Monograph No. 5

Social Marketing Communications

Its Contribution to the Philippine Child Survival Program

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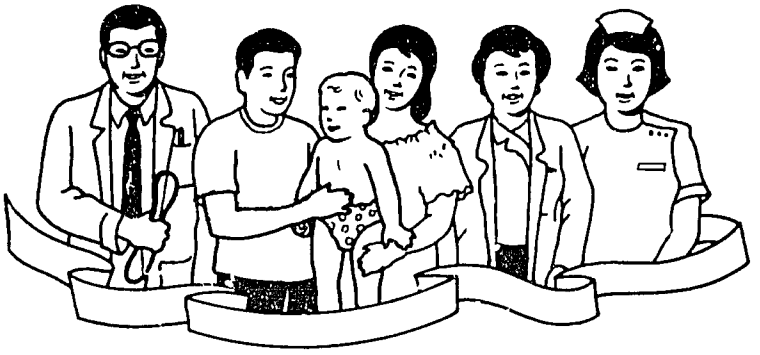
Contents

List of abbreviations used

BCG	-	Bacillus Calmette-Guérin (vaccine for tuberculosis)
BHS	-	Barangay Health Station
CDD	-	Control of Diarrheal Disease
CSP	-	Child Survival Program
DOH	-	Department of Health
DPT1	-	Diphtheria, Pertussis, Tetanus (vaccine), 1st dose
DPT2	-	Diphtheria, Pertussis, Tetanus (vaccine), 2nd dose
EPI	-	Expanded Program on Immunization
FHSIS	-	Field Health Services Information System
FIC	-	Fully Immunized Child
HEMDTS	-	Health Education, Manpower Development and Training Service
IEC	-	Information, Education and Communication
KAP	-	Knowledge, Attitude and Practice
KBP	-	Kapisanan ng mga Brodkasters ng Pilipinas
MCHS	-	Maternal and Child Health Service
MICACS	-	Midwives' Integrated Communication Aid for Child Survival
NGO	-	Nongovernmental Organization
NIC	-	National Immunization Committee
OPV1	-	Oral Polio Vaccine, 1st dose
OPV2	-	Oral Polio Vaccine, 2nd dose
OPV3	-	Oral Polio Vaccine, 3rd dose
ORS	-	Oral Rehydration Solution
ORT	-	Oral Rehydration Therapy
PEVAC	-	Prequalification, Evaluation and Awards Committee
PIA	-	Philippine Information Agency
PIHES	-	Public Information and Health Education Service
PIO	-	Public Information Officer
POS	-	Point of Service
RHU	-	Rural Health Unit
RIO	-	Regional Immunization Officer
USAID	-	United States Agency for International Development

Introduction



The 1980s brought a period of sustained economic recession to the Philippines. The accompanying extreme poverty—not seen in the Philippines since World War II—carried with it the usual social ills of unemployment, congested housing, poor sanitation and inadequate health services, resulting in dramatically high rates of morbidity and mortality among children.

In the Philippines, 50 percent of the population is under the age of 20, and 20 percent is under the age of seven. Under the stress of the recession, mortality rates for the youthful population were particularly grim. In the mid 1980s, 20 percent of all reported deaths were infants (under 12 months old); 300 children (under five years old) died daily.

Persisting disease patterns among infants and children indicated a lack of awareness of available services and subsequent low use of these services. In 1983, according to data reported from health facilities, 66 percent of all pneumonia cases, 59 percent of all bronchitis cases, 57 percent of all diarrhea cases and 67 percent of all measles cases occurred in infants and children under five. In 1984, according to data from death certificates, pneumonia accounted for 24 percent of all infant deaths; diarrhea, nutritional deficiencies and measles accounted for 17 percent of infant deaths; other respiratory diseases accounted for another 16 percent. Thus, easily preventable diseases accounted for more than 50 percent of all infant deaths.

Under the existing health system, health services are provided through private and

public hospitals, Rural Health Units, Barangay Health Stations, private physicians, nongovernmental organizations and traditional health practitioners.

In 1985 there was one hospital bed for every 600 persons, but these beds were distributed unevenly throughout the country. For example, in Metro Manila the ratio was 1:300; in rural areas the ratio was 1:1,100.

Rural Health Units and Barangay Health Stations were distributed fairly evenly throughout the country, but they were located only on major transportation arteries and not easily accessible to remote populations. In these remote areas there was only one physician, nurse or midwife to serve 6,000 people.[1] Nongovernmental organizations tried to fill a gap in health services in these rural areas, but their operations were relatively small.

To address the issue of promotive and preventive health-care services, the Philippine Department of Health and the United States Agency for International Development (USAID) established the Philippine Child Survival Program (CSP). Under the CSP, the principal strategy to generate an increased demand for health services leading to their increased use was social marketing. The social marketing strategy, using a strong information, education and communication (IEC) component, was designed not only to increase consumer demand but also to sustain high utilization rates and encourage the transition of service delivery from the public to the private sector.■

[1]USAID/Philippines. *The Child Survival Program (492-0406) Program Assistance Approval Document.* September 1989.

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1
The problem: generating and sustaining demand for health services

In the Philippines, because of a breakdown in communication on basic public health, people were dying of diseases for which cures and immunizations had long been available. Reports from Department of Health field offices indicated low use of immunization services while infant mortality statistics pointed to numerous deaths from measles. Clearly the public needed to be informed of the advantages of immunization as well as the availability of basic health services. Thus, DOH determined the need for an IEC component as a part of a wider social marketing campaign to increase public awareness of and create a demand for improved child-health practices.

Early IEC support for public health programs amounted to the development, production and distribution of visual aids (posters, leaflets, etc.) and reference manuals for front-line DOH workers to inform, instruct and motivate a target audience. Later efforts included developing materials for radio and television. Before 1986 the central responsibility for IEC support rested with the Health Education, Manpower Development and Training Service, a unit charged with producing teaching materials and training health workers via the health educators. Within this structure, however, the public information element was missing. Although there were public information officers under a separate unit within the Department of Health, they worked independently of the health educators and their tasks were

not clearly defined.[2] IEC projects at this time were not comprehensively researched, were limited in scope and were largely reactive to program needs. Sporadic bursts of activity characterized IEC projects– -often resulting in short-lived results.

1986 saw a change in leadership in the Philippines. The new leaders realized the need for social marketing—a more integrated and strategic approach to promoting public health programs. In 1987 the Department of Health created the Public Information and Health Education Service (PIHES) where health educators and public information officers were grouped together. PIHES was charged with formulating and implementing plans, programs and projects for public education on health as well as communicating DOH policy on health issues in a timely and accurate manner.[3] Thus, through PIHES, the Department of Health now develops public information programs and effectively integrates them into health education programs.

In 1987, shortly after PIHES was formed, the Department of Health and USAID initiated the Philippine Health Communication for Child Survival Program to promote the widespread use of effective child survival strategies. This was attached to the centrally funded Health Communication for Child Survival program (Healthcom), which has been implemented in 17 countries using a research and developmental approach to promote changes in behavior that affect health.[4] The approach draws from the disciplines of social marketing, communications, behavioral analysis, instructional design and anthropology among others. The goals of the project are to apply social marketing techniques to develop communications interventions that would lead to widespread adoption of health behavior to reduce child mortality.[5] Through this child survival initiative, the Department of Health was able to launch social marketing communication campaigns designed to bring about changes in consumer demand for child survival services.■

[2]Department of Health. The Public Information and Health Education Service Priorities, Tasks, and Implementing Guidelines, 1990-1992, 1990

[3]Section 9 of Executive Order 119, Series of 1986.

[4]Zimicki, Hornik, Lee. *The Healthcom Project in the Philippines: Final Case Study Evaluation Report.* March 1991.

[5]Healthcom/Academy for Educational Development. *Draft Final Report of the Philippine Healthcom Project, by Verzosa, Hernandez, de Guzman,* 1990.

2
IEC and social marketing: people are the key

What is social marketing?

Social marketing refers to the design, implementation and control of programs seeking to increase the acceptability of a social idea or practice in a target group. Social marketing uses the four variables of marketing, known as the 4 P's: 1) *product*, 2) *place*, 3) *price* and 4) *promotion* while focusing on the social benefit for the consumer.* The *product* might be a tangible item such as oral rehydration solution, a service such as immunization, or a practice such as breast-feeding. The *price*, which is what the *product* will cost the consumer, could be a monetary expenditure or a social cost such as time. *Place* in social marketing refers to the channels through which the *product* flows to the user and the points at which it is offered, i.e. a public health-care system. *Promotion* refers to the messages that are relayed to target audiences using specific channels of communication. Social marketing promotes products and practices by appealing to individual self-interest, but the change it encourages benefits the individual and society as a whole.

At the center is the key to the process—*people*—or the fifth P. As a people-centered concept, social marketing relies on a fundamental client or consumer orientation. The target audience is systematically consulted throughout the communication process, thereby providing the data for ongoing marketing decisions. In short, the key to successful social marketing is to

*Academy for Educational Development/Healthcom. *Communication for Child Survival* by Rasmuson, Seidel, Smith, Booth. June 1988.

find the consumer need, then fill it.

Who can carry out social marketing?

From experience with the private sector, marketing (generic marketing) has proved to be an immensely powerful tool for effecting mass behavioral change to achieve the marketers' objectives. The success of the top-selling brands of soft drinks, detergents and shampoos attests to the power of marketing in the private sector. Social marketing, as opposed to generic marketing, seeks to influence behavior to benefit a target audience and society (not the marketer).[7]

Two health-care practices aimed at increasing child survival in the Philippines have been addressed effectively by the Department of Health with social marketing--diarrheal disease control and immunization.

Social marketing can be carried out by individuals, informal groups or formal organizations in any area and can involve influencing individuals to use products or services (rehydration solutions, immunizations) or simply change behavior (recognize signs of dehydration, keep immunization records).

Although social marketing can involve sales and profits, many social marketing efforts—such as government programs selling rehydration solutions—serve selfless objectives.

How was social marketing used by DOH?

In the mid 1980s, social marketing was a relatively new technology to the Philippines. But, because of the urgency of health problems, the Department of Health moved quickly to contract with a team of experts to adopt social marketing as the central organizing principle in communications campaigns for key child-survival interventions. As the campaign strategy to educate and inform the public was being developed, the PHES staff learned valuable lessons from the social marketing team. On-the-job-training and workshops on technical skills and research techniques helped reinforce the skills of PHES staff and served to improve the design and execution of subsequent campaigns that promoted other health services.

Evaluation surveys studying the impact of the immunization and control of diarrheal disease campaigns showed that social marketing communications contributed significantly to the increased use of health services.

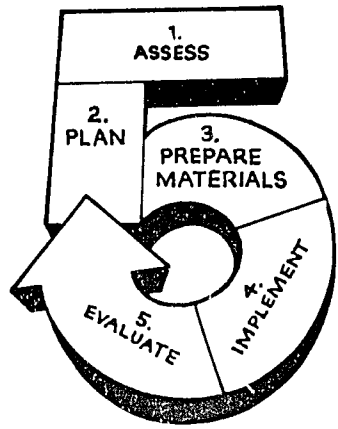
[7]Academy for Educational Development/Healthcom. *Social Marketing: Its Potential Contribution to the Public Sector*, by Alan R. Andreasen. Washington, D.C.

The Department of Health used the concept of social marketing as a management tool as well as a method to increase the use of health services. As a management tool, social marketing principles enabled PIHES staff to translate public health goals into community-based strategies by focusing on the client. They were able to see the child, the parent, the problem and the solution as a coherent whole; to assess the implications of economic and social realities; and to build programs around these factors. PIHES investigated the needs and concerns of a target audience (mothers and children), devised strategies that were mostly to work in context, and analyzed the effectiveness and reach of the services implemented.

Designing a social marketing initiative: a five-step process

In its DOH social marketing campaigns, PIHES used a five-step process of **1)** assessing, **2)** planning, **3)** developing and pretesting, **4)** implementing communication activities and **5)** evaluating results and using feedback to refine the program.[8]

Step 1 involved assessing the population's current knowledge, attitudes and practices as well as



available health technologies. This included assessing the clinical and epidemiological characteristics of the desired health behavior, understanding the national health policies; and conducting developmental research on the consumer, the health provider, the service delivery system and the potential communication channels.

Step 2 involved planning a communication program based on the assessment findings that would bring messages and support to a specific audience segment.

Step 3 included developing and pretesting materials and methods to determine which channels are appropriate, i.e. face to face, community, print, or the mass media and whether or not

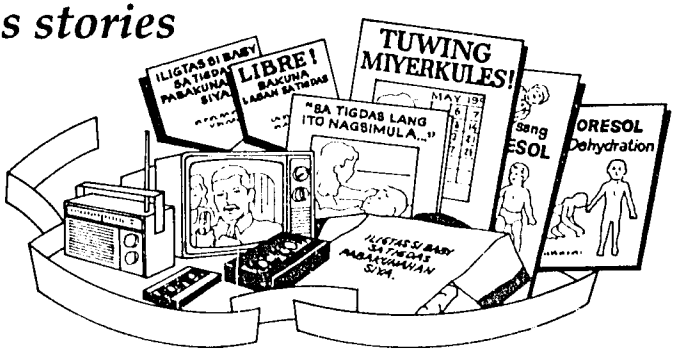
[8]Department of Health/Healthcom. *Managing a Communication Program on Immunization, a Decision-Making Guide* by Verzosa, Bernaje, de Guzman, Hernandez, Reodica, Taguiwalo. December 1989

the message was understood.

Step 4 involved delivering materials, messages and support to complement the timing of the service delivery. The messages were directed through channels that were convincing and provided repeated exposure.

Step 5 included monitoring and then altering tactics, messages, materials and channels to meet audience needs. A major feature of the fifth step was feedback whereby planners listened to the client, and fed evaluation results back into the planning cycle.■

3
The EPI and CDD success stories



Following the five-step process to develop a social marketing initiative, PIHES was able to design and implement several effective social marketing campaigns. Two outstanding campaigns were the Expanded Program on Immunization (EPI) and the Program on Control of Diarrheal Disease (CDD).

Poor consumer demand

In the Philippines, many children die each year of diseases that are largely preventable through routine vaccinations which are available through public health services. Department of Health statistics for 1984 listed measles, bronchitis, tetanus, diphtheria, tuberculosis and whooping cough as the leading causes of infant and child deaths.

At the same time, the Department of Health reports low utilization rates for preventive care. A 1986 report showed that in four surveyed regions (6, 7, 10 and Metro Manila), only 21.3 percent of eligible infants were fully immunized. Of the four selected regions, Metro Manila had one of the lowest full immunization coverage rates at 15.9 percent. And among the six antigens, measles, the deadliest of the immunizable diseases, had the lowest coverage rate.

These findings on low immunization coverage nationwide were confirmed by subsequent EPI reports (fourth quarter, 1986 and first quarter, 1987) indicating the lowest full immunization rate was in major urban and provincial areas.

In 1987 TRENDS, a private market-research firm, did a follow-through survey on the key findings of the 1986 survey by the

Department of Health. The respondents of this survey were 800 low-income mothers with children two years old and below living in Metro Manila and six other cities. The survey showed that awareness of the need for immunization was high, but that compliance was low. The findings also indicated that mothers knew vaccination meant protection and even knew in some detail how many times they needed to return to the health centers for vaccinations.

Despite this knowledge, mothers failed to bring their children back to the health centers to complete the immunization series. The survey showed only 23 percent of children received their vaccinations on time, while only 19 percent completed the series on time. Only 22 percent of children over 11 months had complete immunization coverage as verified by vaccination cards.

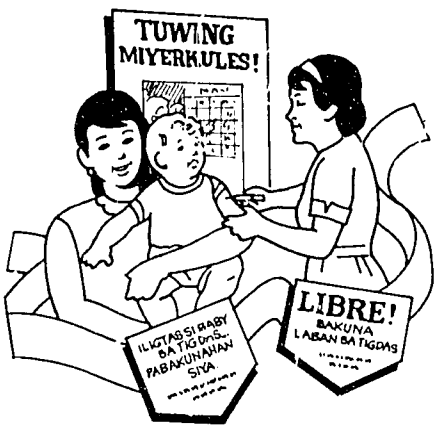
In 1987-88 the Department of Health conducted another survey on diarrhea awareness and management. The respondents were 1,200 low-income mothers with children under five years of age in urban and rural areas of pilot regions 6, 7 and 10. The results showed that most mothers (75 percent) knew when their children had diarrhea, but very few knew that dehydration was an important factor in diarrhea.

The findings also indicated that respondents in two of the regions had a high awareness (76 percent) of the government-marketed rehydration solution (Oresol), but actual use was lower, 47 percent for use in any previous diarrheal episode and 20 percent in the last diarrhea episode.

Poor consumer demand for health services, as identified in these surveys, often indicated the consumer's incomplete knowledge of the need for and the benefits of preventive health care. Low demand can also result from insufficient motivation of consumers to obtain these services. While low use rates might be the result of many factors (low income, poor service, literacy difficulties), the problem of incomplete demand could largely be addressed through social marketing efforts and IEC campaigns.

EPI: Focus on measles

The Expanded Program on Immunization was directed at raising the national level of fully immunized children under one year of age from a low of 28 percent to 90 percent within a five-year period, 1988-93. Departing from the established tradition of focusing communication on full immunization, the EPI campaign addressed itself primarily to complications arising from measles. The em-



phasis on communication efforts directed at measles was guided by several factors: formative research showed that mothers recognized the vulnerability of their children to measles, and the application of the vaccine for measles was the last step in the regular series of vaccinations given to children.

The service outlets of the Department of Health included 2,072 rural health units, 9,194 barangay health stations and 218 puericulture health centers, plus a network of hospitals at the regional, provincial and district levels. PIHES mobilized health educators and public information officers to assess the feasibility of a mass-media campaign, to devise a method that would focus on consumer campaigns and conduct focus group discussions on the conditions that influenced the attitudes and behavior of mothers and caretakers vis-à-vis their knowledge of immunization and services offered by the Department of Health.

EPI Metro Manila pilot campaign preparatory activities: July 1987 to January 1988

The EPI communication plan using the promotion of immunization for measles was tested in Metro Manila. This sector was selected as the pilot area because it had the lowest EPI coverage rate and measles had the lowest coverage rate among the six immunization antigens. Although communication efforts focused on measles only, DOH campaign goals were for full immunization; therefore health centers had to be prepared to give all vaccines.

In keeping with the Health Department's objective of increasing the role of the private sector in matters of health, the strategy also involved working with local private-sector resources in communications and market research. The planning and implementation of the campaign involved a local advertising agency.

The role of the advertising agency that carries the message is almost as vital as the role of the one who defines the message. To

carry the message to mothers and caretakers, PIHES needed the help of professionals who were accomplished at reaching specialized audiences. While some consideration was given to tapping the government's Public Information Agency, past DOH experience had shown that PIA efforts had not been highly effective, mainly traceable to relatively weak creative products and poor media implementation. The so-called access to "free media" was given by broadcast companies in exchange for tax rebates and was, therefore, not really free; moreover, radio and TV spots were aired on run-of-station basis and seldom on prime time.

Private advertising agencies, on the other hand, offered more attractive terms: ads were on prime time and, more important, would enable the Department of Health to negotiate for the price of broadcast spots equivalent to deals enjoyed by the heaviest private advertisers, plus the networks' separate pledge to add their own public-service efforts. Private agencies proved more creative and experienced in marketing techniques. Finally, using a private agency supported the Health Department's drive toward a child-survival program objective of increasing public-private sector collaboration in health.

The selection of the advertising agency as approved by USAID and the Department of Health entailed a review of candidate firms rather than publishing a formal Request for Proposal. From the review of corporate profiles of the 46-firm roster of the Association of Accredited Advertising Agencies, 14 full-service agencies were invited; nine responded with interest. Of these PAC/BBDO received the highest overall rating from the screening committee. PIHES, PAC/BBDO and the team of social marketing experts spent several months in late 1987 developing the communication strategy for the campaign.

A local market-research firm, TRENDS, conducted the formative research which formed the basis for the pilot campaign's creative strategy. The importance of formative research in a social marketing campaign is paramount: its main message must be realistic and founded on a clear understanding of the target audience (mothers and caretakers), the product's supply-demand situation and distribution system (health providers and the health delivery system), and the vehicles for promotion. The formative research identified the obstacles that mothers had to overcome in order to fully immunize their children. These included eliminating the bias

toward underestimating the dangers posed by measles.

The pilot campaign strategy

The pilot campaign was made up of two strategic components—the thematic and the tactical. The thematic component, designed to arouse concern, dramatized the health complications associated with measles such as pneumonia and emphasized that immunization protects a child from measles. The tactical component provided frequent reminders to reinforce the desired action of mothers such as *who* (baby 9-12 months), *what* (free immunization), *where* (at the health center), and *when* (every Friday, 8 a.m. to 8 p.m.).

Authority figures, like the Secretary of Health and credible celebrities, were tapped to endorse the thematic and tactical components of the campaign. The Department of Health also approached and secured the cooperation of city and municipal officials, videotaping the mayor's endorsements for use in the campaign. This active solicitation of local municipal figures is credited with greatly contributing to the success of the pilot.

The strategy of focusing on a single message—the importance of immunization against measles—was borrowed from commercial advertising and departed from the traditional approach of addressing full immunization. Because the pilot site was a metropolitan area and the time frame short, the mass media were the main channel selected for promotional messages.

To prepare the service delivery network—the health centers—for increased demand, the Department of Health introduced a concept from the commercial world. The Department held "sales conferences" to brief health center staff before launching the campaign. At these conferences, staff were briefed on the attributes of the campaign, on the messages being imparted and on the goals to be reached. Consistency of interpersonal communication with mass-media messages was emphasized. Communication materials supporting broadcast messages were developed and distributed to the health centers. These included point-of-service items such as *welcome* streamers, posters, plastic buntings, immunization team T-shirts and stickers for jeepneys and tricycles.

The campaign takes off

In February 1988 the Secretary of Health presented the media with a preview of the TV and radio commercials that would be used in the pilot campaign. The major networks and national dailies all covered the beginning of the campaign, and for 13

weeks the campaign's thematic and tactical messages filled the airwaves. Aimed at reaching 78 percent of middle- and low-income households in Metro Manila twice a week, the TV spots were placed on high-rating variety shows, news programs and soap operas; radio commercials also were placed in time slots with high listenership rates. Broadcast networks added their public-service efforts. Print ads in two leading tabloids, reminding mothers of "Immunization Day," added visibility to the campaign.

The Department of Health used monitoring teams to track the pilot's progress at the health centers. These teams reported local problems to planners at appropriate higher levels. The health centers were given feedback forms to report their findings, and PHIES and Maternal and Child Health Service teams made spot visits to the centers.

Research results from the mothers' surveys conducted in January 1988 and May 1988 revealed the following:

a) The campaign had a significant effect. Measles vaccinations increased substantially among the 12- to 23-month-old children in Metro Manila. The card-verified measles vaccination coverage doubled, rising 22 percentage points from 23 percent to 45 percent between January and May. (*Coverage among 12- to 23-month-old children is the international standard for evaluating vaccination programs.*)

b) Coverage for all other antigens also increased. Card-verified data showed the following increase in coverage between January 1988 and May 1988:

Antigen	1988 Card-verified coverage	
	January	May
	(Percent)	
BCG	31.4%	54.9%
DPT1	37.1	57.0
OPV1	36.7	57.0
DPT2	31.0	51.9
OPV2	30.5	51.9
DPT3	26.2	48.9
OPV3	26.2	45.6
Measles	22.9	45.1

Source: Annenberg School of Communication, University of Pennsylvania, 1989

(c) The proportion of children who had not had any vaccinations decreased. The proportion of 12- to 23-month-old children who had ever received a vaccination increased between January (38.1 percent) to May (59.1 percent), according to card-verified data. This outcome was a welcome result because the campaign aroused the target-audience's interest and awareness of the value of vaccinations in general and measles vaccinations in particular;

(d) During "Immunization

Day,"significantly more mothers came into the health centers than on other days. The pilot campaign had popularized a single day, Friday, for measles vaccinations, although health centers continued to give vaccinations daily;

(e) Mothers cited television ads as the most common source of information on the campaign. Ninety-seven percent of the mothers cited television as their source of information, 37 percent mentioned radio, 21 percent noted the posters at the health center, and 9 percent mentioned newspapers as their source of information about the measles vaccination given free at the health centers on Fridays.

Lessons from the campaign

The pilot campaign showed that focusing on a single message—the importance of measles immunization—is an effective strategy for persuading mothers to bring their babies to health centers for full immunization. In effect, the measles strategy boosted immunization rates for all antigens. However, in order for this strategy to work, the service delivery network had to be fully synchronized. That is, promoting measles immunization only pulled mothers to the health centers; full immunization had to be promoted by health workers once the mothers were in the centers.

The strategy of setting aside one immunization day a week proved effective. It gave mothers a set time in which to act and it prompted the DOH to marshal the resources of the centers efficiently. Hence, missed opportunities were also lessened.

The technique of using the mass media to promote the two key elements of the campaign—one type of immunization and one immunization day—served to reach as many mothers as possible in a short span of time. This proved highly effective in drawing the mothers to the centers, where they could be informed of the benefits of full immunization.

Nationwide implementation: Year 1

The results of the EPI pilot campaign indicated success: Measles vaccinations increased as did coverage for other antigens; the number of uncovered children dropped; and more mothers visited health centers. However, moving from a pilot campaign to nationwide implementation proved to be a complex matter.

The Health Department's organizational structure did not lend itself to an easy transition to a nationwide campaign. All structural levels from top-level management to central-level services, down to field-level

health offices had to be informed, consulted, convinced and mobilized in order to implement a successful nationwide campaign.

The first step in communicating within the Department of Health was to disseminate the results of the pilot campaign to all organizational levels, i.e. regional, provincial and municipal, as well as to the regional immunization officers and the National Immunization Committee. The committee is a policy-making body of representatives from the Department of Health, nongovernmental organizations and donor agencies. It is chaired by the Undersecretary for Public Health, under whose supervision the Maternal and Child Health Service falls. Regional immunization officers are health personnel tasked with implementing EPI at the regional level.

The strategy

Certain strategies and elements used in the pilot campaign were determined appropriate for the national campaign—the focus on cities to improve immunization coverage, the use of communication messages with measles as the hook, and the use of a private advertising agency. Following its successful work in the pilot project, the same advertising agency which handled the pilot campaign was selected by the Health Department as the private agency to do follow-on work on the national expansion. This was a departure from the usual open rebidding process done in previous years.

The Immunization Day was chosen in consultation with all Health Department organizational levels, particularly regional immunization officers. Friday, the Immunization Day for the pilot campaign, was ruled out for several reasons. Besides being a day of worship in Muslim areas, it does not, for most areas, allow next-day follow-up when there are complications. Thus Wednesday was selected as Immunization Day, giving staff two days early in the week to prepare, and two days after immunizations to deal with possible complications. The immunization schedule would be weekly.

Preparations

Because all urban municipalities and cities were to be covered in the national campaign, a number of pre-campaign activities and planning conferences were conducted with city and health professionals. City and municipal officials were briefed on the results of the pilot campaign, informed of the objectives and strategies of the national campaign and consulted on operational issues. The League of City Mayors was consulted early on and, as a result, it supported

the EPI campaign.

"Sales conferences" tested in the pilot project were used to provide orientation for three major groups of clinic personnel in Luzon, the Visayas and Mindanao. These groups were encouraged to establish "echo conferences" in their own regions and to initiate "kick-off" activities involving local mayors, officials and the press. Both the sales and echo conferences reinforced Health Department policies on vaccinations, prepared clinics for increased demand and encouraged the involvement of personnel in the campaign.

Communication materials developed for the pilot campaign were adapted for the nationwide campaign. New broadcast materials reflected the choice of Wednesday as Immunization Day and used thematic and tactical approaches similar to those used in the pilot campaign. PIHES assigned a group to supervise and implement the distribution of point-of-service materials to the health centers. The Maternal and Child Health Service trained the health personnel even as the cold chain was properly set up, ensuring potency and adequate supplies of all antigens in all outlets.

Launching the campaign

The Secretary of Health launched the campaign at a news conference attended by four national television networks, all major radio stations and nine national newspapers. Coverage during the day of the launching, and for several days afterward, was extensive. Regional and municipal offices also held simultaneous launching activities at local levels and received regional coverage.

The mass media aimed to reach 65 percent of all households over a six-month period, using radio as the primary medium nationally, whereas television and print were used as the primary media in major urban areas. Radio placements were within peak listening hours on a cross-channel pattern to ensure a wide reach. Through a package arrangement with the National Association of Broadcasters, or KBP (Kapisanan ng mga Brodkasters ng Pilipinas), which has more than 100 member-networks, high exposure was achieved at low cost by airing spots about measles on all their radio stations, covering virtually the whole country. The TV spots were placed on prime-time programs in Metro Manila and broadcast simultaneously, or a week later, on provincial television stations. Besides radio and television coverage, tactical "ear" ads were also placed in major publications in the country's premier cities.

In the health centers a festive atmosphere was created with the use of buntings, posters and welcome streamers. Adequate supplies of vaccines and syringes were in place in all centers. As in the pilot program, the centers were provided with feedback forms and monitored by joint service groups.

Lessons from the Year 1 campaign

Two evaluation surveys were completed before and near the end of the campaign. A 1989 survey conducted by TRENDS studied caretakers of children less than two years old in Metro Manila, Luzon, the Visayas and Mindanao; a 1990 survey conducted by Kabalikat studied 60 health centers in the same geographic areas. The same questionnaire was used in both surveys.

According to the surveys, between 1989 and 1990, immunization coverage improved substantially: children with complete immunization coverage increased from 54 percent to 66 percent. Timeliness of coverage increased sharply: completion of immunization series by 12 months went from 34 percent to 55 percent. Measles coverage of 9- to 23-month-olds went from 53 percent to 68 percent. And finally, knowledge about measles went from 63 percent to 78 percent on an eight-item index of information about vaccination.

The survey results offered substantial evidence that the program worked to increase knowledge about vaccination among the caretakers of young children. There was also evidence that the increases were due to exposure to the mass-media campaign. Several factors appeared to affect the mass-media coverage.

First, the urban target audience represented a media-owning and media-using population. More than 60 percent said it owns television sets, 73 percent owns radios and more than 50 percent owns both. In the 1990 survey, most of the non-owners also said they were listeners and watchers. About 85 percent of each non-owning group said they listen to each medium at least sometimes.[9] With such heavy use of the media, the intensive mass-media campaign achieved maximum effect.

Second, a high level of expertise was available and the Department of Health took advantage of it to develop and produce high-quality radio and television spots.

[9]Zimicki, Hornik, Lee. *The Healthcom Project in the Philippines: Final Case Study Evaluation Report. March 1991.*

Finally, and most important, the campaign supported a routine in the health centers that was ready to serve when demand was increased by the media campaign.

Some lessons were also learned from the nationwide campaign. The Department of Health had to contract the services of one advertising agency, one nongovernmental organization and two research agencies to implement the campaign. The process of contracting and receiving approval from various government offices and within the Department of Health was slow and threatened the success of the project. Therefore, delays in contracting must be factored in planning for future projects.

Also, the process of retrieving the monitoring form from the field health offices was slow. Other delays were attributed to the newness of FHSIS reporting forms, difficulties in holding joint monitoring visits by MCHS and PHES, and the need for enough time to distribute IEC materials to the health centers.

National EPI sustaining campaign: Year 2

In order to maintain the momentum achieved in Year 1, the Department of Health decided to sustain the focus on measles as its Year 2 campaign. Immediately, PHES moved to follow the five-step HealthCom method but there were obstacles.

The changing political climate and stricter interpretation of auditing regulations pushed the process of advertising agency selection to move away from the previously approved and faster source selection to a public bidding process. As expected, the newly adopted process was tedious and time-consuming. All told, it took more than half a year to identify and contract Image Dimension, the newly selected advertising agency. Finally, the National EPI Sustaining Campaign Year 2 was launched in November-December 1991 and was back on the air in February-March 1992.

As in the previous campaign, thematic and tactical materials were used. To provide continuing interest, realism and credibility, the new stories in advertising were culled from true-to-life case studies from the files of the Department of Health. Mothers' peace of mind was brought in as the ultimate positive consequence, thus bringing the story full circle: after arousing concern and worry in parents, the new advertising assures them the benefit of security and peace of mind, i.e. the near-fatal case of her eldest will not happen to her second child because he is fully covered/immunized.

Tactical materials, essentially

talking the same points, used new endorsers. The major innovations were the development of a 1992 calendar which featured the 12-month development of an infant as it relates to the various stages of receiving the 6 antigens. As in all previous materials, the Secretary of Health was used as the authority figure. For point-of-service materials, new posters, streamers and stickers were also developed.

Implementation ran smoothly in the beginning, but as 1992 came and the current Secretary of Health signified his intention to run for the Senate, the distribution of the 1992 calendars where he appears as the authority figure was stopped by the new administrator, for fear of electioneering. Also for various reasons, payments due to the media which were implemented in November-December 1991 were not released by the Department of Budget and Management, leading to the KPB's suspension of the DOH from advertising in 1992.

Even with all these administrative problems, field reports and anecdotes pointed to the success of the Year 2 measles campaign.

Eradication of immunizable diseases: the ultimate goal

Moving toward 1993, the Department of Health decided to keep EPI as a major priority. Since mothers and caretakers were already in the habit of bringing children to health centers every Wednesday and coverage for all six antigens was already high and being maintained, the Department of Health felt the time was ripe to move on to an eradication strategy—focusing on polio eradication as the first goal. Borrowing from Brazil's National Immunization Day strategy, the polio eradication initiative took place in April 1993. Again, baseline research was conducted and focus group discussions were held to guide campaign development and identify operational issues.

On April 21, 1993, the third Wednesday of the month, the first NID (National Immunization Day) took place. One month later, on May 19—also the third Wednesday of the month—the second NID took place. From hereon, for the next two years through 1995, the plan is to celebrate every third Wednesday of February and March as National Immunization Day.

The program for the Control of Diarrheal Disease (CDD)

The Department of Health has been operating a CDD program since the 1970s. The program has made considerable strides in the training of public health personnel in the management of diarrheal disease and the local production of its brand of WHO-

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formulated powder oral rehydration salts (ORS) called Oresol. However, research has shown that although mothers were aware of Oresol as a treatment for diarrhea, usage was generally low. Several factors can be cited for the discrepancy between awareness and use of Oresol: inadequacies of the government's distribution system for Oresol, inaccessibility of health centers, limited operating hours at the centers, and limited credibility of the health center as a source of service for diarrhea management.

In 1987 a survey was conducted among 1,200 low-income mothers with children under five years of age living in urban and rural areas in Regions 6, 7 and 10. The results showed that in these regions, 79 percent of the mothers surveyed were aware of Oresol, but only 25 percent reported administering the solution during the child's last diarrhea case. Many mothers who were aware of Oresol but did not give it to their children said that "no Oresol supply was available." Moreover, mothers were often looking for a product that would harden stools or lessen the frequency of stool movement, which Oresol doesn't do.

Most mothers seemed unimpressed by the health center's record on managing diarrhea cases and preferred private doctors or clinics. For every one mother who went to the center for the treatment of her child's diarrhea, two mothers sought the services of a private physician.

A three-year audit of antidiarrheals and oral rehydration solution (ORS) prescribed by physicians and sold by drugstores (1985-87) indicated that though antidiarrheals and antibiotics were prescribed more often than ORS, the market share of antidiarrheals was eroding as oral rehydration therapy (ORT) increased from 3 percent in 1985 to 11 percent in 1986, but down to 8 percent in 1987. However, it was also determined that ORS was often prescribed in combination with antidiarrheals and antibiotics.

The audit's findings were validated by another survey conducted in 1988. This survey

established that for diarrhea cases 78 percent of prescriptions by private physicians were for antidiarrheal drugs; only 22 percent were for rehydration solutions, and these were mostly in combination with antidiarrheals.

CDD program objectives

The CDD program objective established in 1987 was to reduce diarrhea-related deaths among children under five years of age by 30 percent in 1989 to 6.3/1000 and to 4.5/1000 in 1992. To achieve this target, the program aimed to increase ORS availability to cover 60 percent of all health outlets (health centers, drugstores, government and private hospitals) in 1989 and to 100 percent by 1992. Additionally, they targeted the percentage of mothers who know about ORS and use it properly to increase to 30 percent in 1989 and to 35 percent in 1992.

The decision to test-market

The survey findings confirmed a vast potential for the ORS market, and a decision was made to test-market rehydration products. Regions 6 and 7, where health workers were well trained in ORT, were selected to market Oresol. Region 10, where training in ORT had just begun, was selected to promote the home fluid *am* (rice water) as prevention for dehydration. *Am* has been traditionally used to prevent diarrhea; Oresol has been used for treatment.

The Maternal and Child Health Service would continue to manage the CDD Program. Among other things, it would accelerate the ORT training of all health workers at all levels and make Oresol available at all outlets—health centers and hospitals alike. Collaborative work with the private medical sector, specifically the Philippine Pediatric Society, would be intensified to strengthen the support of private physicians in the promotion of ORT.

The pilot campaign

Following the social marketing methodology, the CDD test markets were assessed to determine the primary target audience and the health practices to be promoted, and how successful previous attempts to promote these practices had been. Two quantitative studies were conducted to explore the target audience's beliefs and practices regarding diarrhea. Besides the wealth of information provided by these two studies, several qualitative research methods—focus groups and in-depth interviews—were used to obtain more in-depth data on mothers' associations of diarrhea and dehydration and their attitudes

toward ORS and home fluids as a specific diarrhea treatment. For the same reasons that the EPI/measles campaign used an advertising agency, the CDD Program through PIHES contracted Well Advertising.

The pilot to test social marketing strategies for promoting Oresol and *am* for diarrhea management was conducted in two modules. Module A focused on educating the consumer: What does dehydration mean? What are the signs of dehydration? What are the dangers? Module B, the second phase, instructed the mothers or caretakers in the proper treatment of dehydration.

The development of the creative strategy for Module A involved relating the concept of rehydration to diarrhea in a manner that would not offend the sensibilities of the target audience and still convey the dire consequences of dehydration. Animated characters were created to depict diarrhea and dehydration to appear in the campaign. Diarrhea and dehydration would be portrayed as "conspirators" or "*kasabwat*," partners in crime. Dehydration was pictured as the more evil. The ads were pretested in Metro Manila. The pretests showed high recall of messages and, more important, mothers registered agreement and predisposition to provide ORT for their children. Only minor improvements to the ads were necessary before they were ready for use in the campaign.

Launching Module A

The media plan developed for the campaign described how many households would be reached, the number of times these households would be reached, and the media mix of the campaign. Module A involved a multimedia campaign with radio as the primary communications channel used nationally to educate mothers about the dangers of dehydration associated with diarrhea: 73 percent of the budget was allocated to radio; 25 percent to TV; and 2 percent to print advertising.

Radio was chosen as the prime medium in the provincial rural areas because of its very high ownership and extensive geographic coverage and popularity among the C, D and E social classes. Directed at reaching 50 percent of the target mothers over a period of three months, ads were aired in top-rated programs of 37 stations in the regions.

Television was used as the primary medium in urban areas and to provide visual impact and additional audience reach.

Print ads were placed in the regions' top newspapers and

magazines.

In order to brief health personnel on the strategies and objectives of the campaign, PIHES conducted "sales conferences" in each of the capital cities of Regions 6, 7 and 10. The regional health educators and CDD managers were also incorporated into the monitoring plan. A two-day workshop oriented the regional staff to media and health center monitoring and involved them in developing the monitoring plan to be used in the CDD campaign in their region.

Lessons learned in Module A

A postcampaign tracking survey conducted by Consumer Pulse, a private market-research firm, determined that the multimedia campaign achieved its objectives—to develop mothers' knowledge and appreciation of the fact that in diarrhea it is dehydration that is fatal and must be treated. In Regions 6 and 7, there were significant increases in mothers' levels of knowledge of what dehydration meant to them, what symptoms indicated dehydration, whether it was important to treat dehydration, and what should be treated or prevented when their children had diarrhea.

Some 64 percent of the mothers interviewed said it was important to prevent dehydration when a child had diarrhea, and more than 50 percent of the mothers indicated they could detect the signs of dehydration associated with diarrhea.

Several lessons were learned from the first phase of the campaign. Distribution of point-of-service (POS) materials to the health centers was slow; sometimes materials did not reach the field until the campaign had ended. A circuitous approval process in the creation of the materials accounted for some of these delays. In some cases where POS materials arrived on time, inadequate guidance on the use of the materials was given to field personnel.

Lessons learned on media coverage in the three regions indicated that while radio has the widest reach, it was not necessarily the most cost-efficient per specific target-audience reached. On a per-spot basis, radio is less expensive than TV but, given its very specific programming against targeted market segments, it becomes necessary to buy air time from many different stations and programs to reach a targeted level of 65 percent.

On the other hand, TV has a cross-sectional viewership because there are fewer TV programs on fewer channels. Overall, TV was found to provide important support for radio; significant increases in retention and comprehension were trace-

able to TV. For areas not reached by the standard media (such as Bohol) other media such as community movie theaters, posters and billboards were more appropriate.

Launching Module B

Module B, or the second phase of the campaign, promoted ORT for the prevention of dehydration and the management of diarrhea using ORS (Oresol) in Regions 6 and 7, and *am* in Region 10.

The creative strategy was to arouse the concern of the target audience using a "slice-of-life" approach—to convince mothers with children under five years old who had diarrhea to administer ORT. The communication materials for the *am* campaign—radio spots, TV commercials and printed matter—were pretested in Cagayan de Oro City, Region 10. The communication materials for the Oresol campaign were pretested in Iloilo City, Region 6. The latter included two separate TV and radio stories: 1) a thematic commercial emphasizing the benefits of Oresol; and 2) a tactical commercial instructing mothers in the proper preparation and administration of Oresol.

Lessons learned in Module B

A postcampaign tracking survey conducted by Frank Small & Associates, another private market-research company, revealed that the multimedia campaign for both Oresol and *am* in their respective markets achieved their objectives. Findings show that both campaigns were the best known advertisements among children's illnesses comparable only to fever and cold products, which are among the most consistently and heavily advertised consumer brands year-round.

The more concrete measure of the Module B campaign's success, however, lies in the behavioral and attitudinal changes the campaign appears to have had among the mothers:

- Around 40-50 percent of the mothers claimed to have started giving Oresol (in Region 6 and 7) or *am* (in Region 10) during the last diarrhea episode, as a result of what they learned from the ads.
- Significantly more mothers now believe that Oresol (in Regions 6 and 7) or *am* (in Region 10) is: the best thing to give a child during various stages of diarrhea/dehydration, and the best thing to give to prevent a child from getting weak and possibly dying.
- Among those aware of the advertising across regions, the majority of the mothers agreed with the statement that diarrhea can kill because of dehydration (the three regions' average—60

percent), dehydration is the problem in diarrhea (56 percent), dehydration can be prevented by promptly giving fluids like *am* to a child with diarrhea (55 percent).

- Many recalled that the ads encouraged them to seek medical attention (i.e. bring their children to the health center/doctor).

Most mothers who tried Oresol generally followed the correct mixing proportions of one liter of water per packet of powder. Region 6 had the highest percentage of mothers/caretakers using the correct proportion (96 percent); Region 10 had the lowest percentage (73 percent); and Region 7 registered in-between (88 percent).

Nationwide implementation: Modules A and B

The results of the pilot campaigns for Modules A and B were successful: as realization and acceptance of the dangers of dehydration increased, so did the use of *am* and Oresol. Field checks also revealed that more and more mothers and caretakers were going to health centers, attesting to the improved preference for government health services for the treatment of children's diarrhea. Reports from the Philippine Pediatric Society confirmed that more private practitioners were prescribing oral rehydration therapy. However, moving from pilot to nationwide implementation proved to be a very complex matter.

National plans in 1991 to coincide the campaign elements with the rainy months (May to October)—generally referred to as "diarrhea season"—were disrupted by internal changes in the Health Department and numerous administrative difficulties. By November 1991 the national campaign starting with Module A was launched. But it had to stop early the following year, again owing to administrative difficulties and financial constraints inherent in the government system. At the beginning of 1993 the campaign was still on hold until these difficulties could be corrected.■

4
The challenge continues

Sustaining the initiatives and institutionalizing social marketing and IEC in DOH

The Department of Health has recognized a critical need to institutionalize a systematic health communication method not only within the government but with other health organizations in the Philippines. The Department learned, through EPI and CDD, that strategies for institutionalizing public health communication must be initiated at the onset of a project. In both child-survival projects, local advertising and research organizations provided the baseline studies, the strategies and the evaluations that were necessary to a social marketing approach.

The most basic institutionalizing strategy is training. For long-term impact, PIHES focused on training in strategic thinking, communication planning, market research and project management. PIHES staff received on-the-job training and learned by doing on the EPI and CDD campaigns. Orientation sessions and seminar workshops provided PIHES and representatives from various programs and regional offices with the theoretical framework for social marketing, communication planning and management. Technical assistance given to PIHES to organize workshops for health educators and public information officers at the central and regional levels, complemented the staff workshops. A manual documenting the communication process of the EPI campaign was prepared to serve as a guide for DOH educators and communications managers in future projects. The prepa-

ration of a companion CDD manual is under way.

To be effective, efforts at institution building and organizational development had to be accompanied by several changes within the Department of Health. Program managers, health educators and public information officers were asked to look beyond the old ways and to appreciate the value of social marketing and PIHES' enhanced role as the communication arm of the Department of Health. Also, greater efforts were made to impart skills to PIHES staff so that they became communication program managers rather than just implementors.

Other program applications

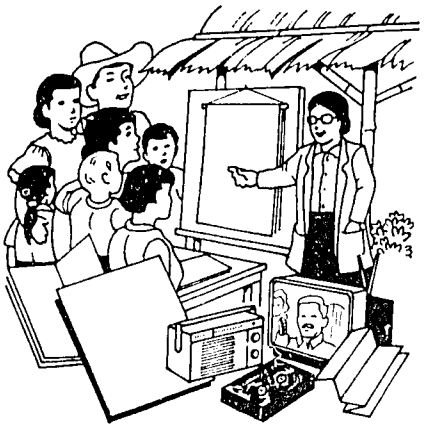
Notwithstanding difficulties encountered in the EPI and CDD campaigns, the Department of Health has accepted IEC/social marketing strategies as effective concepts for increasing the use of health services. IEC/social marketing campaigns have been started in areas other than child survival—tuberculosis, malaria, schistosomiasis, environmental health and voluntary blood donation. In these programs, as in the EPI and CDD campaigns, the Department has involved the private sector and nongovernmental organizations. Thus the development of integrated communications for other programs indicates the Health Department's acceptance of social marketing as a potent tool to accelerate demand for health services as well as the value of collaborating with the private sector as an ally to improve public health.

The paradigm shift: from program to mother and child

Having recognized the need for integrated programs and services and having accepted the concept of social marketing, the Department of Health has moved the concept of promoting health programs to a higher level. In child survival, it has shifted its focus on its individual programs to the mother and child and their integrated health needs. This shift toward integrated planning offers exciting prospects for cost-effective promotion and implementation of child-survival programs and an important opportunity to apply social marketing as the principal strategy for health promotion in the Philippines.

Midwives' Integrated Communication Aid for Child Survival

Even before the paradigm shift, the Department has realized the need for integration at the service delivery level. The Midwives' Integrated Communication Aid for Child Survival represents an early attempt at



such integration as well as the shift to the mother and child paradigm. The MICACS integrated the various health messages imparted by the midwife to the mother. Midwives and mothers were consulted at workshops in selected provinces for their input on what messages to use in the program.

A kit was designed that contained a comprehensive range of messages on child care classified according to age of child and state of health or illness. This kit was pretested in the first quarter of 1993 in the Tagalog, Visayas, Cordillera and Muslim regions. Based on the results of the pretest, the kits will be finalized and given to midwives as a tool to promote health care.

What next?

The primary purpose of the EPI and CDD campaigns was to increase health practitioners' understanding of how best to use modern communication, social marketing and behavior analysis to improve present child care practices and thereby reduce infant mortality. A baseline study in 1991 showed increases in immunization levels and use of ORT. There is greater awareness within the Health Department of the advantages of social marketing; many now see it as a key to solving the problem of poor demand for health services. Because of improved skills, PIHES staff are now able to act as communication program managers. Other services within the Department have turned to them for assistance in designing and implementing health promotion initiatives.

Nevertheless, the Department of Health realizes that much remains to be done. The administrative difficulties and financial constraints encountered by PIHES and others in EPI and CDD campaigns must be resolved. The complicated bidding and contracting process must be simplified. Contracts must be executed and paid on time in order for government to continue working successfully with the private sector. Logistics, drug procurement and distribution as well as timely dissemination of communication materials to

various areas of the country must be made responsive to the dynamism of social marketing initiatives. Other PIHES staff must catch up with the training that others have gone through in order to meet increasing program demands.

The Department of Health would benefit more from those who have gone through the basics of social marketing if they can further hone their skills in creative copy judgement, and analysis of media and market research. But over the short term, these newly trained health personnel must be given further challenges to practice their IEC skills. If these challenges do not materialize, trained personnel may look for greener pastures elsewhere.

Marketing has proved to be a powerful tool for effecting change in mass behavior when carefully thought-out and professionally implemented as in the EPI and CDD campaigns. Skilled marketers realize that if they are not careful about coordination, the elements of the marketing mix (4P's) may be out of synch or work at cross-purposes. Nothing is more frustrating than to mount an effective promotion campaign only to find the product out of stock or explanatory brochures not available at point of service. It is equally frustrating to find a communication strategy for making behavior socially acceptable being innocently undercut by seemingly cooperative agencies which have differing modes of thought.[10]

One should also realize that the process of achieving social goals—eradication of a problem or universal adoption of some behavior—can take a very long time. Therefore, commitment to long-term policies and sustained strategies is essential. Equally important is the commitment to provide adequate budgets and other resources to meet a given challenge.

Finally, a search within the Department of Health for leaders who would build on the success of the EPI and CDD programs, and champion social marketing as a means to improve health-related practices may do much to bring the Department closer to the goals of producing integrated programs to improve public health in the Philippines.■

[10]Andreasen, A.R. *Social Marketing: Its Potential Contribution to the Public Sector.*

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