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SOMARC
SOCIAL MARKETING FOR CHANGE

HISTORY OF CSM, SOME SPECIAL PROBLEMS, AND PROJECT OUTLINES

The marketing of family planning was first undertaken more than 15 years ago with the introduction of programs in India, followed by Sri Lanka and Colombia. The underlying concepts of these programs were first developed formally in a 1971 Journal of Marketing article by Philip Kotler and Gerald Zaltman that defined an approach to planned social change.

This approach was called social marketing and was described as "the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving the considerations of product planning, pricing, communication, distribution, and marketing research"—in short, the application of the full spectrum of commercial marketing techniques and management to the advancement of a social cause.

Social marketing and commercial marketing share with each other a common theoretical underpinning, similar strategic approaches, and the same elements of the marketing mix. When approached comprehensively and with a high level of skill, commercial marketing does indeed take into account areas that many consider to be special problems for CSM. These kinds of problems—which both commercial and social marketing share—include product-line flexibility, availability, availability of research and other marketing resources in LDCs, product positioning, pricing strategies, and the like. The major differences between commercial and social marketing occur in the degree to which these factors affect the development of a marketing strategy. Some problem areas, which weigh heavily in the design of a CSM program, weigh much less with respect to commercial marketing. Competent commercial marketers and particularly international marketers are cognizant of these special considerations but are seldom called upon to address them on the same scale that a social marketer must.

There are, however, several areas in which social marketing seems to differ appreciably from commercial marketing:

- CSM deals with a multiplicity of markets. While commercial marketing is usually primarily concerned with only one market, which is end-user or consumer, CSM programs must satisfy the needs and demands of several markets. These include, in addition to the end-user, host government officials and policymakers, the host country elite that have the power to aid or block the program, religious organizations, AID officials—both in-country and in Washington—and in a very real sense the American people, as represented by Congress. Accommodating all the variables presented by these many markets in a comprehensive strategy is a highly complex task.
- CSM program objectives are not easily quantifiable which makes the selection of evaluation criteria difficult. Commercial marketing's overall objective is simple and basic: return a profit. Likewise, the methods available for evaluating the attainment of that objective are reasonably straightforward. This is not the case for CSM.

Should a program be evaluated on sales, cost recovery, changes in prevalence, actual demographic shifts or a host of other variables? The selection of any one or combination of these evaluation criteria may be perfectly valid, but each one corresponds to a different objective and therefore a possibly different strategic approach for its attainment. It is often tempting to select an evaluation criterion for which data are already available, thereby imposing on CSM a particular objective, rather than to develop new data for evaluating an objective selected as part of the overall social marketing strategy.

- CSM by its very nature deals with closely held core belief. Consumer behavior analysis has helped marketers understand how difficult it is to bring about changes in core values. Most commercial marketers, therefore, choose and are able to deal primarily with less centrally held beliefs. Contraceptive social marketers do not have the choice.
- The benefits of adopting the family planning behavior marketed by CSM projects are principally longer term and not immediately visible. Marketing exists and functions on the exchange principle, and convincing someone to exchange a change in their core beliefs for a benefit that may not be recognizable for some time to come (better financial situation with fewer children, better family health when wife is not continuously pregnant) and at worst may not be visible in the acceptor's lifetime (improvement of the countries economic outlook) is a difficult undertaking indeed.

The Agency for International Development's interest and involvement in social marketing dates from the concept's original application to family planning. The history of AID funding of contraceptive social marketing (CSM) activities begins in 1971 with a study directed by the current head of The Futures Group/Washington, Dr. Robert Smith, titled "The Distribution of Commercial Contraceptives in Eight Developing Countries."

This study produced marketing plans for potential CSM projects in two countries, Korea and Jamaica, and led ultimately to AID's implementing its first project in one of them, Jamaica, in 1974.

Since the time of those original studies and the resultant project, there have been numerous contraceptive social marketing projects put in place worldwide in developing countries. Those programs are not easily described, as they each represent an individual response to a unique set of circumstances found in a particular country. They have been called a hybrid public health oriented social action program grafted onto a commercial distribution and marketing system. However they are described, their evolution and the evolution of the CSM concept have followed a path leading increasingly closer to the adoption of the complete commercial marketing model. That model uses marketing as a managerial process to efficiently organize all the inputs and outputs of the project around a comprehensive marketing strategy arrived at through marketing research.

AID's support of this evolution has been essentially constant. Virtually all AID-funded CSM projects have followed similar paths during their growth: projects typically begin with a centrally funded initial development phase administered by a

subcontractor, followed by mission funding for a maturing project that is often turned over to local management.

The success of these programs has been varied. Some projects have performed well from their inception to the present. Some have started off well and then stagnated or faltered, and a few have never been viable. It appears that at least one important variable in determining how successful a project may be is the degree to which it incorporates the elements of commercial marketing into its strategic design. Those projects that desire and are able to utilize all of the traditional components of the marketing mix seem to achieve better results than the projects that do not or can not.

It is from that viewpoint that the following chronologically ordered descriptions of AID originated and supported CRS programs are presented. Additionally, three new AID projects are included as they represent significant contributions to the body of social marketing knowledge and will probably be eligible for AID technical assistance support at some time under the new contract.

AID INVOLVEMENT IN CSM

PROJECT START	COUNTRY	CURRENT ORGANIZATIONAL STRUCTURE	ONGOING	NOTES
1974	Jamaica	JNFPB/MOH	Yes	(1)
1974	Bangladesh	Independent	Yes	
1976	Tunisia		No	
1976	Nepal	Independent-NPO	Yes	(1)
1976	Ghana		No	
1976	El Salvador	FPA	Yes	(1)
1977	Mexico	Independent-NPO	Yes	(2)
1978	Egypt	Independent	Yes	
1981	Honduras	FPA (ASHONPLAFA)	Yes	
1982	Ecuador	FPA	Yes	(3)
1983	Caribbean Region	FPA-Independent Division	Yes	(3)
1983	Costa Rica	FPA	Yes	
1983	Guatemala	Independent-For Profit	Yes	
1984	Peru	Independent-NPO	Yes	

- (1) Project operates with local management and AID commodity support.
 (2) Project currently operates without AID support.
 (3) Currently centrally funded by AID.

CSM PROJECTS NEVER FUNDED BY AID

PROJECT START	COUNTRY	CURRENT ORGANIZATIONAL STRUCTURE	ONGOING	NOTES
1967	India	Govt. Dept. of Fam. Welfare	Yes	(4)
1973	Sri Lanka	FPA	Yes	(4)
1973	Colombia	Independent-NPO	Yes	(4)

(4) Project has received AID-funded short-term technical assistance.

Brief Description of Marketing Variables and Notable Features of CSM Projects

Jamaica: Jamaica, AID's first CSM project, was started in 1974 with product launch taking place in 1975. The products, "Panther" condoms and "Perle" orals, were targeted at males and females, respectively, in the 14 to 35 age groups. Distribution was through the commercial sector and aimed at pharmacies and general retail stores. Communication activities included mass media, radio, TV, and newspapers, as well as point-of-purchase displays. However, the program has had no advertising money available to it for the past two years.

The program was turned over to the Jamaican government National Family Planning Board, a division of the Ministry of Health, in 1977. This has resulted in some management difficulties due to the low-level civil service designation ascribed, and sales growth has stagnated. Even with these difficulties, the highest level of market penetration achieved by any CSM project, established in the first two years of operations, has not been eroded; and oral sales continue to be the program's leader.

Bangladesh: The Bangladesh SMP was begun in 1974. Products, "Raja" condoms and "Maya" orals, were launched in 1974, and were followed by "Joy" foaming tablets in 1979, "Panther" condoms in 1983, and "Ovacon" orals in 1984. The targeting of markets has increased in sophistication and complexity from the 1975 aim of "fertile couples" to include males and females in various economic strata and geographic location. Distribution is through an in-house system to commercial retailers. Communication activities are wide-ranging and cover the majority of channels that exist in the country, both mass and interpersonal.

The Bangladesh SMP operates with a large staff and represents AID's largest dollar commitment to CSM. Historically, orals have not performed nearly as well as condoms, and the addition of the more "scientific sounding" "Ovacon" low-dose pill in conjunction with heavy detailing is hoped to improve the situation.

Tunisia: Tunisia is one of only two programs started by AID that are no longer operating. This program was begun in 1976 without the benefits of mass media promotion for the condom, "Waha" or oral, "OP 50", products. They were

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targeted for married couples that had never used contraceptives and oral discontinuers. The project ended at least in part due to the Tunisian government's misunderstanding of the program's objectives.

Nepal: Nepal's CRS program started in 1976 with launch of products taking place in 1979. Products included "Dhaal" condoms and "Gulaf" orals as well as expansion products, "Nolocon" orals and "Kamal" foaming tablets. As with Bangladesh, the targeting of markets in the Nepal project has increased in sophistication since the original designation of "married women" and now incorporates individual targets for each product line. Communications includes use of mass channels of radio and press, interpersonal channels to combat the difficulties of extreme isolation of much of Nepal, and point of purchase. Distribution (to wholesalers and retailers) is through a hybrid system of in-house and quasi-governmental organization. The project was transferred to local management in 1983 after a long period of institutionalization due to Nepal's weak infrastructure.

Ghana: Ghana is the other country (in addition to Tunisia) in which an AID-originated program is no longer operating. The program was started in 1976 with product launch not occurring until 1979 when "Panther" and "SSS" condoms, "Coral" foaming tablets, and "Floril" oral contraceptives were sold through the pharmacy system. Condoms and foaming tablets reached their targets of "7.5% non-pregnant women, aged 15-45 who are not contracepting, not living in deep rural areas, and not wishing to be pregnant" through the commercial distribution system. Communications strategies were inhibited by changing government policy regarding mass media promotion. The program closed in 1980, only a few months after the departure of the technical assistance contractor.

El Salvador: El Salvador's CRS program started in 1976 and products were launched first in 1978. They were "Condor" condoms and in 1979 "Perla" orals. The project's ambitious target was "all fertile couples," and products (supplied by both a commercial distributor and CRS staff salesmen) were to reach them through retailers in general stores and pharmacies. Communications included radio and point-of-purchase materials. For the past two years, however, there has been no advertising budget; and presently there is no marketing manager. These deficiencies have manifested themselves in the lack of cohesive marketing strategies, especially in product repositioning where products have proliferated rapidly. Research is currently underway to help clarify the situation and to make the now-trimmed product line more manageable. The project is locally administered and receives AID commodities.

Mexico: The Mexico CRS project was initiated in 1977 with launch in 1979 for a full line of "umbrella" brands including: "Profam" condoms, orals, suppositories, cream, pressurized foam, and foaming tablets. At the time, Mexico was the most heavily funded AID CRS project. Products were retailed to an original of "65% of all fertile couples in two years" through pharmacies and other outlets serviced by an in-house sales force. Communications consisted of the mass channels, radio, TV, and press, as well as point-of-purchase and direct-mail detailing to physicians. The project currently is operating under local management as a private NPO—PROFAMILIA—without AID assistance. The original technical assistance contract was cancelled midstream because of host country political pressures.

Egypt: Egypt's CSM efforts began in 1978 with IPPF funding support. Products were launched in mid-1979. The project's target was limited to lower socioeconomic groups in Cairo to be reached through pharmacies and other retailers serviced by a commercial distributor. In 1980, AID took over project support because the IPPF's resources did not allow for further project expansion. Although its geographic target area is limited to Cairo, Egypt's Family of the Future project represents AID's second-largest funding commitment to CSM. The product line includes "Tops" and "Golden Tops" condoms, "Amaan" foaming tablets, and "Norminest" orals as well as Copper-T and Copper-7 IUDs sold to physicians and consumers. Egypt is the only CSM project selling IUDs and the only CSM project selling a commercially branded product, "Norminest."

Communications strategy includes use of most mass and several interpersonal channels: radio, TV, press, service vans, and point-of-purchase materials.

The Egypt project has a large staff and enjoys the benefits of a well-developed project marketing structure. Test marketing outside Cairo in preparation for expanding the project has been initiated.

Honduras: The project in Honduras was initiated in 1981. Due to a number of management problems, however, products were not launched until early 1984. "Perla" orals were the first commodity to be offered for sale under a phased product launch strategy. A low-dose oral, condom, and foaming tablet will follow. Marketing research is being conducted to determine name, packaging, and pricing for these additional products. Distribution to pharmacies and rural shops, specially licensed to sell program commodities, is through project sales staff and a commercial distributor. Communication will be through radio and print media as well as point of purchase. The local FPA, the project's "parent" organization, is assuming responsibility for social marketing "missionary messages." The CSM project (HCSMP) is taking direct responsibility for product marketing messages.

Ecuador: Ecuador's CSM project was initiated through an AID centrally funded contract in 1982. Because of the host government's failure to close on approvals, products have yet to be launched. Some approvals appear to have been recently obtained. When launch occurs, the first product will be "Evitex" orals, distributed by a commercial distributor to Ecuadorian pharmacies. A communications campaign is under development and will include print and broadcast media. At this time the project is searching for a replacement for the local project manager.

Caribbean: The Caribbean Contraceptive Social Marketing Project began in 1983 and launched products eight months later in 1984. The project is noteworthy for several "firsts." It is the first regional CSM program and employs a regional commercial distributor to deliver its products. "Perle" and "Perle LD" orals and "Panther" condoms are distributed to retail outlets and pharmacies serving the program's target of young couples in lower socioeconomic groups. The project also represents the first organized effort to develop a comprehensive marketing strategy utilizing selected elements from other CSM projects.

Communications takes place through point-of-purchase materials as well as physician detailing, and the mass media channels of TV, radio and print. Ongoing market research is performed through consumer panels and tracking surveys to ascertain customer satisfaction/dissatisfaction, advertising message retention, and source switching tendencies.

AID support for this project will be replaced by mission funding in the fall of 1984.

Costa Rica: The CSM project in Costa Rica began in 1983 with direct funding of the project, contained within the local FPA, by the AID mission. There is no technical assistance contract. Products have not yet been launched. It appears that initial product launch will include one, possibly two, brands of orals and one brand of condom. Communications may prove challenging since brand advertising of ethical pharmaceuticals is not allowed in Costa Rica. Presently marketing strategies are under development. The use of a "service" name--such as "PROFAMILIA"--as a surrogate for brand names in order to circumvent advertising restrictions is being considered.

Guatemala: Guatemala's CSM program was initiated in 1983 and as yet has not launched products. Strategy development is underway for a product line expected to include pills, condoms, and foaming tablets. This project setting is unique in several ways and as such has encountered several difficulties. Because of restrictive GOG policies regarding the sale of commodities by NPOs, the Guatemala CSM project has been set up as an independent, for-profit organization, funded directly by the AID mission. Recently, project activities have begun in preparation for product launch.

Peru: The Peru CSM project is the most recent to be undertaken. At this time, an RFP for a technical assistance contractor to administer the program has been released. Potential difficulties in implementation, identified in a 1979 AID feasibility study, appear to have been mitigated. It is expected that this program will offer both orals and condoms through the typical CSM method of commercial distribution to the indigenous retail system.

Significant, Ongoing, Non-AID Projects

India: India's SMP is the oldest CSM program in the world. Begun in 1967, with launch of the "Nirodi" condom occurring in 1969, this government project has changed little in its 15-plus years of operation. Commercial distributors supplying pharmacies, chemists, drugstores, and retail outlets of all sorts are utilized. Communications utilizes most mass and interpersonal channels available including radio, TV, press, and cinema, as well as point-of-purchase displays. The program is very large scale, but bureaucratic interplay appears sometimes to limit decisions affecting project effectiveness.

Sri Lanka: The CSM project in Sri Lanka also is one of the oldest ongoing CSM projects in the world. It was started in 1973 by the IPPF and initially followed an organizational structure similar to AID-funded projects. The program's first products were launched later that same year. "Preethi" condoms were first, followed by "Mithuri" orals in 1976. More recently a multitude of condoms, pills, and foaming tablets have been added. The original commercial distributor has been partially supplanted for condom distribution to retail shops by an in-house distribution system but has been retained for oral distribution to pharmacies. The original target of newlyweds and rural residents is no longer strictly followed. Communications utilizes mass and interpersonal channels including physician detailing, point-of-purchase, print and some budget-limited broadcast. The project's "Preethi" condom is the market leader, but the program sponsor's recent directive requiring self-sufficiency has forced a strategy of profit-making that has inhibited unit sales. The Sri Lanka CSM program is part of the local FPA, an IPPF affiliate.

Colombia: Started in 1973 the CSM project in Colombia launched product sales that same year. Currently it markets a full line of commodities including: condoms (two brands), orals (10 brands), pressurized foam, foaming tablets, and suppositories. Distribution to pharmacies, cooperative stores, and PROFAMILIA clinics is accomplished through staff salesmen. Products are obtained directly from local and foreign manufactures and sold without any repacking or overpacking and, therefore, without any product-specific product branding. Mass media brand advertising is scarcely used. Limited print advertising of condoms occurs. Communications is largely interpersonal through community-based "instructoras" employing traditional "motivation" activities.

PROFAMILIA, the local IPPF affiliate, is a large, nonprofit organization. Its CSM program is unique in that its sales revenues exceed its cost, even when the cost of commodities is charged against program sales. (This is attributable to the absence of packaging and advertising costs--the two largest costs of other CSM projects.) For the past several years, however, unit sales growth has plateaued.

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