

**COMMERCIAL MARKET STRATEGIES**  
**NEW DIRECTIONS IN REPRODUCTIVE HEALTH**

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**Marketing Reproductive Health Services:  
Moving Beyond Traditional Social Marketing**

*Technical Advisory Group Meeting  
May 3, 2001*

**Deloitte  
Touche  
Tohmatsu**

IN PARTNERSHIP WITH

Abt Associates Inc.  
Population Services International  
Meridian Group International, Inc.



FUNDED BY

US Agency for International Development  
USAID Contract No. HRN-C-00-98-00039-00

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Issued September 14, 2001

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# I. INTRODUCTION

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The Commercial Market Strategies (CMS) Project is a USAID-funded project working with the private and commercial sectors to increase the use of high-quality family planning and other health products and services in developing countries. CMS utilizes a variety of strategies and interventions in working with the private and commercial sectors; among them is social marketing.

Over the past decade, family planning social marketing has moved increasingly from the marketing of family planning products (e.g. condoms and pills) to the marketing of a broad array of reproductive health services and service organizations. Being effective at marketing services (as opposed to products) requires that marketers adapt traditional marketing techniques and develop new marketing tools. It also requires viewing quality and client-provider interactions as central components of the marketing strategy.

To address this topic more fully, CMS convened a Technical Advisory Group Meeting (TAG) on May 3, 2001. Entitled **Marketing Reproductive Health Services: Moving Beyond Traditional Social Marketing**, the objectives of the TAG meeting were to:

- hear about experiences and lessons learned in marketing of services;
- outline common themes and key messages across various examples; and
- identify trends, challenges or implications in the development of services marketing tools.

CMS invited a panel of experts in the field of services marketing to share their experiences with CMS and USAID. The agenda featured the following:

## **Welcome**

*Lizann Prosser, Director, CMS*

*Margaret Neuse, Director, Office of Population, USAID*

## **Services Marketing: Emerging Perspectives (an Overview)**

*Dr. Ruth Berg, Deputy Director Research, CMS*

## **Marketing Health Services: Lessons Learned from PROSALUD**

*Dr. Carlos Cu llar, Senior Associate, Abt Associates, and*

*Pilar Sebasti n, Country Representative, CMS Nicaragua*

## **Extending Product Marketing Programs to Deliver Services: Lessons Learned from DKT s Experience in Bihar, India**

*K. Gopalakrishnan, Director of International Programs, DKT International*

## **In-Reach as a Services Marketing Strategy**

*Dr. Jim Foreit, Senior Associate, Population Council*

## **Creating Brands People Know and Trust**

*Dr. David Shore, Associate Dean, Harvard School of Public Health*

**Marketing Voluntary Counseling and Testing (VCT) Services for HIV/AIDS  
in Zimbabwe**

*Sanjay Chaganti, Marketing Technical Advisor, Population Services International -  
Zimbabwe*

The TAG meeting presentations and discussions were facilitated by Joni Herman of the Training Resources Group (TRG). Following are the proceedings of the day's meeting. A list of participants is attached as Appendix A. Attached as Appendix B are biographies for each of the main presenters.

## II. INTRODUCTORY REMARKS

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### **Welcome Address by Lizann Prosser**

Lizann Prosser, Director, CMS Project welcomed the participants to the 2<sup>nd</sup> Technical Advisory Group (TAG) Meeting for the CMS Project. Ms. Prosser reiterated the mandate of CMS as working with the private and commercial sectors in the areas of reproductive health and family planning. The scope of the CMS project includes social marketing, health financing, policy initiatives, commercial partnerships, and other interventions that are appropriate for the private and commercial sector.

Ms. Prosser briefly explained why CMS identified marketing of services as the topic for this 2<sup>nd</sup> TAG meeting. One reason is that CMS is currently one of the more significant social marketing vehicles for USAID. As such, CMS activities have started to move into, not only long term methods that have a service component but, other non-family planning related services. Another reason is the belief that there is room to talk about how the social marketing of services might be different than the social marketing of products. Ms. Prosser ended her remarks by emphasizing the high level of interest in the topic of services social marketing, and that such interest is a credit to the speakers at the TAG.

### **Opening Remarks by Margaret Neuse**

*Director, Office of Population, USAID*

Ms. Neuse opened the meeting by expressing her own interest in the topic which recognizes a change in social marketing, from the marketing of products, such as condoms, pills, bed nets, ORS, etc. to the marketing of services. She further emphasized the general recognition that the marketing of services requires some adaptation of marketing techniques and may require new tools.

Ms. Neuse mentioned how she has been interested in this topic for a fairly long time, since her first assignment overseas as a Peace Corps volunteer. She further stated that anybody who has lived in rural areas in developing countries has seen the power of marketing to change behavior. She used the term Coca-Colanization to describe what many have seen as the wide distribution of Coca Cola and other products in rural areas. This led her to ask the question: why aren't more health products, things that can really change and influence people's health behavior in a positive way, getting out there too? She points out that social marketing of products can be viewed as one of the success stories in using these techniques and tools for health products, and that now the question is: can we apply those same techniques and tools to services?

Ms. Neuse ended her remarks by emphasizing that services social marketing is important to the Office of Population for the following reasons:

- First, experience indicates that people are more willing to pay for services in the private sector where they can get several needed services at the same time or from the same source. This is not only consistent with the findings and recommendations of the conference at Cairo but also makes marketing sense and service delivery sense.
- Second, it is important to further engage the private sector in reproductive health and family planning services delivery. Many recognize that governments cannot

do it alone, and that the private sector is being used, sometimes more than the public sector, in most places. USAID has had considerable success in the social marketing of family planning and other health products using commercial techniques. But there is much less, though still important, experience on how we can adapt these marketing techniques to services.

- Finally, the area of services marketing is an opportunity for USAID to play a leadership role in defining what models work, and how they can be adapted to the country environments in which USAID works.

# III. BACKGROUND OVERVIEW

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## Services Marketing - Emerging Perspectives

*Dr. Ruth Berg, Deputy Director for Research, CMS*

To help set the stage for the panelists, Dr. Berg provided relevant background information regarding social marketing in general and how it applies to services. She stated that it is the inherent difference between a product and a service that creates services marketing challenges. Some of these differences are:

- It is harder to standardize quality across providers than across products because of the human factor.
- Services are intangible and therefore harder to trust. As a result, the service provider becomes important in building trust. When people seek services, they focus on the provider and the quality of the provider in order to assess the quality of service. Other factors that increase trust are tangible cues (e.g., a clinic setting and what the clinic looks like), and branding and franchising. When people start to recognize a name, they associate it with a certain quality of service which then helps build trust.
- Services require more intimate contact and often more prolonged contact between the consumers and service personnel. The demeanor and behavior of the provider becomes part of the service experience and can affect client satisfaction and whether clients recommend the service to others.

These differences between products and services raise the question of whether the standard Four P model used for product marketing still fits. Dr. Berg explained that there are many marketing models. The Four P s refer to the basic model that guides product marketing: product, place, promotion and price. These components form the marketing mix and are often considered when introducing a product in the market. The basic idea behind this model is that if you get the right product - something that people need, introduce it in the right places - places that people can access, have the right promotional message that resonates with people, and you price it so that they can afford it, you will generate sales.

The question now is whether or not this Four P model is enough, or whether we need something entirely different? Do we need something more when it comes to services, given that services are intangible, etc.. Dr. Berg stated that the point of consensus in the marketing literature seems to be that, at a minimum, the traditional four P s need to be viewed differently. To explain this further, Dr. Berg discussed promotion, in particular, whether or not advertising can be considered the fuel of social marketing<sup>1</sup> when it comes to marketing services. To address this question, Dr. Berg cited three studies that monitored what happened to service utilization after mass media advertising for networks.<sup>2</sup> All three studies found that advertising had minimal impact on service utilization.

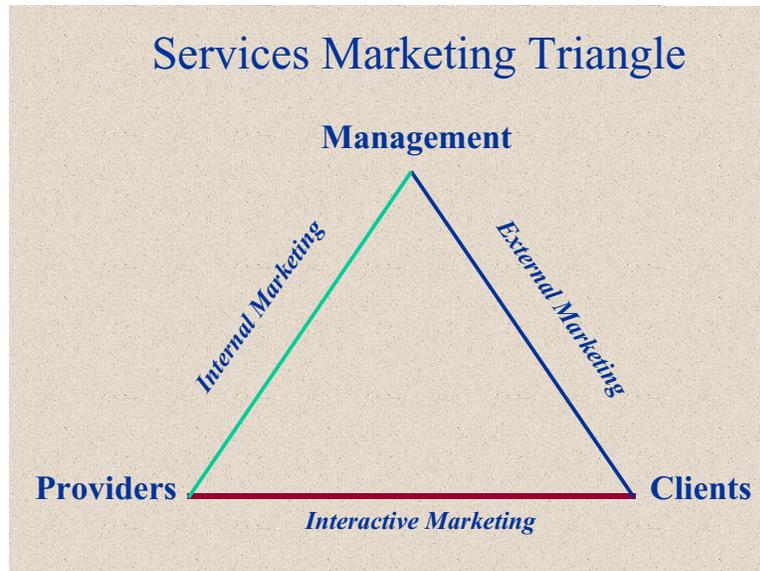
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<sup>1</sup> The phrase fuel of social marketing was used in reference to a chapter entitled Advertising: The Fuel of Social Marketing from the book Let Every Child Be Wanted by Phil Harvey.

<sup>2</sup> (a) Foreit (1997): Turkey KAPS Network; (b) CREHPA (2000): Nepal PSSN Network; and (c) Cuellar et al. (2000): Bolivia PROSALUD

The results of these three studies raise the question of whether or not it makes sense to pour money into mass media advertising for services marketing. Dr. Berg suggests that at a minimum, media efforts should be monitored closely to see when and where it works to promote services.

Dr. Berg discussed the Service Marketing Triangle (see chart below), which includes other forms of promotion, beyond mass media, that are important to services marketing. One form is external marketing. An example is the Green Star network in Pakistan that uses Mahalla meetings for community outreach.



Another form of promotion is interactive marketing, which involves what happens inside the clinic, or opportunities to promote services and products once the client gets through the door. There are at least two options for this type of promotion. One possibility is the in-reach strategy where a client comes to the clinic for one service and the provider assesses broader health needs beyond the service they came in for to see, and recommends additional services.<sup>3</sup>

Another form of interactive marketing is maintaining consistency with the external promotion message. For instance, if your campaign includes brochures, posters or a commercial, giving a message that the clinic is friendly to youth, everyone who interacts with the clients: the staff, receptionist or provider, needs to be consistent and friendly in the way they treat the youth. Consistency with the message is needed if a client is going to walk away satisfied. If you break that promise, you break a certain trust.<sup>4</sup>

<sup>3</sup> See presentation of Dr. Jim Foreit in this same report for a more detailed discussion of the in-reach strategy.

<sup>4</sup> See presentation of Dr. David Shore in this same report for a more detailed discussion of trust.

The last leg of the triangle refers to internal promotion. The idea behind internal marketing is that clinic management (e.g., social marketing management, or NGO administration) ensures that providers have the resources they need to carry through on promises made in the external promotion. This could include training or performing an assessment of the environment. If people are well trained but they are over-worked and under-paid and do not have the equipment that they need, they may not deliver well on a promise.

Dr. Berg summarized by emphasizing that the human factor underlies the marketing challenges. She added that there is no consensus on what models work best to guide service marketing, but that there is consensus on the need to adapt existing tools to services marketing, to adopt new tools, and to share and document lessons learned.

## IV. MAIN PRESENTATIONS

### Marketing Health Services: Lessons Learned from PROSALUD Bolivia

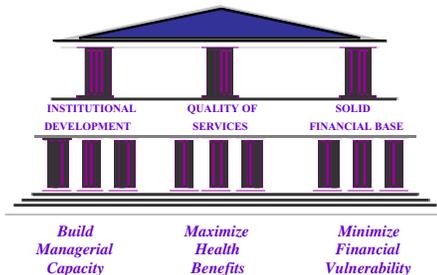
*Dr. Carlos Cu llar, Senior Associate, Abt Associates (Author), and Pilar Sebasti n, Country Representative, CMS Nicaragua (Author and Presenter)*

Ms. Sebasti n began by stating that since PROSALUD began in 1985, the organization has reached its current level of development after long and difficult years of learning, from research, from observing others and from making mistakes. PROSALUD s lessons continue to evolve to this day. Following are the main lessons learned:

PROSALUD s target population. The PROSALUD model is not for the poorest of the poor, but rather for the middle and the low-to-middle class. In Bolivia, PROSALUD is probably now reaching some people who are becoming increasingly poor due to the many social, political and economic problems of the country. But overall, the PROSALUD model is for those who can afford to pay and are willing to pay for quality service.



#### *Sustainability Pillars*



Sustainability PROSALUD has identified three pillars to sustainability. The first is institutional development that includes managerial capacity and the level of organization. The second pillar is quality of services. The third pillar is a solid financial base. These three pillars work together; sustainability cannot be achieved without one of these pillars.

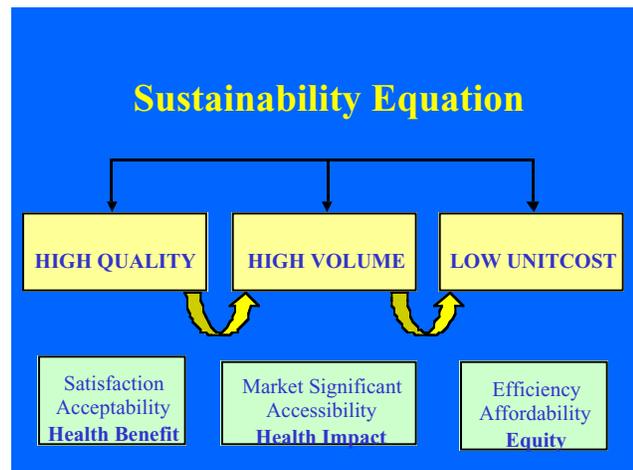
The sustainability equation includes high-quality, high-volume and low unit cost.

You cannot have high volume if you don t have high quality, and you cannot have low

unit cost if you don t have high volume , Ms. Sebasti n says. She continued on to say that these three factors have to be together all the time, and that it was true in Bolivia and holds true as well for Nicaragua (in the CMS network project).

A sustainable health system requires strong management and planning systems and community participation and involvement.

Social Marketing of Services. In addition to the Basic Four P s (i.e. product, price, place & promotion), PROSALUD adds two more: people and physical plant.



People. It is essential to hire talented staff, doctors and nurses, those who can give quality services. They not only should be good at what they do, but they should be loved by the community.

Doctors not only have to be good doctors, but also have to like management. They have to become business people and this can often be difficult for doctors who are not trained in management. At PROSALUD, doctors are provided with training in business to help increase their understanding of expenses and how they affect the sustainability of the clinic.

Personnel costs can take up a large part of a budget (at PROSALUD, personnel costs make up almost 60 percent of the total budget). Clinics often have multi-purpose staff (e.g., nurses who can perform many tasks) and these staff need special training, quality control, supervision, evaluation and monitoring. Providing incentives can be helpful but must be reviewed periodically.

The physical plant must respond to the service delivery model, Ms. Sebastian emphasizes. After 15 years of experience building and running clinics in Bolivia, PROSALUD has learned valuable lessons in designing clinics that are efficient, take into consideration client flow and respond to client's needs. In Nicaragua, CMS, working with PROFAMILIA, had the opportunity to build the clinics from scratch. The designs and plans for these clinics incorporated the best lessons from years of experience with PROSALUD clinics, and as a result, Ms. Sebastian proudly claimed that, compared to existing primary health care clinics, these clinics are the best in the country.

Product. The main lessons regarding product are:

- Focus on people's needs. Respond to the felt-needs first (e.g. by doing market research). Then, respond to the unmet needs (e.g. explaining the value of children's growth and development check-ups and services to clients who don't know about the services).
- Unnecessary demands cannot be ignored. For example, an ultrasound may not be considered important in some clinics, but in Latin America, an ultrasound is deemed important to the client so ultrasound services are provided at PROSALUD clinics.
- Clients value integration of services or one-stop shopping.
- Customize the service based on market research. For instance, PROSALUD's services are not the same at all of the clinics, but rather they depend on local community needs.
- Ensure that there is quality of service, and that the quality is perceived by the community.
- Define an identity: brand the name and the logo. For instance, in Bolivia, PROSALUD started with the brand and the name and now anyone who sees the Blue Cross knows that it stands for PROSALUD. In Nicaragua, the CMS-established clinic network used an established name, PROFAMILIA, an organization that has been in Nicaragua for 30 years, and is known for high quality family planning. However, this raised some difficulty since the new clinics offered a broad range of services, not just family planning.

Prices. The lessons learned with regards to price are:

- Prices are defined largely by the market. Prices are not the same in every place. In some locations, people are willing to pay more, while in others, people can afford less.
- Clients are value driven. The price does not matter as much as the value they perceive they can get for what they are paying. Soon after PROSALUD opened their clinics, they found several young doctors opened up their own clinics nearby, but charged much less. Later, clients who went to these young doctors went back to PROSALUD saying they were willing to pay a little more for the quality of service they received.
- Fee-for-service works better for the low-income population. Pre-payment, at least from PROSALUD's experience, was not popular; the feeling was that if they don't even have money in the bank, why pay for something they are not going to use right away?
- Combos or offering packages of services works well. PROSALUD has combos such as: three pre-natal classes, ultra sound, delivery, post-natal and pediatric consultation for a set price which usually costs just a bit more than the price of deliveries alone. Combos provide better value and are tailored to what people need.
- Cross-subsidization can also help attract more clients. For instance, in PROSALUD and in the CMS network in Nicaragua, growth and development services for children are provided for free. Kids under 5 can get free consultations during their first five years. This is offered as a promotion with the expectation that mothers will try the free services and come back for other services. The cost to provide these free services are subsidized by other revenue-producing services of the clinic.
- Risk-sharing schemes can help keep fixed costs low. Doctor's salaries are one of the larger expenses of the clinic. At the CMS network in Nicaragua, doctors are paid a fixed amount for each consultation. Initial clients are brought in through promotions, but continuity or return visits are based on client satisfaction with the provider's service.
- The staff needs to be trained how to be comfortable charging for services. Initially, staff can be shy about charging, but later, PROSALUD staff was trained on how to charge clients and explain the prices of services.
- It is better to have direct subsidies instead of sliding scales. It is very difficult to classify people by income class, and it is complicated to implement.
- It is essential to monitor costs. PROSALUD staff is careful to review the costs of even minor items on a regular basis.

#### Place

- Location is critical. It is sometimes better to have a small but well placed location, than a large place with a distant and inconvenient location. Also important to consider is the flow of people, or traffic patterns.
- It is important to have a dense population. The PROSALUD model does not work with an area population of less than 10,000.
- It is better to have networked clinics instead of isolated clinics. Ms. Sebastian cited the example that it is better to have 10 clinics in one place, like Santa Cruz in Bolivia has 10, while La Paz has 14. She emphasizes that the minimum

critical mass of the clinics is important to support the management area or unit. She adds that when the clinics are isolated, transportation costs and other management costs increase.

### Promotion

- Word of mouth is the most cost-effective form of promotion. The initial results of one (CMS Nicaragua) clinic's promotion impact study research revealed that:
  - Thirty-seven (37) percent of all (new) clients came because somebody told them something good about the clinic;
  - Nineteen (19) percent learned about the clinic through a promoter or promotional sales person who visited their home; and
  - A mobile unit accounted for just 8 percent of new clients.
  
- With the previous point, Ms. Sebastián felt that mass media does not seem to work as well with health services, probably she said, because no one wants to hear about services related to illness or suffering. What does work, based on her experience, is personal promotion (house-to-house and within clinics). In Nicaragua for example, people usually go to a clinic with a companion, either family or neighbors, etc. The clinic staff uses that opportunity to promote other services to customers or to their family or friends while they are waiting.
  
- Health fairs are effective to create demand in the early stages of a clinic or for special cases. An example of a special case is that in many places, May is considered Mother's Month, so at PROSALUD, they did a special promotion for mothers.
  
- According to Ms. Sebastián, television promotes image, but has no impact on demand. It is also very costly and can often more effectively be used elsewhere. For example, PROSALUD distributed little gifts in a piñata for the kids. The total costs for these toys for a year for six clinics was roughly \$100 and, Ms. Sebastián felt such costs were much more effective than television.
  
- Salaried, professional community health workers are an important part of promotions and are essential to keep and expand the client base.

Ms. Sebastián closed her presentation by stating that the learning process never ends, and that PROSALUD concepts, models and systems are subject to constant improvement and innovation. They are improving things that work and have been proven effective, but they also have to innovate and create new ways to promote, finance and deliver services. She ended by saying that in Nicaragua, they have a saying among her team, that the worse thing is not to be creative.

## **Extending Product Marketing Programs to Deliver Services: Lessons Learned from DKT s Experience in Bihar, India**

*K. Gopalakrishnan, Director of International Programs, DKT International*

Mr. Gopalakrishnan opened by stating that his presentation is split into two parts. The first part discusses the larger framework that DKT India operates under, and the second part discusses the Janani program that DKT has been implementing in Bihar, the poorest state of India, for the last three and a half years.

### *The Framework*

Mr. Gopalakrishnan stated that in various countries, there are three distinct segments. One is the well-off segment, which depends mostly on the commercial sector for its products and services. There are the poorest of the poor, which gets their services and product from the public sector. Finally, there is the middle segment that is served by the social marketing programs. The middle segment would use either of the two channels (private or public) although for the most part it uses the private or commercial sector channels. Though DKT as an entity looks at all three channels, this presentation will not touch upon either the public sector (for the poorest of the poor) nor the commercial sector.

Extensive service delivery, as used in this presentation, refers to every single family, every single household, every single citizen having physical access to the products and services of the program once delivered. For extensive service delivery, there are only two channels available in most countries. One is the vast public sector that has been set up with enormous investments over the years, and the other one is the equally vast private sector.

With social marketing, DKT tried to lock into the private sector channel so that every single family, at least theoretically, can have access to products. Three criticisms of social marketing have since emerged and have been effectively articulated recently: (1) that it is mainly urban; (2) that it focuses on products and it doesn't do justice to services; and (3) it ignores the poorest of the poor. Mr. Gopalakrishnan expressed that the reason for this occurrence is not because of lack of demand for these products in any part of the community, whether it is urban or rural, but because of provider disinterest. In the public sector, there is no pressure on the provider to perform. In the private sector, for reasons to be explained later on, there are real hurdles to getting providers to take an interest, especially in situations where the sales volumes or caseloads are low.

The social marketing of non-clinical products, including condoms, oral contraceptives, etc., is relatively simple because these products can be pre-packaged. Providers do nothing more than act as an intermediary who can sell or move the product and make some money or some profit in the process. Furthermore, market infrastructures have already been developed by commercial companies and are already in place. But according to Mr. Gopalakrishnan, the social marketing of services gets fairly complex for at least three reasons:

1. Clients need to get both products and services, either directly or more often through the provider. If a doctor has to insert an IUD, then a mechanism must be established to ensure a regular supply of IUDs to the doctor in order to continue providing the service.
2. Unlike the marketplace, providers are not organized very well so servicing the providers can be difficult. Even when working through medical associations, it is not a readily available commercial model with which to induce interest among the doctors, and it can become a major stumbling block. On the other hand, the market place is structured to absorb the conduct of business.

3. How to ensure quality of care? Quality of care depends on the provider, therefore, how does a program manager ensure quality of care? What mechanisms need to be in place to ensure quality of care, especially from the consumer's perspective?

DKT identified three elements that can help ensure quality of care: (1) presence of multiple sources of service delivery; if there is a monopoly of any kind, more likely that provider will not provide quality of care; (2) the provider has to have a direct stake in providing services, which could mean rewarding providers for doing a good job and penalizing those who don't perform; and (3) supply should always outstrip the demand — if there is short supply, there is going to be no quality of care. Therefore, constant monitoring is a key component to ensure quality of care.

The question then posed by Mr. Gopalakrishnan was: Can we use the social marketing infrastructure that we've set up in over 70 countries, as an opportunity for creating delivery of services? Can we build on that infrastructure and see what else we can do with it? In services, there are also products, and moving those products have already been established through traditional social marketing channels. So part of the puzzle, he says, can already be solved by using traditional or conventional social marketing models.

Furthermore, the existing social marketing infrastructure is available in urban and semi-urban areas. So the question, he says, is: How do we use that market infrastructure to deliver products to providers of clinical services in the rural areas? How can we create rural networks to tap into the demand that exists? Mr. Gopalakrishnan stated that every survey (NFHS or DHS) shows that unmet need is high, and that the World Bank found that roughly 25 percent of communities across the world have an unmet need for family planning. Therefore, he says the backlog is not so much how to change behavior, but how to address the need which has already been created for providing good quality product and services.

Mr. Gopalakrishnan then asked: Can we extend the use of the service delivery by leveraging the resources which are already available? He said that beyond markets, enormous resources are available but are often unorganized. For instance, there are about 400,000 doctors in India, of which only 20,000 are providing any family planning service; this translates to only 5% of the doctor's population. Most of these 20,000 doctors are specialists or OB-GYNs even though legally, medically and training wise, GPs can provide family planning services. He then asks, Can we leverage those other doctors? Is it possible to add family planning components into resources that already exist? How do we do that?

For instance, the rural providers in Bihar had no interest in family planning. The reason for this lack of interest is not because there is no demand for the product among the community, but because the providers don't find it financially viable to take an interest; the numbers just are not there.

The crucial part of the DKT model lies in understanding the elasticity of profit. It is not good enough to give profit he says, but what is needed is to ensure that the profit promised through the program is adequate or is commensurate with expectations, or with a so-called benchmark. This is the bottom line in the design of DKT s programs.

Mr. Gopalakrishnan identified some of the lessons that are emerging:

1. Providing services can be done in two ways: (1) set up your own clinic - the disadvantage of setting up your own clinic is that the scope can be limited, especially when the population is very large as it is in India; or (2) leverage resources, such as exploring the 400,000 doctors of which only 20,000 are involved in family planning. There are other tradeoffs between setting up your own clinic versus leveraging resources, including being able to exercise greater control at your own clinics, or having to establish management systems to ensure quality of care when leveraging resources. These need to be taken into consideration and weighed against the reach you hope to have.
2. People are willing to pay much more for clinical services than for non-clinical services. Mr. Gopalakrishnan expressed his feeling that social marketing of commodities is not going to be self-sustaining in the foreseeable future. But at DKT s clinics, leaving out the IEC component, he stresses that from day one, they have been self-sustaining and don t need any infusion of funds. They found that people are willing to pay disproportionately more for clinical services, either because it is long term or a one-time service therefore they don t feel the financial burden or pinch. However, when it comes to repeated purchases, for example 100 condoms over the year, then there is probably a little bit of fatigue involved which prevents the provider from charging more.
3. Consider the quality of leveraging resources. To protect the interest of the consumer by keeping the prices low, volume must be large. Unless there are large volumes, the provider is not going to be interested. This, Mr. Gopalakrishnan says, is the irony of leveraging or franchising providers. It s not only the question of what people can afford to pay, but also what price makes providing a service financially viable for the provider and induces them to stay in the network. He said grappling with this question is going to be a crucial part of one s pricing position.

### *DKT s Program in Bihar, India*

Bihar, in Eastern India, is the poorest Indian state. Fifty-five percent of the population is below the poverty line. It has the least contraceptive use. Bihar is also a large state with a population of 102 million. It is the second largest state, the first being Uttar Pradesh. Bihar is very rural; 87 percent of the population are rural and markets are understandably confined to the town or urban areas. There are a large numbers of doctors but, understandably, all confined to the towns. The doctors don t want to live in the rural areas because there is no social infrastructure available to them.

For this reason, the rural communities have depended on an informal network of untrained practitioners for centuries, though the type of care they provide has been moving more towards modern medicine in the last 20 to 30 years. These untrained practitioners focus on non-hospitalized illnesses.

The network is vast; there are roughly 200,000 rural medical practitioners in Bihar. DKT identified this as an opportunity to bring these rural practitioners into the program, to see how they can help in the provision of non-clinical products and become a conduit to the doctors network which provides the clinical services.

DKT has a three-pronged strategy in Bihar:

- to continue to use the conventional social marketing structure to deliver products to clients in urban and semi-urban areas;
- to network the doctors to deliver clinical services, network the rural providers to do non-clinical services and act as a point of referral to the doctors for clinical services thereby earning commissions for the referrals; and
- to use the same social marketing structure to deliver commodities to the providers (doctors and rural practitioners) rather than the consumers.

The DKT model or basic program structure involves using the market structure to reach consumers in the urban areas, and to reach the rural medical practitioners and the doctors who need these commodities to provide services, in the rural areas.

The program is designed to cover the entire state, including:

- 45,000 shops selling condoms and oral contraceptives;
- a network of 1,200 doctors franchised under the Sun logo delivering a range of clinical services; and
- a network of 24,000 rural providers in the Butterfly network for providing non-clinical products (condoms and oral contraceptives) and referring clients for clinical services. (Note: Bihar has 12,000 panchayat or administrative units for its 60,000 villages, so the model planned for two rural providers per panchayat to ensure competition or multiple sources at the village level, and thus ensuring quality of care).

Mr. Gopalakrishnan says that the key is not so much how to establish the network but how to sustain the network. A lot of marketing hype was used in the beginning to attract providers to join the network. Providers are then charged a fee to join the network.

There are two stages in programming:

- (1) Create benchmarks to establish quality standards as well as to advertise those quality standards to the community.
- (2) Franchise benchmarks under the logo, offering them to the for-profit providers to keep their interest going. It is important to consider the profit potential of the provider when creating the benchmark.

Aggressive advertising is important for the providers to take an interest especially in the early stages. A lot of marketing hype was used at the beginning of the program to attract providers to join the program. For this reason, the IEC expenses of the program can be quite sizeable. However, if the IEC expenses are not considered, Mr. Gopalakrishnan reports that the clinical services provision through the doctors can be self-sustaining from the start. Unlike product marketing, such as condoms and oral contraceptives marketing, the services are not subsidized. The services offered are priced at between 20 and 33 percent of the commercial price. However, even at these prices, the poorest of the poor are still unable to afford the services. He emphasizes that this program is not meant to address the needs of the poorest segment because of the assumption that the public sector is addressing the needs of the poorest segment of the population.

The challenge of this program does not lie in creating the network but in sustaining it. For this reason, strong indicators are needed right from the beginning. Rural providers are charged a membership fee to join the network. The membership fee serves to offset part of the program costs, but also serves as an indicator of the program's performance. For instance, if only a small fraction of the rural practitioners who enrolled in the network pay the membership fee later on, that is an immediate signal that something is wrong with the program. The use of fees eliminates the need to wait several years for the results of a tracking study, instead money becomes a monitoring indicator that is immediately available.

DKT took the position early on of keeping its program staff small, so DKT uses an outsourcing model because it can be quite laborious to implement and monitor programs, especially when having to monitor quality. The role of program management therefore is not to implement but rather to oversee implementation. Competition among the providers is used to ensure quality of care. As a result, the role of the program manager is to oversee the program and to streamline where necessary.

To implement outsourcing, the Bihar state has been divided into six regions, with each region given to six rival entrepreneurs. Each entrepreneur is given a certain set of tasks as well as predetermined indicators. To ensure that the tasks are performed, a 25 percent check is done by a rival agency such that detection of bad performance by one agency results in a reward for the agency that did the checking. This intense competition allows program management to step back, although such a set-up is not good for social equations but is the price that the organization is willing to pay, Mr. Gopalakrishnan said. So far, this system has been in place a little over two years and seems to be working, he adds. The advantage of this program design is that it reduced most of the program elements to a manageable set of indicators which then helps move the program forward and facilitates expansion.

IEC has three definitive roles to play: (1) to inform clients; (2) to generate interest among the providers; and (3) to help ensure quality of care.

Mr. Gopalakrishnan explained that a way to ensure quality of care is to make sure that the community or the clients understand the kind of care they should receive and at what price. Communication therefore works to keep the pressure on the providers so that the consumer is empowered to take care of their own interest. This is the only way it becomes possible to manage a program when looking at a population of 100 million he said, since it can become a nightmare to have to physically verify and monitor across 1,200 clinics and 24,000 rural centres.

In this model, DKT uses the rural networks to inform the consumer about the services and products available at the clinics, and at what price they are available as a way of ensuring that the standards are followed.

So far, the DKT program in Bihar has achieved the following results:

- delivered over 1 million CYPs last year;
- 16 percent of the CYPs were derived from clinical services (considered a sizeable chunk since clinical services were added a year and a half ago);
- networked 17,000 rural providers (with women partners) which account for 21 percent of oral contraceptive sales and 10 percent of the condom sales; and
- networked 300 doctors accounting for 43 percent of the clinical services.

DKT has its own benchmarked clinics as well as franchised clinics. The 43 percent figure cited above were achieved through the franchised clinics, which will be the focus of DKT's expansion efforts in the coming years.

## Creating Brands People Know and Trust

*Dr. David Shore, Associate Dean, Harvard School of Public Health*

### *Prelude: Lessons Learned from Power Brands*

Prior to the main presentation, Dr. Shore discussed lessons learned from what he refers to as power brands, such as Coca-Cola.

The first lesson is that **power brands never talk about their product**. From a branding perspective, Coke is at best 10 percent product and 90 percent brand. No one has ever heard Coke talk about its product, rather what one hears about Coke will vary by country. For instance, in the U.S., Coke is positioned as America in a bottle .

Another thing that all power brands have in common is that they **own something that is proprietary**. For 100 years, Dr. Shore says, Coke has gone out of its way to make sure that everyone knew that the formula for Coca-Cola was more carefully guarded than the formula for the hydrogen bomb.

Power brands **own one thing** in the minds of the market place. So it is important to understand what it is that you really have to offer, he stresses. Dr. Shore cited the example of Volvo, that they say they have very safe cars ; they do not say that their cars have good resale value and good gas mileage . A formula often used in marketing is  $E_+ = 0$ , or, if you highlight everything, you highlight nothing.

When wanting to expand into new product lines, Dr. Shore suggests an elasticity test that involves one fundamental question, which is for your brand, for the service you offer, for who you are, does offering a new product or service fit? not fit? or make people feel worse about it? . Having this conversation, he says, will help determine whether or not to introduce a new product or service. If a product or service does not fit the brand, but the opportunity is too attractive to ignore, then this gets into the issue of brand architecture, where, Dr. Shore explained, the question becomes whether you include the new product or service under the existing brand name or introduce a new brand.

Dr. Shore mentioned a saying in the world of branding, and that is cars rust, people die, and brands live forever . He emphasizes the point that there is enormous equity in brands. Brands that are particularly trusted can serve as a firewall in the case of adversity and can sustain inevitable challenges. Dr. Shore cited the example of the Tylenol crisis, and the two reasons why Johnson and Johnson succeeded in handling the crisis. One was that they had a steward of the brand - Jim Burke, CEO of Johnson and Johnson, who was out front providing the public with information and reassurance on how they were handling the crisis. The other reason is because of the trust in the brand.

When brands fail, it is rarely because of some manufacturing malfunction or because something was done wrong, Dr. Shore says, but rather it is almost always because of trust in the brand. Trust, he says, is the currency of all commerce. He cites that 94 percent of patients and 95 percent of physicians say that trust is the single most important variable in the clinical interaction<sup>5</sup>, and when he shared this with colleagues in other countries, they were in agreement.

Power brands live a very long time. Organizations typically calculate the lifetime value of a customer. For instance, how many times a patient will need a given activity or service in the

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<sup>5</sup> Based on U.S. data only

case of health care. With brands, he adds that you don't calculate lifetime value, but rather you calculate across generations. Brands run in families. This is particularly relevant with high quality health care where sustainability is important. If you can get someone in to use your product or service, Dr. Shore says, not only will it be sustained over a period of time, not only do you get a share of the market, but a share of the wallet. Thus, you get clients to use more and be more consistent in their use.

Dr. Shore ended this preliminary part of the presentation by reiterating the lessons learned about branding from power brands such as Coca-Cola, and by discussing the three R's, or what he referred to as the fuel of branding: **recognition, reputation, and repetition**. These three R's, Dr. Shore says, are the essence of service marketing.

Recognition means that the marketplace has to know of your existence and have some familiarity with it, or strategic awareness. To emphasize this point, he quoted Leonardo di Vinci: Nothing could be loved or hated until it is first known.

The reputation you want, Dr. Shore emphasizes, the positioning that you want in the marketplace is around trust. Trust is a universal good, he says. Trust is defined differently in different markets. Dr. Shore argues that anyone who is in family planning is simply not in the family planning business; they're in the trust business. Because the marketplace can't access the quality of the clinical intervention or of the product, they use trust as a substitute.

Power brands own one thing in the market and they repeat it. Repetition is necessary for retention. A brand is a promise that leads to a preference, and the way to do that, Dr. Shore adds, is to say one thing over and over again and then scale it across all of the interventions. One cannot be a power brand if perceived as being ephemeral, or something that changes all the time.

Reputation is necessary for retention. The Rosenthal Effect says that if you tell someone over and over again that this is who you are and this is how to do it, then people begin to believe that; there is a halo effect to brands. So when looking at introducing new products or services into your market, this reputation allows you to do that more quickly. Trust in the brand allows the client to accelerate the intervention or utilization cycle and reduces the cost of access because there is no need to do the due diligence. In buying cars for instance, they don't have to kick the tires. The public does not have to access the product or service in the same way that they do if you're not a power brand. People make assumptions about power brands. Branding, with trust as the key variable, can be used throughout the entire intervention.

### *Main Presentation: Creating Brands People Know and Trust*

Trust, Dr. Shore argues, is the most compelling issue in health care, and has become more compelling because of all the adverse feelings about health delivery. In the U.S. of all service providers across all industries, the health insurance and managed care industry have the lowest favorability in trust levels. Physician's positioning have gone down substantially for a variety of reasons, including profitability. There is an inverse relationship between perceptions about profitability and trust. The more profitable the organization appears, the less trustworthy it appears in healthcare. At the same time, trust has gone down because of the whole consumer movement in health care and the demystification of health care.

The reason trust and branding is so significant in health care is because good clinical care is on-going clinical care. You don't want health care to be episodic where clients go to the provider once and there's no follow up, Dr. Shore adds. What is desired and for all the right reasons is to create a brand dependency or a brand craving where people feel the need to go

and come back for services. Brand dependency is the intersect of importance and ignorance. He goes on to explain that the more important the buy or utilization decision is, and the less familiar or ignorant the client is, the more brand dependent the client will be. Health care is the prototype of this model. The importance of the clinical intervention is extraordinarily high while at the same time, the client's ability to assess the rightness of the treatment protocol is low, so the client becomes very brand dependent.

The other reason why branding is so important in health care, Dr. Shore says, is that brand dependency is particularly important for things that either touch or come in close proximity to skin. He cited the perfume industry as an example: 80 percent of all perfume sales are driven exclusively by brand name because of that touch that comes in close proximity to the skin. In healthcare, on the inpatient level for instance, the patient is stripped naked, medicated, and then cut up; this requires a lot of trust. So in a competitive and tentative marketplace such as health care, and a somewhat unreceptive marketplace at that, what one looks for is a sweetener that makes the brand irresistible or creates a craving, regardless of why you want to do it.

One of the things known about power brands on the mission side is that if clients, patients, families perceive a service as a power brand, then there are higher compliance rates. They are more likely to follow the treatment protocol or come back for appointments. The sweetener is the concept of trust.

Dr. Shore defines trust as an unwritten agreement between two or more parties for each to do what they agreed upon, and, he emphasizes, *without fear of change on the part of either party*. He reiterates here the enormous equity of trust.

The first level of trust, is called WEG: warmth, empathy and genuineness. And historically in family planning services, WEG has been paramount. To really own trust and to actively design the programs to increase trust, one needs to go well beyond that first level of trust or WEG (warmth, empathy and genuineness) Dr. Shore said.

Trust is inexplicably correlated with the notion of a brand, because a brand name provides comfort to buyers that are unsure about their decisions. It gives people peace of mind and such peace of mind is extraordinarily important. Fifty-six (56) percent of people said they would buy a product or utilize a service exclusively, based on the trust that they had in the provider or manufacturer of that product or service.

Trust is an essential ingredient as organizations move from a product-centric to a promise-centric model. The strategy of moving to a promise-centric model makes sense Dr. Shore adds, given, among other things, the inability of the marketplace to differentiate between providers, e-commerce and consumerism, and the time constraints people are under. One of the things that trusted brands do is that they allow clients not to treat every purchase or utilization as a first time purchase utilization. Trusted brands save people mental real estate by allowing people to make some assumptions because of what the brand represents and that is extraordinarily attractive to the marketplace. However, this is far more challenging with services because of the ephemeral nature of it.

Trust is incremental. It is iterative and self-reinforcing. Trust begets trust. While trust is incremental and you have to build on, building distrust is not incremental: it is cataclysmic. The betrayal of trust often requires one single act and once lost is virtually impossible to regain.

The classic trust cues, warmth, empathy and genuineness (WEG) are extremely important. When people were asked to list the most common synonyms for trust, the responses (faith, confidence, reliability, dependence and hope) almost always play and talk exclusively at the first stage, the WEG stage.

From a clinical or physician's perspective, trust involves three variables: A (the patient) trusts B (the clinician) with a valued thing C (high quality health care or clinical intervention). In health care, the clinician is given discretion over what is done regarding the clinical intervention. The patient and the clinician have unequal power and authority. By necessity, the patient gives the clinician more power by bestowing a certain degree of trust in them, and the patient assumes some degree of risk by giving discretion to the clinician with regard to what happens in clinical intervention. Because of the inequity in that relationship, the need and desire for trust becomes all the more important.

In the U.S., in the last three years, the number one health care issue among particularly poor people and unemployed people is access to care. But data shows that eclipsing access to care is the issue of trust. It is the single most important variable in decision making. Another operational definition of a power brand is something that people are willing to pay more for, travel further for and wait longer for. A power brand, Dr. Shore explains, has one willing to drive past two family planning clinics to get to the third.

In health care, unlike a lot of other industries, there are very few examples of trust. Dr. Shore used a Gallup survey showing nurses and pharmacists as being highly trusted (see following page). The reason Dr. Shore says, that nurses and pharmacists are so highly trusted is that they are perceived as giving unbiased advice and counsel. This is the highest level of trust, to be a trusted advisor, to be perceived as having no ulterior motive, no reason for recommending one direction over another other than the client's best interest. That is the highest level of trust, when one is perceived as a guidance counselor or one who has no personal stake in the decision. At the lower end of the continuum, are the marketing professionals (car salesmen, etc.) reiterating that most people believe that these professionals have other objectives other than a client's best interests.

**Trust Poll**  
*Please tell me how you would rate the honesty and ethical standards of people in these different fields.*

Druggists, pharmacists	Congressmen
Clergy	Local officeholders
College teachers	Labor union leaders
Medical doctors	Real estate agents
Dentists	Stockbrokers
Engineers	State officeholders
Police	Insurance salesmen
Bankers	Advertising practitioners
Funeral directors	Car salesmen
Journalists	State governors
TV reporters, commentators	Auto mechanics
Newspaper reporters	Judges
Building contractors	Veterinarians
Senators	Nurses
Lawyers	Grade and high school teachers
Business executives	Accountants

*For the percentage rated very high or high:*

<i>Which 4 had the most favorable ratings?</i>	<i>Which 4 had the least favorable ratings?</i>
1. Nurses	29. Newspaper reporters
2. Druggists, Pharmacists	30. Insurance salesmen
3. Veterinarians	31. Advertising practitioners
4. Medical doctors	32. Car salesmen

*The Gallup Organization, <http://www.gallup.com>, 2000*

David A. Shore

Physicians have moved down in the polls. Dr. Shore explains that the reason for this, at least in the U.S. but can certainly hold true in all settings, is that now 50 percent of physicians are employees and the perception is that they, in fact, have ulterior motives, that they have some stake in what they recommend. So when the physician now schedules a c-section for a certain time, this decision is believed to be in the best interest in the physician's schedule, etc. rather than in the best interest of the patient. As physicians are perceived as having other objectives other than the patient's best interest, that they are no longer unbiased, their trust goes down.

There are five different models of managed care plans, and there is a one to one correlation between the restrictiveness of the model and the perception of levels of trust. That is, the more restrictive a model of both the physician and the patient is, the least trusted the environment. A closed staff model for instance, where one can only go to a certain doctor, where they can't refer or go anywhere else to practice or where the client can't go anywhere else for care is perceived to be the least trusted environment. Conversely, a more open model that allows a patient to go both in plan of the primary provider, but also out of it, is perceived as the most trusted.

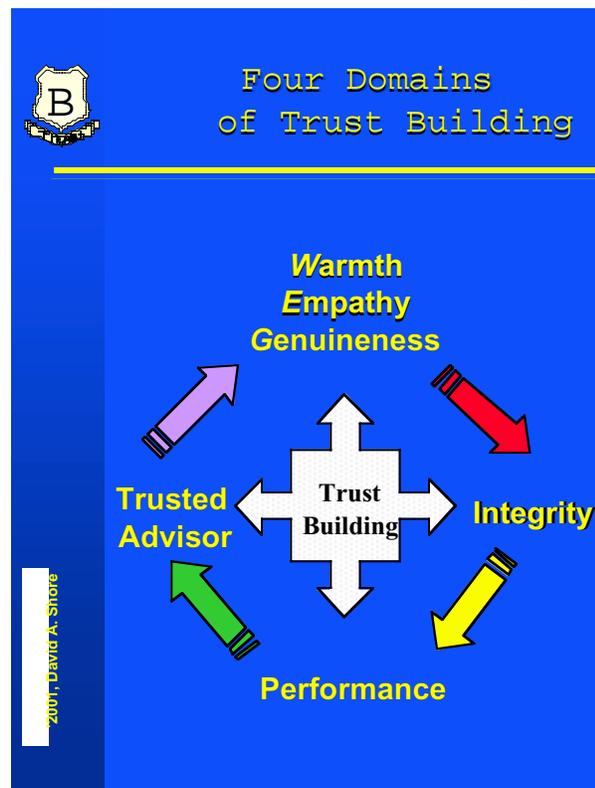
Dr. Shore exhibited a slide showing the four domains of trust building: WEG, Trusted Advisor, Performance and Integrity (see next page). Having an outstanding program product or service is simply the cost of entry. Likewise, on the service side, to be trusted, you have to be liked. People have to feel good about you. But if you don't begin to deliver on the promises and you can't go beyond that, then there is not what is referred to as deep personal trust.

Dr. Shore cited again the example of Johnson & Johnson (J&J). J&J believes that by far the single most valuable asset it owns is the trust that the marketplaces have in them, and that trust does extraordinary things for them, including allowing them to have price premiums. It allows them to break down barriers of entry into new markets. There is an extraordinary elasticity and portability to power brands that allows them to introduce new products and services more quickly.

The variable that creates this deep personal or emotional trust, is this concept of safe. Under the concept of safe, people have to believe that the provider won't hurt the client, Dr. Shore says. The second is that it's personal, it's familial. There is an intimacy with the provider of the service that the provider is established, has been around a long time, is competent, capable of offering good products and good services and is familiar. Dr. Shore asks: If you're going to own trust, one of the things that you have to determine is this: what are the trust cues for you in your market?

Trust cues vary dramatically from industry to industry. Dr. Shore says to ask yourself what do you want to own in the minds of the marketplace that matters to the marketplace? This is relevancy. He says that what they have found is that providers come up with things that make the providers feel good but it's not what the market thinks is relevant or important.

As mentioned earlier, some organizations calculate the lifetime value of a customer. One can do the same thing in healthcare, not in terms of the dollar value but the sustainability. An extraordinary amount of resources are spent getting people in the door. Roughly 80 to 87 percent of all marketing dollars are on patient acquisition, on recruitment. But there is also a back door out of which people leave. Whether your objective is mission or margin, the



acquisition costs are extraordinarily high. Most managed care programs lose money in their first year because of acquisition costs, and it's bad business. So, he asks, how does one amortize those costs over an extended period of time to increase profitability, or sustainability in the case of health care, as well as good clinical care.

This is the template, Dr. Shore emphasizes: if you want to be perceived as a trusted advisor, then think about being perceived as having kind, caring people with strong morals who provide unbiased guidance, all the while putting the customer first on delivering on the promises. In the absence of these four dimensions, Dr. Shore argues that a brand without trust is just a product. And products have very little loyalty or sustainability to them. They are referred to as soft targets. The patient will simply not come back for the service. That doesn't happen with power brands he says; with power brands, the customer comes back.

So the family planning product that can own trust can own their market. Dr. Shore ended his presentation by inviting the audience to think about what else one would rather own given the choices. He argued that there is nothing more compelling than trust, to access customers, clients, patients and also to retain them.

## **In-Reach as a Services Marketing Strategy**

*Dr. Jim Foreit, Senior Associate, Population Council*

Dr. Foreit started by defining in-reach as informing existing clients about available services. It is about selling more services to the people who are already using your services. One of the effects of in-reach is that it reduces the unmet need for preventative healthcare. Dr. Foreit adds that the entire discussion to follow will focus on preventative health care.

There is a connection between in-reach and outreach, Dr. Foreit says. Despite promotion by radio, billboards, brochures and signs, he says that personal referrals, especially from satisfied users, remain a source of major referrals for health care services. The more services that you can sell to a person, the greater the probability of this personal referral. The more in-reach, the more services that a person receives, the more services that they can recommend to their friends and their relatives.

In-reach has both advantages and disadvantages, Dr. Foreit says. He explains that it can be effective, efficient and, usually, inexpensive. The primary disadvantage is that it requires a continuous effort on behalf of the clinic staff, not a sporadic campaign done by outsiders, such as a mass media campaign. It is usually extremely difficult to maintain this kind of in-reach activity, and he pointed out that a number of earlier speakers talked about the need for supervision, the need to stay with it, the need to do unglamorous hard things on a day to day basis. This is very much the case with in-reach, and agencies often don't have that kind of stick to it.

In-reach campaigns have to overcome the single service mentality, Dr. Foreit says. Clients have many preventative healthcare needs. But when they come for a service, they're coming for one service, and Dr. Foreit adds, the provider is concentrating on providing that single service and does not screen for unmet service needs. He also says that as they started doing research, they found that clients tended not to be aware of the fact that other services that they were interested in were, in fact, available from the provider. The problem can be categorized as neither clients nor providers ask.

Dr. Foreit mentioned that there are several barriers to screening. On the provider's side, the provider lacks time or expertise. He cites as an example, a gynecologist who may not feel

confident to get into issues of vaccination. Sometimes, there is a priority given to preventative care, but a lack of positive feedback for the provider is associated with preventative care provision, and providers do not keep screening. For instance, he says you can give a talk about breastfeeding but asks whether you are ever going to get any positive feedback from having done that? Are you going to see a difference in this patient's life?

There are institutional barriers, and he adds that they usually occur in places that have many services available. There may be no marketing plan or treatment guidelines. In addition, the organization's priority services may not be the services that are needed by clients.

Finally, there are client problems as well, including lack of client knowledge, passivity, or lack of money.

To provide evidence of lack of screening and of the magnitude of this problem, Dr. Foreit discussed several studies. In one study of the Ministry of Health Services in Guatemala in 1997, they found (through exit interviews) 167 women who were interested in contraception, but only one of them had been counseled and had received an appointment.

In Mexico, in the Social Security Polyclinics, they found only 16 percent of women who fit the profile for suggested cervical cancer screening were offered that service, and 15 percent who should have been receiving breastfeeding information actually received that during the visit.

To illustrate lack of knowledge among clinic users, Dr. Foreit again cited the Guatemala study (1997). In clinics where family planning services were available, almost a third of the women were unaware that the service was available at the clinic. Even more interesting he says is that 11 percent were not aware of the fact that well baby care was available there. He also cited the study in Peru (1998), at INPPARES, where people were asked what services they wanted INPPARES to offer. About 34 percent mentioned services that the agency already offered.

Dr. Foreit referred to a SOMARC study done in Turkey to illustrate the importance of sticking to it and the importance of job aids. The survey involved exit interviews conducted at private providers, polyclinics, and hospitals. The baseline information showed that seven percent reported that the provider had mentioned family planning. An intervention was then tried, which was three days of knowledge and information training for the provider on why it was important for the provider to offer family planning. As a result, the exit interview findings improved, doubling from 7 percent to 14 percent. But still this was only 14 percent, he added, so another intervention was tried, using the supervisor. This time, the approach used switched from training in general knowledge about why the service is important to training in some very specific things that you can do in less than five minutes. This involves having a discussion with the client that goes something like this: You can get pregnant again within two weeks and the only way to avoid it is to use contraception. If you want contraception, I've got it. If you're not ready to make up your mind on what kind of contraception you want, I can give you a shot of Mesigyna right now that will protect you for 30 days, and give you time to decide. Based on this intervention, exit interview findings increased to 44 percent.

Another model, one that does not use the provider to screen, was tried in Peru. Providers can be difficult; doctors can be intractable, Dr. Foreit stated. So in Latin America, they decided to take a different tack, which was to train the receptionist to screen. The receptionist is typically a very sympathetic person who acts like a counselor and talks to the person, etc. These receptionists were trained to use pamphlets that were organized algorithmically. The receptionist sits down with the client and based on an interview guide, identifies needed health services and offers them to the client.

The importance of sticking with it became evident in this case, Dr. Foreit said. He explained that this concept worked successfully for over a year, until there was turnover at this clinic. The receptionist left and the new receptionist never got trained in using the pamphlet. The pamphlets went into the IEC budget and became the responsibility of the Information and Education Department and not the clinic. The Information and Education Department did not reprint the pamphlets, so in-reach disappeared. It disappeared without anybody wanting it to disappear, through a lack of foresight.

To illustrate some of the results of in-reach campaigns, Dr. Foreit used the Mexico study that used a public health service facility. Among clients not presenting for the mentioned service:

- breast examination offers increased from 8 percent to almost 60 percent;
- family planning offers increased from 2 to 20 percent; and
- immunizations increased from about 4 to 33 percent.

The study above resulted in a significant number of services being provided. Dr. Foreit also cited the study in Peru, which he particularly liked because it is a true experiment with people being randomly assigned to experimental and control groups. The experimental group was exposed to the intervention which is the pamphlet used in training the receptionists to act as counselors. He adds that this is a cohort study. The results were:

- The counseled group received 13 percent more services at their first visit and 64 percent more services within the 30 days of that first visit.
- The estimated increase in annual clinic revenues was \$47,000.
- The estimated annual cost of this in-reach (training and brochure printing) was about \$7,000.

Dr. Foreit adds that there are additional advantages that accrue to provide multiple services at a single visit. For the client, it means less transportation costs: they come once instead of twice. There are also lower opportunity costs for users, and it is less expensive for the institution as well. In Guatemala for instance, researchers started looking at the marginal cost of adding services. A typical visit with one service had an average cost of about \$3.20. That visit, if it contained two or three services, would cost about \$4. It was found that the person would get one service in 17 minutes and two services in about 22 minutes, which has cost savings implications or productivity implications for the provider and for the institution.

Dr. Foreit ended by outlining his conclusions and recommendations as follows:

- In-reach can be effective, efficient and inexpensive.
- In-reach should be thought of as a routine marketing activity, but one that needs to be constantly reinforced.

- Consider having non-practitioners do in-reach and recruit clients for additional services. Do not depend on providers alone.
- Use a job aid or client information tool, either a printed algorithm, or in the case of Turkey, just a little message that they are trained to repeat and can remember easily.

## **Marketing Voluntary Counseling and Testing (VCT) Services for HIV/AIDS in Zimbabwe**

*Sanjay Chaganti, Marketing Technical Advisor, Population Services International - Zimbabwe*

Mr. Chaganti's presentation is divided into three sections: the first provides background information about the VCT (voluntary counseling and testing) program in Zimbabwe; the second part discusses project implementation; and the third part discusses the lessons learned across the four P's.

### ***Background Information***

Mr. Chaganti started by clarifying that VCT represents voluntary counseling and testing for HIV. He identified the three elements of VCT: the service delivery element, which is establishing the clinics which provide counseling and testing; the demand creation element; and the third and often neglected element is post-counseling and testing linkages, which takes place after somebody has actually visited the center. For this presentation, Mr. Chaganti focused on the demand creation or the marketing of VCT services.

Prior to 1988, there were limited VCT services in Zimbabwe. HIV tests were available through some private clinics but were somewhat expensive. Most people found out their HIV status by going to the National Blood Transfusion Center to donate blood. Before donating, they take a blood sample and the center sends you a letter afterwards, which says either one of two things: (1) thank you for donating, please return to donate more blood and (2) thank you for donating, please go and see your doctor. This, he says, is how most people found out whether they were HIV negative or positive. In the mid to late 90s, there were a few NGOs that provided counseling and testing services, but on a very limited scale.

### ***PSI's Program in Zimbabwe***

PSI started the USAID-funded four-year program in 1998 to provide technical assistance and program management to the National AIDS Control Program. At that point, USAID Zimbabwe was considering closing down in Zimbabwe because Zimbabwe was then graduating to a successful thriving economy. So the focus of PSI's program was on financial sustainability and to make the centers as self-reliant as possible.

The first activity was to conduct a large formative research study. Some of the key findings from the study included the following:

- while awareness of HIV was fairly high, the knowledge of what constituted counseling was fairly low and VCT as a concept was fairly unknown;
- there was a fear of knowing HIV status;
- the main reason for not knowing status was loss of hope, fear of discrimination and rejection;
- in general, the perception of VCT was extremely negative;
- very few people had actually received counseling and testing, so there were not enough who could help get the word out about it;
- what people wanted from a VCT service in Zimbabwe was:
  - anonymous confidential services;
  - accessible, preferably 24 hours a day or night;

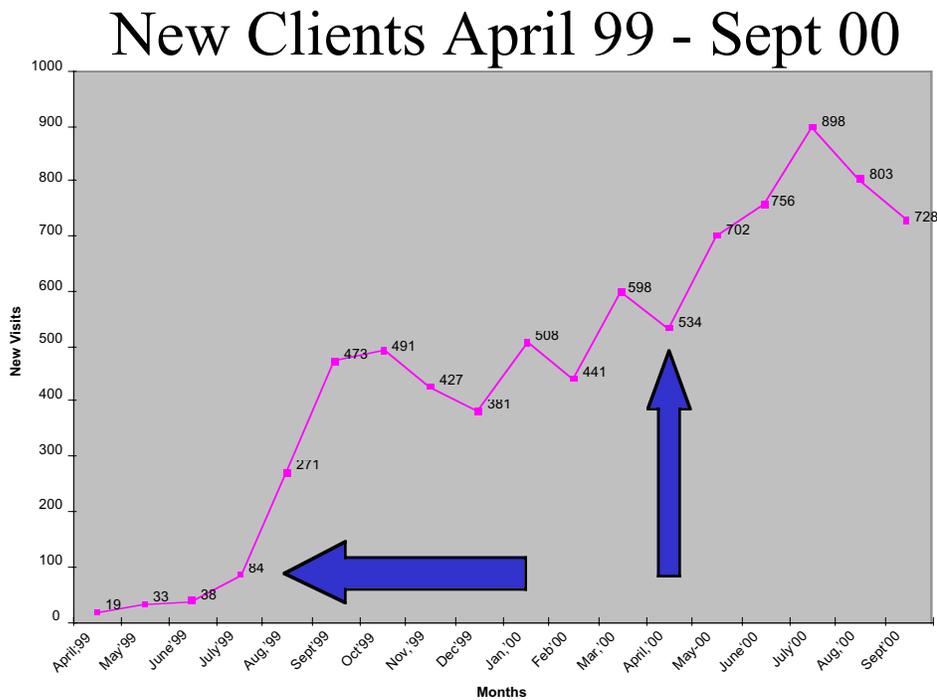
- affordable;
- manned by a professional, caring staff;
- provide other complementary services; and
- emphasis on counseling (they recognized testing but not counseling).

Based on these findings, the initial design of the program was to have VCT centers in six places within existing institutions: public sector, private sector and NGO institutions.

The program had a demand creation component to help bring in people through the door and they established a franchise across these six centers, built on a common brand called New Start . Six New Start VCT centers were initially planned and target groups were selected on the basis of who they thought were most likely to utilize the service and who were also at risk. These centers later grew to nine centers.

Up until September 2000, the nine New Start centers saw about 800 new clients every month. The services cost about 50 Zimbabwe dollars (roughly \$1.20 in Sept. 2000, about \$.50 at the time of presentation) for a counseling and testing visit, which includes a free follow-up visit.

The client inflow numbers, starting from April 1999 to September 2000, are shown in the chart below. PSI launched an advertising campaign at two points: first, in July/August 1999, four months after they established the network; and subsequently, another campaign in April/May 2000. These were two separate bursts of advertising wherein the numbers went up fairly significantly. The lesson here, Mr. Chaganti says, is that for a new service, as opposed to an existing service, mass media can play a significant role increasing client inflow.



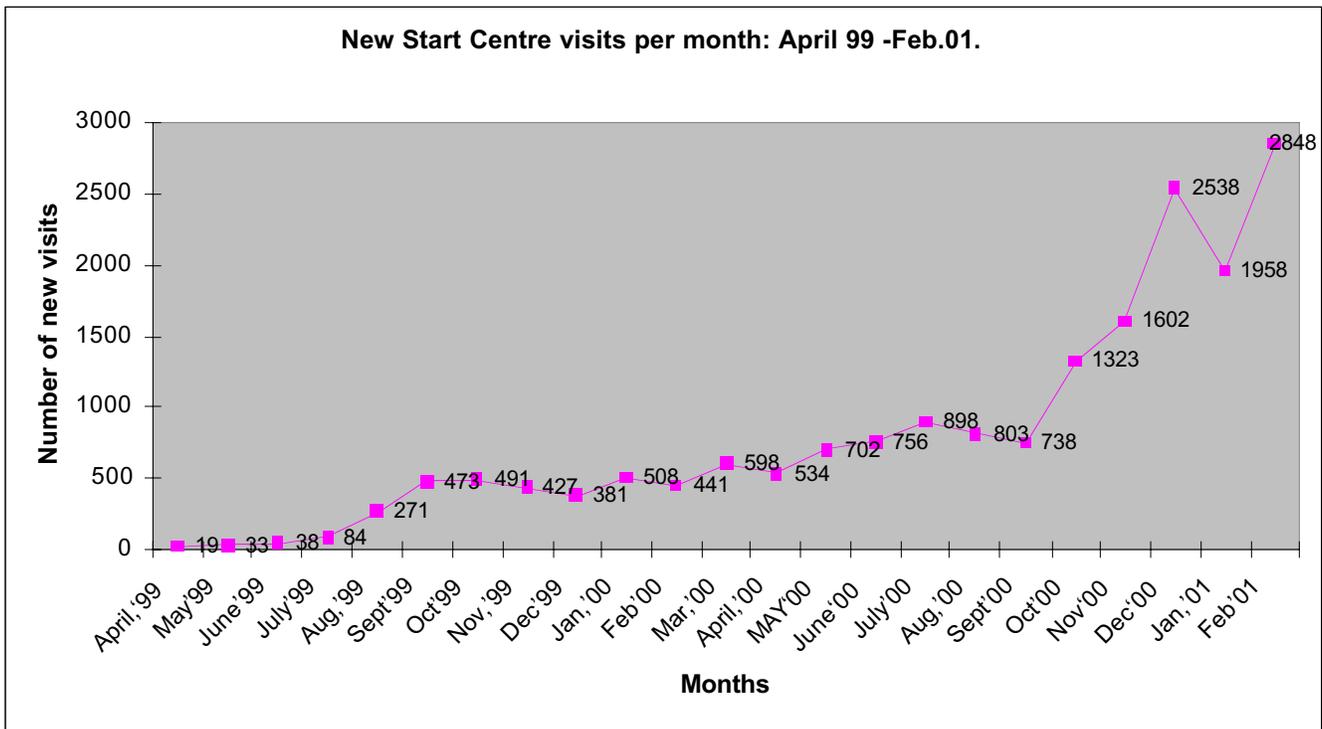
Some of the biggest challenges of the program were the indirect sites. Indirect sites were not controlled by PSI and were established within existing private, public and NGO settings. While PSI had a memorandum of understanding with these centers, enforcing the agreement was difficult due to circumstances beyond PSI's control. The lack of management control over personnel and organizational priorities led to a host of numerous program management and operational issues.

USAID Zimbabwe later reconsidered their position of closing down, started looking at a longer life span, and, encouraged by the success story in Uganda and Malawi where the AIDS Information Center (AIC) in Uganda operate their own sites, became more receptive to the notion of operating their own sites. So the PSI program entered Phase II and in October 2000, opened a direct site in Central Harare that it controls and manages.

The key features of this direct site are the following:

- The location is easily accessible (i.e. central business district, high density area, accessible to transportation); is anonymous and has convenient operating hours (i.e., 8 a.m. to 8 p.m., seven days a week, open on public holidays, etc.)
- The building layout allows for rapid expansion of space and room for growth.
- The personnel were directly hired by PSI Zimbabwe (and thus could be fired for non-performance).
- The site was designed to serve as a laboratory for new initiatives (e.g., impact of extended hours, price, promotion, training, etc.)

The result is that whereas in September 2000, the center received 800 clients, two months later the center receives 1,500 new clients per month. And in the direct site alone, the overall monthly average has jumped up to 2,500 new clients (see chart below).



At this point, Mr. Chaganti mentioned other direct site stories for comparison:

- (1) In Uganda, considered among the most successful VCT stories in the world, the AIDS Information Center (AIC) operates four direct sites and 47 indirect sites. The 47 indirect sites are run through existing public sector clinics. 70 percent of their clients are seen through the four direct sites. The remaining 47 centers see the remaining 30 percent of their clients.
- (2) MACRO, an NGO in Malawi that operates VCT centers has two direct sites and they see about 30,000 clients per year.

### *Lessons Learned in VCT Operations*

#### **Service**

- In VCT, service is equal to high quality counseling (the primary product).
- High quality counseling leads to behavior change.
- Constant training and support is needed.
- VCT centers should be flexible, innovative and customer focused.
- Rapid test kits are being provided.
- PSI is still grappling with the pros and cons of written test results (in some countries they have been subject to misuse).
- Understand that VCT is a channel of communication and not a solution.

#### **Location**

- Go for the larger towns (PSI has found that one center in Harare is worth more than five or 10 center across the country).
- Locate in a central business district if possible.

#### **Price**

- PSI faces the perennial question of whether to charge or not charge for VCT services (AIC in Uganda did not charge for the first four years whereas PSI has been charging from the start).
- PSI decided to follow the principles of social marketing which state that people value a service more if they pay a small amount of money for it.
- PSI will run a free promotion every so often, and it helps to bring in people who are otherwise unwilling to pay for services.

#### **Promotion**

- Identify key barriers and key motivators.
- Involve, educate center staff about communication objectives and strategies.
- Highlight counseling ( come in to talk ) benefit to encourage greater numbers to visit the center.
- Every person walking through the door is a new adopter, so constantly changing demand creation campaigns must be developed to tackle different barriers.
- It is important to get the private and public medical sectors involved.

- Because of the stigma attached to HIV and AIDS, overall strong advocacy is needed to improve the overall image and make testing a norm.

The main communication strategies for promoting VCT in Zimbabwe were:

- (1) Phase 1 (August 99 — March 2001) involves the basic campaign to create awareness of VCT and identify the sites, etc. (to address what, why and where questions)
- (2) Phase 2 (May 2001 — December 2001) is to promote the counseling aspect of the project (98 percent of clients view the centers as being for testing only).
- (3) Phase 3 (scheduled for launch in January 2002) is the testimonial phase, emphasizing satisfaction with services, and coming to terms with fear, etc.

Mr. Chaganti made a final point regarding the monitoring and evaluation part of the program, mentioning the various evaluation tools used, and that the data collected so far is extremely rich and has been useful for designing subsequent programs.

## V. OPEN FORUM

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After the presentations, an open forum was held to allow the participants to address additional issues or questions to all the panelists. Among the many issues that were raised, the following topics were identified as the most relevant themes for further discussion among the panelists:

- Which promotional tools worked best for services marketing;
- The difference between promoting the service versus promoting the provider of the service; and
- How to ensure that we are reaching the target population and what is the public health impact.

In addition, two additional topics that were raised but were not discussed due to insufficient time were:

- What does the marketing of services mean vis-a-vis the policy environment; and
- Question on quality of care.

The following section summarizes the discussion that took place among the participants and panelists.

### *Which Promotional Tools Worked Best for Services Marketing*

Dr. Foreit suggested that what needs to be done is to look at the circumstances, stressing that each situation has to be thought through individually. For instance, is it possible or necessary to successfully market a service, through outreach for instance? Another example he used was that there is no word of mouth promotion of VCT services, so that in this case one may have to do media promotion. On the other hand, he mentions that he knows of a terrible failure to promote female sterilization in Brazil, which is the most popular method in Brazil. In this case, he says it is hard to promote a single provider of a service that is available everywhere and everybody knows about it. Therefore, we need to look at a given situation and say What factors made this different than that? Why did the vasectomy campaign work in Brazil but the female sterilization campaign not work? What is unique about each of those?

Mr. Gopalakrishnan recalled that they used mass media very effectively in the initial or formative stages of their program. But once it gained some kind of a critical mass or critical momentum, they could reduce mass media since it was very expensive. He stresses that there was no doubt in their minds that apart from indicating the source of service delivery, mass media gives enormous credibility because when it comes to services, people need that reassurance which mass media seemed to provide. He pointed out that customers are more likely to try a pill or condom despite unattractive packaging for instance, but clients are less likely to take such risks when it comes to trying services.

Ms. Sebastian added that for them at PROSALUD, mass media worked well to promote the brand, the logo, and to reach opinion leaders. But in her opinion and based on her experience, direct promotion works better for reaching the community itself.

Dr. Foreit added that there is a problem in trying to figure out the real reason why, for instance, a mass media promotion fails. He commented: Is it because mass media is a bad idea for this kind of service? Or is it that we did a lousy campaign? I don't know if you're ever going to be able to tease that out.

A participant asked the panelists whether they felt that there was a timeline issue in terms of impact. In launching a network for instance, there is usually limited project time for achieving impact and showing results. Did the panelists therefore, ever feel that the time constraint affected whether or not to use mass media, and then follow-up with promotion and or outreach?

Mr. Chaganti asked Ms. Sebastian about what the access to mass media was in Nicaragua. Ms. Sebastian responded that the whole country has color TV; it's expensive to have them but they do. I don't want you to have the idea we never use mass media; we did. Maybe sometimes our spots were not good or the objectives were not reached. For example, when we start using mass media, TV spots, we didn't have the results that we expected to have. Then we shift to health fairs, where we use loud speakers and we go house by house and give little pamphlets, and the response was immediate. She went on to say that in their experience, mass media is not bad for the brand, for promotions, for big things.

Mr. Gopalakrishnan made the comment that I don't think it's one versus the other; it's not that when we use mass media, we don't use promotion. It's what level of mixture. What is the optimum mixture between mass media use and promotion? Because with mass media, you can at least measure impact. If you print thousands of posters, how do you ensure those posters go up on the walls? Operationalizing that is going to be a major task, whereas with mass media, you can reasonably show that it goes out. But the posters combined with interpersonal communications, you can probably relate to issues on a one to one basis. So each approach has its strength and we'll have to combine rather than say This versus that. That is never the issue here. That should not be the issue.

Dr. Berg then made a comment in response to Dr. Foreit's earlier comment regarding whether or not a mass media promotion failed because it was a bad idea or a lousy campaign. Dr. Berg responded by referring to the three studies she reviewed earlier, that showed no impact of either a radio campaign or a television ad, and that the point Dr. Foreit raised, that maybe those weren't good ads? Dr. Berg said: That's the first response I've gotten from people who really believe in mass media advertising: Well, I don't believe those results, because those probably weren't good ads. Dr. Berg added that in looking at what works, research finds exactly the things that David Shore was talking about, WEG in particular, that the communication should communicate warmth and empathy and reliability. She emphasized that CMS would design advertisements to include those components.

A participant added the comment that it is important to look at advertising as a necessary but not sufficient component of the overall marketing mix. She continued that You can have a great ad, but if the product that you're advertising is crummy, it's not going to sell it. If you're marketing Alka-Seltzer in a bottle as the tastiest drink out there, maybe you'll get people to try it but they're not going to use it again and they're going to go out and tell two friends how horrible this is, don't try it. So we need to be thinking along those lines.

Another participant emphasized that just as important as having the right ad or a good ad, is having a good media plan, including selection of an appropriate message for the target audience. She mentioned a rule of thumb that if you spend too little money, it's almost like

throwing it out the window, because it's not enough to have the impact. So the media planning itself can be also as critical as the creative element of the advertising.

Ms. Sebastian added that in their clinics, in both Bolivia and Nicaragua, the right time to advertise is all the time. She reiterated a point she made during her presentation that people prefer not to hear about illnesses and that mass media can be expensive, but that they use a lot of internal promotion and in-reach, etc. and have found that the smaller, less costly promotions such as the toys and gifts for children costing only \$100 per year, has worked more for them.

Later in the discussion, a participant raised a question about advertising again, particularly asking for some discussion on branded versus generic advertising. She added that, you generally want to do a generic campaign for a negative message. Is there any sort of parallel marketing side for services with that same issue?

To this question, Mr. Chaganti answered that "We've toyed with the idea of whether we should be tackling certain messages regarding counseling and testing, not by linking it up to our brand name, the logo New Start. For example, de-stigmatizing HIV in Zimbabwe. Should we just tackle them through generic messages? We chose not to do it for two reasons; one is budget. We have a limited amount of money and we have to maximize our impact which, in one way, is measured by the number of clients who come through the door and leave the door and maintain their behavior. The second reason is we haven't found any real justifiable reason. I can see it for condoms, I can see it for pills, where it's important to tackle the myths and misconceptions and separate it out from the brand. I don't yet see whether it's for family planning counseling or for HIV testing counseling. There would be a particular necessity to do it, to separate out the two. I think we can communicate it. In fact, the brand will add value, I think, to that generic message."

***The difference between promoting the service versus promoting the provider of the service.***

A participant made the comment that in many of the countries where CMS works, advertising for private practitioners is prohibited, which has led many of the staff to ask "if mass media is so important, how are we going to do it?" This comment then led into a brief discussion on promoting the provider.

Ms. Sebastian mentioned that they do not have this problem in the countries where she works, that they can advertise whomever or whatever they want.

Mr. Chaganti responded that they do have this problem, that in many of the countries that they work in, including in Zimbabwe where they are not allowed to advertise the brand of any prescription product to begin with, they are not allowed to advertise the providers. The Health Professions Council or the equal entities in these countries don't allow them to promote a particular provider or providers in general. He added that what they (PSI) do is (a) ignore such regulations and try to see what loopholes they can find, and (b) try to lobby for getting such (appropriate) regulations. In Zimbabwe, they tried the former, got their wrists slapped and then had to go back in a year's worth of lobbying and to show that actually communication does, in fact, improve the overall health impact of this intervention. They subsequently got permission to do it. One of the beauties of having a branded network he went on to say, is that you don't necessarily have to advertise the name of a provider. You can promote the logo as we promote in Zimbabwe (a private sector network of providers and a range of contraceptives called the PROFAM Network). So you'll see the logo on the walls of the doctor, you'll also find the logo on the packet of the pills, injectables, Norplant, IUDs

and the condoms, for male and female. So we promote both the network of providers and the range of contraceptive products.

Dr. Foreit then emphasized the importance of differentiating between talking about services and marketing a service, for example growth monitoring, versus talking about promoting an organization, and that we should be careful not to confuse the two. He says it's one thing to promote PROSALUD, which is just getting started and no one has ever heard of them in Nicaragua and so on. It's another thing to try to promote growth monitoring, to have a mass media campaign to promote growth monitoring such as go to PROSALUD to get growth monitoring. I think that when we talk about this and whether it is effective or not effective, this is one of the places where we have to start. We have to be pretty clear about what we're talking about.

A participant added that it depends on the marketing circumstances, for instance if you have a high end demand for the growth monitoring that's not being met because you don't have access to services, then you promote the services. She added that a lot of the decisions you make about what you're promoting and how you promote it are based on the specific circumstances in your marketplace or in your country. She emphasized that it is hard to generalize about what media is most effective, mass media or interpersonal or promotions, etc. and that it is difficult to generalize what sort of message to promote.

Later in the discussion, after responding to another question, Mr. Chaganti returned to this issue, saying But Rita (Leavell, of CMS India) had a question, which still is unanswered and I feel frustrated because I was asked this question before I came out here. Let me state this question and please correct me if I'm incorrect: CMS India has a fixed amount of money, \$100. Rita has been asked to introduce an injectable. She has two ways to go about doing this. (a) She can promote the injectable; (b) She can train providers and promote these providers who would also provide the injectable. Rita is sitting in Uttar Pradesh with 116 million people and say, Okay, I've got this money, what should I do? I'm very good at paraphrasing questions, I'm not very good with answers.

To this, Ms. Leavell added I'm struggling with this question, just in the design of the approach, because the injectable is not a known commodity. And as a matter of fact, it's a frightening commodity that has a number of quality of care issues attached to it as well as a number of political issues attached to it. I'm just thinking through here whether or not it makes more sense to promote the idea of the injectable and look very closely at gathering consumers and doctors into the idea of the injectable, and making the product available, or whether to promote it as a service available only at certain spots.

Ms. Leavell added that that's one side is the product and then next is the service point and I suppose in the continuum along that, you would also go into if you had a number of PSS clinics. You know, they just added the service, they're promoting PSS. They never bothered to mention that they had that particular product. There's a whole continuum here in terms of promoting services, whether or not you're just promoting that one particular service like the VCT or whether you're promoting a place, where you will get a number of different items. I would just like to hear some pros and cons as to which one is going to get you better utilization and better quality of care?

To this question, Mr. Chaganti responded that they had similar problems in Zimbabwe. He went on to say At least my recommendation is that you can aim to do both and you probably need to do both. You will need to promote the product as well as the provider, in this case who are trained to provide the product. As you are fully aware, this (the injectable) is a fairly different product than the condom or pill which are primarily, to some extent, a

consumer useable product. This (the injectable) requires an active participation of the provider in this case. So my recommendation, without understanding the Indian situation very well, is that you would need to promote the product. You would need to create certain awareness, like the Goli ham joli campaign that demystified or tackled the myths regarding oral contraceptives in India. You would need to do a similar activity. But at the very same time, you would need to harness the potential of at least the private medical sector, a handful of them or not more than a handful, if you want to have any impact there, to make sure that people can go to adequately trained providers. Not just for the provision of the injection one time, but for follow up counseling and dealing with amenorrhea and every other side effect associated with the injectable. So, for long term impact, I would suggest getting the providers on board, allow what (Mr. Gopalakrishnan) did in Bihar is where I would put my money.

Mr. Gopalakrishnan then added that If you look at OCs and injectables, what is happening with oral contraceptives in India is that there s no prescription, it s an over the counter product. But at this stage, injectables have also landed on the scene with a fair degree of controversy and a lot of hoopla about the history of how this was brought. You ll have to demystify it, there s absolutely no doubt, for a variety of reasons plus the feminist groups that are there, are still there and very active. And then there is the choice, of promoting a product and saying, So and so injectable available and then leaving the choice to the consumer. And my gut feeling is that it s very unlikely that the consumer is going to take the initiative to go and get the product to the provider and get injected.

He added the other way is to indicate where the service is available, because that s one hurdle you are crossing on behalf of the consumer. And that, at this stage, is very essential. Again, this is my gut feeling and it will have to be validated through good research. Gut feeling is where the service is available, including the product, whether the consumer buys it and goes to the service center to get it or comes as a package, it s something in which we ll need at this stage, because of the background, especially in India.

### *Reaching the Target Audience and Achieving Public Health Impact*

Ms. Sebastian commented on this issue, saying that in the case of PROSALUD, since the start, the project was designed to serve the low to middle income population. The project was referred to as self-sustainable primary healthcare. She explained that Bolivia is a very big country, and that the rural areas are very hard to reach. In Nicaragua, the project has been written as part of the recovery project, after Hurricane Mitch. The project there was also designed for a similar population, not the rural population because they are so hard to reach. She added that to you could only reach some of these rural areas by helicopter. She acknowledged that there is a population that they can t reach. However, she pointed out that in PROSALUD studies, they have found that 25 percent of their activities are done for free and that therefore, they are able to provide services to clients who are among the poorest of the poor and cannot otherwise afford to pay. She said We don t promote that, but that is the case. It s going to be more or less the same thing in Nicaragua; the clinics are open and we don t say that free services are prohibited but nobody can go out without any service.

She also added that preventative services are not provided as fee-for-service, but that they are costly, and that this is the cost of development . She explained that it can cost more than a doctor s visit to a client because of the time, that even though the nurses get paid less, these services are costly because of the time it takes to do what is needed. However, these services are subsidized by other visits.

To this, a participant made a follow-up comment about target populations and USAID's target populations, saying I really appreciate that dialogue because I think that being up front as social marketers, as you often are, about saying, look, we are not reaching the very poorest of the poor and we're not reaching the rural populations who are often actually the poorest of the poor, but we're really trying to get numbers (of relatively low income people). She added that the interesting follow-on to that is, and it's a question that the jury is still out on but, I think it reinforces the need to really document well what it is that we're seeing in terms of impact, is that in fact, we still don't know whether, if we provide these high quality services, if we are then pulling off some of the people who were utilizing the public sector at high costs for donor organizations and for governments and actually allowing those governments or donor organizations to really reach those people who are extremely poor with other funds. So I laud you because I think you have, for the most part, been very upfront with saying, Look, we are not about serving the poorest of the poor. But I also challenge you to really continue to think about who you're serving and what's happening and looking at what's happening with those people. Who are they? Are they public sector users? Are they new users? What do we know about that population or those populations who are using our social marketing services and products?

To this, Mr. Gopalakrishnan responded: It's inevitable that when you offer services and where the quality is good, there's bound to be a shift from the public sector, where the quality may be indifferent. Plus, the providers in the private sector may also lose their clientele because of the quality available, and the price element is going to be much more supportive of what our segment can absorb. The challenge about poorest of the poor is something which is emerging as a very important challenge and that's something, I think it's our responsibility to address in the coming years. It's the traditional reaction of the poorest of the poor, when you ask the social marketer Oh, there's nothing we can do, because our sector, for us to activate the sector, we need a profit element. And that profit element, therefore, leads to a given price and that is needed for us to work the system. That is not good enough any more, because we also have to place it in the context of what is really needed for the poorest of the poor.

Variety of options, because by saying that the poorest of the poor should rely on the public sector, what you're also saying and doing is to expose the most vulnerable segment to the least efficient of the three sectors that are available, which is not really fair. Most of the public sector progression, trying to address the poorest of the poor, have been in terms of motivating the employee of the public sector without really realizing that the poor woman is at the mercy of the provider and there is nothing in her hands to get good quality service. What we are attempting to do and we are in the preliminary stages of discussions, is what instrument can you use to get good quality service? When I want to buy a cake of soap from a shopkeeper, how is it that we get good quality of service? We have an instrument, which is money, and by buying it from a shop, if there is a shopkeeper who doesn't talk to us nicely, we go to another shop, because there is that choice available to us. And by denying this profit to that first shopkeeper, we are able to penalize that shopkeeper, but reward the second shopkeeper who gives us good price.

In the service industry, when it comes to the poorest of the poor, that arrangement doesn't work. So what we are exploring is some kind of a coupon system or a voucher system where this voucher will entitle this poor woman to get the service from any sector, whether it's the public, private, or NGO sector and who will provide the service and will be compensated by the government or the World Bank or any other donor. So in effect, you're giving her that instrument with which she can reward for good quality service. But we'll have to look at constructive ways of handling it. But if you expect a conventional social marketing structure to handle the issues of the poorest of the poor, it's not going to happen because that's not

the way the system works. Just based on the commercial application and we are trying to borrow that, we are trying to spill over into what we want to do. But if you want to address the needs of the poorest of the poor in a sector, a sector which looks at maximizing profit as its objective, you're not going to be very induced by what we have to do. We'll have to look at other dimensions of it.

## VI. CLOSING REMARKS

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Susan Mitchell concluded the day's events by thanking all the panelists and participants. She stated that CMS as a project are left with a lot of good ideas, a lot to think about and a lot of questions. She announced that the CMS staff would be meeting the following day for the purpose of discussing what more CMS can do going forward. Ms. Mitchell also requested the panelists and participants to fill out the evaluation forms provided, and to provide further suggestions for how CMS can continue the dialog on services marketing.

Lizann Prosser ended the TAG meeting by naming and thanking each of the panelists at the TAG. She emphasized that their participation involved spending time, not only that day, but time spent during the weeks that preceded that day, planning and preparing with the organizers of the TAG. In particular, Lizann thanked Ms. Susan Mitchell and Dr. Ruth Berg of CMS who, she said, over the last couple of months have put a lot of thought into today, not only on how it should be structured but, also who should be here, what kind of topics we want to try to tackle, and how do we then take those issues and the knowledge that we picked up today and bring it back into the CMS Project. Ms. Prosser commended them for doing a great job, and thanked everyone who worked in collaboration with them in providing suggestions and inputs for the day's event. Lastly, Ms. Prosser recognized Ms. Joni Herman who as facilitator, helped keep everyone on track for the day.

## APPENDIX A: LIST OF PARTICIPANTS

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## APPENDIX B: BIOGRAPHIES

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**Dr. Carlos J. Cu llar** served in the last two years as the Deputy Director of the Commercial Market Strategies Project (CMS) project.

Dr. Cu llar earned his MD from the Catholic University of C rdoba in Argentina, his MPH from the Institute of Tropical Medicine in Antwerp, Belgium, and a Diploma in Management and Administration from NUR University in Santa Cruz, Bolivia, his hometown. In 1985, Dr. Cu llar co-founded PROSALUD — now the single largest NGO in Bolivia- of which he was the Executive Director until 1998, when he moved to the United States to work for Population Services International, one of the consortium members of CMS. He continues to serve PROSALUD as a member of the Assembly of Associates and a consultant. In February 2001, Dr. Cu llar joined the Primary Health Care Initiatives (PHCI) Project in Jordan as Deputy Chief of Project and Management Advisor.

**Ms. Pilar Sebasti n** has served as the Country Director for CMS Nicaragua since November 1999. She and her team of 10 CMS staff recently participated in the opening of their third franchised clinic in Sebaco, Nicaragua. This clinic, along with the other two CMS clinics are among a select group throughout the country that have received full accreditation from the Nicaraguan Ministry of Health. CMS Nicaragua aims to open a total of six franchised clinics by October 2001.

Prior to CMS, Ms. Sebasti n served for 13 years with PROSALUD in Bolivia. With PROSALUD, her posts included Deputy Director and Director of Marketing. Ms. Sebasti n has a background in nursing, public health and health management. Ms. Sebasti n has conducted consultancies in reproductive health throughout the region and in Europe and authored several publications.

**K. Gopalakrishnan** has over 14 years of experience in social marketing and social franchising programs -- first with Population Services International in India and later with DKT International. After completing his Masters degree in management, economics and language applications he worked for the HINDUSTAN TIMES in Delhi. He joined Ulka Advertising in 1985 to head its development communication division, and helped design communication campaigns in the area of family planning, child survival, health, nutrition and conservation.

In 1987, he joined PSI and was among the core team that set up the vast social marketing program covering an estimated 400 million population. It was in PSI he was introduced to social marketing. In 1995, he joined PSI's sister organization, DKT International, and moved to Bihar in eastern India to establish the Janani program. He is a member of the Population Commission in India of which the Prime Minister is the chairman. Gopalakrishnan has been part of the team that worked on the social marketing and social franchising policy in India.

In January 2001 Gopalakrishnan moved to the headquarters of DKT International in Washington DC, and is currently responsible for the incorporation of lessons from the Janani program in other DKT programs worldwide. Gopalakrishnan remains the President of Janani.

**Dr. David A. Shore** teaches the popular graduate course Strategic Marketing: Gaining Competitive Advantage Through Positioning and Branding at Harvard, where he is also Associate Dean at the Harvard School of Public Health.

Shore's customized Branding Boot Camp<sup>sm</sup> and branding audits have been provided to numerous organizations. His presentations make use of the case method and related instructional approaches for fast-paced active learning. In 2000 he delivered keynote addresses to such diverse meetings as the American Society of Association Executives, The Wall Street Journal Healthcare Summit, American Gem Society and the Sprint Executive Forum on CyberBranding. In 2000 he delivered the keynote addresses for both of the American Management Association's Branding Forums and will do so again in 2001. In 1999 and 2000 he chaired the first and second national executive Conferences on Branding, Positioning and Competitive Strategy for the Healthcare Industries and will chair the 2001 Conference as well. He advised the Direct Marketing Association on the DMA 2000 Brand Marketing Conference and will deliver the keynote address for the 2001 DMA Brand Marketing Conference. He serves on many advisory boards. He is an active consultant, working with a wide range of organizations and industries on creating, building, managing and evaluating brands. His formula for building branding equity, brand dependency model, and brand equity test have been widely adopted. He is currently developing the concept of trust as an integral part of brand building.

Shore is the author of more than 100 publications. His marketing columns have been a regular feature in several magazines. He is currently completing a Branding Resource Guide. He frequently appears in the press, recently interviewed in a wide range of publications including Growing Your Business, The Healthcare Strategist, Association Management, Selling Power, and The Wall Street Journal. The three 1999 and 2000 extended interviews with Shore on "Developing and Building Your Brand," "Positioning Your Product or Service," and "Building Customer Loyalty" in Growing Your Business were among the most popular in the magazine's history. He was also featured on the PBS program Best Practices in Marketing.

Shore is Executive Director and PricewaterhouseCoopers Director at the Center for Continuing Professional Education at Harvard University School of Public Health. The PricewaterhouseCoopers Directorship is the first and only named directorship in continuing and executive education. He is also Co-Director of the Harvard Program on Continuing Education for the Health Professions.

In all his work, Shore strives to build constructive links between theory and practice.

**Dr. Jim Foreit** is a Senior Associate at the Population Council. He has been working with family planning and reproductive health programs for 30 years, and has spent 17 years as a resident abroad in developing countries working with programs. He specializes in operations research, but has also been involved in marketing studies off and on for several years, specifically in the areas of willingness to pay surveys, location of services, and marketing additional services to current clients.

**Sanjay Chaganti** has been employed for the past eight years with PSI in various capacities. He is currently serving as a Senior Technical Advisor at PSI Zimbabwe. He oversees all research, communications and marketing functions for various products and services, including the "New Start" VCT program, the "ProFam" range of contraceptives and the network of private sector medical providers and male and female condom social marketing programs. He has wide experience in managing social marketing programs and is a specialist in research and communications. Chaganti holds a Masters degree in Economics from Tufts Univeristy and a Masters in Communication Management from the Annenberg School for Communications at the University of Southern California.