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# Lifestyles *for* Survival

The Role of Social Marketing in Mass Education



**William A. Smith, Ed.D.**  
**Academy for Educational Development**

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**in**

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cause of most disease remains either lifestyle decisions or circumstances. Therefore, many authors now refer to this complex of illness as "lifestyle disease."

Many studies from around the world demonstrate that most people still lack the knowledge, skills, and motivation prerequisite to preventing heart disease, cancer, diarrheal dehydration, immunizable disease, sexually transmitted diseases (particularly AIDS), unwanted pregnancies, and malnutrition. To this list of well-known killers, we must add the thousands who die in automobile accidents because of the lack of seat belt use and the staggering human and financial toll that drug and alcohol abuse extracts from societies around the world. Indeed, the very survival of our planet has become an issue of public education, as people become more aware of environmental and nuclear threats through education. If we broaden our focus just a bit, the devastating tragedy of rapid population growth takes its place as one of the greatest health, economic, and social dilemmas of our time.

Data concerning the relationship of disease to behavior are striking.

- During 1986 in developing countries, some three million children under the age of five are estimated to have died from diarrheal dehydration. At least 50 percent of these deaths could have been avoided if mothers had understood how to manage diarrhea successfully in the home.<sup>12</sup>

## 1. INTRODUCTION

### IGNORANCE, THE PRIMARY CAUSE OF DISEASE

Four factors are generally believed to influence human health: **environment** (sanitation, safe water, overcrowding, and refrigeration); **medical care** (quality of and access to medical facilities, practitioners, and effective medication); **heredity** (genetic predisposition to illness); and **lifestyle** (what people do that either prevents or predisposes them to illness and death).

The major cause of disease in the world today is lifestyle behavior. People--because of what they eat, whether they exercise adequately, how they behave sexually, or how they care for themselves and those they love--contribute to the majority of human disease and premature death. While specific diseases differ from the industrial to the nonindustrial countries of the world, the basic

- Scientists estimate that 75 percent to 80 percent of cancer deaths in the U.S. are linked to lifestyle risk factors.<sup>16</sup>
- Between 1964 and 1985, in the United States, approximately three quarters of a million smoking-related deaths were either avoided or postponed as a result of decisions to either quit smoking or not start.<sup>16</sup>
- Birth spacing studies show that babies in developing countries born **less** than two years after their next oldest brother or sister are twice as likely to die as babies born **after** at least a two-year interval.<sup>5</sup>
- Dr. Victor Fuchs demonstrated in 1974 that almost six times as many young men died of cirrhosis of the liver and lung cancer in the state of Nevada, where smoking and drinking are common, than in the neighboring state of Utah, where religious values depress both drinking and smoking rates dramatically.<sup>17</sup>

## THE COST OF IGNORANCE

The cost of disease is measured in human, societal, and financial terms. Suffering caused by preventable diseases needlessly depletes societal resources and national self-confidence. AIDS, in many countries of Africa and the Americas for

example, not only causes measureless human suffering, but attacks and eventually destroys some of the most productive and educated members of these societies. In Africa, where the population growth rate is now the world's highest, the consequence of unchecked population growth is an increase in the number of primary school age children from 92 million in 1986 to 149 million in the year 2000 and a twofold increase in the number of jobs needed from the current 130 million to more than 280 million by the year 2000.<sup>19</sup>

The growing financial cost of disease represents an intolerable burden for already over-extended health care systems in both the industrial and nonindustrial world. For example:

- The U.S. Office of Technology Assessment estimates the direct health care and indirect productivity cost of **smoking** to be \$65 billion a year in the United States alone.<sup>16</sup>
- **Job absenteeism** has been shown to be 50 percent higher for smokers than for non-smokers.<sup>16</sup>
- The costs related to **alcohol abuse** in 1983--resulting from direct treatment expense, premature deaths, lost productivity, alcohol-related accidents, and crime--was estimated to be \$116.7 billion in the United States--plus \$59.7 billion for drug abuse.<sup>16</sup>

- **AIDS treatment costs** in the United States, including lost wages, represent \$6.3 billion for the first 10,000 cases of AIDS alone. A single case of pediatric AIDS can cost \$75,000 a year in the United States.<sup>10</sup>

**Clearly, we can no longer afford to clinically treat diseases that we know how to behaviorally prevent.**

### **EDUCATION CAN HELP**

We have various ways to assist people in modifying unhealthy behavior. We can **pass laws** to prevent certain practices, such as drug abuse or prostitution. We can **provide rewards** for good behavior, such as reducing insurance rates for people who avoid traffic accidents. We can **remove obstacles** that prevent people from adopting new practices, such as making contraceptives, immunizations, or medicines more available. We can **teach the facts** that people need to make beneficial changes. And we can **motivate people** to want to make the needed changes and organize for change.

Each alternative is generally considered more effective when combined with an integrated system of control, support, and rewards **plus** education. During World War II, the United States military combined a sexually transmitted diseases (STDs) educational program with condom distribution and rapid, non-judgmental treatment. As a result, rates of syphilis infection fell dramatically, even prior to 1943 when the introduction of penicillin further accelerated the

decline.<sup>2</sup> Too great a reliance on legal supply systems alone has led to disappointing results. For example:

- **Laws requiring manufacturers to install seat belts in automobiles** have resulted in almost universal seat belt availability in the United States but much lower levels of personal compliance with their use.<sup>3</sup>
- **Use of oral rehydration remedies and contraceptives** have increased as new supply systems were put in place, but usage rates remained stable at median levels until promotion and education were added.<sup>8</sup>

Indeed, education has been shown to play a key role in reducing lifestyle disease. For example:

- **Immunization**--Immunizable diseases kill approximately three million children each year. A four-dosage immunization cycle administered prior to children's first birthdays could save their lives. Mothers, however, have to know about, believe in, and know when to get the immunization services. This is the primary job of **education**.<sup>7</sup>
- **Breast Cancer**--Breast cancer kills some 40,000 women each year in the United States. Breast self-examination can reduce that death toll by 30 percent. Women, however,

have to know how to, and more importantly, be willing to, carry out their own breast examination at home. This again is a task uniquely suited to **education**.<sup>16</sup>

- **AIDS**--Five to ten million people worldwide are estimated to be infected with the Human Immunodeficiency Virus (HIV) associated with AIDS. The only cure or vaccine is prevention. People must learn what the virus is and how it is transmitted, and they must alter their own behavior to avoid infection. Again, **education** is fundamental to success.<sup>10</sup>

**Education, in most of these settings, has the dual job of teaching facts and skills plus finding ways to motivate people to want to make difficult lifestyle changes. Without education, our programs of social control, personal support, and rewards may go unnoticed and unheeded.**

The evidence from a broad base of scientific research is conclusive. Education can teach beneficial facts; it can develop necessary skills; and it can motivate people to want to change their own unhealthy behavior. While evidence that education works is extensive, data also demonstrate that not **all** educational interventions are effective. Poorly planned or executed programs have little or no value. Indeed, in some cases, they have misled the public and caused damage to program goals. Early AIDS education

campaigns, for example, spread fear and denial as well as fact. Even more importantly, we now know that positive attitudes and knowledge alone do not change behavior.<sup>18</sup> To make education work, we must understand the specific needs of each lifestyle disease complex and learn from the lessons of effective behavior change planning and implementation.

## **WHY MASS ADULT EDUCATION MATTERS**

Why not begin in schools and in homes to educate our children about diarrhea, immunization, cancer, heart disease, AIDS, family planning, and so forth? We should. We must also, however, be prepared to invest in family life education for those adults most at risk of lifestyle diseases. Why?

First, because school and parents are not always willing or able to carry the full educational burden of teaching about these difficult and sensitive problems. We cannot overlook the reality that most parents do not talk about sex, drugs, or alcohol with their children. This situation is particularly true for many of the children most at risk. These children are often the children of alcohol-dependent parents, broken homes, or the streets, where parents and schools are unavailable to them.

Second, we must recognize that while early education might act as a sort of "cognitive inoculation" against some lifestyle disease, adult education is also needed as a "booster shot" to reinforce early lessons during the adult period of greatest risk. The adult health consumer--whether the illiterate rural mother struggling with her child's diarrhea, the urban "Romeo" in search of easy love and companionship, or the middle-age female facing breast cancer--must have the information, emotional support, and practical services that only adult education can provide. We shall not succeed in reaching all of those in need through their schools and parents, but even if we could, we must also be prepared to give them the timely information and support they need as adults.

Finally, we cannot rely entirely on schools or homes because our knowledge and services are changing every day. Lessons learned about AIDS, diet, cancer, and diarrheal disease even five years ago are now out of date. We must have the capacity to update people; to inform at-risk adults of new services, new practices, and new products they need to protect themselves from illness; and to protect society from the burden of preventable disease.

**Social Marketing** provides a framework for planning a comprehensive program of behavior change helping to organize educational inputs into a broad framework designed to meet people's real needs. The following section of this booklet describes the evolution of social marketing and provides evidence of its effectiveness.

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Social marketing looks beyond piecemeal education strategies toward a process of comprehensive research and planning focused on the consumer. Increased emphasis on primary care, new child health technologies, mass campaigns, development communication, and the principles of marketing and behavior analysis have contributed to this development.

The goal of social marketing is to promote change in health-related practices and, in turn, health status. This accomplishment often requires increasing the demand for specific products and services essential for improving health behavior and for ensuring that consumers use healthy products and practices appropriately.

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## 2. THE EVOLUTION OF SOCIAL MARKETING

### THE PAST--PIECEMEAL APPROACHES

Health education, as traditionally practiced, often suffered from a lack of comprehensive planning. Frequently, the education component of public health programs consisted of:

**lectures** on community participation for health workers who were too overworked to teach clients or organize community groups

**a few slick TV spots** which pleased the decision-maker but provided little useful information to people at risk

**radio programs** which advertised services that did not really exist or gave advice no one was inclined to follow

a poster, pretested with a single neighborhood mother because *"she's from a rural area;"*

a flipchart developed for group presentations that never took place because there was no money for the participants to travel--or because the flipchart got lost on its way to the health center.

Too often we have pushed ill-conceived messages through weak communication channels at inappropriate audiences. Even more often we have employed education methods which, while effective in teaching individuals, have minimal impact upon the health status of large populations. At the root of both problems is an installment approach to health education--media promotions, training programs, and community events which may appear on the surface to be successful, yet fail to bring about sustained change in health-related practices.

The flaws in such efforts are not always evident because they are strategic. Program managers may have made inaccurate generalizations about the audience (their current practices, their needs, their preferences, their access to media). Planning of media activities may have been insufficient to ensure that messages with the necessary impact reached an adequate number of people. Training of health workers may have been lacking because of resource constraints. There may have been little or no program monitoring or midcourse adjustments.

Moreover, health education has often been at the bottom of public health allocations in terms of both human and financial resources. This situation

is especially critical in developing countries where budgets are stretched thin. The lack of resources easily results in piecemeal strategies.

**The Elements of Change.** Beginning in the 1970s, a number of developments enlarged our view of how health education could and should be practiced, given the constraints commonly faced by those countries most in need of such programs.

In 1978 at Alma Ata, USSR, the World Health Organization (WHO) initiated a fundamental change in the world's view of disease, stressing prevention and the needs of the rural poor. This **primary health care strategy** aimed at providing comprehensive basic services in maternal and child health, expanding activities in health education, and making increasing use of village health workers.

The practice of health education began shifting toward a greater emphasis on actual behavior as the health variable of most concern. Health educators combined traditional face-to-face instruction in formal school settings with mass media and nonformal education activities directed at adults. The field of **development communication** made several important contributions to health and population education programs, including systematic message design and testing and a renewed interest in radio.

A number of large-scale studies demonstrated effective ways to promote important health changes through communication programs. Tanzania, for example, launched its **mass**

**campaigns** on health and nutrition in the early 1970s. Two million people participated in 75,000 study groups organized around basic educational programs broadcast by radio. These campaigns, encouraging people to construct latrines, to tend vegetable gardens, and to improve their dietary and hygienic practices, demonstrated the power of integrated media activities to produce impressive short-term changes. They also demonstrated the need to follow up initial instructions with sustained reinforcement.

In 1969, Philip Kotler and his colleagues began publishing their ideas on how the *"marketing"* theory could be applied to social causes. The principles of **social marketing** were incorporated into a number of international health programs, particularly retail sales of contraceptives. At the same time, research studies in the United States and Europe opened the principles of behavior analysis to prevention programs for chronic diseases. The Stanford Heart Disease Prevention program, for example, demonstrated that risk factors for heart disease could be reduced significantly through a community education approach based on large-scale **behavior management**.

More recently the child survival movement, supported by USAID, UNICEF, WHO, and many other national and international bodies, has encouraged the rapid adoption of **new health technologies** and practices (such as immunizations and oral rehydration therapy) among national populations.

All of these efforts have contributed to the evolution of a more comprehensive approach to health education. The challenge has been to develop systems that reflect how people learn and what works in the real world of minimally-trained and overworked staff, scant and unstable budgets, and varying health conditions.

## **SOCIAL MARKETING: THE ORGANIZING PRINCIPLE**

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Social marketing incorporates the theories and methods of several disciplines. Marketing provides a framework for selecting and segmenting audiences and for promoting products and services. Behavior analysis supplies tools for investigating current practices, defining and teaching new practices, and motivating change. Anthropology reveals perceptions and values that underlie existing practices and that can help sanction new ones.

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In his book Marketing for Nonprofit Organizations, Philip Kotler defines social marketing as **"the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group."**<sup>1</sup> Social marketing is not essentially different from commercial marketing; it relies on the same analytical techniques (market research, product development, pricing, accessibility, advertising, and promotion). Social marketing sells products and practices by appealing to people's self-interest. It encourages changes in behavior,

however that will benefit society as well as the individual.

In international health programs, social marketing may involve both the selling of a **commodity** and the selling of an **idea or practice**. In fact, social marketing almost always begins with promotion of a health-related attitude or belief. It builds upon that to make recommendations for a new product or service and to provide instructions for effective use. The fact that little or no money changes hands in such marketing efforts--that what is exchanged may seem intangible but heavily value-laden--can make these programs considerably more challenging than conventional marketing.

Although socially beneficial products (such as condoms, birth control pills, and oral rehydration salts) are often subsidized, the actual selling process can be critical because it raises consumer motivation, stimulates entrepreneurial activity among wholesalers and retailers, increases the potential for long-term program self-sufficiency, and is a simple measure of program success. Marketing techniques are also essential to the "*selling*" of new practices. The consumer must make complicated trade-offs between old and new beliefs, and between familiar and unfamiliar practices, and make investments of time and effort to achieve unverifiable and sometimes unpleasant short-term results.

Socially beneficial products, or "*social products*," differ from commercial ones in important ways:

- Social products are often more complex to use than commercial ones.

- They are often more controversial.
- Their benefits are often less immediate.
- Distribution channels for social products are harder to use and to control.
- The market for social products is difficult to analyze.
- Audiences for social products often have limited resources.
- The measure of successful "*sales*" or adoption of social products is more stringent than for commercial ones.

These additional challenges mean that the research and the planning stages of a social marketing effort must be particularly sound.

**The Consumer at the Center.** Social marketing relies upon a fundamental **consumer orientation**. The consumer, or user, is not only the primary audience but also the measure of whether activities are appropriate, desirable, and successful. The consumer is systematically consulted throughout the communication process, providing the data for critical marketing decisions.

Before a new product is introduced, the first step is to research thoroughly the environmental and psychological factors that will affect an audience's attitude toward the product. The audience for almost every social marketing program will be comprised of various subgroups, each having

unique views, values, and needs. Research, therefore, begins with **audience segmentation**-- a process of identifying subgroups and determining which media are most prevalent and appropriate to each. Subgroups are usually determined by (1) demographic characteristics-- age, sex, income, education, literacy, social class, family size, occupation, religion, race, or culture; (2) geographic characteristics--region, size of place, population density or mobility; or (3) psychographic or behavior characteristics--lifestyles, values, or stages of product *'readiness.'*

Child survival efforts put great weight on the considerations of parents' or caretakers' income and product readiness. The primary audience generally consists of lower income populations--those most in need of health products and services. This group, however, may include individuals in various stages of product awareness, ranging from ignorance of the product, to unenthusiastic acquaintance with the product, to various levels of enthusiasm. Understanding the readiness stage of different audience segments is essential to positioning a product correctly.

**The Marketing Mix.** Social marketing conceives of the consumer as the center of a process involving four variables: product, price, place, and promotion. A successful program is organized around a careful analysis of each variable and a strategy which considers how they will interact.

A proposed **product** (whether a commodity, idea, or health practice) must be defined in terms of the users' beliefs, practices, and values. *'Product position'* is the term social marketing uses to describe the mental and market niche created for

each promoted item to distinguish it from competing products or ideas. Extensive audience research guides the development of the product (its name and packaging, its tone, and its rationale) and the portrayal of the benefits it offers.

**Price** can refer to a monetary expenditure, an opportunity cost, a status loss, or a consumer's time. The fact that a rural woman pays no money for a vaccination does not mean that it costs her nothing. Indeed, the day of travel, the inconvenience to family, or the risk of a child's reaction may seem too costly relative to perceived benefits. The price of a particular product is never fixed; it varies according to the target audience segment and often according to the individual.

The concept of **place** refers to the channels through which products flow to users and the points at which they are offered. Product availability and distribution may involve not only retail and wholesale supply systems but also the efforts of health providers, volunteer workers, friends and neighbors. *'Place'* may be a store, a health center, or even a person--such as a traditional birth attendant who carries a supply of ORS. Child survival products and services are frequently not as easily available to users as competing and less appropriate products, because of weak public-sector supply systems. An important planning task in a social marketing program is the choice of appropriate and powerful channels for bringing products to intended audiences. Every *'place'* has its *'price'* and the challenge is to reduce that price as much as possible.

In any social marketing activity, promotion requires more than simple advertising. It requires extensive consumer education to ensure appropriate use of products. While public health communicators use marketing tools to increase the impact of promotional efforts, they must also draw from principles of instructional design to teach complicated consumer skills. Motivational strategies are also essential in encouraging adoption of new ideas and social products. Particularly in closely knit rural areas, community activities can be effective promotional devices.

#### **BEHAVIOR ANALYSIS: SELECTING MESSAGES AND IMPROVING INSTRUCTION**

**Behavior analysis** provides social marketing programs with a rigorous focus on the consumer. It acts as a sort of microscope to reveal what people are actually doing with regard to a particular health problem, and why. Behavior analysis is the study of environmental events, or determinants, that maintain or change behavior patterns. It offers systematic methods for observing and defining behaviors, for identifying behaviors that are conducive to change, and for bringing about and maintaining behavior change. Its principles have been successfully applied to a wide range of health issues, including prevention of heart disease, use of seat belts, dietary management, smoking cessation, and, recently, diarrheal disease control.

Within the context of child survival, an individual caretaker--usually the mother--is faced with difficult choices between existing practices and new behavior. Recommended practices may require her to take a well child to a health center to be

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#### **A Successful Promotion--and a Proper Reward**

The national PREMI child survival campaigns in Ecuador combined vaccinations, distribution of ORS packets, and growth monitoring for children up to two years old. Each of the four campaigns required extensive nationwide promotions.

The highlight of the promotion was a vaccination diploma. Each mother whose child completed the three-vaccination cycle during the campaign received a diploma signed by the Ministry of Health. Calendars, posters, and TV and radio spots promoted the diploma, along with the message, *"each child needs three visits for completing protection."* Approximately 153,000 mothers received a diploma on the mobilization day. Some women came to the vaccination posts even though their children were already vaccinated, so that they could receive the diplomas they had earned.

Later, the diploma was refined to help motivate mothers to bring in their youngest children for vaccinations. Each mother received a gold star on the diploma if her child was fully vaccinated by the age of one.

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stuck with a needle and possibly become fitful all night; and to remember the correct preparation of home oral rehydration solution; to remember when to introduce weaning foods and to determine which ones are best. She may have to determine whether her child is malnourished or just small. She may also discuss having fewer children with her husband who wants another male child.

Each decision or response to a given situation is determined by a complex set of behavioral influences. Whether a new pattern of practice is

easy or difficult to adopt, it may not be easy to accept. Behavior analysis can help probe for the reasons that a given practice persists and determine how alternate behavior might be best introduced--how the behavior can be introduced and encouraged, to ensure that it is adopted and maintained over time.

**Analyzing Complex Behavior.** Not all health practices that sound promising in theory are practical in real life. In the first place, behavior is often more complex than it initially appears. What may at first seem to be a simple practice (such as mixing a package of ORS in a liter of water) often turns out to be a complex cluster of behaviors made up of many separate steps--some of which require new skills or engender costs to the individual. One of the most significant contributions of behavior analysis has been to focus our attention on the complexity and sequential nature of the behavior required of a target audience. It has also provided us with tools to break down practices into their component and observable parts, so that they can be more readily addressed in an instructional program.

A change in behavior may require the target audience either to modify an existing pattern or to learn a new one. In either case, program designers need to understand the full context in which a new practice or set of practices will occur:

What are the environmental events which precede or stimulate the behavior--its antecedents? Are there any natural antecedents (such as a child's thirst when dehydrated) that could stimulate a new behavior (such as giving ORT)?

What are the characteristics of the behavior itself? How simple or complex is it; how frequently must it be performed?

What is the nature of the events which follow a behavior--its consequences? Are they readily apparent, rewarding or punishing, immediate or delayed? How will they affect the repetition of the behavior?

By breaking down health practices into these component parts, planners can gain a clearer idea of where along the chain of events to focus program messages most effectively.

**Selecting Target Behaviors.** In general, the behavioral approach is to try to identify existing practices that are compatible with the new ones, to look for approximations to the new practices already existing in current behavior, and to evaluate the actual costs and benefits--both social and economic--of adopting new practices. Behavior analysis helps to identify the positive consequences that follow adoption of a new behavior and suggests ways to either avoid or eliminate negative outcomes. It emphasizes that, while there are many means of shaping a new behavior pattern, positive consequences, or at least the avoidance of negative ones, are essential to its maintenance.

For numerous reasons, it may be difficult to introduce a health practice to a given audience. Behavior analysis identifies six circumstances that may account for the absence of desirable behavior:

- Necessary skills or knowledge may be lacking.
- Knowledge of when to practice the behavior may be lacking or incorrect.
- Necessary materials may be unavailable.
- Apparent positive consequences for engaging in the behavior may be lacking.
- Positive consequences for engaging in incompatible behavior may exist. (For example, withholding of food during diarrhea may actually reduce the symptoms, whereas oral rehydration therapy may temporarily increase them.)
- Punishing consequences may exist that discourage the desired behavior pattern. (For example, a child may develop a fever after receiving an immunization.)

While the ease with which individuals might adopt a new practice is important in selecting target behaviors, it is also important to determine whether the frequency and persistence with which a new behavior must be practiced are realistic within a rural context. Some changes in behavior, clearly, would have greater effect than others. The potential health impact must be weighed against the likelihood of adoption.

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### **What a Behavior Looks Like Under the Microscope**

A brief example from the Honduras ORT program operational plan shows the degree of detail behavior analysis required in breaking down an apparently simple process into its discrete steps. Below is a list of steps involved in the correct mixing of the local ORS packet.

#### **Mixing Procedure**

- Identify a one-liter vessel.
- Ensure that the vessel is washed and free from foreign matter.
- Fill one liter container with the cleanest water possible.
- Open salt packet without spilling salts.
- Add the contents of one package, with minimal spillage.
- Add nothing else to the solution.
- Stir or shake.
- Do not boil the mixture.

Other elements in the Honduras behavior analysis included maternal diagnosis of diarrhea and dehydration, recognition and acceptance of ORS, knowledge of where to procure it, ORS administration, referral, and post-episode treatment--a total of more than 100 separate steps.

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**Defining Effective Learning Strategies.** The process of learning is not simply that of acquiring knowledge but of mastering new skills and entire patterns of action. Behavior analysis stresses the importance of testing new behavior in real-life situations--much as marketers test new products--to identify problems that individuals may encounter in adopting them. It also emphasizes the need for careful instructional design in

accurately teaching and reinforcing new practices. Critical behavior principles used in designing instructional programs include **modelling** of new behaviors, **repeated practice**, **discrimination** between correct and incorrect performance, and use of **positive reinforcement**.

**Aiding Effective Management.** Health communication planners can use some of the same principles of analysis which help them to understand the environment in which caretakers adopt new practices, and to help them reflect on and influence the environment in which the social marketing professionals work. The program's success will depend partly upon its measurable achievements in affecting a target group's behavior and in bringing about improvement in morbidity and mortality rates. These are the **immediate and positive outcomes** of the program. Other consequences of the communication efforts, however, include various social, political, and financial costs. Managers should be aware of these different consequences and use various behavioral principles--such as modeling of new behaviors, repeated practice, and positive reinforcement--at all professional levels. Just as **long-term maintenance** of new behaviors is the primary goal of communication activities, institutionalization of the communication strategy is the long-term management goal.

## **ANTHROPOLOGY: BEHAVIOR IN CONTEXT**

**Anthropology is the study of human beings, their cultures, and their relationships in society.**

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### **The Strength--and Importance-- of Local Beliefs**

Mothers in Honduras worry about empacho, a type of diarrhea accompanied by cramps and a hardening of the stomach. They consider it quite distinct from other forms of diarrhea. The medical profession has no equivalent for the term and considers empacho a fallacious local belief. Although communication specialists thought it would be a good idea to incorporate empacho in messages about Litrosol, the new ORS product, the Ministry of Health was reluctant to be associated with nonmedical terms.

At the end of the first phase of promotional broadcasts, monitoring showed that women in fact were not using Litrosol for cases they diagnosed as empacho--a good third of all cases of diarrhea. When asked why, mothers responded simply, "*because you never said it was good for empacho.*" Although women consider empacho diarrhea, the term has such a great importance that cases would not be treated unless Litrosol was identified as a remedy for that. The Ministry of Health and communication specialists worked out a compromise. They developed a series of spots which said "*Litrosol is good for all diarrheas*"--a simple addition which clarified the message and led to increased numbers of mothers using Litrosol, even for cases of empacho.

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If behavior analysis serves as a type of microscope for human actions, anthropology can explain the cultural context in which these actions thrive.

Successful social marketing programs consider the cultural context in which it operates--the prevailing perceptions, beliefs, and values, as well as practices. Through the observational techniques,

key-informant interviews, and other approaches of ethnographic research, enable health communicators to look clearly at the traditions of their audiences and to develop programs compatible with them.

We know that anthropology can help us understand cultures different from our own. We often fail to recognize the importance of being sensitive to beliefs and value systems when interacting with close neighbors, however. Anthropology, like social marketing and behavior analysis, reminds us that every audience is made up of subgroups having different characteristics--all of which determine how a promotional effort will be received.

All societies are in constant transition. In developing countries, the shifts are often more pronounced, and the contrasts more poignant. Societies may hold firmly to some aspects of the past while at the same time rushing to adopt new technologies and new behavior. Cultural differences, even within a small country, result in different beliefs and practices regarding a particular health issue. Moreover, individuals change at different rates. Studies of early adopters often mislead planners into believing that change is easy, while analysis of late adopters can lead to skepticism about the possibility of change.

Techniques of ethnographic research, including observations, interviews, and methods of evaluation, can provide valuable information about a culture's perceptions, beliefs, and practices--and the meaning it attaches to them. **Ethnography** is

the recording, reporting, and evaluation of culturally significant beliefs and behavior in particular social settings. Such research generally requires long periods of study and active participation in the day-to-day life of a group, community, or organization under investigation. Ethnographers work in the spoken language(s) of those they study and generally tend to place a greater emphasis on intensive observation and verbal interactions with knowledgeable members of the community ("*informants*") than on documentaries or surveys.

Ethnographic data can provide a wealth of marketing information, but credible ethnographic research requires flexibility, patience, a certain amount of trial and error, and long, hard effort. Some programs may be unable to afford intensive, long-term ethnographic research. Program planners, however, can benefit from tapping the professional expertise of anthropologists in conducting interviews with consumers and in designing research instruments. Moreover, the cultural and linguistic sensitivity that an anthropologist brings to the design of a survey or an intervention is itself valuable.

In addition, ethnographic literature is quite extensive for many parts of the world. These secondary data, gathered by anthropologists living in the program areas, can provide essential information on:

- the economic structures of households and families, and male-female relationships

- traditional beliefs about health and illness
- specific health practices.

It is important to keep in mind that both ethnography and qualitative marketing research may be subject to a fundamental criticism: they depend heavily upon the individual expertise and experience of the persons doing the observing, interviewing, and analyzing.

### A WINNING COMBINATION

Social marketing provides the framework upon which to build a solid mass education program. Behavior analysis focuses on actual health-related practices and helps identify areas of greatest opportunity for change. Anthropological investigation uncovers meaning in the observed practices and suggests mechanisms for linking new ideas to traditional values. Each discipline provides a significant contribution to program design. Used together they promise new levels of success in public health programming.

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**A "Place" for Everything.** Although child survival products are usually part of public health promotions and are available at public health centers, sometimes these centers are not accessible enough or popular enough with local audiences to be effective as the only "place" where products are available.

In Egypt and Indonesia, audience research determined that pharmacies were important sources of both medicine and information to large portions of the population. Program planners, therefore, decided to promote retail sales of ORS, while also making it available at health centers. Pharmacists received special training in diarrheal disease management so that they could provide correct information to consumers whenever they distributed the packets. In Honduras, a program is under way to involve private pharmaceutical companies in ORS through *pulperias*, or small general stores in rural areas. It is anticipated that these outlets will be the most popular with the rural population and that the volume of ORS sold will satisfy private firms.

In Malawi, where malaria accounts for at least ten percent of hospital deaths, chloroquine has been available at both health centers and retail stores. Neither type of outlet, however, was accessible enough to most people. Program planners wondered whether they could "create" a new "place" for chloroquine distribution. Because traditional birth attendants (TBAs) are respected and active in most rural areas, planners decided to conduct a pilot study to train a group of them to distribute chloroquine and to instruct mothers in its use and in preventive measures which can be taken around the home, such as burning of cow dung and elimination of mosquito breeding sites. Results showed the TBAs would be highly effective in this role.

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percent of the population had changed their attitudes or behavior toward AIDS.<sup>10</sup>

- In India, condom sales increased from fewer than 25 million in the late 1960s to more than 160 million in 1979. Seventy-five percent of these new sales were a specific brand called Nirodh, which was introduced through a social marketing approach relying heavily on consumer education.<sup>8</sup>
- In the United States, rates of venereal disease increased after government funding decreased. Rates of STDs declined when the legislation was rescinded.<sup>2</sup>
- In a landmark study of three communities in northern California, the Stanford Heart Disease Prevention Program compared: (1) no intervention against heart disease; (2) a mass media education program against heart disease; and (3) a mass media plus interpersonal support program. Interventions 2 and 3 showed significant improvement over non-intervention 1, and 3 showed gains over 2.<sup>8</sup>

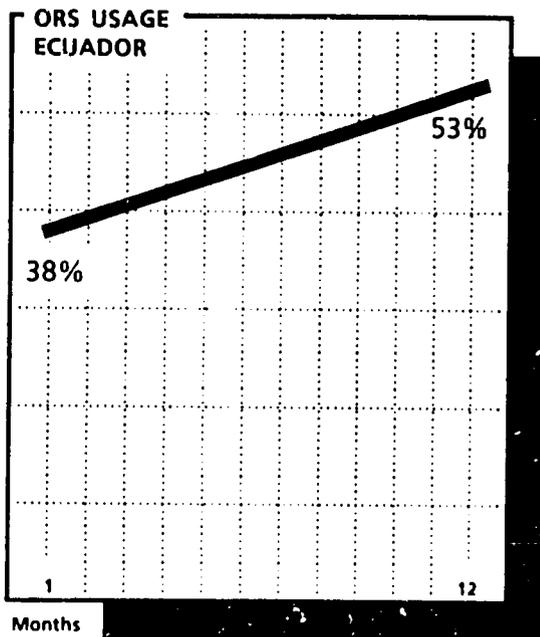
### 3. SOCIAL MARKETING WORKS

Social marketing has made a significant contribution to improved child health when the methodology has been applied conscientiously. It has been effective largely because of its emphasis on the consumer, through preliminary research and field testing of products and practices. Although individual countries have unique cultures, special problems, and varying constraints, the general strategy as presented here has proved to be adaptable worldwide.

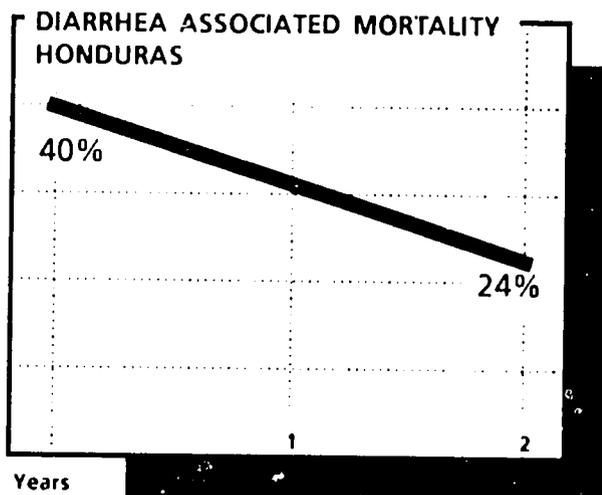
The goal of social marketing strategies is to bring about changes in health-related practices and, in turn, in actual health status. A few illustrations from results obtained during the recent past demonstrate the possibility of such success.

- In Australia, a dramatic AIDS awareness education campaign using mass media plus pamphlets and print advertisements showed that 44

**In Ecuador**, during 1985 and 1986, the National Child Survival Program (PREMI) conducted a series of mass mobilizations supported by extensive media efforts to immunize and weigh all

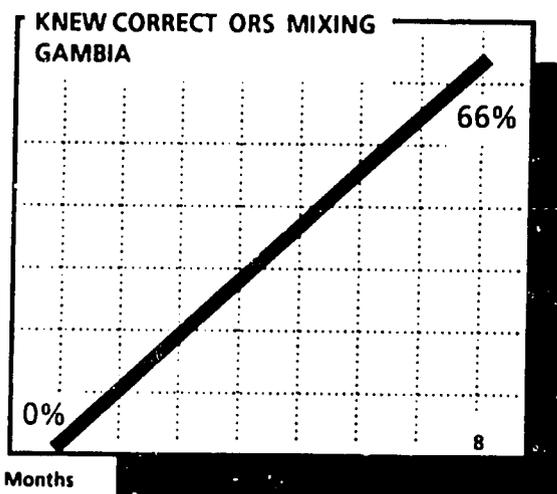


children under five and to distribute packets of oral rehydration salts (ORS). In less than a year, by the end of the third phase, the program had delivered 1,200,000 vaccinations and had distributed more than a million ORS packets. Seventy-five percent of Ecuadorian mothers had an ORS packet in the home and the percentage who reported using it had increased from 38 percent to 53 percent.

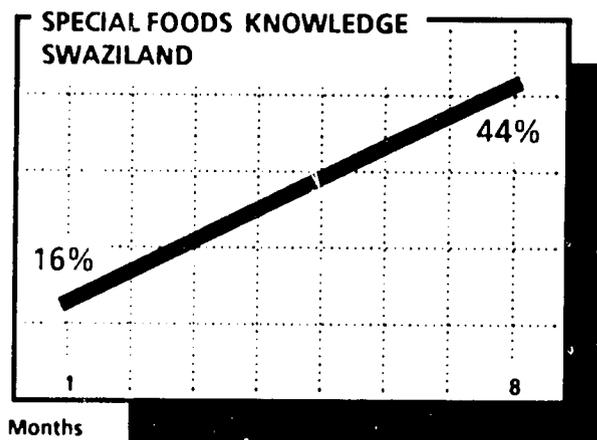


In Honduras, mothers were taught to use a new oral rehydration solution called Litrosol. After two years of promotional radio broadcasting, 60 percent of the rural women interviewed reported

using the government's new ORS product; 35 percent of all cases were reported to have been treated with oral therapy. Mortality associated with diarrhea in children under five dropped from 40 percent to 24 percent in the target region during the two-year period.



In The Gambia, after an intensive eight-month communication effort focusing on oral rehydration therapy, 66 percent of rural mothers in the intervention could recite the correct formula for a home-mixed formula using locally available bottles and bottle caps. After two years, 70 percent could recite the formula and 62 percent of mothers surveyed reported treating recent cases of diarrhea with the solution.



**In Swaziland**, a communication intervention helped teach mothers how to improve dietary management of diarrhea in the home. After eight months, the number of mothers who reported that children should be fed special foods after an episode of diarrhea increased from 16 to 44 percent.

**In Egypt**, an aggressive social marketing campaign and face-to-face educational efforts by health personnel and pharmacists increased the reported use of ORT from 1 percent to 69 percent in less than a year. After two years, 90 percent of all physicians reported routinely prescribing ORS, and a study of death registrations in Alexandria suggested that during the diarrheal season, overall mortality in children under one year old dropped by approximately 30 percent between 1982 and 1984.

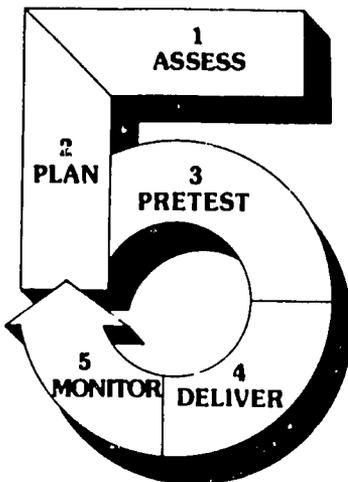
**In Bangladesh**, the Oral Therapy Extension Program (OTEP) has since 1980 taught four million mothers about ORT through intensive face-to-face instruction. An evaluation showed that 90 percent of the tested mothers were able to mix a safe and effective ORS solution several months after their original instruction.

**In Indonesia**, the Nutrition Communication and Behavior Change Project used communication to strengthen the mother's role in child feeding. An evaluation showed that by 24 months of age, 40 percent of the project infants were better nourished than infants in the comparison group.

1. Assess
2. Plan
3. Develop and pretest
4. Deliver
5. Monitor and revise

Each of the foregoing stages involves a number of steps. The strategy is not a linear one, however, but a cyclical one. As with the process of human learning itself, social marketing is an iterative process in which the results of experience feed back into and shape subsequent action: planning leads to interventions; monitoring of those interventions leads to subsequent changes in planning. Research into consumer needs and responses shapes every stage of the communication effort, often requiring midcourse adjustments and rethinking.

#### 4. FIVE STEPS TO SUCCESSFUL SOCIAL MARKETING



Social marketing provides a strategy for planning and conducting long-term programs to produce specific, sustained behavior change in large target populations. This plan of action consists of five steps:

The basic action steps of the social marketing are as follows:

**Step 1. Assess** the problem, the audiences' present behavior, knowledge and attitudes toward the problem, and the delivery mechanisms available to influence those audiences.

**Step 2. Plan** a communication program that delivers messages and support to a specific audience segment through various channels in a way which is attractive, persuasive, and provides repeated exposure.

**Step 3. Develop and pretest** materials and tactics for face-to-face, community, print, and mass media channels.

**Step 4. Deliver materials, messages, and support needed to complement service delivery timing.**

**Step 5. Monitor and change tactics, messages, materials, and channels as needed to meet changing audience needs.**

A lifestyle communication program is by nature a cooperative venture. The program's success will depend upon the involvement, interest, and support of ministries, health professionals, auxiliaries, private firms, the media, international donors, public officials, popular opinion leaders, and volunteers.

education and our relationship as health professionals to patients, their family, and their community. Many of us believe now that to approach the possibility of successful lifestyle education we must ask ourselves: **Is our program. . . .**

**1. Audience centered. . . .**

Is our program built on how the audience understands the problem and does it provide something they want and believe in?

**2. Targeted. . . .**

Is our audience segmented into groups of people that we can reach and influence with our messages? Are our objectives narrow enough to be achievable, and are they phased in ways which permit us to measure whether they are being achieved?

**3. Comprehensively Planned. . . .**

Have we considered **all of the factors** that influence behavior change: the behaviors themselves; the obstacles our audience will face in using these new practices; the means to distribute information and products to the right people, on time; and the means to inform, motivate, and teach our audience about the new behaviors in ways which are both accurate and persuasive?

**4. Integrated. . . .**

Are we using more than one delivery system, mass media, interpersonal, and print, and do these channels **interact** to support each other with the same clear message?

**5. Data-Based?**

Do we have data to support and guide our basic decisions? Are we relying too heavily on experience, intuition, and anecdotes? And, are we willing to **recognize our mistakes** and use existing data to make needed midcourse changes?

## **5. LESSONS: THE BIG IDEAS THAT REALLY MATTER**

A decade of experience, working with more than 25 countries on problems as challenging as diarrheal dehydration, maternal child nutrition, immunization, child spacing, and acute respiratory infections produced a plethora of lessons, insights, data, beliefs, and anecdotes about what works and what does not. Five key ideas emerge in the author's mind as the truly "*big*" ideas that should shape our thinking about lifestyle education and perhaps even our entire education strategy as we face the new challenges of AIDS, environmental health, and other lifestyle education problems.

Perhaps these lessons are best summarized as questions to ask ourselves as we plan and develop programs. Each question poses a challenge to our old ways of thinking about health and

Within the answer to this question lies the possibility of shaping programs that help people to protect themselves and their children from some of the most deadly and harmful diseases of humanity.

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<sup>1</sup> Kotler, Philip, and Alan Andreasen. Marketing for Nonprofit Organizations. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975. (Revised edition in 1987 published as Strategic Marketing for Nonprofit Organizations.)

This paper has been adapted in large part from the book Communication for Child Survival, Rasmuson, Seidel, Smith, and Booth.

## PHOTOGRAPH AND VIDEO CREDITS

### VIDEOS

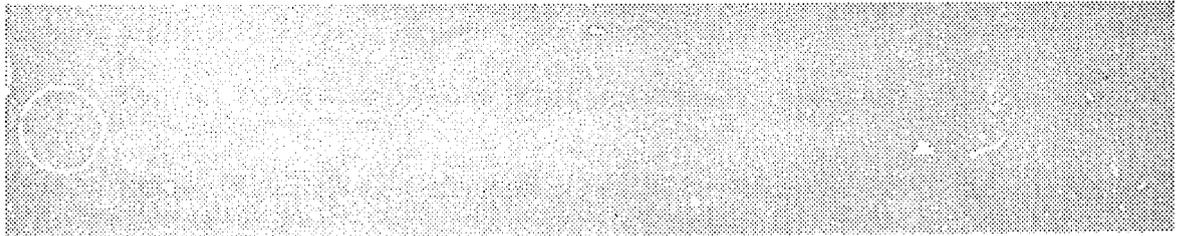
Communication for Child Survival. HEALTHCOM/USAID--Office of Health/Academy for Educational Development.

SOMARC. SOMARC/USAID/Futures Group.

Women Take the Lead. AIDS Control Program; Dominican Republic/AIDSCOM/USAID/Academy for Educational Development.

### PHOTOGRAPHS/ART WORK

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