

The performance of social marketing in reaching the poor and vulnerable in AIDS control programmes

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The article reviews evidence on the impact and effectiveness of condom social marketing programmes (CSMPs) in reaching the poor and vulnerable with information, services and products in the context of HIV/AIDS/STD prevention and control. Ideally, the success of CSMPs would be judged by whether they contribute to sustained improvements in sexual health outcomes at the population level. Given methodological and attribution difficulties, intermediary criteria are employed to assess effectiveness and impact, focusing on changes in behaviour (including condom use) among poor and vulnerable groups, and access by the poor and vulnerable to condoms, services and information. It remains difficult to reach definitive conclusions about the extent to which CSMPs meet the sexual health needs of the poor and vulnerable, due largely to reliance on sales data for CSMP monitoring and evaluation. CSMPs (like many health programme strategies) have traditionally collected little information on client profiles, health-seeking behaviour, condom use effectiveness, and supply-side issues. Recent data indicate that CSMPs are unlikely to be pro-poor in their early stages, in terms of the distribution of benefits, but as CSMPs mature, then inequities in access diminish, followed by reduced inequities in condom use. The paper assesses the extent to which social marketing is effective in improving access for the poor and vulnerable using a number of variables. In terms of economic access, it is evident that low-income groups are particularly sensitive to CSMP price increases, and that a cost-recovery focus excludes the poorest. Convenience is significantly improved for those who can afford to pay, and CSMPs appear to be addressing social and regulatory constraints to access. Conventional CSMP monitoring systems make it difficult to assess the effectiveness of behavioural change IEC strategies, although data on this dimension of the social marketing approach are beginning to emerge.

Introduction

This article reviews evidence on the extent to which condom social marketing programmes (CSMPs) are able to reach the poor and vulnerable with information, services and products in the context of HIV/AIDS/STD prevention and control.¹ The introduction defines the key concepts used in the review and discusses briefly how CSMPs identify their target population. The main sections of the review cover, respectively, lessons learned on CSMP impact and effectiveness, and recommendations for improving monitoring and evaluation in CSMPs.

Social marketing

Social marketing is the application of marketing tools, concepts and resources to encourage positive behaviour change among those underserved by existing public and private health systems. It advertises and promotes commodities, services and behaviour change through mass media, indigenous drama, songs and poetry, and through interpersonal communications; and usually charges subsidized prices for products and services distributed by commercial distribution systems to retail outlets, and through clinics and community groups (such as market traders, community promoters and

sales agents). Social marketing's behaviour change strategy seeks to promote access to and demand for goods and services by integrating health education with commercial brand advertising.

Sustainability strategies

Social marketing programmes (SMPs) can be differentiated according to their objectives and sustainability strategies, which in turn shape their poverty focus. SMPs that focus on graduating from dependence upon donors aim to reach financial self-reliance through full cost recovery (see SOMARC III, 1997, p. 3). Some social marketing organizations, such as Population Services International (PSI), argue against financial self-reliance as an objective in and of itself, and emphasize that ability to demonstrate effectiveness and efficiency is more important than cost recovery in assuring the long-term viability of social marketing. Such an approach assumes donor funding will continue as long as is needed, on the basis that meeting priority health needs of low income populations is consistent with the principles of public economics, and an essential condition for realising social marketing's social mission.²

Impact

Given the difficulties of measurement and attribution associated with health outcomes, programme impact is assessed in this review in terms of whether target populations are responding to programme interventions. Impact is thus defined here as the extent to which a CSMP meets the needs of the *poor* and *vulnerable*, demonstrated through behaviour changes likely to benefit the individual's or the wider community's health status, such as increased inter-partner discussion of HIV and condom use, decrease in number of sexual partners, safer sexual practices, and increased utilization of services/products promoted and distributed by the CSMP³ (the latter being equivalent to what are conventionally termed demand-side factors). The hypothesis in this conceptualization of impact is that behaviour change (including service/product utilization) contributes to the wider development goal of reduction in HIV/AIDS incidence.⁴

Effectiveness

Effectiveness is operationalized as the extent to which a CSMP is able to improve the supply environment, measured in terms of improved access for the poor and vulnerable to quality products, services and information, and increased awareness of those services and of the benefits of behaviour change. Access is defined here as the extent to which services (including information) are obtainable at an acceptable level of effort and cost.

Poverty and vulnerability

Poverty and vulnerability are relative concepts, which are context-specific. Vulnerability refers to exposure to risks: the vulnerable being those least able to make and carry out informed decisions freely (Mann and Tarantola 1996a, p. 441). Although vulnerability and poverty are conceptually distinct, they are usually linked. This is clearest in relation to HIV/AIDS, where poverty increases vulnerability both to disease and to the social and economic impacts of the disease (Mann and Tarantola 1996b, p. 444). Notwithstanding the need to contextualize vulnerability, risk of HIV infection and of suffering disproportionately from its effects are likely to be linked to livelihood strategy, economic status, ethnicity, sexuality, disability, and particularly age and gender. For instance, young people are less likely to be in stable unions, often lack access to sexual health information and services (because of reluctance by authorities to acknowledge early sexual relations), and have higher incidence of HIV infection than other age cohorts – around half of all people who acquire HIV become infected before the age of 25 (UNAIDS/WHO 1999). Multi-site surveillance data in sub-Saharan Africa show that girls and young women are at up to six times greater risk of HIV infection than their male age cohorts. While young women are prone to vaginal trauma which facilitates HIV transmission, differential rates of infection between young women and men cannot be explained by biological predisposition: they reflect the persistence of low female status and the associated sexual exploitation by older men (see Price and Hawkins, in press).

Social marketing's clients

SMPs typically define their target population as upper lower-income and lower middle-income groups. In targeting consumers with regular disposable income, SMPs aim to exclude those rich enough to afford commercial costs of commodities or services. They also effectively exclude the poorest (those with little or no disposable income). At the programme design stage the criteria used to define the socioeconomic status of target groups need to be transparent, in order to allow the development of indicators to monitor impact in equity⁵ terms. In some cases, an initial focus by CSMPs on the non-poor may be appropriate, as the risk of HIV infection and transmission in this group is sometimes greater in the early stages of the HIV/AIDS epidemic (this issue is discussed later). In appraising their target population in HIV/AIDS prevention and control programmes (for a detailed guide to conducting social appraisals for sexual and reproductive health programmes see Hawkins and Price 2000), social marketing organizations, like other agencies focused on HIV/AIDS, need to examine chronologically:

- (1) Which groups are vulnerable to STD/HIV infection.
- (2) The behavioural determinants of that vulnerability, specifically the local social and economic contexts which shape sexual behaviour – public health interventions aimed at reducing high-risk sexual behaviour often fail to address adequately the importance of social identity, vulnerability, marginalization, and relations of power and control in influencing sexual behaviour (see Hawkins and Price 2000).
- (3) Vulnerability in terms of service access, specifically why certain groups are excluded from information and services, and what are the sources of systemic institutional bias that make policies, systems and/or programmes unresponsive to the needs and realities of the poor and vulnerable (Norton and Bird 1998, p. i–ii) – how, for instance, does social identity, gender, culture and ethnicity constrain access and shape institutional bias (again see Hawkins and Price 2000)?
- (4) Whether and how the behavioural, service and institutional determinants of vulnerability and risk are amenable to CSMP interventions.

Lessons learned on impact and effectiveness

Despite a thirty-year history, there has (until recently) been little lesson-learning of social marketing impact and effectiveness, beyond the collection and analysis of aggregate sales data⁶ and the computing of Couple Years of Protection or CYP (see Janowitz et al. 1992, p. 110). The limitations of CYP as a proxy for continuation and effectiveness of use are well known (see Shelton 1991; Price 1994; Fort 1995). Sheon et al. (1987) and Ahmed et al. (1987) highlight the shortcomings of using CYP as a proxy indicator for condom prevalence in Bangladesh: estimates of CSMP condom use produced by national prevalence surveys in Bangladesh in the 1980s were much lower than estimates based on sales, distribution and CYP figures.

Few SMPs have collected data on the socioeconomic or vulnerability status of their clients, or on social practices and health-seeking behaviour. In continuing to overlook the socioeconomic contexts that shape behaviour and risk perception, CSMP monitoring continues a tradition started by family planning programmes, which give little credence 'to the idea that perception of birth control methods would be influenced by traditional notions of health and illness' (Warwick 1982, p. 37).

The number of published studies that go beyond the commercial marketing approach in SMP evaluation and research is limited. Notable exceptions include sociological studies of client-provider transactions in the commercial sector at community pharmacies and stores (Fox 1988), user-intercept studies on method and source switching (Green 1988), new-user studies of socially marketed commodities (Bailey et al. 1989), and studies of switching from fully commercial to social marketing sources (Janowitz et al. 1992). There have been some encouraging recent developments, as social marketing organizations begin to be more systematic and sophisticated in their programme research and monitoring.⁷ This is much needed, especially as social marketing moves into the fields of STD treatment, and voluntary HIV counselling and testing.

Impact

Recent reviews of the (albeit limited) data indicate that SMPs do not reach the poorest (Price and Pollard 1999, p. 22–24; Price and Hawkins 2000), and that making cost recovery a lower priority would enable social marketing to reach more poorer people (GTZ 1997). Social marketing's identified target population – economically active, lower-income groups – reflects the need for clients to have disposable income.

Schellstede and Ciszewski (1984) report that buyers of socially marketed condoms cover the socioeconomic spectrum in Bangladesh. Other studies in Bangladesh show that rural and urban users of socially marketed oral contraceptives (OCs) were middle-class, with educational and economic status much higher than that of the general population (Davies et al. 1987, p. 165), thus fitting the pattern found in a cross-country study which concluded that successful social marketing of OCs is related to higher levels of socioeconomic development (Boone et al. 1985).⁸ These findings confirm Ciszewski and Harvey's (1994, p. 33) observation that in

Bangladesh, socially marketed OC clients are more affluent than users of socially marketed condoms.

HIV/AIDS-prevention CSMPs are unlikely to be pro-poor initially in terms of the distribution of benefits. A recent survey in Zimbabwe (Adetunji and Meekers 2000), for instance, showed that consistent condom use in non-marital relationships was greater among those of higher socioeconomic status (SES). However, socioeconomic differences diminish as the HIV/AIDS epidemic and CSMP mature locally.⁹ Stallworthy (1998) found that socioeconomic differences among clients are smaller in countries affected early by HIV/AIDS and where the CSMP is mature than in those affected later by the epidemic, even where the CSMP is mature, and than in those affected earlier but with newer CSMPs. Reductions in socioeconomic inequities are found initially in the supply environment (access and awareness), and only later in condom use and other behaviour changes. What are the reasons for this early socioeconomic inequity in the distribution of benefits from AIDS-prevention CSMPs?

First, in the early phases of an HIV/AIDS epidemic, although the non-poor are likely to be more aware of HIV risk factors because of higher education and exposure to health promotion messages, they are likely to be at higher risk of HIV/AIDS infection as they are more mobile, have a greater likelihood of residing in urban areas where STD prevalence is higher, and have more disposable income for commercial and non-regular sexual partners. Recent data from Rwanda (see Calves 1998, p. 29) and from Cameroon (see Fotso et al. 1999, p. 178–80), for instance, show a direct relationship between higher socioeconomic status (or in the case of Cameroon, level of education as a proxy for SES) and number of sexual partners (see Tables 1 and 2). Thus, although many clients of commercial sex are poor, CSMPs designed to impact on HIV/AIDS by targeting commercial

Table 1. Percentage of men reporting multiple sexual partners in the 12 months prior to survey, by socioeconomic status: Rwanda

Socioeconomic status	% reporting multiple sexual partners
Low	9.7
Medium	10.9
High	13.7

Adapted from Calves (1998, p. 29).

Table 2. Percentage of people reporting having two or more partners in the 12 months prior to survey, by gender, education and marital status: Cameroon

Level of education	% married men reporting ≥2 sexual partners	% single men reporting ≥2 sexual partners	% single women reporting ≥2 partners
None	5.9	15.7	3.1
Primary only	29.6	38.5	17.7
Secondary and higher	48.6	50.6	19.9

Adapted from Fotso et al. (1999, p. 179–80).

sex workers and their clients will adopt strategies that are quite different to those designed primarily to benefit the poor (Stallworthy 1998).

Secondly, CSMPs tend to reach the non-poor first because formal distribution networks make sales of social marketing products easier in urban areas; it takes time and effort to develop informal distribution networks in peri-urban and rural areas (Stallworthy 2000). Similarly, mass media can be used quickly to reach urban middle-income consumers, whereas many of the communications strategies that are most appropriate for low-income groups (low-literacy materials, local language spots, community theatre, mobile video) take extra time and resources to develop. However, even if risk of HIV/AIDS is greater among the less disadvantaged in the early stages of an epidemic, an intervention focused on the non-poor is likely to have long-term benefits for the poor because it will limit the subsequent spread of HIV/AIDS to the poor, who are more vulnerable to its impact (World Bank 1997).

Recent PSI surveys conducted in Nigeria, Mozambique, Rwanda and Zambia (reported in Stallworthy 1998) offer insight into CSMP's ability to redress socioeconomic inequities related to condom use and other sexual behaviour change. Although CSMP condoms are priced to be affordable to the poor, and promotional and educational activities target the poor in all four countries, the non-poor response to these stimuli and opportunities is greater than the poor's. Thus in all four countries, socioeconomic differentials exist in relation to two key variables: condom use by men with non-regular partners, and the numbers of non-regular sexual partners that men have. The survey data show the following:

- Socioeconomic differentials in relation to the two behavioural variables diminish as the CSMP becomes established (and as the HIV/AIDS epidemic matures). This is most notable in Zambia (which has the most mature HIV/AIDS epidemic and the longest-standing CSMP of the four countries).
- In Mozambique, all socioeconomic groups in provinces with a mature CSMP were less likely to report a non-regular partner during the previous 12 months than their counterparts in provinces with new CSMPs.
- In Zambia higher income groups are no more likely than lower income groups to have had a non-regular sexual partner.
- In Mozambique, men in all socioeconomic groups in provinces that have had more exposure to social marketing are more likely to use condoms with non-regular partners than their counterparts in the provinces with less exposure to social marketing. However, the increase in the tendency to use condoms with non-regular partners that is associated with exposure to social marketing is greater for men of middle SES than for men of lower SES (who are slower to respond to social marketing communications) and higher SES (who are more likely to already use condoms).

Effectiveness

The effectiveness of CSMPs can be judged in terms of the extent to which they facilitate improved access and increased awareness, the defining characteristics of the supply environment and key determinants of whether people decide to seek out, adopt and sustain use of a service/product. This section reviews the evidence on effectiveness in each of these generic areas.

Access

Access refers to the extent to which services (including information) can be obtained at a level of effort and cost that is acceptable to and within the means of the poor and vulnerable. Evidence shows that low health service access is the product of a number of dimensions of poverty and vulnerability (Norton and Bird 1998), notably:

- *Financial*: charging user fees affects the ability, particularly of the rural poor, to consume routine, preventive services (see Price and Hawkins 2000). Intra-household vulnerability means that women, the young, the disabled and the old are often unable to control household income.
- *Physical*: physical isolation has been linked to limited mobility, inadequate geographical coverage, and low levels of service outreach.
- *Social/cultural*: a key factor in social exclusion from services relates to social identity (ethnicity, class, caste, age, gender, marital status and sexuality), which shapes relations between poor or marginal clients and service providers.

These three sets of factors that constrain access to socially marketed services and products are explored in more detail below.

Economic access (affordability): Affordability is the extent to which commodity or service prices constrain access. There have been few methodologically sound studies of the extent to which income is a barrier to condom use. Recent research in Pakistan (Agha 2000b) concludes that income (especially low income) differentially influences use of socially marketed condoms and modern contraception (over traditional methods). Green (1988), using data from a user-intercept study in the Dominican Republic, also concludes that low-income consumers have difficulty affording SMP prices.

However, there is a significant body of literature which demonstrates that lowering prices for socially marketed health commodities leads to increased prevalence of use among low-income people, and vice versa (price rises result in reduced prevalence). Harvey (1994), for instance, shows a clear negative correlation between condom prices and sales in 24 SMPs worldwide. Sheon et al. (1987) report that raising prices in order to generate sufficient revenue to cover running costs led to SMP distribution becoming restricted to a middle-class market in Colombia, Sri Lanka and Mexico, where coverage also dropped significantly. This is contrasted with Bangladesh, where in the 1970s and 1980s coverage (not

cost-recovery) was the primary goal of the SMP (as donor resources were secure). Sheon et al. (1987) conclude that a cost-recovery orientation results in the exclusion of the poor. Two studies in Pakistan (Davies and Agha 1997; Agha and Davies 1998) on the effect of price rises on condom use discovered level of use by low-income people to be price-sensitive: the greater the price increase, the larger the drop in condom use among low-income people. An increase in price from 1 to 1.5 rupees led to a 21% dropout by low-income users; a rise to 2 rupees led to 56% of low-income users stopping. Ciszewski and Harvey (1994) demonstrate similar levels of sensitivity of price increase for condom and contraceptive sales in Bangladesh: their study of the effect of price increases on socially marketed OC and condom sales showed that over the 12 month period immediately following the SMP's price increases, total sales dropped by 46% from the preceding 12 months. Agha et al.'s (1997) evaluation of the Green Star Clinic social marketing project in Pakistan also concluded that the programme would serve more of the project's primary target group (low-income urban population) if prices for services were lower.

Geographical proximity (convenience): Social marketing has the potential to make commodities more accessible in areas not reached by health facilities and community outreach programmes, as retail systems tend to be more extensive in developing countries than either of these service delivery systems. Stallworthy (1998) reports that after 3 years of social marketing in Zambia, there was no difference among socio-economic groups in terms of physical access to condom sources measured in terms of geographical distance from residence. Retail outlets provide *convenience of access* because of their proximity to the homes or workplaces of potential clients. A retail outlet survey in urban Zambia shows that widespread availability of socially marketed condoms in kiosks and grocery shops has 'resulted in highly equitable access to condoms' (Agha and Kusanthan 2000, p. 11): 66% of low-income respondents and 56% of wealthier respondents reported being within 10 minutes walk of a condom source. A survey of low-income contraceptive customers in Nigeria found that they used pharmacies (rather than health facilities) because they provide fast service, are uncrowded and close by, prices are affordable and they rarely experience stock-outs (Lande and Blackburn 1989). In relation to HIV and other STD prevention and control, social marketing's success in making condoms readily available in settings where the likelihood of high-risk (unprotected) sexual activity is greatest (such as bars, lodging houses and brothels) is now evident.

Social and regulatory constraints: Regulatory constraints include rules that inhibit advertising and that limit access to condoms because of age, marital status, or through restrictions on the types of outlets offering services. By its very nature, social marketing represents a service delivery approach that overcomes many of the social and regulatory constraints inherent in clinic-based service delivery. A critical dimension of social access is the *interaction between client/customer and provider*. One of the key constraints for many marginal and vulnerable groups (such as young people, unmarried women, ethnic minorities) to accessing condoms

and other health commodities is in the nature of the provider-client relation. Social status, identity, ethnicity and culture shape client-provider exchanges. Despite a shortage of data on client-provider transactions in SMPs (Lipton et al. 1987; Mitchell et al. 1987), a small number of studies show that retail outlets are often the preferred source of sexual and reproductive health information, advice and products, because retailers share interaction patterns, cultural values, and indigenous languages and/or dialects with local people, and are thus able to communicate more openly and clearly than medical and health professionals. Interactions with retailers also appear to allow customers greater trust and more control than they are able to exercise in their relations with doctors and nurses (see Bailey et al. 1982 on Honduras; Mitchell 1983 on Jamaica; and Lande and Blackburn 1989), and provide privacy and confidentiality (see Meekers et al. 1997, on young people in Botswana). Switching behaviour should be an important analytical variable for SMPs: a basic assumption of marketing is that people engage in exchange (buy products) or adopt new behaviours because they expect to be better off as a result.

Awareness

CSMPs classify the communication strategies that they employ to increase awareness into two broad types: brand promotion and IEC (information, education, communication). Brand promotion seeks to create and sustain awareness and knowledge of the availability and location of the socially marketed condom brand; with IEC strategies aimed at increasing awareness of the benefits of modified behaviour (including condom use). A typical social marketing communication programme is thus composed of mass media campaigns (aimed at promoting condom use by raising awareness of the condom brand and its availability); and IEC and behavioural change interventions (aimed at creating awareness of HIV/AIDS and other STDs, promoting condom use and safer sexual practices, and increasing risk perception and self efficacy). IEC campaigns, using mass media, traditional media, interpersonal techniques and public health promotion methods, are generic (not brand-specific), as they deal with subjects that are considered negative and counter-productive to branded product promotion.

Some social marketing organizations have recently increased their efforts to evaluate IEC and behavioural change communication activities. The two short examples that follow serve to illustrate.

In Mozambique (Stallworthy 1998) men in higher income groups are more likely to *know of a condom source* than men in lower income groups, although social marketing significantly improved knowledge and awareness of condom sources among all socioeconomic groups. Thus, men in all social groups were found to be nearly 50% more likely to know of a condom source in provinces that had more exposure to social marketing than in those that had less exposure. As a result of the CSMP, knowledge of condom sources doubled among men of lower SES, increased by approximately 30% for men of middle SES, and increased by only 10% from an already high level for wealthier men. The

difference between the poorest and richest also narrowed considerably: higher income men in provinces with little exposure to social marketing were three-times as likely to know a condom source as low income men, whereas higher income men in CSMP provinces were only 40% more likely to know of one than low income men.

An evaluation of adolescent sexual health SMPs in Cameroon, Botswana, South Africa and Guinea (Agha 2000a) concluded that the Cameroon programme was the only one to have had any significant effect on condom use and sexual behaviour. Its success, relative to the other programmes, was attributed to its combined use of mass media and interpersonal communication, which allowed the programme to reach substantial numbers of young people with information and behavioural change communications.

Like most HIV/AIDS prevention programmes, however, CSMPs are struggling to understand the underlying cognitive and social constraints to behaviour change, an understanding necessary if CSMPs are to be able to attribute behaviour change to their communications interventions.

Measuring impact and effectiveness

Measuring the equity and poverty focus of CSMPs

Information on the socioeconomic and vulnerability status of clients is essential for monitoring the equity and poverty focus of CSMPs. In many poor countries income data are difficult to obtain, and even when available are unlikely to provide an accurate measure of households' command over resources (i.e. poverty levels). Households draw incomes from multiple and fluid sources: the transitory nature of employment and the uncertainty of net economic return make it unlikely that any one-year's income data will be representative of incomes over a longer time-span. Furthermore, most households transfer resources across time periods, and will save and borrow to shield against income variability (see Montgomery et al. 1999). CSMPs thus need to use *proxy indicators of poverty and vulnerability*.

Proxy poverty indicators will include:

- Household assets: the Amenities and Possessions Index (API) produced by DHS, based on household access to water, electricity, sanitation and consumer durables, allocates API scores to households surveyed of low, medium, medium-high and high (see Kishor and Neitzel 1996).
- Type of housing (such as materials used in construction, size, etc.).
- Education/literacy level.
- Household structure (e.g. female-headed).
- Occupation: however, the convention of using husband's occupation as a proxy for a household's socioeconomic status should be avoided, as in many settings there is unequal allocation of resources within the household, the frequency of marriage dissolution is considerable, informal unions are important and spouses need not co-reside.
- Location of residence and outlets: a useful proxy indicator for assessing whether poor groups are being served is the

percentage of 'non-traditional' outlets, such as bars, kiosks, petrol stations, street vendors, small shops etc., stocking socially marketed condoms. Non-traditional outlets are 'more important than traditional outlets (pharmacies, clinics, supermarkets) if the objective is to reach low-income people' (Berman et al. 1997).

Vulnerability indicators require client profile data by gender, sexuality, occupation (such as the military, those who work in the leisure industry, truck drivers, migrant labourers, etc.), age (especially young people) and ethnicity.

The percentage of CSMP clients who are poor (low-income) is a measure of the effectiveness of *equity targeting*. The percentage of low-income people who use CSMP products (or the odds of low-income people choosing CSMP as opposed to another service) is a measure of the programme's *poverty focus* (its ability to serve low-income people). Other *equity indicators* should seek to demonstrate reductions in differentials, such as:

- no (or reduced) difference in proportion of medium- and low-income groups who report price as a barrier;
- no (or reduced) difference by socioeconomic status among those who know a healthy-looking person can be HIV positive;
- reduced relative odds of condom use by SES, controlling for age, marital status, etc.;¹⁰
- increase in the percentage of young and unmarried sexually active people, ethnic minorities, migrants, commercial sex workers, etc. who report being able to access services and products (equitable access for vulnerable groups); and
- increase in the number of individuals who report that their decision to use condoms was a joint decision made with their sexual partner(s) (gender equity).

Measuring behaviour change

The main quantitative and qualitative indicators currently available (but often under-employed in CSMPs) for measuring changes in condom use and other sexual behaviour are set out below.

Condom use

In addition to condom distribution/sales figures, useful indicators include:

- numbers of new condom acceptors (acceptance rates);¹¹
- (increased) correct and consistent condom use (e.g. reported use with last commercial or casual sex partner, or reported regular use with commercial or casual partner).

Sexual behaviour change

Main indicators include:

- (decrease) in reported number of sexual partners;
- (increased) age at first intercourse;
- (decrease in) number of unprotected casual sex acts per sexually active male;

- (reduction in) reported incidence (especially by young people) of coerced sex;
- increase among women in their ability to negotiate safe and satisfying sexual relationships (e.g. women able to enjoy sexual relationships free of fear of HIV/STDs, commercial sex workers able to negotiate condom use).

Indicators of intermediate behaviour change are also needed to monitor the relationship between awareness and behaviour change, e.g. the percentage of individuals who:

- perceive personal risk of infection/transmission;
- discuss IEC messages with friends;
- discuss HIV risk or condom use with partners.

Measuring access

Affordability

CSMPs have traditionally set retail prices at or below 1% of a household's disposable income (or 1% of GNP) for a year's supply, following Harvey (1994). In recognition of the problems with household income data, some CSMPs have begun setting product prices in relation to retail prices of selected household items, what is known as the 'basket of goods' approach (as recommended by Schellstede and Ciszewski 1984, p. 30), such as a measure of rice, bar of soap, box of matches, single cigarette, cup of tea, etc. It is suggested that all CSMPs monitor affordability through a combination of indicators, such as:

- retailers respect the recommended retail price;
- retail price in relation to the cost of selected household goods is appropriate;
- clients report that commodity/service price is not a constraint to use;
- reduction in the percentage of discontinuers reporting price in decisions to discontinue;
- non/never-users report that price is not the reason for non-use.

In measuring affordability, CSMPs should also seek to demonstrate reductions in differentials: e.g. decline in difference in proportion of high, medium and low-income groups who report price as a barrier to condom use.

Convenience

Indicators for measuring convenience could include:

- the number of outlets stocking socially marketed condoms, differentiated by outlet type, location, opening hours;
- the percentage of people who know where to obtain socially marketed condoms, and/or who report they can readily buy condoms whenever they want to (this covers time and costs of travel).

Social and regulatory access

Assessment of the extent to which a CSMP is addressing social and regulatory constraints requires the use of a number of indicators, such as:

- the nature and extent of switching behaviour, e.g. percentage of condom users who have switched to SMP brands, the sources from which they have switched (government, private, NGO), and their reasons for switching;
- the percentage of survey respondents (differentiated by gender, marital status, age, ethnicity, etc.) who express satisfaction with providers (e.g. feeling comfortable buying condoms), with the level of confidentiality/privacy, and with the supply of information;
- whether the CSMP is engaged in lobbying regulatory authorities to address age restrictions on condom provision, restrictions on IEC and advertising, etc.;
- is condom social marketing articulated as a key strategy in national HIV/AIDS control programmes?;
- the level of increase in knowledge among, and the nature of changes in attitudes of, key community groups, activists, opinion formers;
- whether condom use, safer sex practices, and HIV/AIDS are positively and accurately reported in the mass media (editorials, letters to editors, as well as regular features in newspapers, magazines, TV and radio programmes).

Measuring improved awareness

Monitoring the role of CSMPs in effecting behaviour change is fraught with difficulty, most notably in terms of attribution in settings where social marketing organizations are not the only institutions undertaking IEC and behavioural change interventions. Social marketing organizations have traditionally, however, been effective in their use of surveys, focus-group discussions, product and message tests etc. to gain insights into consumer responses to branded products. Over the past 3 years or so, they have devoted much more energy to evaluating their generic IEC and behavioural change strategies by *inter alia* tracking changes in the percentage of respondents who:

- can identify STD/HIV infection risk factors, and accurately assess own risk of infection;
- know how to protect against STD/HIV infection, and where to purchase condoms;
- report receiving messages about safe sex/condom use/HIV, and who can recall messages.

Conclusions

Ideally, the success of CSMPs would be judged by whether they contribute to sustained improvements in sexual health outcomes at the population level. Given methodological and attribution difficulties, intermediary criteria were employed in this review to assess effectiveness and impact, focusing on changes in behaviour (including condom use) among poor and vulnerable groups, and access by the poor and vulnerable to condoms, services and information.

It remains difficult to reach definitive conclusions about the extent to which CSMPs are effective in meeting the sexual health needs of the poor and vulnerable. This is due largely to the reliance by social marketing (until recently) on sales data and CYP in monitoring and evaluation. CSMPs have

traditionally collected little information on client profiles, demand-side issues (such as health-seeking behaviour, condom use effectiveness and continuation rates), or on supply-side issues (such as improving access and provision of information to raise awareness). Recent data indicate that social marketing does not reach the poorest, and that its appropriate target is economically active, lower income groups (to reflect the need for a small disposable income). CSMPs are unlikely to be pro-poor in their early stages, in terms of the distribution of benefits, but as they develop and mature, then socioeconomic differentials in access diminish, followed by reductions in inequities in condom use.

The paper has assessed the extent to which social marketing is effective in improving access for the poor and vulnerable using a number of variables. In terms of *affordability*, it is evident that low-income groups are particularly sensitive to CSMP price increases, and that a cost-recovery focus effectively excludes the poorest. *Convenience* is significantly improved for those who can afford to pay, and CSMPs appear to be addressing the types of *social and administrative constraints* inherent in clinic-based service delivery. Conventional CSMP monitoring systems make it difficult to assess the effectiveness of their behavioural change *IEC* strategies, although data on this dimension of the social marketing approach are beginning to emerge.

Endnotes

¹ Although programmes have started marketing STD treatment kits, and voluntary HIV counselling and testing, there are few data on the impact and effectiveness of these approaches, and thus the paper focuses on condom social marketing and its associated behaviour change activities.

² However, in middle-income markets such as Brazil, Costa Rica, Venezuela and Turkey higher levels of financial self-reliance have been achieved without apparently compromising social objectives.

³ CSMP impact can also be measured in terms of increased use of public sector and fully-commercial condoms, as a result of CSMP advertising and promotion (what is sometimes known as the halo effect).

⁴ A further measure is the extent to which programmes lead to improvements in social and economic wellbeing, sometimes referred to as *social impact* (see Price 2000). In evaluating this dimension of social marketing, key questions include: does the programme impact positively on the lives of sales agents, in terms of reported self-enhancement and increased autonomy? Do salaries/remuneration for CSMP staff/agents have a significant effect on family livelihood and community-level empowerment? Does the CSMP impact positively on community demand for other health care (an indicator of community mobilization/participation)?

⁵ Equity is the distribution of benefits according to demonstrable need rather than on the basis of political, social or economic privilege. Inequitable health outcomes relate to differences that are unjust and avoidable.

⁶ The importance attached to such data are reflected in Boone et al. (1985, p. 30–31), who argue for performance measurement using sales data, because "... high sales represent 'success'".

⁷ For example, PSI has recently enhanced its research and monitoring capacity and launched two publication series, *Monitoring tools* and *Research division working papers*, the latter often subsequently published in peer-reviewed journals.

⁸ Janowitz et al. (1992, p. 111–13), from a study in Honduras, also report that a SMP did not increase OC prevalence among the

urban poor, and found higher income women switching from commercially priced OC brands to the subsidized socially marketed OC. However, Bailey et al. (1989) and Green (1988) report OC SMPs reaching low-income women in Honduras and Dominica respectively.

⁹ There is, of course, an issue of attribution here: the maturing HIV/AIDS epidemic is likely to change sexual and other behaviour independent of CSMP interventions.

¹⁰ Although few SMPs collect data on differentials, Stallworthy (1998) reports from a study undertaken by the London School of Hygiene and Tropical Medicine in Orissa, India, that in 1996 higher-income couples were 3.6 times more likely to use temporary (spacing) methods of contraception than lower-income couples; by 1998 this differential had dropped to 2.9, representing a '19.4% decrease in the differential of modern temporary method use between lower income and higher income couples over this period'.

¹¹ This indicator should focus only on those who have never, or very infrequently, used condoms.

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Biography

Neil Price is subject leader in population and international health at the Centre for Development Studies, University of Wales Swansea. He has undertaken anthropology fieldwork in the Caribbean, China, Cambodia, Kenya and Zambia, and has extensive experience of advisory and commissioned research with international development agencies throughout sub-Saharan Africa, Asia, Latin America and the Caribbean. His main areas of advisory expertise are in the appraisal, monitoring and evaluation of reproductive and sexual health programmes, and in social and institutional analysis in the health and population sectors.

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