Texto 12

A social marketing approach to increasing enrollment in a public health program: A case study of the Texas WIC Program

Human Organization
Washington
Fall 2001

Authors: Carol Bryant
Authors: James Lindenberger
Authors: Chris Brown
Authors: Ellen Kent
Authors: et al

Volume: 60
Issue: 3
Pagination: 234-246
ISSN: 00187259
Subject Terms: Public health
Case studies
Marketing
Enrollments

Geographic Names: Texas

Companies: **Company Name**
Special Supplemental Nutrition Program for Women Infants & Children

Abstract:
The Texas WIC Program used social marketing to recruit new program participants and improve participant and employee satisfaction with the program. This article focuses on research conducted by anthropologists and public health researchers to identify target populations who were eligible, but had not enrolled in the program, and discusses the role research played in developing a comprehensive, multifaceted outreach plan.

Full Text:

The Texas WIC Program used social marketing to recruit new program participants and improve participant and employee satisfaction with the program. This article focuses on research conducted by anthropologists and public health researchers to identify target populations who were eligible, but had not enrolled in the program, and discusses the role research played in developing a comprehensive, multifaceted outreach plan. Systematic observations, in-depth interviews, focus groups, and a survey were used to identify factors that motivate and deter eligible families from enrolling in the program. Research results revealed that most eligible families had positive attitudes about the WIC program but were unfamiliar with the program's benefits. Women were deterred by a number of barriers: confusion about eligibility guidelines; reluctance to accept government assistance; problems signing up for WIC; and fear they would be treated disrespectfully by program staff or grocery stor! e cashiers. Research findings were used to develop a social marketing plan to increase enrollment in WIC, improve program satisfaction, and enhance service delivery. Evaluation results point to significant growth in the program and suggest that social marketing can be helpful to program planners who want to improve their delivery of

services and motivate new groups to utilize their services.

Key words: social marketing, WIC program, program utilization, program participation, audience segmentation, Texas

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was established by the United States government in 1972 to provide target populations of women, infants, and young children with nutrition education, supplementary nutritious foods, and referral to appropriate health and social services. During ensuing years, numerous studies have documented WIC's positive impact on pregnancy outcomes and early childhood growth and development (Abrams 1993; Brown, Watkins, and Hiett 1996; Kennedy and Kotelchuck 1984; Metcoff et al.1985; Rush et al 1988a, 1988b, 1988c). WIC's costeffectiveness has been demonstrated by the reduced incidence of infant mortality (Moss and Carver 1998), small-forgestational-age births (Buescher et al. 1993), and low birthweight babies born to women receiving WIC services (USGAO 1992).

As a result of these achievements and the fact that the program serves only a portion of eligible women, infants and children, Congress has continued to appropriate additional funding to increase WIC enrollment. With increased funding, state programs were challenged to design outreach strategies that motivate eligible women to enroll and fully participate in this beneficial public health program.

To meet the challenge of increasing enrollment and improving service delivery, Texas WIC public health administrators contracted with a social marketing firm, Best Start Social Marketing, to develop marketing strategies to increase enrollment among the state's diverse, rapidly growing population. With the state's rapid growth, Texas WIC had been unable to reach many families in need of its services; only 40 percent of the eligible population was served during fiscal year (FY) 1993 (Texas Department of Health 1994), when this project was initiated. The major objectives of the Texas WIC Marketing Project were to: increase enrollment among target groups of eligible families not currently being served; enhance service delivery; and raise participant and staff satisfaction.

This paper summarizes research conducted to determine why eligible families were not enrolling in the Texas WIC Program and how research findings were used to develop a comprehensive social marketing plan designed to motivate families to enroll in Texas WIC. In addition, this article demonstrates how anthropologists can assist program planners to understand the values, needs, and expectations of potential program participants and develop culturally appropriate strategies to encourage use of health and social services. (See Bryant et al. 1998 for a more detailed discussion of the other study components.)

The Social Marketing Approach

Social marketing offers a consumer-based approach to promote socially beneficial behavior change in specific populations. According to Andreasen (1995:7):

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of society.

Social marketing is distinguished from other management approaches by its adherence to six basic principles: 1) a consumer orientation; 2) the use of marketing's full conceptual framework to design behavior change interventions; 3) recognition of competition; 4) reliance on formative research to understand consumers' desires and needs; 5) segmentation of populations and careful selection of target audiences; and 6) continuous monitoring and revision of program tactics to achieve desired outcomes (Andreasen 1995; Coreil, Bryant, and Henderson 2001).

Unfortunately, many people still incorrectly equate marketing with sales and advertising (Kotler 1999). However, marketing's consumer orientation is actually the antithesis of a sales orientation. In contrast to the belief that sales-- stimulating devices are needed to bring results, marketing's

consumer orientation begins with existing or potential consumer needs and plans a coordinated set of programs and services to meet those wants, needs, and values, thus satisfying its goals by creating consumer satisfaction (Cooper 1994:10). As Kotler and Andreasen (1991:43) note, a consumer orientation assumes that "success will come to the organization that best determines the perceptions, needs and wants of target markets and satisfies them through the design, communication, pricing, and delivery of appropriate and competitively viable offerings." As a result, social marketers are willing to develop or modify programs to fit consumers' wants and needs. This willingness to modify! the product is a central feature of social marketing and distinguishes it from health communications approaches that only attempt to persuade or educate people to bring about behavior change. Inherent in this orientation is an emphasis on cultural relativity and cultural appropriateness in designing, implementing, and evaluating behavior change programs.

Several disciplines contribute to the social marketing approach. The most important of these are marketing, education and health communications, and anthropology (Andreasen and Kotler 1991). In this interdisciplinary mix, marketing serves as the organizing concept and provides an important conceptual framework, analytic techniques for audience segmentation, product development, pricing, testing, and distribution. Five key concepts are involved in marketing's framework: the product (the health behavior, commodity, or service being promoted) and its competition (the behavior currently practiced); the price (social, emotional, and monetary costs exchanged for the product's benefits); place (where the exchange takes place and/or the target behavior is practiced); and promotion (activities used to facilitate the exchange). Social marketers realize that people do not adopt new health behaviors or utilize programs (the products) unless the benefits they expect to receive exceed ! the time or costs (price) they must expend or pay. They conduct research with consumers to identify the most compelling benefits to offer, costs that must be lowered or made more acceptable, the best place to offer services, distribute products and information about them, and plan other elements of their promotion strategy to meet consumers' needs and expectations. Social marketers also conduct research to pilot test program interventions and materials before implementing them and monitor program progress to make any necessary mid-course corrections (Sutton, Balch, and Lefebvre 1995; Kotler and Andreason 1991).

Education and health communications provide an understanding of how to inform, persuade, and motivate people to change. This is no easy task in today's sophisticated marketplace. Social marketers turn to communication experts for guidance in designing messages that are attention getting, highly memorable, believable, attractive, easy to comprehend, and motivational. Communication specialists also conduct the channel analyses that enable us to transmit messages that reach the audience when and where they are most likely to respond. Mass communications helps social marketers distribute information to a large and diverse array of audience groups. Many projects contract with mass communication specialists and organizations when developing and executing promotional campaigns, such as advertising agencies, media planners and buyers, creative and design teams, production companies, and media outlets. These groups are experts in turning marketing strategy into effective communica! tions approaches. Finally, education contributes instructional design and curriculum development. Many comprehensive social marketing plans call for professional training programs, instructional videos, and print materials as part of the comprehensive strategy for bringing about desired change. As a result, social marketing teams often rely on specialists in adult learning techniques, instructional design, and curriculum development (Kotler and Andreasen 1991).

The social and behavioral sciences offer research tools and theoretical models that help marketers understand and change consumer behavior. Anthropology has played a particularly important role in social marketing. "In fact, the adaptation of social marketing principles to public health in general was significantly influenced by anthropological perspectives" (Coreil

and Mull 1990:8). A key feature of a modem social marketing approach is its commitment to fully understand consumers' wants and needs and produce products that enable them to better solve their problems and realize their aspirations (Kotler and Andreasen 1991). This consumer orientation is consistent with anthropologists' commitment to the "native" viewpoint (van Willigen 1993).

Social marketers often rely upon social anthropologists to conduct formative research to understand consumers' wants and expectations. Social anthropologists are familiar with the qualitative and quantitative research methods needed to understand existing beliefs, practices, and values that influence culture change processes. Ethnographic research is valued for its ability to generate insights into the cultural context in which change occurs as well as consumers' perceptions of the health behaviors or services being promoted. Anthropologists, like marketers, recognize intracultural variation within populations and methodically divide the larger group into more homogeneous subgroups-what marketers call audience segments (Andreasen 1995).

Social marketers often call upon anthropologists to conduct the repeated analyses needed to assess program impact as it is "enhanced and blunted by existing cultural elements" (Coreil and Mull 1990: 8). Process, contextual and impact evaluation are critical steps in the social marketing process, allowing program planners to make important midcourse revisions and optimize program acceptability and impact. Anthropological research helps monitor the target audience's response to the communication strategy and messages employed, and it illuminates the cultural context needed to interpret evaluation results (Smith and Clift 1968).

In addition, anthropology offers a rich ethnographic literature about many of the peoples that social marketers hope to influence. These secondary data sources provide information on the economic structures of households and families, male-female relations, power relationships within communities, traditional beliefs about health and illness, and specific health practices (Rasmuson et al. 1988). Also, social anthropology's conceptual insights into the diffusion of innovations and culture change processes enable them to identify the social and cultural factors they must consider in developing and promoting social products (Kotler and Andreasen 1991).

Social anthropologists creative interpretation of research results often result in the development of effective messages by identifying culturally appropriate words and symbols to use in promotional materials, appropriate people to use as spokespersons, and the best places to communicate with target audiences (Andreasen 1995; K! otler and Andreasen 1991; Manoff 1985; van Willigen 1993).

Project Goal: Increasing Participation in the
Texas WIC Program

In designing the Texas WIC Marketing Plan's enrollment component, research with eligible women who had never enrolled in WIC was used to identify their perceptions of WIC, understand why they had not previously sought its services, and develop effective strategies to encourage them to enroll. Formative research addressed the following questions:

1. What are the major factors that motivate women to enroll in Texas WIC?
2. What are the major deterrents to enrolling in Texas?
3. How can the target population of eligible, yet never enrolled, women be segmented by sociodemographic and attitudinal characteristics to identify families who may benefit most from marketing efforts?
4. What are the unique characteristics of women who have never enrolled in Texas WIC as compared to current and previous participants?

Results from the enrollment component were combined with findings from the program satisfaction and service delivery study components (Bryant et al. 1998) to develop a comprehensive marketing plan.

Literature Review

When this project was initiated, relatively little was known about the reasons for families' reluctance to use the WIC program (Ku 1989). Embarrassment to accept government assistance, lack of child care and transportation, and perceived lack of program benefits were reported to deter some families from enrolling (Kahler et al. 1992).

To identify populations in greatest need of WIC benefits, some researchers have used cluster analysis to locate geographic areas with the highest risks and frequencies of poor birth outcomes (Buechner et al. 1991). Other researchers have linked WIC files with birth certificate data to detect underserved populations of high-risk families (Yip et al. 1991). Many state WIC programs have attempted to increase enrollment through outreach activities, including television and radio advertising, use of prior participants as WIC program ambassadors (Ku 1989), and recruitment of eligible enrollees by prenatal care providers (Kahler et al. 1992). However, these approaches had not been based on consumer research, nor had they been coordinated as multifaceted, continuous programs.

Study Methods

The study used a combination of quantitative and qualitative methods. First, a computer match of pregnant women enrolled in the Texas Medicaid Program and the Texas WIC Program was used to generate a random sample of 15,000 Medicaid recipients who were automatically income-eligible for the program. A 28-item survey instrument was developed, translated into Spanish, and pretested in rural and urban settings with over 50 Medicaid recipients. The survey was mailed by the Texas Medicaid Program, accompanied by a letter from then Governor Ann Richards asking families to participate in the study. Twenty percent (2,944) returned the survey in time to be included in the study sample, and 56 percent of these survey respondents gave permission to be contacted for interviews. In the sample of 2,944 survey respondents, 64.6 percent were "current" WIC participants (n = 1,842), 5.5 percent were "previous" participants (n = 156), and 28.2 percent had "never" enrolled in WIC (n = 852).

Although 20 percent is a low response rate for surveys in the general population, it is within the expected norm for the Medicaid population, where response rates typically fall below 25 percent (NCQA 1995). While additional data collection analysis might have improved generalizability to the population of eligible families who were not enrolled in WIC, doing so was not feasible. Financial constraints and Medicaid confidentiality guidelines also prohibited follow-up activities or a comparison of respondents and nonrespondents.

Frequency distributions, cross tabulations, and chi-square automatic interaction detection analyses (CHAID) of the survey data were conducted using SPSS PC+. CHAID analyses (Magidson 1992) were used to compare the relationship between multiple independent variables (e.g., sociodemographic characteristics) and dependent variables (e.g., enrollment in WIC). CHAID has a tree-based interface that segments the sample into distinct, homogeneous subgroups and identifies the categories in the "tree" with the highest and lowest proportion of respondents exhibiting the dependent variable. This method of audience segmentation can identify target groups that may benefit from programmatic interventions (e.g., information about enrolling in WIC) (Forthofer and Bryant 2000; Sutton, Balch, and Lefebrve 1995).

Five focus groups (n = 38) and 81 telephone interviews were conducted with women who indicated on the survey that they would be willing to talk further with researchers about why they had never enrolled in Texas WIC. All qualitative and quantitative instruments, consent forms, and research procedures were approved by the University of South Florida's Institutional Review Board.

Focus group and in-depth interviews were transcribed and entered into a computer-based text file. Transcripts were then loaded into Text-based Alpha, a software package that allows transcripts to be numbered, coded, and sorted into different topical categories (Qualitative Research Management 1989). For each topic, two researchers identified recurring themes, the range of diversity in responses, and selected quotations to be included in the research findings.

Finally, three anthropologists (Brown, Bryant, and Schreiber) and other members of the research team systematically observed the delivery of WIC services (the waiting area, registration and check-in procedures, individual assessment, and counseling and nutrition education activities) and the process used to redeem food vouchers in grocery stores. Although participant observation was conducted during the initial research period to provide researchers with an understanding of WIC's organizational culture and factors that influence client and staff satisfaction, it was continued throughout the study to supplement information obtained by other data collection methods.

Results

In keeping with marketing's conceptual framework, research focused on nonenrollees' perceptions of program benefits and costs. This section presents qualitative and quantitative data collected from nonenrollees.

Product Benefits: Factors Motivating Enrollment in Texas WIC

Many nonenrollees had a positive impression of the WIC program. Sixteen percent of survey respondents rated the program as "very good" and an additional 24 percent rated it as "good." Not surprisingly, the majority (59 percent) said they were "not sure." Only I percent rated the program as "bad" or "very bad."

Most of the women who participated in focus group discussions knew that WIC provided infant formula and dairy products, but few were familiar with other items in the food package. Infant formula was the single most attractive item, in part, because the price of infant formula places this product out of reach for most of the families interviewed. Many women who did not want to enroll in WIC during their pregnancy said they would need to participate after the baby arrived to be able to purchase formula.

"I need just the formula thing-that's the big thing right there...."

"Pero lo mas que me interesa es la leche cuando nazca mi bebe."

(But what interests me the most is the mild when my baby is born.)

Yeah, I don't take the rest, like why should I?"

Almost none of the focus group participants knew that WIC offers individualized nutritional risk assessment and counseling, education classes, or immunizations. When they learned about these program benefits from other focus group participants, many indicated that these additional services would make it worthwhile for them to enroll. One 22-yearold, Mexican American mother said (translated from Spanish): "I would like classes to learn how to give my child good nutrition. It is very important to know what foods will help her and how to give them to her."

Another 28-year-old Anglo American woman described the educational services this way:

I think (nutrition education) would be good because you're not just gonna give someone a car and not teach them how to drive it. You know, I think if you're going to give someone something you gotta teach them about it, how they're going to use it, how they're going to benefit from it and how to use it appropriately.

In sum, most families were attracted to the educational and other health benefits they would receive by participating in WIC but viewed the program largely as a source of dairy products and infant formula. When they learned of WIC's full benefit package, many said they would be interested in enrolling.

Product Price: Perceived Costs and Other Barriers to Enrollment in Texas WIC

Despite an overall positive impression of the Texas WIC Program, many families had not enrolled in WIC because of a number of perceived and real barriers.

Confusion about Eligibility

One of the most formidable barriers to enrollment was confusion about WIC's eligibility criteria. As illustrated in Figure 1, CHAID analysis indicated that although automatically income-eligible, 40 percent of the nonenrollees did not know they were eligible for WIC, including 9 percent who believed they were ineligible and 30 percent who were unsure. Chi-square analysis revealed significant differences in the proportions of nonenrollees who were aware that they were income-eligible for WIC by age, education, income, and other sociodemographic characteristics.

During focus group discussions, many women reported the mistaken belief that WIC served only "very poor families," and their family income exceeded eligibility requirements:

Moderator: What have you heard about who qualifies
for WIC?

25-year-old Anglo: I haven't heard anything, but with the stereotypes when you do hear somebody talk about it, they usually make it seem like its going to be people with the lower class.

[IMAGE CHART] Captioned as: Figure 1.

27-year-old Anglo: And people very poor.

29-year-old African American: People who are very poor.

Many focus group participants also incorrectly assumed they would not qualify for WIC because they were living with relatives whose income or other assets (e.g., a car) made them ineligible for the Food Stamp Program, which has stricter income guidelines than WIC. These misperceptions were further reinforced when they called for a WIC appointment and were told incorrectly that they would have to bring proof of income for all members of the family. One 33-yearold African American woman who was married to a freelance writer said:

I kind of thought WIC was the same as food stamps because we only qualified for food stamps for a couple of months and then we didn't qualify, because we had too much money, or something like that. So I thought that if we don't qualify for food stamps then you probably won't qualify for WIC, 'cause I thought it was all in the same whole process so I never really took the time to call.

In addition to confusion about income eligibility, other women did not understand the program's categorical eligibility guidelines. Some women, for example, did not realize that women who breastfed their babies were qualified or that they could obtain a postpartum package if they bottle-fed. Many also did not know that children from two to five years of age qualify.

Particularly disturbing was the finding that some Medicaid recipients had not been referred to WIC even after being told by a health provider that they had a nutritional problem that placed their pregnancy in a high-risk category. Although medical data was not collected from study participants, it is noteworthy that 6 of the 48 women interviewed in focus groups talked about needing a program like WIC because they were diabetic, anemic, or underweight. Three complained of being hungry during much of their pregnancy; yet none of these women had been referred to WIC and all doubted their eligibility.

I really don't know if I qualify.... I got two children and it's just hard to go anywhere, and stuff like that, so I really hadn't gone and my last pregnancy I was diabetic and I don't know if I qualified then or not but I just really had trouble 'cause I was on a diet and I (inaudible) get to eat my breakfast, a snack, my lunch, a snack, and I was on insulin so I really needed to have those little snacks...and I really couldn't get them sometimes-buy the peanut butter or whatever, and I think (WIC) would have helped me a lot you know.

Reluctance to Accept Government Assistance

Families' hesitancy to enroll in WIC was often due to their fear of being stigmatized and the embarrassment they would feel if identified as a recipient of free food. The issue of stigmatization is an important one and involves a number of interacting variables: cultural norms

that govern selfsufficiency, the role of the male as provider, and the need for problems to be kept within the family. Many women have witnessed a WIC participant being told by a grocery store clerk to return certain food items not covered by the program and noticed the responses of other customers who sighed impatiently or muttered comments about how their taxes were being wasted. Some families also felt embarrassed when using food stamps or other forms of government assistance. Finally, some women who had worked as cash register clerks recalled the negative attitudes they once had toward WIC participants. Regardless of how these fears were acquired, all respondents shared a common goal: to maintai! n their pride and dignity. In the words of one 20-year-old Anglo woman: for me personally, it's so embarrassing to ask for help..but if somehow the stigma could be removed, I think people would be, or I would be, more willing to accept it instead of trying to squeeze every last dollar and eat beans for a week to try to get by.

Some nonenrollees said they felt acceptance of free food would "rob" them of their sense of self-sufficiency. In one focus group, when the moderator asked women what kept them from applying for WIC, the following discussion ensued:

25-year-old Anglo: I think pride has something to do with it.

30-year-old African American: That has a lot to do with it, I think.

28-year-old African American: It's a government program. We are supposed to be self-sufficient and take care of ourselves.

Some women were also reluctant to accept WIC benefits because they thought that benefits were in short supply and should only be accepted by those with the greatest need. These women felt strongly that government programs are designed to help only those who cannot provide for themselves. While they did not think it was shameful for people to accept help when it was truly justified, they did believe others should feel embarrassed to accept help if they could work and be self-sufficient. One 31 -year-old African American woman commented: "And if you don't feel like you need it and you're able to work, don't get it because it's out there to be gotten, just work."

A related concern was women's fears that enrollment of their own families in WIC might displace other women and children whose needs were far greater than their own. Some nonparticipants said they did not feel justified in accepting help in feeding their families. One 32-year-old Anglo American woman said: "Well, I just feel like if I'm there using it, well, I don't need it, and this person next to me might really need it, so they might as well. I look at it as a space...."

Compared to other families, significantly higher proportions of Anglo Americans ($X2 = 55.77$; $p<.0001$), women with at least a high school education ($X2 = 24.08$; $p = .0005$), and women not on food stamps ($X2= 5.70$; $p = .0577$) stated on the survey they felt it would be embarrassing to be on WIC. CHAID analysis revealed that the subgroup with the highest proportion of never-enrolled women who thought it would be embarrassing to be on WIC was comprised of Anglo Americans, Asian Americans, and others (10.5%) (See Figure 2.)

Problems Enrolling in the Program

Some families did not enroll in WIC because of the inconveniences they encountered in their initial efforts to become certified. While none of the people in this sample had successfully enrolled in WIC during their recent pregnancy, 22 percent had tried, and 8 percent had actually gone to an appointment. In focus groups, women mentioned a myriad of system barriers that made it difficult to enter the WIC system. Among these barriers were difficulty finding the WIC phone number, calling a WIC number that was busy or was not answered, thinking that a WIC clinic was not nearby, and having to wait several weeks for an appointment.

Negative perceptions about participating in WIC

Some women did not enroll because of problems friends and relatives had encountered as WIC recipients. Long waits at WIC clinics to obtain food cards and listen to educational videotapes,

rude treatment by WIC staff, lack of Spanishspeaking staff, and rude treatment while redeeming WIC food vouchers at the grocery store were mentioned repeatedly. Together, these inconveniences and insensitive treatment represented an unacceptable "price" or barrier to participation. Nonenrollees did not want to encounter the shame their friends and relatives felt because of being forced to wait for what seemed like unnecessarily long periods of time or being spoken to discourteously. Instead, they chose to forego the benefits of the program to avoid being treated poorly.

[IMAGE CHART] Captioned as: Figure 2.
Place: Where Families Learn About the
WIC Program
Women learn about the WIC program from a variety of information channels. The most frequent information sources were friends and relatives, public health clinics, social service agencies, private doctor's offices, and mass media. Most people in the study knew someone who had participated in the program, making the satisfaction level of participating families a key element in the program's ability to attract new participants.
Promotion: Respondents' Recommendations
for Increasing Program Participation
Focus group participants were asked to offer suggestions for making the Texas WIC Program more appealing. Most recommendations focused on ways to improve the "product" rather than advertise it. They recommended that the program publish eligibility guidelines, expand the food package and program services, eliminate income eligibility criteria, remove WIC's negative stigma by making it available to everyone or focusing on the educational services, and train staff and grocery clerks in customer relations.
Audience Segmentation of the WIC-Eligible
Population
Statistical analyses were conducted on the total sample of pregnant Medicaid recipients to identify the sociodemographic characteristics of three audience segments-current participants, previous participants, and never enrolled. Chi-square analysis revealed significant differences between women who had never enrolled and current or previous WIC clients according to the variables of race, income, age, marital status, education, employment, geographic location, and participation in the Food Stamp and AFDC Programs. CHAID analysis was used to identify the segment with the highest proportion of women not participating in WIC (49.4 percent). This segment was comprised of women who were Anglo Americans, were not married, and not receiving food stamps. The segment with the lowest proportion of currently enrolled WIC participants was comprised of women who were Anglo American, married, divorced, separated or widowed, and not receiving food stamps (11.7 percent). The segment with ! the highest proportion of currently enrolled participants was comprised of Spanish-speaking Hispanic food stamp recipients (87.3 percent) (Figure 3).
Discussion
This case study illustrates how social marketing can be used to: 1) identify segments of a economically disadvantaged population (pregnant Medicaid recipients) that are eligible but not being served by a public health program (Texas WIC); 2) understand their values, needs and expectations; 3) identify program changes needed to accommodate the target populations desires and needs; and 4) motivate them to enroll in a valuable public health program (WIC).
First, extensive consumer research, the bedrock of the social marketing process, provided valuable information about why eligible women did not enroll in WIC. Emergent themes were identified in both the qualitative and quantitative research, such as confusion about eligibility; reluctance to accept government assistance for fear of stigmatization and embarrassment; a value

placed on self-sufficiency; fear of losing dignity by accepting free food; and the expectation of being treated disrespectfully by WIC staff and grocery cashiers.

[IMAGE CHART] Captioned as: Figure 3.

Many eligible families believe that the "price" of participating in WIC (the inconveniences of waiting for appointments, the embarrassment of being treated rudely and the stigmatization of being on a government program) is too high to pay for WIC's benefits (nutritious food, nutrition education, counseling, and immunizations). Thus, they decide not to enroll.

Other researchers have observed these central themes in their studies of participation in WIC and other public assistance programs (Kahler et al. 1992). Studies conducted in other states also have found that service delivery problems and reluctance to accept government assistance affect program satisfaction and may contribute to decisions to stop using program services (Bellamy et al. 1995; Bryant et al. 1994, 1996a, 1996b).

Second, audience segmentation was used to identify characteristics of women who had never enrolled in the Texas WIC Program. This profile of nonenrollees was used to identify audience segments that might benefit from intensive outreach efforts and ways to recruit them. In Texas, CHAID analysis indicated that the segment with the lowest proportion of women who thought they would qualify for WIC was comprised of women who were not on food stamps and over 21 years of age. These analyses indicated that working families who do not qualify for other public assistance programs like food stamps or AFDC, but who are still below 185 percent of the federal poverty level, comprise an important target for outreach efforts.

Third, research findings were used to design a comprehensive social marketing plan to help families understand eligibility guidelines, streamline the certification process, and make it easier for health and social service professionals to refer women to WIC. The plan addressed women's misperceptions of the program's benefits and guided the design of outreach messages that emphasized the nutrition education, health check-ups, immunizations, and referrals WIC provides. These messages featured WIC as a nutrition-education and health-referral program rather than a food-assistance program. In light of women's concerns about self-sufficiency, WIC's image was also repositioned as a temporary-assistance program, "Helping Families Help Themselves." The "new" WIC program was depicted as one in which families can maintain their pride and self-esteem as they earn their WIC benefits and learn about nutrition and other ways to help their families.

Because many women did not know they were eligible for the program, the marketing plan also emphasized ways to help families understand eligibility guidelines, streamline the certification process, and make it easier for health and social service professionals to refer eligible women. For example, a television advertisement addressed the most common misperceptions about WIC eligibility, featuring a working father and his two daughters, a pregnant teen who lives with relatives, and a married woman as participants who are qualified for program benefits. In the ad, the narrator informs people that many families qualify for this valuable program, including those who don't qualify for food stamps, working families, and those living with relatives, and encourages viewers to call a toll-free line to find out if they are eligible.

Placement and promotional strategies were also designed for the Texas WIC Program. Message design guidelines were developed to guide the creative team in preparing television, radio, and print messages consistent with the plan's overall goals. Audience segmentation results were used to determine the regions within the state and specific media outlets where radio, television, and billboards should be placed. Audience-- segmentation data showing that Anglo Americans were the most likely to believe it is embarrassing to accept government assistance were used to select talent for a second television advertisement. In this spot, an Anglo American family shares breakfast together while the narrator describes the many nutrition and health services the program offers. Print and electronic materials were pretested with the target audience for

comprehension, relevance, believability, and persuasiveness, then revised to maximiz effectiveness in motivating eligible families to! enroll in the program.
To increase referrals from other social and health care services, a community organizer's kit w developed with materials that clarify WIC services and eligibility guidelines and offer helpful suggestions for referring clients to WIC.
The social marketing plan also recommended extensive improvements to address service delivery problems. These included methods to decrease waiting times, improve nutrition education materials and activities, the introduction of a peer-buddy system, and customer service training for clinic staff. A training program was developed to teach grocery store cashiers how to handle difficult WIC transactions, while treating WIC participants respectfully. Finally, a permanent data collection procedure was designed to track program enrollment and program satisfaction. (See Figure 4 for a summary of the marketing plan.)
Program Implementation and Evaluation
Almost immediately after the social marketing plan had been developed, the state agency began modifying policies and encouraging local agencies to make programmatic improvements. In 1995, new clinics were established and other changes made to the program's infrastructure to enable it to serve more families. Clinic hours were expanded to evenings and weekends to better accommodate working families. Nutrition education activities were enhanced to meet the wants and needs identified in the formative research. Customer service training was provided through a variety of means, including teleconferencing. A statewide media campaign was implemented and the participant and staff satisfaction tracking system (PDCS) was successfully pilot tested in eight sites. Food vouchers were modified to look like bank checks so that they were more efficient and less conspicuous when participants redeemed them.

[IMAGE CHART] Captioned as: Figure 4.
The following year, the peer-buddy system and a childfriendly clinic system were successfully pilot tested in two demonstration sites. A brochure was developed to help WIC participants more easily identify foods that they could purchase with WIC vouchers and decrease confusion at the cash register. The customer service training program for grocery clerks was successfully pilot tested and supporting print materials produced. Another wave of television and radio ads were broadcast statewide, and outdoor media were placed in 68 communities with high proportions of eligible families. Other portions of the project, implemented more recently, include modification of store labeling of approved foods and limitations on food selection to make it easier for WIC participants to identify approved items and to avoid problems while redeeming their vouchers.
Unfortunately, the Texas Department of Health decided not to fund a formal evaluation of the project, making it impossible to carefully track program modifications and their impact on participation rates, or compare growth in intervention and control sites. The lack of a comparison group is unfortunate because numerous factors influence caseload size, including the program funding level, the number of eligible families in the state, the proportion of eligible families already served, current economic conditions, the priority placed on caseload growth as opposed to other program activities by state administrators, and the infrastructure available to accommodate additional participants. Even with these limitations in mind, it is still possible to track changes in the number of families participating in the Texas WIC Program using program participation estimates from Texas Department of Health. The program's caseload grew from 582,819 in October 1993 to 778,558 in October 19! 98-an increase of almost 200,000 participants.
Evidence that the outreach component of the marketing project contributed to caseload growth comes from two sources. First, the number of callers to the program's tollfree information line who said they learned about the program from television or media advertisements increased dramatically during the weeks the media campaign was broadcast. Moreover, 89 percent of these

callers were categorically eligible for the program, suggesting that the ads succeeded in reaching the target audience. Second, a survey of families enrolling in the program revealed that 47 percent of new participants recalled seeing a television ad and 17 percent recalled hearing a radio spot for the WIC program (Brown 1996).

More important than caseload growth is the marketing project's impact on the program's organizational culture. The Texas WIC Program now monitors customer satisfaction annually, routinely pretests all outreach and marketing materials, consults consumers for their opinion on operational improvements, and has added a social marketing specialist to its state agency, thereby institutionalizing its commitment to a consumer orientation.

Conclusions

Social marketing provides program planners with a valuable approach for redesigning program services to better meet the wants and needs of program participants. In this component of the Texas WIC Marketing Project, social marketing enabled program planners to identify the benefits that are most attractive to eligible participants and develop ways to lower the price or barriers to program participation, making it possible to reach thousands of families who were not benefiting from program services. Other components of the project resulted in program improvements in service delivery and increased staff satisfaction (Bryant et al. 1998). By making the program more consumer friendly, current participants were more easily retained and more likely to promote the program to other families who were eligible but not participating. Since the Texas WIC Marketing Project has been implemented, at least six additional state WIC programs (Georgia, North Carolina, Indiana, Kentucky, Cali! fornia, and Massachusetts) have used a social marketing approach to increase program utilization and/or improve customer satisfaction.

We would like to conclude with a few remarks about the role of social anthropologists in social marketing. At the heart of the social marketing approach is the assumption that an understanding of consumers' values and aspirations is needed to develop programs people truly want and will use. Anthropologists play an important role in both conducting the formative research upon which culturally appropriate program strategies can be built and recommending effective culture change strategies. Social marketing organizations turn to anthropologists because of the discipline's holistic approach, mastery of qualitative research methods, and understanding of culture change. Anthropologists' understanding of culture and the impact of values, norms, and beliefs on consumer behavior make them a valuable resource to the consumeroriented social marketer. As researchers, they use qualitative and quantitative research methods to understand how various subgroups or segments in a population! view health behavior and services and appreciate the cultural context in which change is directed. In addition to formative research, social anthropologists are skilled at helping design and pretest message concepts and promotional materials, helping ensure that they are culturally appropriate and effective. Their insights into organizational culture and "native viewpoints" allow them to play a key role in designing culturally appropriate service delivery systems. Social anthropologists are also important members of the evaluation team, monitoring the long-term impact of the communication strategy on the target audience and other community members of the community, and conducting other process and impact evaluation studies. The Texas WIC Marketing Project illustrates the valuable role anthropologists can play in redesigning the product and the messages used to promote it, enabling the program to better meet the needs and expectations of culturally diverse target populations! .

References Cited

Abrams, Barbara
1993 Preventing Low Birth Weight: Does WIC Work? Annals of New York Academy of Sciences 678:306-316.
Andreasen, Alan R.

1995 Marketing Social Change: Changing Behavior to Promote Health, Behavior, and the Social Environment. San Francisco: Jossey-Bass.
Bellamy, Hilary, Carol A. Bryant, and James H. Lindenberger
1995 The Indiana WIC Social Marketing Study. Tampa, Fla.: Best Start Social Marketing.

Brown, Chris
1996 Marketing Mass-Media Campaign of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Formative and Process Evaluations. Austin: Texas Department of Health, Bureau of Community Oriented Primary Care Health Communications Division.

Brown, Haywood, Kevin Watkins, and A. Kinney Hiett
1996 The Impact of the Women, Infants and Children Food Supplement Program on Birth Outcome. American Journal of Obstetrics and Gynecology 17:1279-1283.
Bryant, Carol A., James H. Lindenberger, Chris Brown, H. Janet, C. Schechter, and Valery Uccellani
1994 WIC at the Crossroads: The Texas WIC Marketing Study. Social Marketing Quarterly 1-2.
Bryant, Carol A., Joanne Wood, Katrina Gonzalez, Ellen Kent, Rebecca Hemmick, and Carl Newman
1996a North Carolina Marketing Study: Inactive Participants. Report submitted to the North Carolina WIC Program. Tampa, Fla.: Best Start Social Marketing.

Bryant, Carol A., James H. Lindenberger, and Hilary Bellamy
1996b Georgia WIC Marketing Study. Report submitted to the Georgia WIC Program. Tampa, Fla.: Best Start Social Marketing. Bryant, Carol A., Eileen Kent, Chris Brown, Marta Bustillo, Cliff Blair, James Lindenberger, and Marsha Walker
1998 A Social Marketing Approach to Increase Customer Satisfaction with the Texas WIC Program. Marketing Health Care Services 4(2):5-17.
Buechner, Jay S., H. Denman Scott, John L. Smith, and Alan B. Humphrey
1991 WIC Program Participation-A Marketing Approach. Public Health Reports 106:547-556.
Buescher, PaulA., Linnea C. Larson, M.D. Nelson, and Alice J. Lenihan
1993 Prenatal Participation Can Reduce Low Birth Weight and Newborn Medical Costs: A Cost-Benefit Analysis of WIC Participation in North Carolina. Journal of the American Dietary Association 93:163-166.

Cooper, Philip D.
1994 Health Care Marketing. A Foundation for Managed Quality. 3rd ed. Gaithersburg, Md.: Aspen Publishers.
Coreil, Jeannine, Carol Bryant, and Neil Henderson
2001 Social Marketing. In Social and Behavioral Foundations of Public Health. Jeannine Coreil, Carol Bryant, and Neil Henderson, eds. Pp. 211-231. Thousand Oaks, Calif.: Sage.
Coreil, Jeannine, and J. Dennis Mull, eds.
1990 Anthropology and Primary Health Care. Boulder, Colo.: Westview Press.
Forthofer, Melinda, and Carol Bryant
2000 Different Strokes for Different Folks. American Journal of Health Behavior 24:36-43.

Kahler, Lucinda R., Robert M. O'Shea, L.C. Duffy, and Germaine M. Buck
1992 Factors Associated with Rates of Participation in WIC by Eligible Pregnant Women. Public Health Reports 107:60-65. Kennedy, Eileen T., and M. Kotelchuck
1984 The Effect of WIC Supplemental Feeding on Birth Weight: A Case-Control Analysis. American Journal of Clinical Nutrition 40:579-585.
Kotler, Philip
1999 Kotler On Marketing: How to Create, Win, and Dominate Markets. New York: Free Press.

Kotler, Philip, and Alan R. Andreasen,
1991 Strategic Marketing for Nonprofit Organizations. Englewood Cliffs, N.J.: Prentice Hall.
Ku, Leighton
1989 Factors Influencing Early Prenatal Enrollment in the WIC Program. Public Health Reports 104:301-306.
Magidson, James
1992 SPSS/PC + CHAID Version 5.0. Belmont, Mass.: Statistical Innovations.
Manoff, Richard K.
1985 Social Marketing: New Imperative for Public Health. New York: Praeger.

Metcoff, Jack, Paul Costiloe, Warren M. Crosby, Seshchalam Dutta, Harold H. Sandstead, David Milne, C.E. Bodwell, and Stephen H. Majors
1985 Effect of Food Supplementation During Pregnancy on Birth Weight. American Journal of Clinical Nutrition 41:933-947. Moss, Nancy, and Karen Carver
1998 The Effect of WIC and Medicaid on Infant Mortality in the United States. American Journal of Public Health 88:1354-1361. National Committee for Quality Assurance (NCQA)
1995 Medicaid HEDIS-An Adaption of the Health Plan Employer Data and Information Set 2.0/2.5-Draft Version. Washington, D.C.: National Committee for Quality Assurance.

Qualitative Research Management (QRM)
1989 Text-Based Alpha Users Manual. Desert Hot Springs, Calif.: Qualitative Research Management.
Ramsuson, Mark R., Renata E. Seidel, William A. Smith, and Elizabeth Mills Booth
1988 Communication for Child Survival. Washington, D.C.: Academy for Educational Development.
Rush, David, Nancy L. Sloan, Jessica Leighton, Jose M. Alvir, Daniel G. Horwitz, W. Burleigh Seaver, Gail C. Garbowski, Sally S. Johnson, Richard A. Kulka, Mimi Holt, James W. Devore, Judith T. Lynch, Thomas G. Virag, M. Beebee Woodside, and David S. Shanklin
1988a Longitudinal Study of Pregnant Women. American Journal of Clinical Nutrition 48:439-483.
Rush, David, Jessica Leighton, Nancy L. Sloan, Jose M. Alvir, Daniel G. Horwitz, W. Burleigh Seaver, Gail C. Garbowski, Sally S. Johnson, Richard A. Kulka, M. Holt, James W. Devore, Judith T. Lynch, Thomas G. Virag, M. Beebee Woodside, and David S. Shanklin
1988b Study of Infants and Children. American Journal of Clinical Nutrition 48:484-511.

Rush, David, Jose M. Alvir, David A. Kenney, Sally S. Johnson, and Daniel G. Horvitz

1988c Historical Study of Pregnancy Outcomes. American Journal of Clinical Nutrition 48:412-428.
Smith, William A., and Elayne Clift
1986 The Communications Impact: Uses for Child Survival. International Health News 3 (Spring):7.
Sutton, Sharon M., George B. Balch, and R. Craig Lefebvre
1995 Strategic Questions for Consumer-Based Health Communications. Public Health Reports 110:725-733.

Texas Department of Health
1994 Texas WIC News 12. Austin: Texas Department of Health. United States General Accounting Office (USGAO), Human Resources Division
1992 Federal Investments in Early Intervention, GAO/HRD-9218. Washington, D.C.: U.S. Government Printing Office.
van Willigen, John
1993 Applied Anthropology: An Introduction. Westport, Conn.: Bergin & Garvey.

Yip, Ray, Lee Fleshood, Thomas C. Spillman, Nancy J. Binkin, Faye L. Wong, Frederick L. Trowbridge
1991 Using Linked Program and Birth Records to Evaluate Coverage and Targeting in Tennessee's WIC Program. Public Health Reports 6:176-181.

Carol Bryant, James Lindenberger, Chris Brown, Ellen Kent, Janet Mogg Schreiber, Marta Bustillo, and Marsha Walker Canright

Carol Bryant is an associate professor in the Department of Community and Family Health at the University of South Florida College of Public Health. She is also cofounder of Best Start Social Marketing. James H. Lindenberger is executive director of Best Start Social Marketing, a nonprofit social marketing organization in Tampa, Florida. Chris Brown is director of the Texas Fatherhood Initiative and acting section head for the Marketing, Outreach, and Education section of Best Start. Ellen Kent is grants support coordinator at the University of South Florida College of Public Health. Janet Mogg Schreiber is president of Lorien Consulting, a clinical faculty member in the Department of Community Medicine, University of New Mexico Medical School, and director of the Grief Counseling Program, Southwestern College, Santa Fe, New Mexico. Marta Bustillo is an assistant professor at the University of Puerto Rico College of Public Health. Marsha Walker Canright is senior communic! ations advisor to the Texas Commissioner of Health.

We would like to express our appreciation to Clifford Blair, Ph.D., who assisted with data analysis, Stephen Cole, Ph.D., who conducted chi-square automatic interaction detection analyses (CHAID), and Carol Cannon, M.A., who conducted telephone interviews. Janet Schiller, Ed.D. helped us obtain data on the number of income-eligible participants in Texas and elsewhere, and provided advice on evaluating the Texas WIC Social Marketing Project. We also would like to thank Robert J. McDermott, Ph.D., for his comments and editorial suggestions on an earlier draft of this manuscript. This research was funded by Texas WIC Bureau, Texas Department of Health.