Texto 10

In van Willigen, John (1993) Applied Anthropology. An Introduction.

9

Social Marketing

Social marketing is a social change strategy that combines commercial marketing techniques with applied social science to help people change to beneficial behaviors. Some examples of the issues targeted by social marketing are contraception (Schellstede and Ciszewski 1984), blood cholesterol screening (Lefebvre and Flora 1988), heart disease prevention (Maccoby et al. 1977), safer sex (BEBASHI 1990), high blood pressure reduction (Ward 1984), oral rehydration therapy use (Clift 1989), and smoking reduction (Altman et al. 1987).

Used in both the developed and developing countries (Manoff 1985:221), social marketing represents a synthesis of "marketing, mass communication, instructional design, health education, behavioral analysis, anthropology, and related social sciences" (Academy for Educational Development 1987:67). While commercial marketing is an organizing concept in social marketing, as it "provides analytical techniques for segmenting market audiences, product development, pricing, testing, and distribution," the core of social marketing practice is "a commitment to understand consumer needs and to produce products, programs or practices to enable them to better solve their problems" (Bryant and Lindenberger 1992:1). Social change is promoted through culturally appropriate messages carried through mass media. These efforts are highly coordinated, working cooperatively with local agencies and community groups.

Social marketing requires skills and viewpoints that are part of being an anthropologist, and therefore increasingly we find anthropologists working in all stages of the social marketing process. The anthropologist's primary role in social marketing is research. Social marketing uses qualitative and quantitative research during all phases of planning, implementation, and administration. Good ethnographers bring many useful skills to the process, including the "creative interpretation of research into ingenious message design" (Manoff 1988:4). The attitudes of social marketers about research are highly consistent with those of

ethnographers. Both have a strong commitment to the "native" viewpoint and skepticism about survey research.

In this chapter social marketing is illustrated by the BEST START project. Directed by anthropologist Carol A. Bryant, this project is directed at increasing the number of low-income women that breastfeed in the southeastern United States.

While social marketing draws heavily from commercial marketing, there are differences (Academy for Educational Development 1987:70). First, the changes called for in commercial marketing are often less complex than those aspired to through social marketing. For example, it is less complicated to persuade people to switch cigarette brands than to stop smoking. Second, the new behavior or product may be more controversial. The promotion of safer sex practices is made difficult because of public modesty standards. Third, the new products or practices advocated in social marketing may be less satisfying to people. In the case of smoking, for example, present gratification is exchanged for future health improvements. Fourth, often the intended audience of social marketing has fewer resources and cannot easily act on their new information. Many times the target population is poor. Fifth, the politics of social marketing often require high levels of success. In the commercial realm a small increase in market share may justify substantial marketing investment, while in the public arena large, sustained increases are demanded.

DEVELOPMENT OF THE APPROACH

The use of the term social marketing dates from the late 1960s and grew out of discussions between Philip Kotler and Richard Manoff (Kotler 1975; Manoff 1985). Kotler was a professor of marketing from Northwestern University and Manoff was director of a marketing firm that had begun to approach nutrition and health education as a marketing problem. The term social marketing was used to distinguish between marketing commercial products and marketing better health practices.

The early 1970s saw increased academic interest in the idea; there were more publications on it and, of course, considerable debate about the "but is it marketing" question. During that time social marketing approaches were used in many different areas, mostly relating to promoting ideas, practices, and products in health and nutrition.

KEY CONCEPTS

There are a number of concepts that are fundamental to understanding the process. *Marketing* involves those activities that result in the movement of goods and services from producer to consumer in response to consumer demand, satisfying consumer needs, and achieving the goals of the producer. Increasingly marketing is seen as a process of communicating ideas rather than the movement

of goods and services. This may involve informing consumers of products and services or the discovery and communication of consumer needs by producers. The goal of commercial marketing is a profit or increase in market share. In social marketing the goal is societal improvement or social problem solving, a process that often involves creating demand for a socially beneficial product and developing products or programs to meet consumer needs.

The people to whom social marketing efforts are directed are referred to as the *target audience*. The primary audience is the people you wish would accept the new behavior. This group may be segmented in various ways. There may be a difference between rural and urban people, rich and poor, for example. The secondary audience is an audience that influences the decision making of the primary audience. For example, the mothers and husbands of potentially breastfeeding women are a good example of a secondary audience. The tertiary audience may be opinion leaders in the community or the general public. These are people whom others look up to, or who in other ways influence decision makers. Effective social marketing is often based on identification and targeting of a large number of audience segments. In a Brazilian breastfeeding promotion project, eight distinctive target audiences were identified. These were doctors, health services, hospitals, infant food industry, industry in general, community, government officials, and mothers (Manoff 1985:48).

Communication channel refers to the media through which the message is communicated. Typically, mass media like radio and television are combined with print media and personal communication. An important task is the identification of available communication channels, or channel analysis. An important task in social marketing is to identify the most effective channels for communicating each message. In general, mass media are used to transmit short, persuasive, or informational messages and create a climate conducive for change. Print material is used for more lengthy, instructional messages, and personal communication is used for the more complex information that requires interaction and social support.

Resistance points are the constraints that prevent people from adopting a new behavior. Resistance points can be of "social, cultural, economic or religious origin, or the product of ignorance" (Manoff 1985:107). These constraints will vary between audience segments. The resistance points are very important to identify and overcome. This is a very important aspect of the social marketing process.

Social marketing has various functions. *Demand creation* involves letting people know about the availability of a particular service or product. This requires more than simple publicity: the people need to know the relative advantage of a particular innovation and the community itself needs to be motivated to act on a particular situation. *Appropriate use* is a more complex goal (Academy for Educational Development 1987:68), because often the new practices are complex and can be applied in a variety of ways.

SOCIAL MARKETING PROCESS

The social marketing process consists of a long-term program to produce sustainable changes in a clearly defined set of behaviors in a large population (Academy for Educational Development 1987:75). There are various conceptions of the process in the literature on social marketing (Manoff 1985; Kotler and Roberto 1989; Fine 1981). The following description is based on the discussion of process that was developed in the BEST START project (Bryant and Lindenberger 1992).

The social marketing process has five phases, according to Bryant and Lindenberger. These are formative research, strategy formation, program development, program implementation, and program monitoring and revision (1992). While there are five phases, in practice the different stages are repeated depending on the experience with the specific project. That is, if a part of the strategy is not working, the team will go through a phase of the process again. The process is iterative. You change what you do, based on what you learn.

Stages in Social Marketing

I. Formative Research
II. Strategy Formation
III. Program Development
IV. Program Implementation
V. Program Monitoring and Revision

The formative research stage starts with review of recent literature on the problem and examination of existing programs that deal with the problem. Often staff of exemplary programs are interviewed and materials produced by their program are reviewed. The formative stage includes the design of a research plan in which qualitative and quantitative data needs are specified, along with potential data sources and research objectives. Identification of program partners, including collaborating agencies, occurs in this phase. Research makes use of in-depth interviews, focus groups, and surveys of various types, creating a foundation for the project.

Formative research includes preliminary research on the community and agency context of the project. Social marketers need to know the nature of the organizations and persons with whom they will be working. These people need to achieve consensus on the nature of the problem. It is this consensus that makes things work. It is very important to identify the "real players" rather than the formal leadership as depicted in the organization chart. When the concerns of the cooperating professionals are not understood and addressed, projects fail.

Formative research identifies the target population's perception of the problem and the nature of resistance points. This research typically has a very large qualitative component, often based on the focus group technique. The strategy development stage also requires the identification of the primary, secondary, and tertiary target audiences, with the appropriate segmentations.

Staff identify media that are available for the project. It is important to find out what the target audience listens to, watches, and reads. In developed countries this information is often readily available; in less developed countries it may be necessary to research the question of media exposure. This information is necessary for the formulation of an effective media plan.

During this early phase the team carefully establishes network ties with organizations that may be interested in the project's problem. These can be private voluntary organizations, religious organizations, commercial organizations, and various governmental organizations. This collaboration will back up the media campaign. Organizational networking is done to multiply the impact of messages, to obtain feedback from stakeholders and to decrease interagency competition.

The second stage in the social marketing process, *strategy formation*, is done in planning sessions with staff and key advisors, who are often representative of stakeholders and program partners. The first step in strategy formation is to produce a definitive statement of the problem. Once the problem is defined, the social marketing team expresses it as project objectives. Objectives are described in measurable action terms that relate to the goals of the project. Objectives need to be measurable, expressed in terms of "required input, desired output, and a time frame" (Manoff 1985:106). Manoff warns that they can be "too broad, too vague, too unrealistic, or 'off-target' " (1985:106). It is important to have measurable objectives so that evaluation of performance is possible.

The strategy formation stage is concluded with identification of the elements in the messages that will be included in the campaign. This includes selection of message content, spokespersons, and tone. These decisions create the basis of a marketing plan.

The third stage is *program development*, a stage often carried out with the help of an advertising agency. Program development includes message design and materials development. The entire program development stage is directed at producing a written media plan, which describes the formation of the project strategy. The plan includes the messages, the target audience and its segments, media to be used, the products, the research design for tracking the project, and the plan for integrating the project with other organizations. Media planning includes "preparation of draft or prototype materials; materials testing; final production and program inauguration" (Manoff 1985:111). The actual media can be developed "in-house" or they can be purchased from advertising agencies. Prototype versions of public service announcements, pamphlets, instructional tapes, advertisements, and other messages are prepared, pretested, and revised. This pre-testing is to decide whether the developed messages are "comprehensible, culturally relevant, practical, capable of motivating the target audiences, emotionally appealing, memorable and free of negatives" (Manoff 1988:3). Product development includes decisions about product names, packaging, price, and supportive promotion and sales materials. All this requires the technical

skills of persons trained in media. The anthropologist will bring skills in research that will support the development of the product through research.

After pre-testing, the materials enter final production. The team makes presentations of the project to public officials and community groups for approval and guidance. The presentation will include supporting research results that can guide their decisions about the effects of the materials.

Also part of the development stage is identification of "primary, secondary and tertiary audiences and their component segments" (Manoff 1988:3). As part of this process, resistance points that limit the potential for change in behavior are identified. Persons and institutions that can advocate the desired change need to be identified. The team looks for opinion leaders in the community or any person that would "enhance credibility" of the messages, thus increasing the chances for change in behavior. The last component of the strategy development stage is the determination of the media use patterns of the population.

Channel analysis continues as part of the program development phase. In channel analysis researchers identify the pathways through which messages, products, and services can be delivered to a population (Lefebvre and Flora 1988:305), and how these pathways complement and compete with one another. In the social marketing framework this can include everything from electronic and print media to social networks and opinion leaders. It is necessary to inventory all the places where a person encounters messages; these in turn become possible channels to use in the marketing process. Lefebvre and Flora speak of the identification of "life path points," which they exemplify from an American urban setting as laundromats, groceries, restaurants, and bus stops. In channel analysis the researcher not only knows which channels the population is exposed to, but which ones are most influential and important. For example, for certain health behavior changes the mass media do not present credible information, while personal networks do.

The fourth stage is *program implementation*. This includes implementation of policy changes, training of professionals, and distribution of educational materials. Also the public information program may be launched.

The last phase of the social marketing process is *program monitoring and revision*. This has two components, formative and summative. The formative evaluation determines strengths and weaknesses of project components so that the project can be improved. The team introduces improvements in the process to increase effectiveness. Summative research finds out the actual impact of the project. Much of the summative research consists of studies to identify knowledge, attitudes, and practices of the project's products by potential consumers. These are repeated, with uniform measures and sampling, so that the results can be compared wave after wave to answer questions such as what the target audience knows and does because of the project. These may be supplemented with qualitative data collection to get at meanings that cannot be investigated with surveys.

SOCIAL MARKETING AND FOCUS GROUPS

A research technique often used in designing the social marketing plan is the focus group, or group depth interview. Sociologist Robert K. Merton developed the focus group technique while doing research on German propaganda films done during World War II. Merton wanted to provide an interpretive framework for quantitative data collected with propaganda film viewers to try to find out why they answered questions the way they did about their psychological responses to propaganda films (Merton and Kendall 1946; Merton, Fiske, and Kendall 1990). Examples of use of focus group research in social marketing can be found in many areas, including social action programs (Schearer 1981), family planning (Folch-Lyon, Macorra, and Schearer 1981), vitamin supplement use (Pollard 1987), and educational evaluation (Hess 1991).

A focus group is a small group discussion guided by a moderator to develop understanding about the group participants' perceptions of a designated topic. While it can be argued that data collection efficiency is improved because you are increasing the number of interviewees being interviewed at one time, more important are the effects of the interaction of the participants being interviewed. Morgan states this clearly: "The hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group" (1988:12). While the interaction deals with the content specified by the moderator, the interaction should be informal and lively. Morgan describes it as being like a conversation between neighbors or friends.

The composition of focus groups is carefully planned to produce representative information about the population. The difficulty and cost of recruiting participants can vary considerably with the nature of the research problem. When a highly specialized population is being researched it may be expensive to find qualified participants. The number of group participants is typically between six and eight, although sometimes the groups are larger (Morgan 1988).

Smaller groups involve more interviewee participation and are more susceptible to the impact of domineering persons. Larger groups require more moderator participation. Unless you are investigating the life of a small organization it is unlikely that your research results will be statistically generalizable. It is best to overrecruit participants so that persons that are inappropriate can be easily replaced. The sessions usually do not last more than two hours.

It is important to be very aware of the problem of bias in participant selection. It is also important to screen the participants carefully so that you are sure they do share the relevant attributes. As Morgan states, "participants must feel able to talk to each other, and wide gaps in social background or life-style can defeat this" (1988:46). Gender, ethnicity, age, and class may influence willingness to discuss a topic. While participant similarity is important, it is better if the interviewees do not know each other.

The number of focus groups to be completed is an important consideration both methodologically and practically. The increase in the number of types of participants of course will lead to an increase in the number of groups. For example, if urban and rural differences are important you will need groups for each type.

An important part of quality data collection is the creation of a permissive, nonthreatening atmosphere, conducive to revelation and disclosure. Moderator skill and group homogeneity are important factors in establishing these conditions. Moderator involvement varies with the purpose of the research. As Morgan states, "if the goal is to learn something new from participants, then it is best to let them speak for themselves" (1988:49). High moderator involvement may be called for when it is necessary to get the discussion back on the topic, when the group loses energy, when minority positions are stifled, when domineering individuals need to be shut down, and when some participants need to be encouraged (Morgan 1988:51).

Morgan encourages low moderator involvement through a process he calls group self-management. To a large extent this involves simply giving the focus group participants expectations for their own behavior through instructions that will lead them in the desired direction. For example you might tell them to expect that if they get off track a member of the group will pull them back. Other practitioners of the technique may more directly intervene. It is also possible to intervene more at the end of the session to help make sure that the ground is covered. In any case the interviewer "must develop the practice of continuously assessing the interview as it is in process" (Merton Fiske, and Kendall 1990:11).

Like other techniques, focus group interviewing has both strengths and weaknesses. The technique is practical because it can be done quickly and easily. Morgan says that "when time and/or money are essential considerations, it is often possible to design focus group research when other methods would be prohibitive" (1988:20). A focus group–based research project does not require large teams of interviewers. Kumar estimates that a project based on ten to fifteen interview sessions can be carried out within six weeks under normal conditions (1987:6).

Focus groups are most useful for discovery, and less useful for hypothesis testing. When you are unfamiliar with the content or are potentially biased, focus groups offer real advantages. The approach may not work well on topics that are highly private, and it is sometimes difficult to get all persons in the group to participate equally. It is important to note that an important principle in ethical research practice is that the researcher does not share information obtained from one informant with another. While this is the essential feature of the focus group approach, people can choose not to talk. While this solves the ethical problem it raises considerable methodological issues. Privacy and confidentiality may go far to encourage talk.

CASE STUDY: BEST START—A BREASTFEEDING PROMOTION PROJECT

The BEST START project was a joint effort of public health agencies in eight southeastern states to promote breastfeeding among low-income women by developing effective promotional messages and a workable strategy for communicating them. The developed materials and strategies were made available for use to programs around the country through a nonprofit organization called BEST START, Inc.

A team led by anthropologist Carol A. Bryant planned the project. Doraine F. C. Bailey contributed to the research and planning and subsequently served as the coordinator of the Kentucky state project and the local project in Lexington, Kentucky. Jeannine Coreil contributed to the formative research and strategy formation phases of the project by conducting focus groups among audience members and health professionals. The project was a collaboration between local health departments and three national organizations—the Healthy Mothers, Healthy Babies Coalition, the National Center of Education in Maternal and Child Health, and the National Maternal and Child Health Clearinghouse.

Breastfeeding offers considerable advantages over bottle-feeding. Mothers benefit because it offers a quicker recovery from childbirth, stronger bonding with the infant, and an emotionally satisfying activity. The infants are better off because it offers the best nutrition for normal growth and development, protection against disease, especially ear infections and gastrointestinal illness, and decreased risk of allergies. There are significant societal benefits. Breastfeeding results in stronger family bonds, increased self-esteem of women, decreased cost of infant formula in food subsidy programs, and decreased health care costs for infants (Bryant 1989:11).

Because of these advantages the U.S. Surgeon General, in his series of national health objectives for the year 2000 (U.S. Public Health Service 1991:379), included the goal of increasing breastfeeding to 75 percent of mothers at hospital discharge, from 54 percent in 1988. Increasing breastfeeding is a matter of national policy in the United States.

In spite of the advantages of breastfeeding, and considerable investment in public health education programs, the rate of breastfeeding among low-income women remained low. The rate of breastfeeding has increased among middle- and upper-income women.

The BEST START: Breastfeeding for Health Mothers, Healthy Babies Program is addressing these goals for a consortium of public health agencies in eight southeastern states, based on social marketing principles. Specifically BEST START's goal is to "enhance breastfeeding's image among economically disadvantaged women and the public at large" and "to motivate economically disadvantaged women, especially those participating in WIC [a federal mother and child food supplement program], to breastfeed" (Bryant et al. 1989:15).

Bryant's team used the social marketing approach because the traditional clinic-based health education directed at low-income women did not work (Bryant et al. 1989:642). Low-income women were not given the information they needed to make the decision to breastfeed. The messages used were culturally inappropriate. The clinical staff did not have the time for education activities. Further, the constraints faced by low-income women were poorly understood.

During the formative research phase, project staff completed forty focus group interviews with low-income women in Tennessee, Kentucky, Georgia, Florida, North Carolina, and South Carolina. Most of these women were recruited from public health programs. BEST START researchers conducted focus groups among black and white women, teenaged and older women, urban and rural women, and women that were bottle-feeding and breastfeeding. These interviews were conducted in health department conference rooms.

The location of the interviews was the place where the women usually received health services or their WIC support. Interviews involved from three to eight people, plus one or two moderators. The first moderator introduced topics and interjected questions and guided the discussion. The second person helped supervise audio or video recording and helped interpret questions. The interviews lasted from one to three hours. Often participants expressed satisfaction about participating in the process because it gave them positive feelings and they learned so much from their peers.

The analysis emulated Krueger's "chronological sequence of analysis" and made use of ideas expressed by various other researchers (Krueger 1988; Agar and Hobbs 1985; Glaser and Straus 1967; Miles and Huberman 1984). After each session the moderators prepared short summary statements on various topics. Focusing on each participant, they identified any problems with the recruitment criteria and considered "level of enthusiasm, strength of infant feeding preference, consistency of comments and reported behavior" (Bryant and Bailey 1991:30). Also identified were themes concerning breastfeeding constraints and motivational factors that might stimulate change. Differences between participants were noted. Researchers considered the way these women spoke about the topic; this information often influenced the questioning process in subsequent sessions. The moderator's techniques and the interview success were evaluated.

Researchers processed each interview with the help of a computer program called The Ethnograph (Seidel et al. 1988). This program allows the coding, indexing, and subsequent retrieval of portions of the interview transcript. Codes reflected questions in the interview guide and were expanded as analysis proceeded. Retrieval with The Ethnograph is done in terms of subsets of the sample so that comparisons can be made by ethnicity, parity, respondent age, residence, and other variables. For example, the statements made by black teenagers on a particular topic can be retrieved from the data base and read and written about. This software allows the nesting and overlapping of codes. Some might assume that the use of this software makes analysis a mechanical exercise. The software serves only as a more efficient and complete means for shuffling through and

reading all the field notes. It is still necessary to think it through and interpret the meaning.

Through the focus groups, the BEST START team learned factors that were attracting women to breastfeeding. An important component of attraction was the mother's aspirations. Like other mothers these women hoped for a special relationship with their children; they wanted a closeness with the baby that would endure beyond childhood. Mothers wanted to give their children a better life than they had when they were young. Especially they wanted health, happiness, and a good education for their children. Participants saw breastfeeding as a means for establishing an exclusive relationship between mother and child.

Teenage participants viewed motherhood as an opportunity to come of age, to gain positive attention from friends and family, and to establish a long-term relationship with their child. They also thought that breastfeeding can indicate maturity and responsibility and a certain adventurousness that can set her apart from her peers. These mothers were also concerned about their children becoming too attached to the people that often provide child care. They felt that breastfeeding can help prevent the child from becoming too attached to these other caregivers.

Most of the focus group participants were aware that breastfeeding offers significant health benefits to the child, such as protection from infection, fewer allergies, and better nutrition. Breastfeeding mothers expressed these ideas with pride and said they felt they were giving their children the best. Many bottle-feeding mothers accepted these claims, but questioned their significance. Some challenged these claims, citing their own observations, and a few believed bottle-feeding is superior.

The breastfeeding mothers regarded nursing as a special time that only a mother can enjoy with her children. They noted that it makes them feel relaxed; some even reported falling asleep. Many women cherished the experience as a memory that makes motherhood worthwhile.

The research team identified several barriers to breastfeeding. The most important constraint to starting and continuing breastfeeding was many women's lack of confidence in their ability to produce good milk in an adequate supply. These women often did not understand how milk is produced. Often, in response to their fears of milk inadequacy, they would use formula supplements, resulting in a real reduction in the supply. These women felt that breastfeeding is a more complex, difficult to learn skill than it really is. Their lack of confidence made them more easily discouraged when they heard of other women's negative experiences.

An important constraint was the embarrassment that women might feel about breastfeeding when others are present. There were significant differences between breastfeeding and bottle-feeding women in this regard. Some saw breasts as sexual objects that would arouse men and make their husbands and boyfriends jealous. They thought breastfeeding would make other women jealous and that it might be viewed as disgusting. These women resented having to go and "hide"

in a public rest room, their car, or the bedroom at home when they were breastfeeding. Others said they would feel comfortable in public if they could be discreet. Many said they feel comfortable breastfeeding in the presence of their husbands or boyfriends, mothers, sisters, or other female relatives or friends; others felt uncomfortable breastfeeding in the presence of these people. A small number of focus group participants felt that breastfeeding was not possible for them; for them breasts were strictly sexual and the idea of putting a baby's mouth on them was disgusting.

Historically, promotional materials have used women who are unusually attractive or well-dressed as models, and have stressed the importance of being healthy and relaxed. These messages reinforced the poorer women's fears that they might not be able to meet their health and nutrition needs and follow the practices needed to breastfeed successfully.

The women expressed concern that breastfeeding would cause them to lose freedom. They saw breastfeeding as incompatible with an active social life. Younger women thought that it would prevent them from having time for themselves and their friends. Women expressed these ideas in various ways—breastfeeding will make it hard to leave the child with the babysitter, for example, and the breastfed child will cry when its mother is not nearby. These women tended not to know how to mix breastfeeding and formula use. Some thought the use of breast pumps was messy, painful, or a "hassle," and that school and work were constraints on starting and continuing breastfeeding. Some felt that they couldn't cope with breastfeeding while going to work.

The women were concerned about their ability to make life-style changes such as cessation of smoking tobacco and drinking alcohol. They also expressed concern about their ability to eat properly, to get enough sleep, and to be relaxed. Some women thought that breastfeeding might be more painful than they could tolerate and that breastfeeding would disfigure their breasts.

The formative research was used to formulate guidelines for design of messages and other aspects of the program. The development team concluded that the tone of the campaign should be strongly emotional, "to reflect the strong feelings women attach to their aspirations for their children and themselves as mothers" (Bryant and Bailey 1991:32). The messages themselves were to be succinct and easy to understand, in order to "counteract the mistaken belief that breastfeeding is complicated or difficult" (Bryant and Bailey 1991:32). The development team thought it was important that the women featured in the materials be of the same economic level, ethnic backgrounds, and ages as the targeted population. They concluded that images used in print and broadcast media should communicate modernity and confidence, and that celebrity spokespersons should be avoided.

The educational campaign was to emphasize that most women can produce enough good milk despite differences in diet, stress levels, and health status. The research showed there was a need for social marketing efforts that made use of various mutually supporting activities to change the image that lower-

income women had of breastfeeding, and to help these women in overcoming the barriers to this behavior.

The project developed many educational materials based on the formative research that helped to overcome barriers to breastfeeding. These emphasized benefits identified in the focus groups as appealing to low-income women. Public information materials included five television public service announcements and seven radio public service announcements, in English and Spanish. Educational materials included videotapes featuring testimonials taken from focus group interviews with WIC food supplement recipients.

A pre-test of this tape revealed an interesting oversight that had to be corrected later. When pilot tested among clients, the tape was seen as highly motivational: women enjoyed seeing WIC clients discuss their fears and how they overcame them. The health professionals were less enthusiastic. They mistakenly believed that the WIC participants, who were more expressive and articulate in a focus group than a clinic setting, were actresses working from a script. Program designers had to revise the tape to explain that the women were, in fact, all WIC participants. This tape has also been produced using Spanish-speaking WIC participants.

Other educational materials included five posters, ten pamphlets in English, seven in Spanish, and ten pamphlets written for a low literacy population. For health professionals, a motivational videotape, training tape, and accompanying training manual have been produced to teach a new counseling approach. New and revised materials are being developed with proceeds from sales.

The team developed a counseling strategy for breastfeeding promotion based on what they discovered in the formative research. The team developed a three-step approach to breastfeeding promotion in order to "counteract the lack of confidence and lack of knowledge that are at the root of these women's fears and doubts" (Bryant 1990). The counseling steps are 1) elicit client's concerns; 2) acknowledge her feelings; and 3) educate.

The experience of the focus groups revealed that women need assistance with sorting out their feelings. The first step in the counseling process, therefore, is an open-ended exploration. Clients are asked about their feelings about breastfeeding, as opposed to direct questions about whether they want to feed with a bottle or breast. A typical question is "what have you heard about breastfeeding?" (Bryant 1990:C–4).

In addition to their feelings, the women's knowledge of breastfeeding is explored. Step one of the counseling process represents a kind of emotional and cognitive diagnosis that helps the counselor select materials to stress in further counseling. Inviting women to speak about their concerns validates these concerns and allows resolution.

In step two the counselor acknowledges the women's feelings. The most consistent problem is that the client thinks her response is unusual. With acknowledgment, the client's comfort increases as the encounter feels safer, es-

pecially if she receives positive reinforcement. It is important to respect her. As Bryant expresses it, "by laying this foundation of trust, you also build her self-respect and self-confidence, which is a prerequisite for successful breastfeeding" (1990:C–3).

The third step is education of the client with carefully targeted messages. The new information allows the woman to ignore misinformation that she has received in the past. Women tend not to understand the lactation process and therefore are easily influenced by fear-producing misinformation. The formula producers provide information about the quality of the product that is reassuring. Breast milk, on the other hand, does not come with an ingredient list.

It is important not to overload the women with new information, as the BEST START team found that can reinforce her fears. The counseling strategy can address women's lack of confidence, embarrassment, her concerns about loss of freedom, dietary and health practices, and the negative influence of family and friends. The counseling education strategy reflects the team's recognition that a major barrier to breastfeeding was lack of confidence, and that the foundation for the solution was listening to the women. Empowerment is very important.

The use of the focus group data was comprehensive. The whole fabric of the content of the campaign was based on these materials. In retrospect Bryant felt the educational materials should have been pretested with professional health educators. These people serve as gatekeepers, as they make the decisions about local program design and the purchase of media. It would have been very useful to know what their concerns were. It also would have been useful to have interviewed husbands and boyfriends.

The use of materials developed through this project is widespread. About thirty state programs are using the materials at one level or another. Ten of these programs have been funded by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services as part of an effort to build state-level programs. Evaluations have shown that the materials have a high impact: substantial increases in breastfeeding among low-income women have occurred at various sites.

SUMMARY

Social marketing is an approach to producing changes in people's behavior through the use of culturally appropriate education and advertising media, widely disseminated through communication channels, including mass media. Social marketing draws heavily from practices associated with commercial marketing although it is generally recognized that social marketing is more complex and difficult. The technique is most widely used in the area of public health and has had an impact on smoking, sexual behavior, and cardio-vascular problems, among other concerns.

The development of media with culturally appropriate content is an important

part of social marketing. The media development process uses social science research to identify cultural and social constraints to behavioral change and to select communication channels that have the potential for high impact. Anthropological research skills are often used in social marketing because of the importance of understanding the viewpoint of members of the community.

Focus-group research techniques are an important data-collection technique in social marketing. Based on the work of sociologist Robert Merton, focus group technique involves a group interview process that is quite consistent with cultural anthropology research practice. A focus group's leader facilitates discussion among a small group of informants selected for their capacity to illuminate a particular marketing problem. The texts that document this discussion represent the primary product of focus-group technique. These materials are analyzed and help shape the research that is used to structure the media campaign.

FURTHER READING

Bryant, Carol, and Doraine F. C. Bailey. 1991. "The Use of Focus Group Research in Program Development." In *Soundings: Rapid and Reliable Research Methods for Practicing Anthropologists*. NAPA Bulletin no. 10, John van Willigen and Timothy J. Finan, eds. Washington, D.C.: American Anthropological Association.

A detailed and concrete discussion of the formative research process in the BEST START project. It shows in remarkably clear terms how this process works.

Kotler, Philip, and Eduardo L. Roberto. 1989. *Social Marketing: Strategies for Changing Public Behavior*. New York: Free Press.

This comprehensive and straightforward guide shows how organizations can be more efficient using a social marketing approach.

Manoff, Richard K. 1985. *Social Marketing: New Imperative for Public Health*. New York: Praeger.

A readable, concrete account of the social marketing process.