Healthcare Consumerism: Increasing use of Condoms through Social Marketing in Fiji

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Keywords: condoms, social marketing, Fiji, HIV/AIDS, STIs, monitoring & evaluation

Abstract

This paper discusses the impact of using social marketing principles to increase the use of condoms amongst youths in Fiji so as to inhibit the spread of HIV/AIDS and other STIs. Program assessment shows that the CSM program was successful in increasing the acceptability, accessibility, and usage of TRY TiME condoms in Fiji. In spite of such results, responses received from a sample of sexually active people through a survey conducted in January–February 2009 showed that there might still be a need to raise mass awareness about quality/branded condoms, maintain adequate supply of condoms at distribution sites, and train sales-people at traditional and non-traditional distribution outlets. In line with the theme of this conference, this paper argues that social marketing can increase healthcare consumerism by using innovative techniques to promote consumption of goods and behavior that protect individuals from sexually transmitted diseases and unwanted pregnancies.

Introduction

Social marketing strategies can be used to increase the use of health-related products, increase access to health services, or create changes in health behavior and practices (Israel & Nagano, 1997). In the 1970s, developing countries began applying social marketing principles in family planning (Cugelman, 2010), followed by issues related to sexual & reproductive health such as HIV/AIDS. As a matter of fact, condom social marketing was one of the first applications of social marketing and HIV/AIDS prevention on an international level (Lombardo et al., 2007). When used in such context, social marketing programs have helped to improve the distribution of contraceptives, increase sales of contraceptive products, spread knowledge, and stimulate wider use of contraceptive methods (Honeyman, 2008; Novelli, 1989). The UNAIDS (2000) report concurs that condom social marketing programmes have helped to make condoms accessible, affordable, and acceptable in many developing countries such as Haiti, Mozambique, India, Cameroon, Kenya, and Colombia. Bangladesh reportedly used social marketing techniques to raise awareness and distribute contraceptives such as pills, condoms and foaming spermicidal suppositories (Rosenfield et al., 1987; Schellstede & Ciszewski, 1984). Additional reports show that social marketing was adopted by Colombia and Egypt to promote the use of contraceptives as well as oral rehydration therapy (Fox, 1988; Vernon et al., 1988).

The earliest record of the use of social marketing in the Pacific region dates back to July 1993 when the South Pacific Alliance for Family Health (SPAFH) attempted to promote contraceptives through social marketing in Fiji, Solomon Islands, Tonga and Vanuatu (Duve & Samuel, nd). This project was part of Project EXCEL (Expanding Country Efforts at All Levels) funded by Australian Agency for International Development (AusAID) and United States Agency for International Development (USAID). The social marketing of *Protector* condoms through Project EXCEL proved successful, especially in creating acceptability and visibility of condoms in Fiji (Duve & Samuel, nd). In later years, the Condom Social Marketing (CSM) program was designed and implemented by the Marie Stopes International Pacific (MSIP) – which operated as a non-governmental organization in Fiji. This program was launched in February 2006 for a period of three years, but it was later declared as an ongoing project. The program aimed to increase awareness and utilization of safer sexual practices and facilitate positive behavior change amongst vulnerable groups, especially young people considered to be at risk of sexually acquiring HIV and STIs (MSIP, 2007). Unfortunately, the program was suspended in December 2010 due to the phasing out of MSIP's Fiji-office and its STI Clinic to Papua New Guinea. Nonetheless, program evaluation reports show that the CSM program has raised mass awareness about TRY TiME condoms and recorded increased sales of condoms in Fiji. This paper aims to provide valuable insights into the design, implementation, and impact of the program; and highlight important lessons for future social marketing programs in Fiji.

Background

Over the years, many awareness programs have helped people in the general acceptance of the HIV/AIDS epidemic in Fiji (Fiji Times Online[1], April 2007). However, there has been a steady increase in the number of reported HIV/AIDS cases over the past decade in Fiji, in spite of implementation of multiple prevention programs and increased accessibility to health services,

[1] http://www.fijitimes.com/story.aspx?id=61605

(WHO, 2005). Factors that fuel the HIV epidemic in Fiji include early initiation of sex or teenage pregnancy, cultural taboos related to sexuality, high rates of sexually transmitted infections, gender inequalities, practices such as tattooing and polygamy, and a youthful and transient population (SPC, 2009; WHO et al., 2006). As of 31 December 2009, Fiji recorded a cumulative total of 333 HIV cases amongst a mid-year population of 843, 888 people (SPC, 2010). Although the current prevalence of HIV/AIDS remains low, health agencies remain concerned about underestimating and possibly the underreporting of the overall HIV cases in Fiji. Such concerns are heightened and justified from records of sexually transmitted diseases, which often act as a better picture of the ongoing sexual practices of sexually active people. Fiji reported an average number of 1348 cases of Gonorrhea annually during 1998 till 2004 (WHO et al., 2006). External evaluators, such as Fowler et al. (2007), report that the quality of prevention strategies in the Pacific has not been high due to the fact that specific interventions are developed in isolation from broader program frameworks. The authors revealed that programs were primarily targeted at raising awareness about HIV/AIDS and such interventions were often equated with behavior change, and there was hardly any program evaluation. In the mid-review report of the Pacific Regional Strategy on HIV (2004-2008), Fowler et al. state that ongoing risk behaviors appear to be present even amongst those who have accurate knowledge of HIV/AIDS; thus, indicating a need for more intensive and sustained behavior change interventions (WHO et al.,2006).

Methodology

This paper reports on relevant findings obtained from the study conducted in 2009–2010 by the author as part of a Masters program at the School of Management & Public Administration at the University of the South Pacific. All documents and reports related to the Condom Social Marketing program were acquired during face-to-face interview with the program coordinator in February, 2009. An assessment was then carried out using Andreasen's benchmark criteria (Gordon et al., 2006; and Stead et al., 2007) to ascertain whether the CSM program contained all the social marketing elements (in particular: behavior change objective, consumer research, segmentation & targeting, 4 P's of the marketing mix, exchange theory, and competition). Additionally, a cross-sectional survey was carried out in January-February 2009 to collect information regarding people's usage of condoms (in particular, reasons for using or rejecting condoms, frequency of use, and type of condoms purchased), affordability of condoms, place where condoms were purchased, common experiences during condom transactions, reaction of salespeople and the need for proper condom etiquette, and the need for more condom awareness amongst the public. Structured questionnaires that were self-administered by the target audience were distributed to a sample of two-hundred sexually active people such as youths or people of reproductive health.

Results

Design and Implementation

Fiji's Condom Social Marketing has adequately addressed all the characteristics outlined in Andreasen's benchmark criteria (see table 1). The prime focus of the CSM program was to promote TRY TiME condoms amongst the youths of Fiji. Since TRY TiME condoms had existed in Fiji markets from 2004, Marie Stopes International Pacific hired the Tebbutt Research agency in 2005 to examine its use. Results from Tebbutt Research (2005) showed that a total of 321 people (approx 25%) within a sample of 1271 people were aware of TRY TiME condoms. Such

statistics prompted MSIP to relaunch TRY TiME condoms through the Condom Social Marketing program in February 2006. Apart from supplying TRY TiME condoms to traditional and non-traditional outlets, peer educators advocated and distributed TRY TiME condoms during community education sessions and mobile clinical outreach programs (MSIP, 2007). The highly noticeable feature of the program was that it provided education workshops to advocate for protection against STIs and condom use at places that were most convenient to their target audience. For instance, the CSM program provided education session directly to church groups and faith-based organizations that requested them (MSIP, 2007).

Table 1: Attributes of Fiji's Condom Social Marketing Program

Andreasen's Benchmark Criteria	**Description**
1. Behavioral Objective	To increase awareness and utilization of safer sexual practices and facilitate positive behavior changes amongst vulnerable groups, esp. young people, in the South Pacific.
2. Research	MSIP used findings from the Tebbutt Research and health statistics from Fiji Ministry of Health to design the CSM program. As part of monitoring & evaluation, MSIP carried out a baseline survey in 2009.
3. Segmentation & Targeting	The CSM Project focused on the youths of Fiji because it believed that this was the most vulnerable group that was supposedly at the highest risk of contracting STIs. The project targeted schools, workplaces (such as hotels and factories), community events, social events (like festivals and concerts), sports functions, churches, and faith-based organizations as a means of reaching young people.
4. Marketing mix	**Product:** *Actual Product*: TRY TiME Condoms *Supplementary Product:* Informational booklets (brochures), TRY TiME stickers, T-shirts, Caps, Umbrellas, Drink bottles, Wrist bands, and Pens. *Services:* VCCT services (voluntary testing, counseling & support), pap smears **Price:** - TRY TiME condoms were sold at a *subsidized rate* and distributed to traditional and non-traditional outlets around Fiji - *Cultural barriers* included criticisms made by some faith-based organizations regarding sexual education and condom use (this was more persistent in Samoa but also existed in Fiji) - *Social Taboos (*Code of Silence on sexual & reproductive health) - *Common Myths* still existed within some communities in Fiji and this posed as a barrier to contraceptive use since it resulted in formulation of negative attitudes towards condoms **Place:** - MSIP supplied TRY TiME condoms to pharmacies, community-based sellers, small canteens, supermarkets, bars, nightclubs, and hotels around Fiji. The project team often visited rural communities and outer islands to identify new distribution outlets. - The CSM program often sponsored activities (such as dance competitions), hosted concerts, and participated in marches organized during national and social events celebrated in the capital city (Suva). - Peer educators carried out education workshops in rural communities, schools, workplaces (such as garment factories), churches, and other faith-based organizations around Fiji. - The project team also set up information booths and promoted TRY TiME during major sports functions in Fiji (e.g. during rugby or soccer games) **Promotion:** The CSM Project made use of several promotional tools. These included: - Participation in 2 major concerts held in June and December of 2007 in Suva. - Publication of relevant articles and advertisements in local magazines such as Marama (for Women), Turaga (for Men), Just Sport, and Just Teens magazines.

	- Billboards advertising TRY TiME condoms were placed at certain locations around the country to promote their usage - Participation in national events such as the Hibiscus festival by sponsoring dance competitions. - Inclusion of sports celebrities (especially from the Fiji Rugby team) to advocate about HIV/AIDS during events organized by the project team. - Fiji-based peer educators participated in radio-talkback shows (such as the Domo I Viti show) to discuss issues related to adolescent health, STIs and HIV/AIDS. - Participation in street marches organized during World AIDS Day celebrations.
5. Exchange	Subsidized condoms, free information package, voluntary testing, counseling & support were offered as part of the exchange process.
6. Competition	Free condoms were distributed by certain organizations that interfered with the sale of TRY TiME condoms. In addition, different varieties of condoms and contraceptives were available in the market at competitive prices.

Source: Information presented in this table was analyzed from various documents provided by MSIP-Fiji.

Impact of the CSM Program

One of the weaknesses of the program was that it lacked rigorous and consistent program evaluation data. Some of the data recorded in the 2007 program report were withheld when the report was made available to the author during the interview. It was clear that the program initially lacked proper monitoring and documenting protocols. The information that is discussed here was obtained from later issues of the program report and information that was publicly available on the internet. The impact of such a program can be measured through indicators such as increase in contraceptive use and HIV testing (Christopoulos et al., 2009). A recent report by MSIP revealed that during the period of 2007 till 2010, MSIP had distributed 218,815 family planning pieces in the Pacific through its clinical services located in different Pacific Island countries (MSIP, 2010b). In Fiji, MSIP had managed to sell over 184, 078 TRY TiME condoms towards the end of 2009 (ibid). In 2009 alone, MSIP reported that the Condom Social Marketing program had delivered 1,824 Couple Years Protection in contraception services, performed 120 pap smears, and carried out 36 VCCT for HIV detection in Fiji (MSIP, 2010a). In comparison to previous years, MSIP recorded delivering 55% more CYPs in 2009 than in 2008, and 44.6% more CYPs in 2009 than in 2007 (MSIP, 2010a). More notably, MSIP claimed that it had achieved 70% brand awareness within government and community health organizations for TRY TiME condoms and that it supplied contraceptives to 1 in every 54 women in Fiji (MSIP, 2010a).

Implications for Future Social Marketing Programs in Fiji

Certain factors such as inconsistent program evaluation data and existence of multiple health interventions make it difficult to trace behavioral changes to a particular health intervention. For such reasons, population surveys can often provide a general indication of the existing KAPB levels with regards to HIV/AIDS. A good example is the second generation surveillance survey that was conducted in six Pacific Island countries during 2004-2005 (WHO et al., 2006). In contrast, this paper tried to assess people's responses towards 4 P's of the marketing mix that are commonly present in social marketing programs. Such information may not be usually present in epidemiological and health reports. For instance, table 2 shows that a higher number of respondents experienced negative emotions while purchasing condoms and many agreed that shop owners and sales people need to have proper condom etiquette. The overall condom use amongst respondents remained low despite the popular opinion that condoms were affordable. Some of the common reasons people did not use condoms included their dislike for the product, inconsistent availability, and moral reasons that often included religious beliefs regarding

condoms. People generally preferred to use branded or quality condoms in comparison to those that were available free of charge. Future health interventions need to utilize such findings and place greater emphasis on addressing all the elements of the marketing mix.

Table 2: Survey Responses towards the 4P's of Marketing Mix (N=137)

Marketing Mix Element	Response (%)
BEHAVIOR	
i. Had sexual relations with >1 partner?	Yes – 54.4; No – 45.6
ii. Overall condom use	None – 38.3; Low – 45.7; High – 16
iii. Frequency of condom use with partner	All the time – 8.2; Sometimes – 36.7; Hardly – 16.3; Never – 38.8
PRICE	
i. Are condoms affordable?	Yes – 53.8; No – 17.9; Don't know – 28.2
ii. Type of condom used	Branded/Quality – 28.5; Free – 12.4; Available – 11.7; Attractive packaging – 10.2; Affordable – 8; Special offer – 5.1
iii. Feelings during condom purchase	**Positive emotions***-21.1; **Negative emotions***- 37.1; Neutral – 19.7
PRODUCT	
i. Reasons for not using condoms	Don't like it – 21.9; Irregular supply – 19; Moral reasons – 17.5; Other reasons – 13.9; Breaks easily – 5.8; Too costly – 5.8; Don't know where to buy – 2.9
PLACE	
i. Place where condoms were purchased	Pharmacy – 36.5; Shops – 19; Other places – 4.4
ii. Reaction of people where condoms were purchased	No reaction –34.3; Provide encouragement –10.2; Humiliate you – 6.6; Praise you – 4.4; Tease you – 3.6; Speak rudely-1.5
iii. Shop owners & sales people need to have proper condom etiquette	Absolutely yes –29; Yes –41; DK –20; No-8; Not at all – 2
PROMOTION	
i. Seen condom advertisement	Yes – 97.7; No – 2.3
ii. Place where condom ad was seen	Television – 73.7; Radio – 48.2; Newspapers – 47.4; Magazine – 47.4; Brochures – 46.7; Billboards / Posters – 38; Internet – 27; Others – 2.2
iii. Do condom ads stimulate condom use?	Yes – 38.9; No – 37.9; Don't know – 23.2
iv. Need for more condom awareness?	Yes – 65.8; No – 9.2; Don't know – 25

Note: * *Positive* emotions involved proud, used to it, or confident; while *Negative* emotions involved angry, insecure, embarrassed, self-conscious, shameful, or uncomfortable.

Conclusion

This study is limited in the sense that it simply provides a descriptive analysis of the CSM program with limited post-evaluation data. The author additionally acknowledges that the survey results may not be directly related to the CSM program. While findings presented here could be interpreted as merely reporting the short-term impact of the CSM program, it has significant implications for future social marketing programs in Fiji. The foremost lesson is the need for proper monitoring and documenting practices to provide reliable information about a program's impact, especially in ongoing projects. Secondly, there is a need for more rigorous assessment of programs in Fiji to determine which factors have specifically created an impact (i.e., identify cause & effect relations). Moreover, adequate funding is required to sustain social marketing programs. To conclude, social marketing programs have found relative success in Fiji but undoubtedly require consistent monitoring and rigorous evaluation.

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