

Social marketing: Achieving changes in nutrition behavior, from household practices to national policies

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Abstract

A case is made for bringing behavioral concerns onto a par with epidemiological, economic, and clinical considerations in nutrition programming. Several successful programme examples demonstrate the key role that family behavior plays in nutrition-status outcome and how modifications in family practices can result in improved nutrition status. The approach used to discover and address behavioral concerns in these programmes was social marketing. The paper describes how social marketing goes beyond communications activities into the design and implementation of all programme components where actions are needed to facilitate beneficial practices. By ensuring that the voice of the client is heard in programme decisions, social marketing assists in bringing programmes closer to community needs and thus enhances the potential for success. A list of recommendations is included for putting a behavior-change focus into nutrition planning.

- ❖ A mother in Indonesia explains that she does not add green leafy vegetables to her child's rice because they are difficult for a baby to digest; she knows, because when she tried they made her baby's stool green. Later, however, after hearing advice from a doctor on the radio and being counseled by her local community health worker, she feeds her child a mixed food with green leaves. So do 85% of the mothers in this province. As a result of their following this and other advice related to improved child feeding, 40% of children under two years of age have significantly improved nutrition status. [1]
- ❖ In the highlands of Ecuador' a mother talks about goitre as something normal, given by God. She is unaware that two types of salt, iodized and non-iodized, are available in most markets. But within a year after a radio mini-drama, "A story about a little thing like salt" is introduced, making families aware of the

seriousness of goitre and of the possibility of buying the specially marked bags of salt, purchases of iodized salt increase fourfold among mestizos and tenfold among Indians. [2]

- ❖ A young woman in Sao Paulo, Brazil, states that she could not possibly breast-feed her baby—she does not have milk that is good or abundant enough to satisfy the child. She says she knows this without even trying to breast-feed. All her friends feed their babies with a bottle, just as they see rich ladies doing. Also, the doctor gave her some free milk to take home after her child was born.

During the next 18 months, however, societal and health-service norms begin to change. Policy makers become convinced that breast-feeding can help to reduce the tremendous drain on their foreign exchange, a popular mass-media programme is launched, and hospitals are mandated to promote breast-feeding [3]. More women begin breast-feeding, and do so longer. There are hospital reports that child abandonment has been dramatically reduced in Recife. And in Sao Paulo, after five years of the breast-feeding promotion, researchers attribute 12% of the reduction in infant mortality that has occurred in that city to the improvement in breast-feeding practices. *

These are just a few of the dramatic improvements in nutrition outcomes that occur when social marketing is used to address consumer needs. There are more examples: an increase in the early initiation of breast-feeding (within six hours of birth) from 42% to 68% in Jordan (R. Hornik, personal communication, 1992); a doubling of the daily consumption of green leafy vegetables among young children and women in western Sumatra, Indonesia [4]; and a halving of severe and moderate malnutrition in the Dominican Republic at a time when economic conditions were deteriorating [5].

All the programmes that produced these results carried the label of social marketing. Since their introduction two decades ago, such programmes have continued to show results. When well implemented, their efficacy is no longer in question. Over the 20 years, methods have been refined and programmes made more cost-effective and sustainable. Old notions of social marketing are no longer valid. The full range of what social marketing offers must be explored and applied to programme design and implementation.

What is social marketing?

Some people think social marketing is a dating service; others, a mass media campaign of public service announcements; others, any programme that establishes a product-distribution network. But it is more. Social marketing defies quick definition because its programmes are not easily stereotyped.

Social marketing is the application of marketing principles to the design and management of social programmes. It is a systematic approach to solving problems, in this case public health nutrition problems related to the adoption of health-promoting behaviors such as the enhanced use of services, the trial and continued use of a product, and the improvement of household or community practices. Because it is an approach and not a solution, there is no template for others to copy. The examples highlighted at the beginning of this paper were selected because they illustrate a range of social marketing activities in nutrition programmes.

◆ In Indonesia, where the concept of improved child feeding incorporating local perceptions was created, an enriched home-made infant food for daily use was developed with a subset of programme clients. It was promoted and its preparation taught by radio and individual counseling together with reminder sheets linked to a growth-monitoring activity.

◆ In Ecuador, people were made more aware of goitre and were informed about commercial iodized salt. Acceptance and continued use of the salt were achieved through mass-media advertising and market-place promotion, including the distribution of free samples.

◆ In Brazil, a social-marketing perspective was used to identify and address the various kinds of resistance mothers face in breast-feeding. There was a coordinated effort to provide motivation to policy makers; medical personnel were retrained or trained; women's support groups were established and crèches were set up in the workplace; and a campaign was conducted in the mass media to let women know that they can breast-feed and to change the way the public view breast-feeding.

Social marketing provides a voice for consumers— the programme beneficiaries— and is concerned with their perspectives and practices and with making it easier for them to follow better practices. Social-marketing techniques can lead to modifications and innovations in the design of all programme components, not just

the communication component, where they are usually applied. Social-marketing specialists can inform planners about changes needed in clinic procedures to enhance the use of services, or about alternative systems to distribute iron pills to women, or about the need to manufacture a feeding bowl to help mothers measure their children's food, in addition to showing them how to craft messages to motivate people to try out and adopt new practices. Thus, while communications is an element of social-marketing programmes, it is not their sole area of concentration.

Why the term?

The fundamentals of the social-marketing approach come from marketing principles. This point of departure distinguishes social marketing from other health education approaches and broadens its applications beyond communications.

The focus is on consumer needs. Programme organization and management can be structured to reflect a marketing operation. For example, health workers' job descriptions and their training are restructured so that they become better sales agents for the programme, not just deliverers of services.

Commercial avenues are sought for products traditionally kept in the health sector. Alliances are forged with private-sector agencies to bring consumer research, advertising, and marketing skills into programme design, implementation, and monitoring. A marketing orientation is brought to bear, and progress toward achieving goals is constantly measured.

However, "social" is an important modifier of "marketing" and distinguishes us from our commercial colleagues. Commercial marketing techniques cannot be applied directly for several reasons. The clientele we address are segments of the population not usually targeted by commercial marketers. They are not as assimilated into the market-place. Therefore, we have learned the benefit of working with social-science researchers to understand the needs of our clientele better.

The programmes we work with are usually public-sector programmes promoting products, services, or behaviors that carry a benefit to society and promise little in the way of profit. The budget for the programme is usually very low and does not fluctuate depending on sales of the product or the use of the service, and this sometimes reduces the motivation for doing well. Social-marketing products or concepts are not sold by image alone, and so the technical side of the health issue is critical. There is need for good scientific information to frame the problem and assist in crafting effective solutions.

What are its hallmarks?

To describe social marketing, I want to highlight five of its aspects: three that relate to what can be expected from social marketing—that is, what it can do for a programme in terms of (1) focusing on behavior, (2) creating demand, and (3) enhancing creativity—and two techniques that social marketers use, (4) qualitative research and (5) audience segmentation, or programme targeting. I present these features in order to promote the recognition of social marketing as a tool for programme planning, a perspective that should be brought into play from the beginning of programme conceptualization.

Changing behavior

Social marketing has as its objective changes in behavior, not just the imparting of information. It is well recognized that people can know that their behavior is harmful to their health, for example smoking, but not act on that knowledge for a variety of reasons. Going beyond information alone, social marketers have their eye on what it will take to get people to try a new practice and continue it, whether it is going to the health centre, cooking green leafy vegetables every day for their children, or enacting new policies.

As we know, behavior can be influenced in a variety of ways, of which education is only one. If peer pressure, legislation, or a new product will lower people's resistance to adopting a new behavior, social marketers work to implement these activities.

When it comes to promotion and education for improved practices, information that is not relevant to taking an action is not included. Thus, in social-marketing efforts in nutrition, the food groups probably will not be mentioned. In promoting exclusive breast-feeding, what women already know—that breast-feeding is best—is not repeated. Instead, women will be given support and information on specific techniques to overcome problems, and work will be done to change the image of who breast-feeds and who bottle-feeds to enhance motivation and create a positive social climate for breast-feeding. In addition, the use of formula in hospitals will be limited to exceptional circumstances, restrictions will be placed on its promotion outside hospitals, doctors and nurses will be retrained, and hospital norms will be changed.

Cresting demand

Social marketing's emphasis on trying new or modified behaviors and sustaining them means that it concentrates on the half of the marketing equation that is often ignored—creation of demand. Far too often we think only of supply: building health clinics, producing nutritious infant foods, supplying iron pills, and so on. But often the health clinics are empty, infant foods not bought, and iron pills not picked up or are not taken properly. Demand has not been realized because we have not understood consumer needs and desires and catered to them. This is something our commercial counterparts have done very well, whereas we have assumed that everyone will seek the advice of a health centre doctor, will buy an infant food as long as it is nutritious, or will take an iron pill when told to do so just because it is "good" to do. We are only beginning to recognize and learn how to find out what consumers look for in health services or seek in an infant food, and how to adapt our services and products for them. When we do this, we make programmes more cost-effective. The biggest waste in health programmes may be the money and effort spent on infrastructure without providing for effective promotion and education. Growth-monitoring and prenatal care facilities, for example, are not cost-effective if only 25% of the target population attend. As the percentage rises, cost-effectiveness improves.

Enhancing creativity

Social marketing requires creativity not just in message design, where persuasive, captivating, and memorable messages are the goal, but also in implementing qualitative research free of researcher bias, and in developing programme strategies through the creative interpretation of research findings. It is particularly the latter that should distinguish social marketing: creative programme strategies. Too often we find that good research has been done but either programmes have returned to standard solutions or messages, believing that they must convey the textbook information, or they have simply written messages directly from the research, losing the creative interpretation that makes messages special and memorable.

Qualitative research

In promoting behavior changes, in creating demand, and in searching for creative solutions, social marketing uses what has been called a feed-forward approach that minimizes "feedback shock" [6], or as others would call it, formative research. That is we go to the community, to the consumers, to find out what they want. This helps us to shape our product, service, or concept and to fine-tune the promotional angle. For

example, breast milk can be promoted as the best food for young babies and as protective because it is full of antigens. However, the appeal that will motivate mothers most effectively may be that it is a convenience food, if convenience is what they want.

Our commercial marketing counterparts do their research well. When they sell cars, tennis shoes, or laundry soap, they know precisely what the consumer is looking for. Although we may think they go too far when they sell on image alone with the goal of a 2% improvement in their market share, it is nevertheless true that our own promotion efforts could benefit from some of their consumer insights.

As an aside, I might mention a finding of some interest from our recent qualitative research: as our techniques have become more refined, we have recognized that the research that makes programmes stronger, more helpful, and meaningful to women is not necessarily related to health but more related to understanding the lifestyle context in which they are operating and making decisions. By "lifestyle context" I refer to what a woman wants from life, her aspirations for herself and her children, what her dreams and fears are, what makes her feel inadequate or happy, how much she feels she is in control or can influence things. Social-learning theory that emphasizes the importance of self-efficacy is the foundation for what is being learned in the field. Major breakthroughs for nutrition programmes will occur as we develop more precise techniques for doing the research that improves our understanding of basic perceptions such as self-worth and self-confidence.

I say this because work we have been doing in child-feeding programmes on women's self confidence [7] indicates that the more confidence mothers feel in themselves and in their abilities generally, the more likely it is that their children will be better nourished, since maternal confidence seems to influence such practices as breast-feeding—both its initiation and its duration—the timing of the introduction of other foods, especially avoiding very late introduction; the mother's willingness to try new foods or practices; the quickness with which she will take action when there is a problem: and her willingness to persist in feeding when the child does not want to eat.

Audience segmentation

Social marketing calls for careful audience segmentation based on the formative research. This segmentation means that programmes not only can target their messages better but can target all their activities better. One of the most beneficial outcomes of the formative research is that it should give an idea about the extent to

which families can do more for themselves. Household trials or test-market work should give a realistic picture of where poverty and the lack of coping skills are so significant that the mother, family unit, or community just cannot change behavior enough to have significant nutritional impact.

For example, in our work in a part of Java, it seemed that almost all families (90% or more) could and would do a lot to improve their practices related to child feeding. However, in Ghana, parts of Swaziland, and the high sierra in Ecuador, the picture was not so encouraging, with close to 20% of families having a serious shortfall in resources. In another project, in poor rural and tribal areas of India, the ability of families to meet their children's needs is even worse. *

This research, though far from quantitative, gives us an idea that without some type of economic assistance, it will be difficult for many people to do much better. From the results we can define generally who needs assistance, where it is needed, and how much is needed. The basic programme, however, for the majority of families, who can do a bit more with what they have, continues to be to encourage them to do so. The other resources that are available, then, will support household or community activities.

The role of social marketing for behavioral change in nutrition programming

The importance of informing families about improved practices has been recognized in nutrition programming for decades, albeit often as an afterthought. This entire area of operations has been marginalized because of doubts about its efficacy. However, now the application of social marketing to nutrition education has been shown to be effective in several studies and evaluations of operational programmes. Examples were cited at the beginning of the article.

The next doubt that is raised concerns its cost and cost-effectiveness. That the application of social-marketing techniques can make nutrition education a cost-efficient intervention is illustrated by figures from the Indonesian Nutrition Communication and Behavior Change Project:

The annual cost per participant of that programme was US\$3.94 during the pilot phase, including formative research and design and testing of messages, and is

estimated at US\$2 for subsequent expansion. This can be compared with US\$12 per participant for a programme to weigh children and screen them for malnutrition, and to US\$56 for an integrated programme that includes feeding. If the coverage of the behavior-change project were extended nationwide in Indonesia, it would cost about 0.15% of the national budget, or less than one-tenth the cost of an average institutional feeding programme or one-twentieth that of consumer food subsidies.

When the costs and effectiveness are considered together, the results of the Indonesia behavior-change programme remain impressive. The cost per child of improving nutrition status was US\$9.80 a year during the pilot phase and is estimated to be US\$3.90 a year for an expanded programme, which is considerably lower than figures for nutrition improvement from studies on other interventions, including feeding programmes [8].

Clearly, social marketing, which makes behavioral change the fundamental goal, has made a difference in nutrition education. Yet, inherent in the approach is its relevance to other programme decisions. Why has it not been used more as a decision-making and management tool for nutrition programming generally? In part, it is because there are also strong links between malnutrition and poverty, so that economics has driven much of the analysis and solution of problems. In part, it is because of the strong links between malnutrition and infection, so that epidemiology and clinical analyses have been the underpinning of project plans. While both of these points of view clearly must be included in the analysis and solution of problems, there is now a clearer articulation [9] and a growing appreciation of the importance of behavior and the influences on practices that relate to child and family well-being. To date, in only a few programmes has a behavioral analysis been the framework for planning. It makes sense to shift our thinking more in this direction— obviously not abandoning the economic, epidemiological, and clinical analyses but bringing behavior onto a more even footing. The following are some supporting arguments for this point of view.

- ❖ The majority of families can do more within their social and economic constraints to improve significantly the nutrition status of their most vulnerable members— women and young children. They should be given the tools to make these changes.
- ❖ Malnutrition often persists when the incomes of poor families rise, and when more food enters the household and the available food exceeds the household energy requirements [10].

- ❖ Commercial market influences require countering when they lead to detrimental practices. These influences have been most profound in the areas of breast-feeding and weaning.
- ❖ Working to help families become more self-sufficient within existing resources cuts down on psychological dependence.
- ❖ Beginning a programme by trying first to achieve improvements in practices, measuring their impact on nutrition, and later introducing economic and health assistance means that the more expensive activities can be better targeted to those truly in need.
- ❖ Behavior change programmes should be more sustainable at lower cost and have more persistent benefits (those that last once the programme activities cease) than other kinds of activities.

In a recent speech, Alan Berg, a senior nutrition adviser at the World Bank and a long-time skeptic of the feasibility and impact of behavioral-change programmes, surprised the audience when he called for more resources for social marketing. He said:

A compelling case can be made that social marketing, or nutrition communication for behavior change, is one of the most potent tools we have, both directly for changing the behaviors of mothers to improve nutrition and, more broadly, for serving as a basis of understanding and advocating what else we must do. *

He cited the reductions achieved in cardiovascular disease because of lifestyle changes in the United States and Europe as cause for optimism that over the next ten years focusing on behavior change will have a major impact on malnutrition in developing countries, provided adequate resources are available. The point is that social marketing for behavior change deserves higher priority on the agendas of nutrition departments and governments. INCAP can become an important advocate and practitioner for this priority in its region. What will it take to put social marketing, or nutrition planning focused on behavior change, into practice? I suggest the following. The first need is for a commitment to the place of behavior change in nutrition programming—if not making it a centerpiece, then at least recognizing its importance and preparing to be able to undertake behavioral analyses and plans of action to address behavioral issues. That means, for example, in addressing micronutrients, not seeing increased consumption of vitamin A-rich foods as the only

behavior-change issue, but viewing capsules and iron tablet consumption as a behavior-demand creation problem, and, similarly, iodized salt or any other fortified product.

Also necessary is a thorough understanding of social marketing. Although some people may quibble over the name, the principles are clear, and the directions to take are well established from previous projects. There is an art to be learned. From this foundation, innovations are needed. In understanding social marketing, beware of those who are not real practitioners. Fuzziness about the definition has meant that many partial practitioners have learned to run a focus group and then say they are social marketers. INCAP should undertake to offer the full process, from good formative research through evaluation, and to argue confidently with governments for it.

One element of the above point deserves special mention: One of the most important principles of social marketing is to represent the consumer's perspective, that is, always begin with the formative research. While this research has been streamlined over the years to reduce the time required and the costs, it is not without time or costs. This must be recognized and not compromised. INCAP should advocate that this research must inform all programming decisions, not just those related to communications. INCAP has a good beginning in this area, which should be applied to larger-scale programmes.

A core group of professionals, expert in behavior-change strategies (particularly communications), must be formed, trained, and given the opportunity to gain experience. Because of the diversity of skills required for a good social-marketing programme, a group is required that can work together, with each member learning from the others until each one is at least acquainted with the perspective and types of questions to be asked at each stage of the process. This means combining social scientists—anthropologists and psychologists—with communicators, marketers, and nutrition technical experts. In selecting these individuals, do not be deceived. Although the work of designing behavior-change strategy may seem deceptively simple, it is the simple things that often require the greatest talent. Not everyone has the perceptions and talent required. The best professionals with the requisite skills should be sought.

INCAP's experience and technical assistance must focus on building the behavioral perspective into programme planning. Nutrition departments and nutrition planning bodies should be made current on the state of the art, not through long papers or

studies but by taking one or two aspects of their present programmes that could benefit from what social marketing has to offer and putting these concepts into place and demonstrating their impact. It is not easy—this approach is not bought in one bite. My experience is that it takes two to three projects before self-sufficiency is built. Start now.

Use social marketing for what it is best known for—behavior change at the individual, household, or community level—but remember that it should also be working at the advocacy/policy level for behavior changes. Social marketing is important in strengthening institutions, from creating an image for an institution such as INCAP to enhancing the interpersonal communications skills of community workers. It has much to offer if allowed to develop.

Nutritionists and other medical professionals training at INCAP need exposure to and experience with the perspective and principles of social marketing as they apply to the work they will do, even if it is limited to counseling patients. However, any person being trained who may have programme management responsibilities needs a much greater appreciation and understanding of the process and its potential outcomes. Developing applied training curricula in this area will be a necessity.

The prescription is one that requires a commitment to social marketing for behavior change in nutrition programming within and outside of the institution. Within the institution, this means strengthening its capacity to undertake social marketing by creating a group of skilled professionals who are recognized in their own right, not as an appendage of another programme, and who can work from the beginning on project conceptualization. Outside the institution, it will involve advocacy to begin to shift long-held ideas about nutrition programming to incorporate this perspective.

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