Expert Exchange Forum Comments

Susan Mitchell
02/05/08 3:49PM

Phil mentions that social marketing has successfully moved into offering more provider-dependent family planning methods such as injectables and IUDs. I'd be interested in hearing from Phil, or others participating in this conference, on what you see as the challenges and lessons learned from social markeing these products.

Denise Averbug
02/07/08 12:27PM

Bruce mentions the important role government needs to play in scaling up social marketing programs, citing the case of India. What would it take to make this happen in other countries?

Mary Segall
02/28/08 6:10PM
Building on that idea...
In response to Conference Administrator (4)
What is DKT's experience with providers of services?

How does DKT manage ensuring quality of injectables (Depo-Provera)?

Mary Segall
02/28/08 6:27PM
Building on that idea...

In response to Conference Administrator (8)
Reed, I was wondering about your ideas in terms of ensuring that not only are the products "quality products" but the way that they are provided to the client is also "quality"?

What experiences have you had in introducing specific products for new borns - products to promote the health and wellbeing of newborns?

John Harris
02/29/08 4:03PM
Building on that idea...

Reed, you recommend a type of social marketing where social marketers don't market any (in-country) products or services themselves. This sounds like a good way to reduce risk for the social marketing organization, while generating significant overheads. In this

model, do social marketers plan and coordinate markets like the Soviet Union did, or do they take a "meetings for all" approach like the UN?

Bruce Mackay
03/03/08 10:37AM
Next steps...
In response to Denise Averbug (9)
Denise,
I think there are three things the sort of people who log onto this sort of website can do.

1. Be aware of how narrow a segment we are, and promise ourselves and each other to get out more.
Like all great initiatives, social marketing has been driven by pioneers, and spread by evangelists. These types are still necessary, but they are not great ambassadors for the next stage, for which UNAIDS (bless them) invented the term 'mainstreaming'. Social marketers and folks like me who are interested in private health markets and how they serve and screw poor people should spend 90% of their spare time talking to the unconverted, and only 10% on websites like this.

2. Do attitude research among government policy-makers and budget controllers and district health team managers, and realise how strongly the associate 'social marketing' with 'donors'. Think of the problem like an HIV/AIDS stigma-reduction campaign, and being good marketers, start with where the consumer currently is, not where you want her/him to be. It is not at all self-evident to such people that they should give much time (and certainly not much money) to social marketing or private providers (let alone to the 'health-seeking behaviour which dare not speak its name', self-medication).

3. Itis actually self-medication which is the best entry-point for changing donor and government thinking, response and programming. Most health plans do not start with health-seeking behaviour. If they did (as they should) then self-medication would be there at the front of most government health plans for helping the poor, because that is whatmost poor people do first. So instead of promoting social marketing or social franchising or all these fancy donor-funded fun and games, we should challenge donors (especially donors like DFID and the Banks who want to fund governments) and government health planners to really do the 'evidence-based policy-making' they claim to promote, and start every plan with the evidence of what poor people actuallydo when they get sick - which is mostly to first buy some tablets from a shop, and then seek advice from an unregistered and often unqualified person whom they pay from their own pocket.

Bruce Mackay
HLSP

Francoise Armand
03/03/08 4:48PM
I have a different perspective

HI Bruce,

I read your response to Denise with great interest. We dedicate a lot of time to "mainstreaming" efforts on the PSP-One project, trying to get governments and donors to recognize the critical role of the private sector in public health (and by extension, any social marketing program using private distribution and communication channels). In most countries, there is a growing acceptance of this role, which is easy to demonstrate with the type of market research you mention.

But I have also observed wo diametrically opposed and equally maddening attitudes in public health circles: 1) Yes, poor people go to the private sector for products and services, and that's a sign that public health programs can be farmed out to the private sector (ie: exit strategy) 2) Yes poor people go to the private sector but they should not have to because health products and services should be free to them.

Doesn't it seem that social marketing has managed to strike a balance between these two extremes? Whether it is NGO-based and subsidized, or partnership-based and commercially viable, we are still tapping into what the private sector does best (responding to demand, making products widely accessible, and communicating with people) and compensating for its drawbacks (lack of coverage or high prices). So why do you think of social marketing as "fancy donor-funded fun and games"?

Francoise Armand
PSP-One project

Reed Ramlow
03/05/08 3:40PM
Response to Mary Segall

Thanks for your questions, Mary. To address your question on quality, we at AED believe that we should invest heavily in quality improvement and quality assurance for programs that involve service delivery (as well as monitor quality of products that our partners deliver through a total market approach or "Full Market Impact", as we call it). I am sure you would agree that overall service quality (which includes a range of factors) is about the top selling feature for a private health provider, much more important in fact than the promotion dimension that we admire so much in social marketing!

For example, under the PSP Nepal Social Marketing and Franchise (N-MARC) Project, AED and partners EngenderHealth, Nepal Fertility Care Centre and the Nepal Contraceptive Retail Sales Company are reinvigorating efforts to improve and assure quality of family planning and reproductive health services delivered through large pharmacy-based and clinic-based service delivery networks. We recently revised and updated training and reference manuals, completed a baseline quality assessment, and we are enacting vigorous training programs and external and self-assessment quality monitoring protocols. We believe our investments will pay off with improved quality, as demonstrated through tracking reports. I should also note that we plan to institutionalize

responsibility for quality assurance for FP/RH services, at least for physicians who belong to a private provider network supported by N-MARC, within a professional society, the Nepal Society for Obstetricians and Gynecologists (NESOG). We believe such an association with professional societies is the best way forward for sustaining "fractional" private provider networks and quality assurance efforts that focus on the delivery of specialized services, such as family planning and reproductive health.

To answer your second question, I have had experience in the social marketing of the Clean Home Delivery Kit (CHDK) in Nepal, the first of its kind in the world. This kit is a potential lifesaver for both mothers and newborns as it helps prevent septic infection, a major cause of maternal and neonatal death in Nepal. The vast majority of births take place in theory "at home" i.e., not in maternity centers in Nepal. However, the reality is that many of these deliveries are not "in home" due to a widespread cultural belief ...more...

Reed Ramlow
03/05/08 3:45PM
Response to John Harris

To address your question, John, AED acts as an "honest broker" for a variety of marketing partners with no stake in any particular product or enterprise when we implement our version of the total market approach, which we call "Full Market Impact" (FMI). We do not believe an organization could facilitate a total market approach any other way. If the facilitating organization has products in the mix, that is akin to letting the "fox in the henhouse". The other partners, particularly commercial organizations with "skin in the game" (money invested), will not trust the "facilitating" organization since they will see it as looking out for its own market interests, above all. The FMI model or a genuine total market approach is fundamentally a free enterprise model that will facilitate and build the participation of commercial organizations in public health social marketing programs. Such an approach is the antithesis to communist planning models. In fact, the more traditional social marketing approaches that squeeze out commercial competition arguably bear far more resemblance to the state monopolies that the former Soviet Union championed.

Francoise Armand
03/06/08 4:37PM
I have a question...

I would like to ask a question to the expert panel group (others please feel free to chime in). Having listened to the other interviews, I noticed a few references to the "bottom of the pyramid" approach. (For those who are unfamiliar with this concept, the bottom of the pyramid is the largest, but poorest socio-economic group, particularly the four billion people who live on less than $2 per day, in developing countries). This terminology has been used most recently to describe a new business model that targets the poor and hard to reach. Because this expression is increasingly creeping into the social marketing jargon, I am curious to hear from my colleagues whether they think this is a truly new

approach, compared to what social marketing programs have been doing for 30 years, minus the profit of course. If it is new, how do we incorporate this approach (business model targeted to the poor) in our models of intervention, and then is it still called social marketing?

Francoise
PSP-One Project

Jeff Barnes
03/07/08 5:55AM

I would like to pick up the thread of Bruce MacKay's comment about starting with health seeking behavior of consumers. I agree that in most lower income countries, the majority of health care is via self-medication through drugs obtained in a market, lower tier drug shop and dispensed with advice from someone that is unqualified. As marketers, we should be responding to consumer behaviors and doing more to deliver health at these delivery points most used by the consumers. However, I don't think social marketing programs have solved the public health issues around pursuing such a strategy. Following the principle of first do no harm, social marketers have to be careful to avoid reinforcing health seeking behaviors that lead to ill treatment, drug resistence and complications. If there is no significant risk in delivering products and services at informal delivery points, we have to make the policy case. There have been some successes in this regard (e.g. getting authorization to have condoms and ORS sold outside pharmacies). But what about where there are risks? Can we do more to raise the quality of service delivery? Or do we support regulatory efforts that redirect consumers to providers they "should" be going to?

Susan Wright
03/07/08 8:42AM

I have enjoyed hearing these different perspectives on social marketing. Reed mentions the role of targeted subsidies such as voucher programs in creating more sustainable but not economically restrictive social marketing programs. Since I am in Ghana I can attest that vouchers have played an important role here in providing affordable bednets to vulnerable populations while also encouraging development of a range of commercial partners. That approach has resulted in commercial market expansion, making ITNs lower cost and more available for the general population. However, since production, distribution and redemption of vouchers all have logistical and transactional costs, I have trouble seeing how that approach could be used for lower cost products such as contraceptives. On the other hand perhaps vouchers or similar instruments would be a good approach to subsidize services such as uinsertion of IUDs, sterilization or implants provided by the private sector. Are there examples of this elsewhere?

As a somewhat separate topic, I would be interested in hearing about the linkage, if any between social marketing of roducts or services and third party payment schemes - since such schemes are starting to make more headway in developing countries. Thank you.

John Scicchitano
03/07/08 4:20PM

TMI: cost per unit
What do AED's TMI programs cost, per unit of product sold?

It would interesting to look at total program budget of such programs, and divide by the number of units that have been sold in their focus countries, to examine the marketing subsidy per unit.

The same question could be asked of voucher program or traditional social marketing programs. Choices must be made about which approach works best, so that limited resources are allocated to the programs with the best value.

Jeff Barnes
03/09/08 7:43PM
John you raise an interesting question about cost per product sold. Having looked at this while working with PSI and in other programs, I can tell you it is not always a straightforward question. The first problem is what costs should you consider-- only donor costs? Fromthe donor perspective this might be all that is relevant. But if you are trying to analyse costs to draw broader conclusions about what approaches are most cost-effective, this is not sufficient. Many important costs are borne by the private sector, by consumers or hidden in organizational costs that are not always treated in the same way. The other issue is what time frame you should consider. Many people in the free distribution camp can show that there cost per unit distributed is well below that in social marketing and commercial partnerships. This is because they have virtually no up front costs to negotiate partnership agreements, develop brands or build advertising campaigns. If one extends the time frame well into the future, per unit costs of free distribution programs begin to look less cost effective because it has to be repeated over and over whereas more sustainable partnerships (after having high up front costs) can sustain product supply and demand creation with no additional donor support. The key factor in all approaches is achieving scale. Unit costs are never competitive until a program achieves large scale. For this reason, it is important not to compare results from a program in India with one in, say, Benin.

Tennyson Levy
03/10/08 2:53AM

Social Marketing & BoPM
In response to Francoise Armand (17)

Francoise,
The bottom of the pyramid in developing countries is defined as the poor and near poor who though partaking in the economy do so on an entirely different scale. What makes them a potent market however is the magnitude. These are consumers who purchase for immediate consumption given very constrained disposable income. They utilize

community based retail outlets that know and cater to their simple but specific needs. They purchase what they want/need at the moment. Some marketers have very successfully catered to this market recognising the peculiarities of this segment. Cigarette marketers picking up on the habits of small shops have now resorting to packing ans selling cigarettes for single stick purchase. Manufacturers of shampoo, detergent and tomatoe sauce for example market and distribute their products in single use satchets. Food manufacturers eg soup do likewise. Why, because that is what the market can bear but it become viable because of volume.

Social marketing programs with the exception of some condom marketing efforts have never really reached down to this market. One would argue thats because you couldn't do that with pills.And there in lies the big difference. Marketing to the bottom of the pyramid requires its own unique product configured specifically for that market, requires a specific distribution system that reaches that very special retail outlet in the community, requires acertain degree of risk taking and above all requires a commitment to that specific consumer.

Its not a matter of low/cheap/price...its the whole package that has to come together strategicall to effectively reach the consumer at the bottom of the pyramid. So ow do you do that with the pill. Break the mold.Change the paradigm. Market pills in blister packs of 5 or 7 pills. Compliance? Is it that great with the existing package configuration. Just a thought

Tennyson Levy
03/10/08 3:01AM
Yes, I agree...

In response to Susan Wright (19)
Agree with Susan that the logistical and transactional costs associated with vouchers requires a focused application. In the Philippines the thrust is to expand the delivery of long term and permanent methods of contraception through the private sector. Given that these methods have provider costs in addition to "product" costs vouchers are a prime consideration. In fact vouchers are likely to play a major role in promoting tubal ligation and vasectomy especially since these are one time events thereby negating the logisticals costs associated with renewable methods. Of course there is always the issue of informed choice and whether a voucher can be considered an incentive rather than a facility. Bright minds will easily address that issue I am sure.

Reed Ramlow
03/10/08 9:18AM
Response to Susan Wright

Thanks for your question, Susan. I would agree that, on the face, vouchers would seem to be an impractical solution for lower cost health products. However, we are currently exploring the idea of providing coupons to low-income sex income workers that would enable them to get a significant discount on full-priced female condoms (retail price of

US $1.85 for two condoms), recently launched by one of our commercial partners in Nepal. Given the logistics and transaction costs you mention, we will have to be innovative on how we design such a scheme. For example, perhaps we could make the female condoms available at private clinics, and then couple the condom discount with a discounted or free STI check-up/treatment at the clinic. This way we could get a "twofer" - increased check-ups/treatments (since the evidence shows many sex workers are not reporting to clinics for STI treatment) and prevention - at the same time, and make the logistics/transactional costs of this limited intervention worth our while.

There is past and present experience of providing vouchers for health services. The governments of Korea and Taiwan offered vouchers for sterilization services at private clinics, in Central America, there was a scheme to provide vouchers to sex workers for STI treatment (hence the idea outlined above). The World Bank supported a scheme to provide vouchers for private midwife services in Indonesia, and in India there is work in the area of health service vouchers, as well. It seems there is growing momentum for using vouchers as a targeted subsidy for the indigent or specific target groups (e.g., sex workers, pregnant women, mother reporting with young children for vaccinations) as opposed to implementing costly and inefficient "blanket subsidies" for an entire population, including those who can afford to pay full price.

Many of us are intrigued at the prospect of third party payment schemes for public/preventive health services in the developing world, and once these take hold, a whole new world for the private health sector opens up and interventions such as vouchers would be rendered irrelevant. Don mentioned there could be voucher scheme for sterilization services in the Philippines (such as in Korea and Taiwan). However, some years ago there was discussion about incorporating FP services in the Philippines national health ...more...

Reed Ramlow
03/10/08 9:21AM
Response to Francoise Armand

We would all agree that a key rationale for health product-oriented social marketing over the years has been to reach the "base of pyramid" (BOP). What is gaining momentum however is the growing interest of business (multinational and domestic, big business and small and medium enterprises) to tap new markets, i.e., the large base of the pyramid, in developing and emerging markets to achieve growth. Hence, we have seen for example the emergence of Hindustan Lever's "Shakti" program and similar programs that aim to reach the base of the pyramid through community-based entrepreneurs and the like. For many years, we have rationalized the introduction and existence of social marketing organizations to address "market failure" because business ostensibly was not interested in serving the poor with affordable health products. This increasingly is not the case, as businesses in developing countries understand the mass market lies at the base, not at the apex of the socioeconomic pyramid. We are finding for-profit businesses can be an excellent partner in reaching the poor and underserved with relatively affordable health products. Innovative schemes such as vouchers and coupons can further stimulate BOP

consumer demand for a broad range of full-priced "sustainable" products (with some limitations as pointed out earlier), while motivating distributors to extend distribution to new outlets that serve the BOP, as they "chase the vouchers". We could still call this "social marketing", albeit with different and varied set of partners that is a departure from the usual way of doing business.

Reed Ramlow
03/10/08 9:38AM
Yes, I agree...
In response to Jeff Barnes (21)
Jeff, I agree with your response. The cost per unit sold discussion, particularly when comparing countries and their different cost structures, program objectives and circumstances (e.g., the state of overall demand or sustainability, i.e., maybe you pay more upfront but you have an exit strategy as opposed to recurring costs in perpetuity), etc is like comparing the proverbial "apples with oranges".

Jeff Barnes
03/10/08 11:30AM
Building on that idea...

To respond to Susan Wright and add to the previous comments about vouchers....
The use of vouchers for nets does seem to be the most straightforward application. However, KfW has developed a very promising model for vouchers for a package of services that have to be delivered over a given time frame. This model can be used to deliver ART for people living with HIV, for pre and post natal care (including family planning services), STI testing and treatment, TB DOTS-- basically whatever package of services you want to subsidize. The key is that the voucher program has to be combined with a system for accrediting service providers so that consumers will know they will receive quality services at those providers. In such a situation, the voucher serves as (1) a mechanisms to deliver a subsidy to the target group, (2) an incentive to providers to meet and maintain quality standards (so they can join and stay in the scheme) and (3) as a reminder to consumers to receive their services according to the appropriate timeframe. The third piece in the model is an independent voucher management agency, usually an accounting firm which establishes the redemption value of the voucher by monitoring provider costs, controls vouchers to prevent fraud and makes the payments to the providers. This model is currently being implemented in Uganda and Kenya and I personally believe it merits wide replication.
Some may object that such a scheme is costly or is unsustainable. Voucher programs should not be judged on their sustainability. Vouchers deliver subsidies which by definition are not sustainable in the usual sense of that term. Moreover, they are a tool that can be used to enhance the overall sustainability of the provision of products and services because they stimulate commercial provision as opposed to crowding it out which free distribution and highly subsidized programs are apt to do.

Patricia Allman
03/10/08 12:39PM

Building on that idea...

Building on Francoise's question and Don and Reed's perspectives on BOP, I'd like to offer some insight gained through our ongoing work with Hindustan Unilever in India. Through PSP-One India, we are working with Hindustan Unilever (HUL) to add health products to the Shakti basket of products. HUL has a robust and profitable pipeline in place that accesses purchasing power in over 40,000 villages with populations of less than 2,000. Their analysis indicates that there is sufficient purchasing power in these rural villages for their products as well as health products - so purchasing power is not a barrier. We've discussed the commercial opportunity with manufacturers of OCs and condoms - all agree that identifying a price point that is both accessible to this consumer population and commercially attractive is feasible. They are also willing to invest in the education and marketing required to change behaviors and build the market, which is what HUL had to do for shampoo and soap. The biggest hurdle that we've encountered is regulatory - there are more stringent regulations that govern the distribution of health products (through pharmacies or chemist shops) than consumer goods. While the India government has exempted small villages from these regulations, Multi-national pharmaceutical companies are worried that delivering their products to Shakti Entrepreneurs could be perceived as breaking or stretching the law. We are in an environment where the President of Pfizer is a lawyer - regulatory issues are paramount for multi-national pharmaceutical companies.

While PSP-One is working around this issue, I believe there are some valuable lessons learned.
1. It's time to challenge our preconceptions about the barriers to rural areas. That's what HUL did by building the Shakti pipeline and they are finding that there is huge commercial opportunity there.
2. The BOP paradigm of building on existing infrastructure works - HUL leveraged micro-finance programs in rural India by offering HUL products as a micro-enterprise opportunity - PSP-One is now building on HUL's infrastructure to add health products.
3. It takes time and persistence to build a new paradigm - HUL spent five years developing the Shakti model - through trial and error and pilot testing - overcoming the challenges of incorporating health products will take time and trial and error as well - we must ...more...

Tonia Marek
03/10/08 3:26PM
Building on that idea...

In response to Jeff Barnes (27)
Jeff, I agree with your perspective on vouchers. I was wondering if, in this age of technology, we could not improve on the old fashioned paper voucher and use cell phones. For ex. for ART, the prescriptor could input data into the patient's phone which would be linked to a central data system. When the patient goes back home and needs to fill out his prescription, the pharmacist will check and input data (just like a SMS) into

the patient's phone. Data are updated almost instantly this way, and you could even set up reminders such as beeps/messages so that the patient does not forget to go for tests, etc... This would save administrative costs greatly. I think they are doing something like that in S. Africa. Do you have more information on this ?

Oladipupo Awosika
03/10/08 4:03PM
Building on that idea...

It has been most interesting listening to all the experts. The common thread is a concern about scalling-up and sustainability. I believe a way has to be found to tap-unto and integrate the entrepreneural disposition of the local small-scale commercial entities in developing countries. They are familiar with the cultural and behavioural tendencies of the local population. They can be a potent vehicle towards achieving the behavioural change that is pivotal to sucess of Social marketing.

Phil Harvey
03/10/08 4:23PM
Just testing, folks. I'll be back.

Phil

Phil Harvey
03/10/08 4:35PM
A few points in response to various folks:

1. The social marketing of contraceptives (CSM) has been marketing to the bottom of the pyramid for decades. CSM serves 40 million couples in the developing world, and they aren't all rich. BOP is a big part of the CSM market in Bangladesh, Ethiopia, Nigeria, a good many others.

2. It is a cop-out to say that we can't calculate a meaningful figure for cost per unit delivered. SM generally delivers a CYP (100 condoms, 14 cycles of pills, etc) for $10. DKT does it for $2 because our clients in the in between economies (Indonesia, Philippines, parts of India) pay a significant part of the costs. Donor cost (yes, that's the meaningful figure and should include any local government subsidies) per unit of output is an indipensible yardstick for measuring success.

3. Some SM programs are (or are becoming) financially self-sufficient, even profitable. What does that make them?

Jeff Barnes
03/10/08 5:36PM
In response to Tonia Marek (29)
Tonia--

Thanks for your contribution. I couldn't agree more with your idea of replacing the paper voucher with more up to date technology. In terms of using the voucher as a behavior change tool, having some physical manifestation that the consumer can keep to remind him/her has its advantages. However, in terms of operational use, being able to send reminders to patients to take their medications via SMS seems compelling in countries where cell phones are in widespread use. You probably know more than I do about the examples from South Africa, but PSP One is exploring this strategy in India through intervention with rural saleswomen in the Shakti network and using SMS messaging for promotional messages in the Sathiya campaign. Perhaps others have ideas? Given how low the costs of cellphones and air time has gone, it is not unreasonable for programs in which compliance is critical (ART and TB DOTS) to consider allocating cellphones to patients.

Jeff Barnes
03/10/08 6:23PM
I have a different perspective

In response to Phil Harvey (32)
Phil--

I should clarify that I am not saying that we can't or shouldn't measure cost per unit sold. We should for a number of reasons, the most important of which is to track how our own programs improve year after year. However, I think we have to avoid unfair comparisons in which, say we compare the cost per unit sold at the end of a three year time period between a commercial approach that is trying to segment the market in a smallish country like Ghana with the unit cost per product sold in a large country under near monopolistic conditions like Ethiopia. That is definitely comparing apples with oranges.

Bruce Mackay
03/11/08 5:47AM
Building on that idea...

In response to Jeff Barnes (21)
I recall a presentation which Guy Stallworthy of PSI gave to DFID in London 7-8 years ago, in which PSI's 'cost per unit' went down in an impressively straight line against just one very simple (and intuitively obvious) variable, namely 'Years since program started'.

This is one reason why I made the first point I made in my opening presentation, that there is a mis-match between donors, who tend to think and act short-term, and building markets and changing consumer behaviour, which are long-term. All credit to Phil Harvey for hanging in there and 'sticking to his knitting', but in the grand scheme of things you need profitable companies or governments (or both) to take on such endeavours if you want to get the continuity needed for large-scale and sustained impact.

I suspect Hindustan Lever has a 20-year or longer plan for its Shakti distribution - just like the toothpaste marketers who I remember arriving in a dusty Indian town in 1995 and putting on a promotional show which was 20-50 times more lavish than the modest video-van PSI had there for Masti condoms. Someone up in the Colgate hierarchy later told me 'there will be growth in this market for at least one hundred years'.

Jeff Barnes
03/11/08 10:15AM

In response to Bruce Mackay (35)
Bruce-- The impressive decline of cost per unit sold by many of PSI programs is due in part to the fact that many of them operate social monopolies. Even when commercial operators take a long term view, competition for market share rarely allows them to achieve the steady sales growth and decline in cost per unit sold that you can achieve when you dominate the market, subsidize price, distribution and promotion. And I don't think we should be too hard on donors. Although it is inevitable that the commercial world has a superior business model to the donor funded project, there has been steady support for social marketing over the past 25 years in spite of donors having to rely on somewhat fickle legislatures. PSP-One, for example, is the descendant project of SOMARC 1, 2, 3 and CMS, going back over 20 years.

Francoise Armand
03/11/08 3:56PM
Here's a new twist...

I have been thinking about Patty's question about "breaking the mold" of social marketing and in the back of my mind is Phil's comment that social marketing "has been so consistently successful"..." that everybody is bored with it". So instead of answering the question (nice cop-out isn't it?) I am starting a discussion room on this topic. The title of the discussion is: "Is Social Marketing Stuck in a Time Warp'? To go there, return to the conference hall and click on "discussion room". Meet me there!
Francoise

Craig Lefebvre
03/12/08 8:23AM
I have a different perspective

I wonder whether social marketers are stuck in a time warp - which I think is occurring in social marketing no matter where it is practiced - or if there is a lack of innovation in the model itself. When we talk about TMA, vouchers and the BOP, my sense is that we are beginning to explore innovations to the business model for social marketing: How we deliver value to our clients. What I find is that how we think about that question can limit our ability to be truly innovative in taking social marketing from being people talking in an 'echo chamber' to engaging with the BOP community (and be sure to read the report The Next 4 Billion if you're interested in the subject), social entrepreneurs and what will undoubtedly be a new wave of enthusiasts following Bill Gates' speech at Davos to shift

our focus from one directed solely at consumers of health information, products and services to one that also recognizes their important role in the marketplace as potential producers of them. Mechai Viravaidya was interviewed in the 25 September 2007 issue of Health Policy. In it he describes the Positive Partnership program that he sums up as; when you're providing health services, the 'welfare' approach provides benefits in the short term only, but if you combine health with income-generating activities, it can be sustainable in the long term.

Francoise Armand
03/12/08 11:01AM
Yes, I agree...
In response to Craig Lefebvre (38)
Hi Craig,

Thanks for joining us! I am glad you are here because you spent a big part of your career working on domestic (US) social marketing, which is much less product-focused than what we do in the developing world. I have always found social marketing programs in the US and Europe to be justifiably focused on "pushing the righ buttons" in people, so they will see the value of changing their behavior. So much of what we do in developing countries is based on the exchange of goods that I think we lose sight of what the real goal is: behavior change. In my opinion, the real shift in paradigm has to come from a better integration of communication, research and, yes, market-based approaches, but not just in terms of figuring out the right "model" for marketing products. And you are absolutely right, its about creating "value" for the behavior itself.

FYI: I created a discussion room on the "Time Warp" issue if you care to join us there.
Francoise

Patricia Allman
03/12/08 11:21AM
I have a different perspective

One could argue that commercial marketing is struggling with a time warp. Technology is turning traditional marketing on its head. The traditional constructs for promotion and distribution have been blown out of the water by the internet, TEVO and mobile phones. And billions of dollars are going into the "web" sector - where the business model is still a big question mark. There don't seem to be any rules, which presents both challenges and opportunities. What are the implications for development and for public health? Are we pushing hard enough to answer these quesitons?

In the '80s projects like SOMARC were pushing the pharmaceutical industry into new territory through consumer advertising (now known as DTC) and new business models that reduced margins but grew volume and resulted in significant net growth (arguably BOP). The commercial, NGO and donor sectors all played a role in these innovations. No doubt there is still a role for these "traditional" social marketing constructs. But are we as a social marketing community pushing the envelope to meet the needs of our

constituencies by developing creative solutions that leverage all of the new tools at our disposal?

Should we be exploring more efficient distribution and promotion through technology - that can result in sustainable lower pricing? Are we leveraging the growth of generics? Is there a new frontier for family planning products through biotech? Are we as a social marketing community pushing the envelope hard enough? Or are we still relying on models that are now 15 to 20 years old (and still arguing about which is better)?

I can barely navigate this virtual conference - so am hopeful that there is fresh, young blood out there that understands new technology and can generate ideas that will move the cause forward. Or creative old blood that understands technology and has some new ideas... If you're out there -- don't be afraid to speak up!

I also posted this in the discussion section...where this is also being discussed.

Lisa Tarantino
03/12/08 5:17PM
Response to Susan Wright

You may be interested in the Romania experience in terms of methods to target subsidies for low cost contraceptives and the employment of a third party payment scheme. USAID was highly involved there. Family doctor practices work under a contract with the National Health Insurance House there. To expand access to the underserved, FP counselling (including some prescriptions and distribution of donated products) was included in the contract of covered basic services. Doctors in rural areas only, where 70% of the poor live, were given access to donated and MOH purchased contraceptives for distribution. Later, urban doctors were given contraceptives to distribute to eligible patients only, such as the officially unemployed and registered full-time students. While usage rose among those receiving OCs from family doctors, the commercial provision of FP also grew and is thriving. The Romania system is not perfect but it is functional, sustainable, and has succeeded in increasing access and usage. Someone from JSI or PSI may have more to add to this.

Iain McLellan
03/14/08 12:50PM
Building on that idea...

I have enjoyed discussion on the nuances of different social marketing approaches and the highlighting of new uses of it. I note Mr. Harvey's suggestions on treating reaching policy-makers on social marketing like normal communication challenge with obstacles to overcome. But
I would like to know more on why social marketing still needs to be sold to policy-makers and donors considering the proven track record of social marketing success over the last two decades? Also, is social marketing getting its fair share of donor resources? Why is there still so much opposition on the part of many public health policy-makers to

the approach? What else can be done better explain what social marketing is and its value?

03/13/08 6:09AM

Dear ALL,
I am happy to see a number of familiar names here...
My name is Luise Lehmann, a (female) German consultant with a background in communications, media and behaviour change interventions. I am currently involved in developing a regional model policy on condoms for the Caribbean (CARICOM-PANCAP) and in preparing expansions of a regional SM programme in Central Africa - two quite disperse environments! Since the mid-90s I have been assisting German institutions to develop and evaluate SM programmes in different world regions focussing on reproductive health in its various aspects.
In this conference, I am keen to learn from implementers, programme planners, visionaries about lessons learned and future trends of social Marketing. My special interest is to get SM accepted by Governments as part of their public health goals (which is not yet universal). Pro-poor and national coverage aspects are an issue in this debate.
Looking forward to the next days and beyond,
Luise

Teresa Carpio
03/13/08 11:33PM

Been visiting the conference hall, nosing about in the discussion rooms, looking at the exhibits on `display' since Tuesday this week, and enjoying it.

Teresa Carpio here, Private Sector Development Specialist at the Office of Health in USAID Manila. I am an Activity Manager for the Private Sector Mobilization for Family Health or PRISM project. PRISM aims at expanding the role of the private sector plays in addressing the demand of the Filipino families for family planning and maternal and child health services. But I logged in here on my own - as someone interested in social marketing, not just of contraceptives and health products, but indeed of health policies as well, as Patricio Murgueytio started discussion on. Have been in the `development world' for nearly 20 years, 17 years outside of USAID, and the idea of reaching the underserved in the best way remains a challenge. And the ideas that evolve to address this challenge are so exciting and stimulating...

Kudos to PSP-One for this e-conference! You should make this a regular thing.