



## **REVIEW OF DFID APPROACH TO SOCIAL MARKETING**

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**2003**

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**ABBREVIATIONS**

AG	Accountable Grant
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communications
CBD	Community based distribution
CBO	Community based organisation
CMS	Commercial Market Strategies (Project)
CPR	Contraceptive prevalence rate
CSM	Contraceptive social marketing
CSW	Commercial sex worker
CYP	Couple year of protection
DFID	Department for International Development
DHS	Demographic Health Survey
DKT	DKT International, a US headquartered SMO
DoH	Department of Health
FDI	Foreign direct investment
FGE	Futures Group, Europe
FP	Family Planning
GNP	Gross National Product
GoP	Government of Pakistan
GoSA	Government of South Africa
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
IEC	Information Education and Communication
ILO	International Labour Organisation
IMR	Infant Mortality Rate
ISO	International Standards Organisation
ITN	Insecticide treated (mosquito) net
IUD	Intra uterine device
KfW	Kreditanstalt fur Wiederaufbau (German Development Bank)
LLN	Long-Life Net
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MMR	Maternal Mortality Rate
MR	Mortality Rate
MSH	Management Sciences for Health
MSI	Marie Stopes International
MSM	Men who have sex with men
NGO	Non government organisation
OC	Oral contraceptive
OPR	Output-to-Purpose Review
ORS	Oral Rehydration Salts
PPP	Public-private partnership
PS	Private Sector
PSD	Private sector development
PSI	Population Services International
PLWA	People living with AIDS
SADC	Southern African Development Community
SFH	Society for Family Health (South Africa)
SM	Social marketing
SMO	Social marketing organisation

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SMP	Social marketing project/programme
SOMARC	Social Marketing for Change (USAID project)
STI	Sexually transmitted infection
SWAPs	Sector-Wide Approaches
TMA	Total Market Approach
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

## EXECUTIVE SUMMARY AND RECOMMENDATIONS

### 1. *The principal overall conclusions are:*

- i) Social marketing (SM) represents an extremely valuable tool to induce behaviour change of public health significance, and to improve access to health goods and services. There are important and valuable complementarities and synergies between SM and other DFID support to the health sector, especially the mainstay efforts to strengthen the public sector health provision.
- ii) But, performance is not always matching potential; changes in existing practice are recommended in relation to SM programme design and management, strengthening national ownership, and DFID capacities and procedures.

### 2. *The evolution of social marketing and DFID support for SM*

2.1 DFID support for social marketing is currently in the order of £20-30 million annually (or about 10-15% of global SM donor funding), having risen sharply since DFID first started funding SM in 1991 (although there remains an element of uncertainty about some of the expenditure figures). Over the period 1999 - 2003, SM constituted between 8 and 16% of total DFID health expenditures. Funding is predominately for HIV prevention, family planning and to a lesser (but growing) extent, malaria control. All except one of the projects encountered involves the distribution of a commodity (e.g. condoms or bed nets), alongside behaviour change messages. (Annex 3 presents DFID support for social marketing in greater detail).

2.2 The fit between social marketing objectives, and DFID's wider development goals, is good, with SM directly addressing 8 of the 13 indicators that relate to the 5 targets and 3 health improvement goals enumerated in the Millennium Development Goals.

2.3 DFID has contributed to the evolution of SM into a versatile tool for addressing health care market failures and distortions (Section 2). Over the past decade, SM has enlarged its product range, diversified distribution channels, and introduced new modalities of behaviour change communication. The main models of SM include the "own brand" or NGO model (espoused amongst others by Population Services International (PSI)), which usually involves a considerable subsidy to the retail price, and the manufacturer's model, particularly associated with The Futures Group; for the latter, the major part of donor funds is generally spent on promotion. A detailed treatment of the different models is in Annex 2.

2.4 A "total market approach" (also 3<sup>rd</sup> generation model) is increasingly being considered. This takes a sector-wide view of commercial (private), SM, NGO and public sector actors in the health domain, and manages integrated, national interventions across all sectors (or sub-sectors as appropriate). Such an approach also has an obvious potential 'fit' with SWAP and budget support approaches.

### 3. *Equity, Effectiveness and Efficiency*

3.1 SM is not intrinsically pro-poor, since it depends on consumer ability and willingness to pay, and on access to retail and commercial outlets and services, which are not equally distributed across the population (Section 3). Whilst SM can be designed to serve the poor by a combination of additional subsidies, targeted BCC, and partnership with community-based agents such as NGOs, CBO's and the public sector, such strategies are not well articulated within most programmes. Typically, the very



poor are assumed to be unreachable, or the remit of the public sector. Definitions of 'low-income' as a target group are usually not clearly identified (or quantified) by socio-economic strata or residence. (At the same time, all programmes appear to assume implicitly that the fact that subsidies are provided means that the poor are an essential remit - even where log frames do not mention 'low-income' or the 'poor' as a target group.)

3.2 Serving the poor to a greater extent would make SM programmes more costly - as a result of the additional subsidies, and more expensive marketing, targeted selling, and communications components. This would apply particularly where SM programmes move towards community-based distribution and BCC activities - whether these are managed and financed directly as part of the SM programmes themselves, or through other collaborative arrangements.

3.3 SM programmes generally fail to elucidate their cost effectiveness in relation to specific target audiences (as against the totality of their sales). Estimating the additional costs (or the increased cost per beneficiary) which might be needed to make SM programme more poverty-focused is therefore not easy. Decisions as to whether community-based, targeted approaches are the 'right remit' of SMO programmes, or alternative programme strategies are more appropriate (e.g. through NGOs and/or the public sector) may also be problematic in any specific environment.

3.4 Pro-poor approaches are only being articulated to a somewhat uncertain and variable degree in DFID SM projects. Greater attention is however being directed at those who are 'vulnerable' (for example, at-risk of HIV, or vulnerable to malaria by age or pregnancy). The outcome of SM in terms of meeting equity or poverty focus targets is reliably known only for a limited number of projects, for which quantitative consumer research has been performed. In general, SMOs continue to measure success in terms of aggregate sales volumes, with only indicative insights into reach to defined target audiences; as a result, there remains a dearth of reliable evidence on the impact of SM on subsets of consumers.

3.5 The assessment of SM effectiveness is equally complex. Conventional reporting, which converts sales data into "person-years of protection", and then into presumed health status gains, is prone to overstatement of impact. Research does show the general effectiveness or otherwise of SM interventions, but rarely indicates the scale of achievement relative to the presumed level of need in the entire population. Data on market share are available, but they do not indicate the degree of potential market penetration. Subject to these limitations, data from 5 of 6 condom SM case study projects show a high share of retail sales attributable to SM, and a more variable share of total use (which is affected by the considerable volume of public sector distribution in some countries). Of the four ITN case studies, three show a high market share for SM products.

3.6 SM cost-effectiveness assessments, including the comparisons of cost per CYP, are frequently uninformative, because the alternatives are seldom clearly identified and rigorously costed. Even the research literature is weak, rarely describing an explicit alternative to the SM programme under review. Whilst SM operations become more cost efficient as they mature, it remains unclear how they are to be sustained -- whether through modified pricing strategies, innovative solutions to improving efficiency, diversification into more profitable lines, diversification of donor (or consumer) inputs, or national policies to continue subsidies. Strategies will vary considerable between programmes, depending on their targeting strategies and product lines. Long-term goals to sustain inputs (and SM operations) need to be better articulated.

#### *4. Role of the Private Sector*

4.1 The private sector has a central role to play both generically in economic development and specifically in SM, with up to 75% of SM project funds being spent through the private sector on products and services (Section 4). Services supplied to SM programmes by the private sector include transport, marketing, warehousing, research and communications. SM products and services are primarily marketed through networks of wholesalers and retailers (as well as the more recent and much smaller scale efforts through public sector and NGO facilities and services). In some instances, domestic manufacturers have invested heavily to meet the demand from SM projects (examples include up to \$4m in bed net production in Tanzania, and \$150,000 in a new facility to produce oral contraceptives in Pakistan). In some DFID SM programmes, social franchising of private medical service providers has been applied, for example, in Pakistan. The subcontracting of all these services increases income and employment in the local economy.

4.2 Evidence on “crowding out” commercial suppliers from a market is sparse and inconclusive, although specific cases have occurred, and undoubtedly the potential exists for subsidised products to undercut established suppliers.

4.3 At the same time, “crowding in” also manifestly occurs - where the promotional efforts of SM (and others) expand demand for all supplies, so that commercial suppliers enjoy increased sales. The Tanzania and Nigeria ITN programmes are specific examples here, although ‘crowding in’ is occurring in all programmes in one way or another.

4.4 SM managers are not always paying adequate attention to investments in the development of the private sector. There is a tendency to prefer to develop in-house capabilities, where private sector services may be weak. This approach can militate against the sustainability of SM operations in the long term, and should be convincingly explored in programme design, through analyses of programme efficiency against alternatives.

#### *5. National Government Ownership and SM Programme Management*

5.1 SM is favourably regarded by governments in most case study countries, with government ownership assessed as less than satisfactory in only two of the eleven cases (Section 5). Social marketing is increasingly included in national health policies and strategies. However, substantial and sustained national involvement in planning, funding, commodity supply, use of public sector distribution capacity, or influence over programme strategies remains less common.

5.2 Some capacity building (of local social marketing organisations (SMOs) and of national government) has taken place in the context of SM programmes. But, this has been neither systematic nor extensive. This deserves greater attention if the growing trend of host country governments playing an increasing role in the planning and monitoring of SM programmes, and eventually in the procurement and management of SM services, is to be sustained and accelerated.

5.3 Partly as a result of the variable national government ownership and involvement, sustainability and exit strategies have not been rigorously developed. A genuine sector-wide approach, developed at the planning stage and embracing public sector, private sector and NGO providers, would provide a better framework for addressing such core concerns as part of a long term holistic perspective.

## 6. *Monitoring and Evaluation*

6.1 SM monitoring of sales, quality assurance, logistic operations, and media activities is generally satisfactory. Weaknesses persist however in relation to tracking prices, allocation of costs between different forms of SM activity (where multiple activities are being managed), and accounting for capital items (Section 6).

6.2 Impact evaluation, particularly in relation to the different socio-economic strata, remains the major problem area, owing to a dearth of direct information on the consumer base. As programmes increasingly employ diversified methods of BCC and distribution through multiple channels, there is a need for separate identification of the associated costs and outputs so that calculations of cost-effectiveness can be made.

6.3 The cost appears to be a constraining factor from the donor perspective in implementing rigorous M&E components. But, without these inputs it is not possible to analyse the functionality of SM (as against alternatives). This is particularly the case where SM programmes move towards community-based and BCC activities. Where multiple donors fund SM programmes, M&E costs can be shared.

## 7. *DFID Capacities and Procedures*

7.1 DFID's own capacities in SM are primarily vested in the country health advisers. There has been no central quality assurance function. This has resulted in inconsistencies - in project design and management, procurement practice, and in the sharing of lessons learned between and within countries (the latter, as health advisers have left and others arrived). While there is no substantive evidence that these inconsistencies have contributed to inappropriate choice of SMO, or to ineffectiveness or inefficiencies, there are risks that this may happen.

7.2 SM projects are managed by a small number of specialised organisations, either for-profit firms or NGOs. Different DFID procurement rules and practices (through accountable grant arrangements) have been applied in the past to NGOs. Since not all SMOs are NGOs, more systematic and equitable approaches to SM procurement are desirable, including the tendering of programmes.

7.3 Brand ownership (of commodities and/or service networks) in any particular market has presented a constraint to tendering, and can reinforce perceptions of SMOs having a dominant position. No donor would want to, or should, give up all the investments made in a brand if that donor changed the management of a project through competitive tender. USAID insists on brand transfer from one SMO to another. DFID has recently built this requirement into new contracts (see Annexes 2 and 9), but has not yet addressed this issue in existing contracts.

## 8. *The Future*

8.1 The total market approach is arguably central to the future of social marketing. There is a clear trend in this direction most particularly within USAID programming. KfW and DFID are also beginning to test out these approaches. Such an approach should be based on more in-depth 'market and social environmental' analyses. These will establish the framework for better harnessing the resources of all sectors and create the opportunity for equitable reach and impact across all target groups. A broader SM role is possible (and in several cases, desirable) in a range of respects, including: strengthening behavioural change elements, including those that go beyond the selling of commodities or services; increasing use of diversified distribution

channels across sectors; innovative extensions to SM operations, social franchising of service delivery; and associated sustainability and exit possibilities.

8.2 Donors, national governments and SMOs will have to develop new ways of working, strengthen capacities, and build new relationships, to apply the more flexible market approach.

8.3 There is scope for greater donor collaboration - and interest in this on the part of KFW and USAID. (Both these donors have indicated that this report - and any follow up - offer a ready opportunity to find ways of working more closely with DFID.)

## **SUMMARY OF RECOMMENDATIONS**

- i) DFID should continue to expand its commitment to social marketing as a cost-effective means of delivering reproductive health and communicable disease interventions. (Section 3)
- ii) Where agreements can be reached, DFID should adopt a "total market approach" as the basis for the design of future SM support, rather than funding SM programmes in isolation from public sector, NGO and commercial sector activities. (Sections 2 and 7) (see also Recommendation xvi below for additional detail)
- iii) All DFID SM programmes should (i) explicitly identify the extent to which they address the needs of poor people; and (ii) justify their current and future 'poverty focus' in the context of national programme objectives and strategies to widen access to health services and products (including and especially to the poorest and most vulnerable). To this end, all DFID SM programme plans and budgets should include provision for ongoing market research (both quantitative and qualitative) on the socio-economic profile of both programme and non-programme users -covering access, affordability and knowledge, attitudes and behaviours.
- iv) DFID (and other donors) and SMOs should actively encourage the participation of national Governments in planning, monitoring and evaluating SM projects, and facilitate capacity building support to government officials in order to improve knowledge and expertise in the areas of SM policy analysis and programme management. This is particularly relevant to the funding of 'total market' approaches that integrate all sectors under one central management. (Section 5)
- v) DFID and SMOs should ensure that the potential role of, and impact on, the private sector should be evaluated during the planning of SM projects. This should include the potential for "crowding out" or "crowding in" of the private sector. (Section 4)
- vi) All DFID SM projects should be competitively tendered. (Section 2, Section 4 and Annex 9). There should be a single and consistent set of rules for selecting SMOs, regardless of corporate status. (Section 4 and Annex 9)
- vii) DFID tendering, procuring and contracting procedures should be standardised and tightened – including a consistent basis for remunerating SMOs (Annexes 7 & 9): more consistent formality in amending contracts where log frames are revised (Section 6, Annexes 2 & 7); standardised agreements on the use of income from sales (Annexes 7 & 9); and proper depreciation of a programme's

capital costs (Section 6). Terms of reference should be more clearly specified. The possibility of assessing the social accountability of suppliers of SM services and goods on a pilot basis should be considered. (Section 4 and Annex 9)

- viii) All SM project design should build in much more explicit components to assess the cost effectiveness of reaching defined target groups by different distribution methods (e.g. retail, NGO, institutional). This will entail identifying different forms of distribution as separate cost centres. (Section 6)
- ix) All SM programmes engaged in behavioural change activities should undertake baseline surveys and periodic evaluations of their success. Behaviour change activities should be identified as a separate cost centre, to facilitate analysis of their cost effectiveness. (Section 6)
- x) Building local capacity (including private sector capacity) should be a component of all project designs. In DFID's case, the tender process should require SMOs to demonstrate the nature and extent of partnership with, or sub-contracting to, the private sector, NGOs or other organisations – identifying the benefits and, where relevant, the costs involved (Section 4.3). This should be reflected in the contractual obligations of SMOs to DFID. Where necessary and appropriate, other Technical Assistance channels should be actively considered. (Section 5).
- xi) DFID should increase its own capacity in social marketing, especially at the central level. Options for this include:
  - borrowing from, and adapting, the "sustainable livelihoods office"<sup>1</sup> approach to establish internal capacities (within DFID); and/or
  - having SM as a defined competence in a Resource Centre.

DFID may also wish to consider other options, in the light of the recent Policy Division re-organisation.

This capacity strengthening should embrace (a) the development of design, evaluation and OPR templates around which future SM projects should be planned (or present ones reviewed and revised), and (b) building a better database of people with relevant and pragmatic market experience who can assist in the planning and monitoring of future SM projects, including the development and implementation of total market approaches. (Section 5)

- xii) DFID should institute measures to facilitate more proficient capturing of information from databases and lessons learned, and better sharing across programmes. In addition, specific references should be included in the TORs for OPRs to review the fundamental design of projects and propose revisions if required. (This summarises a number of more specific recommendations in Sections 6.1, 6.2, 6.3 and Annexes 2 & 8).
- xiii) The sustainability of all SM operations needs to be more actively explored - especially the potential for greater public-sector ownership and funding of programmes in countries where that is practical and possible. Issues of sustainability (including definitions of sustainability), and exit where appropriate, must be considered as a project is being planned and not when problems arise or when unexpected success leads to an unanticipated demand for additional funding (section 5.5 (Section 7)).

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<sup>1</sup> See 5.6.2 for a fuller explanation

- xiv) More focus is needed on the development of models involving “social franchising” (including their sustainability) – (Section 7 and Annex 8, Appendix 2).
- xv) DFID should reach agreement with all SMOs that all brands (commodities or service networks brands) can be transferred from one SMO to another irrespective of the donor that invested in them or the age of the programme. (Section 2). Donors should collaborate in articulating and ensuring consistent approaches to the contractual arrangements with SMOs on this matter. (Section 7)
- xvi) When implementing a total market approach (Section 7), DFID should (inter alia):
- (with other donors) actively explore options to integrate the interests and activities of all parties operating in the market. This might be undertaken by either extending existing SMO operations, or hiring an SMO to manage these ‘total market’ approaches (including any SM programme within that country, where appropriate).
  - encourage SMOs to increase the emphasis on community-based forms of BCC, leading to better targeting of SM products and services and the creation of new users. The management of these BCC components needs to be clear and robust;
  - encourage SMOs to explore the option of selling through (non-retail) distribution systems, and/or adding community-based distribution to the SM portfolio. This will typically require alternative funding and management arrangements. SMOs with significant sales through outlets other than retail shops should separate out the costs of each, as cost centres, and report effectiveness separately;
  - consider the management and contracting implications - for both the public sector and SMOs. Capacity strengthening may be needed in both cases. Equally new contracting options and arrangements may need to be explored - including, if necessary, sub-contracting some aspects of the central management function to a management agency.
  - work towards effective government ‘ownership’ of SM programmes (and the implicit and explicit ‘market segmentation’ strategies within these) as a pre-requisite of any “total market approach”;
  - consider the wider application of market methodologies and analyses (building on SM experience) as part of its contribution to national health policy and programme development;
  - as appropriate, consider the evolution of the programme over more than one phase of financing, along with the long-term ‘corporate’ goals and strategic ‘positioning’ of SM in each country environment.
- xvii) The wide range of recommendations in this review will have implications for other donors (especially KFW and USAID, and perhaps UNFPA) as well as DFID. DFID should respond positively to the expressions of interest by KFW and USAID to consider potential future joint or mutually agreed actions in the light of this review. One possibility (amongst others), will be to arrange a Forum of donors and SMOs to explore thoroughly these recommendations.

## 1. INTRODUCTION

Social Marketing (SM) is generally used to improve public health (including nutrition) but can be more widely applied. DFID currently uses SM primarily in relation to its health and population development programmes (family planning, HIV/AIDS and other sexually transmitted infections (STIs), and communicable diseases, especially malaria). DFID-funded SM programmes are currently operating in over 30 countries. DFID's current annual commitment to SM is around £30 million, whilst the total annual commitment of donors as a whole to SM programmes is in excess of £250 million<sup>2</sup>. In the light of this level of expenditure, and the importance of health within the Millennium Development Goals, DFID has commissioned a review of its approach to SM, which is addressed by this report. Whilst the terms of reference cover a wide range of issues, the key issues that the report is asked to address are the following (numbers in brackets denote the section or annex where the issue is addressed) :

- (a) To what extent does SM contribute to DFID's broader development objectives? (section 2.1)
- (b) What is the evidence base behind SM approaches? (sections 2 & 3, Annex 5)
- (c) Does SM reach the very poor, and what is the impact on the very poor? (section 3.1 and Annex 5)
- (d) How efficient and effective is SM in increasing the availability and consumption of quality health products and services? (section 3, Annex 5)
- (e) To what extent does SM introduce innovation and raise awareness of (new) products and ideas? (section 2.4)
- (f) When it is justifiable for donors/Governments to intervene through SM? (section 2.1.11, Annex 5, Appendix)
- (g) Are there alternative ways of achieving the same objectives that are more equitable and cost-effective? (section 3)
- (h) Does SM build local capacity, develop systems and innovation and other issues linked to sustainability? (sections 2.4 & 5, Annex 8)
- (i) Are there any incentives for SMOs to outsource or to develop innovative partnerships? (section 4.3, Annex 8)
- (j) What are the implications of PSI's dominant role in delivering DFID's SM projects and what steps, if any, should be taken in relation to this? (section 2.3, Annex 6 and Annex 9)
- (k) What issues arise in relation to brand ownership and how should these be addressed? (section 4 and Annex 9)
- (l) Does SM stimulate or restrict the development of the indigenous/local private sector? (section 4, Annex 8)

### 1.1 Response to the terms of reference

1.1.1 The responsibility for conducting this review was entrusted to the Health Systems Resource Centre, which engaged a team of three consultants, the authors of this report, and provided 10 days of research assistance from Caz Marshall. The consultant team were supported by Jackie Mundy, Knowledge Manager of the HSRC (Chris Allison in the final stages) and a panel of DFID staff, partner organisation representatives, and independent experts. Jane Pepperall was the focal point of this panel, with Alex Ross as alternate. The panel were consulted on the choice of case study countries, on various technical issues, and on the content of the draft final report.

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<sup>2</sup> Based on the combined income of the major SMOs.

1.1.2 The consultant team held two face to face meetings in London, at the initiation of the review and before drafting the report. The main data collection methods were a review of relevant literature, consultations in person or by telephone with key informants, including personnel of the social marketing organisations (SMOs) who were unfailingly helpful to the review; and a series of case studies which was considerably expanded beyond the original conception to capture a representative selection of current practice in different regions, with different products, different models of social marketing and different organisations. The projects finally selected were:-

<b>Country</b>	<b>Product</b>	<b>SMO</b>	<b>Model</b>
Mozambique	ITNs	PSI	Own Brand
Mozambique	Condoms	PSI	Own Brand
Nigeria	Condoms + Other FP	PSI	Own Brand
Nigeria	ITNs	FGE	Manufacturer's
South Africa	M+F Condoms	PSI	Own Brand
SADC Regional	M+F Condoms	PSI	Own Brand
Tanzania	ITNs + treatment kits	PSI	Evolving
Kenya	ITNs + treatment kits	PSI	Own Brand
China	Condoms	FGE	Manufacturer's
Pakistan	OCs + Injectables	FGE	Manufacturer's
Pakistan	Condoms	PSI	Own Brand

1.1.3 It was not possible to visit Pakistan, but a variety of interviews were conducted in person and by telephone. The SMOs provided extensive documentation.



## 2. REVIEW OF DFID POLICY AND PROFILE OF CONTRACTED ACTIVITIES

### 2.1 Social marketing---what it is, and how it works

#### Definitions of social marketing

2.1.1 There have been many attempts to come up with a definition of social marketing in the public health context that is accurate and comprehensive. The following is an example:

**“Social marketing programs engage the resources, techniques and dynamics of the private commercial sector to bring about behavior change and make products and services with a public health benefit widely available and affordable”** *adapted from MSI definition*

2.1.2 Although not part of the definition, it may be observed that third party financing (or external subsidy) is usually involved; (in a few cases, an SMO itself has provided bridging finance from its reserves).

2.1.3 No definition can adequately express the many forms and models that have been developed within SM programming. There are in practice almost as many forms and models of SM as there are country programmes, because social marketing is so versatile (and has been in continuous evolution since its inception).

2.1.4 The core competency of SM programmes is the distribution of commodities through commercial sector channels. But there are social marketing projects that aim at behaviour change only, such as breastfeeding or hand-washing, where no product is involved. Many definitions emphasise skills in exploiting established commercial distribution networks---but there are social marketing programmes which utilise NGO, CBD and public sector distribution systems in addition, and in a number of cases SMOs have set up their own direct sales force to expand outreach. The many applications of social marketing are described more fully in Annex 2.

#### Social marketing- how it developed and what it does now

2.1.5 As developed at greater length in Annex 2, the origins of social marketing lie in the efforts of the Indian Government to expand the availability and use of family planning commodities, and particularly condoms, in the 1960s. The success of that early experience led to widespread emulation in family planning programmes throughout the developing world. When the HIV epidemic emerged, social marketing was seen as a ready-made tool for the distribution both of behaviour change messages (abstinence, fidelity, and safe sex) and barrier devices to prevent disease transmission. Independently, USAID in the 1970s began searching for ways to create demand for a wide range of MCH products and services through the use of commercial marketing expertise. There is also a domestic European and US tradition of promoting healthy behaviours such as smoking cessation, traffic law compliance, and reduction in drug abuse, where no commodity sales are involved, but where there is an emphasis on the employment of marketing professionals and their techniques.

2.1.6 Today, an extensive range of health related products are socially marketed by many different types of agencies, though there is still a preponderance of reproductive health commodity projects managed by international NGOs. There has been a recent large scale move into ITNs as a cost-effective intervention against malaria, heavily supported by USAID's NetMark project and by DFID. But there is a host of other products from soap to water chlorination tablets, ORS sachets to iodised salt that are currently being marketed. PSI even sells viper boots as a protection against snakebite. In Pakistan and other countries where private medical practice is strong, services as

well as products are socially marketed using a franchising strategy. In India, Bangladesh, Columbia and Ghana, there are indigenous organisations capable of managing social marketing programmes without the direct involvement of the international players. However, between them PSI, DKT and The Futures Group (all originally US based) dominate the global scene.

### **Models of social marketing**

2.1.7 A simple dichotomy between the NGO or “own brand” model and the manufacturer’s model does not do justice to the many sources of variation in SM practice. Nonetheless, as explained in Annex 2, it is still useful as a starting point. The base version of the NGO model involves donated commodities or procurement, either from domestic manufacturers or more commonly by import, of commodities which then pass through regular commercial distribution channels to consumers. The retail price may be subsidised, sometimes heavily. The product, normally branded by the SMO, may be promoted like other branded consumer goods using the mass media and mass promotional forms of communications. The base version of the manufacturer’s model involves negotiating an agreement with domestic manufacturers or importers whereby the product is sold at commercially viable prices through the manufacturer’s existing distribution network, but with additional promotion organised and financed by an SMO. The negotiated price may be well below historic retail prices as the manufacturer anticipates a greatly increased market as a consequence of the additional promotion.

2.1.8 Both models are vulnerable to criticism. The NGO model is criticised on the grounds that it may provide subsidies in excess of need, that it may undermine the local private sector, and that there is no clear exit strategy for donor financing. The manufacturer’s model is criticised for drawing donor funds into marketing products which may be still out of reach of the poor, for being dependent on private firms whose strategy may change when project support is withdrawn, and for only being viable in middle income countries. Both models have in common that they tend to focus on limited segments of the market, and may take insufficient account of public sector free or subsidised distribution.

2.1.9 In the condom market for HIV/AIDS prevention it seems to be generally assumed that very low prices (often set below the ex-factory cost of production) are needed. Few programmes have been developed for the manufacturer’s model in the condom market for this reason. The market for hormonal contraceptives has been found to offer the best opportunities for the manufacturer’s model, as has the ITN market (along with smaller markets for products such as iodised salt and ORS packs). In these cases manufacturers are able, in general, to bring very low-priced products into the market providing that they can see strong potential for growth, and eventual profits. However experience to date indicates that few markets have achieved this goal and then only in more middle-income countries (primarily in South America and Turkey) where pricing pressures are less severe. The rule of thumb suggested by Harvey (Harvey, 1999) is that a year’s supply of contraceptives should be priced below 1% of per capita GNP, or 0.25% of GNP per capita expressed in purchasing power parity terms. This suggests that product affordability is highly variable across countries, and therefore pricing strategy and the associated choice of model should be sensitive to income levels, particularly among target groups.

2.1.10 SM programmes employ a range of models and strategies to gain better reach to target audiences, including low-income groups. These include direct support to distribution systems; direct selling to institutional entities (including the public sector), and a variety of forms of CBD distribution often in collaboration with NGOs/CBOs. Several models of collaboration are noted. SM programmes may support separately funded NGO/CBO operations or may fund and manage these arrangements, either

directly or through a sub-contract with a managing NGO. Some experience and constraints within these activities are noted at 3.4 and 7.2.4 – 7.2.7.

2.1.11 Most DFID funded SM programmes engage in some form of BCC programming in order to strengthen message strategies through their mass-communications components. Efforts to expand BCC message delivery through community-based activities is acknowledged as desirable as it is noted that mass media and mass promotional forms of activity, while quickly attracting early adopters, is less capable of gaining the more recalcitrant late adopters. Management and collaborative arrangements through NGO partners have followed those for distribution as per 1.1.10 above but have been very limited owing to constraints towards achieving significant coverage. (See also 3.4 and 7.3)

2.1.12 With a view to overcoming the limitations inherent in both established models, a new “total market approach” (also known as the 3<sup>rd</sup> generation model) is being developed (see 7.2). This approach has been supported by USAID (through the CMS project) and KfW and can be seen in DFID’s design for ITN programmes in Tanzania and Mozambique. The new Pakistan CSM programme is also evolving along these lines. With a total market approach, a pragmatic view is taken of the possibilities of growing the entire market by interventions across all segments - existing private sector players, SMOs, NGOs and the public sector. Starting with an assessment of what the private sector can achieve, currently and potentially, and the contributions from other current or potential players, a range of intervention options (including for donor support) are considered, and an explicit plan for an exit strategy is devised (or a clear justification for why there should not be one over the short and medium terms). Depending on the outcome of the analysis, interventions could approximate to either of the established models, or other forms of support, such as quality assurance or generic promotion. See 7.2 and 7.4 for additional detail.

**Recommendation: DFID should consider the total market approach as the basis for the design of future SM support. As appropriate, the design should provide for the evolution of the SM programme over more than one phase of financing.**

#### **When is it justifiable for donors/governments to intervene through SM?**

2.1.13 Social marketing is a potential response to a situation where there is both market failure and government failure. Market failure commonly occurs in the health sector because of the existence of externalities, information asymmetries, unequal income distribution, monopolies of many types and failure in the associated market for health insurance. These factors all have added force in poor countries. To take the example of condom supply in the face of an HIV epidemic, markets will not work well (in the sense of supplying and ensuring the use of the volume of condoms necessary to contain transmission) when the potentially infected are unaware of the causes, transmission routes and potential preventive measures, when they do not take account of the consequences of their infection to themselves leave alone third parties, when purchasing power is too low to buy imports priced to sell to elites, and when the only carriers of the goods are pharmacies in the big cities. The associated failure in insurance markets is that no one has health insurance (except the elite, whose policies do not cover condom purchases). But failure in the public sector delivery system is equally common in poor countries.

2.1.14 There are a number of factors which inhibit governments in poor countries from compensating action to address market failure. The potential response to failure in the condom market might be that the Ministry of Health supply condoms to all who need them, either free or at a highly subsidised price. But, with highly constrained budgets for social services, limited administrative capacity, and limited population outreach by public sector health facilities, this may not occur on a scale commensurate with the need. Even when the public sector is able to provide a basic service, public provider

systems may be inconvenient to use, insensitive and/or indifferent to the needs of some groups, and weak in logistics, resulting in frequent stock outs of drugs and commodities. As a result, a high level of unmet need can co-exist with a theoretically free and universally accessible public provider system.

2.1.15 A marketing response can address the deficiency of consumption (and adoption of the preferred behaviours associated with use of the commodity) from both the demand and supply side. Demand can be increased both by brand promotion, stressing the merits of the specific product for sale, and by generic promotion, stressing the benefits of behaviour change and identifying the type of products that can help. Supply can be improved by lowering the price, by multiplying the points of sale, and by modifying the product characteristics in accordance with consumer preferences for size, colour, unit quantity and packaging. Compared with free distribution, the advantage of charging a positive price at the point of retail sale is that wastage is reduced, since consumers who have paid are likely to use the product for its intended purpose, and accountability is improved throughout the distribution system.

2.1.16 Whether SM is appropriate in any particular case, and in what form, depends on a range of considerations, including certain intrinsic qualities of the good or service concerned. Some medical products require clinical skills to dispense or apply; these do not lend themselves to distribution via regular channels for consumer goods, but SM can be used to enhance distribution through clinical channels, as in the Pakistan Private Sector project distributing hormonal contraceptives. On the other hand, there is a considerable range of products of public health significance which do not need, for reasons of efficiency or safety, to be distributed through clinical services. Condoms, certain other contraceptives, ITNs, ORS, water treatment tablets, some vitamin supplements, belong in this category and are well suited to SM.

2.1.17 While social marketers profess expertise in behaviour change communications (BCC) so also do other agencies. In cases where the behaviour change sought is unrelated to consumption of a commodity, and in those cases where a product is involved but it is knowledge and motivation to consume that are in question rather than availability or affordability, then the alternative of supporting a purely BCC demand side intervention should be considered.

2.1.18 In almost all cases, DFID support to SM is alongside one or more public sector strengthening interventions (Burma is an exception). As such, SM assistance has been assessed and justified as an alternative to additional public sector donor support. In cases where the public sector system is well funded and staffed, where almost all of the population (and especially the poorest) have physical and financial access to quality health care, where logistics and accountability for supplies are good, and the government is keen to undertake the responsibility, then the case for SM becomes somewhat weaker - even though SM is widely practised to address behavioural-change issues in developed country environments (anti-tobacco programmes in the USA or the HIV/AIDS programme in Switzerland). Unfortunately, these conditions still seldom co-exist with the market situation typically seen before a condom or ITN SM project became active: a low volume of often imported product, priced to appeal to upper income consumers, available only from a few outlets in the bigger cities. As a result, the conditions justifying a donor financed SM operation - alongside public sector support - are frequently encountered.

### **How DFID perceives and uses social marketing**

2.1.19 DFID seemingly perceives social marketing in a highly variable light. Each adviser appears to have an idiosyncratic approach. There is no one settled policy, no policy manual or guidelines, and not even a focal point for information. In a single country, successive projects have been informed by radically different perspectives, while across countries, different priorities have generated projects with different

purposes and different outputs for a comparable aim. Whilst there is no evidence of serious adverse consequences, there are obvious risks in such a 'free for all' way of working.

2.1.20 Such variability could easily be a source of confusion and inefficiency. Alternatively, it may be seen as a commendably experimental approach to a new modality of health sector support. DFID has been prepared to take risks in extending the conventional boundaries of SM in a variety of ways, from the explicitly innovation encouraging Asian Regional Project, to quality assurance of condom manufacture in China. It has also taken on the vital role of funder of last resort, providing bridging finance when other donors have left established programmes with critical funding gaps (Nigeria, Pakistan, Uganda).

2.1.21 There are some basic observations that can be made of current practice. There are two main themes, control of HIV in both Africa and Asia, and control of malaria in Africa, with family planning now taking a subordinate place, though condom social marketing projects aimed at adolescents obviously have a dual impact. The SMO most frequently engaged by DFID is PSI, giving rise to concerns about its dominant position, see section 2.3. With the exception of a voluntary counselling and testing (VCT) project in Namibia, it appears that all the projects captured in our database are commodity projects (some have associated service delivery components), and this was certainly true of all 11 projects included in the country case studies. No projects dealing exclusively with behaviour change have been encountered.

### **How well does social marketing fit with DFID's wider goals?**

2.1.22 There appears to be a strong coincidence between the practice of social marketing and DFID's wider goals, as expressed in the 1997 and 2002 White Papers. In "Eliminating World Poverty" the first commitment is to support the international development targets (subsequently the Millennium Development Goals, MDGs) including promotion of human development, especially health and education. As later reformulated, 3 of the 8 MDGs refer to health, 5 of 18 targets, and 13 of 48 indicators, with two more targets and four more indicators referring to the health related areas of nutrition, water supply and sanitation. With the focus of social marketing projects around reproductive health and malaria control, 8 of the MDG health indicators are being directly addressed (those relating to <5 MR, IMR, MMR, HIV prevalence among 15-24 year olds, CPR, AIDS orphans, malaria prevalence and death rates, and % using effective malaria protection).

2.1.23 Beyond health objectives, there are other connotations of social marketing that resonate with DFID's highest level policy pronouncements. These include the concern for public-private partnerships (which is the essence of social as opposed to commercial marketing) and for efficient markets. The phrase "make markets work for poor people" might have been coined with social marketing in mind, even if the very poor may have to be excluded from the SM mandate.

2.1.24 If there is one lingering concern, it is whether social marketing really serves the very poor. This issue is addressed at greater length in section 3, but to anticipate a conclusion, it does not necessarily do so. However, if there is a defined purpose of serving the poorest, SM has the potential to do so, thanks to the great versatility of the technique and its capacity for creative alliances with other agents. The costs of serving the poor may be significantly higher, both from the need to apply a higher subsidy to the retail price, and because the promotional and distributional costs are likely to be higher, but provided there is third party willingness to pay, social marketing is able to deliver.

## 2.2 DFID Funding and Support for Social Marketing

2.2.1 DFID funding and support for social marketing is considered in detail in Annex 3. DFID first started funding SM projects in a small way in 1991. Annual commitment of bilateral funds to SM has increased steadily from around £5 million in 1996 to a peak of just under £30 million in 2001/2<sup>3</sup>. Total bilateral funds committed by DFID<sup>4</sup> to the identified 73 SM projects in relation to the period 1994 – 2008 amount to £216 million. A further (estimated) £12 million has been spent on SM through central funds (see sections 2.2.5 – 2.2.7). The average cost of a project is £2.97 million but the cost of individual projects ranges from £81,000 to £52.8 million whilst the term of SM projects ranges from 6 months to 8 years.

2.2.2 Almost three quarters of DFID funding has been committed to seven countries (Ghana, India, Kenya, Nigeria, Pakistan, Tanzania and Zimbabwe); over 33% of total funding has been committed to Nigeria.

2.2.3 The utilisation of DFID funds on SM projects by category<sup>5</sup> is shown in table 1 below. Nearly three quarters of total commitment has been allocated to projects addressing primarily HIV/AIDS and other STIs, including general education on STIs and family planning. Within that figure of 75%, 69% is focused on men and condoms, and 6% is focused on women [OCs and other female contraceptives] including commercial sex workers (a group that also involves condoms). Thus more than 70% of total commitment on SM has involved condom social marketing. The value of projects managed by different SMOs is shown in % terms in table 2. Over the period 1999 - 2003, SM constituted between 8 and 16% of total DFID health expenditures - or between 16 and 30% of expenditures on communicable disease control, health education, reproductive health, HIV/AIDS cross-cutting health and multi-sector response HIV/AIDS.

2.2.4 SM projects are funded primarily through bilateral funds, but there has been a limited amount of funding of projects that fall within SM through the Joint Funding Scheme (JFS), the Knowledge Fund (KF), the Seed corn Fund (see 2.2.5) and the Civil Society Challenge Fund. As an example, over the implementation period 1998 – 2004, PSI secured funding from these sources valued at just over £1.6 million. Of this, 18% was from the Seed corn Fund, 12% from the Knowledge Fund, 40% from the CSCF and 30% from the JFS. These projects will be subject to formal evaluation on their completion.

2.2.5 The Health and Population Department (HPD) provided funding for innovation and research through the Seed corn Fund, which evolved into the DFID Health and Population Scheme. This was established in 1995/6 as a mechanism by which innovative and high risk interventions to (a) improve sexual, maternal or reproductive health or (b) reduce suffering from communicable diseases should be tested in operational settings. Priority was given to projects that provided an operational response with the potential to make a direct and significant impact on these areas. Grants (up to £200,000 over two years) were given in the areas of sexual and reproductive health, family planning, social marketing and HIV/AIDS. Funding from this source has been in the region of £8 million and more than fifteen organisations benefited<sup>6</sup>.

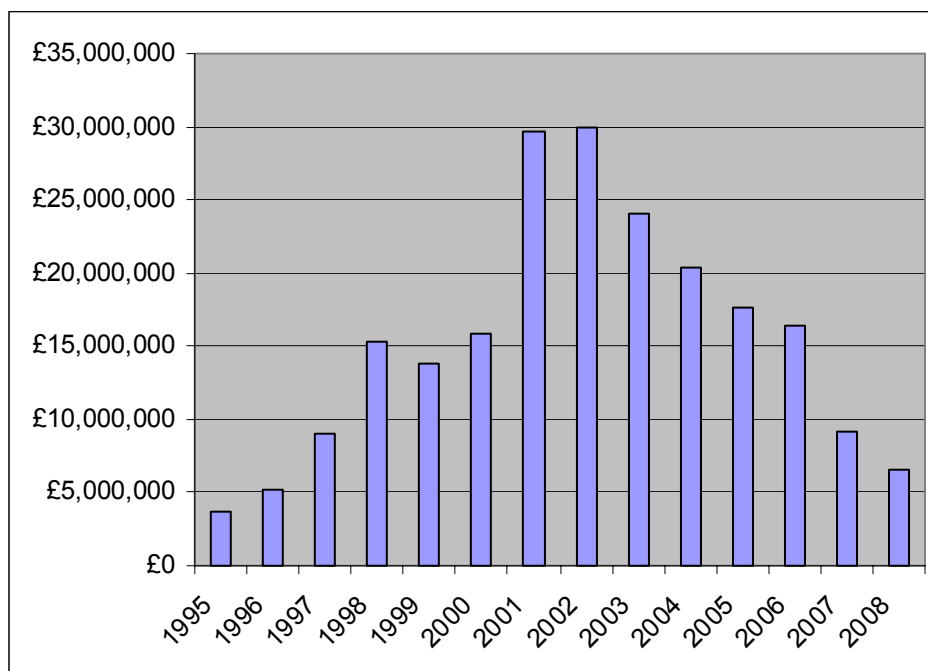
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<sup>3</sup> Annualised data not being available from DFID, annual spend has been calculated by dividing the original financial commitment by the number of project years (see Annex 3).

<sup>4</sup> As at 31 March 2003

<sup>5</sup> see Annex 3 for definitions

<sup>6</sup> Successful grantees included the London School of Tropical Medicine, Marie Stopes International, Family Care International, PSI, Population Concern, AVSC, IPPF, The Futures Group, Plan International, SCF, LSE, CARE, Cambridge University, University of Birmingham and the Naz Foundation.

**FIGURE 1. DFID BILATERAL<sup>7</sup> FUNDS COMMITTED TO SOCIAL MARKETING PROJECTS<sup>8</sup>****TABLE 1 UTILISATION OF DFID FUNDS ON SM PROJECTS BY CATEGORY**

Category of project	% of total funds
Projects focusing on HIV/AIDS, including general education on STIs and family planning.	69.0
Women focused-family planning projects, including work with CSWs	6.4
Malaria prevention projects	16.3
General reproductive health projects	7.9
Miscellaneous	0.4

**TABLE 2 ANALYSIS OF SM COMMITMENT BY SMO**

Projects managed by:	% of total DFID commitment on SM
PSI	77.6
Futures Group Europe	8.6
Local organisations	7.1
Other EU/international SMOs	5.4
Unallocated/not known	1.3

2.2.6 In addition, HPD allocated to PSI what were termed core grants for research and innovation to a total of £6 million over the period 1999/2000 – 2002/3. These funds were placed within PSI's discretionary fund, access to which was through bids from PSI country managers. Such bids had to focus on the most vulnerable segments of society with effective, cost-efficient and increasingly innovative health interventions. Funds were utilised in over 60 PSI projects. The way in which the funds were used, the lessons learned and how they were applied are summarised in Annex 3 Section 7 and

<sup>7</sup> "Bilateral" is used in this paper to refer to country programme funding.

<sup>8</sup> See also footnote 2 on the preceding page

provided in detail in Annex 3 Appendix 2. Reporting on the use of such funds was through annual reports.

2.2.7 In the absence of formal evaluation reports<sup>9</sup> on the utilisation of these central funds, it is not possible to comment in detail on the relevance or cost-effectiveness of the activities so funded. However, such information as is available suggests that there could be benefit from continued access for SMOs to such funding for innovation and research on a challenge fund basis. This can only be confirmed if/when the use of such funds is formally evaluated.

2.2.8 Analysis of project commitment by type of contract (accountable grant or contract) has proved difficult in the absence of MIS codes and other pointers.

2.2.9 The DFID funds committed to the 22 SM projects currently in operation amount to just over £140 million. Of this:

- 78.5% is committed to projects focused on HIV/AIDS (including general education on STIs and family planning), on women focused-family planning projects (including work with CSWs) and on general reproductive health (categories 1, 2 and 3 in table 1 above)
- 21.5% is committed to projects focused on malaria prevention.
- 39% is committed to Nigeria and a further 28% is committed to 3 other projects (Ghana [HIV/AIDS], Kenya [ITNs] and a global initiative for the promotion of safe motherhood).

2.2.10 In brief, DFID commitment to SM has grown steadily. Having peaked in 2001/2 the future trends are not clear since the information on future SM projects planned is not available. Over two thirds of DFID's total commitment has involved condom social marketing on and over three quarters of DFID's SM funding is being managed by PSI.

2.2.11 Considerable difficulty has been experienced in obtaining this information on financial commitment, which is scattered in different places and not easily accessible. The term "social marketing" is not included in the Project Header Sheet Guide. As a result the tables here (and presented in more detail in Annex 3) have been pieced together from many sources and crosschecked where possible. Despite these uncertainties, the trends are clear and increasing the accuracy of the data is unlikely to significantly alter the conclusions drawn.

### **2.3 Which are the main SMOs contracted by DFID?**

2.3.1 PSI is the SMO that has been most frequently engaged by DFID (table 2). PSI has traditionally operated the "own brand" model, although it is increasingly widening its repertoire of approaches.

2.3.2 DKT has similar policies, but restricts itself to countries with populations in excess of 50 million. DFID has co-financed a DKT project in Ethiopia, and has agreed to fund a project in Vietnam, which is not yet active. FGE currently has 3 projects, all of which (Nigeria ITNs, Pakistan Private Sector and China) were included in our case studies.

2.3.3 FGE has been traditionally associated with the manufacturer's model, though it has moved on to a "3<sup>rd</sup> generation" or "total market" approach (see 2.1.10). For further details of the SMOs and their finances, see Annex 6.

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<sup>9</sup> The PSI (JFS, CFCS, Knowledge Fund) projects have yet to be evaluated (due on completion); no evaluation reports were available relating to the HPD Health and Population Scheme; the contracts for the core grants for innovation and research agreed with PSI allowed for monitoring visits, if required, but in practice were not felt to be necessary.



### The “monopoly” position of PSI

2.3.4 Reference in the TORs to PSI as “more of a monopoly service provider” is unfortunate – since PSI clearly does not have the exclusive right to provide SM services to DFID. However, as noted in section 1.2, PSI is the dominant SMO, managing roughly three quarters of DFID-funded SM projects by value. On a world scale, PSI claims that it has just over one half of the total market. There seem to be two types of factors, independently of any intrinsic merits that PSI might have over competitors, which account for its prominence in the DFID portfolio. The first set include the good fit between PSI’s historic operations in poor countries deeply afflicted by the HIV/AIDS epidemic, where the urgency of intervention might be thought to justify the substantial subsidy associated with the NGO model espoused by PSI, and DFID’s wish to intervene against the epidemic in those countries. In addition, in some cases, as manager and owner of a brand already established in the market, PSI’s position may have appeared incontestable in the eyes of both DFID and potential competitors. Lastly, in some cases DFID was approached to take over funding that had previously been provided by USAID.

2.3.5 The second set of factors concerns the contractual process itself. Because PSI is an NGO, DFID is able to employ the accountable grant (AG) mechanism to channel funds to it. This route is quicker and obviates the requirement for a competitive tender. In at least one instance PSI was awarded a contract on these grounds of convenience, whilst FGE was denied the opportunity to compete because, as a for-profit entity, it could not be contracted except by a competitive process.

2.3.6 That this should occur reflects a shortcoming in DFID procedures rather than any indictment of PSI.

2.3.7 It is widely recognised that competition has many benefits. Such competition could be encouraged through changes to contractual procedures requiring all (or almost all) projects to be competitively tendered and changes in intellectual property rights (including brand ownership). These are outlined in section 4, and discussed at greater length in Annex 9.

### **Recommendation : All SM projects should be competitively tendered.**

2.3.8 Other responses might include experimenting with “unbundling” the package of services making up SM in any particular project – separating the independent development of (local) subcontractors and leaving the coordination of projects to international SMOs. This would not only make the contracts more contestable, but it would potentially bring new players into the market. There is no known experience with this practice within SM, and it does carry the possibility of increasing the administrative burden on DFID if the project is not well structured. Competition could also be increased through growing the market, and expanding the use of SM techniques into non-traditional areas where other organisations have experience or comparative advantage – in turn encouraging alliances between organisations which build on their relative strengths. Further, support for participation could be created through easing the financial burden on SMOs (likely to be a major disincentive to new, smaller entrants) or encouraging innovation and participation through the use of challenge funds<sup>10</sup>.

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<sup>10</sup> *Challenge Funds have been established by DFID mainly within the field of private sector development to encourage private companies to extend their activities into new developmentally beneficial areas. Companies present proposals to such funds and those competitively selected generally receive funding to supplement the company’s own investment. This ensures the commitment of the participating companies in a way which may not develop through simple competitive tendering. Challenge funds already exist in areas such as financial sector deepening and the development of business linkages ([www.challengefunds.org](http://www.challengefunds.org)). For example, the DFID Business Linkages Challenge Fund in Ghana is supporting the franchising of 600 chemical sellers (typically one-person private business operators who have acquired a licence from the Pharmacy Council (PC) of Ghana to sell/retail Over the Counter (OTC)*

2.3.9 Brand ownership in any particular market has presented a constraint to tendering, and reinforces perceptions of a 'monopoly position'. Clearly no donor would want to, or should have to, give up all the investments made in a brand if that donor changed the management of a project through competitive tender. USAID insists on brand transfer from one SMO to another. DFID recently built this requirement into new contracts. (See Annexes 2 and 9). The difficulty that may arise is in the situation where a brand has already been developed, probably with funding from another donor, and DFID then engages the SMO which owns the brand. In order to put all bidders on a comparable footing, DFID will need to make it a condition of entry to the tender process that the brand is transferable to the successful bidder, either in the current bidding round if one is taking place, or on next renewal.

**Recommendation: DFID should reach agreement with all SMOs that all brands can be transferred from one SMO to another irrespective of the donor that invested in them or the age of the programme. It would be advisable that all donors agreed to the same contractual arrangements with SMOs on branding issues.**

## 2.4 Innovation

2.4.1 Innovation in SM is about service delivery and expanding product portfolios, not about developing new technologies. Many SM programs are exploring innovative ways to harness their skills within markets. These include, but are not restricted to, expanding private sector delivery of FP services through 'franchised', trained providers (Pakistan), the establishment of VCT services, improvements to STI services both through public and private sector providers (in a range of countries and often, but not always linked to provision of STI kits) and adding a wide range of products to the more traditional FP and STI/HIV/AIDS commodities. These include pregnancy kits, clean delivery kits, ORS, multi-vitamins, iodised salt, safe water treatment and even snake boots and reflective belts. PSI in Zimbabwe has tested the distribution of commercial sector products through their distribution system. Society for Family Health (SFH) in South Africa is negotiating a for-profit contract to act as a marketing and sales agent for several condom manufacturers. Lessons learned from the use of DFID funds channelled through PSI's Discretionary Fund can be found in Annex 3.

2.4.2 The process by which SM programmes mature and develop appears to have been inadequately strategised in many countries. This includes exploring opportunities for innovation in the wider context of long-term SMO strategies in each country - paying due attention to long-term sustainability, appropriate exit strategies, better use of the strengths of each SMO, clearer analysis of total markets and the role of SM within each (including clear market segmentation strategies) and more collaborative arrangements with all other sectors. SM managers claim - with some but not full justification - that donor funding availability, donor preferences and funding cycles are restricting their capacity to plan long term and in the strategic development of their operations.

2.4.3 In addition to the innovation that has occurred spontaneously within bilaterally-funded projects, DFID has also directly funded innovation through the centrally managed funds noted in section 2.2 and in Annex 3 section 7. In most cases, DFID has responded to proposals for innovation and research. More than 15 organisations have benefited from such funding, utilised in more than 80 projects<sup>11</sup>. Apart from

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*drugs), where the "franchising" involves improved and more cost-effective procurement and the standardisation of drugs.*

<sup>11</sup> This includes the 60 PSI projects involved in the core funding for innovation and research together with those projects undertaken by the 15 other participating organisations. Whilst all of

reports from participating organisations on the work undertaken, and occasional project evaluations, there has been no formal evaluation of the utilisation of these funds. This, together with the lack of a central coordination function for SM within DFID and the fact that SM programmes are generally devised and managed by health advisers who are rarely able to see a programme through from concept to conclusion, suggests that the outputs of such innovation and research are not being adequately analysed, catalogued or disseminated within DFID or its partner organisations.

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these activities have been directly engaged in health and population issues not all have necessarily been involved directly in social marketing.

### **3. HEALTH AND POVERTY IMPACT AND VALUE FOR MONEY: THE EQUITY, EFFICIENCY AND EFFECTIVENESS OF SM**

#### **3.1 Who benefits? Meeting the needs of the poor and vulnerable**

3.1.1 While poverty reduction is the over-arching goal of development efforts, it is the supporting goals of improved health, particularly reproductive health and control of communicable disease, which are the goals of social marketing programmes. Correspondingly, SM target groups have typically been specified in terms of vulnerability to the disease, rather than in terms of socio-economic position, as shown in Table 3.

3.1.2 There is an explicit poverty focus in the logframes of only three of the eleven case study projects. However, in all programmes, even where “at-risk” groups rather than “the poor” were the primary focus, SMO managers were intent on reaching “low-income” at-risk groups as a sub-focus as far as they were able (even though few programmes have clearly articulated the ‘poverty line’ implicit when referring ‘low-income’ groups). In the Private Sector project (which used the manufacturer’s model to promote sales of oral and injectible contraceptives) in Pakistan, not only was the target group defined to exclude the poorest, but management was instructed at the outset not to attempt to serve the very poor, on the grounds that they would be better off obtaining free supplies from government. This was, prior to the 1997 White Paper, considered as a “reasonable remit” for SM programmes. In the China condom project, the target groups were identified as those critical to the containment of the concentrated HIV epidemic. The most pronounced attention to the poverty dimension was found in Tanzania where, although the primary targets were specified by age, there was both a poverty focused rider to the overall target (80% of children sleeping under bednets by 2007, including 70% in the lowest income quintile) and a pilot voucher scheme to assist the poor to purchase bednets. The Mozambique ITN project specifically targeted the poor through community-based distribution that accounted for some 40% of all sales. Research on the level of reach to low-income groups through retail (60% of sales) is pending.

3.1.3 The DFID supported SM projects are not dissimilar to SM programmes as a whole. In an article focused on the impact of SM on the poor and vulnerable, Price (Price 2001) states: “In targeting groups 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)”. This formulation is congruent with the frequent assumption in the SM literature that SM products are positioned between a commercial distribution system which typically serves a small niche of high income customers able to pay commercial prices, and a public distribution system which provides a product, often perceived as inferior, at a zero or heavily subsidised price to a large group of low income customers. Such a neat market segmentation appears not to coincide with the common observation that the public system may itself serve the poorest members of society less well than the more affluent, due to a combination of formal and informal price barriers, location of service delivery points, and social and cultural differences between providers and clients.

**TABLE 3 DESIGNATED BENEFICIARY GROUPS IN LOGFRAMES OF CASE STUDY PROJECTS**

<b>Project</b>	<b>Beneficiaries</b>	<b>Explicit Poverty Focus</b>	<b>Reach to targets tracked</b>
Mozambique ITN	Pregnant Women, <5s	No	No (pending)
Mozambique condoms	At risk for STI/HIV/AIDS	No	By outlet
Nigeria PSRHH	Poor and vulnerable to HIV/FP	Yes	Yes
Nigeria ITNs	Pregnant women, <5s	No	No
South Africa CSM	Youth 15-35, CSWs, truckers	No	By Outlet
BLNS STD/HIV	At risk youth, CSWs	No	No
Tanzania ITNs	<5s, especially in poorest quintile	Yes	Yes –5s, No poor
Kenya ITNs	All pregnant women, <5s, especially rural	No	Yes
Pakistan Hormonals	Urban and peri-urban, C and D+ income groups	No	No
Pakistan condoms	Urban, peri-urban low income	Yes	Yes
China condoms	High risk: CSWs, IDUs, MSM, PLWA	No	No

3.1.4 Where Case Study programmes were able to offer qualitative survey findings of the socio-economic profiles of their consumers (Nigeria and Mozambique condoms), both demonstrated that, of those consumers with access to them, low-income groups were reached at least in proportion to their demographic profile within the population at large. At the same time all other programmes that endeavoured to reach low-income groups had at least some qualitative data that indicated they were being reached.

3.1.5 Price adds two significant observations. The first is that because of a long tradition in social marketing, going back to its origins in family planning, of heavy if not exclusive reliance on aggregate sales data, there is little information available on the socio-economic or vulnerability status of clients. (For further discussion on this point, see section 6 and Annex 5). There are some exceptions to this general observation in the form of the recent research studies constituting the PSI evidence base, see Annex 5, which tend to confirm the initial expectation that, historically, SM reached the poorest less frequently. (Although the two Case Study programmes in this Review indicated that they did reach low-income groups they served through retail in proportion to their profile in the population at large.)

3.1.6 This does not mean that SM programmes necessarily fail to serve the poor, only that some of their benefits have accrued to non-poor groups as well. Any programme which reaches large numbers of people in sub-Saharan Africa or South Asia is certain to be reaching large numbers of poor people, though there may be a need to improve access for the very poorest through supplementary demand-side financing measures, such as voucher schemes or more creative forms of distribution through rural retail markets.

3.1.7 Price's second observation is that differences in the relative levels of consumption stratified by socio-economic status tend to diminish with the increasing

duration of a SM programme. This is partly explained by the fact that the more affluent can more readily access formal distribution systems that already exist in urban settings, while it takes time and effort to develop distribution networks in previously underserved rural and peri-urban areas. Similarly, the more affluent are more readily reached by mass communications, while the communication strategies more appropriate for low income consumers (low literacy materials, local language spots, community theatre, mobile video) take more time and resources to develop.

3.1.8 Whilst acknowledging that SM programmes historically have neither had the explicit purpose of reaching the poor, nor been designed to achieve that purpose, it is clearly the case that the potential exists for SM programmes to be designed to reach greater numbers of poor people. Given the evolving scope for SMOs to partner NGOs, CBOs and the public sector, there are clear opportunities for more effective targeting of the poor by a combination of promotional and pricing strategies (including, where appropriate, a proportion of free distribution). But, such an approach will entail increased unit costs (and, almost certainly higher programme subsidies), and will require greater management inputs. Moreover, a strong poverty focus is probably easier to attain with the NGO model; there may not be ready compatibility with the manufacturer's model - unless it is accepted that direct price subsidies are applied, and the promotional costs will be higher.

3.1.9 Inferences on use by vulnerability category are equally difficult to make with confidence - given the reliance on aggregate sales data for programme monitoring. More refined measures, including actual use of condoms or bednets by defined population categories, are needed to assess the distributional impact of SM programmes. Systematic monitoring tools that survey total populations of users and determine the precise profile of SM users, as against other users, are still the exception rather than the rule. In the 11 Case Studies reviewed only three (Mozambique condoms, Nigeria condoms and OC pills and Pakistan condoms) have clear, quantitative analyses of the socio-economic profiles of their consumers, although research was pending in the Southern Africa Regional and Mozambique ITN projects. The general lack of a convincing evidence base for reach, through retail, to target audiences established for programmes is put down to the high cost of undertaking such research and a lack of budget provision for it. This is a weak excuse (for both DFID and SMOs) in the light of cost estimates for undertaking appropriate consumer research in the range \$20,000-\$50,000 per round (for national studies). This level of expenditure at a baseline and repeat every two years should not strain most programme budgets. In smaller country programmes 'sentinel' forms of research could be conducted for as little as \$5,000 per round that would provide at least some quantitative indications of reach to a defined profile of socio-economic groups. Many SM programmes, and SMO operations, are funded by multiple donors. The sharing of evaluation costs across donors (and even across programmes where applicable) should be strengthened. See Section 6.

**Recommendation: All SM programmes should (i) explicitly identify the extent to which they address the needs of poor people; and (ii) justify their current and future 'poverty focus' in the context of national programme objectives and strategies to widen access to health services and products (including and especially to the poorest and most vulnerable). To this end, all SM programme plans and budgets should include provision for ongoing market research (both quantitative and qualitative) on the socio-economic profile of both programme and non-programme users including, access, affordability and knowledge, attitudes and behaviours. SMO donors should collaborate in sharing evaluation costs.**

### 3.2 Effectiveness in increasing availability of quality health products and services

3.2.1 The review team have taken the position that the effectiveness issue is not whether the underlying technology is effective, whether it be impregnated bednets as a protection against malaria or condom use as a protection against STI/HIV transmission, because this is amply reviewed in the technical literature, but whether social marketing makes an effective contribution to delivering these technologies to the population in need. (This is different from the treatment of effectiveness in the PSI evidence base, which does focus on whether the anticipated results are achieved, but not on the scale of the achievement, see Annex 5 and Appendix).

3.2.2 The contribution of SM programmes to national prevalence rates varies considerably across countries. Data on the impact of SM programmes are, generally, weak. Few countries have reliable data that clearly delineates use, by consumers, of products procured across all potential sources. Most programmes make some effort to estimate market share based on commodities distributed. Where, however, reliable research is available on usage, data derived from sales reports are found to be unreliable. The recent national study in South Africa, for example, notes that SM and commercial sector condom sales account for less than 4% of all condoms distributed whereas usage data suggest 16% of consumers purchase condoms from retail sources.

3.2.3 SMOs record the percentage share of SM sales although, in many countries, reliable data on actual commercial sector sales are inadequate often owing to 'grey markets' for products and leakage into the commercial sector from the public sector. These data can only be regarded as estimates. In 5 of the 6 condom projects used as case studies for the review, (excluding China where the project is tiny relative to the national population), market share was significant, and estimated as shown in Table 4.

3.2.4 The first row compares SM with all sources including the commercial and public sectors. The second row excludes public sector distribution.

3.2.5 The four ITN case study projects offer somewhat different insights. In Mozambique and Nigeria the projects cover 1 province and 4 states respectively, while the Tanzania and Kenya projects are nationwide in coverage<sup>12</sup>. Within the project areas, the Mozambique project has an 89% market share, but population coverage remains to be measured. In Tanzania, the project has 100% of the market for (re)treatment kits, but only around 10% of households have treated nets. In Kenya, SM nets account for 60-70% of the market, and very high rates of net use are reported in a 2002 user survey --78% for under fives, 53% of pregnant women. In Nigeria, there is no clear information either on market share or market penetration.

**TABLE 4 SOCIAL MARKETING CONTRIBUTION TO TOTAL CONDOM USE**

Country programme	Mozambique	South Africa	SADC	Nigeria	Pakistan
% share of total market	33%	2.5%	43-48%	86%	63%
% share of retail market	89%	66%	98%	81%	87%

3.2.6 The PSI evidence (Annex 5, Appendix) clearly demonstrates that SM works in the sense of delivering benefits of the type expected; what remains less clear in general is the scale on which SM works. Evidence from other sources (PSI and DKT

<sup>12</sup> Although in the case of Kenya, the ITN project focuses on areas where malaria is endemic. Highland and arid areas, where malaria is unlikely but an epidemic is possible following heavy rainfall or flooding, are kept under observation.

annual reports) suggests that, in global aggregate terms, the scale is considerable for contraception, HIV prevention, and selectively for malaria protection. Harvey (Harvey 1999) makes the case that SM of contraceptives has contributed substantially to the reduction of fertility in Bangladesh and some Indian states. The case studies suggest the relative magnitude of SM and other sources, but do not indicate how well the total market is served. Nevertheless, the reports do suggest that SM has achieved substantial penetration of the ITN market in Kenya, good penetration of the contraceptives market, at least in urban and peri-urban Pakistan, and significant contributions in Mozambique, Nigeria and the Southern African Region project.

### **3.3 The cost-effectiveness and efficiency of social marketing**

3.3.1 The cost-effectiveness of SM as a method of distribution requires comparison of both costs and outputs with alternative modes of delivering the product or behaviour change. The alternative which is always implicit is delivery of the same product by the public health provider system using its network of clinical services and facilities. In some case, NGOs and public sector community based distribution, and commercial distribution, are relevant alternatives. Unfortunately, there is very little good evidence of the relative costs of different modes of delivery.

3.3.2 Harvey (Harvey 1999) quotes a number of comparative figures in terms of cost per CYP. (However, his concept of cost is net cost to the donor, which is very different from total cost, regardless of the source of finance.) The limitations of the CYP as a measure of output are well rehearsed, but are not fatal flaws in the present context. Harvey has figures for cost per CYP for different modes of service delivery, but does not clearly define either the auspices (public, private for profit, private non-profit) or the product mix to which the figures relate. His figures show a considerable range, but the averages tend to be lower for social marketing than for clinic based services (with the exception of sterilisation, which is the least cost method) or community based distribution. The figures are: \$1.85 for sterilization; \$2.14 for social marketing; \$6.10 for clinic services excluding sterilization; CBD \$9.93, and for CBD plus clinics, \$14. Since clinic based services are usually associated with public providers and CBD with NGOs, there is an implicit comparison with other auspices and models of service delivery, and very often, with non-comparable target audiences. See also Annex 5 and Appendix.

3.3.3 In Pakistan, the large PSI programme is credited with (donor) costs per CYP of below \$5, whereas the estimated cost per CYP in the public system was \$15. However, this comparison, like many in the literature, is undermined by the non-comparability of the target populations. Whereas the SM project is largely limited to urban and peri-urban areas, the public system is assumed to reach rural populations as well, with necessarily higher costs of distribution and promotion. The only valid comparisons in cost effectiveness analysis are those when the alternatives under consideration are equivalent in all material respects; this essential condition is violated when unit cost comparisons are made between urban and rural, high risk and general populations, or products and services with different impact characteristics. This said, the large order of magnitude difference between SM and public sector distribution of contraceptives provides reasonable assurance that SM is much the more efficient.

3.3.4 Most SM programmes continue to record cost effectiveness based on the cost of provision of commodities per unit quantity. In family planning programmes, the data may be converted into a cost per CYP basis, and in other programmes into a cost per person-year of protection. For a discussion of the limitations of these measures, see Annex 5. PSI reports the net average cost per 100 condoms sold in 2001 across 42 countries at \$10.80; the net cost per female condom sold across 11 countries at \$2.23; OC pills per cycle across 21 countries at \$0.57; injectible contraceptives per vial across 14 countries at \$1.95; ORS per sachet across 10 countries at \$0.31; ITNs across 12 countries at \$6.35 and retreatment kits at \$3.79.



3.3.5 Even among otherwise similar SM programmes, there is considerable variation in unit costs associated with population size and maturity of the programme. Data for 1994 relating to programmes in existence for at least three years, expressed in costs per CYP, show a strong inverse relationship between population size and unit cost, from less than \$6 (India, Bangladesh, Nigeria, Pakistan, all with populations at or above 100 million) to more than \$28 (Haiti, Central African Republic and Guinea, all with populations less than 10 million) (Harvey, 1999). On the effect of programme maturity, the reported average cost per condom sold (Stallworthy and Meekers, 2000) across 23 SM programmes fell progressively over a seven year period - with an end cost of around one third of the starting cost.

3.3.6 Notwithstanding the limitations of the evidence base, the review team endorses the implicit view of donors that SM programmes broadly meet acceptable levels of cost effectiveness, reach and health impacts to target audiences even though the empirical data to support these assumptions can be much improved.

**Recommendation: DFID continue to expand its commitment to social marketing as a cost-effective means of delivering reproductive health and communicable disease interventions.**

### 3.4 Operational Efficiency

3.4.1 The above data are useful in defining the cost effectiveness of retail distribution. The Review Team, however, noted that most programmes were also distributing commodities through non-retail modalities – public sector, NGOs and through institutions – and that the pricing (and even commodities distributed) in these latter cases were quite different from the retail effort. Adding the distribution of free commodities through NGOs to total costs of commodities sold, for example, severely distorts cost effectiveness. Different forms of distribution should be separated out as separate cost centres.

3.4.2 At the same time, many SMOs are implementing behavioural change components that have nothing to do with selling a commodity (reducing sexual partners in HIV/AIDS programmes for example). Again, adding in the cost of these BCC efforts to the cost of commodities sold distorts cost effectiveness. Where significant BCC components are in place these need to be segregated out from commodities' selling costs, and reported as a separate cost centre. No programme was found to be doing this effectively.

**Recommendation: SM project design should build in much more explicit components to track the cost effectiveness of reaching defined target groups (by use); as appropriate, this will entail segregating out different forms of distribution, and BCC activities, into separate cost centres.**

## 4. THE ROLE OF THE PRIVATE SECTOR IN SOCIAL MARKETING

### 4.1 Introduction

4.1.1 The role of the private sector (PS) in health care, and its potential contribution to achieving the MDGs (health and poverty) is receiving growing attention. Social marketing can serve as an important dimension of this effort.

4.1.2 Up to 75% of SM project budgets are disbursed through the private sector – procured as products or services. The majority of SM products are distributed through the private sector and where SM products need clinical support this is frequently provided by the private healthcare sector. The quality, efficiency and effectiveness of these private sector providers – and the management of the relationship through approach to procurement, supervision, margins, incentives and structured relationships - significantly affects the impact and cost-effectiveness of SM interventions.

### 4.2 The private sector and its importance in addressing poverty

4.2.1 Annex 8 considers in detail the role and contribution of the private sector in SM, drawing on the lessons learned from the case studies. A distinction is made between the private sector (defined as privately-managed and financed risk-taking enterprises seeking a return on investment) and the NGO sector (organisations pursuing development agenda, largely financed through public funds).

4.2.2 The private sector - a continuum from informal petty traders to multinationals - is the primary source of innovation, wealth, employment and of government revenue from which social infrastructure is financed. DFID recognises<sup>13</sup> that a vibrant private sector contributes directly to reducing poverty by creating jobs and by marketing/adding value to primary products and indirectly by generating fiscal revenue from taxation (corporate and income) and from duties. In many developing countries the private sector is also the major provider of healthcare, an issue that DFID is currently and separately reviewing<sup>14</sup>.

### 4.3 The role of the private sector in social marketing

4.3.1 The case studies demonstrate that SM uses the private sector as a manager (normally an SMO), as a supplier of SM products (generally a manufacturer), as a subcontractor (providing physical [e.g. transport] and professional [e.g. medical or communications] services) or as a distributor. It provides the primary distribution mechanism through which SM products and services are delivered and the most extensive (retail) interface with the target clientele. The extent of private sector participation varies considerably with the focus of the project and the characteristics of the country concerned. Case study experience in China (pre-project, condoms could only be sold in pharmacies), Nigeria (with its fluid politics and poor infrastructure), South Africa (with a large manufacturing base and with 55% of retail sales through supermarkets) and Mozambique (minimal manufacturing activity, poor infrastructure and distribution systems) confirms that great caution has to be applied in transferring experience from one country to another or in making generalisations. Accordingly, whilst learning lessons from the case studies, Annex 8 also provides some templates for evaluating the role of the private sector at the project planning stage.

4.3.2 *The private sector as SM manager.* SM projects are generally managed by an SMO – which may be either an NGO or a private company. However, the distinction

<sup>13</sup> E.g. DFID (2000a) Private Sector Policy Department and Oxford Policy Management; Making markets work better for the poor.

<sup>14</sup> Support to DFID's strategy for strengthening public-private sector engagement for improved (health) service delivery to the poor in low and middle-income countries

between NGOs and private companies is becoming less well defined. The margins generated by private SMOs are low and generally reinvested in building capacity and there is no evidence that private SMOs are generically any more or less effective or efficient than NGOs. The professional experience and capacity of the SMO should be considered more important than its corporate status and **it is recommended that there be a single, consistent set of rules for the selection and appointment of SMOs, whether private or NGO. This is covered in detail in 4.7 and Annex 9.**

4.3.3 *The private sector as manufacturer.* Manufacturers relate to SM projects as suppliers, as competitors or as business partners. Local manufacturing is most likely with more basic products (such as bed nets), except where large markets (such as China, South Africa or Pakistan) may encourage local or foreign direct investment (FDI). Quality assurance can be an issue for local manufacturing. The Kenya ITN project identified deficiencies in the widely-used WHO specification for bed nets, resulting in products from both local and international manufacturers largely failing the inspection process. A new, comprehensive procurement specification is a welcome and unplanned output of this project.

4.3.4 Analysis of the advantages and disadvantages of using locally manufactured products remains generally unstructured. A first step at a structured approach can be found in Annex 8 (Appendix 1). Where project funds are spent in encouraging local manufacture, such investment needs to be linked to meeting targets on quality, volume and price. SM-linked manufacturers may also generate new investment and employment (e.g. up to US\$4million and 500 jobs for bed net production in Tanzania or US\$150,000 for OC manufacture in Pakistan).

4.3.5 *The private sector as service-provider.* The private sector is also contracted to provide a range of services – physical (warehousing and transport) and/or professional (research, communications or medical). These are generally and satisfactorily purchased on a competitive basis. The degree of choice of such services available to SMOs reflects the strength, and the degree of liberalisation, of the economy in which entrepreneurs have felt confident enough to invest – a direct effect of PSD policy on SM projects (see 4.3.4 above). Subcontracting pushes funds into the local economy, helps to build local business capacity and should be encouraged – although there are currently no specific incentives to do so.

**Recommendation: The tender process should require SMOs to demonstrate the nature and extent of partnerships and sub-contracting in their proposed management arrangements – identifying the benefit and, where relevant, the costs.**

4.3.6 *The private sector as distributor.* The majority of SM products are commodities where, given demand for an affordable product, retail distribution holds the key. All case studies demonstrate the importance of using private sector distribution systems to broaden access to essential health care.

#### **4.4 Market distortion and crowding out**

4.4.1 Crowding out of the private sector can occur when an SM subsidy causes unfair competition, resulting in a fall in sales of existing privately manufactured/distributed products of a similar nature. Genuine crowding out occurs when existing products of equivalent quality are already competitively priced – their sales falling because the subsidised product undercuts them on price. Crowding out is less easy to define when existing products are **not** competitively priced, enjoy oligopoly status/high margins or exhibit poor or inconsistent quality. The evidence on both “crowding out” and “crowding in” is sparse and inconclusive – although it appears to be more likely when price differentials are small and there is no natural market segmentation. However, there are instances where crowding out has occurred and the commercial market has

been distorted, as well as instances where SM has grown the market. This should receive attention as part of the planning process, when assessments of how SM projects can both enhance and distort the market, and the likely impact of SM interventions on the market, should be considered.

4.4.2 The Case Study countries revealed two potential (but unproven) instances of 'crowding out'. In South Africa the SM project had raised prices of its condom brand and launched a lower-priced condom brand. Durex had complained that the rise in the price of the original brand had 'eaten into' their market. However they could produce no concrete evidence for this and their sales had continued to climb. DFID's response to this was to cease support to the higher-priced brand. The SMO's attitude was that this brand was gaining them income to offset the higher subsidies on the cheaper brand. Also that commercial sector brands were benefiting greatly from the significant spend by many players on condom use for HIV prevention. Within Mozambique, where there was no real commercial sector activity at all, the SM brand was clearly developing a dominant ITN market position; this could, very likely, hinder the commercial sector from entering the market in future. DFID Mozambique has responded to this through developing a next phase of the programme that would segment the market for the SM brand, to develop a clear long-term 'exit strategy' and to tangibly support the introduction of commercial sector brands. The vision presented for the future was an SM model that would be supporting only domestic brands, as in Tanzania once the market had sufficiently developed.

4.4.3 Social marketing may also have a future role in "crowding out" of inferior quality products. In Pakistan, poor quality condoms (which would not meet ISO standards) were becoming available in some cities; some consideration was being given as to how SM might help in ensuring such products were priced out of the market.

4.4.4 A further area where SM programmes may be unwittingly distorting the market is in distribution systems. For example, PSI in Zimbabwe has tested the distribution of commercial sector products through their distribution system, whilst SFH in South Africa is negotiating a for-profit contract to act as a marketing and sales agent for several condom manufacturers. The potential "crowding out" implications of such activities do not appear to have been fully addressed.

4.4.5 The evidence of "crowding out" or "crowding in" from the case studies is summarised in table 5. In addition, Annex 8 (Table 3), provides a step by step approach to assessing the implications of SM interventions and how possible distortions (such as crowding out) might be addressed.

**Recommendation: The potential for such "crowding" in or "crowding out" should be evaluated during the planning of SM projects as part of the wider review of the role of the private sector (see 4.6.1).**

**TABLE 5 OCCURRENCE OF CROWDING IN AND CROWDING OUT IN THE CASE STUDY PROJECTS**

	China condoms	Kenya ITNs	Mozam. Condoms	Mozam ITNs	Nigeria condoms	Nigeria ITNs	P/stan Private Sector	Pakistan Condoms	Tza ITNs	S.Africa condom	S.S.A. Regional
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**CROWDING OUT**

Has the project significantly crowded out manufacturers and suppliers of commercial product and damaged the commercial market?	No	No	No	No	No	No	Yes	Yes	No	Yes	N/a
Has the project temporarily but reversibly crowded out manufacturers and suppliers of commercial product?	No	Yes	No	No	No	No	N/a	N/a	Yes	N/a	N/a

**CROWDING IN**

Has the project significantly increased the overall market for the product?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Have commercial manufacturers & suppliers maintained or increased their market share?	Maintain	Maintain	No local mnfrs	No local mnfrs	No local manfrs.	Yes	No	No	Yes	No	N/a

#### 4.5 Public private partnerships (PPP)

4.5.1 The term PPP has become devalued. From a private sector perspective, a partnership is a legal entity in which risks/liabilities and rewards are both defined and shared. It also implies a degree of equality between the partners. Such partnerships in SM are currently rare, since neither the donor nor the SMO has either the mandate or the resources to share the commercial risks of failure. There are exceptions, such as PSI's partnership with a Tanzanian company to manufacture Watergard, where PSI is using its own discretionary funds.

4.5.2 Governments in the developed world do enter into risk-sharing partnerships, although the results are mixed, and donors can help facilitate governments in the developing countries to do the same. The associations developed with the private sector under the current contractual arrangements – such as on condom quality in China (Futures) or on ITNs in Tanzania (PSI) - should be encouraged, ideally within a competitive environment, leveraging in each other's strengths and reducing transaction costs. In certain circumstances (Annex 8 section 5.4) "social franchising" has merits, although financial sustainability has yet to be demonstrated. The Sustainable Healthcare Enterprise Foundation in Kenya, commercially financed but with donor-funded TA from Management Sciences For Health (MSH), has financial sustainability as its primary focus. It anticipates breaking even when it has 300 franchisees and, if successful, should provide a valuable template for the future.

#### 4.6 Bringing together DFID interests in healthcare, SM and PSD.

4.6.1 Donors, including DFID, commit significant levels of funding to supporting private sector development (PSD). USAID has always laid particular emphasis on PSD in general as well as within its SM interventions, where utilisation of the private sector is a stated priority<sup>15</sup>. No similar link between PSD and SM is apparent within DFID. The extent to which PSD advisers have been included in SM project development varies greatly. DFID currently utilises SM almost exclusively within the health sector as one of a range of mechanisms for achieving health outcomes. It would be inappropriate to distort a health programme solely to achieve PSD objectives. However, given that such a large proportion of SM budgets are disbursed through the private sector, it is clear that there may be risks that SM projects can distort local markets. Moreover, DFID may be funding parallel initiatives to support the private sector in other ways to strengthen its direct contributions to economic development and addressing poverty. For these reasons, serious attention should be given during project planning, both to understanding and strengthening the contribution that the private sector can make, and to the impact of the project on the private sector. This should involve professionals with experience of PSD in general and SM in particular. Some useful relevant lessons from the Tanzania ITN project are noted in Annex 8 section 4.3.3.

**Recommendation. The potential role of, and impact on, the private sector should be evaluated during the planning of SM projects.**

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<sup>15</sup> For example through its CMS and Netmark projects.

#### 4.7 DFID Procurement Policy

4.7.1 SM activities funded by DFID are managed primarily by SMOs. SMOs have been appointed either through a tendering process (leading to a contract), or through an accountable grant agreement (AG). Only NGOs (such as PSI or MSI) are eligible for appointment through an AG<sup>16</sup> and such appointments are typically made without tendering. Private companies (such as Futures Group) must tender for SMO projects, with successful bidders (whether private company or NGO) being awarded contracts under more comprehensive arrangements that involve greater pre-financing costs. There are significant differences between AGs and contracts in terms of requirements from the SMO. In particular, an AG is simpler and less demanding on the SMO, with currently no requirement for DFID's Procurement Department to be advised when a project is awarded using an AG.

4.7.2 DFID also currently has no way of knowing whether its suppliers guarantee the basic rights of their workers (defined in auditable standards such as Social Accountability 8000<sup>17</sup>).

4.7.3 Of the current 22 SM projects, at least half involve AG arrangements<sup>18</sup>. Whilst there is no substantive evidence that the AG process has contributed to inappropriate choice of SMO or to ineffectiveness or inefficiencies, there are risks that this may happen. Annex 9 defines a number of uncertainties and concerns arising in the current SM contractual arrangements<sup>19</sup> on which the following recommendations are based.

**Recommendations: There be a single and consistent set of rules for selecting SMOs, regardless of corporate status, and that all SM projects be subject to tender;**

**Contracts be tightened in specific areas;**

**Procurement regulations be standardised for both contracts and AGs and more rigorous attention given to product specification and inspection;**

**For an initial trial period of one year, all suppliers to SM projects should be required to have a voluntary code of social accountability, which will extend developmental benefit beyond the SM target group.**

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<sup>16</sup> Although NGOs may also be subjected to tendering, in which case they may be appointed using a contract rather than an AG

<sup>17</sup> Social Accountability 8000 (or SA 8000) is a common auditable standard seeking to guarantee the basic rights of workers. It was established by the Council on Economic Priorities Accreditation Agency (CEPAA) in 1997 based on ILO conventions and related international human rights instruments. A code which has a similar ethos is the DFID-supported and, UK – based, Ethical Trading Initiative (ETI).

<sup>18</sup> 38% in value terms. However, 61% of the value of projects involving contracts is accounted for by the Nigerian CSM project.

<sup>19</sup> These include defining how earned income is used, the basis for making appointments, significant differences in how fees and income are calculated, the basis for project extensions, budgetary increases, contract amendments, issues relating to brand ownership and procurement procedures.

## **5. GOVERNANCE AND CAPACITY BUILDING ISSUES**

### **5.1 National ownership of the SM programmes?**

5.1.1 Despite the fact that the very first SM programme, the Nirodh condom programme in India, was very much a public enterprise, donors and SMOs have been the dominant players, and governments have frequently been left on the sidelines. Some governments remain openly resentful of what they see as the diversion of aid funds away from remedying the deficiencies of the public provider system, into the hands of foreign and private enterprises whose motives they suspect. Some SMOs are perfectly happy to keep governments at arm's length, in part because there has been an unhappy tradition of inappropriate government intervention in operational decisions on matters such as pricing, personnel selection and contracts. In one project, the SMO and its donor tacitly conspired to allow to lapse coordination mechanisms with government which were written into the project memorandum, precisely to escape such inappropriate interventions.

5.1.2 While there is undoubtedly scope for increasing government ownership of SM, the current situation is far from uniform, and some very positive instances of government involvement were encountered in the case studies. Although recipient government contributions to funding were rare (the one case study exception being some government funding for the female condom in South Africa, though other instances are known), and distribution networks usually bypassed the public sector, in most cases national policy documents recognised SM as a useful strategy and in some instances projects were directly requested by government (Tanzania ITNs). Although governments were generally regarded as having little influence over programme strategies (Pakistan, South Africa and Tanzania being exceptions) the overall ratings of government ownership by the review team were good in 4 instances, modest in another 4, and weak or poor in only 2<sup>20</sup>. These findings are summarised in table 6.

### **5.2 The role of host country governments in SM**

5.2.1 The role of governments is extremely variable, ranging from strained tolerance through active participation in planning, operational oversight and monitoring, to full commitment including a role in funding and contracting. It would obviously be advantageous, not least to their own citizens, if host country governments would take a wider view of their responsibilities and not identify so narrowly with the public provider system. If the SWAP approach could genuinely be sector wide, embracing private and NGO providers as well as the public system, then SM would be seen as a significant option for the use of national resources, whether originating with domestic or donor sources.

5.2.2 SMOs seem oblivious of the threat to traditional funding sources as donors move to SWAPs and general budget support, and very reluctant to embrace the notion of national governments as clients. The former may in part be due to the fact that, even where SWAPs have been launched, donors have allocated separate funds for NGOs.

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<sup>20</sup> The SADC Regional project is omitted from this analysis, because the situation varies by country.



**TABLE 6 EXTENT OF GOVERNMENT OWNERSHIP IN SM CASE STUDIES**

Country/ /Project	Is SM programme written into national strategies?	Was Govt involved in planning of the project?	Does Govt provide funding / commodities to programme?	Does programme sell through public sector?	Does Govt have any significant influence over programme strategies?	Overall assessment of Govt ownership of programme?
Mozambique ITNs	Yes – project has influenced national strategies	Yes	No	Yes	Modest	Active partner but modest in practice
Mozambique condoms	Yes	No	No	No DFID SM, other yes	No	Modest
Kenya ITNs	Yes	Not significantly – due to political constraints	No	Yes	Yes – at operational level, including all generic BCC	Limited at the political level but positive at the operational level and in the field
Tanzania ITNs	Yes	Yes	No	Not at significant levels	Yes	Good
South Africa condoms	Policy supportive of modest SM	Yes	Yes – female condoms	No	Yes	Modestly supportive of SM. Govt. contract with SMO for TA to govt. programme.
Nigeria Condoms, FP products	Yes – integrated national/ progr. evaln managed by SMO	Yes	No	Occasionally	Modest	Modest but growing
Nigeria ITNs	Yes		No	No	No	Modest
China Condoms	No	No	No	Occasionally	Modest	Weak
Pakistan Private Sector (hormonals)	Yes	No	No	No	Modest	Good
Pakistan condoms	Yes	No	No	No	Modest	Good

5.2.3 In Tanzania, and in Pakistan, government itself preferred to continue with direct DFID funding of the SM programme, rather than involve itself in contracting the SMO

directly. In the case of Pakistan, this appeared to be due to the government's perceived wish to avoid entering into what might turn out to be an "accountable grant type negotiation" with an SMO with international connections. A future in which governments positively embrace SM as an efficient means of achieving their public health objectives, and commit funding to programmes, may be a far remove from historic experience, but it should not be distant from the ambitions of SMOs and donors.

5.2.4 Even before that vision is realised, there is considerable scope for national governments to become more actively involved in planning and monitoring SM projects, a process in which both SMOs and donors need to take a positive facilitating role. This might include sensitisation/training courses for officials, and short-term attachments of key staff to SMO headquarters and national offices. In some instances, governments could help by removing obstacles to private sector development, including inappropriate tariffs on commodities.

**Recommendation: Donors and SMOs actively encourage the participation of national Governments in planning, monitoring and evaluating SM projects, and facilitate capacity building support to government officials in order to improve knowledge and expertise in the areas of SM policy analysis and programme management.**

### **5.3 The role of SM when the policy environment is poor**

5.3.1 SM, like other forms of NGO funding, has attractions for donors in situations where the government is not an acceptable or capable partner (or has completely collapsed) but there is a desire to bring essential services to the population. SM may also be relevant in post conflict situations where much reconstruction activity is already necessarily undertaken with little government involvement. SM may serve to distance donor from the regime in countries such as Burma . An additional element of distancing applies in this case, since the programme there draws on a regional fund, itself managed by an NGO rather than directly by DFID. KfW also proposes to use the device of a regional fund in the Caribbean/Latin American region, partly on account of the small size of individual countries, but also to escape the need for direct bilateral agreements. Similar strategies are applied by DFID to the Southern Africa regional condom programme.

### **5.4 Building local capacity**

5.4.1 Building local capacity is an element of sustainability and is a priority for DFID. Yet, this has not been given priority in the planning of SM projects. Building capacity can be interpreted in many ways including the capacity of government (policy, delivery, administration), of local SMOs, and of the SMO's local NGO or private sector partners. When building local capacity, there is often a conflict between the desire to get things done as quickly and cost-effectively as possible and the higher costs and slower pace of a planning and delivery system which builds local capacity. In general, the SMOs point to their efforts to train distributors, advertising and research agencies, and in some cases to devolve management responsibility to local affiliates with varying degrees of independence. On the other hand, the continuing tradition of expatriate management, and the attachment of SMOs to their donors rather than host governments, may be seen as factors inhibiting capacity development, certainly in the public sector. The need to

build local capacity is one more area that must be accorded priority in the planning of future SM projects.

**Recommendation: Building local capacity should be a component of all project designs. This should be reflected in the contractual obligations of SMOs. Where necessary and appropriate, other Technical Assistance channels should be used<sup>21</sup>.**

## 5.5 Sustainability and exit strategy issues

5.5.1 Although the term “sustainability” is frequently associated with having a clear exit mechanism associated with decline in/withdrawal of donor funding, sustainability can be interpreted in several ways, all of which have developmental value. These include:

- Generating income from user fees and reducing the level of subsidy
- Achieving a level of awareness of benefits associated with specific behaviour that such knowledge will be self-replicating
- Achieving a diversified approach to service delivery
- Mobilising/shifting towards the use of private resources
- Maintaining a specific level of market penetration or achieving a level of spontaneous demand for SM products
- Making more use of local staff and building local capacity
- Purchasing locally rather than from overseas
- SM being integrated into national policies and strategies

5.5.2 Any discussion on sustainability must therefore start with a definition of what element of sustainability is being discussed and agreement on the areas in which sustainability is sought. Whilst some factors will be more strongly determined by local economic and cultural realities, others may fall more within the control of the SMO managing the project. There are inevitable conflicts between targeting the poor and achieving financial sustainability and in many circumstances an exit strategy for one donor necessarily involves finding another source of grant financing, or splitting a project into sustainable and non-sustainable elements through increased targeting. In certain situations it may be concluded that an early exit by either donor or SMO is not feasible and long-term support has to be assured (ideally in a SWAP context by a mix of multiple donors and domestic resources, when social marketing is fully internalised as a national strategy).

5.5.3 Issues of sustainability (including definitions), and exit where appropriate, must be considered as a project is being planned and not when problems arise or when unexpected success leads to an unanticipated demand for additional funding. A summary of the exit strategy/status for each of the case study projects is shown in table 6. If sustainability is defined as full recovery of the cost of manufacture/distribution of the SM product, but excludes the cost of continuing IEC, then sustainability is likely in one instance (Tanzania ITNs), improbable in three instance (CSM in Pakistan, Mozambique

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<sup>21</sup> This might include TA provided in associations with SWAPs and Budget Support mechanisms, or project TA (e.g. to strengthen national policy and management capacities within Ministries of Health).

and Southern Africa regional programme) and possible but unlikely in the remaining seven instances. It is stressed that this is only one of the several possible definitions of sustainability

5.5.4 The review team perceive a need for a more strategic, long-term vision to be brought to bear on the planning and operations of SM projects. This vision should embrace the notion of total market development, and it should extend to multiple phases to accommodate evolution of population needs, market conditions and financial sources. Developing such a vision and negotiating a smooth transition between phases should be seen as a joint responsibility of donors, SMOs and host governments. The vision should address the issues of subsidy/pricing, procurement sources, distribution channels and BCC in a dynamic evolutionary context.

**Recommendation: Issues of sustainability (including definitions of sustainability), and exit where appropriate, must be considered as a project is being planned and not when problems arise or when unexpected success leads to an unanticipated demand for additional funding.**

**TABLE 7. SUSTAINABILITY AND EXIT STRATEGIES**

<b>Country/Status</b>	<b>Is there a clear strategy for DFID to make a responsible exit at the end of the contract period?</b>
Mozambique ITNs	Trial project completed. To be expanded through new 5-year programme under design that stresses the development of the total market, including sustainability through the commercial sector market.
Mozambique condoms	Sustainability unlikely due inherent poverty and poor infrastructure. However load shared by USAID and other donors.
Kenya ITNs	Sustainability actively considered but not as clear-cut as in Tanzania. Uncertainties remain over the impact of LLNs (higher initial cost may reduce affordability), commercial distribution of rural nets (higher subsidy on rural nets may encourage leakage) and role (if any) of local manufacturers. Continued subsidy will be needed for generic promotion/IEC.
Tanzania ITNs	Yes. All nets are already manufactured and distributed wholly commercially. Subsidies are applied to project management, insecticide kits and generic marketing/IEC. ITN/LLN market is expected to be fully commercial by 2007. Continued subsidy may be needed for generic promotion/IEC.
South Africa condoms	Complex due high level of free condoms from GoSA. Sales of Lovers Plus SM brand likely to be sustainable since brand now recovers all costs. Continued donor funding needed for Trust brand.
Nigeria Condoms & FP.	Very cost effective on basis of cost per condom sold and sustainability relates to high cost of promotion rather than distribution of condoms, now assured through DFID 7 year commitment. Joint funding with USAID on FP products.
Nigeria ITNs	Although sustainability achievable in principle, will be difficult since project focuses on four of the poorest states. Sustainability will depend upon achieving national, or part national, coverage.
China Condoms	Too early to assess since essentially a trial programme. Current product, based on subsidised manufacturer's model, unlikely to be sustainable and cheaper product being considered for Phase 2
Pakistan Private Sector (hormonals)	Project designed to achieve a target of retail prices covering all product and distribution costs by termination. However, concern about outcome if no continuing support for promotional costs and competition from other SMP projects. In practice, project likely to be extended.
Pakistan condom SM	The PM argues that the SMP position is not sustainable from sales income given low income of target group and urgency of responding to GOP fertility reduction targets.
Southern Africa Regional (condoms)	Continued donor support expected due high incidence of HIV/AIDS. High cost/condom expected to decline due to increased sales. Also linking with private sector bodies to reduce distribution costs.

## 5.6 Building capacity within DFID.

5.6.1 The overwhelming majority of current DFID expertise in social marketing is vested in country health advisers. The way in which these advisers perceive and plan SM programmes varies considerably. Despite the importance of SM (geographically and as a % of budget), there is currently no central focal point in DFID where options for the application of SM are considered, lessons learned, sources of expertise/information (professional and written) accumulated or institutional memory developed. DFID staff in the field could benefit extensively from an objective central point of reference in order to evaluate the relevance of SM to achieving a specific outcome; and if relevant to address the issues in developing a PM, evaluating bids etc. Without such a focal point the current lack of coherence (where SM initiatives may be driven by an SMO rather than by DFID, where academics might be contracted to plan SM projects which SMOs find difficult to deliver in the field, or where there are inconsistencies in the contractual terms under which SMOs operate) will continue. The review team see two options for developing DFID central SM capacity<sup>22</sup>.

5.6.2 There may be some benefit in learning from how DFID developed its approach to sustainable livelihoods which, like SM, is an approach to achieving outcomes. DFID established a sustainable livelihoods office with a full time professional in charge plus support staff. External people with experience in the sector were identified and became part of a SL resource group, which met quarterly. Workshops were held, lessons learned from other donors, a web site established and guidebooks written and a number of specialists were trained to assist DFID offices on a draw-down basis. After five years, having established policies, mechanisms and a network of participating institutions, the office was wound up. Given the wide variation in the potential application of, and techniques used by SM it is recommended that a similar approach be considered for SM. Critical to this will be to ensure that the findings, lessons learned and experience gained are retained within DFID's institutional memory.

5.6.3 Alternatively, DFID may wish to add this competence to the portfolio of one of its Resource Centres.

**Recommendation: DFID should increase its own capacity in social marketing, especially at the central level. Options for this include:**

- **borrowing from, and adapting, the "sustainable livelihoods office" approach to establish internal capacities (within DFID); and/or**
- **having SM as a defined competence in a Resource Centre.**

**DFID may wish to consider other options, in the light of the recent Policy Division re-organisation.**

**This capacity strengthening should embrace (a) the development of design, evaluation and OPR templates around which future SM projects should be planned (or present ones reviewed and revised), and (b) building a better database of people with relevant and pragmatic market experience who can assist in the planning and monitoring of future SM projects, including the development and implementation of total market approaches.**

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<sup>22</sup> This review was however conducted at the time of the DFID Policy Division reorganisation, This reorganisation may open the way to other options (and indeed appears likely to influence the relative strengths and weaknesses of alternative options).

## 6. MONITORING & EVALUATION

### 6.1 Monitoring

6.1.1 The "Guide for DFID on the Appraisal, Monitoring and Evaluation of SM Programmes" (Price, Pollard, 1998) is increasingly used as a 'standardised reference' for all DFID-funded SM programmes.

6.1.2 A number of monitoring weaknesses persist however - in particular those highlighted in section 3. The most serious weakness is the continuing failure to collect regular data on both SM and non-SM users. In part, this stems from a reluctance by donors to allocate adequate budgets to produce timely baseline and evaluation studies, owing to the 'high' costs involved (\$20 - 50,000 being quoted at baseline and every two years). On rough and ready estimates, obtaining this data should increase average project costs by no more than 2-3%<sup>23</sup>. Such additional costs would be amply justified, by the increased efficiency and effectiveness of current programmes, as well as assisting in the planning of future programmes. The sharing of both monitoring and evaluation costs across donors (where multiple-donors are funding SMO programmes) would provide added support to M&E costs.

6.1.3 In the 11 case studies, only three programmes had collected quantitative data on users and non-users, although most had some indications of use by low-income groups through qualitative research.

6.1.4 A second monitoring weakness concerns tracking affordability and pricing. For the former, some programmes (Tanzania ITNs, Nigeria condoms/FP, Mozambique condoms) have developed relatively sophisticated measures – tracking affordability through comparators set against a basket of consumer goods found affordable to low-income groups<sup>24</sup>. However this approach appears to be an exception rather than a rule. Many programmes do little - relying on more general surveys of affordability or, simply, on sales data to determine whether prices are affordable. (Nigeria ITNs, Southern Africa Regional condoms, China condoms, Mozambique ITNs).

6.1.5 Equally, few programme managers are making ongoing assessments as to whether prices can be adjusted, either upwards to gain increased cost recovery, or more generally, to reach to different defined target audiences. More complex tracking to assess the dynamic relationships between demand and pricing was also unconvincing in the Case Studies. As programmes mature, it could be expected that a growing willingness to pay would occur. One good example of this was found within the ITN market in Mozambique where even very poor consumers appeared willing to pay relatively substantial sums for an ITN (\$1.20 or more) once they understood its utility in malaria prevention, as they quickly grasped the 'value' of an ITN as against the cost of treatment. Such detailed tracking remains however the exception rather than the rule.

6.1.6 Otherwise, the SM programmes reviewed demonstrated sound monitoring of routine implementation activities.

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<sup>23</sup> Based on surveys costing \$20-50,000, carried out 3 times over a 5 year project, within a total project cost of \$7.5 million.

<sup>24</sup> Such an approach might be questioned on the grounds that it still fails to address the relative "wants" and "needs" between SM products and/or services, in comparison to the items in the basket of goods. More sophisticated measures should ideally be developed and adopted.

6.1.7 *Distribution and Sales* – SMOs have established sophisticated methodologies for monitoring distribution and sales, with stock movement records, sales outlets reports, retail audits, point-of-sale placement and, as appropriate, warehousing management and product quality assurance reporting systems all being employed.

6.1.8 *Retail audits* - many programmes are conducting regular retail audits - generating data on product availability in retail outlets. (Such audits are a potentially useful source of data on 'leakage' from public sector programmes - and as such can be shared more widely, including to other donors, than at present.)

6.1.9 *Media Placement and Promotional Spend* – monitoring and tracking of media and promotional activities through assurance systems of placement and scheduled activities appears robust.

6.1.10 *Tracking BCC Impact of Programmes* – Most SMOs engage in some level of routine monitoring of BCC impact on target audiences – including receipt of messages, understanding of messages and behavioural actions through a selection of focus group discussions; client profiling; and/or intercept surveys.

6.1.11 *Quality of Care* - Where programmes are providing a service (STI partner referral programmes, FP provision networks, VCT services) SM programmes appear to have established adequate mechanisms for tracking quality of service issues.

6.1.12 *Unit Costs* – Unit costs are still generally tracked by monitoring the ratio of products sold to total costs; such an approach is insufficiently detailed to allow assessments of the efficiency of different SM programme components.

6.1.13 *Financial accounting procedures* - SM programmes typically have robust and effective accounting procedures in place. (This is confirmed by a number of OPRs). However, programmes tend to operate on a cash basis and rarely allocate and depreciate capital costs over time. This may distort the high front-end cost of programmes (particularly those establishing distribution systems that require vehicles or pre-paid rentals). Amortising these costs would give a fairer picture of relative cost effectiveness over time.

6.1.14 *Market Share and Reach* – most programmes are able to produce data on market share based on estimates of sales (or distribution) of products through the commercial, public and SM sectors. These data can be regarded as illustrative only. (Actual use data taken from secondary sources (DHS surveys or more formal commercial-sector surveys) are often unreliable). If reliable secondary data on usage are not available from other sources, it is essential that SM programmes fill this gap by funding the required studies (see baseline and evaluation below).

**Recommendation: Monitoring of SM programmes should be strengthened to assess trends in use and non-use by different population groups, in particular the poorest. In addition, monitoring should be improved to track affordability, prices, unit costs, and market share and reach. In all of the above cases, the potential benefits should outweigh the increased management and M&E costs.**



## 6.2 Evaluation

6.2.1 *Evaluation at Goal Level:* SM Logframe Goal Statements generally reflect broader national health and population Goals and, sometimes but not always, the MDGs. Specific health impacts, directly relevant to the particular SM programme focus, are however not always indicated in the Goal formulation.

6.2.2 Few programmes are attempting rigorous evaluation at the goal level. This applies especially to assessing the differential health impact for different population groups. PSI and DKT are beginning to present illustrative measures of health impacts of SM programmes (but using methodologies questioned in this review - see Annex 5).

6.2.3 *Evaluation at Purpose Level.* Purpose Statements generally reflect desired impacts on use and behaviours in specific target groups. Again however, the associated indicators and targets are often imprecisely expressed, with Goal and Purpose baseline estimates either frequently not included (as they are unavailable), or simply guesstimated. If baseline data are available (or when these become available), target setting may be either excessively over-ambitious, or baselines are set so high that no real improvement can be expected. In these cases, the logframes have had to be significantly revised - often very late in the programme cycle (and sometimes so late as to make it difficult to assess real impacts). Some Logframes have been produced before focus group discussions are undertaken to define the precise behaviours changes that the programme will seek to achieve. Again, it was found necessary to revise the logframes after some time had elapsed. As a result, not a few programmes are operating with out-dated log frames, making OPRs complex difficult and less than fully productive.

**Recommendation: The process for agreement and approval of revisions to logframes, in many programmes, needs to be improved. BCC components, within logframes, need to be more fluid and subject to a more systematic and regular review.**

6.2.4 *BCC Objectives and Components:* Some SM programmes are addressing issues of health-seeking behaviours through BCC components. These require different forms of Purpose statement, and indicators that go beyond the sales of specific products or services. Sometimes there is a conflict with sales aims - for example where the aim is to reduce numbers of partners to slow the spread of HIV/AIDS. However, many SM programmes continue to evaluate themselves based on the cost of commodities sold. No programme could be identified by this review that had established convincing evaluation mechanisms for such BCC objectives and components.

**Recommendation: It is essential that stronger evaluation methodologies are put in place to determine the behavioural change impact achieved by SM BCC components. The effectiveness and efficiency of the specific behavioural-change approaches should also be more directly monitored.**

6.2.5 *Evaluation at the Output Level:* There are two areas where additional evaluation at the output level would be desirable. First, SM programmes are increasingly engaging in collaborative distribution arrangements with NGOs and CBOs, the public sector and large firms. These different forms of distribution may be included in logframes as activities, but no effort is being made to evaluate the relative cost effectiveness of each approach. SM programmes need to maintain accounting systems which allocate the

costs of different forms of distribution to separate cost centres, and evaluate the cost per commodity distributed for each form of distribution.

6.2.6 Second, most logframes include issues of 'programme ownership' and collaboration with the public sector as Outputs. The indicators employed here are often more qualitative rather than purely quantitative; as result, assessments of the value of this collaboration are sometimes rather shallow. This is partly due to the public nature of logframes and the wish to avoid 'controversial' topics within them. All the same it is evident that many SM programmes are creating good working relationships with the public sector, and these deserve to be more fully documented.

**Recommendation: The evolving relationships between SMOs, governments and the public sector should be reviewed and reported on. This should either be via reporting against logframe outputs, or, where this is not appropriate, through documenting separate agreements. This should be done at the time of OPRs (if necessary in a confidential annex).**

### **6.3 Output to Purpose Reviews (OPRs)**

6.3.1 The Review Team analysed some OPR activities within the 11 Case Studies. In general, SM project OPRs are being periodically conducted.

6.3.2 SM OPRs are generally being executed as stipulated in the original project memoranda and logframes. Rarely do OPR TORS specifically call for a thorough review of the original design of the programme. OPRs should, routinely, include this. OPRs should also include a specific component that reviews the long-term goals of the SM programme (even beyond the funding period) and its role within the context of its specific environment.

6.3.3 OPRs do not seem to be routinely shared across countries. Most SMOs have some form of sharing of lessons learned across their country operations. The routine sharing of OPRs across all countries (and DFID Country Advisers) should be put in place.

**Recommendation: DFID should ensure that OPR terms of reference include a specific component to review the original project design and strategies. This would include assessing relevance of the design and strategies within the context of the evolving 'market environment'. (As necessary, OPRs would then recommend design and strategy changes.) OPRs should also review the long-term corporate goals of the implementing SMO (and again recommend changes as necessary). DFID should encourage the routine sharing of OPR findings across country advisers.**

## 7. THE FUTURE OF SOCIAL MARKETING: TOWARDS A TOTAL MARKET APPROACH

### 7.1 The Total Market Approach (TMA)

7.1.1 This review concludes that the development and implementation of a “total market” approach, in which all interested parties operate in an integrated way, will be the best way of taking forward the evolution of SM programmes<sup>25</sup>.

7.1.2 Such an approach should remedy several weaknesses identified in the review – including, in particular, the fact that SM programmes continue, all too frequently, to operate in complete or partial isolation from the wider “total market” around them (public sector supply, NGO provision, and the commercial sector). It will also allow some key issues to be more rigorously and appropriately addressed: including key equity concerns (and market segmentation); the long-term role of SM programming and ‘exit’ strategies; pricing and cost recovery strategies; leakage from one sector to the other; and the potential for greater commercial sector involvement whether through explicit ‘manufacturers’ models’, or the handing over of SM brands and/or other functions of marketing and promotions.

7.1.3 Attempts to develop a total market approach are already underway. The USAID Commercial Market Strategies Project (CMS) is testing, in Northern India, a more comprehensive strategy, aimed at segmenting the market in the most efficient way, whilst ensuring that those presently without access are reached. This initiative will also implement wholly integrated ‘demand generation’ components. An overall ‘management’ function has been established – with the public sector, NGOs, SMOs and the commercial sector, all agreeing on the role each will play. The State Family Planning Board (BKKBN) in Indonesia manages a comprehensive programme designed to move significant segments of the population from the public sector to the commercial / private sectors within its “Building Self-Reliant Families” initiative.

7.1.4 Movement in a ‘total market’ direction is also seen in a number of DFID programmes. DFID Mozambique is designing a next phase of its ITN project to support and ‘prime’ the total market whether public, NGO, SM or commercial. PSI in South Africa is actively supporting the large-scale public-sector distribution of condoms through a DFID funded TA contract with the Department of Health, whilst at the same time continuing to manage its own SM brands, and negotiating with two new domestic manufacturers of condoms to act as their marketing and distribution agents, for profit.

7.1.5 The remaining sections of this review are intended as a contribution to the considerable further development work that will be required in order to develop and apply this approach. They highlight some (but not all) of the issues that will have to be addressed in this process.

**Recommendation: DFID (and other donors) should actively explore options to integrate the interests and activities of all parties operating in the market. This might be implemented by either extending existing SMO operations, or hiring an SMO to manage these ‘total market’ approaches (including any SM programme within that country, where appropriate).**

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<sup>25</sup> The Review team has used the term TMA here as a matter of convenience. It is expected that a refinement to this terminology will emerge, such as “Integrated Market Approaches”.

## 7.2 SM Objectives

7.2.1 Gaining agreement on the social marketing contributions towards the attainment of national equity objectives will be an integral element of a total market approach. The extent to which SM programmes should be poverty focused - within any given country and for any specific product/ or health service activity - would be determined in the light of, and alongside, the poverty and equity objectives for public sector and NGO programmes.

7.2.2 Moreover, a 'total market' approach will the trade-offs (in specifying SM objectives) to be evaluated between :

- A broad market focus (and equity of provision within this);
- fulfilling 'latent' demand through commercial-sector approaches;
- extending the remit of the SMO into the arena of complex familial, social and behavioural-change components in the creation of new users at the community level;
- the extent of any SM remit in 'priming' and opening up markets (whether commercial sector markets or franchises/networks of provider services) for eventual sustainability through the commercial / private sectors;
- the role of SM as a resource to the public sector to improve its own services and/or to support the development of explicit strategies to move consumers to the commercial / private sectors and thus more efficiently segment the market; and
- the role of SM in supporting any cost recovery and sustainability strategies within the public sector and NGOs.

## 7.3 SM Strategy Development

7.3.1 The application of a total market approach will influence the development of SM strategies in a range of ways.

### **Movement towards targeted selling beyond retail shops**

7.3.2 In order to target better low-income groups and those at risk (particularly for HIV/AIDS), SM programmes are progressively moving away from a reliance on retail selling through the commercial sector. Selling via NGOs and even the public sector is increasing (44% of condom sales in Lesotho are not through retail shops, 40% of Mozambique ITNs are sold through community-based activities and health centres), along with workplace sales and distribution through, for example, the military. Commodities may even be provided at no cost or at prices below standard SM pricing.

7.3.3 A number of constraining factors limit the wider adoption of these approaches. Many NGOs cannot operate effective mechanisms for on-selling and re-purchase; these often request free commodities. SM programmes are often unwilling to provide branded condoms, and supply 'generic' condoms instead. Tracking usage of these condoms by SMO managers can prove difficult and expensive (experience in Nigeria). To try to resolve this problem, either the SMO has sub-contracted a 'management NGO' (Nigeria), or the SMO and the 'managing NGO' are placed under a separate management (Mozambique ITNs and UNICEF). These approaches relieve the SMO of a significant management burden but do not, necessarily, resolve the intrinsic problems of developing, and sustaining, widespread community-based distribution (and BCC activities) nor whether they are better managed through SMO contracts or as separate programmes. These issues need to be much better articulated at programme design stages.

7.3.4 If SMOs are to gain significant coverage through NGO (or public sector distribution), then better strategic analysis and prioritisation will be essential. There is good experience to learn from in Nigeria (as a 'large country' environment), and countries such as Lesotho and Swaziland as small-country environments.

7.3.5 In pursuing such strategies, SMOs and donors must recognise that the costs and cost structures for these distribution mechanisms will differ from those of general retail selling through shops. Setting total sales (through all distribution mechanisms) against total costs will give a distorted picture of cost-effectiveness.

**Recommendation: SMOs should explore the option of selling through (non-retail) distribution systems, and/or adding community-based distribution to the SM portfolio. This will typically require alternative funding and management arrangements. SMOs with significant sales through outlets other than retail shops should separate out the costs of each, as cost centres, and report effectiveness separately.**

#### **Increased Opportunities for Social Franchising**

7.3.6 SMOs are starting to employ alternative approaches to improve service delivery networks through both the private and public sectors. These include: establishing 'franchise' networks for FP service delivery (Pakistan); the management of VCT centres either in-house or through collaboration with the public or private sectors; and improvements to STI services in the public sector. These are innovative extensions of marketing processes to improve service delivery in 'clinical' environments.

7.3.7 Whilst these approaches are important developments, they require skills and management capacities which may not be currently available in some SMOs. SM programmes introducing such strategies should therefore take care to avoid overloading management capacities.

7.3.8 Franchising options are also likely to have long-term sustainability implications - different to those in other SM programmes. Care will need to be taken to avoid such approaches creating unsustainable SM activities without clear exit strategies.

**Recommendation : More focus is needed on the development of models involving "social franchising" (including their sustainability)**

#### **Demand Generation and BCC approaches**

7.3.9 Most SM programmes currently employ mass media, and other mass communication forms of demand generation. This will continue as a core BCC strategy under a total market approach. However, given the limitations of these approaches (in that they create demand only from those who are pre-disposed towards health-seeking behavioural change (early adopters)), one-on-one community-based BCC approaches will also be required to reach the "more difficult" consumers. The division of responsibilities in the area of community based BCC efforts will therefore be a key design issue in developing a total market approach.

**Recommendation: A total market approach should increase the emphasis on community-based forms of BCC, leading to better targeting of SM products and services and the creation of new users. The management of these BCC components needs to be clear and robust.**

## 7.4 SM Internal Programme Management

7.4.1 The management of a total market approach will require several shifts in current SM programme management practice. In particular, SM management will be a part of the wider national programme structure, with SM management responsibilities defined in part alongside the management roles and functions of all sectors – the public sector, NGOs, and the commercial market. SM programmes will have to address a number of current management weaknesses, which include

- The difficulties frequently encountered in managing community-based BCC activities on a large-scale (although many are doing so quite successfully on a small scale).
- Gaining a much deeper understanding of the cost-effectiveness and efficiency of different dimensions of SM work, through establishing cost centres for key SM components (e.g. BCC components), thereby enabling both component costs and outputs to be more closely monitored and evaluated.

## 7.5 National ownership and Oversight

7.5.1 Implementing a “total market” approach will necessitate even wider national ownership of SM programmes; it is encouraging to find this is already occurring in a number of SM programmes<sup>26</sup>.

7.5.2 National health policies should become more explicit in recognising the importance of ‘marketing’ analyses and inputs for both public and private sector commodities and services (covering both the supply and demand sides). Such analyses should lead to national market segmentation strategies based on clearly defined assessments of the total market, and the market forces at work within this. Other potential issues which might be given greater prominence in health policies (as result of adopting a total market approach) are set out below<sup>27</sup>.

7.5.3 A second key policy issue will be to map out a clear division of roles and responsibilities. This will include distinguishing what might be deemed as essential government functions (e.g. regulation, some degree of market monitoring) from the areas where markets should be left to operate free of outside intervention.

7.5.4 Health policies should include a formal acknowledgement of the “public health interest” of both the SM and commercial sectors.

<sup>26</sup> These include: India (supply of commodities and promotional cost to all SMOs); Indonesia (national market-segmentation approaches and funding); Botswana (the primary funding agency for the SMO); and Namibia (the establishment of a new SMO with MSI). The Southern Africa Regional programme is managed by SADC, as are DFID disbursements. The DoH in South Africa contracts the SMO (SFH) to undertake promotional activities and to support (with DFID funding) the development of free distribution of its condom.

<sup>27</sup> These areas include:

- Implementing specific strategies designed to move public sector consumers to the private commercial sector (targeting public sector services to those unreachable by other sectors).
- Expanding the selling of commercial sector products through public sector outlets
- Providing active support to the targeted expansion of social marketing (SM) interventions
- Promoting method mix strategies conducive to commercial sector participation (short-term methods)
- Promoting the availability of services and commodities through all sectors so as to create demand on all sectors, to give consumer choice
- Promoting BCC activities to create new users across all sectors
- Working with the SM and private / commercial sectors to provide joint services through public sector facilities

7.5.5 Health sector financing policies typically pay inadequate attention to social marketing. With a total market approach, pricing and cost recovery strategies will be one obvious area of mutual interest. For the future, the growing interest in demand side financing (including the potential use of vouchers and other social transfers) will have implications for SM programmes - as would any increased application of health insurance schemes.

7.5.6 A 'total market' approach will require stronger management systems, capacities and expertise in respective Ministries, SMOs, NGOs, the commercial sector (where appropriate) and donors. As this review has shown, such management capacity building is starting from a relatively low base. This management function necessarily goes beyond the traditional co-ordination function and will require a mandate to oversee the implementation of agreed strategies and activities.

**Recommendation: Effective government 'ownership' of SM programmes (and the implicit and explicit 'market segmentation' strategies within these) will be a pre-requisite of any "total market approach".**

**Recommendation: DFID should consider the wider application of market methodologies and analyses (building on SM experience) as part of its contribution to national health policy and programme development.**

## **7.6 Implications for SM Organisations**

7.6.1 Application of a TMA will require SM organisations to operate less independently and in closer co-operation with other interested parties in the public, NGO, commercial and private sectors - where appropriate handing over some SM activities to others, and exploring more innovative partnerships with all other sectors (public, NGO and commercial / private sectors). SMOs play a key role in the delivery of commodities and services (and the creation of demand for them) through their own in-house resources. The kinds of changes that are proposed must take into account the interests and concerns of SMOs - including their need for motivation, a wish to participate on a medium/long term basis, the need to be professionally and financially strong, and the need to sustain their own operations etc. This will have to be balanced with more explicit opportunities for building up the capacity of other organisations (both public and private) that can provide access to targeted clientele - and, through the use of these additional financial, managerial and knowledge-based resources, help to build innovative models of sustainability.

## **7.7 Implications for Donors**

7.7.1 Present SM programme design and development appears to be too highly influenced by the personal backgrounds and preferences of individual DFID country advisers (and SMO country managers), and by donor preferences and funding cycles. Such 'ad hocism' needs to be addressed if TMAs are to be pursued systematically.

7.7.2 Greater co-operation is needed amongst donors, and between donors and governments, to agree objectives and SM strategies. There is considerable immediate scope for this in that two of the main SM donors, KFW and USAID, have both indicated (through their very helpful comments on drafts of this report) that they see this exercise, and the recommendations, as having implications for themselves as well as for DFID.

7.7.3 Donors also need to work with SMOs to understand each other better (in terms of objectives, resources, constraints and opportunities) - generically as well as specifically

in relation to sectors and countries. This is necessary to build a greater sense of partnership, whilst recognising that SMOs need to compete for specific projects in future.

7.7.4 DFID (and other donors) need to explore practical ways to increase the number of organisations interested in, and capable of, managing SM projects. The USAID NetMark project was won by the Academy for Educational Development, an SMO with significant experience in the application of SM (and BCC) within the MCH field. DFID might explore the potential for new SMOs, which may spring from similar BCC backgrounds.

7.7.5 The application of a total market approach is unlikely to have major implications for the choice of aid instruments. In principle, private sector approaches (and, by implication, SM programmes) can be financed and supported via SWAps, budget support in various forms, and projects. In practice, depending on the context, some aid instruments may be preferred over others<sup>28</sup>.

7.7.6 In addition, both USAID and KFW have rightly noted that some of the recommendations (e.g. on contracting and brand ownership) may - if implemented directly by DFID - have wider ramifications, affecting their own future activities.

7.7.7 More positively, there is scope for sharing of costs (by donors) - especially in relation to monitoring and evaluation.

**Recommendation: The wide range of recommendations in this review will have implications for other donors (especially KFW and USAID, and perhaps UNFPA) as well as DFID.**

**DFID should respond positively to the expressions of interest by KFW and USAID to consider potential future joint or mutually agreed actions in the light of this review. One possibility (amongst others), will be to arrange a Forum of donors and SMOs to thoroughly explore these recommendations.**

**DFID should extend its portfolio of technical support documentation (beyond the present "Guide to Monitoring & Evaluation") to include guidance to Country Advisers in programme design, OPR management and establishing sustainable SMO programmes and organisations.**

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<sup>28</sup> A budget support option was considered in 2002 for the next phase of the Pakistan FP SM programme. However, the Ministry of Population Welfare indicated a strong preference for continuing with project funding.



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**ANNEX 1:****Terms Of Reference - Review Of DFID's Approach To Social Marketing****1. Background**

1 Social marketing is an important way to deliver needed health products and services to lower-income people in developing countries. Social marketing combines education to motivate healthy behaviour with the subsidised distribution and marketing of health products and services through the private sector. Effective communications, through brand advertising and educational campaigns, are a key component of the approach. As the retail price is mostly lower than the manufacturing cost, donor contributions are an important element of the social marketing process.

2 A number of social marketing initiatives function in countries which are implementing a sector-wide approach (SWAP) to health. In a SWAP environment, or where a country is moving towards a SWAP, there are a number of specific issues to be considered as social marketing programmes are planned for and implemented. These include the need to fit closely with national health strategies, the importance of coordinating closely with other related activities, consideration of financial flows, and the nature of the partnership between the public and private sectors. In countries where a SWAP approach is not appropriate, for example where the policy environment is not favourable, social marketing remains a valuable tool in contributing to the achievement of the MDGs and DFID country level PSA/SDA targets

**1.1 Models**

1 There are two recognised models of social marketing programmes. However, approaches to social marketing need to be tailored to respond to often considerable variations in markets, both within and between countries. It is accepted that current situations and future approaches will continue to display such differences.

2 The typical and traditional product social marketing programme involves developing a brand; establishing an in-country management unit; and selling and promoting through the local infrastructure. The "manufacturer's model" of social marketing involves giving grants to commercial manufacturers and their distribution agents, in return for which the product is advertised more than would otherwise be the case and/or the retail price is reduced. Risks include the possibility that when any subsidies end, promotion declines, retail prices rise and sales may drop.

3 Social marketing has had a role in introducing innovation and raising awareness and adoption of new products and ideas. This has included female condoms and the social marketing of services. Reproductive health services and HIV counselling and testing, for example, are in the early stages of development. The approach involves developing accreditation, training and quality assurance schemes with private providers, on the assumption that increased demand will result with better outreach and marketing of services that are of perceived high quality by consumers.

## 1.2 Social Marketing Organisations

1 A number of social marketing organisations exist, which typically work using different models and philosophies. These include Population Services International (PSI), the Futures Group and DKT International. DFID support to Futures includes a large programme of support in Pakistan, and more recently ITNs in Nigeria using innovative new approaches. DFID support to DKT includes a grant in Vietnam.

2 PSI is a Washington based NGO, works in more than 50 countries and has gained the leading market share in social marketing. They specialise in AIDS prevention, family planning, and maternal and child health. DFID support for PSI has included bilateral funding and funding through the Civil Society Challenge Fund. Essentially PSI procures products, establishes an office and distribution system, and sells the products through the existing wholesale and retail network. Products and services are branded, attractively packaged, widely marketed and sold at low prices affordable to the poor. By selling products PSI can expand coverage by tapping into the resources of the extensive local commercial infrastructure, which is financially motivated to stock and sell the products.

## 1.3 Issues

1 Given the significant amount of DFID funding allocated to social marketing, this assignment timely in undertaking a review of both DFID's approach to social marketing and the approach of those organisations which DFID funds. Issues raised to date include:

- the need to examine the congruence between social marketing approaches and DFID's broad development objectives
- the need to review and develop an understanding of the evidence base behind social marketing approaches
- whether social marketing models / approaches are reaching the very poor, and the overall impact on the very poor (as data allows)
- the efficiency and effectiveness of social marketing in increasing the availability and consumption of quality health products and services
- the importance of social marketing in introducing innovation and raising awareness of (new) products and ideas
- knowing when it is justifiable for donors/government to intervene and when social marketing is appropriate
- whether alternative approaches would be more equitable and more cost-effective in achieving the same objectives
- whether social marketing approaches build local capacity, develop systems and innovation, and other issues linked to sustainability
- PSI's strong market position - what are the issues for DFID as PSI moves towards operating more as a "monopoly" service provider?
- branding ownership issues
- the existence of incentives for social marketing organisations to outsource or develop innovative partnerships
- whether social marketing is stimulating the development of the indigenous/local private sector, or, in certain circumstances, restricting it.

## 2. PURPOSE AND APPROACH

### 2.1 Overall

1 DFID would like to undertake a review of social marketing in the context of DFID's overall development objectives. Through the use of country case studies and key informant interviews, the review will bring together lessons learnt of different models and approaches to social marketing, collate the evidence base, undertake a synthesis of effectiveness and make recommendations to inform future support. A clear analytical framework will be developed that will contribute to the development of future policy, rationale and approaches governing social marketing.

2 The findings will be useful for all DFID's development partners that are supporting and implementing social marketing programmes. In particular, the review will allow DFID to:

- Determine the extent to which the approach is contributing to the achievement of DFID's broader development objectives
- Determine the extent to which DFID's objectives are congruent with those of the social marketing organisations it funds.
- Consider alternatives, if any, to achieve stated social marketing objectives, with a focus on relative cost-effectiveness and efficiency.
- Identify the assumptions made about social marketing, review the evidence base behind the approach and determine the value for money of the approach in terms of achieving the MDGs.

3 The review will focus on the main social marketing organisations that DFID has experience of working with.

### 2.2 Scope of work

4 Through the case studies, literature review and key informant interviews the review will identify lessons learnt and best practice and undertake a synthesis of effectiveness and efficiency. The review and analysis will generate the following.

#### 2.2.1 Review of DFID policy and profile of contracted activities

5 The clarification, with DFID, of the **existing working definition of DFID objectives and approach to social marketing** in the context of goals linked to poverty reduction, public health, and health system capacity building and to enterprise development and economic growth. It is anticipated that this may vary between countries and will facilitate the raising and articulation of concerns and issues related to social marketing approaches.

6 Determination of **the level and extent of DFID funding and support** for social marketing – both centrally and through bilateral funds. This should include the specification of the social marketing organisation receiving support.

7 Clarification of the objectives, approaches and impacts that social marketing has, or is likely to have. This will involve a review of the **stated policies and methods of working of the key social marketing organisations**, including PSI, at global and country levels, and include procurement practice and options and brand ownership.

Determine the market share of the various social marketing organisations, in financial and geographical terms.

8 A determination, through examples, of **how important social marketing has been in introducing innovation**. For example, the extent to which SM has been able to introduce innovation, sometimes in difficult settings, in ways that have a wider, positive, impact? This will involve consideration of social marketing as a strategy for introduction, awareness, adoption and acceptance.

9 The articulation of a **clear analytic framework for the rationale for social marketing and recommendations for DFID**. This will include consideration of the different possible objectives and impacts that social marketing is likely to have and identify how to balance these or where there are trade offs. The framework should allow analysis of the role social marketing can play within overall health strategy.

### 2.2.2 Health and poverty impact and value for money

10 **Consideration of equity issues and the efficiency and effectiveness of social marketing as means to target subsidy**. To what extent are socially marketed health products reaching the poorer groups within countries? How successful has social marketing been in reaching identified target groups? If possible (as data allows) what is the *overall* impact on the very poor? These questions will involve an analysis of who benefits, what strategies are being used to target products to different income and social groups (e.g. different brands for different income groups) and whether cross subsidisation is actually achieved by this means. It will consider the arguments for and against subsidies and the extent social marketing subsidises products and services purchased by the 'less poor'. This will involve a consideration of wider public health gains in terms of increasing health product use over time more generally. It will also include some exploration of the extent to which social marketing is contributing to complementing national initiatives based on well established models for health promotion (e.g. developing supportive and enabling environments for **behaviour change**).

11 Consider the issue of **who pays for the product**. How can the transfer of the cost burden from donors to governments or consumers be successfully achieved without significant reduction of consumption of the socially desirable products? How important is the establishment of the brand-quality link of the product marketed in moving towards consumers paying?

### 2.2.3 Critical analysis of the role of private sector(s) in social marketing

12 **Relationship with the private sector**. What are social marketing's strengths and weaknesses with respect to DFID's broader aims for working with the private sector? Do social marketing approaches support or undermine the local private sector in any way? Is there any evidence that social marketing has displaced or restricted development of the local private sector, or otherwise? If so, what are the conditions and stages in the process in which displacement is likely to occur? Can displacement be justifiable under certain circumstances? Consider examples of pricing strategies that have been adopted with regard to different health products and services (by both the private sector and donor actors) in developing and developed countries, and conclude



with regard to the effectiveness of these strategies on short and long term demand and profits, and the effect on competitors.

**13 Public-private partnerships.** What are the possibilities for developing a public-private partnership approach to social marketing? What might be the characteristics and nature of a successful public-private partnership?

14 Consideration of **when it is justifiable for donors/government to intervene** in medical supply markets and when social marketing as a method of intervention is appropriate. **Consider alternatives** to achieve stated social marketing objectives, with a focus on relative cost-effectiveness and efficiency and whether other mechanisms are more appropriate for reaching the very poor. These could include: franchising; voucher schemes; setting up a local ORS factory; the use of other intermediates that governments could use to subcontract private organisations; public distribution of condoms, including via social marketing approaches; the promotion of condoms overall by social marketing, not just brands "owned" by social marketing organisations. For example would the education, procurement, distribution and marketing elements be provided better through a facilitated consortium of public and private organisations particularly skilled in each? Are there circumstances where more of a role for the private commercial sector should be considered (e.g. Tanzania ITNs)? This assumes there will be some data and evaluations available to allow comparisons to be made. In examining relative cost-effectiveness it will be important to focus on standard measures used in SM programmes, including cost per CYP and possibly unit cost per DALY. This will be important to make comparisons cross programmes and approaches.

#### **2.2.4 Governance and capacity building issues**

15 An assessment of the extent to which the countries under consideration have **ownership of the social marketing programmes** in their country? Is social marketing part of nationally owned health sector strategy and policy? How much of a role are governments playing in social marketing? How is social marketing strategy incorporated or integrated into health sector planning/financing as part of a SWAP, for example. In countries where the policy environment is risky and fragile, and so not favourable for a SWAP, do SM approaches still deliver worthwhile outcomes and contribute to the achievement of the MDGs?

16 Assessment of whether governments should be playing a more appropriate role in social marketing. This will include a **consideration of whether there is a role for more government buy-in of social marketing techniques**, both in terms of the (so far) limited promotion and use of social marketing techniques in 'marketing' public sector services, and in broader regulatory/governance functions. This will include, for example, governments playing a more facilitative role, such as in promoting tax exemptions for imported products and more structured opportunities for broadening government engagement with the private sector via social marketing's aim to accredit providers.

17 Consideration, with examples, of **whether current approaches to social marketing facilitate the building of local capacity**. Is the use of social marketing organisations, such as PSI, hindering or facilitating the development of effective in-country capacity? This should include consideration of public sector capacity and could include a focus on capacity in policy analysis, health systems development, marketing and branding, procurement, distribution, and demand generation.

18 Assuming there is a role for greater government involvement, **assessment of in-country policy analysis capability**. To what extent do national MOHs have the capacity (skills, experience, knowledge), and can employ the right policy processes, to consider the policy implications of social marketing and establish the strategic position of social marketing vis a vis other mechanisms for delivering health products and messages? What analysis and TA is required at the country level when considering the role social marketing can play within an overall strategy?

19 Consideration of **what DFID could do to build local capacity for social marketing**? This should include consideration of in-country policy analysis capability (as above) and an exploration of the following questions:

20 In what ways could DFID incentivise social marketing organisations to be more 'developmental' in their approach? For example, in addition to delivering messages and products, how could DFID encourage organisations to also consider local capacity building, including local production?

21 Is it feasible to identify organisations that could facilitate a network of players who may each contribute different skills and services in respect to capacity building?

### 3. DELIVERABLES

22 The consultant team will provide a report in draft by xxx 2002 to the DFID HSRC. The report will include an executive summary and will highlight any areas where a lack of evidence has hindered progress against the terms of reference. Any additional steps and time/skills required for a more in-depth analysis of these complex issues will be recommended. The main text of the report, excluding the executive summary and annexes, will be no more than 25 pages in length.

### 4. MANAGEMENT AND INPUTS

#### 4.1 Activities

23 It is envisaged that the following activities will be required for the review.

24 Desk review of recent research, evaluations and literature, including:

- DFID Output to Purpose Reviews and any other key synthesis studies and policy papers. HPD's Centre for Health Information's H&P News and PRISM OPRs / reports on social marketing will provide information on DFID-funded social marketing programmes
- work completed by the LSHTM
- relevant work by DFID supported Knowledge Programmes
- relevant work by the Resource Centre for Population, Reproductive, Maternal and Sexual Health
- papers by PSI and other social marketing organisations.

25 Initial briefing and ongoing contact with the DFID commissioners of this review in Central and Southern Africa region, including the DFID Africa-wide HIV/AIDS Adviser (Carole Presern) and the Enterprise Development Department (Claudia Smitherman and Ingrid Fossgard-Moser), and HPD, London.

26 Interviews with DFID staff members, ICSD, consultants, researchers and organisations who have been involved in social marketing, including evaluations and OPRs. This could include the SARH team in HPD, relevant DFID Knowledge Programmes, LSHTM, the Resource Centre for Population, Reproductive, Maternal and Sexual Health, Options and key expert individuals.

27 Interviews with key bilaterals supporting social marketing, to understand their level of support, policy positions and current thinking on key issues. To include USAID and KfW.

28 Discussions with PSI, Futures, DKT and other social marketing organisations, including at country level. PSI has its own research unit which should be consulted. It will also be important to look at the experience of Netmark (USAID supported).

29 Country case studies. Specific case studies to be undertaken will be decided with the DFID CSA team and the SARH team in HPD, as an early activity in the review. It is envisaged that three case studies will be required, preferably from countries with different social marketing models and / or characteristics. It is recommended that examples from Africa and Asia are included. Suggested case studies include the South Africa condom programme, ITNs in Tanzania, ITNs and condoms in Kenya, Uganda, Nigeria (contraceptives and ITNs), Ghana, Pakistan, Cambodia. It will also be crucial to consider the experience of DFID support to PSI in India since 1996.

30 The establishment of an expert group to inform the review. It is clear that many of the issues to be considered under this review are complex. Often it will be found that the evidence base is incomplete. Much thinking has already been done on these issues and it will be important to bring this in. An expert group will add value to the review. It is envisaged that this will be made up of DFID staff, researchers and other key individuals, who can meet "virtually". Conflict of interest considerations will need to be taken fully into account when forming the expert group. The consultant team will liaise closely with DFID over this issue.

31

#### 4.2 Inputs

31 The review will require a small team of three consultants, with the following skills:

- Social marketing
- Health and development economics
- Health systems capacity development
- Private sector development; business development, private/public partnerships

32 The review will require a total of 113 days (split between 3 consultants), plus 10 days for a researcher, and take place over five months (mid November 2002 to mid April 2003). There are three clear phases.

- *UK based literature review and desk analysis* (completed by end 2002). This will include the desk review, briefing, interviews and setting up of the editorial board envisaged under Activities in the TORs. This will allow initial discussions with key advisers, social marketing organisations and other

fundlers. It will facilitate the clarification of DFID's working definition of social marketing and bring together key documents and issues, while highlighting gaps in information. The output of the review will facilitate DFID and the team to clarify next steps and agree the case studies. A team meeting will precede this phase.

- *The three case studies* (completed early 2003). These will then be brought together and discussed at a team meeting, with key inputs from the expert group.
- *Report writing and analysis, presentation and consultation*

33 Inputs required as follows:

- Two team meetings - at beginning of the exercise and after the case studies have been drafted, prior to the drafting of the final report (2 days per meeting - three consultants - two meetings = 12 days)
- Expert group - suggest 4 people to meet "virtually" (to be selected by DFID and to possibly include representatives of the research community, DFID, other key donors and the country level). Two days each - one day following the desk review and one day immediately prior to report writing - for four experts = 8 days total
- UK based literature review and desk analysis -10 days for research assistant plus 10 days for key consultant = 20 days total
- Case studies - 10 days per study - three studies - two consultants per study (social marketing / private sector expert working with a health economist) = 60 days total
- Meetings and discussions with DFID CA, HPD and other staff, other organisations - 5 days
- Analysis, follow-up and report writing - 15 days
- Presentation and consultation following report drafting - 3 days

34 The assignment will be managed by the HSRC on behalf of the DFID Central and Southern Africa team. Following discussions with HPD, it is proposed that HPD fund a proportion of the costs, give the wider benefits to DFID of the review.

NB These terms of reference were confirmed at the outset of the review. However, helpful comments were received, notably from Alex Ross, which resulted in the addition to the report of a section on monitoring and evaluation. A larger number of country case studies was undertaken than originally planned