Health education through social marketing

Social Marketing

According to the WHO, information and education provide the informed base for making choices. They are a necessary and core component of health promotion, which aims at increasing knowledge and disseminating information related to health. Health promotion is one of the most important components of health care and health education forms the core of such promotional activity.

Health education is a process that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes as needed to facilitate these goals and conducts professional research and training to the same end.

Health education is any intentional activity which is designed to achieve health or illness related learning to bring about a relatively permanent change in an individual’s capability or disposition. There are different methods of health education. For small groups the usual methods employed for health education have been health talks, demonstrations, role plays, and the use of audio-visual aids. For the general public, the health education tools have conventionally been the television, the radio, the press, films, health magazines, posters, health exhibitions and health museums. Mass media is not very effective in changing human behavior because communication is usually one-way. If health education is provided, but the products or services necessary to change behavior are not easily available, then the value of the health education is lost. It is therefore important to provide cheap and reliable services along with behavior changing health

education. For instance, if health education brings about an awareness in a community that the occurrence of HIV/AIDS can be significantly reduced by use of condoms, this message alone is of no value if condoms or not readily available either because of an unaffordable price or because of a difficult location. Making available these services is therefore as important as making people aware of the benefits of the services.

Health education is not a substitute to other health services, but it is needed to ensure the proper use of available services. If the behavior of the individual group or community can be the main cause of a health problem, then that same behavior can be altered to serve as the main solution as well.

In the world of marketing and advertisement, it is often said that propaganda is one of the most powerful instruments in influencing people. Television, radio and the popular press have emerged as the most potent vehicles for propaganda. There are three widely accepted strategies of mass communication. The psychodynamic model depends on modifying cognitive factors to influence behaviour namely the needs, fears and attitudes of the individual. The socio –cultural strategy requires persuasive messages to define the rules of social behaviour for individuals or to redefine existing ones. This method is used widely by television commercials. The meaning construction approach works differently. It identified certain unintended influences on target audience that were undesirable. Meaning construction or modification of meanings which people assign to some product, person, cause or issue can also bring about change in behaviour.

Methods traditionally used to deliver health products and services in developing countries often do not reach a large portion of the population, especially those at the lower end of the economic ladder. Overburdened public health systems generally do not have enough outlets and provide services that are often not valued by the consumer. Many studies have found that when people do not pay for a service – they are less likely to value and utilize it. Marketing health generally raises awareness and increases utilization rates. This has been effective in the case of diarrhea, malaria, undernutrition, vitamin deficiency, voluntary HIV counseling and testing and reproductive services. When people pay for these services, they tend to value it better.

In social marketing, two concepts are important – the exchange theory and the four P’s of marketing namely the product, the price, the place and the promotion. The product is the behaviour, program or service exchanged for a price. The price is the cost to the target audience in terms of money, lifestyle and effort of engaging in that behaviour. The place is the outlet through which the product is available or the situations in which behaviour change can be made. Promotion is the combination of advertising, media relations, promotional events and entertainment to communicate with the target audience about the product

The choice of a tool for health education depends on a variety of factors – the objectives, the target audience, the time constraints and the availability of resources.

The concept of Social marketing was introduced by Kotler and Zaltman in 1971. Social marketing is defined as the design, implementation and control of programs which attempt to increase the acceptability of a social idea or practice, in a target group. Social marketing is the use of commercial marketing concepts and tools in programs designed to influence individuals' behaviour to improve their wellbeing and that of society. It draws from diverse fields like economics, psychology and medicine. Social marketing is a new approach to very old human endeavours. Attempts have always been made to inform, influence and motivate people to reinforce positive behaviour or to modify risk taking behaviour.

Traditional Educational programs are found to be more effective when the target groups are involved in the planning process and participatory approach has been found to increase uptake of health services. Many studies have been found to be limited in that the evaluation of health education programs is based more on distant outcomes like morbidity and mortality rather than attitude change. For a social marketing program to be effective, two different research approaches are required to obtain the best picture about the issue being addressed, the target audience and the effectiveness of the program. These methods are qualitative and quantitative research. Both these methods have their strengths and weaknesses when used in isolation, but complement each other when combined to produce the best research results. The research has to be consumer focussed – quantitatively to produce data that can be generalised for a larger target group and qualitatively to understand the nature of people's attitude and behaviour

both to the health issue involved as well as to the health services provided to them.

Social marketing is a process of continuing development and testing. It has borrowed many of its techniques like focus group discussions, consumer marketing databases and intercept surveys from commercial market research, the difference being that social marketing sells ‘ public health’.

Issues that have to be examined are what the consumers feel they have to know, how they would like to know this and what are the barriers to change potentially harmful behaviour. Before any new educational material is launched, prototype materials have to be pre-tested with consumer focus groups

Social marketing has been used for health promotion in various fields like smoking, drinking, drug abuse, HIV/AIDS, breast cancer and mental ill health. Other issues like environmental pollution, education and human rights have been most effectively addressed by this process. Social marketing involves many different stake-holders – the funding agency requires outputs in terms of gains made and the target group gain the health outcome, but apart from these obvious stakeholders, there are many others involved in partnerships for the social marketing of health education. This partnership helps to maximise limited resources, promote consistent messages and also help to reach diverse audience thus maximising impact of the program.

This has been shown to function well in the case of HIV/AIDS. A nationwide strategy has been organised by many developing countries. The funding agencies are international bodies that work in collaboration with local

governments. Non governmental or charity organisations are identified and trained by an initial training workshop. These agencies then conduct focus group discussions and key informant interviews with those most likely to benefit from the health education program. These target groups could be those at high risk for HIV/AIDS due to sexual contact – women in prostitution, youth and adolescents. The groups are identified and their key concerns are discussed. Barriers to their seeking healthy behaviour are identified. The groups also discuss the best health education methods and techniques suitable for their unique situation. Concerns of time and place of the health education session are detailed. Target groups from conservative societies did not prefer being given information about HIV/AIDs in public places or in the presence of the opposite sex or their family members. They were more willing to listen to health messages that were non judgmental or coercive. All these suggestions are incorporated into the health education strategy. Along with the health education campaign, local and international agencies are involved to provide essential health services in the form of cheap but reliable condoms, doctors trained in counselling and diagnosing HIV/AIDS as well as reliable referral and treatment centres. A small sample is then identified and a pilot project is undertaken to do a field trial of the health education tools. Further changes are made as required and a large scale program is put into effect. Mid term participatory evaluation is conducted regularly using external evaluating agents to assess the knowledge, attitudes and practice of the high risk group. The other stakeholders are also involved in this evaluation to see how they could further improve their contribution to the health education and health seeking process. Thus the process is constantly evolving. At the end of the program, final evaluation is undertaken and the

results are available for all the stake-holders. This serves as a learning lesson. During the final evaluation, issues of sustainability of the project are also addressed.

This approach is very different from the regular health education sessions which are primarily a top-down approach and hardly participatory.

The other example of social marketing being very effective is in the case of nutritional educational programs targeting teenagers. The food intake data in countries like Britain and America indicate that the intake of nutritious food like fruits, grains, vegetables and dairy products is low while intake of foods rich in sodium, saturated fats and sugars are high. Any large scale intervention to target the scale and magnitude of this problem requires an in-depth knowledge of the target population, their food sources, their barriers to seeking healthy foods, the methods of health education available and required as well as the available resources in terms of healthy foods.

Volunteers in the adolescent age group are asked what benefits they associate with increased consumption of nutrient rich food, what factors prevent them from consuming these foods, how they prefer to learn about foods and nutrition. They are also asked questions about what they think would be a ‘ cool’ advertisement for food, where they usually hang out and how they would market products to their own age groups. Many of the youngsters indicate that they like yoghurt, chocolate drinks and fruits but not vegetables. They also prefer foods that are convenient and familiar while increasing scholastic and physical performance. Some of the suggestions given by the teenagers included disguising the taste and appearance of less

favoured foods and improving the taste of some foods by adding other foods. They also felt that the nutrient rich foods were less available as forms of snacks and more difficult to procure and prepare. The potential channels of delivery were posters, television, computers, billboards, cooking shows and radio contests. They also preferred hands on experience of preparing foods. This then leads to the next step of social marketing of the health education program with focus on the placement, pricing and promotion of these nutrient rich foods. Traditional methods of health education do not take into account many of these issues. They may be outdated and ‘ out of sync’ with the new generation which might most require the educational input. Repeating the same message over and over again amounts to ‘ flogging a dead horse’ and is unlikely to have the desired outcome. The media can provide very strong and contradictory messages that can confuse the audience. Many television programs may re-inforce the message that drinking and smoking is a sign of maturity or that it is fashionable. Many of these commercial advertisements are televised following extensive Market research about what attracts and appeals to the audience. Beauty, style, health and being better than one’s peer group are important reasons for the target audience to choose certain products. This play on psychology can be adopted to improve the health seeking behaviour of the target groups.

Social marketing combines the best elements of the traditional approach to social change using the latest advances in communication techniques and marketing strategy.

Though public health educators do not sell products, they use similar marketing skills to understand the consumer’s knowledge, the barriers to

changing risky behaviour and the best methods of communicating. Before any new educational campaign is launched, prototype materials are pretested with consumer focus groups. This provides vital information on how well the target audience understand the materials. This knowledge can be used to tailor the educational material to suit specific target groups. Charity organisations or other funding agencies contribute to subsidise the process to make it financially accessible and available for those marginalised groups that most need them.

Some Primary Care Trusts had brought out videos for public screening on key health messages as envisaged in the White Paper. These videos were screened in busy shopping areas and a qualitative study was conducted to assess the impact of the video. No baseline research was conducted and the target group was not involved in the decision making process. The study found that many people found the video irritating and intrusive; some ignored it while others thought that it was a marketing gimmick. The suggestions given were that the video be screened in places where people are more likely to be relaxed like eating places. Many people also found the video clips to be boring and inconspicuous, the suggestion being to add more colour or cartoon characters. If all these suggestions had been initially obtained and incorporated into the making and presentation of the video, the impact would have been a lot more beneficial. Thus traditional health education strategies would do well to adopt the social marketing methods before they embark on any program of intervention.

Thus health education is a constantly evolving process. It does not force people to modify their behaviours, but encourages them to make their own

choices for health. Health education must acknowledge the experiences and requirements of target groups. Preventive health education goes a long way in improving health of societies and the benefits gained are many, but a poorly planned and executed health education program is a waste of money and resources. Public health would gain to learn from the acumen of the market that sells products purely for a commercial purpose. The ultimate goal is for the target to use the product. This is best achieved by using social marketing skills. Thus social marketing of health education ensures maximum output to bring about behaviour change in large groups of people. This behaviour change is the basic requirement to make people responsible and responsive to their own health needs and is the only way to bring about empowerment of people for their own health.

References

Gilbert GG and Sawyer RG 2 nd Edition (2000) *Health Education: Creative Strategies for School and Community Health.* Jones and Bartlett Publishers.

Lefebvre RC and Flora JA (1988) *Social Marketing and Public Health intervention* Health Education Quarterly 15 299 – 315

Neumark-Sztainer D, Story M, Perry C, Casey MA (1999) *Factors influencing food choices of adolescents. Findings from focus group discussions with adolescents* Journal of the American Dietetic Association 99(8) 929 – 937

Vaughn S, Schumm JS and Sinagub J (1996) *Focus group interviews in Education and Psychology* Thousand Oaks CA Sage Publications.

Ghai OP and Gupta P (1999) ‘ *Essential Preventive Medicine: A clinical and applied Orientation’* Vikas Publishing House.