

*PW-ACE-315*

**Getting from  
Awareness to Use  
Lessons Learned from  
SOMARC III  
about  
Marketing Hormonal  
Contraceptives**

**SOMARC III  
Special Study 6**

**The Futures Group  
International**

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Marketing Hormonal Contraceptives**

**SOMARC III Special Study 6**

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## EXECUTIVE SUMMARY

The Social Marketing for Change (SOMARC) project has worked in a wide range of developing countries not only to improve awareness of oral and injectable contraceptives, but more importantly to translate awareness into increased use. Three important demand-side barriers to greater trial and consistent use of hormonal methods are 1) consumer concerns about the possibility of side-effects and/or health-effects, 2) lack of knowledge about the product/method, and 3) lack of understanding about compliance.

To address these concerns, SOMARC has applied a variety of communication techniques, ranging from large-scale mass media advertising to interpersonal counseling, and has adapted these techniques to the specific needs and capabilities of each country. This paper presents the key lessons learned from SOMARC's experience using mass media, consumer hotlines, and community talks to overcome consumer concerns about hormonals and highlights the extent to which removing these concerns actually moves women from awareness to use. The paper relies on case studies of social marketing campaigns in Kazakstan, Turkey and Uganda. Key lessons are presented below.

### Lessons Learned

- Mass media messages can be highly effective at alleviating non-health-related concerns about oral contraceptives. Moreover, messages about project products in general can have positive spill-over effects on women's views about oral contraceptives in particular.
- By contrast, mass media messages that directly address the health-related concerns held by many women about oral contraceptives appear to have little effect on those concerns.
- Even substantial reductions in non-health-related concerns about oral contraceptives (e.g., convenience, availability and price) do not necessarily translate into increased use of this method. Nevertheless, they can play a role in shifting pill consumers away from public sector sources toward private sector sources.
- Information hotlines, which have the "wide reach" of mass media and the "high-touch" of interpersonal counseling, offer a promising approach to improve both consumer and provider knowledge about new methods on the market and ultimately motivate use.
- Community-based, interpersonal talks can reach large numbers of women of reproductive age.
- Community talks, with their ability to respond immediately to key questions and concerns about hormonal methods, have a direct impact in motivating behavior change, especially when conducted within areas with reasonable access to trained providers and clinics.

## I INTRODUCTION

The Social Marketing for Change (SOMARC) project manages the social marketing of oral contraceptives and injectables in over 20 countries worldwide. While these two products typically differ in a number of respects (e.g., mode of delivery, consumer perceptions of convenience, median age of consumer), they share three important demand-side barriers to increased and sustained use:

- consumer concerns about the possibility of side-effects and/or health-effects,
- lack of knowledge about the product/method,
- lack of understanding about compliance

To address these obstacles, SOMARC has relied on a variety of communication techniques ranging from large-scale mass media advertising to smaller-scale one-on-one counseling and has adapted these techniques to the specific needs and capabilities of each country. This paper presents the key lessons learned from SOMARC's experience in using various communication approaches to overcome consumer concerns and lack of knowledge about hormonals. The study also discusses the extent to which removing these concerns actually moves women from awareness to use.

The paper relies on three case studies—Kazakhstan, Turkey and Uganda—to highlight key lessons learned. The Kazakhstan case study examines the extent to which **mass media** messages were able to overcome both health-related and non-health-related concerns about oral contraceptives in that country. The case study for Turkey describes the role of **consumer hotlines** in improving both consumer and provider knowledge about injectables and alleviating consumer concerns about this method. The Uganda case study discusses the extent to which **community talks** can address consumer concerns about both oral contraceptives and injectables and motivate their use. Before the case studies are presented, we first provide a brief review of the four P's (product, price, placement and promotion) as they relate to hormonals.

## II MARKETING HORMONALS OVERVIEW OF THE FOUR P'S

### A *Product*

SOMARC III programs support the marketing of only low-dose oral contraceptives. With perfect use, the efficacy rate is high at 99.9 percent, and use is completely reversible. User compliance is, however, a major issue. Recent research shows that, due to incorrect use of orals, actual efficacy can be as low as 92 percent.

The majority of the injectables provided by SOMARC programs are the three-month Depo-Provera, however, both one-month and two-month injectables are also provided in some countries. Most of the packages sold by SOMARC contain disposable syringes and reminder cards. The efficacy for this method is also high at 99.7 percent for both perfect and actual use, *daily* user compliance is not an issue here, although ensuring the client's return for her follow-up injection is important.

## **B Price**

In its efforts to set the “right” price, SOMARC aims to balance the need to both set prices low enough to make the product accessible to the majority of people and at the same time high enough to yield some cost recovery and eventually lead to a sustainable program. Which of these two objectives receives priority depends on both the objectives of the USAID mission and the level of development of the market.

SOMARC relies on several sources of information to determine price. Initially, preliminary research is performed where prices of other products are examined, in addition, consumers are often surveyed to determine how much they are willing to pay for a product. Prices for other methods also are used for comparison purposes. In Brazil, for example, the SOMARC price for Depo-Provera is comparable to the amount that C and D consumers pay for a three-month supply of orals. When the purchasing power of consumers is very low, the World Health Organization (WHO) guidelines are utilized, where costs should not exceed 2 percent of the minimum monthly wage in a country.

## **C Placement**

The ethical status of hormonal products limits their distribution to select medical establishments, typically pharmacies and/or clinics and hospitals staffed by a physician. In some countries, such as India, oral contraceptives have over-the-counter (OTC) status, and so do not require a prescription. In those countries where prescriptions for oral contraceptives are required legally, this requirement is often not strictly enforced, this is the case throughout much of Latin America. Thus, “one-stop shopping” exists for oral contraceptives, a woman may obtain orals from a public clinic, from a midwife or from a pharmacy in one setting at one time, reducing transaction costs. SOMARC utilizes a variety of places to provide orals, from market-day midwives in Ghana, to pharmacists in Nepal, to midwives with a traveling road show in Uganda.

The situation is quite different for injectables, and varies by country. Sometimes there is “one-stop shopping” for injectables, as in Nepal, where the pharmacist is both the provider and the source of supply for the method, other times there are as many as three places to visit to obtain an injection from the private sector. For example, in Jamaica, a woman must first visit a provider for an injectable prescription, go to a pharmacy to obtain the product, and then re-visit the provider for the actual injection. The barriers governing this process vary by country, and can be legal or cultural. For example, in Uganda, *legally* a medical provider must perform injections. In other countries, such as Turkey, the *cultural* norm has been that medical providers perform injections, and so some women do not trust pharmacists to provide the service.

## **D Promotion**

SOMARC typically focuses its promotional efforts on the “easy sell” first and then branches out to more difficult-to-persuade and more difficult-to-reach groups in any given population. For example, SOMARC often begins its promotional campaigns in urban areas because, compared to rural consumers, urban consumers typically have higher incomes, a greater degree of acceptance of family planning, and easier access to a

variety of communication channels and distribution points. SOMARC then typically develops separate campaigns to address the specific needs of harder-to-persuade and harder-to-reach segments of the population. For example, SOMARC is currently attempting to reach rural markets in Mexico by using radio as the main communication channel and by concentrating the distribution of orals to market towns that neighboring villagers tend to travel to regularly rather than trying to distribute orals directly to each individual village. By contrast, in rural Uganda, where radio exposure is relatively low, SOMARC relies on midwives to address large crowds of villagers with community discussion talks.

Public relations activities under SOMARC III have been many and varied. In Nepal, the introduction of Depo-Provera was accompanied by parades, elephants, national press coverage and promotional give-aways. In the Philippines, an outreach program using the "Tupperware" sales incentive approach has been utilized. In various countries, there are Midwife of the Month contests, traveling road shows, market-day midwives, and sponsorship of television and radio shows.

The ethical status of hormonal products has an impact on demand creation by making brand-specific promotion illegal. While promotion of a whole category of products (e.g., oral contraceptives or injectables in general) does create awareness and motivate use, SOMARC's experience is that it is not as effective as brand-specific advertising. One reason is that brand-specific advertising can go into more detail about the benefits of a particular brand. Another reason is that brand-specific advertising motivates manufacturers to invest in the promotion of their product, whereas generic advertising can actually discourage private sector investment in promotion because manufacturers do not want to contribute to the promotion of their competitors.

### III CASE STUDIES

#### A *Kazakhstan*

SOMARC's central demand-side objectives in Kazakhstan are to increase modern method use (especially use of hormonals) and to increase the purchase of modern methods in the private sector. Currently, fertility regulation in Kazakhstan is characterized by relatively high rates of induced abortion (total abortion rate is 1.8 abortions per woman)<sup>1</sup> and IUD use (86 percent of currently married women who use a modern contraceptive method use an IUD). By expanding the supply of alternative pregnancy-prevention methods in the private sector, SOMARC contributes to USAID/CARs objectives to reduce the general abortion rate and to improve the sustainability of social benefits and services.

In late 1993, SOMARC began planning its communication campaign to launch low-dose oral contraceptives in three pilot cities (Almaty, Karaganda and Ust-Kamenogorsk) in Kazakhstan. Preliminary research indicated that while awareness of oral contraceptives was high in these pilot cities, widespread lack of information and negative perceptions about oral contraceptives represented strong barriers to increased use. Women in focus

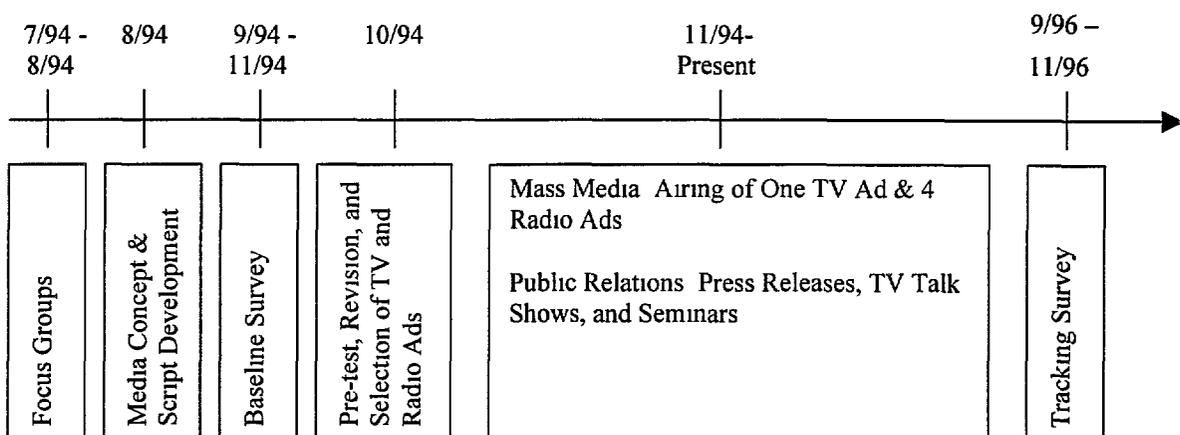
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<sup>1</sup> The total abortion rate refers to the total number of abortions a woman will have in her lifetime if she experiences the current age-specific abortion rates.

groups voiced several concerns, including the belief that oral contraceptives are difficult to remember to take, that they cause undesirable side-effects (e.g., weight gain, development of male characteristics), that they are dangerous to a woman's health (e.g., upset metabolism, damage organs) and that they are not readily available (BRIF 1994). At the same time, the focus group research also revealed an opportunity for product positioning. None of the women in any of the focus group discussions had heard of low-dose contraceptive pills. However, when the concept was explained, it appeared to be reassuring to some of the women.

Based on these findings, SOMARC decided to rely on mass media and public relations to highlight the fact that low-dose pills are "gentler" than the high-dose varieties that had historically been used in the region, and that the few side-effects that might occur would usually go away within a few months. It was also decided that communication messages would directly address women's concerns about availability, health safety, and having to remember to take the pill every day. Communication activities for low-dose oral contraceptives included a series of public relations activities (press releases, talk shows and seminars), one television advertisement and four radio advertisements that ran from November 1994 to the present. SOMARC conducted a baseline survey immediately before the launch of the communication campaign and a tracking survey after two years of communication activity. Figure 1 shows the chronology of SOMARC's communication and research activities.

**Figure 1 Chronology of Communication & Research Activities for Oral Contraceptives in Kazakhstan**



**Results**

The concerns raised by women in the focus group research mentioned above can be classified into two broad categories: 1) non-health related concerns (i.e., convenience and availability), and 2) health-related concerns (i.e., hormone induced side-effects and health-effects). Tables 1-6 below show the change in non-health concerns about oral contraceptives after two years of the communication campaign, while Tables 7-10 show the results for health-related concerns.

The results in Table 1 reveal a dramatic shift in women's opinions about the difficulty of having to remember to take the pill. Immediately before the launch of the campaign, 66 percent of women in the three pilot cities agreed (and 48 percent *strongly* agreed) that it is difficult to remember to take the pill. Two years after the communication campaign began, only 39 percent agreed with this statement (and only 18 percent *strongly* agreed).

**Table 1 "It Is Difficult to Remember to Take the Pill"**  
**Percentage of Women of Reproductive Age Who Agree or Disagree Kazakhstan (Three Pilot Cities)**

	Sept-Nov 1994 %	Sept-Nov 1996 %
Strongly Disagree	21	26
Somewhat Disagree	7 > 28	14 > 40
Somewhat Agree	18	21
Strongly Agree	48 > 66	18 > 39
Don't Know	6	21
Total Percent	100	100
Total Number of Women	870	1,000

Table 2 shows that women who recalled being exposed to the communication campaign were substantially more likely to disagree that the pill is difficult to remember to take than those reporting that they had not been exposed to any of the campaign material. This suggests that the communication campaign is largely responsible for the shift in opinion about pill convenience shown in Table 1.

**Table 2 "It Is Difficult to Remember to Take the Pill"**  
**Percentage of Women of Reproductive Age Who Agree or Disagree by Media Exposure Kazakhstan (Three Pilot Cities), 1996**

	Mass Media Exposure	
	None %	Some %
Strongly Disagree	20	28
Somewhat Disagree	7 > 27	16 > 44
Somewhat Agree	22	21
Strongly Agree	21 > 43	18 > 39
Don't Know	31	18
Total Percent	100	100
Total Number of Women	166	833

In addition to reducing concerns about the convenience of taking the pill, the campaign also appears to have created positive perceptions about the availability of pills on the market. Table 3 shows that while 39 percent of women in 1994 agreed that birth control pills are not readily available, only 6 percent agreed with this statement in 1996. Moreover, the results show a relatively large jump in the percentage of women who *strongly* disagree that oral contraceptives are not readily available, from 37 percent in 1994 to 59 percent in 1996.

**Table 3 “Birth Control Pills Are Not Readily Available ”**  
**Percentage of Women of Reproductive Age Who Agree or Disagree Kazakhstan (Three Pilot Cities)**

	Sept-Nov 1994		Sept- Nov 1996	
	%		%	
Strongly Disagree	37		59	
Somewhat Disagree	12	> 49	19	> 78
Somewhat Agree	18		3	
Strongly Agree	21	> 39	3	> 6
Don't Know/Undecided	13		16	
Total Percent	100		100	
Total Number of Women	870		1,000	

Table 4 shows that women who were exposed to the communication campaign were substantially more likely to disagree that pills are not readily available than women who were not exposed to the campaign

**Table 4 “Birth Control Pills Are Not Readily Available ”**  
**Percentage of Women of Reproductive Age Who Agree or Disagree by Media Exposure Kazakhstan (Three Pilot Cities), 1996**

	Mass Media Exposure	
	None %	Some %
Strongly Disagree	44	62
Somewhat Disagree	20 > 64	19 > 81
Somewhat Agree	3	3
Strongly Agree	3 > 6	2 > 5
Don't Know	29	13
Total Percent	100	
Total Number of Women	166	

While none of the oral contraceptive advertisements directly discussed the price of oral contraceptives, Table 5 shows that perceptions about the price of pills also improved over the communication campaign period. The percentage of women who agreed that birth control pills are expensive dropped from 73 percent in 1994 to 48 percent in 1996

**Table 5 “Birth Control Pills Are Expensive ”**  
**Percentage of Women of Reproductive Age Who Agree and Disagree Kazakhstan (Three Pilot Cities)**

	Sept-Nov 1994		Sept- Nov 1996	
	%		%	
Strongly Disagree	6		9	
Somewhat Disagree	6	> 12	17	> 26
Somewhat Agree	20		23	
Strongly Agree	53	> 73	25	> 48
Don't Know/Undecided	15		26	
Total Percent	100		100	
Total Number of Women	870		1,000	

Table 6 shows that women who were exposed to the communication campaign were more likely to disagree that pills are expensive or to say that they did not know if pills are expensive. This finding may be due to the fact that SOMARC marketed the low-dose pills under the Red Apple Logo and general commercials about Red Apple products stressed their affordability

**Table 6 “Birth Control Pills Are Expensive ”**  
**Percentage of Women of Reproductive Age Who Agree or Disagree by Media Exposure**  
**Kazakstan (Three Pilot Cities), 1996**

	Mass Media Exposure	
	None %	Some %
Strongly Disagree	4	10
Somewhat Disagree	13 > 17	18 > 28
Somewhat Agree	16	24
Strongly Agree	34 > 50	24 > 48
Don't Know	36	25
Total Percent	100	100
Total Number of Women	166	833

**Lesson Learned #1** Mass media messages were highly effective at alleviating non-health-related concerns about oral contraceptives held by many women at the start of the campaign launch. Moreover, messages about Red Apple products in general appear to have had positive spill-over effects on women’s views about oral contraceptives specifically.

Tables 7 and 8 show the relationship between media exposure and health-related messages<sup>2</sup>. Table 7 shows that women who were exposed to the communication campaign were more likely to agree that pills today have fewer hormones and are gentler to the body than women who were not exposed. However, the differences are modest compared to the effect of media on non-health-related opinions. Moreover, the positive shift in opinion appears to be tentative in that the difference between those who have been exposed to media and those who have not is primarily in the extent to which they *somewhat* (as opposed to strongly) agree that pills are now gentler.

**Table 7 “Pills Today Have Less Hormones, Are Gentler to Body than Pills Available Years Ago ”**  
**Percentage of Women of Reproductive Age Who Agree or Disagree by Media Exposure**  
**Kazakstan (Three Pilot Cities), 1996**

	Mass Media Exposure	
	None %	Some %
Strongly Disagree	6	4
Somewhat Disagree	8 > 14	10 > 14
Somewhat Agree	11	19
Strongly Agree	17 > 28	20 > 39
Don't Know	58	46
Total Percent	100	100
Total Number of Women	166	833

<sup>2</sup> The health-related statement “pills today have less hormones and are gentler to the body than pills available years ago” was only asked in the tracking survey because research indicated that there was no awareness of low-dose oral contraceptives at the time of the baseline survey. The health-related statement about the safety of pills for a woman’s health was also only asked in the tracking survey because of a shift in communication strategy that occurred after the baseline survey had already been conducted.

Table 8 shows no appreciable difference in opinions about the safety of oral contraceptives between women who have and have not been exposed to the communication campaign

**Table 8 “How Would You Describe the Safety of Birth Control Pills ”**  
**Percentage of Women of Reproductive Age Who Respond “Safe” or “Dangerous” by Media Exposure Kazakhstan (Three Pilot Cities), 1996**

	Mass Media Exposure	
	None %	Some %
Extremely Safe	7	8
Somewhat Safe	27 > 34	31 > 38
Somewhat Dangerous	39	44
Extremely Dangerous	8 > 47	5 > 49
Don't Know	19	11
Total Percent	100	100
Total Number of Women	166	833

Given the modest effect of the media on health-related concerns about oral contraceptives, it is not surprising that views about the quality of oral contraceptives have only slightly improved Table 9 shows that 37 percent of women in 1994 agreed that pills today are of good quality versus 44 percent in 1996 Moreover, Table 10 shows that women who were exposed to the communication campaign were not only more likely to agree that pills today are of good quality, they were also more likely to somewhat disagree

**Table 9 “Pills Available Today Are of Good Quality ”**  
**Percentage of Women of Reproductive Age Who Agree and Disagree Kazakhstan (Three Pilot Cities)**

	Sept-Nov 1994 %	Sept- Nov 1996 %
Strongly Disagree	7	4
Somewhat Disagree	10 > 17	14 > 18
Somewhat Agree	16	23
Strongly Agree	21 > 37	21 > 44
Don't Know	46	38
Total Percent	100	100
Total Number of Women	870	1,000

**Table 10 “Pills Available Today Are of Good Quality ”**  
**Percentage of Women of Reproductive Age Who Agree or Disagree by Media Exposure Kazakhstan (Three Pilot Cities), 1996**

	Mass Media Exposure	
	None %	Some %
Strongly Disagree	4	4
Somewhat Disagree	5 > 9	16 > 20
Somewhat Agree	16	24
Strongly Agree	22 > 38	21 > 45
Don't Know	54	35
Total Percent	100	100
Total Number of Women	166	833

**Lesson Learned #2 Mass media messages that directly addressed the health-related concerns held by many women about oral contraceptives had little effect on those concerns**

With respect to oral contraceptive use, the tracking survey showed no increase in the percentage of women of reproductive age who use oral contraceptives (oral contraceptive prevalence in the three pilot cities was 7 percent in both 1994 and 1995). However, the tracking survey did reveal a substantial shift among oral contraceptive users away from government health sources toward private sector sources. Specifically, the percentage of oral contraceptive users who obtained their method from the private sector increased from 62 percent in 1994 to 79 percent in 1996.

**Lessons Learned #3 Substantial reductions in non-health-related concerns about oral contraceptives (e.g., convenience, availability and price) did not translate into increased use of this method. However, they may have played a role in producing a significant shift of pill consumers away from public sector sources toward private sector sources, which were promoted by the campaign.**

***B Turkey***

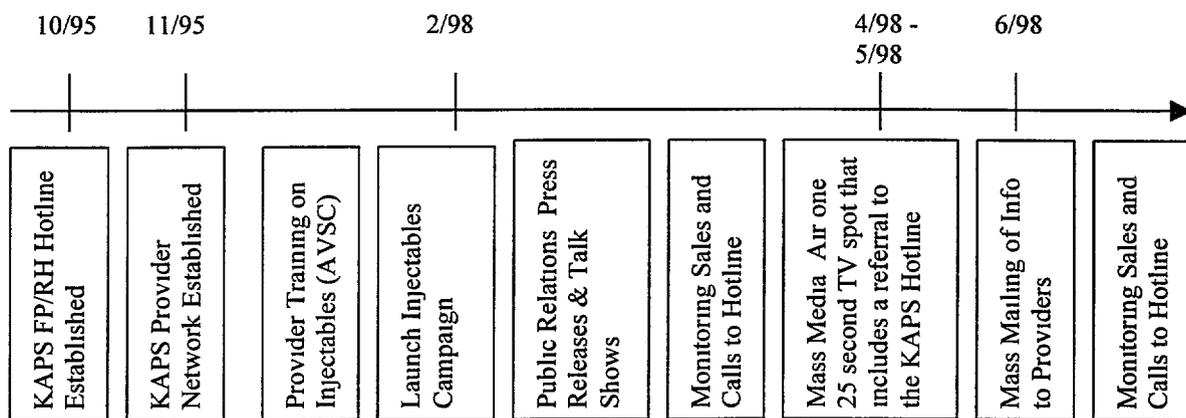
In October 1995, SOMARC established the KAPS Reproductive Health Information Hotline in Turkey as part of its broader effort to improve the quality of reproductive health information and to provide support to the newly established Women's Health and Family Planning Service System (KAPS). The hotline, which is managed locally by SOMARC and The Turkish Family Health and Planning Foundation (TFHPF), provides easy access to counseling on specific contraceptive methods and reproductive health problems as well as general information about available reproductive health services. Use of the hotline has been substantial. By July 1998, the hotline had received over 44,000 calls from consumers and providers asking for reproductive health information and guidance.

In addition to correcting misinformation about existing contraceptive methods in Turkey (most notably oral contraceptives), the KAPS Information Hotline represents a clear opportunity to educate both consumers and providers about new reproductive health products on the market. Recognizing this, SOMARC referenced the hotline in all of its promotional material in its recent launch in Turkey of the one-month (Mesigyna) and three-month (Depo-Provera) injectable. The launch of these two products represents the first time in the hotline's two-year history that it was used to support the introduction of a new reproductive health product. In preparation for the launch, the hours of live consultation on the hotline were extended from 10 a.m. to noon Monday through Friday to 9 a.m. to 6 p.m. Monday through Friday. The option for automated information about specific reproductive health methods and services remained available 24 hours per day, seven days per week.

Figure 2 shows the chronology of communication and monitoring activities surrounding the introduction of Mesigyna and Depo-Provera in Turkey. With respect to communications, public relations activities began in February 1998 and continue to the

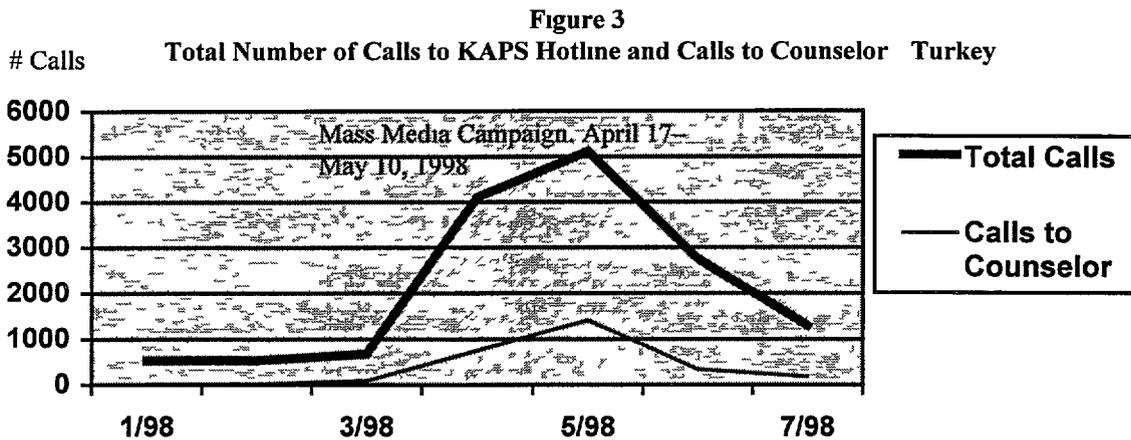
present, a 25-second television ad aired from April 17 to May 10, 1998, and in June, SOMARC mailed information about the two products to 17,350 pharmacists and 150 nongovernmental organizations (NGOs) and cooperating agencies (CAs). In August 1998, additional information will be mailed to Ob/Gyn specialists and health centers throughout Turkey. With respect to monitoring, both quantitative data on hotline calls received (e.g., number of calls by topic and number of calls from providers versus consumers) and qualitative information (e.g., verbatim notation of types of questions and concerns about the new products) was collected throughout the media campaign.

**Figure 2 Chronology of Communication & Monitoring Activities for Injectables in Turkey**



**Results**

Figure 3 shows the total number of calls to the hotline and the total number of calls to a live counselor (via the hotline) for the three months that preceded the campaign launch and for the two months that followed the launch. Total calls to the hotline before the campaign launch averaged 583 calls per month and calls to live counselors averaged 43 calls per month (i.e., 7 percent of all calls). By contrast, a total of 3,727 calls were received during the three-week mass media campaign period and a total of 1,672 of the calls were to live counselors (i.e., 45 percent of all calls). The number of calls to the hotline peaked in May with 5,120 total calls and 1,418 calls to live counselors. Calls to the hotline dropped off during the two months that followed the mass media campaign, June and July, but remained higher than pre-campaign levels.



Data collected by TFHPF (Balkan 1998) show that the vast majority of calls to live counselors (96.8 percent) during the mass media campaign period represented queries about contraceptives. The remaining 3.2 percent of calls to live counselors pertained to sexual problems, infertility, abortion and pregnancy. The data also showed that 91.7 percent of calls to counselors about contraceptives were calls about injectables. Most callers (85 percent) who asked for information about injectables were non-users of injectables who heard of the product for the first time from the campaign's television advertisement. Ten percent were non-users who first heard of injectables in the news. The remaining 5 percent were current users of injectables.

The qualitative data reported by the hotline counselors provide insights to the types of concerns raised by consumers and providers about Mesigyna and Depo-Provera. Non-users of injectables tended to call to clarify information that they had received from their doctor about injectables or to seek out information about injectables to determine whether they were preferable to methods recommended by their provider. The following examples represent typical calls that hotline counselors received from *non-users*.

- A 36-year-old woman who had an abortion three months prior to her call to the hotline said that her doctor told her to return to his office after three months for an IUD insertion. However, he did not provide any counseling to prevent pregnancy in the three-month interim. The woman did not want to use the IUD and asked for information about injectables.
- A 31-year-old woman wanted to use Depo-Provera but her doctor told her that injectables cause heavy bleeding. She was subsequently reluctant to use the method, so she called the hotline to get more information.
- A 31-year-old woman called to say that her doctor counseled her not to use injectables because of the irregular bleeding that might result. After talking with the hotline counselor about potential side-effects of the one- and three-month injectables, she expressed her intention to try Mesigyna.

By contrast, callers who were current injectable users tended to focus on a broader array of questions, including the effectiveness of the method, side-effects, compliance and clarification of information they received from their provider. The following represent typical types of calls from *users*.

- A woman who has been using Mesigyna called the hotline to discuss its level of effectiveness and its potential side-effects. She mentions that because she is unsure of Mesigyna's effectiveness, every month when she gets her shot she says to herself, "I hope I will not get pregnant this month."
- An 18-year-old woman who has been using Depo-Provera called to discuss her concerns about the amenorrhea that she is experiencing.

- A 24-year-old woman began to use Mesigyna and began bleeding after 15 days. She called the hotline because she was worried that this was a signal that she was no longer protected from pregnancy and that she must go for another injection.
- A 21-year-old woman who has been using Depo-Provera called the hotline to discuss amenorrhea. She mentioned that she has been getting a pregnancy test every month because she thought that the amenorrhea might mean she is pregnant.

Providers, who represented less than 5 percent of the total calls to the hotline, tended to call for clarification about the difference between Mesigyna and Depo-Provera. For example, one pharmacist called saying that “here in Konya the doctors say that Depo-Provera should be used monthly, but in the counseling sheet that you sent us it is written that Depo-Provera should be administered every three months. Which is correct?”

Calls to the KAPS Reproductive Health Information Hotline appear to have been generated not only by the campaign’s promotional materials, but also by word of mouth. According to hotline counselors, many of the calls from current users of injectables began with a statement such as, “After talking to you, a friend of mine was so relieved, so I have some problems I would also like to discuss.”

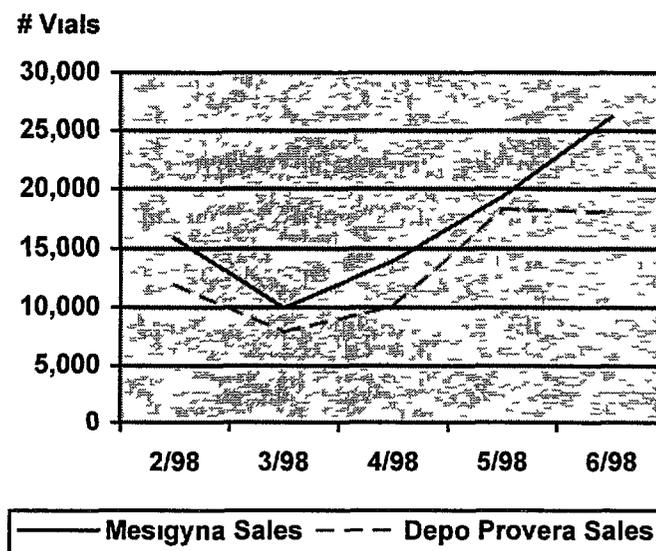
With respect to actual use of Mesigyna and Depo-Provera, sales figures of both contraceptive methods exceeded manufacturer expectations. Table 11 shows that the number of vials of Mesigyna sold in the first five months of the SOMARC campaign more than doubled expected sales. Similarly, the number of vials of Depo-Provera sold was 45 percent above expected sales.

**Table 11 Actual and Expected Sales of Injectables Turkey 2/98–6/98**

Injectable Type	Actual Vials Sold	Manufacturer’s Expected Sales in Vials
Mesigyna	85,271	34,375
Depo-Provera	66,225	45,625

Figure 4 shows the sales in vials of Mesigyna and Depo-Provera from the pharmaceutical distributors to pharmacies during the first five months of promotion. Sales of both products dipped during March, the second month of promotion, possibly because of some over-stocking during the first month. Thereafter, sales increased steadily for Mesigyna and through May for Depo-Provera, at which point sales of Depo-Provera leveled out (due to a shortage of supply).

**Figure 4 Distributor Sales to Pharmacies of Mesigyna and Depo-Provera Turkey 2/98–6/98**



**Lesson Learned #4 Information hotlines—which have the “wide reach” of mass media and the “high touch” of interpersonal counseling—offer a promising approach to improve both consumer and provider knowledge about new methods on the market**

### *C Uganda*

As part of its overall objective to increase access to and use of modern family planning methods in Uganda, SOMARC is marketing hormonal contraceptive products through the private sector. Contraceptive prevalence in Uganda is low, with only 8 percent of married women of reproductive age using a modern contraceptive method (Statistics Department and Macro International, 1996). Yet there is also a substantial unmet need for family planning information, products and services. To address this need, SOMARC Uganda launched Pilplan (low-dose contraceptive pill) in 1993, and Injectaplan (Depo-Provera, three-month injectable contraceptive) in 1996. Emphasis was placed on making both products as affordable and as widely available as possible, particularly in rural areas.

In mid-1997, SOMARC began planning its communication campaign to support sales and distribution of Injectaplan. As with Pilplan, mass media efforts such as radio advertising and road-show promotions were included to increase general awareness about Injectaplan (e.g., what is an injectable contraceptive, where is the product available). However, experience and research suggested that, in addition to basic awareness messages, SOMARC would need to address the serious informational gaps, misconceptions and negative perceptions that many women had toward pills and injectables. Anecdotal information from providers and focus group research with current and/or potential users indicated several concerns about hormonal contraceptives regarding how they work, who should use family planning, possible side-effects and

long-term negative health-effects. The research also suggested that, while such issues presented significant challenges, most women were interested in learning more about family planning and would be open to the advice of a trusted provider.

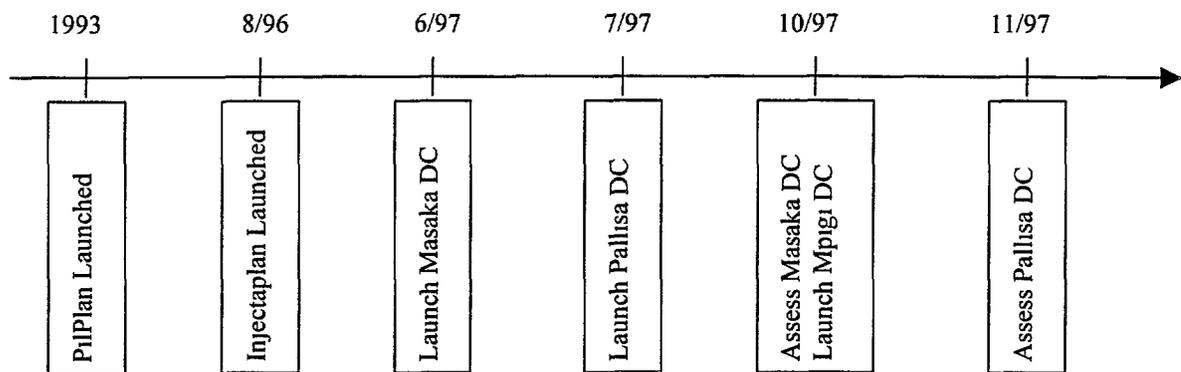
Based on these findings, SOMARC developed a program of community-based, interpersonal talks aimed at breaking down informational barriers to hormonal contraceptive use. Initiated in June 1997, these "community talks" were conducted by trained midwives working in specified catchment areas (usually within a 10-mile radius of the midwife's private maternity). With the assistance of local officials and organizations (e.g., religious groups, technical schools, factories), the midwives identified groups of women who were interested in family planning information. The midwives and local contact persons would determine the time and place for each talk in advance and make all necessary arrangements for mobilizing an appropriate audience. The one-hour talk on Pilplan and Injectaplan included information on the benefits of family planning, method choice, mechanism of action for pills and injectables, and common side-effects. Midwives also allowed considerable time for questions and answers at the end of each talk.

Attendees were given simple leaflets containing key information about oral contraceptives and injectables (in local languages). While actual services were not available during the talks, clinic locations for all SOMARC-trained providers in the area were also distributed. Referral sheets indicated date/venue/presenter of the talk attended and requested all providers to add information regarding the date of visit and the method received by each referred client.

Community talks were initiated in Masaka District in June 1997, followed by Pallisa District in July 1997. A third district, Mpigi, was added in October 1997. Approximately 10-15 midwives were recruited and trained in each district. Each midwife was expected to conduct four (4) talks per month and maintain detailed records of all activities.

Figure 5 shows the chronology of communication and monitoring activities surrounding community talks in Masaka, Pallisa and Mpigi. Both qualitative and quantitative data were used to monitor the program on a continuing basis. Qualitative data were drawn from midwives' reports (e.g., general description of attendees, common questions or concerns raised during talks). Quantitative data included information on numbers of attendees, as well as referrals collected from area providers. Sales information for Pilplan and Injectaplan in project areas was also considered. Overall assessments of each district's program were conducted after the fifth or sixth month of activities.

**Figure 5 Chronology of Communication & Monitoring Activities for Oral and Injectable Contraceptives in Uganda**



### **Results**

The qualitative data from midwives' reports present an important picture of communities in Uganda and the key information barriers to family planning use. Talks were very well received by all communities, regardless of location, rural/urban setting, primary occupation or religious/tribal characteristics. In fact, one midwife in Pallisa District was able to tour the mosques and Catholic churches of her area, holding talks with women after Sunday services. Midwives were often approached by local leaders who had heard about the program and who wanted to make sure that their community was included.

Talks were well attended by women in the target age group (approximately 15-45 years), as well as by men and older women. By moving midwives into communities, the talks were able to access many interested women who could not easily travel away from home. Fears about male interference and intimidation were surprisingly unrealized, in several cases, men were strongly supportive of family planning education, if not of actual method use.

**Lesson Learned #5** Communities were overwhelmingly supportive of the community talks and welcomed the opportunity to learn about hormonal methods from a trained provider. The talks provide an effective medium for reaching large numbers of participants, especially women of reproductive age.

The majority of attendees were women of reproductive age, most of whom had never used a modern contraceptive method. The questions raised often revealed some of the commonly held rumors and misconceptions about hormonal methods, especially regarding immediate and long-term effects. The following are examples of commonly raised issues:

- Many men and women were concerned that use of pills and/or injectables can lead to infertility, cancer and birth defects. (*Midwives comment: Often, an unrelated illness or condition that occurs in a current or former family planning user will be attributed to the method used.*)

- One young mother in Mpigi reported hearing that oral contraceptives are dangerous, since the pills collect in the fallopian tubes and thereby cause sterility *(Midwives' comment Knowledge of reproductive anatomy and physiology is very low in most communities Midwives often spend a great deal of time describing a woman's menstrual cycle before explaining the different mechanisms of action for pills and injectables )*
- Several people believed that injectables are a strong contraceptive that should only be used by women with at least three children *(Midwives' comment This belief is reinforced by providers who are not familiar with current national guidelines and who incorrectly prevent some women from using the method )*
- In virtually every talk, questions were asked about injectable side-effects, especially regarding irregular menstrual bleeding Amenorrhea was often seen as a sign of being unhealthy Several women expressed a real fear that in an amenorrheic woman, the menstrual blood collects, forming a large, perhaps fatal, "clot" in her body *(Midwives' comment Menstruation is very important in most Ugandan cultures Any change or disruption in the natural cycle is therefore seen as unhealthy and "bad ")*
- Many attendees did not know where they could obtain high-quality contraceptive products and services Some thought that injectables were only available in government clinics *(Midwives' comment Most providers do not discuss family planning openly with clients and will not advertise the fact that they have such products/services )*

Feedback from the midwives emphasized how fundamental and widely held some of the misconceptions about hormonal methods were Both the midwives and their audiences appreciated the interpersonal communication approach of the talks, which enabled midwives to respond immediately to questions and concerns Midwives were seen as caring, knowledgeable providers who were "sincerely" trying to assist the community Overall, the talks helped create a more positive attitude (both on an individual and a community-wide level) toward family planning methods and providers

**Lesson Learned #6 The direct, interpersonal communication approach of community talks can be an effective way of improving knowledge and reducing concerns about hormonal methods The ability to respond immediately to key questions and concerns about hormonal methods is very important in breaking down some of the informational gaps and negative perceptions that prevent family planning use Also, the positive, proactive role of the midwife creates a positive image of a family planning provider**

Table 12 summarizes the quantitative data collected from the community talks in the three districts Project assessment focused on two points 1) the number of women of reproductive age who attended the talks, and 2) the number/percent of women attendees who then obtained a modern contraceptive method A detailed explanation of terms follows

- **#WRA**

*Number of women of reproductive age attending talks during the specified month*  
Numbers are based on rough estimates reported by midwives and may include women who were not immediate candidates for family planning (e.g., women who were pregnant, breastfeeding or already using a contraceptive method) Older women and/or men in attendance are not included

- **#Ref**

*Number of referral sheets submitted to and collected from clinics indicating that a woman attendee of a talk during a specified month later obtained a modern contraceptive product* Numbers are based on referral sheets collected by SOMARC staff from SOMARC-trained clinics in project areas The numbers do not include women who may have received family planning counseling only Also, any women who obtained products from a drugshop (Pilplan only) or a non-SOMARC clinic are not accounted for

- **%Ref (#Ref/#WRA)**

This calculation shows the percentage of women of reproductive age who attended talks during a given month who later obtained a modern contraceptive product from a referred clinic

**Table 12 Quantitative Data Collected from Community Talks in Three Districts, Uganda**

	MASAKA			PALLISA			MPIGI		
	# WRA	# Ref	% Ref	# WRA	# Ref	% Ref	# WRA	# Ref	% Ref
Month 1	750	167	22.3	1,217	200	16.4	478	78	16.3
Month 2	636	90	14.2	1,313	168	12.8	1,312	223	17.0
Month 3	779	51	6.6	1,332	167	12.5	1,355	161	11.9
Month 4	984	78	7.9	989	91	9.8	1,001	71	7.1
Month 5	872	93	10.7	1,080	66	6.1	934	39	4.2*
Month 6	758	67	8.8	NA	NA	NA	1,070	44	4.1*
Total	4,779	546	11.4	5,931	692	11.7	6,150	616	10.0

\*Given the time delay between attending the talk and obtaining services SOMARC anticipates the number of referrals from talks given during these months (March 1998) may increase

As project data indicate, an average of 11 women per 100 who attended a community talk later obtained a modern contraceptive method (Pilplan, Injectaplan and/or Protector) from a SOMARC-trained clinic Given the fact that not all women attendees were candidates for family planning during the six-month assessment period and given the unavoidable gaps in tracking referrals, SOMARC believes that the actual number of women attendees who took positive action was significantly higher Even so, the return rate of 11 percent confirmed that the community talk program was an effective communication intervention

Sales data from project areas before and after the communication intervention (Table 13) also supported this conclusion. While it is difficult to attribute an overall increase in sales solely to community talks, the startling increase in six-month composite sales figures did suggest that the talks were having an impact.

**Table 13 Product Sales Before and After Community Talks in Three Districts, Uganda**

	MASAKA		PALLISA		MPIGI	
	Pilplan	Injectaplan	Pilplan	Injectaplan	Pilplan	Injectaplan
January-June 1997	10,800	1,620	2,340	590	16,620	840
July-December 1997	<b>Community Talks Intervention</b>					
January-June 1998	31,800	3,880	2,580	1,760	17,520	3,590
% Increase	194%	140%	10%	198%	5%	327%

One interesting pattern that emerged from the assessment was a general decrease in the number of referrals seen after five or six months of program activities. This trend seemed to follow the midwives' move into more remote, deeply rural areas. While attendance and interest in the talks remained high, fewer women living in these communities were able or willing to seek out clinic services. The data suggest that there may have been a geographic limit to community talks, beyond a certain point, the positive impact of the talks in breaking down informational barriers was negated by the lack of easy access to providers/clinics.

**Lesson Learned #7** By breaking down informational barriers to family planning use, the community talks are effective in encouraging women to seek out contraceptive methods and services from area providers. The interpersonal communication approach had a direct impact in motivating behavior change, especially when conducted within areas with reasonable access to trained providers and clinics.

#### IV DISCUSSION

This study has presented key lessons learned from three different communication approaches that SOMARC has used to overcome consumer concerns and lack of knowledge about hormonal methods, mass media messages, consumer hotlines and community talks.

While the ability of the mass media to raise awareness and create positive attitudes about family planning in general has been frequently demonstrated (Kiragu 1996, Westoff and Bankole 1997), little is known about its ability to effectively change ingrained and negative perceptions about oral contraceptives in particular. SOMARC's experience in Kazakstan suggests that mass media messages can significantly change negative non-health-related perceptions about oral contraceptives, even when those concerns are present among a majority of women. SOMARC's experience also suggests that in countries where many women have a long-held distrust of hormonal methods and strong

concerns about the health-effects and side-effects associated with them, direct appeals to these concerns through the mass media are likely to be only modestly effective at allaying these concerns. This does not mean that mass media efforts to address health-related concerns about hormonals should be abandoned in these countries. Rather, it suggests that mass media approaches to overcome health-related concerns should be supplemented by other communication approaches.

One of the main advantages of mass media is its wide reach. It is a powerful tool for imparting information, raising awareness about new products, and for motivating behavior change among large groups of people. However, a serious limitation of mass media as a communication vehicle is that, for the most part, it does not allow the consumer the opportunity to “talk back” and elaborate his or her concerns and elicit further reassurance about products that he or she does not trust. Radio talk shows, like SOMARC’s *Capital Doctor* show in Uganda, represent an attempt to address this limitation by combining the wide reach of mass media and the “high touch” of interpersonal communication. Similarly, the Turkey case study shows that consumer hotlines offer an opportunity to provide consumers with the interpersonal interaction that is often necessary to correct misperceptions, alleviate concerns and motivate use. While community talks do not have the same level of reach as mass media or telephone hotlines, the Uganda case study shows that they can nevertheless reach large numbers of individuals and provide in-depth information about hormonals and ultimately yield a sizeable impact on use.

Further work is needed to assess the three communication approaches discussed in this study in other settings. For example, it is possible that direct appeals to the health concerns of consumers via mass media messages may be more effective in countries where these concerns are not as ingrained as they are in Kazakhstan. Similarly, while the Turkey case study demonstrated that the consumer hotline addressed thousands of consumer questions about injectables, a population-based survey is needed in this and other countries to determine the extent to which the increased use of injectables can be directly attributed to the consumer hotline. Lastly, while the community talks were successful at motivating use in Uganda, it would be useful to determine whether this success can be replicated in other settings both within and outside of Africa.

## V CONCLUSION

Mass media is most effective when it is used to establish awareness, increase basic knowledge about the product, increase the consumer’s familiarity with the product, and to refer consumers to specific sources for further guidance and counseling. Mass media is also effective at promoting a brand, building a brand image and expanding a brand’s franchise. Every hormonal program will benefit from some type of mass media promotion, especially when used in combination with other methods of motivation for behavior change.

Hotlines represent an effective compromise between the wide reach of mass media and the high touch of one-on-one counseling. They allow privacy, anonymity and “multiple visits.” Their main limitation is that they require ready access to telephones.

Community talks are most effective at addressing the specific concerns of the audience in the context of the custom and environment of the audience. This communication vehicle works best when it relies on trusted, credible and respected presenters (e.g., community midwives in the case of Uganda). Community talks are excellent motivational vehicles because they not only generate action through the appeal of the presenter but also through peer influence. However, it needs to be recognized that community talks are labor-intensive and time-intensive as they involve building demand one village at a time.

## REFERENCES

Balkan, E 1998 *KAPS Hotline Evaluation of Injectables Campaign* The Turkish Family Health and Planning Foundation

BRIF 1994 *Attitudes Toward Oral Contraceptives, Injectables and Social Marketing Program Logos in Kazakstan – Highlights of Focus Group Research* SOMARC Project

Kiragu, K, S Krenn, B Kusemiju, J K T Ajiboye, I Chidi, and O Kalu 1996 *Promoting Family Planning Through Mass Media in Nigeria Campaigns Using a Public Service Announcement and a National Logo* Baltimore, Maryland, Johns Hopkins Center for Communications Programs

Statistics Department [Uganda] and Macro International Inc 1996 *Uganda Demographic and Health Survey, 1995* Calverton, Maryland Statistics Department [Uganda] and Macro International Inc

Westoff, C F , and A Bankole 1997 *Mass Media and Reproductive Health Behavior in Africa* Calverton, Maryland, Macro International