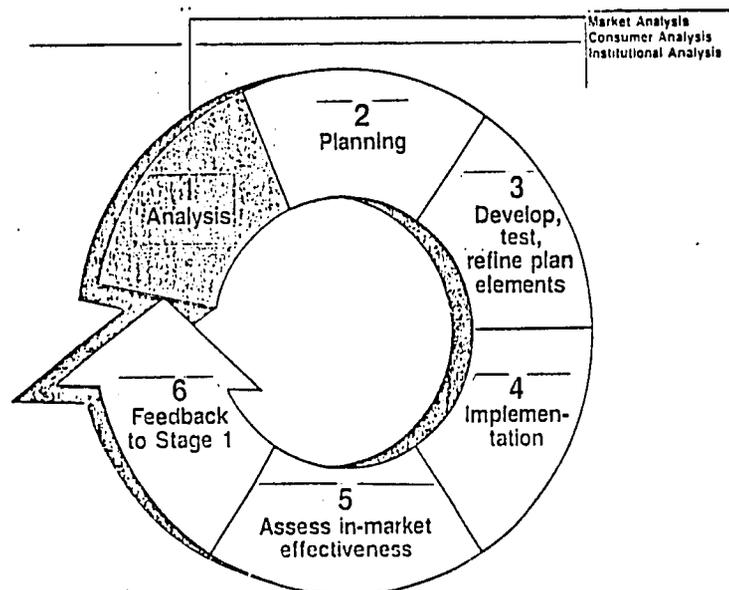
Activities during program roll-out — tracking of sales records vs. targets, tracking impact on consumers (awareness, trial, usage).

On-going activities — periodic studies of users and non-users, in-depth assessments of subgroups for segmentation, in-store studies.

The following process model for marketing analysis, planning, implementation and control is circular, or iterative, with the last stage feeding back into the first in a continuous cycle of replanning and improvement. At each stage, marketing research is integrated into the process.

The six stages, or steps, are: 1) analysis, 2) planning, 3) development, testing and refining of the plan elements, 4) implementation, 5) assessing in-market effectiveness, and 6) feedback to stage one. The process is designed to enable CSM program managers to: take into account consumer wants, needs, expectations and satisfactions/dissatisfactions; formulate program objectives; utilize an integrated marketing approach and marketing mix; and continuously track consumer and market response.

The First Stage — Analysis



In this initial step in the marketing process, it is necessary to examine three broad areas: the market, the consumers who make up that market, and the organization and structure within which the CSM program must operate.

Market Analysis

Begin with the marketplace as the first unit of analysis. In a totally open marketing situation, one would be looking for large markets, with high levels of consumer demand and reasonably few competitors. Search for areas of opportunity, either because there appears to be a segment of consumers with unmet needs or because of flaws in the marketing approaches of one or more of the "competitors." The competitors may include commercial companies and also health clinic systems which CSM efforts are seeking to complement rather than compete with, in the strict sense of the term.

Once these areas of opportunity are identified, market definition is undertaken. This involves making quantified estimates of the current and future sizes of the market. How big is it economically? How fast is it growing, if at all? How are "sales" divided among companies, health clinics, community agencies and others? What are the levels of promotion expenditures?

A second element of market definition is geographical scope. The more precise the identification of the geographic area to be covered by a CSM program, the better the plan will be. In developing a marketing effort for, say, two urban areas in Egypt, one would gather and interpret the economic data for those specific areas. A related issue is whether the market being analyzed has any geographic skew. Since contraceptive usage is usually heavier in urbanized areas, this would be an important CSM consideration.

Distribution and sales outlets also fall within market definition. It is necessary to know how the current market is structured, since the development of distribution channel strategies will later be an important part of the CSM marketing plan and program. How do current products now reach the target consumers? What are the places, or outlets, in which these contraceptives are purchased? For example, in Guatemala, pharmacies are important outlets for

contraceptives purchased by Ladinos. However, it appears that Indians are not regular customers of pharmacies. Interviews with pharmacists and physicians can provide the requisite information (Novelli and Hayes, 1981).

A sense of timing is a necessary part of the market definition. Is the market growing or contracting? Market trends and growth projections are necessary for planning budgets, product introductions, levels of promotion, and other aspects of a CSM marketing plan.

A final part of the market analysis is an examination of the local resources available for conducting marketing efforts. This includes such needs as quality advertising and public relations agencies, distribution firms, colleges and universities (containing faculty with marketing-related skills), local marketing research companies, and printing and packaging firms. Part of the need for analyzing available resources within the market may be a first step for planning ways to supplement limited local resources.

Consumer Analysis

The second broad area of analysis is the consumer — the individual involved in the marketing exchange. In CSM programs, the ultimate consumer is couples of child-bearing age. However, the analysis should also take into account those who can support and reinforce the ultimate consumers, such as religious leaders and other influentials, retailers and health professionals. To cite one example, efforts to promote intrauterine devices to the public must be accompanied by marketing IUDs to pharmacists and physicians, including training programs to teach physicians how to insert the IUDs.

Demographic characteristics are usually the easiest consumer attributes on which to gather data. These attributes might include age, sex, income, education and literacy, social class, family size, stage of life, occupation, religion, race, culture, and ethnicity. The more that is known about the consumer population being analyzed, the easier it will be to construct a plan to segment, reach and motivate the target audience ultimately selected for CSM marketing programs.

Geographic attributes of consumers also can be important. The region, size of place (e.g., villages, small towns, large cities) in which target consumers live, population density, and mobility each may be significant in analyzing consumer populations as a prelude to effective marketing planning.

Finally, an understanding of psychographic attributes, including behavioral characteristics is an essential part of the consumer analysis. It is far more difficult to collect psychographic data than to assemble demographic and geographic information. Moreover, it is often difficult to use psychographic data after they have been collected. However, even if the effort must be a limited one, this part of the consumer analysis can be useful in understanding how, why and when the market audiences will or will not engage in the trial, and continued usage of CSM products.

One of the most important psychographic areas involves consumer responses to current marketplace offerings. What do they appear to expect? Do they say that they are satisfied or dissatisfied with current offerings, and why? Other psychographic traits include lifestyle and personality. Couples who perceive themselves as upwardly mobile may be more inclined toward family planning, while those with traditional village lifestyles may be less inclined.

The benefits which consumers seek can be useful attributes of psychographic analysis. For instance, women who have had unacceptable experiences with the side effects of oral pills may place the absence of side effects as the key benefit they seek in a contraceptive method. They may be prospects for a vaginal suppository product, and may accept such a product despite some disadvantages which other consumer segments find unattractive.

User status is another analytical consideration. For example, individuals may be nonusers, potential users, occasional users, regular users, or ex-users of condoms. Usage rate and loyalty (to the brand and the method) are related to the user status attribute.

Another important psychographic variable is the readiness stage in which consumers are situated. In virtually any population, different audience segments are, at any one time, at different stages of contraceptive usage and nonusage.

Consumers may move along a continuum: they may be unaware, aware, knowledgeable, interested, ready to try, users, and possibly ex-users.

Finally, media patterns are consumer traits that must be analyzed as part of psychographic attributes. For instance, a recent survey in Egypt revealed that about 80 percent of the respondents claimed that they watch TV for one to three hours a day, with evenings (particularly after 8 p.m.) as the prime viewing period (State Information Service, 1980).

Institutional Analysis

The third broad area of marketing analysis concerns one's own CSM organization and other institutions and agencies which are directly or indirectly involved. Are sufficient financial, management and staff resources available to mount an effective marketing program? It is necessary to determine the size and scope of these resources, so that program planning can be scaled to the resources that are available. There are many ways to set marketing budgets and determine program size. But it is always prudent to have an initial understanding of the resources available.

Equally important to the resources at hand is the organizational commitment that can be expected. The parent agency (if there is one), the board of directors, the cognizant government ministry, the media and perhaps the nation's religious hierarchy may be instrumental in facilitating or blocking the development of a successful CSM effort.

This assessment of internal objectives, procedures and resources is called a marketing audit. An audit can vary in terms of formality and depth but should be conducted in an objective systematic fashion. For purposes of objectivity and to increase the chance that the audit findings will be accepted by members of the organization, outside firms are frequently asked to conduct the audit.

Marketing audits frequently consist of in-depth interviews with significant members of the organization. Marketing audits typically address the following areas of concern:

- o senior staff perceptions of organizational objectives;

- o channels for communication and accountability;
- o responsibilities of senior staff and departments;
- o allocation of internal resources and budgets;
- o systems for monitoring organizational performance;
- o perceived problems or obstacles to the organization's attainment of its goals; and
- o external resources available to the organization.

The marketing audit incorporates all the findings and makes recommendations regarding the organizational structure, resource allocation, and operating procedures to improve the program's chances of achieving its goals.

As one of several agencies or organizations working in family planning, it is important to analyze the efforts and activities of the other organizations which also are involved. Friendly "competitors" can help in many ways, but they can also contribute to fragmented efforts, funding problems and other difficulties. Interviews with administrators of these and other organizations are essential for identifying the activities of these organizations, their target markets, products, distribution channels and communication tactics. In addition, interviews can yield vital information for locating local resources, learning from the failures and successes of these organizations, and identifying possible areas for collaboration.

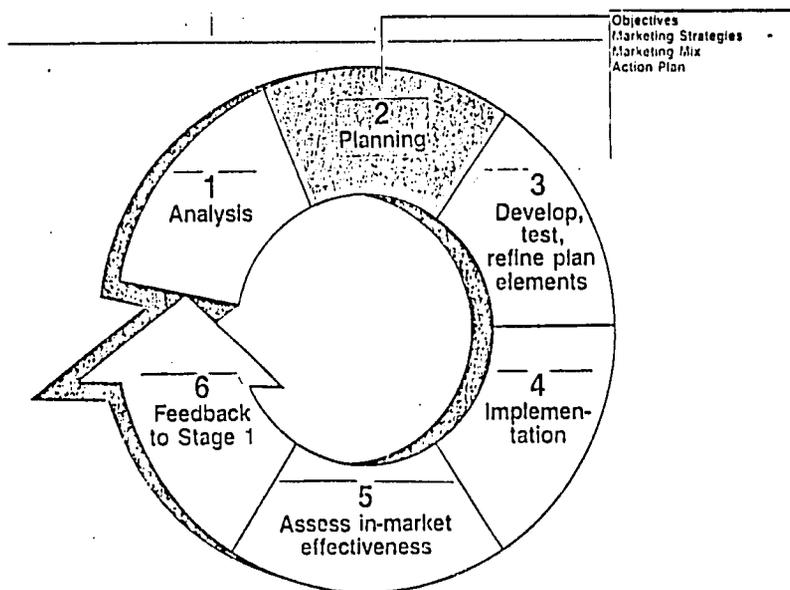
The data for these areas of analysis in the first stage of the marketing process may come from a number of sources. Existing demographic, socio-economic, epidemiological, fertility and contraceptive prevalence data are all helpful. As discussed in Chapter 2, these may include World Fertility Surveys and Contraceptive Prevalence Surveys.

Existing materials and documents containing relevant analytical data may be gathered from government programs and clearinghouses, health agencies, voluntary health organizations, health foundations, and trade associations.

Standard media reference books, if available, can provide statistics on media outlets, audience coverage and reach and other media information. Media professionals within the geographic market area can also be consulted. Local health organizations may be helpful sources of information.

In addition, it may be necessary to conduct new research efforts to supplement extant data. Personal interviews with individuals, representative of target market consumers, influentials, retailers and physicians may also be necessary to feed into the CSM planning process.

The Second Stage—Planning



The data collected and analyzed in the first stage now serve as the basis for Stage Two—Planning. The marketing planning phase includes four broad areas: objectives; marketing strategies; the marketing mix; and an integrated action plan.

Setting Marketing Program Objectives

Once the marketing structure is set and the organizational goals are clear, it becomes important to identify specific marketing objectives. These objectives must be realistic. It is tempting to overstate, or overpromise objectives in terms of contraceptive behavior change. But CSM programs have come to realize the enormity of the task involved in changing traditional views and lifestyles. Problems have included censorship in the mass media, legal constraints, insuf-

efficient program resources, lack of continuity, single rather than multiple approaches and channels, and insufficient research. Many of these difficulties may have begun with objectives that were too ambitious, too broad or too hard to translate into action.

In addition to being realistic, marketing objectives must be set in priority. Not all objectives are equally important. Some must precede others. With limited budgets and staff, CSM managers must carefully set priorities for a given set of objectives. Program corrections must often be made in the course of implementation phases. To plan these corrections and to assess overall progress, it is necessary to quantify objectives, to the extent possible, in early stages of planning.

Finally, CSM marketing objectives must be consistent over time. If objectives are frequently varied, it may disrupt the continuity needed to move consumers beyond awareness and interest to a point of contraceptive trial, acceptance and maintenance.

Market Target Segmentation

Consumer populations are seldom, if ever, monolithic. For instance, men may differ from women in selective exposure to messages and in acceptance of contraceptive responsibility. Younger individuals sometimes respond to different appeals than older consumers. Risk factors, benefits sought, lifestyles and other factors vary from one population segment to another. To effectively market contraceptives, it is necessary to isolate high priority segments and to tailor the marketing program for each segment. Undifferentiated marketing--i.e., treating all consumers the same way--ignores the basic differences among clusters of target populations and lessens opportunities for success.

Marketing Mix Strategies

Once objectives have been set and audiences segmented, strategies can be devised for each element in the marketing mix. The first of these is the product. An important decision is determining product positioning. This involves a careful study of market segments in order to select a viable niche in which to locate the product. The point is to position the product (e.g., a new oral contraceptive) at some point on the spectrum of what the audience wants and in relation to where

competitive offerings are located. Assume that high-priced, high quality foreign condoms are offered in pharmacies in a given market. At the same time, health clinics offer low priced, unlubricated condoms in cellophane, with no outer packaging. If consumer research indicated potential interest, there may be a niche between the two existing kinds of condoms for a medium-priced brand that is differentiated from both the high and low-priced items.

Other product strategy decisions involve carefully selecting appropriate characteristics for the offering. One useful way to look at a health product is in terms of performance characteristics and perception characteristics. As an example, consider the introduction of a new oral contraceptive into the marketplace in a developing country. Performance characteristics are those attributes which relate to the product's efficacy. Perception characteristics do not directly relate to how well the product works, but do provide signals about the product which influence consumer acceptance. Such attributes as color of the pills, package design and product name are examples of perception characteristics. There may be some attributes of an oral contraceptive, such as usage instructions, which overlap both performance and perception.

Distribution strategies are also part of planning the marketing mix. The regular movement of contraceptive products from a storage area to the point-of-purchase may take several approaches, including the use of commercial distributors, on-staff personnel using CSM program vehicles or a combination of these or other systems. Considerations may include warehousing, security, insurance, inventory control, transportation logistics, scheduling, compensation arrangements and verification.

Another aspect of distribution strategy development is to determine the outlets in which products will be made available to consumers. CSM planners must balance the social objective of widespread availability with distribution costs and retailers' interests (product movement, margin and profit). Examples of outlets include pharmacies, general stores, small vendors and vending machines.

Perhaps the most difficult strategies relate to price. The price/value relationship presents research problems, and usually requires actual marketplace

experience based on testing price variations. Perceptions of price/value may be assessed via survey research, or in laboratory (controlled experiment) settings, but there appears to be no real substitute for in-market, "real world" experience. As with other CSM components, price strategies must be constantly assessed. Inflation often necessitates periodic price increases to protect CSM programs as well as wholesalers and retailers. But price increases may not be approved by governing bodies. This may lead to the necessity of introducing product variations at higher prices than the products that are replaced.

The fourth element in developing marketing mix strategies, after product, distribution and price, is the communication strategy. As with the other strategies in the mix, this strategy statement is based on the earlier stage of analysis. The communication strategy should contain: the primary benefits which the target consumer can expect; supporting reasons why the consumer can/should believe the benefit promise; the specific action the consumer is expected to undertake; and the tone or image to be conveyed over time. (An example of a communication strategy is provided in Appendix 1).

The purpose of this strategy is to establish long-term continuity for communication and to provide guidance and direction for "creative" message development. Moreover, the strategy should also serve as a benchmark for measuring communication impact. An effective communication strategy should be clear, it should be simple, with a minimum of ideas and directions, and it should be devoid of executional considerations (i.e., it should cover what will be communicated, not how).

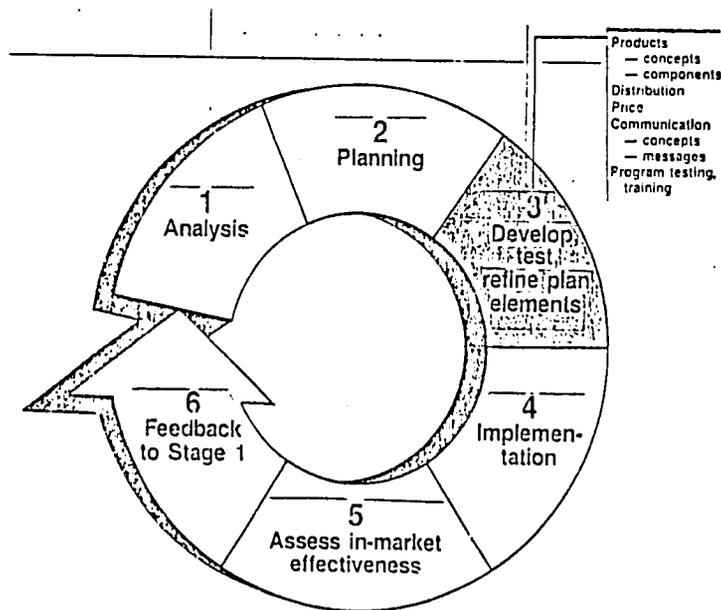
In addition to the strategy statement, other parts of the communication component should include tactical considerations:

1. Mass Media--Identify the media that will be used and the weight that will be given to each in terms of budget and effort, the approaches that will be taken (e.g., publicity, paid and/or public service advertising) and the timing (e.g., continuous steady level, periodic "bursts" or "flights," heavy introductory phase followed by lower sustaining levels).

2. Interpersonal Channels--This should be integrated with the distribution strategy, especially if intermediaries are to be involved as communicators, such as community organizations, opinion leaders, physicians and professional associations. Other interpersonal considerations may include promotions, point-of-decision (e.g., pharmacy or child care center displays), village demonstrations, conference exhibits, rallies at work sites, and other "events."

When all of this planning is accomplished and reviews and approvals are complete, the final step in this stage of the marketing process model is to integrate all components into a single action plan. This plan is the blueprint for everything that follows. It incorporates all preceding elements, and includes schedules, milestones in terms of process measures (e.g., levels of awareness, trial, adoption, numbers of brochures distributed, prescriptions filled), outcome measures (e.g., sales), a total marketing budget, and a budget and schedule for each element in the marketing mix.

The Third Stage—Development, Testing and Refinement of Plan Elements



The first steps in executing the action plan occur in Stage 3 of the marketing process. Here, the elements in each of the four components of the marketing mix are developed and tested, and the program is refined.

The initial step in this stage is product concept development and testing. The concept is the underlying idea for positioning new products or repositioning established ones in relation to target market wants, needs and expectations.

In the commercial products field, a product concept might be:

"a hair conditioner that keeps your hair looking beautiful all the time, because you can use it anytime--when you shampoo and between shampoos."

In developing a family planning program for a developing nation, consumer, market and institutional analysis and product strategy development might lead to this example of a contraceptive product concept:

"a contraceptive for women that you use only when you are having intercourse--no insertions by a doctor, no injections, and no side effects."

It is important to carefully formulate and test product concepts before full program development. Testing at this stage is usually small scale, and is designed to determine market interest and to remedy any weaknesses that are uncovered.

Product concept tests are designed to assist in reducing the number of possible product alternatives or to evaluate the "goodness" of a product idea. In a concept test, consumers are exposed to a series of concepts. The concept is usually presented verbally, but it can be accompanied by a picture or photograph.

Product concept tests typically explore the following:

- o what the concept statement communicates to consumers;
- o how meaningful and relevant the information provided in the statement is felt to be;
- o how unique, how important and how believable is the statement made about the product;
- o consumers' specific likes and dislikes about the product described in the statement; and
- o consumers' interest in buying or trying the product.

A second aspect of product development is to create and test product components. These might be such things as package design, sizes, instructions, colors, textures, shapes, dosages, and disposability.

Testing of these factors usually requires that visual materials--i.e., dummy packages, logo designs, instruction pamphlets--be developed. These materials are shown to respondents during the research study as topics for discussion, or choice alternatives.

Name tests for a product or product line must consider several major dimensions including:

- o the overall rating or appeal of the name;
- o the pronounceability and memorability of the name;
- o associations with the name;
- o negative connotations of the name;
- o suitability of the name for contraceptive products; and
- o uniqueness of the name.

In Mexico PROFAM was selected as the name for a complete line of contraceptive products (oral contraceptives, condoms, vaginal cream, foam and suppositories). Qualitative research showed that the word had positive connotations related to family planning. Consumers interpreted the name to be an abbreviation of the phrase "programa familiar" (family program) or "planificacion familiar" (family planning). However, in accompanying package tests it was also shown that the name should be supported with the family planning symbol (male and female stylized figures) since omission of the symbol decreased the positive association with contraception (PIACT de Mexico, February 1979).

Logo tests are similar to name tests in that they seek to measure overall appeal for different designs. Although logos are not verbal stimuli, like names, they are usually symbolic or stylized, hence, it is important to assess consumer perceptions of what they represent. For example, a test was conducted in Jamaica to determine which of five black-and-white logo designs women preferred for a vaginal foaming tablet. The test involved asking the respondents

to describe what they thought of as they looked at each design. They were then asked to select the design they liked the best. After selecting the design that most appealed to them, each respondent was asked whether the design would best represent a "toilet soap, cologne, contraceptive, or cough medicine." Finally, they were asked whether their favorite drawing would be very appropriate for a contraceptive product or whether any of the other drawings would be better (Dunlop, Corbin, Compton Associates, 1981).

Package tests can explore several aspects or components such as the package color, the package design (e.g., foil wrapped vs. a tube) as well as other communication elements (e.g., pictures, designs, descriptions, etc.) It is important to consider all of the dimensions when testing packages since consumers' reactions to the product can be influenced not only by the package design as a gestalt, but also to the individual packaging elements. Findings from studies evaluating the effectiveness of various package elements have shown that they differ across different types of contraceptive products. These are described in Chapter 2.

Piata de Mexico examined different color schemes for the PROFAM contraceptive product line. Most of the dark tone color schemes were rejected since they connoted strength or even danger. On the other hand, dark brown was considered quite appropriate for the condom color scheme since it supports the image of masculinity (PIACT de Mexico, April, 1979).

A very important component of contraceptive packaging is the development of instructional package inserts which accompany products. CSM programs service target markets that generally have low levels of knowledge regarding contraceptive methods; thus, it is necessary that inserts convey to potential consumers essential steps in the correct use of the products. Not only should the inserts describe correct usage in terms and vocabulary understood by consumers, but instructions should also be pictorial for illiterate groups. This is especially important because user failure is often perceived as method failure, and discontinued use results.

Research has been used successfully to identify problems and develop approaches for instructional inserts. A study of 400 persons chosen at random

from urban and rural areas in Mexico helped to identify the best terms to describe "the purpose of contraceptive use," "side effects," and "the container" in which the oral contraceptives were packaged. For example, respondents were asked the question "Do you think contraceptives are used to 'practice family planning' or 'to avoid pregnancy'?" Seventy-five percent of the persons interviewed answered that contraceptives are used to avoid pregnancy (PIACT de Mexico, April 1979).

In Bangladesh, testing revealed that consumers misunderstood the meaning of the pictures used on the Joy foaming tablet instructions. As a direct result of the research, the instructions were revised for greater clarity.

Distribution elements may also be examined during Stage 3. The channels of distribution may be pilot tested, as well as point-of-purchase outlet preferences. For instance, commercial distributors may be given several geographic sectors to cover. Their performance may be compared to each other, and to an in-house distribution staff in terms of cost, retailer satisfactions, record keeping, etc.

Studies to assess consumer response to alternative pricing strategies also are conducted in Stage 3. Several factors related to pricing may be studied in a pricing study. If the CSM program plans to raise or lower the price of an item in its product line, how will this change be perceived by consumers? Or, if the CSM program plans to introduce a new oral contraceptive at a lower price than those already available, will it be seen as a product of poorer quality? If priced higher than other orals on the market, will it be seen as a better, more prestigious product?

Pricing studies may be conducted in several ways. The technique used most widely by CSM programs has been to survey consumers directly in regard to pricing attitudes and perceptions. Laboratory experiments which try to simulate actual purchasing behavior may be designed to assess alternative pricing strategies. Finally, field tests may be conducted in one or more markets for one month to gauge changes in sales due to price increases or decreases.

Communication concepts and messages, each based solidly on the communication strategy, are also developed and tested during this stage. Concepts

may consist of rough art, words and phrases, and may include a key summary line. These key summary lines bring vitality to the strategy, and make the concept memorable and perhaps provocative.

Pretesting concepts at this stage can provide direction for eliminating weaker approaches and identifying message concepts that appear to have the most potential. Sometimes variations, or entirely new concepts, emerge from respondent reactions. For instance, a picture of a bride and groom was shown to Egyptian women to determine if newlyweds were appropriate spokespersons for Amaan (a spermicidal tablet). Many respondents said that newlyweds should have children before contracepting. They thought it was not credible or appropriate for just-married couples to practice family planning--first, it is important to determine if a woman is fertile (Family of the Future, and Porter, Novelli & Associates, 1982).

Once the concepts (often with summary or promise lines) with the most potential have been prepared, pretested and refined, entire messages can then be created. These may be full radio announcements, booklets, posters, transportation placards, television spots, or other vehicles.

These messages should be produced in rough form, for pretesting and refinement, if warranted, before the expense and commitment of final production. The pretesting is necessary to assess comprehension, estimate message recall, identify strong and weak points in the message, assess personal relevance to the market target, and gauge sensitive or controversial aspects of the message that may require revision.

Once these steps have been taken to develop and pretest product, distribution, pricing, and communication elements, the next series of steps in Stage 3 are concerned with program refinement. The three steps of program refinement are prototype evaluation, full test market and regional distribution. A fourth aspect at this point is training--of the staff, intermediary organizations, spokespersons, distribution firms and necessary support personnel.

Prototype evaluation consists of assembling all components of the program in a form as close as possible to its final form, and obtaining a realistic

assessment of market reaction. In this way, changes may be made before more extensive, more costly steps are undertaken.

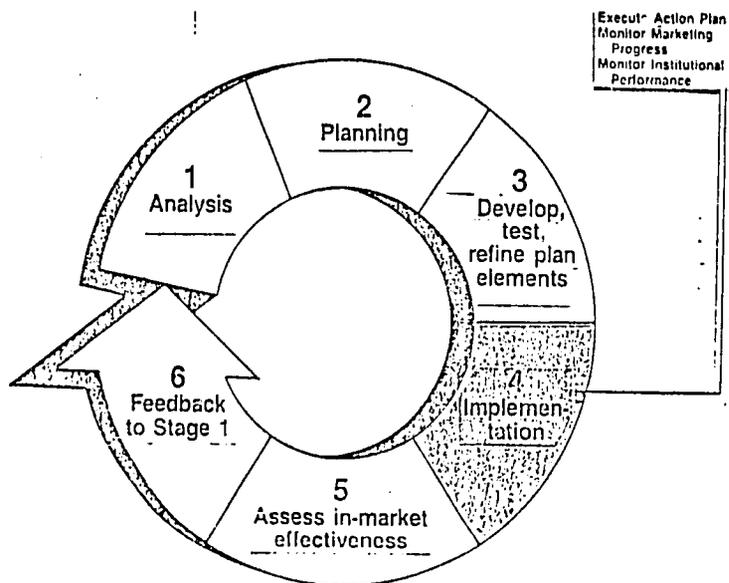
This might be done in a small section of an urban area, or perhaps using panels (20 or so selected consumers). Mass media usually cannot be used in these prototype assessments, but may be simulated with posters, audio tapes or other devices.

While compromises will have to be made in simulating the full program, sufficient realism should exist and feedback will be gained to make revisions, if necessary, in the program components before proceeding to the next level--a full-scale test market. In the test market stage, a larger, more realistic assessment is possible. Perhaps two variations of the program will be developed, with one applied to Market A and the other to Market B. Control markets may also be necessary.

The next expansion of the program may be that of a regional distribution. Although not always necessary or affordable in terms of time or budget, a regional distribution is the best indication of how the program will fare in full, national distribution.

At an early point in the process of program refinement, it is usually necessary to prepare training materials and conduct training sessions for the staff and middlemen involved in the program. Training may be appropriate for retailers (e.g., pharmacists who counsel patients), physicians (e.g. on prescribing orals and in IUD insertion), volunteers and staff (who conduct rallies), spokespersons and distributors. This training, like the other program components, can be refined and expanded as more is learned at each level of development.

The Fourth Stage—Implementation



At this point in the marketing process, the full program is put into effect. This requires implementing the plan of action prepared in Stage 2, monitoring marketing progress, and monitoring the institutional/structural performance of the CSM organization.

In implementing the plan of action, the full expansion, or "roll-out" of the CSM program is undertaken, from whatever level of testing was last employed (prototype, full test market or regional distribution). This is a critical point in the marketing process. It is the least creative or analytical, and for that reason may be delegated to staff or receive less management attention than previous steps. Yet, the details and logistics control of this implementation are central to the success of the entire program. The most well-conceived and well-designed program may not achieve full potential if it is not properly put into place so that it can work.

As part of executing the marketing plan, the communication elements-- advertising, publicity, interpersonal channels, promotion, and point-of-purchase/point-of-decision--must be fully activated. Also, the schedule of events must be closely followed, and necessary adjustments made in the time frame that was prepared as part of the plan of action.

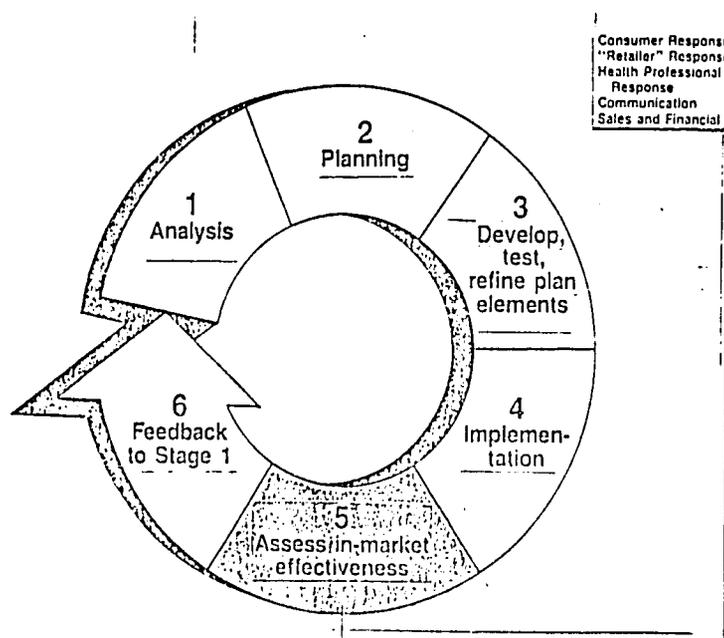
Just as the careful implementation of the program is essential, so is the monitoring of this phase. Distribution channels must be monitored closely to determine that the products are moving to the marketplace, that adequate supplies are in the pipeline, and that no out-of-stocks exist at retail.

Specific retail areas to be monitored may include prices, point-of-purchase or point-of-decision displays, shelf space, inventory and competitive reaction. The monitoring of sales revenues, share of shelf facings and share of market may be called for.

Finally, communication must be monitored as part of the process of tracking progress in the marketplace. This may involve verifying the placement of paid and/or public service advertising, quantifying the amount of print and broadcast publicity that was generated, and tracking interpersonal communication.

Another aspect of the implementation phase also requires monitoring--the institutional performance of the CSM organization itself--to assure that the organization is functioning effectively. This includes staff performance, management attention and response to recommendations, funding, the flow of internal and field communications and the process of decisionmaking.

The Fifth Stage--Assess In-Market Effectiveness



As the implementation proceeds, a systematic assessment is applied to determine: the degree to which the marketing program is meeting its objectives; midcourse corrections in the program which may be required to address deficiencies or capitalize on new opportunities; and how to replan the next cycle of the marketing process.

The ongoing monitoring in Stage Four and the continuous assessments in this stage should fit together into an effective management information system. The purpose of this system is to gather, process and report timely, adequate and accurate data for marketing decision-making. Part of this system includes a comprehensive internal process for storing and retrieving relevant program information, and a marketing intelligence network using members of the distribution force, field workers or others to gather and send in useful data. Syndicated services (e.g., commercial store audits) and other sources of information may also be tapped, depending upon the budget and the availability of these services locally.

The program areas in which assessment is needed usually include: consumer (i.e., target audience) reaction and response; retailer response; physicians' and other health professionals' responses; communication penetration and impact; and sales and financial measures.

These assessments must be tailored to the individual CSM program and its objectives. The following are examples for consideration:

Consumer Response--Measure and track over time: consumer trial of the products; contraceptive buying patterns; user status (i.e., nonuser, potential user, occasional user, regular user, ex-user); usage rate, loyalty status (brand, method); readiness state (unaware, aware, knowledgeable, interested, ready to buy/ contraceptive); satisfactions/dissatisfactions (by product, by consumer segment, by geographic sector/region).

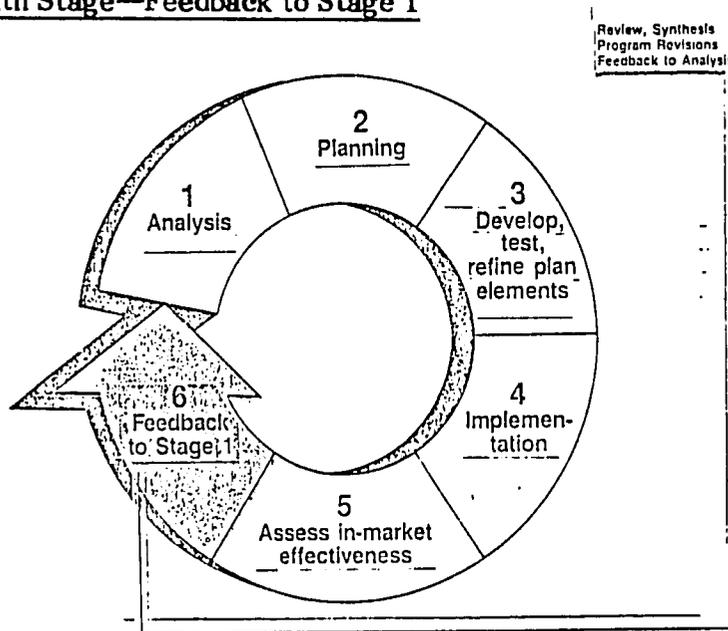
Retailer Response--Establish retail audits and panels to track: location of products in store (e.g., on shelf/shelf facings, behind counter); reorder rates; trade reaction to incentives; inventories (by product); trade reaction to consumer purchasing behavior; role of retailers in screening and counseling consumers.

Physicians', Other Health Professionals' Response--Measure and track over time: reorder rates (of IUDs); number of patient visits for reproductive-related needs; reaction to consumer behavior; role and reported activities in screening and counseling patients.

Communication--Tracking studies to periodically measure awareness, recognition, comprehension, recall, reaction, perceptions--by brand and for overall contraceptive communication.

Sales and Financial--Collect and analyze data in terms of: sales, market share, sales-to-expense ratios, and profitability--by product, sales territory or other geographic unit, consumer segment, trade channel, and size of order.

The Sixth Stage--Feedback to Stage 1



As stated earlier, the marketing process is iterative. There can be no let up. The marketplace changes, programs enter phases of decline and the CSM organization may be in a state of change, as well. The last stage--Stage 6--therefore must feed back into the first.

The monitoring and assessment that has occurred in previous stages has been undertaken to measure progress, to make as-needed program adjustments, and to prepare for replanning. Now, in Stage 6, preparations for this replanning are undertaken. All the information that has been collected (research, analysis,

field intelligence and other relevant data) should be reviewed carefully to uncover problems, identify weaknesses that must be addressed, and identify opportunities that can be exploited in the next cycle.

On the basis of these synthesized data, additional revisions may be undertaken in the marketing program. This procedure of tinkering with the program, of making mid-course corrections, is a never ending process that can be undertaken at any point at which it seems necessary, at any stage of program development. Finally, all the reviewed data are recycled into Stage 1.--Analysis to begin anew the continuous and systematic process of refinement and improvement.

The process model for marketing programs reviewed in the preceding sections can bring order and discipline to bear on marketing problem-solving. The systematic approach to planning and implementing marketing strategies, and incorporating market research at critical decision points, can enhance the CSM program's chances of achieving organizational goals. The following section of this paper reviews major methods of marketing research and their applications to CSM programs.

Chapter 2

MARKET RESEARCH—METHODS AND
APPLICATIONS TO CSM PROGRAMS

I. INTRODUCTION

Marketing research is any planned and organized effort to gather and analyze information relevant to a given problem in order to make better marketing decisions. Over the years, a number of formal market research methods have been developed for gathering marketing information. These are nothing more than "tools of the trade" to help do a better job in obtaining meaningful and useful information.

This gathering of knowledge can, and should, be done in a systematic fashion. The search for such information can be organized by writing up clear and definite objectives, giving consideration as to how marketing research data can be gathered completely and without bias, and putting the findings and conclusions together to choose the best course of action for a CSM program. As discussed in the previous chapter, market research data can be the cornerstone for planning, conducting, and evaluating the success of CSM programs.

This chapter is not meant to be a comprehensive text on marketing research. Rather its purpose is to provide the reader with a general understanding of market research methods and issues of importance in applying them to CSM programs.

II. PRIMARY vs. SECONDARY RESEARCH

There are two broad, basic sources of marketing research information: primary sources (those data which have to be collected) and secondary sources (those data already available that have been compiled by someone else).

A wise program manager takes advantage of work previously done by other people if it is available and relevant to the problem. Otherwise, CSM programs may very likely waste valuable time and money and may unnecessarily "reinvent the wheel." Primary research usually involves major out-of-pocket costs while secondary research involves only the staff time to look up and analyze the data. Secondary research is not only less expensive, but it is also much faster to gather and analyze than primary research if data addressing your needs are available.

At times, sound decisions can be reached by reorganizing and reanalyzing existing data--provided they are skillfully reanalyzed and reinterpreted. Such reinterpretation and appraisal is often necessary because secondary data have been produced in a different context of time, place and problem, and are not usually in exactly the right form for new uses in somewhat different situations.

Hence, in using secondary research, there are several cautions and limitations which must be considered:

- o The quality of secondary research is dependent upon the quality of sources and references available.
- o Sometimes, only information indirectly related to the problem is available and some amount of extrapolation is necessary to make it useful.
- o Due to the time required for compilation and publication of reference materials, current data usually are not available.
- o Often, the exact information needed does not exist.

Upon examining available secondary research, it may be necessary, after all is said and done, to conduct some primary research, either to supplement the existing data or to create a data base from scratch. Primary research can be designed to ask people (current users, potential users, retailers, physicians) questions aimed at obtaining the exact information needed for a specific problem. Depending upon the nature of the request, this information gathering could be just as fast as a search for relevant secondary sources.

Both the uses and sources of primary and secondary research are discussed in detail below.

A. Secondary Research: Uses and Sources

The use of secondary research sources can be helpful to CSM programs not only as a replacement for primary research but also as an aid to primary research both in planning better studies and in getting a better understanding of primary research findings.

- o Secondary research is especially useful during Stage 1 Analysis when program planners are conducting their market, consumer and institutional analyses.

- o Secondary research can provide background on a country, identify the present situation and serve as a basis for projections and trends. Hence, the integration of information from various secondary sources can provide an initial or a general background framework from which target markets can be better defined and approached.
- o Secondary research information can provide direction for additional primary research efforts. For instance, the planners for PROFAM conducted a review of 52 previous studies on family planning in Mexico prior to designing additional research to help launch an information campaign (PIACT de Mexico, February 1979).
- o Some sources may help in the actual planning of primary research such as, providing information for choosing which areas would provide the most productive field work. Based on the PROFAM review, it was decided to focus the consumer oriented marketing research on middle and lower class urban and suburban couples in the 18-35 year old range.
- o Published sources may supply information that will fill in answers or provide the reasons "why" certain trends or patterns have been found. Such findings can thus enhance the value of any primary research because it can be shown within the context of the whole picture that is presented.
- o Statistical series published on a regular basis, such as census data on fertility rates, can give benchmarks to measure the progress of a family planning program.

Secondary research related to CSM programs is available for many countries. Demographic, socioeconomic, epidemiological, fertility, and contraceptive usage data from the World Fertility Survey (WFS) and Contraceptive Prevalence Surveys (CPS) currently exist for many countries and can be used as references. Much of these data are easily obtainable and can be quite useful in solving problems (Singh, 1980 (a); Singh 1980 (b); and Westinghouse Health Systems, no date).

Existing materials and documents containing relevant analytical data may be gathered from government programs, health agencies, voluntary health organizations, health foundations, and trade associations. There are also standard reference books and trade journals which are useful sources. Some of these major sources are discussed briefly below:

Government Agencies: Government publications are a good place to begin for basic statistics. Of particular help are census data published by the country where the CSM program is being conducted. Census data provide information on the demographic characteristics of a population such as age, religion, race, education, health and fertility and also information on the various distribution and retail outlets/channels in an area. Governments also conduct other research which is often reported in special bulletins or other literature.

Voluntary and Professional Organizations: Associations such as the Population Council, New York, the International Planned Parenthood Federation (IPPF), London, and local family planning associations, often conduct their own studies for membership information or for publication. These are usually on subjects important to their members and some of these are published. Various medical and professionals associations also should be contacted and searches conducted of their journals and publications.

Professional Journals: Publications such as Population Reports and Studies in Family Planning are useful in providing information about fertility rates and contraceptive practices in various countries. These publications often publish their own series of relevant statistics. (See bibliography for additional references.)

Private Companies: Members of private industry such as contraceptive manufacturers may have conducted private studies on various aspects of producing and promoting their products. While these are often proprietary, companies may be willing to share some of this information with non-profit organizations. They also may be a good source of information on distribution and sales outlets.

B. Primary Sources: Qualitative vs. Quantitative

Primary research is usually divided into two categories: qualitative research and quantitative research. Qualitative research is seen as exploratory, providing indications and impressions; quantitative research provides projectable and definitive information about the target market.

Qualitative research usually consists of a loosely structured sample, a relatively small number of respondents, an interview consisting mostly of open-ended questions and probes, responses taped or recorded by the interviewer, and a nonstatistical approach to analyzing the information.

Basic techniques used in qualitative research are direct, open-ended questioning (e.g., asking questions in terms of "what do you think, how do you feel, etc.") and projective techniques (e.g., role playing, cartoon composition, free flow associations). The indirect techniques are an attempt to get at the whys of consumer behavior through the unconscious projection of a respondent's feelings, attitudes, and opinions toward various stimuli. Sample questions might include: What type of person would buy this product? What words best describe the product?

With qualitative studies, the results are considered "impressions" rather than definite answers and no attempt should be made to draw any hard and fast conclusions. Two major types of qualitative research are focus groups and individual in-depth interviews. (Both are discussed in detail later.)

Quantitative research, on the other hand, seeks to count or quantify the information and normally applies some statistical form of analysis to the data for a more definitive answer to the problem under study. Quantitative data are gathered from a large, representative random sample; the results accurately reflect the characteristics of the population being surveyed and the analysis can reveal whether apparent differences are statistically significant. Market segmentation, for example, is based on quantitative studies of consumer populations.

Quantitative studies are appropriate and necessary when the purpose is to collect data which is definitive and from which generalizations to the total population under study can be made. Examples of such quantitative research are surveys--telephone, mail or personal--which are used to collect information from large numbers of respondents typical of the target market.

Three types of quantitative research studies have been used widely by CSM programs for planning marketing strategies as well as for monitoring progress. These are: knowledge, attitudes and practices (KAP) studies, World Fertility Surveys (WFS), and Contraceptive Prevalence Surveys (CPS).

During Stage 1--Analysis, CSM managers should take fullest advantage of applying the data from these studies. Given the cost of conducting such large-scale quantitative research, the information from a CPS or KAP study conducted within the last 18 months will probably be adequate for meeting Stage 1 needs. This would permit program resources to be allocated for a baseline KAP study just prior to implementation that could be tailored to more specific program needs.

There are, of course, gradations between the qualitative and the quantitative study. Examples of such research are central location intercept interviews, consumer and retail panels and field tests. These research methods are quantitative in the sense that the results are tabulated and some effort is made to make the sample as "representative" as possible; however, the samples are not random and theoretically the findings should not be generalized to a larger population. Table 3.1 summarizes the characteristics of qualitative and quantitative research methods.

III. QUALITATIVE MARKET RESEARCH METHODS

A. Uses of Qualitative Research

A qualitative approach is useful when the researcher wants to obtain an idea of the possible range and importance of attitudes and behavior without concern at this point to their proportionate distribution in a particular population. Ways in which qualitative research can be used to gain insight include:

General understanding -- to get a "feel" for how consumers talk about contraceptives, or family planning, and how they judge and evaluate this subject.

Table 3.1

QUALITATIVE VERSUS QUANTITATIVE METHODS

General Characteristics

<u>Qualitative</u>	<u>Quantitative</u>
o Small sample	o Large sample
o Not representative or generalizable	o Usually representative and generalizable
o Exploratory	o Measured estimation
o Relatively inexpensive	o Usually expensive
o Quick turnaround	o Slow turnaround, need more lead time

Techniques

<u>Qualitative Interviews</u>	<u>Quantitative Surveys</u>
o Focus groups	o Personal
o Individual in-depth	o Mail
	o Telephone
o Central location intercept interviews	
o Panel Studies	
o Field test	

- o Hypothesis formulation -- to explore a subject area so that well-defined hypotheses, or questions for further study, are generated. For example, to develop a hypothesis concerning whether "newly weds" should be a priority target market for CSM programs.
- o Questionnaire design -- to help identify variables or attributes to be examined in a quantitative study and to get an idea of consumer language so that relevant question wordings can be correctly developed. For example, "How do consumers describe the side effects of foaming tablets?"
- o Complex issues -- if the product, service, or concept is new or complicated, qualitative methods offer opportunities to demonstrate capabilities and has the advantage of high respondent involvement.
- o Embarrassing or personal topics -- one-on-one personal interviews, in particular, offer a degree of confidentiality and intimacy for difficult topics.
- o Impressions of new product concepts -- to assess consumer reactions to current products in comparison to new products, to test which packaging is best, to determine whether new package instructions are understood, etc.
- o Impressions of creative concepts, headlines, and copy -- to gauge target audience reactions to and comprehension of ideas at an early stage; also can be used to generate new ideas.
- o Interpret previously obtained quantitative results -- to find out "reasons why" target audiences think, feel and behave as reported in a quantitative survey that cannot probe these issues in depth.

While both qualitative and quantitative studies can be used to examine a wide variety of subjects and materials, qualitative research has a number of advantages that have made it very popular:

- o Considerable flexibility to explore various topics;
- o Researchers learn directly from consumers in their own words;
- o Program planners have a chance for direct consumer contact ;
- o "Get below the surface" to find out the reasons why consumers hold various attitudes or opinions;
- o To investigate the functions that attitudes serve for people;
- o Gives a better understanding of the formative process and complexities behind a single attitude or opinion;

- o Can usually be initiated rather quickly to provide immediate feedback; and
- o Relatively inexpensive compared to quantitative research.

Unfortunately, the popularity and ease of doing qualitative studies has created all too many occasions where such research has been misused. Qualitative research also has its disadvantages:

- o Small sample sizes do not yield projectable data;
- o Not indicative of how extensive the attitudes expressed really are;
- o Not always followed by quantitative research as originally planned;
- o Depends heavily upon the interviewer's skill in conducting interviews and in interpreting the results;
- o Results are sometimes used to support preconceived notions; and
- o Easily misused because there is often evidence to any position.

Planners must be made aware that there is a place and a purpose for both types of research, but that quantitative research is the only research that yields definitive results. The conservative course is to use qualitative research as a preliminary step to generate hypotheses for later quantification. When that second step cannot be taken, the user should weigh the risks just described.

The two most widely used qualitative research methods for gathering target market information are focus group interviews and in-depth individual interviews. These techniques are described below.

B. Focus Group Interviews

Focus group interviews are used to obtain insights into people's perceptions, beliefs, and language. Group interviews provide insight about how consumers think and feel about contraception and the various methods available, how they use different methods, the reasons why they select certain methods or brands, the language they use to describe products, and their purchasing behaviors. Product and message concept testing during Stage 3 is effectively carried out using this market research method.

Focus group interviews are conducted with a group of about 8-10 respondents simultaneously and usually last about 1½ hours. Respondents are generally paid a stipend to insure their attendance at the session.

Using a discussion outline, a moderator starts off the discussion covering overall attitudes and behavior and eventually focuses on the specific topics at hand. The moderator keeps the session on track while allowing respondents to talk freely and spontaneously. As new topics related to the outline emerge, the moderator probes further to gain useful insights. This discussion and probing can uncover the type of "below the surface" information that a large, more structured and impersonal quantitative study fails to explore. In this type of research, consumer reactions can be more thoroughly understood and explained.

As with all research, focus group respondents should be typical of the intended target audience. Various subgroups within the target audience should be represented so that a range of opinions can be heard. For example, in testing product or message concepts about IUDs aimed at a general audience of women, a cross section of individuals--women with and without children, older and younger women--should be recruited for the focus groups. If a particular subgroup is of special interest (e.g., women aged 25 to 34, ex-users), entire groups can be recruited based on the relevant characteristic. Besides the consumer, groups also can be conducted to explore the attitudes of selected persons who have an impact on a family planning program--physicians, pharmacists, midwives, and health clinic operators.

Respondents are recruited 1 to 2 weeks in advance of the interview sessions. They may be recruited "at random" (i.e., from a central location) and interviewed to determine if they qualify for the group. Or, they may be recruited from a group of individuals representative of the target population (e.g., clinic users).

There are several important criteria for conducting effective group interviews. Respondents should not know the specific subject of the sessions in advance, and they should not know each other. Knowing the

subject may result in respondents carefully formulating ideas in advance and thus not talking spontaneously about the topic during the session. Knowing other respondents may inhibit individuals from talking freely. Finally, all respondents should be "newcomers" to focus group interviews. This allows for more spontaneity in reactions and eliminates the problems of "professional" respondents who may lead or monopolize the discussion.

It is desirable, especially when pretesting on sensitive or emotional subjects, to segregate respondents by age, sex, race, socio-economic status, or whatever other variable is likely to hinder freedom of expression. For example, because of differences in attitudes toward contraceptive use, it may be best to separate users from non-users.

There is no set rule on the number of focus groups that should be conducted. The number of groups inevitably depends upon program needs and resources. If target audience perceptions appear to be comparable from one group to the next, two to four focus groups should suffice. If perceptions vary, and the direction is unclear, additional groups may be necessary. Likewise, if particular subgroups are important, at least two focus groups per subgroup are usually considered a minimum.

An experienced, capable moderator, who can skillfully handle the group process, should be used. The moderator must be well-informed on the subject and the purpose of the groups in advance. A good moderator builds rapport and trust and should probe respondents without reacting to and thereby influencing their opinions. The moderator must be able to lead the discussion, rather than be led by the group. A good moderator keeps the discussion on track while talking as little as possible and makes it clear that he or she is not an expert on the subject.

In the planning stages of a CSM program, focus groups can be used to develop the hypotheses (or broad research issues) for larger quantitative studies. These interviews are extremely helpful when little is known about a new product category. Focus groups can help determine public perceptions, misconceptions, and attitudes before a questionnaire is developed and the field research is conducted. The areas of research can be probed in

focus groups to help generate ideas and develop hypotheses which are then fully assessed in the large quantitative study. For example, focus groups were conducted as a first step in the research design for PROFAM in Mexico to gather further insights into the depth of knowledge about contraception and attitudes about its usage. This information was then used in designing the questionnaire for a quantitative study consisting of over 2,000 personal interviews (PIACT de Mexico, 1979).

Group interviews are especially useful as a tool in the concept development stage of the communication process to examine spontaneous reactions to specific topics and often are used as input for creative development (concepts, strategy, creative executions). They provide insights into target audience beliefs about contraceptive methods, allow program planners to obtain perceptions of message concepts and help trigger the creative thinking of communication professionals. The group discussion stimulates respondents to talk freely, providing valuable clues for developing promotional materials in the consumer's own language.

In Egypt, focus groups were conducted to test reactions to several advertising concepts for Amaan vaginal foaming tablets and Tops condoms. Respondents were recruited from pharmacies and central gathering places (coffee houses, bazaars, and health centers) in Cairo and the surrounding suburbs. Respondents represented both men and women, literates and illiterates, and individuals who were married and between the ages of 18-40. They were also selected on the basis of usage/non-usage of various contraceptive methods. In the group sessions, these people were shown storyboards representing commercial executions and various print ads. The moderator probed for reactions to the various materials that were presented (Family of the Future and Porter, Novelli & Associates, 1981).

As noted earlier, the results of focus group interviews should be interpreted carefully. It is useful for an unseen observer (behind a one-way mirror) to take notes as well as to tape record the session for later review. In interpreting the findings from group interviews, program planners should look for trends and patterns in target audience perceptions rather than doing just a "he said...she said" kind of analysis.

Focus group interviews provide up-front developmental input only, not a definitive evaluation. Focus group results are not projectable. While they can indicate the range of attitudes that exist, they do not indicate to what extent these attitudes prevail in the general population.

Focus groups indicate group reactions toward various topics; they are not measures of individual reactions. When individual responses or quantitative information are needed, other methods should be utilized. For example, when assessing the final copy for a brochure, or patient package inserts, it is more important to gather individual rather than group measures of comprehension, perceptions and intended use.

C. Individual In-Depth Interviews

In some situations, focus group interviews are not as useful as individual in-depth interviews. When the "product" or subject is too personal to be discussed in a group, when the group interview situation may hinder individuals from speaking honestly about their own views and opinions, when extensive sequential case histories are needed, when the specific respondent is difficult to recruit for a group (physicians, for example), or when it is necessary to interrelate ideas, attitudes, and events at the individual level, it is usually better to interview people one at a time. For example, in-depth interviews can be used to pretest questionnaires for KAP studies. In Haiti, they were used to learn about attitudes of Haitian pharmacists toward selling contraceptives and displaying contraceptive promotional material.

These interviews can be conducted among a variety of people, depending on the information being sought. Conceivably, consumers, physicians, distributors, and retailers all could be used in in-depth interviews. Such interviews tend to be quite long, lasting from 30 minutes to an hour and are used to assess feelings, emotions, attitudes, and prejudices. These are areas in which responses are not normally elicited in the more common public opinion interviews.

Individual in-depth interviews are like one-on-one conversations between the respondent and the interviewer. Like focus group sessions,

they should be conducted by experienced interviewers who usually follow a discussion outline. A structured questionnaire can be used in those cases where the researcher is concerned about obtaining respondents' reactions to a core set of items. What a more structured approach loses in depth, it gains in standardization.

The interviewer must be skilled at building rapport so that respondents feel comfortable to talk freely. Interviewers also should be adept at probing respondents about their feelings and reactions. The interviewer's sensitivity is crucial in conducting interviews on emotional subjects and/or with individuals who may react emotionally.

In-depth interviews can be conducted nearly anywhere, although a quiet spot where both interviewer and respondent can concentrate is preferable. Interviews conducted in the home may be useful when the session requires some demonstration or easy recall of in-home practices or when specific hard-to-reach individuals must be contacted.

Tape recording the sessions allows the interviewer to concentrate fully on the interaction and also facilitates analysis of the interviews later on. Respondents should be assured of anonymity and given an explanation of how the interview results will be used.

Because of the amount of time involved in conducting in-depth interviews, it is advisable to schedule appointments in advance. For special target audiences, such as women who use IUDs, staff members at clinics may assist program planners in identifying respondents.

Like focus groups, in-depth interviews represent a qualitative method usually conducted with small numbers of respondents. It is usually not practical to obtain a probability sample in a study of this kind because the costs are so high and the data are usually qualitative, not quantitative, so they are not readily amenable to statistical analysis. The subjective nature of responses and the small sample size require careful interpretation of results. This information, gathered through probing respondents in depth, is to be considered an aid to professional judgment and should not be used

to make broad generalizations without further research confirmation using quantitative methods.

Certain disadvantages of in-depth interviews should be considered by program planners. They are expensive because they require skilled interviewers; they also are time consuming. The amount of time and expense involved in recruiting respondents, administering the interviews, and analyzing the results are the most significant factors.

In-depth interviews are an excellent way to develop extensive sequential case histories (such as histories of IUD users) and to examine interrelated components regarding birth control practices. Since the conversation is "private," topics can be discussed that would not ordinarily be discussed in public, and the respondent is not influenced by comments made by others. Because there are no group dynamics, the quality of the conversation tends to be more personal and more related to the unique experiences of the individual respondent.

IV. QUANTITATIVE MARKET RESEARCH METHODS

As noted earlier, quantitative research methods are applied when the CSM program needs an accurate projectable picture of consumer or retailer perceptions. When secondary sources cannot provide this information, particularly in Stage 1 Planning, it may be necessary to implement a quantitative study. Quantitative research is also necessary for assessing in-market effectiveness of marketing strategies during Stage 5.

A. Survey Research

The term "survey" in marketing or public opinion research generally refers to a planned effort to collect data from a statistically representative sample of a specific population. Representative surveys are based on a probability sample, whereby respondents are selected with a known probability. This sampling procedure permits inferences to be drawn concerning the entire population. Probability samples also establish confidence intervals to estimate error variance in the data.

The survey is a flexible method which can be used to provide information about the characteristics, knowledge, attitudes and behavior of the population as a whole, or for specific segments of the population such as women aged 25 to 35. During analysis, the data can be manipulated in many ways so that the researcher can look at intergroup differences and examine the influence of certain variables such as age, income, family size, or education on behavior.

The two most important considerations affecting the amount and quality of the data collected are the availability of time and resources. Since surveys can be designed at almost any level, the planner must first try to gain some notion of the cost and time parameters as they relate to the purpose of the survey (e.g., KAP, benchmark survey, segmentation study). The purposes of surveys can be as diverse as the range of problems which created a need for them. The fundamental aspects of the survey design should be dictated by the study's purpose. A survey can be designed to be carried out on a one-time basis or as a tracking study to show trends over time among the same population or among the same group of individuals.

Most surveys collect the desired data directly from the respondent by three basic methods: personal interviews, telephone interviews, and mail surveys. In some developing countries, telephone surveys of consumer audiences will not be feasible. This method of survey research is included here because it may be useful in certain situations (e.g., for research among physicians or pharmacists) and may be feasible in certain countries.

1. Personal Interviews

Personal interviews are the most common and well known method of gathering data in marketing research. In areas where there are relatively few telephones and where there is a high illiteracy rate, it also may be the only way to conduct a survey. All of the major Contraceptive Prevalence Surveys (CPS) have been conducted through personal interviews. Another application is a survey conducted in Sri Lanka of 200 retailers to determine their attitudes toward family planning and the retailing of various contraceptive

methods (International Planned Parenthood Federation and Population Services International, 1974).

The physical presence of an interviewer during the survey is the characteristic that differentiates the personal survey from the telephone or mail survey. This factor affects the quality and content of the interview.

When an interviewer is present, the market researcher may explore and examine a wide range of topics. The interviewer can go through a straightforward, structured questionnaire or one that is quite complicated. More important, interviewers can use visual or mechanical aids, displays or other props during the interview. The interviewers can demonstrate a product or have the respondent participate by feeling the shape of an object, seeing its actual packaging, and testing its strength.

The mere presence of the interviewer also motivates the respondent to answer and cooperate more fully. This one-on-one personal relationship results in more accurate recording of responses, and results in a higher response rate, both for the overall study and on a per-question basis (i.e., with personal interviews, the interviewer may repeatedly call the home of hard-to-reach respondents to get them to participate). Interviewers read all survey questions to the respondents, so that illiteracy is not a problem. Interviewers can also clarify questions without changing their meaning or influencing the respondent. Responses are more complete because interviewers have been taught when and how to probe for fuller answers.

Another advantage of personal interviews is that, unlike other research methods, interviewers can make observations about the respondent and his or her environment. Observations such as type of neighborhood, general appearance, and overall reactions may be helpful in determining relationships between the respondent's environment and overall attitudes toward the family planning program.

Personal interviews are the best method for obtaining a true probability sample. Residential areas are used for the sampling frame, and are more likely than lists to include everyone in the population being sampled. The lack of dependence on lists (which are used for telephone and mail surveys) also ensures that the sampling frame is current.

Personal interviews are costly, hence, so there is a tendency to obtain as much information as possible once a respondent has agreed to be interviewed. Care should be taken to keep the questionnaire at a reasonable length to avoid respondent fatigue and to maintain respondent willingness to cooperate if he or she is contacted again in the near future. If the interview must be quite lengthy, the interviewer should be instructed to set up an appointment in advance or to use some type of incentive.

Personal interviews are not only costly, they also are time consuming. The interviewer must usually travel to different locations; for example, interviewers see physician in their offices, retailers in their stores, and housewives in their homes. Thus, the number of interviews that can be conducted by an interviewer on any one day is limited. If the survey covers more than one community, additional time is required to train the interviewers in each area.

Another concern with personal interviews is the lack of central control over the interviewing situation. Basically, interviewers go on their own to the interview location. Hence, it is necessary to make sure that interviewers are carefully selected and are responsible, intelligent, dedicated workers. It is important to be sure that they be well-trained, know exactly how to handle all interview situations, and have a thorough understanding of the dynamics of the questionnaire.

Because of costs, more than timing or control, most programs considering survey work determine first if it is at all feasible to use methods other than personal interviews--such as telephone interviews

or mail surveys. In developing countries, however, where labor is not usually expensive, personal interviews may be the best approach.

2. Telephone Interviews

Telephone surveys are used extensively in the U.S. because they are more efficient and economical than personal interviews. There are, however, sampling problems, in that only those individuals who have a telephone may participate. In countries where most households have a telephone, it makes sense to consider this method for surveys where observations and visual aids are not needed, and where the topic is not too "personal." In countries where few households have telephones, this method obviously cannot be used for the general population. The fact that the topic of contraception is too "sensitive" is another consideration against using the telephone.

If the study is designed to assess perceptions and behaviors of groups such as physicians or pharmacists, and these groups have telephones, telephone interviews might be a feasible approach. A list of phone numbers is essential for sampling purposes.

When there is a choice, the advantages of telephone interviewing, compared with personal interviews, are considerable. Telephone interviews:

- o provide data very quickly;
- o can reach wide geographic reach and dispersion;
- o allow closer control of interviewers (by having interviewers call from a central location and by monitoring the calls);
- o allow the same probing and clarification of questions as personal interviews;
- o are much less expensive than personal interviews; and
- o have closer control of sample selection (interviewers have no decisions about the sample selection).

Assuming there is a group that can be interviewed by phone, the easiest sampling method is to use a list of phone numbers and to select each number on an "nth name basis" starting from a random point.

In telephone interviewing, the questions are likely to be close-ended and simpler than those used in personal interviewing. There is usually less emphasis on probing in depth and the questionnaire design is less complex. In general, telephone interviews are considerably shorter than personal interviews. Interviews by phone usually take less than 20 minutes, but can be longer if necessary. If the interview is long, it is standard procedure to set up an appointment to talk with respondents at a convenient time.

Telephone interviewers should be chosen with care. They must, above all, have a clear, understandable, pleasant voice. Interviewers with heavy accents or speech problems should not be used for telephone work.

When the telephone is not the primary survey method, it is often used as a useful adjunct to other studies. The telephone can be used to set up appointments for personal interviews, to validate other studies, or be used as a follow-up method for mail surveys.

3. Mail Surveys

Mail surveys are conducted by mailing self-administered questionnaires to respondents. Occasionally, self-administered questionnaires are delivered in person to a respondent's home or office and completed and mailed in by the respondent at a later time.

A high literacy level among those being sampled is required for mail surveys using self-administered questionnaires. In addition, there must be a reliable delivery system or postal system to ensure that mail will be delivered to prospective respondents.

Since low levels of literacy may be a problem for CSM programs, mail surveys may not be feasible. If the degree of literacy in the general population is too low to work with self-administered questionnaires, mail surveys may be a possible alternative for interviewing certain professional groups such as physicians or pharmacists.

Since the mail survey is self-administered, there is no personal interviewer to ask the questions or to guide the respondent. Thus, the survey design, questionnaire construction, and return rates are different for mail surveys than for telephone or personal surveys.

To conduct a mail survey, there must be a mailing list. Often these lists are incomplete, out-of-date, include only persons who are members of certain organizations, or contain duplicates. Every effort should be made to develop a complete list that includes the entire target population. This will reduce the sampling biases created by an incomplete list.

A self-administered questionnaire should be a reasonable length (no more than 6 pages for consumers) or the respondent may not complete it. Open-ended questions should be used sparingly. Close-ended questions should be used so that the questionnaire is easy to understand and will take little time to answer. Self-addressed, stamped envelopes should be included to stimulate a high rate of return. To increase the response rate, follow-up visits to respondents or additional mailings can be made.

Self-administered questionnaires allow program planners to elicit detailed information from respondents who may not be accessible for personal interviews, such as doctors or community leaders. They also allow respondents to maintain anonymity.

The major advantage of mail surveys is the ability to reach a large number of respondents at a very reasonable cost. If the mail delivery system is adequate, respondents throughout the country may be surveyed.

An example of a successful mail survey is a study conducted among Mithuri (oral contraceptive) users in Sri Lanka (Family Planning Association of Sri Lanka, 1982). This study provides an example of ingenuity in designing and conducting a mail survey. The problem was to obtain information about Mithuri users without going to considerable expense to find these users. Mithuri is only available at non-clinical outlets, hence, there was no way of obtaining names through clinics. A contest for prizes was devised as a means of gathering names and addresses of users. Contest entry coupons were inserted into every packet of orals and this was given publicity in the national press. Retailers were provided a monetary incentive to encourage users to fill out the contest form at the store. This list provided the sampling frame.

A questionnaire (6 pages in length, using closed-ended questions) was then mailed with a cover letter informing respondents that if the questionnaire was correctly and truthfully filled in before a specific due date, they would be eligible for one of three cash prizes. Respondents were told that the study was to improve the marketing of Mithuri and were assured confidentiality. Information was obtained on purchasing habits, user patterns, dealer-consumer relationships, level of consumer satisfaction, type of factor that motivated product use (e.g., physician, husband, advertising, dealer), prevalence of side effects, degree and level of medical consultations, consumer reaction to price increase, and consumer attitudes to the product's advertising in mass media.

Two primary problems with mail surveys are low response rates and the need to recontact respondents to encourage them to return their questionnaires. It is important, therefore, to over-recruit respondents or to offer an incentive to ensure a sufficient number of returns. The Sri Lanka survey of Mithuri users had a very good

response rate (65 percent) which was due in large part to the ingenuity of the incentive offered (i.e., eligibility in a contest).

The mail survey method often takes much longer than personal or telephone interviews because of delays in delivering mail and in receiving responses. In addition, response rates for individual questions on the questionnaire may be low. Even when the questionnaire is pretested and designed in a simple format, there will be respondents who will not understand all questions, who will not answer all of them, or who will not answer them correctly.

A final problem is that respondents who return the questionnaires may be different from those who do not. A certain degree of bias may be introduced and the results should be interpreted with this in mind. To examine respondent representativeness, respondent demographics can be compared with census data for that population group.

B. Survey Sampling

A basic problem in survey design is the size, nature and method of the sample selection. The survey sample should be representative of the relevant universe or population. A planner's first question in considering the sample is whose opinions or behaviors need to be measured. Sometimes the answer is obvious, such as all women of childbearing age. At other times it may not be so simple, as in trying to sample women who stopped using an IUD.

One major consideration is the geographical boundaries of the universe. At one extreme, the survey might be restricted to a single community or village. At the other extreme, the universe might be the entire country. Between these two extremes are many possibilities, such as certain regions of the country.

Shaping this type of decision is the statistical fact that it usually takes as many interviews to achieve a given level of sampling precision in a single community as it does for an entire country. Thus, a sample of 500

interviews in a community will be as representative of that community's population as a national sample of 500 is representative of the entire nation's population of childbearing women. It also follows that if one wants to conduct a survey of five communities and look at each community separately, one is actually conducting separate surveys for each community and the total sample would be five times the size considered for a single community. On the other hand, if one merely wants to pool the data from these cities, one needs only as many interviews to represent the communities in total as to represent a single place.

The planner must also consider the appropriate demographic characteristics of the population as well as geographic boundaries. Depending on the purpose of the survey, one might study only women or both men and women regarding attitudes toward contraception. The age span may be very wide (e.g., 16 to 49 year olds), or quite narrow (e.g., 19 to 25 year olds). Income, education, marital status, or presence of children may be relevant considerations.

The sample may be designed to screen prospective respondents for appropriate characteristics. Obviously, the more narrow the specifications and the more "hidden" the characteristics, the more difficult and more expensive the survey becomes. For instance, screening for women is simple because about half of the population is women and the characteristic is easily recognized; screening for contraceptive use is more difficult because only a small fraction of the population may qualify for the group and the characteristic is not easily observed.

Sampling methods depend on the purpose and budget of the survey and can range in level of complexity. The simplest method is convenience sampling which consists of interviewing the most readily available persons, such as those passing a town square. This method does not generate a probability sample and results should not be generalized to the population.

The quota method is similar to convenience sampling but ensures that an adequate number of several types of respondents are interviewed (e.g., older women as well as younger women). In sampling the general public, the normal practice is to assign interviewers to a particular area and then give them quotas for age, sex and possibly different levels of socio-economic status, based on residential area, education, or income. Quotas may be used to ensure that there is a representative sample of all groups of women of childbearing age, or to examine specific groups such as women with four or more children.

When time and resources permit and when accurate projections to the population are important, the planner should consider some form of probability sampling. Probability sampling refers to the unbiased selection of a sample of people in a statistically random manner, for example, selecting every "nth name" from a complete list starting at a random point. In area probability sampling, and then the individuals or households are selected within those areas. Using this method, every adult living in the community (or every person of childbearing age) would have a known chance of selection for the sample. The characteristics of the sample could accurately be projected to the total population with a known degree of error, depending on sample size. World Fertility Surveys (WFS) and the Contraceptive Prevalance Surveys (CPS) are examples of studies using area probability sampling.

There are several problems associated with area probability sampling. Individuals designated to be interviewed are not always available or cooperative, and interviewers are often reticent to go after selected respondents in certain areas. Efforts to reach these respondents generally take considerable time and money.

For some populations, lists of potential respondents may exist (e.g., physicians, managers of health organizations, or women buying contraceptives from a clinic). Where such lists exist, the planner can have someone apply a probability sampling method directly to the list; the list must include the entire universe of the population to be studied, however.

In Egypt, the Ministry of Health maintains a list of all licensed pharmacies that is updated every six months. This list served as a sampling frame for a personal interview survey of 300 pharmacists (Family of the Future and Porter, Novelli & Associates, November 1982).

Probability sampling methods also can be applied to lists of telephone numbers from a telephone directory or to a list of patients, providing that the list contains all known persons of interest to the sampler. The major disadvantage in working with lists is that they usually do not contain the entire universe of that population; even if they do, the list might not be up-to-date.

C. Steps in Conducting a Survey

While each market research study is unique and all surveys require their own particular emphasis and approach, there is a standard sequence of steps which should be followed in the design of each study. This section reviews these steps, using the stages involved in conducting a Contraceptive Prevalence Survey (CPS) as an example of the procedures that should be followed:

1. Define Study Objectives

The first step in any research project is to define what problems need to be studied. Only when the problems are carefully defined can research be correctly designed to provide pertinent information. Problem definition entails specifying the objectives of the research project. For a CPS, the overall purpose is to develop information to assist in the design and evaluation of family planning programs. The objectives may include:

- o to determine current contraceptive use, knowledge and availability within a specific country; and
- o to compare this information among geographic areas within the country.

2. Design Sample

In designing the sample, the planner must take into consideration the population to be interviewed, the sampling frame, and a

strategy for selecting the sample and determining the sample size. The sampling frame is the list of population elements from which the sample will be drawn. For the CPS, the population under study is all women of childbearing age (15-44). The sampling frame can be households taken from the census listing or a national labor force survey of that country. Deciding on sample size requires that the size be large enough to answer the research questions with the requisite precision and confidence levels needed, within the cost and time constraints of the study.

The number of households sampled in CPS surveys has ranged from 3,000 in Pernambuco state, Brazil, to 20,000 in South Korea. Usually, approximately equal numbers of households are selected in two or three residence strata — urban areas and rural areas of the capital city, other urban areas, and rural areas. For example in Latin America, a sample of about 1,500 households in each stratum was selected. Among these 1,500 households, roughly 1,000 were expected to include at least one woman of childbearing age. In each household, one respondent is then selected from among the eligible women.

3. Develop Questionnaire

While the sample is being designed and selected, the questionnaire is developed, taking into account the survey method used (personal, telephone, mail) and the topics asked. CPS and WFS use a core questionnaire, although some modification may be made to suit a country's need for specific data, to increase the likelihood of getting accurate replies, or to increase the relative ease of processing and analyzing the findings. The questionnaire should be based on earlier qualitative research and other secondary information. (A copy of a model CPS questionnaire may be found in Appendix 2).

4. Pretest Questionnaire

As with CPS studies, the draft questionnaire should be pretested in the field for each country. Pretesting reveals whether the

questions are clear, the order of questions is correct and the answers are easy to enter on the questionnaire. Pretesting also tests the list of precoded responses to ensure that the questionnaire contains all of the most likely answers, a step that will facilitate data processing later on.

5. Collect Data (Field Work)

Data collection, unless for a mail survey, will involve a field force of some type. The use of personnel to collect data involves consideration as to the selection, training, and control of the interviewers who are responsible for completing the questionnaires. Teams of supervisors and interviewers are recruited and trained. Interviewers are usually female, and the training period commonly lasts one or two weeks. Field work (interviewing women in their homes) takes 2 to 3 months, depending on local conditions and sample design.

6. Process Data

When the field work is complete, questionnaires are edited, coded and the data are entered onto computer tape. The data tapes are then checked and corrected, and the data tabulated. Editing is the process by which the data collection forms are reviewed to assure that they are complete, consistent, and that the instructions were followed. Coding is the assignment of numerals to the responses so that the data can be more readily analyzed. Tabulation refers to the classifications and cross-classifications that result from examining the findings. These coding, editing, and tabulation functions are common to all quantitative research surveys.

7. Analyze Data

At this stage, the data are examined and findings are interpreted with regard to their impact on the program. All analyses should be examined in relation to the project's objectives. Statistics, if any, are applied to the data.

8. Write Report

Writing the research report completes the process. The research report is the document submitted to management that summarizes the research results and conclusions. It is imperative that the research report be clear, accurate, and pertinent to the problem. No matter what the proficiency with which all previous steps have been completed, the project will be no more successful than the final written results. This written document later serves as secondary source data for other planners.

Preliminary results of CPS and WFS surveys can be available to family planning program administrators within 4 to 6 months of completion of field work in most cases. This rapid turnaround is possible because the questionnaires are basically rather short and standardized so that coding, editing and analysis can proceed quickly.

V. **SEMI-QUANTITATIVE MARKET RESEARCH METHODS**

The following sections describe market research methods that fall between traditional qualitative and quantitative methods. These include central location intercept interviews, panels and field tests. These methods are qualitative in the sense that they do not use probability samples. They are quantitative in that they typically call for large samples and tabulated data analysis.

A. Central Location Intercept Interviews

Central location intercept interviews involve stationing interviewers at a point frequented by individuals from desired groups and asking them to participate in the study (this is called convenience or quota sampling). Such locations can be pharmacies, clinics, or gathering places like public markets, bazaars, and coffee houses. There are two advantages to this method. First, a high traffic area can yield a number of interviews in a reasonably short time. Second, a central location for hard to reach target audiences can be a cost effective means of gathering data. Any information that can be gathered by personal interviews can be obtained by this method; however, the results are not projectable.

A typical central location interview begins with the intercept. Potential respondents are stopped and asked whether they would be willing to participate. Then, specific screening questions are asked to see whether they fit the criteria of the specific group of respondents being sought. If so, the interviewer then proceeds with the remainder of the study.

Although the respondents intercepted at central locations may not be statistically representative of the entire target population, the sample is larger than those used in focus groups or individual in-depth interviews (i.e., usually 100 interviews or more). Program planners often use the central location technique when assessments of comprehension, attention, believability and other reactions are essential from a fairly large group of respondents. In Egypt, users and non-users of various contraceptive methods were intercepted at ten pharmacies and three clinics. Respondents were asked about their perceptions of the advantages and disadvantages of contraceptive methods, satisfactions and dissatisfactions, usage patterns, purchasing behavior and brand awareness (Family of the Future, and Porter, Novelli and Associates, February 1982).

The central location intercept is a particularly useful method when testing the product, packaging, or pricing during Stage 3 of the marketing process. In an evaluation of the preferred color for an oral contraceptive tablet, Mexican women were interviewed in large public markets frequented by a middle and lower class individuals, the principal target population for PROFAM products (PIACT de Mexico, A.C., February, 1979). In Jamaica, interviews were conducted in Kingston and in two rural areas among 115 women aged 18-29 to determine preferences among five package designs (Dunlop, Corbin, Compton Associates, 1981). Similarly, in Egypt, television announcements promoting vaginal foaming tablets were pretested by intercepting women typical of the target market, exposing them to the announcement, and assessing their recall, comprehension and reactions to the advertisements (Family of the Future, and Porter, Novelli and Associates, May, 1982).

Unlike focus group or in-depth interviews, the questionnaire used in central location intercept interviews is usually highly structured and

contains primarily multiple choice or close-ended questions. (See Appendix 3 for examples of questions that have been administered through central location interviews.) The sample size and nature of the questions often make use of computer data analysis desirable if not necessary. Open-ended questioning, which allows for free flowing answers, should be kept to a minimum because it takes too much time for the interviewers to record responses and later code them for analysis. The questionnaire, as in any type of research, should be pretested before it is used in the field.

Clinic waiting rooms, pharmacies, markets, community centers, government offices or other locations frequented by individuals typical of the sample group can be used for central location intercept interviews. It is advisable to obtain clearances or permission to set up interviewing stations in these locations well in advance.

A major disadvantage of central location intercept interviews is that they are not statistically projectable. The method should not be used if respondents must be interviewed in-depth, if the subject matter is sensitive, or if respondents are likely to resist being intercepted on the spot. Although it is more time-consuming to set up prearranged appointments, this approach may save time in the end if it is too difficult to recruit cooperative respondents through central location intercept interviews.

B. Panels (Consumer and Retail)

Sometimes, it is desirable to measure and analyze changes in the market by studying the behavior of users and retailers over time. Panels are an excellent method of measuring and helping to explain such changes. In a panel, essentially the same individuals serve as respondents over the period of the study. Measures can be taken before and throughout the life of the program.

Individuals selected to serve on the panel may be representative of the general population of childbearing women, of retailers who sell contraceptive devices, or of contraceptive users. Panel members (who are

literate) can be asked to keep continuous records (daily or weekly) of their expenditures, types and brands of contraceptives used, and package size purchased. Or panel members be interviewed in several surveys administered over a period of time.

Consumer panels can be used to examine product use by geographic region, purchasing patterns, satisfactions and dissatisfactions, usage patterns (regular, periodic), experience and response to side effects, etc. More important, panels allow for an analysis of the dynamics of user behavior over time; for example, the number of new contraceptive acceptors, the number of repeat purchasers, and the number who are switching methods or changing from one brand to another.

On a retail level, panels or store audits can be used to measure sales. Like consumer panels, these involve recruiting a sample. Here, it would be a sample of stores or individual store owners who are trained to provide information on product movement within the stores. Store audits provide information on the amount of shelf space allocated, the types, sizes, and brands of contraceptives sold, the price ranges, and any point-of-purchase sales information. This involves taking an initial audit of what is available in the store and periodic audits throughout the test period to track changes in sales.

Usually, respondent cooperation is secured through the same techniques used in other research. Introductory letters, personal contacts with well-trained field personnel, and stipends or incentive fees to induce continuous cooperation may be used.

Panels are subject to several potential problems. The most important is the problem of recruiting a representative sample. Since low income populations are less likely to cooperate than middle class respondents, it may be difficult to obtain a group that is characteristic of the target market for CSM programs. Panels also presuppose a certain level of literacy for any requisite recordkeeping.

Another problem is respondent attrition. Panelists may die, move, change their circumstances (e.g., become pregnant) or stop cooperating with the study; these people must be replaced. In addition, participation in a panel may "condition" some respondents regarding behavior and answers. Panel members may subtly alter their behavior or reporting (often unconsciously) to reflect what they think is the correct or desired response. Care and effort is needed to overcome these difficulties in the design and operation of the panel.

Designing a sample plan for a panel and setting up the panel is a detailed and somewhat costly process. It requires setting up a procedure for obtaining the cooperation of certain respondents to fill out the forms on purchase/sales on a continuing basis, and a procedure for replacing these respondents as time goes on. Because the panel is an ongoing study, respondents initially asked to participate may later prove unwilling or unable to give the requisite time to the project. This operation may require a lengthy field trip to maintain the panel in the areas of both continual respondent recruitment and data collection.

Nevertheless, panels are an excellent method because they record actual behavior (sales/purchases) over time within the natural environment. With regular and frequent measurements of the same individuals (or stores), there is an effort to minimize the sampling error that occurs when different groups of respondents are measured over time. Also, once panel members have been recruited, it is less expensive to interview them on a periodic basis than to continually conduct interviews with new respondents over the same time period.

One variation on the consumer panel that can be used in contraceptive social marketing research is the product placement test. Individuals are recruited to serve on a panel and are given a contraceptive product. When the product is placed, the participating respondent may also be shown various promotional and instructional materials for the contraceptive. After the contraceptive is used for a period of time, the respondent is then contacted and asked about his/her satisfaction with the

product, interest in continued use, comparisons with other contraceptives, and any other relevant questions.

This type of panel allows for an examination of usage in a natural environment among potential purchasers. It is not a truly "natural" purchase, use, reuse situation like the other panels discussed above because the respondent was given the product rather than actually buying it. It can, however, provide very useful information for refining marketing strategies related to new product introduction.

C. Field Tests (Pilot Studies)

A field test is a market research method for gauging how well a CSM program will be received. It consists of placing the entire marketing program within a specific area (e.g., city or region) to see how people will react under actual market conditions. Field tests expose the program to the "real world" before a national launch, while changes in marketing mix elements can still be made.

In designing a field test, one must give careful consideration to the type of variables encountered in different regions such as race, ethnicity and size of area. Two or three selected test market locations usually cannot reflect the different segments of the entire population, and therefore, cannot predict results for the nation as a whole. This does not preclude conducting a field test since the information gained from piloting the program on a small scale basis can only be obtained from such a study.

At least two field test locations are recommended: for instance, one urban and one rural area. Ideally, two comparable markets would be selected as controls. The use of control markets allows the researcher to actually measure the field test results over time as compared with other market results. Obtaining such measurements in both the field test and control markets accounts for any non-field test influences which might affect the variables being measured. Measuring the change in the control markets as against the test markets gives the net change, or "true" results, of the field test. Practically, however, the selection of such control markets may be impossible because of the difficulties of matching comparable markets for comparison.

Before a field test is introduced, benchmark measures of consumer awareness, knowledge and use of contraceptive methods, as well as levels of contraceptive sales in the various outlets (pharmacies, clinics, etc.) should be obtained. These measurements should be gathered continuously throughout the period of the field test. In Sri Lanka, KAP surveys were conducted to provide benchmark data prior to marketing the Preethi condom in a field test (International Planned Parenthood Federation and Population Services International, July, 1974). This field test took into account both test and control areas. Comparisons were made of changes in levels of awareness, usage and knowledge of contraceptive methods. These measurements, along with sales figures, are the only way to determine actual changes in behavior and attitudes as a result of the new program; they are the only way to evaluate how well the program has met its objectives.

Another important consideration in conducting a field test is to ensure that enough control is exercised over the various market functions involved in the field test. If a field test is assessing particular marketing strategies, the plan for implementing this strategy should be followed. Any deviations or adjustments to the plan must be noted as potentially affecting the overall results. For example, if distribution is forced beyond what it would be on a national level, or if the quantity of promotional materials is increased, the field test results will not accurately predict the program's potential impact. Many field tests attempt to translate every anticipated national action as realistically as possible into the test area in an attempt to predict national results.

The field test should last at least a year. It usually takes this long to establish the distribution and promotion channels and to reach the various segments of the public. It also allows time for repeated purchases and seasonal variations that might affect test reactions. In this vein, it is advisable to continue measurements (attitudes, usage and sales) in the field test areas after the test to determine how people are reacting after the program has reached maturity, and the stimulus and newness of the program introduction has disappeared.

The strength of a field test lies in the fact that the entire gestalt of a new program (its service, product, promotions, pricing, etc.) can be tested to see how potential users will react in a normal market environment. It brings together the interactions and interdependence of the various elements in the market mix. Such interrelationships are hard, if not impossible, to discern in a more sterile, experimental situation when only one or two variables (such as packaging, pricing or logos) are examined at any one time. Field tests are the best way to make intelligent inferences about the interactive relationship of all the program elements working together.

The experience, training, and information obtained in a field test will prove to be extremely valuable prior to a full program roll-out. No one can accurately or realistically anticipate all the problems of putting a new program into operation nor see how all the various elements (packaging design, distribution, media, price, etc.) will work together until they are actually put into the field. A field test will prove invaluable in:

- o checking each element in the marketing mix and seeing how they work;
- o discovering and ironing out any "bugs" in the system;
- o training CSM staff in running an entire program;
- o examining how the program staff operates in any particular region or market;
- o measuring real life costs; and
- o indicating what type of social, cultural, and/or other problems may be encountered.

An added advantage of conducting a field test is that the test results can be used to sell program ideas to others. These results can be shown to obtain better cooperation from such groups as physicians and pharmacists, for example. With facts and figures, the planner can prove just how successful a CSM program can be.

The two major disadvantages with field testing a program are the costs and time involved in determining the results before making a final

decision. The costs are considerable and they may turn out to be more on a community basis than they would be for that community when the study is organized on a national basis. It takes time to determine consumer reactions and to analyze the results prior to rolling out the program. Another concern is that in a dynamic world, there will always be certain variables that will change by the time the program moves from a field test to national placement. Hence, field test results may not always be able to predict the results of a national roll-out.

Chapter 3

CONSTRAINTS AND CONSIDERATIONS

The process model for applying market research in contraceptive social marketing, described in the previous chapters, provides a framework for CSM program operation. The model represents an ideal. Most CSM programs do not have the financial or personnel resources to follow each step of the model. Nor do most have the resources to conduct research to guide each marketing decision. In addition to these resource constraints, there are several other problems which must be considered in conducting market research for CSM programs.

A. Lack of Market Research Resources

Lack of financial resources aside, other resources necessary for conducting market research in developing countries are another major constraint confronted by CSM program personnel.

Specifically, many of the basic "tools of the trade" that are taken for granted in Western countries are not available. These include marketing research companies that can assist in recruiting respondents, survey research firms with capabilities for designing a quantitative study and for carrying out a nationwide survey, trained interviewers, and computer facilities for data processing.

Resources for conducting research in developing countries, if they are available at all, tend to be found within universities or social research centers. The orientation of these groups, however, is not necessarily marketing-based. Hence, they may lack expertise or experience in applying market research methods or marketing concepts to the design of consumer research. This lack of expertise presents additional problems, notably that the state-of-the-art in market research in LDCs has not been very well developed. The appropriate wording of questions, efficient techniques for recruiting respondents, extant demographic and lifestyle profiles, and other tools of market research have not been refined or tested for CSM programs to tap or to learn from.

To overcome these constraints, consideration should be given to the following. CSM program managers might seek to identify indigenous organizations that have conducted related social science research studies.

Discussions should be held with these organizations regarding their capabilities and the training of their personnel. U.S. personnel who provide technical assistance to CSM programs can help in assessing capabilities and in determining the feasibility of working with experienced researchers and orienting them toward the needs of CSM market research. Using a team approach--in which anthropologists, psychologists, sociologists, communication/education researchers and marketing professionals, work together--may prove useful in developing appropriate market research methods. It is essential, too, that CSM program personnel also be involved in this process so that their skills and understanding are upgraded.

B. Communication and Cultural Barriers

Several problems related to communication and cultural barriers also may impinge upon applying market research to CSM program decision-making. For example, market research methods, themselves, may breach cultural norms. "Non-directive or "non-reinforcing" interviewing techniques may be alien to researchers in developing countries, but these two techniques are essential for obtaining reliable and valid information that goes beneath the surface. Interviewers may feel compelled to educate and inform respondents throughout an interview, rather than remaining neutral and objective. Respondents may be put off by probing questions. U.S. technical assistants and CSM program managers must consider these issues in the early stages of developing market research studies. Here, too, the team approach to designing research may be invaluable in developing the correct research protocols.

The research questions that market research is concerned with--psychographic profiles, perceived product benefits, attributes, satisfactions/dissatisfactions, purchasing behavior, brand awareness, trial and usage--are endemic to a discipline that has been developed in countries where consumer products in a multitude of categories are abundant. The situation in developing countries is often quite different and the processes of consumer choice and decisionmaking may vary substantially from those of western cultures. To that extent, it is essential that CSM programs spend time and effort in learning how the process of the marketing exchange can best be studied in developing countries. Exploratory research

and pilot studies, prior to full scale launch of major research projects, are needed to ensure that the questions asked will provide valid indicators of consumer wants, needs and perceptions.

A related communication problem is that of question wording. In the U.S., there are standard questions to assess brand and communication awareness, perceptions of product benefits and attributes, etc. These questions have been refined and tested in countless studies by market researchers to obtain accurate measures of consumer response. CSM program managers often do not have an advanced state-of-the-art to draw upon. In addition, CSM programs face potential problems in asking respondents questions about issues that may be quite sensitive and private.

Simply translating questions used by American market researchers and applying them to CSM programs often may not be effective. Much still needs to be learned in how to word questions so that respondents fully understand their intent, so that they are not offended, and so that they do not simply provide socially acceptable responses. Social anthropologists again may be very helpful in this regard. Their understanding of cultural norms and values can provide direction for designing questionnaires that will avoid the forementioned problems.

C. Integrating Market Research into the CSM Organization

While there appears to have been an increased use of market research by CSM programs in recent years, these efforts generally have not been part of an integrated, decision-oriented marketing program. Many studies have been conceived as "one-shot" efforts, lacking follow-up research to track changes overtime, or to monitor progress for making midcourse corrections.

Just as research studies have been seen as isolated events, research managers have not been integrated into the CSM organizations. Many programs have relied on outside sources for research services to conduct baseline knowledge, attitudes and practices studies or other evaluation research. As a result, internal capabilities are not developed to respond to marketing decisionmaking needs.

In some cases, CSM program research staff members may not necessarily be integrated into the organization. For example, a link is not made between those staff members responsible for consumer research and those responsible for the management information system. Yet, these two staff units can be most useful to CSM managers when they share intelligence to explain current trends or to forecast future needs.

Development of the annual marketing plan is an excellent opportunity to integrate market research into program operations. For example, the research staff, working with other CSM program units, should be responsible for the analysis required in Stage 1 of the marketing process. This analysis indicates which elements within the marketing mix will require additional information for setting strategies and evaluating past efforts. Further, as CSM program managers lay out plans for Stage 3--Development, Testing and Refining Program Elements--the research unit will need to interface with communication, distribution, sales and other staff members to begin designing the necessary market research. Assessments of in-market effectiveness also will require close cooperation between research and the other CSM program units to determine the key measures for evaluating program effect. Finally, providing the feedback required for replanning in Stage 6 is essentially the function of the research group. It is this group that must analyze, synthesize and interpret the market research data gathered throughout the six-staged process to provide CSM managers with direction for replanning.

Chapter 4

CONCLUSIONS AND RECOMMENDATIONS

With limited time, personnel and budgetary resources often the norm for contraceptive social marketing programs, conducting market research at each stage in the marketing process is unfeasible. Several guidelines may be helpful in allocating limited resources for marketing research. Priority should be given to the following:

1. Research that will fill serious information gaps--It is frequently the case that secondary data already available address issues or problems at hand. In these instances, it may be wiser first to expend resources on analyzing existing data rather than initiating primary research.
2. Research that is most likely to be applied for marketing decision-making--If the chances are slim that marketing mix elements will be revised or refined based on research, because of time, budget or other constraints, the research should not be undertaken. Research resources should be directed toward program areas that will benefit most from the data that are gathered.
3. Research that will reduce the risk or uncertainty associated with making major program changes--When CSM programs are considering major changes in marketing strategies, particularly if such changes represent a dramatic departure from previous activities, it is recommended that research be conducted to assess potential response. Examples include new product introductions, price changes, changes in product packaging or labeling, launching a new advertising campaign, etc.
4. Research that provides essential, periodic indicators of market response to on-going program activities--CSM programs must periodically assess the extent to which goals and objectives are being met. Tracking and monitoring consumer and retailer response at regular, periodic intervals are essential for identifying program areas that need adjustment.

In addition to these guidelines for allocating resources to market research, program managers should consider the following. Conducting some research

usually is better than none at all. This research should be formulated with a clear statement of objectives and an understanding of what actions may be taken based on the research. Conducting research to prove a preconceived viewpoint or merely as a "fishing expedition" is a waste of program resources. Small scale, qualitative research can serve as an aid in judgment and often can stimulate innovative thinking. It must, however, be used and interpreted with caution.

The function of market research in CSM programs must always be kept in perspective. Research is intended to be an aid to managers in making program decisions. Research findings must be considered along with other information, previous experience and professional judgment. In many marketing organizations, managers fear "a bad report card" or become slaves to the "number crunchers." Neither of these situations is productive for the marketing organization. It is best to utilize available research resources for taking remedial action, avoiding unnecessary risks, and planning future activities.

One final point. Applying the marketing process model to CSM programs requires a professional and efficient management organization. The marketing effort is complex, and managers must integrate and coordinate many elements simultaneously for sound program operation. At any given point in time, there are actually several marketing processes in motion. Condoms may be a mature product in the product line and at the assessment stage. Oral contraceptives may be in the planning stages of new product introduction. IUDs may be at the pilot stage. CSM program managers must continuously move these products along through the various stages of the marketing process without losing opportunities for success and yet reducing the risk of failure. It is hoped that the model for applying market research in contraceptive social marketing, discussed in this paper, will assist CSM managers in meeting the challenge.

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Population Reports

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Public Health Reports

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Public Relations Journal

Published by the Public Relations Society of America, New York, N.Y.

Studies in Family Planning

Published by the Population Council, New York, N.Y.

APPENDIX 1.
SAMPLE COMMUNICATION STRATEGY FOR CONDOMS

Reprinted from: Family of the Future, and Porter, Novelli & Associates. "Media Plan, FY 1982-1983," Unpublished Paper, Cairo, Arab Republic of Egypt, March 1982.

IV Communication Strategies

A. Communication Objectives

1. To increase awareness of FOF brands among couples of child-bearing age;
2. To dispel misconceptions and mistaken beliefs regarding the safety and effectiveness of FOF brands;
3. To improve public attitudes and perceptions of FOF family planning methods and brands;
4. To teach consumers correct and proper usage of FOF brands;
5. To reinforce the behavior of individuals who are already practicing family planning and to encourage their continued usage of FOF products.

These objectives will need to be quantified when accurate and reliable baseline data are in hand.

B. Target Audiences

1. Primary Target Audience.. General Public

The primary target audiences for FOF communications is married men and women of reproductive age, especially young newly married couples and couples who have only two children. More specifically, the target audience can be defined as those who are disposed toward practicing family planning and are ready to try modern methods of contraception.

2. Tops Condoms .. Target Audiences

- a) Men whose wives have tried several female contraceptive methods but have been unsuccessful either because of side effects or other dissatisfactions;
- b) Men who are currently using other condom brands;
- c) Men who are currently using TOPS and need reinforcement to continue use.

3. Golden Tops .. Target Audiences

- a) Men who are currently using TOPS or another brand of condom and are willing to try a new condom of familiar brand;
- b) Men who are currently using other condom brands;

- c) Men whose wives have tried several female contraceptive methods but have been unsuccessful either because of side effects or other dissatisfactions.

4. Secondary Target Audiences.. General Public

- a) Spouses of individuals identified as primary target audiences.
- b) Influentials.. individuals in the public, voluntary and religious sectors who monitor the FOF programs; communications must be designed to build their support for family planning and to avoid offending these groups.

5. Primary Target Audiences .. Health Professionals

- a) Obstetricians and Gynecologists who recommend family planning, prescribe oral pills and insert IUDs.
- b) General practitioners who recommend family planning, prescribe oral pills and insert IUDs.
- c) Pharmacists who carry any or all of FOF's products.

6. Secondary Target Audiences .. Health Professionals

- a) Nurses who work in physicians private offices.
- b) Nurses who work in public clinics.

C. Messages

1. Communicating the Benefits of FOF Brands

The following product benefits must be placed in messages that position FOF brands as quality products, products that are different from brands distributed through government clinics, and products that can be counted upon for their effectiveness and safety:

a. TOPS

- 1) Condoms are a "natural" barrier method and do not cause side effects or risks to health in either the man or the woman.
- 2) TOPS are inexpensive but are of high quality, they are strong, thin, lubricated and provide a proper fit.

92

- 3) Condoms are a socially accepted method. Millions of people around the world use condoms and have used them for many years. Consumers need not feel embarrassed to ask their pharmacists for TOPS.
- 4) Couples may wish to begin practicing family planning with the barrier methods. They are the simplest and have the least potential for side effects.
- 5) Individuals who practice family planning are contributing to Egypt's future and should be recognized as such.

b. GOLDEN TOPS

- 1) Condoms are a "natural" barrier method and do not cause side effects or risks to the man or the woman.
- 2) Golden TOPS are the quality condom. They are strong, thin, lubricated and provide a proper fit.
- 3) Condoms are a socially accepted method of contraception.
- 4) Couples may wish to begin practicing family planning with the barrier methods. They are the simplest and have the least potential for side effects.
- 5) Individuals who practice family planning are contributing to Egypt's future and should be recognized as such.

2. Educating and Instructing Consumers Regarding Proper and Regular Usage

Efforts to educate and instruct target audiences regarding correct and regular usage of FOF brands will be critical to continued usage. This is especially important for Amaan. Instructions must be explicit and easily understood.

3. Encouraging Trial of FOF Brands

With increasing awareness and improved knowledge about FOF brands, the challenge will lie in motivating target audiences to action. Several appeals may have potential for achieving Program objectives.

4. Reinforcing Continued Usage

Hundreds of thousands of Egyptians are already practicing family planning. It is important to reinforce their behavior and recognize them as role models for "Families of the Future." These individuals should be encouraged to seek help or guidance should they experience any problems with the methods they currently use. Also, they should be instructed in what is the most appropriate way to resume contraceptive method use following the birth of a child.

5. Communicating to Health Professionals

Little communications research exists which describes Egyptian health professionals' attitudes toward family planning. Until this research can be conducted FOF should use the following guidelines in messages directed at health professionals.

a. Benefits of Family Planning

- Physicians and pharmacists and nurses should be encouraged to tell their patients about the benefits of family planning:
1. Couples who practice family planning will live a more prosperous life than those who do not.
 2. Family planning is in the best interest of Egypt and couples who practice family planning are contributing to a better future for Egypt and should be recognized for it.
 3. Many methods of contraception are available to meet the diverse needs and dispositions of patients.
 4. Side effects of any method of contraception can be dealt with by changing methods, brands, or living through the initial period of adjustment.

b. Physicians' and Pharmacists' Roles in Family Planning Counseling

Identifying the best methods of family planning may require trying out several products. Each FOF brand has its own set of advantages and disadvantages which couples need to consider before setting on their particular method of choice. FOF's ethical detailing should emphasize the pharmacists and physicians role in assisting consumers in their decision-making. Physicians and pharamcists should be encouraged to explain the proper way to use each contraceptive. Because side effects can occur with several types of contraceptives, physicians should take time to explain to patients what side effects they may experience, how to treat or live with the side effects, and when it may be wise to switch brands or methods.

c. Benefits of FOF Methods

Physicians and pharmacists are in the position of recommending contraceptives and methods of contraception to their patients.

To do so, these health professionals must believe the product is worthwhile, must benefit financially from patient use of the contraceptive and must purchase contraceptives from FOF. The following information should be included in materials FOF provides to physicians and pharmacists about FOF brands.

1) TOPS

- a. Condoms are an effective method for preventing pregnancy when used properly.
- b. Condoms should be used each time a couple has intercourse.
- c. Tops are strong, lubricated, and fit the Egyptians male properly (52 mm).
- d. Condoms should be recommended for use by males with communicable skin disorders.
- e. Patients using condoms should encourage their wives to use Amaan foaming tablets at the same time to decrease the chance of pregnancy.
- f. Instructions for use:

2) Golden Tops

- a. Condoms are an effective method for preventing pregnancy when used properly.
- b. Condoms should be used each time a couple and intercourse.
- c. Tops are strong, lubricated and fit the Egyptian male properly (52 mm).
- d. Condoms should be recommended for use by males with communicable skin disorders.
- e. Golden Tops are a new version of the popular condom Tops.
- f. Instructions for use:

APPENDIX 2.
CONTRACEPTIVE PREVALENCE SURVEY—MODEL QUESTIONNAIRE

Reprinted from: Westinghouse Health Systems. "Contraceptive Prevalence Survey: Model Questionnaire," Columbia, MD: Westinghouse Health Systems, no date.

SECTION I. BACKGROUND CHARACTERISTICS

101. It is important in this study to know your exact age. How old were you on your last birthday?

AGE _____

102. In what month and year were you born?

MONTH _____ 19 _____

AFTER EXAMINING THE RESPONSES IN 101 AND 102 CAREFULLY AND PROBING AS NEEDED, ENTER THE RESPONDENT'S AGE BELOW. ESTIMATE THE RESPONDENT'S AGE IF IT CANNOT BE DETERMINED BY PROBING.

AGE _____

103.

CIRCLE THE APPROPRIATE CODE FOR THE ACTION YOU TOOK IN DETERMINING THE RESPONDENT'S AGE.

- 1 Questions 101 and 102 both answered. Verified responses were consistent.
- 2 Questions 101 and 102 both answered. Responses were not consistent and age determined by probing.
- 3 One or both age questions were not answered initially. Age determined by probing.
- 4 No age response given. Age estimated because it could not be determined by probing.

IF RESPONDENT IS UNDER 15 OR OVER 49 YEARS TERMINATE INTERVIEW. THANK RESPONDENT FOR HER TIME AND FOLLOW INSTRUCTIONS FOR SELECTING THE NEXT RESPONDENT.

104. Have you ever attended school?

- 1 Yes
- 2 No — (SKIP TO 106)

105. What is the highest grade you passed at school or college?

CIRCLE LEVEL AND GRADE.

LEVEL	GRADE								
1 Elementary	0	1	2	3	4	5	6	7	8
2 Secondary		1	2	3	4				
3 College		1	2	3	4	5	6		

106. Now I would like to talk with you about your occupation. Aside from doing their housework many women have jobs for which they receive payment in cash or kind.

Since _____ or _____

Date

Event

did you do any work for which you received payment either in cash or kind?

- 1 Yes
- 2 No

SECTION II. FERTILITY

201. Now I would like to ask some questions about childbearing. When did you have your last menstrual period?

- 1 Less than 1 month ago—(SKIP TO 203)
- 2 One month to less than 2 months ago
- 3 Two to 9 months ago
- 4 More than 9 months ago

202. Are you pregnant now?

- 1 Yes—(SKIP TO 204)
- 2 No
- 8 Not sure/does not know

203. Have you ever been pregnant?

- 1 Yes
- 2 No—(SKIP TO 211)

204. Have you ever had a live birth?

- 1 Yes
- 2 No—(SKIP TO 210)

205. How many live births have you had? Please be sure you include all the children you have given birth to, even if some lived only a short time.

NUMBER _____

206. When did you have your last live birth? Please give me the date.

MONTH _____ 19 _____

IF DATE NOT GIVEN, PROBE:

How long ago was your last live birth?

YEARS _____ MONTHS _____

IF THE LAST LIVE BIRTH OCCURRED WITHIN THE PAST THREE YEARS (SINCE _____ 19 _____), GO TO 207. OTHERWISE SKIP TO 208. (month)

207. Are you currently breastfeeding that child?

- 1 Yes
- 2 No
- 3 Child is not living

208. How many of your children are living now?

NUMBER _____

PROBE: Have you included children living away from home?

- 1 Yes
- 2 No —(CORRECT 208)

IF THE RESPONDENT HAS NO LIVING CHILDREN, ENTER 00 (ZERO) FOR 208 AND SKIP TO 210. OTHERWISE GO TO 209.

209. How many are boys and how many are girls?

BOYS _____

GIRLS _____

SUM THE NUMBER OF BOYS AND GIRLS AND MAKE SURE THAT IT AGREES WITH THE TOTAL NUMBER OF LIVING CHILDREN IN 208.

210. Do you want to have children in the future (in addition to the one you are expecting)?

- 1 Yes —(SKIP TO 212)
- 2 No
- 8 Not sure/does not know } —(SKIP TO 214)

211. Do you want to have children in the future?

- 1 Yes
- 2 No
- 8 Not sure/does not know } —(SKIP TO SECTION III, PAGE 7)

212. How many (more) children do you want to have in the future?

NUMBER _____

213. If it were entirely up to you, when would you prefer to have your next (first) child?

- 1 Within one year (seeking pregnancy now)
- 2 After 1 but before 2 years
- 3 After 2 years
- 4 Whenever it happens/when God wants
- 5 Other _____
(Specify)
- 8 Not sure/does not know

SKIP TO SECTION III ON PAGE 7.

214. Before you became pregnant the last time, did you want to have more children?

- 1 Yes—(SKIP TO SECTION III, PAGE 7)
- 2 No
- 8 Not sure/does not know

215. If you could have had exactly the number of children you wanted, how many would you have had?

--	--

NUMBER _____

IF RESPONDENT DOES NOT KNOW ANY METHOD (NO "YES" CODES CIRCLED IN COLUMN A or B), CIRCLE 90 IN COLUMN D AND SKIP TO SECTION V ON PAGE 18

304.

FOR EACH METHOD CIRCLED "YES" IN COLUMN A OR COLUMN B ASK:

Have you (*has your spouse) ever used _____ ?
(Method)

CIRCLE RESPONSE IN COLUMN C

305. Are you or your spouse currently using some family planning method or doing something to avoid a pregnancy?

- 1 Yes—(SKIP TO 307)
- 2 No

306. Have you or your spouse used any method in the last month?

- 1 Yes
- 2 No (CIRCLE CODE 90 (NOT USING) IN COLUMN D AND SKIP TO 315)

307. What is (was) that method?

IF THE RESPONSE IS ABORTION, CHANGE THE CODE IN 306 TO "2" (NO) AND FOLLOW THE INSTRUCTIONS GIVEN THERE. OTHERWISE, WRITE THE NAME OF THE METHOD BELOW AND CIRCLE THE METHOD CODE IN COLUMN D .

METHOD _____

IF METHOD 06 OR 07 IS CIRCLED IN COLUMN D OF TABLE I ABOVE, SKIP TO 312; OTHERWISE GO TO 308.

308. If it were entirely up to you, what would you prefer to use now—your present method or some other method?

- 1 Present method
 - 2 No method
 - 3 Some other method
- } —(SKIP TO 311)

95

309. What method would you rather use?

- 01 Pill
 - 02 Condom
 - 03 Vaginal Methods
 - 04 Injection
 - 05 I.U.D.
 - 06 Female Sterilization
 - 07 Male Sterilization
 - 08 Abortion
 - 09 Rhythm
 - 10 Withdrawal
 - 11 Other _____
(Specify)
 - 12 None
 - 98 Not sure/does not know ..
- }—(SKIP TO 311)

310. Why are you not using that method now?

311. Now I have a few questions about the family planning method you are using at this time. Since you started using your present method, have you ever stopped using it for more than one month?

- 1 Yes PROBE: Why? _____

- 2 No
- 8 Not sure/does not know

312. How long have you been using your present method (without interruption this time)?

YEARS _____ MONTHS _____

313. Have you had any problems or difficulties with your present method?

- 1 Yes
- 2 No—(SKIP TO SECTION IV, PAGE 12)

314. What problems did you have?

SKIP TO SECTION IV ON PAGE 12.

315. LOOK AT 202 AND MARK THE APPROPRIATE CODE BELOW. THEN FOLLOW THE SKIP INSTRUCTIONS.

- 1 Code 1 (Yes) is circled in 202—(SKIP TO 318)
- 2 Code 1 (Yes) is NOT circled in 202

316. What is the main reason that you are not using any family planning method to avoid or postpone a pregnancy?

317. Any other reasons?

318. If you were to use a family planning method someday, what method would you choose initially?

- 01 Pill
- 02 Condom
- 03 Vaginal Methods
- 04 Injection
- 05 I.U.D.
- 06 Female Sterilization
- 07 Male Sterilization
- 08 Abortion
- 09 Rhythm
- 10 Withdrawal
- 11 Other
- 12 None/would not use—(SKIP TO 321)
- 98 Not sure/does not know

--	--

--	--

319. In general would it be most convenient for you to get family planning services in the morning, afternoon or evening?

- 1 Morning
- 2 Afternoon
- 3 Evening
- 4 No preference
- 8 Not sure/does not know

320. What day of the week would be most convenient for you to get family planning services?

- 01 Monday
- 02 Tuesday
- 03 Wednesday
- 04 Thursday
- 05 Friday
- 06 Saturday
- 07 Sunday
- 08 No preference
- 98 Not sure/does not know

321. In general do you approve or disapprove of a couple using family planning?

- 1 Approve
- 2 Disapprove
- 3 It depends
- 8 Not sure/does not know

SECTION IV. AVAILABILITY

401.

CIRCLE BELOW THE METHOD CODE MARKED IN COLUMN OF TABLE I ON PAGE 7. THEN FOLLOW THE SKIP INSTRUCTIONS.

- 01 Pill
- 02 Condom
- 03 Vaginal Methods
- 04 Injection
- 05 I.U.D.
- 06 Female Sterilization } —(SKIP TO 403)
- 07 Male Sterilization }
- 09 Rhythm
- 10 Withdrawal
- 11 Other } —(SKIP TO 420)
- 90 Not using }

402. Who usually obtains the method that you are currently using?

- 1 Respondent
- 2 Spouse
- 3 Other _____
(Specify)

403. Now I would like to ask you some questions about the source of your method. From where do (did) you (your spouse) obtain your method?

- 1 First Source
- 2 Second Source
- 3 Third Source
- 4 Fourth Source
- 5 Home Delivery—(SKIP TO 414)
- 6 Other _____
(Specify)
- 8 Not sure/does not know—(SKIP TO 420)

404. How much time does it take to get from your home to this place?

HOURS _____ MINUTES _____
998 Not sure/does not know

405. Would you (your spouse) walk or use some means of transportation to get there?

- 1 Walk
- 2 Use transportation
- 8 Not sure/does not know

406. Is it difficult or easy to get there?

- 1 Difficult/sometimes difficult
- 2 Easy } —(SKIP TO 408)
- 8 Not sure/does not know . . }

407. Why is it difficult?

--	--

408. Do you think there is any reason why someone interested in family planning would not want to obtain services at this place?

- 1 Yes
- 2 No
- 8 Not sure/does not know ... } —(SKIP TO 410)

409. What reasons would they have?

--	--

410.

CIRCLE BELOW THE CODE MARKED IN COLUMN ON TABLE I ON PAGE 7. THEN FOLLOW THE SKIP INSTRUCTIONS.

--	--

- 01 Pill
 - 02 Condom
 - 03 Vaginal Methods
 - 04 Injection
 - 05 I.U.D.—(SKIP TO 420)
 - 06 Female Sterilization
 - 07 Male Sterilization
- } —(SKIP TO SECTION V, PAGE 18)

411. If it were up to you, would you prefer to go to obtain your family planning method in the morning, afternoon or evening?

- 1 Morning
- 2 Afternoon
- 3 Evening
- 4 No preference
- 8 Not sure/does not know

412. On what day of the week would you prefer to go to obtain your method?

- 01 Monday
- 02 Tuesday
- 03 Wednesday
- 04 Thursday
- 05 Friday
- 06 Saturday
- 07 Sunday
- 08 No preference/any day
- 98 Not sure/does not know

--	--

413. Is the source for your method open at the time you consider most convenient for you?
- 1 Yes
 - 2 No
 - 8 Not sure/does not know

SKIP TO 418.

414. If it were up to you, when would you prefer (the home delivery agent) to visit you—in the morning, afternoon, or evening?
- 1 Morning
 - 2 Afternoon
 - 3 Evening
 - 4 No preference
 - 8 Not sure/does not know

415. On what day of the week would you prefer her to visit?
- 01 Monday
 - 02 Tuesday
 - 03 Wednesday
 - 04 Thursday
 - 05 Friday
 - 06 Saturday
 - 07 Sunday
 - 08 No preference/any day
 - 98 Not sure/does not know

416. Do you think there is any reason why someone interested in family planning would not want to obtain services from the home delivery agent?
- 1 Yes
 - 2 No
 - 8 Not sure/does not know
- } —(SKIP TO 418)

417. What reasons would they have?
-

418. Have you always been able to get your method from this place (home delivery agent)?
- 1 Yes—(SKIP TO 420)
 - 2 No
 - 8 Not sure/does not know—(SKIP TO 420)

419. What did you do when you couldn't obtain your method there (from the home delivery agent)?
- 1 Obtained method from another source
 - 2 Used another method
 - 3 Did not use family planning
 - 4 Other _____

420.

CROSS OUT (X) THE METHOD CODE IN THE FIRST COLUMN OF TABLE II BELOW:

1. IF A CODE 3 IS CIRCLED FOR THAT METHOD IN COLUMN **[b]** OF TABLE I (SEE PAGE 7).
2. IF THE CODE FOR THAT METHOD IS CIRCLED IN COLUMN **[d]** OF TABLE I.

IF ALL METHODS ARE CROSSED OUT, GO TO SECTION V ON PAGE 18.

Now we are going to ask you some questions about sources for family planning.

FOR EACH METHOD NOT CROSSED OUT ASK:

From where would you obtain _____ ?
(Method)

CIRCLE THE RESPONSE IN TABLE II.

TABLE II						
Method	First Source	Second Source	Third Source	Fourth Source	Home Delivery	Don't Know
01 Pill	1	2	3	4	5	8
02 Condom	1	2	3	4	5	8
03 Vaginal Methods	1	2	3	4	5	8
04 Injection	1	2	3	4	5	8
05 I.U.D.	1	2	3	4	5	8
06 Fem. Sterilization	1	2	3	4	5	8
07 Male Sterilization	1	2	3	4	5	8
08 Abortion	1	2	3	4	5	8

IF NO SOURCE IS CIRCLED GO TO SECTION V ON PAGE 18.

CIRCLE AT THE TOP OF TABLE III (►) EACH SOURCE MENTIONED IN TABLE II.

LOOK AT 403. CROSS OUT (X) IN TABLE III (▶) THE SOURCE MARKED IN 403.

IF NO OTHER SOURCE IS CIRCLED IN TABLE III, GO TO SECTION V ON PAGE 18.

ASK 421-427 FOR EACH SOURCE CIRCLED BUT NOT CROSSED OUT AT THE TOP OF TABLE III (▶).

TABLE III

▶	First Source	Second Source	Third Source	Fourth Source	Home Delivery Agent
	01	02	03	04	05
421. You mentioned _____ (Source) How long would it take to get there? (WRITE HOURS OR MINUTES.)	Hours____ Mins____ 998 NS	Hours____ Mins____ 998 NS	Hours____ Mins____ 998 NS	Hours____ Mins____ 998 NS	GOTO PAGE 17
422. Would you walk there or use a means of transportation? 1 Walk 2 Use transportation 8 Not sure/does not know	1 2 8	1 2 8	1 2 8	1 2 8	
423. Is it difficult or easy to get there? 1 Difficult/sometimes difficult 2 Easy } —*(SKIP TO 425) 8 Not sure/does not know	1 2* 8*	1 2* 8*	1 2* 8*	1 2* 8*	
424. Why is it difficult? _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	
425. Do you think that there is any reason why someone interested in family planning would not want to obtain services at this source? 1 Yes 2 No } —*(SKIP TO 427) 8 Not sure/does not know	1 2* 8*	1 2* 8*	1 2* 8*	1 2* 8*	
426. What reasons would they have? _____ _____	_____ _____	_____ _____	_____ _____	_____ _____	
427. Have you ever obtained family planning information or services there? 1 Yes 2 No	1 2	1 2	1 2	1 2	

GO TO 421 FOR NEXT SOURCE. AFTER LAST SOURCE GO TO PAGE 17.

<input type="checkbox"/>							
<input type="checkbox"/>							

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

IF CODE 5 (HOME DELIVERY AGENT) IS CIRCLED BUT NOT
CROSSED OUT IN TABLE III, GO TO 428. OTHERWISE SKIP TO
SECTION V ON PAGE 18.

428. Now I would like to ask some questions about (the home delivery agent). Has she ever visited you?

- 1 Yes
- 2 No—(SKIP TO 430)

429. Has she visited you in the past three months?

- 1 Yes
- 2 No
- 8 Not sure/does not know

430. If it were up to you, would you prefer (the home delivery agent) to visit you in the morning, afternoon or evening?

- 1 Morning
- 2 Afternoon
- 3 Evening
- 4 No preference
- 8 Not sure/does not know

431. On what day of the week do you prefer her to visit?

- 01 Monday
- 02 Tuesday
- 03 Wednesday
- 04 Thursday
- 05 Friday
- 06 Saturday
- 07 Sunday
- 08 No preference/any day
- 98 Not sure/does not know

432. Do you think there is any reason why someone interested in family planning would not want to obtain services from the home delivery agent?

- 1 Yes
 - 2 No
 - 8 Not sure/does not know
- } —(SKIP TO SECTION V, PAGE 18)

433. What reasons would they have?

SECTION V. MARITAL STATUS

501. What is your marital status? Are you currently married, divorced, separated, widowed, or single?

- 1 Married
 - 2 Living or visiting relationship
 - 3 Divorced
 - 4 Separated
 - 5 Widowed
 - 6 Single
- } —(SKIP TO 504)
- } —(SKIP TO 503)

502. Have you ever been in a conjugal union?

- 1 Yes
- 2 No—(TERMINATE INTERVIEW)

503. At present, do you have a conjugal life or are you living with a man?

- 1 Yes
- 2 No—(SKIP TO 509)

504. As far as you know, is it physically possible for you and your spouse to have a child in the future if you want to have one?

- 1 Yes
- 2 No—(SKIP TO 506)

505. Now I would like to ask you some questions about your spouse. Do you think that he wants to have more children in the future?

- 1 Yes
- 2 No

506. Do you think your spouse approves or disapproves of family planning?

- 1 Approves
- 2 Disapproves
- 3 Says it depends
- 4 Does not care/has no opinion
- 8 Not sure/does not know

507. Did your spouse ever attend school?

- 1 Yes
 - 2 No
 - 8 Not sure/does not know
- } —(SKIP TO 509)

105

508. What was the highest grade he passed at school or college?

CIRCLE LEVEL AND GRADE.

LEVEL	GRADE
1 Elementary	0 1 2 3 4 5 6 7 8
2 Secondary	1 2 3 4
3 College	1 2 3 4 5 6
98 Not sure/does not know	

--	--

509. Now think back to the time when you first entered into a conjugal union. Please give me the date you began your union.

MONTH _____ 19 _____

--	--	--	--

IF NECESSARY PROBE: How old were you when you first entered a conjugal union?

AGE _____

--	--

THANK THE RESPONDENT AND TERMINATE THE INTERVIEW.

APPENDIX 3.

SAMPLE QUESTIONNAIRES FOR TESTING:

Product Usage and Satisfaction

Brand Awareness, Usage and Purchasing Behavior

Packaging

Pricing

Advertising Awareness

Logo Designs

Product Names

Reprinted from: Family of the Future, and Porter, Novelli & Associates. "Final Report, Pharmacy-Intercept Study," Unpublished Paper, Cairo, Arab Republic of Egypt, February 1982.

FINAL

[Contains Computer Formats]

[Serial No.]
 Col. 1-3 Respondent No. _____
 Col. 5 Pharmacy No. _____
 Interviewer Name/No. _____
 Date of Interview ____/____/____
 Col. 4 Type of Respondent _____
 Col. 6 Card code [1 or 2] _____

CONDOM QUESTIONNAIRE

Hello. My name is _____.
 As the pharmacist told you, I am taking a scientific survey. It is about family life, and especially family planning. I am interested in talking to certain men age 18 to 45 and getting their opinions on several issues related to this subject. We are interested in your opinion and everything you say will be kept strictly confidential.

1. Can you please tell me, first, are you and your wife now using, or have you used, any method to avoid pregnancy in the last month?

Yes1 GO TO QUESTION 2
 No2 TERMINATE AND TALLY

TOTAL PRACTICING	NOT PRACTICING	TOTAL
	.	

2. What method is that?

Condoms.....1 GO TO QUESTION 3
 Methods other than condoms.....2 TERMINATE AND TALLY

TOTAL	Not Using Condoms	Using Condoms	TOTAL

Col. 7 3. Can you please tell me the (brand) name of the condom you are now using or have ever used?

DO NOT READ

TOPS1
 Other2
 Cannot name3 PROBE PACKAGE OR CONDOM COLOR AND CATEGORIZE AS TOPS OR OTHER

TOPS USERS	OTHER BRAND USERS

PRODUCT USAGE AND SATISFACTION

Col. 8, 9,10 4. What methods of family planning have you and your wife ever used?

Pill1
 IUD2
 Tablet3
 Rhythm4
 Other5
 No other method6

Col. 11, 12 5. You said that you are currently using the condom for family planning. How long have you been using it?

Number of months _____
 Number of years _____

102

6. During this period of time, have you used the condom regularly as the primary method of family planning or have you used it intermittently along with another method?

Col. 13 Regularly1
Intermittently2

7. Have you and your wife used any other method with the condom?

Col. 14 Yes1 ASK QUESTION 8
No2

8. What family planning methods have you and your wife used with the condom?

Col. 15, Pill1
16, 17 IUD2
Tablet3
Rhythm4
Diaphragm5
Other6
Does not apply0

10. What advantages, if any, does the condom have over other methods of family planning?

Col. 18, Easy to use1
19, 20 No side effects for me or my wife2
It's a more "natural" method3
It's inexpensive4
Makes intercourse last longer5
Other6
No advantages7

DO NOT
READ

11. What, if anything, do you dislike about the condom?

Col. 21, Decreases the man's sensitivity1
22, 23 It's difficult to use2
It can break3
It's not reliable4
Other5
No dislikes6

DO NOT
READ

12. Thinking about condoms, there are certain qualities which are important to some men and other qualities which are not so important. I'm going to read you a list of qualities or characteristics men have told us they look for in condoms. Some may be very important to you and others less important. As I read each one, please tell me if it is very important, somewhat important, or not important to you.

Col. #		Very Important	Somewhat Important	Not Important
24	Thin	1	2	3
25	Strong - doesn't break	1	2	3
26	Made in U.S.A.	1	2	3
27	Lubricated	1	2	3
28	Colored	1	2	3
29	Smells good	1	2	3
30	Inexpensive	1	2	3
31	Includes instruction on use	1	2	3
32	Size	1	2	3
33	Made in Egypt	1	2	3

BRAND AWARENESS AND USAGE

13. There are a number of different brands of condoms. Can you
 *Col. 34, please tell me which brands you know of? Any others?
 35

Circle Brand mentioned under Column 1 below

For each brand not mentioned in Question 13, ask:

14. Have you ever heard of (BRAND)?

Col. 36,
 37,38,
 39,
 40 [blank]

Circle (1) for brands heard of and circle (2) for brands not heard of.

For all brands circled (1) in columns 1 and 2, ASK:

15. Which best describes your use of (BRAND); I currently use
 Col. 41, brand, I never used brand?
 42,43,
 44,45

Circle Correct Answer for Each Brand under Column 3 Below

Method/Brand	Column 1	Column 2		Column 3	
	Mentions Spontaneously	Heard of Brand	Has not Heard	Used Before	Currently Use Brand
(1) Tahiti gold package	1	1	2	1	2
(2) TOPS blue package	1	1	2	1	2
(3) Durex	1	1	2	1	2
(4) Fulex	1	1	2	1	2
(5) Other _____	1	1	2	1	2

0 = already know
 mentions spontaneously
 0 = does not apply
 1 = ever used
 2 = Currently use
 3 = used ever and currently use

*Codes are based on codes assigned to brands and given two (2) columns (e.g. 10, XL)

PURCHASING BEHAVIOR/BRAND LOYALTY

16. Where do you usually buy condoms?

Col. 46

DO NOT
 READ

Government clinic1
 Pharmacy2
 Kiosk on street3
 Other _____4

17. When you need to buy condoms, how do you identify for the pharmacist or the storekeeper the condom you want him to give you?

Col. 47

DO NOT
 READ

By the name TOPS1
 By another brand name2
 By color of package3
 By price4
 Other _____5
 I just ask for a condom (generally)6

BRAND USUALLY PURCHASED

Col. 48 18. What brand of condom do you usually buy?

**DO NOT
READ**

- Tahiti1
- TOPS2
- Durex3
- Fulex4
- Other5
- No brand preference6 **GO TO QUESTION 24**

Col. 49, 50, 51 19. The first time you bought it, why did you choose it?

**DO NOT
READ**

- Pharmacist gave it/recommended it1
- Friend/neighbor/relative recommended it2
- Saw ads in newspaper, magazine3
- I liked the package4
- I liked the price5
- Other6
- Does not apply.....0

Col. 52 20. Is the brand you usually buy usually available or do you have difficulty getting it?

- Usually available1
- Difficult to get2
- Does not apply0

Col. 53 21. If you were shopping for (BRAND RESPONDENT USUALLY BUYS) and it was not available, would you buy another brand; wait for the brand to be available, or go to another place to buy the brand?

- Buy another brand1
- Wait for the brand to be available2
- Go to another place3

Col. 54 22. Overall, would you say you are satisfied with the brand you usually buy or do you have some complaints about it?

- Satisfied1 **GO TO QUESTION**
- Has complaints2 **ASK NEXT QUESTION**

Col. 55, 56, 57 23. What complaints or problems do you have about (BRAND RESPONDENT USUALLY BUYS)?

**DO NOT
READ**

- It tears easily1
- It's too expensive2
- It's not always available3
- It's not sensitive enough4
- It's not lubricated5
- Other6
- Does not apply0

OUTER PACKAGE PREFERENCES

I'd like to show you several different brands of condoms that are sold in Egypt. Please take these packages and put them in order with the package on the right being the one you like most, the second to the right the one you like second best and so on. The package on the left would be the one you like least. (Packages: TOPS, Tahiti, Settebello, Fulex).

24.
Col. 58, 59,
60, 61

Order of Preferences

- # 1 _____
- # 2 _____
- # 3 _____
- # 4 _____

25. a. Why do you like this one the most?

[name] _____

b. Why do you like this one the least?

[name] _____

ADVERTISING AWARENESS

26. TOPS is one of the condoms that are sold in Egypt. What do you think of the name TOPS?

27. Have you ever heard or seen any advertisements or information about TOPS?

Yes1

ASK NEXT QUESTION
GO TO QUESTION 29

No2
Not sure3

28. Where have you heard or seen any advertisements or information about TOPS?

64,65
TV1
Radio2
Newspapers3
Magazines4
Posters5
Rallies6
Other7
Not sure8
Does not apply.....0

PACKAGING PREFERENCE QUESTIONS

29. Condoms come in 2 kinds of packages -- flat like this (SHOW FLAT PACKED) or crimped like this (SHOW CRIMPED PACK). Which do you prefer?

Flat1
Crimped2
No difference3

30. The flat-packed condoms can be covered on both sides (SHOW PACKAGE) or clear on one side (SHOW PACKAGE). Which do you prefer?

Covered on both sides1
Clear on one side2
No difference3

31. TOPS used to look like this (SHOW OLD TOPS). Now they look like this (SHOW NEW TOPS). Which of these condoms do you prefer?

New1
Old2
Both3
Neither4

32. These packages have a drawing on them. What comes to your mind when you see this drawing?

33. What do you think this drawing is?

PRICING QUESTIONS

34. TOPS Cost 5 piastres for 2 condoms. In your opinion, is
Col. 69 this price expensive, fair, or inexpensive?

- Expensive1
- Fair2
- Inexpensive3

35. TOPS could be sold in packages of 2, 6, or 12. If each
Col. 70 condom still cost the same, no matter how many were in the
package, what size package would you prefer to buy?

- 2-pack1
- 6-pack2
- 12-pack3
- Makes no difference.4

36. If TOPS were packaged in boxes of 6, would you be willing
Col. 71 to pay 15 piastres for a box of 6?

- Yes1
- No2

37. If TOPS were packaged in boxes of 12, would you be willing
Col 72 to pay 25 piastres for a box of 12?

- Yes1
- No2

LOGO DESIGN QUESTIONS

Now, I'd like to show you several possible inner packages for a
TOPS condom. These are not finished packages; they are rough
ideas for what the real package would look like. These packages
would go into this TOPS box.

HAND RESPONDENT THE PACKAGES

38. Which of these packages do you like best?
Col. 73

- Panther1
- Man & Woman2
- TOPS3
- Coin4

39. Which one do you like second best?
Col. 74

- Panther1
- Man & Woman2
- TOPS3
- Coin4

40. Which one do you like the least?
Col. 75

- Panther1
- Man & Woman2
- TOPS3
- Coin4

41. Looking at all of the packages, is there anything about them
Col. 76 that bothered you?

- Yes1 ASK NEXT QUESTION
- No2

41. a. What bothered you? (write in and number comments)

#1 _____

#2 _____

#3 _____

114

AWARENESS OF FAMILY OF THE FUTURE

42. Can you please tell me the names of any family planning
Col. 77 organizations in Cairo that you have heard about?

Family of the Future	1	<table border="1"><tr><td>GO TO QUESTION</td></tr></table>	GO TO QUESTION
GO TO QUESTION			
Other	2	<table border="1"><tr><td>ASK NEXT QUESTION</td></tr></table>	ASK NEXT QUESTION
ASK NEXT QUESTION			
Don't know any.....	3		

43. Have you ever heard of Family of the Future?
Col. 78

Yes	1	<table border="1"><tr><td>ASK NEXT QUESTION</td></tr></table>	ASK NEXT QUESTION
ASK NEXT QUESTION			
No	2	<table border="1"><tr><td>GO TO QUESTION</td></tr></table>	GO TO QUESTION
GO TO QUESTION			
Does not apply	0		

44. Where did you see or hear information about Family of the
Future?

	Newspapers	1	
	Magazines	2	
	Radio	3	
	TV	4	Col. 5,6,7
	Posters	5	
	Friends/neighbor/ Relatives.....	6	
	Rally/presentation...	7	
	Other	8	
	Not sure	9	
	Does not apply	000	

Card 2
1-3 Serial #
4 card #

115

DEMOGRAPHICS

Do you mind if I ask you just a few more personal questions to help us develop a picture (profile) of the people who are participating in this study. The information will be kept strictly confidential and only will be used for classification purposes.

45. How old are you?

Col. 8-9 (YEARS) _____

46. Have you ever attended school?

Col. 10 Yes1
 No2 GO TO QUESTION

47. What is the highest grade you passed at school or college?

CIRCLE HIGHEST GRADE COMPLETED

Col. 11, 12,13, 14	1. Primary	1	2	3	4	5	6
	2. Preparatory	1	2	3			
	3. Secondary	1	2	3			
	4. College	1	2	3	4	5	6

48. What is your occupation?

Col. 15 _____

49. How many times have you been married?

Col. 16 _____

50. How many years in total have you been married?

Col. 17,
18 _____

51. How many children has your wife borne who are still alive today?

Col. 19,
20 NUMBER OF LIVING CHILDREN _____

(IF RESPONDENT OR HIS WIFE HAS NEVER BORNE CHILDREN, GO TO QUESTION).

52. How old is your youngest child?

Col. 21,
22 _____

53. How many of your children (is your child) are:

Col. 23,
24 Male _____
 Female _____

54. Do you intend to have more children some day?

Col. 25 Yes1
 No2

55. How many more children do you want to have?

Col. 26 (Number of additional children desired) _____

Reprinted from: Dunlop, Corbin, Compton Associates. "Unpublished
Results of a Logo Test Conducted for Foam Tablet,"
Kingston, Jamaica, 1981.

LOGO TEST

INTRODUCTION

Hello, I'm from Market Research Ja. Ltd., an independent
Research Company. Could you please give us a few minutes
of your time to answer some questions?

SCREENING DATA

NAME

ADDRESS

<u>OCCUPATION:</u>	Student	()	<u>AREA:</u>	Kingston	()
	Housewife	()		Rural	()
	Employed	()			
<u>AGE:</u>	18 - 23	()	<u>SOCIO-GROUP</u>	C	()
	24 - 29	()		D	()

INTERVIEWER : Shows black and white drawings one at a time.
For each drawing ask

1. What do you see, what do you think of, what
comes to the mind when you look at this drawing
(Record answers verbatim and turn each drawing
over after answer).

G _____

K _____

R _____

W _____

N _____

- 2a. (INTERVIEWER: Turn all black and white drawings face up
and ask :)

Which one of these five drawings do you like the best?

G () K () R () W () N ()

2b. Which one of the others would be your second choice?
G () K () R () W () N ()

2c. Which one of the remainder do you like least?
G () K () R () W () N ()

3. Why do you like this one the least?
(Record answer verbatim)

4. You selected this one as your favourite.
Why do you like this one best?

5a. Let's say this drawing (point to one liked best)
is used as a symbol on a product ... for which
of these types of products do you think this
drawing would be most suitable?

TOILET SOAP
COLOGNE
CONTRACEPTIVE
COUGH MEDICINE

5b. Let's say this drawing (point to one liked best)
is used as a symbol on a Contraceptive product
for women, do you think this drawing would be very
good on a Contraceptive product, good, fairly
acceptable, bad or very bad on a Contraceptive
product?

VERY GOOD
GOOD
FAIRLY ACCEPTABLE
BAD
VERY BAD

6a. Are there any of these other four drawings you would like better as a symbol on a Contraceptive product. If so, which one?

G () K () R () W () N ()

6b. Why would you like this one better?
(Record answer verbatim)

7. Lastly, have you ever used or heard of a Contraceptive Foam Tablet?

USED
HEARD OF
NOT AWARE

Question 2

If each of these was the name of a product, for what type of product would you say _____ is most suitable ?

Coral _____

Joy _____

Perlon _____

Question 3

Please look at this card. (Logo/brand name design)

Based on what you see here does this give you the impression that a product with this name would be :

- | | | |
|-------------------------|--------|---------------------|
| For women | () or | For men |
| Good quality | () or | Poor quality |
| Made in Jamaica | () or | Made overseas |
| Expensive | () or | Economical |
| Modern | () or | Old Fashioned |
| For a younger person | () or | For an older person |
| Sold in Pharmacies only | () or | Sold everywhere |

(To be repeated for all three designs)

Question 4

What if anything do you dislike about the design?

(To be repeated for all three designs)

Question 5

(Hand respondent all three designs)

Which one of these do you think would be the most suitable name for a new contraceptive product?

Coral ()

Joy ()

Perlon ()

Question 6

Which would be your second choice of a name for a new contraceptive product?

Coral ()

Joy ()

Perlon ()

Question 7

Why did you choose _____ as the most suitable name? (Probe for details)

Question 8

Have you ever used or heard of a contraceptive foam tablet?

USED ()

HEARD OF ()

NOT AWARE ()

Question 9

Are you currently using a contraceptive method?

YES () NO ()

APPENDIX 4
STANDARD COMPREHENSION AND DIAGNOSTIC QUESTIONS FOR
PRETESTING RADIO AND TV ADVERTISEMENTS

Reprinted from: National Cancer Institute. Pretesting in Health Communications, NIH Publication No. 81-1493, Bethesda, MD: National Cancer Institute, 1980.

**STANDARD COMPREHENSION AND DIAGNOSTIC QUESTIONS FOR
PRETESTING RADIO AND TELEVISION ADVERTISEMENTS**

1. Main Idea Communication/Comprehension

What was the main idea this message was trying to get across to you?

What does this message ask you to do?

What action, if any, is the message recommending that people take?

In your opinion, was there anything in the message that was confusing?

Which of these phrases best describes the message?

Easy to understand

Hard to understand

2. Likes/Dislikes

In your opinion, was there anything in particular that was worth remembering about the message?

What, if anything, did you particularly like about the message?

Was there anything in the message that you particularly disliked or that bothered you? If yes, what?

3. Believability

In your opinion, was there anything in the message that was hard to believe? If yes, what?

Which of these words or phrases best describes how you feel about the message?

- Believable
- Not believable

4. Personal Relevance/Interest

In your opinion, what type of person was this message talking to?

- Was it talking to . . .
- Someone like me
 - Someone else, not me

- Was it talking to . . .
- All people
 - All people but especially (the target audience)
 - Only (the target audience)

Which of these words or phrases best describes how you feel about the message?

- Interesting
- Not interesting

- Informative
- Not informative

Did you learn anything new about (health subject) from the message? If yes, what?

5. Other Target Audience Reactions

Target audience reactions to messages can be assessed using pairs of words or phrases or using a 5-point scale. The following is an example of how this is done.

Listed below are several pairs of words or phrases with the numbers 1 to 5 between them. I'd like you to indicate which number best describes how you feel about the message. The higher the number, the more you think the phrase on the right describes it. The lower the number, the more you think the phrase on the left describes it. You could also pick any number in between. Now let's go through each set of words. Please tell me which number best describes your reaction to the message.

Too Short	1	2	3	4	5	Too Long
Discouraging	1	2	3	4	5	Encouraging
Comforting	1	2	3	4	5	Alarming
Well Done	1	2	3	4	5	Poorly Done
Not Informative	1	2	3	4	5	Informative

12/6

Is there anything in the message that would bother or offend people you know?

6. Impressions of Announcer

Please select the one answer from each pair of phrases which describes your feelings about the announcer.

Believable

Not believable

Appropriate to the message

Not appropriate to the message

Gets the message across

Doesn't get the message across

APPENDIX 5.

.SAMPLE FOCUS GROUP MODERATOR'S GUIDELINE

Reprinted From: Family of the Future, and Porter, Novelli & Associates. "Moderator's Guidelines: Focus Group Interviews on Family Planning Methods and Products," Unpublished Paper, Cairo, Arab Republic of Egypt, August 1981.

128

MODERATORS' GUIDELINES:
FOCUS GROUP INTERVIEWS ON
FAMILY PLANNING METHODS AND PRODUCTS

Sections I and II are to be included in each focus group. Guidelines tailored to specific target groups follow these general guidelines.

I. INTRODUCTION AND WARM-UP

- A. Welcome and thanks for participating. Your opinion is important. Meeting should last about 90 minutes.
- B. Introduction of moderator and his/her role to hear what participants have to say.
- C. Purpose of Meeting:
 - 1. Discuss issues related to health and family life
 - 2. Gather participants' ideas, comments and suggestions
 - 3. All comments are important -there are no right or wrong answers
- D. Groundrules:
 - 1. Tape recorder so that moderator doesn't have to take notes.
 - 2. Only one person speaks at a time so that opinions can be recorded.
 - 3. Everyone should feel free to speak and present their ideas during the session.
 - 4. Respondents should be open and truthful — don't say what you think moderator wants to hear, but what's true for you; speak from your own experience; remember there are no right or wrong answers.

E. Respondent Introductions

Tell group your name and tell us about your family, number of children, how long you've lived in this area, and anything you want the group to know about you.

II. GENERAL FAMILY PLANNING ISSUES

- A. Knowledge of family planning.
- B. Perceptions of family size -- what is large? What is small?
- C. Attitudes toward family planning -- spacing births vs. limiting family size; approval, disapproval; reasons why.
- D. Decision-making process in adopting family planning -- communication between partners, when initiated discussion, reasons for initiating discussion, who makes final decision, perceptions of respondents'/spouses' responsibility in family planning.
- E. Attitudes toward contraceptive methods in general -- what do respondents want and expect from a contraceptive method, satisfactions and dissatisfactions with currently available methods (cover issues such as reliability, safety, ease of use, availability, etc.).

(NOTE TO MODERATOR: Continue focus group interview with guideline tailored to specific group being interviewed.)

Stimuli: Microvlar
Primovlar
Nordette
Anovlar
Plastic Case - 28-Day Pills

Current Pill Users

KNOWLEDGE, ATTITUDES AND PRACTICES REGARDING THE PILL

A. Knowledge About The Pill

- o How does it prevent pregnancy?
- o How often do you take it?
- o What if you forget to take it?
- o What side effects?
- o How long do they last?
- o What do you do if have side effects?
- o How safe is the pill?
- o Are some pills safer than others?
- o Are there some women who shouldn't take pills?
- o How reliable (i.e., how effective) in preventing pregnancy?

B. Attitudes Toward The Pill

- o Advantages/disadvantages of pill use.
- o Preference rating of the pill as one of several contraceptive methods.
- o Satisfactions/dissatisfactions with the pill based on current or previous use.
- o What's your husband's reactions to your use of the pill?

C. Use Of The Pill

- o Reasons for deciding to use the pill.
- o How long have you used it? Plan to continue?
- o Are you using the pill to space children or to prevent any further births?
- o Do you read directions that come with the pill? Are they clear?
- o How do you remember to take them?
- o 21 vs. 28 day cycle.
- o Have you had side effects? How long lasted? What did you do?

D. Purchasing Behavior

- o Where do you purchase?
- o Did you get a prescription?
- o What brand do you use? Have you used other brands? Why switched?
- o Do you buy pills yourself or send someone else?
- o How easy is it to get pills in your area?
- o Did pharmacist or physician talk to you about the pill?
- o Price -- too high? Too low?
- o Show them existing pills and ask for their reactions to packaging and price. Which ones do you recognize? Have you seen any advertising for any of these? Which packages do you like best? Why?

E. Attitudes Toward New Product

- o If you were to design the ideal oral pill, what would it be like and what would you want it to do?
- o 21 vs. 28 day cycle (show both).
- o Number of cycles in package.
- o Name Brevacon -- Egyptian or English name?
- o Packaging cardboard vs. compact. Color, size?
- o Recommendations on price -- single cycle, three cycle?
- o Type of instructions?

F. Wrap Up

132