

Framework for the Social Marketing of Clinical Preventive Services in Nigeria

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Abstract Non-communicable diseases are now very prevalent in Nigeria, but the uptake of clinical preventive services (CPS) that have been shown to be very effective in their control has been very poor, even among those that greatly need the services. There is therefore the need to make extra effort to improve the uptake. We therefore propose a framework for the social marketing of CPS, to help increase the uptake of the services in Nigeria. The framework was created with data collected from libraries, electronic databases, and personal communications, which were used to gain an in-depth understanding of the clients; and to create a “marketing mix” of product, price, promotion, and place, for the social marketing project. The CPS was consequently packaged and branded as a single product, to be delivered in one service point, to make for easier access to clients; to be offered at subsidized price, to ensure its affordability to most Nigerians; to be promoted with messages that emphasize the immediate benefits of the services, even as the long term goal is a long and healthy life; and designed to be provided as close as possible to where people live and work, not only in health facilities, but also in community events and facilities. We believe that the use of this framework for the social marketing of CPS would result in a significant uptake of the services in Nigeria.

Keywords: social marketing, framework, non-communicable diseases, clinical preventive services, south-south nigeria

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1. Introduction

The high prevalence of non-communicable diseases in Nigeria is difficult to manage, with the acute care approach that dominate health care delivery in Nigeria. Glycaemic control was only achieved in 34.3% of young diabetic patients [1]; good hypertension control was achieved for just 24.2% of the patients seen [2]; cancer was responsible for 7.6% of all the deaths in the medical ward of a Nigerian hospital, with a mean age at death of less than 45 years [3]; as many as 45% of patients admitted for hypertension-related illness in a Nigerian hospital died [4]; while 5.36% of patients admitted into the medical ward of a tertiary hospital asked to be discharged against medical advice, for reasons that include poor treatment outcome, and a desire to seek other treatment options [5].

The WHO advocates a paradigm shift in health care delivery, to better manage the non-communicable diseases, in favour of preventive and more proactive health care, through its Innovative Care for Chronic Condition (ICCC) framework [6]. Preventive health care services consist of community preventive services that are delivered

collectively, to large numbers of people, often outside the clinical setting, and in the form of laws, regulation, or mass media campaigns; and clinical preventive services that are delivered to single asymptomatic clients, in a clinical setting, and by health care professionals. Clinical preventive services include immunization, disease screening, chemo-prophylaxis and behavioral counseling interventions that assist patients in adopting, changing, or maintaining behaviors known to affect health outcomes or health status [7].

Clinical preventive services are currently available in most Nigerian tertiary hospitals, but are provided in multiple service points, and by different specialist health professionals. The services are often poorly utilized, due to factors that include lack of awareness, cost and poor attitude towards the services [8,9], the fact that the clients are used to accessing medical care only when they are sick [10], and the time and inconveniences of accessing the required services, from different service points in the hospitals[8]. There are also indications that those that truly need the clinical preventive services might not access the services, as indicated by the inverse care law [11], hence the need for an extra effort to aid the uptake of the services, and prevent the exacerbation, rather than the narrowing of health inequalities [12].

The factors militating against the uptake of the clinical preventive services for non-communicable diseases can be addressed with a social marketing programme [13,14]. Simply put, social marketing is the use of commercial marketing techniques in the promotion and distribution of health services and products, not for profit, but to achieve social goals. It is however formally defined as the application of commercial marketing technologies in the analysis, planning, execution and evaluation of programmes, and products designed to influence the voluntary behaviour of target audience, in order to improve their personal welfare and that of the society [13].

Social marketing has been successfully used in improving the uptake of health products in Nigeria [15], and is the method of choice for promoting lifestyle changes, and the uptake of preventive services in developed countries [13,16,17].

Social marketing places a lot of emphasis on the packaging, pricing and promotion of the product, to make it very attractive to clients [13,14]. The social marketing of clinical preventive services would require the packaging of the services into a single health product that is delivered in an integrated way; promoting it to encourage the uptake by clients, even when they are healthy; and making the packaged services available, as close as possible to where the clients live or work, and at a price most clients can afford.

Health is in the concurrent list in the Nigerian constitution, a social marketing programme to improve the uptake of clinical preventive services in Nigeria can therefore be launched by the federal and state ministries of health, tertiary hospitals and even health professional associations like the Nigerian Medical Association, for their own respective interests. The ministries of health need to encourage the uptake of the services, to help reduce the disease burden, and increase the GDP and tax returns; tertiary hospitals in Nigeria require the social marketing programme, to drive up the demand for their services, increase the satisfaction of their patients [18], and improve the productivity of the staff engaged in the hospitals to provide the services; while health professional associations need the increased uptake of the services, to improve the effectiveness of their members, and restore the professional pride that has been seriously dented by the persistent use of the ineffectual acute care model, in the management of non-communicable diseases [5]. This article presents a framework the various stakeholders can utilize in launching a social marketing programme, to increase the uptake of clinical preventive services in Nigeria, and other similar developing countries.

2. Materials and Methods

The framework was created with data collected from libraries, electronic databases, and personal communications with researchers and practitioners of social marketing. The searches were conducted in July 2014, with search phrases that include “social marketing”, “marketing health services” and “uptake of clinical preventive services”; and preference was given to information in peer-reviewed journals. The identified documents were accessed, critically analyzed and then used as building blocks for the framework.

Social marketing programmes start with a deep understanding of the clients, followed by the creation of a “marketing mix” that facilitates the uptake of the services or products offered by the programme¹³. The formative information for the audience research and the “marketing mix” are influenced by various health behaviour theories, including the theories on diffusion of innovation [19], social cognitive [20], stages of change [21] and the various communication theories [14,17]. The required information can be collected from already existing body of knowledge, but most times, specific information needs to be collected using mainly qualitative data collection methods. The authors of a framework for the social marketing of behavioural changes to fight antibiotic resistance, advocated for the use of focus group discussion, face-to-face in-depth individual interviews; immersion hikes (day trips with members of the target audience that permit relaxed, open discussions); ethnography (observing target audiences in their everyday environments); and person-on-the-street-interviews (interviewing unscreened respondents in locations where behaviour takes place) [22].

The following framework that addresses audience research and “marketing mix” can therefore be used for a social marketing programme, to increase the uptake of clinical preventive services in Nigeria, and other similar developing countries.

2.1. Audience Research

The audience research provides insight into the reasons behind the beliefs the clients hold about clinical preventive services, the benefits and barriers they see in utilizing the services, and how they wish the messages of the social marketing programme to be communicated to them [22]. Audience research came out of the realization that success in health education programmes are better achieved with a deeper understanding of the audience, especially on how individuals view the particular public health issue that is being addressed, within the context of their own reality.

The most important audience information for the social marketing of clinical preventive services in Nigeria is linked to the religiosity of Nigerians, which affects their health beliefs and health behaviours [23]. Studies have shown that people that fail to attend health checks are less likely to feel susceptible to ill health, and less likely to perceive the conditions being screened for as serious [24]. They also have low self-efficacy, feel less in control of their health and are less likely to believe in the efficacy of health checks [25,26].

Most Nigerians are adherents of Christianity, Islam and the traditional religion that have specific practices for disease prevention, and are therefore accustomed to preventive health practices. Nigerians and other sub-Saharan Africans are also known to complement these preventive services with those provided by orthodox medicine [27]. However, in recent years, an increasing number of religious denominations believe that non-communicable diseases are the will of God, with minimal self efficacy in their prevention and control [23]; while several others believe in miracle, and therefore the potency of prayers and other religious rituals in the prevention and management of chronic diseases [27].

These beliefs can adversely affect the uptake of clinical preventive services, and therefore need to be addressed in the social marketing programme [28].

Audience segmentation is also often carried out, as part of the social marketing programme, to gain a further understanding of the audience. It is the fallout of the lessons learnt from the 'one size fits all' strategy of earlier behavioural change initiatives that yielded insignificant results [22]. It takes into consideration the stages of change theory that posits that individuals in an audience pass through a series of steps before reaching the desired behaviour [21]. This allows social marketers to identify the subgroups in the audience they can realistically reach with available resources, and permits the motivation of distinct groups, based on their needs and values [22,29].

A review of the literature reveals that the uptake of clinical preventive services follows an inverse law, with those in greater need of the services, such as those in the lower socio-economic classes less likely to use the services [11], and therefore requires extra effort to encourage their utilization [12]. Studies also show that marital status affects the uptake of the services, with the uptake significantly more amongst married or cohabiting persons [30]. This was attributed to the fact that most of the decisions for the uptake of preventive services were made by the partner, with this initiation behaviour found to be prevalent across a number of socio-demographic factors [31].

2.2. Marketing Mix

The social marketing process involves the identification of an effective "marketing mix" of **product**, **price**, **promotion**, and **place**, to ensure that the products/services are provided with clear and compelling benefits, minimal barriers, and an advantage over the competition [13].

2.3. Product

This involves the packaging of the socially marketed "product" into a form that makes it very attractive to the clients. The "product" can be a physical product like condom, but several socially marketed products are intangible products such as idea, social cause, and in most cases a change of behaviour. No matter the tangibility, all socially marketed products are packaged into forms that are compelling to the client. This is often accomplished using the Rogers' diffusion of innovation theory that identified a number of compelling product attributes that include relative advantage (is the product better than what it will replace?), compatibility (does the product fit well with the intended audience?), complexity (is the product easy to use?), trialability (can the product be "tried out" before making a decision to purchase it?), and observability (are the results of the product visible and measurable?) [17,19].

The social marketing of clinical preventive services would involve the packaging of the services into a single product that is delivered in one service point. This would make the uptake of the services significantly easier for the clients who hitherto had to access the services from various service points in the hospital, often with multiple registration processes. The package should not however contain every known clinical preventive service, not only because of the time it would take to deliver all the services

[32], but also because studies have shown that not all the services lead to net improvement in health [33]. Inappropriate testing can lead to false-positive results, further testing, and side effects [34], while excess tests lead to wasted money and decreased quality of care [35]. Efforts should however be made to include the full range of clinical preventive services: screening tests, immunizations, counseling, and chemoprevention; and that the included services are evidence-based to be effective; cost-effective, in terms of how much gain in "health" the service is able to deliver for a unit of cost; and how well it can be delivered with local conditions and capabilities [36]. The United States National Commission on Prevention Priorities (NCPP) identified very effective clinical preventive services to include childhood and adult immunizations; disease screening for cancers, hypertension, diabetes, alcohol misuse, obesity, HIV infection; and counseling about smoking cessation, diet, aspirin chemoprophylaxis and breast cancer genetic susceptibility and chemoprophylaxis [33].

The composition of the service package should preferably receive the input of religious bodies, because of their influence on the health seeking behaviour of the adherents [23]. Studies have shown that collaborations that allow religious bodies to adapt and weave the framework of a social marketing programme, to conform to their doctrines often result in significant uptake of the services [37,38]. For instance, Project Joy, a program for the reduction of the cardiovascular risk profile of female African American Christians started with no spiritual attachments, but the participating churches quickly included sessions that incorporated group prayers, health messages that were enriched with scriptures, physical activities that combined aerobics with praise and worship, and church organized health events, among others [38]. These resulted in significant improvements in the body weight, waist circumference, systolic blood pressure and sodium intake of the women in the churches, compared to women in the self-help group; with even greater improvement recorded amongst women in the top weight decile [38].

Branding is the final act in the packaging of a socially marketed product. It involves the creation of a name, mark or symbol that is associated with the product [39]. This is often done through the use of slogans and compelling images that are easy to recall. For example, the programme for the reduction of the cardiovascular risk profile of female African American Christians was branded Project Joy, taken from the Bible verse, "...for the Joy of the Lord is your strength"(Nehemiah 8:10b) [38]. A social marketing programme for clinical preventive services, to be delivered in conjunction with religious bodies in Nigeria can be branded "The Methuselah Project" to emphasize its ability to lead to a long and healthy life.

2.4. Price

This is the price clients are ready to pay in exchange of the socially marketed product. Unlike commercial marketing where the price usually refers to the monetary value placed on the product; in social marketing, the price also include non-monetary barriers such as social, behavioural, psychological, temporal, structural,

geographical and physical barriers that an individual must overcome to patronize the socially marketed product [17,40].

Most social marketing programmes involve the reduction of the non-monetary costs of the product. This is usually accomplished using the social cognitive theory which addresses the interactions between clients and the non-monetary barriers [20]. The social cognitive theory asserts that people learn not only from their own experiences, but by observing the actions of others, and the benefits of those actions; and are more likely to try out the experience, irrespective of the barriers, when they are convinced of their personal agency or self-efficacy [20]. Lowering the non-monetary costs of the socially marketed clinical preventive service package often involves the other “marketing mix”. For example, bundling the services into a single product reduces the time spent in accessing the services separately, while the promotional messages used in the social marketing stress the long period of morbidity and the high mortality that are associated with non-communicable diseases, so succinctly that it is clear to clients that it is far cheaper to utilize the services, than suffering and dying from the non-communicable diseases the services prevent.

However, monetary factors have been shown to significantly affect the uptake of clinical preventive services, especially in Nigeria where out-of-pocket payment is still being made for health services [9]. A Study carried out as part of the formative research for this article indicates that even as most of the clients of clinical preventive services are willing to pay the prevailing market price for the services, the price can be up to 30% of the average monthly income of the clients, hence the need to address the monetary factors. Clinical preventive services are known to suffer severe market failures, due to imperfect information and imperfect credit [41]; and governments are known to intervene in such circumstances, to remedy the situation and achieve the social optimum [41]. Clinical preventive services are provided free to clients in several countries, with financial inducement sometimes used to further increase the uptake of the services [42]. The subsidization of the services is however advocated in Nigeria, as is currently being done for immunization. This is especially as it has been shown that the increased uptake of the services is able to significantly add to the quality life years of the population. For instance, it is estimated that the optimal delivery of just eleven clinical preventive services to adult Americans, from the current rates to 90% would result in the addition of more than 2.5 million life years, with the delivery of smoking cessation programmes alone estimated to add 1.3 million life years [43].

2.5. Promotion

This is the most visible and most applied component of the marketing mix [22]. It is the process used in convincing the clients that the uptake of the clinical preventive services is in their own best interests. This is accomplished through the use of a number of communication theories that provide guidance on the appropriate communication messages and channels for the programme. The stages of change theory provides insight on the stages people go through before adopting a new

behaviour [14,21], and hence is important in designing the messages for the social marketing programme. The theory posits that people do not immediately make a behavior change upon exposure to a message, but often pass through a series of steps, quickly for some people, more slowly for others, before getting to the desired behavior. This process begins with precontemplation (not really considering making the change); continues with contemplation of making the change, preparation (intention to make the change), and action (making the change); and finally, ends with maintenance of the new behaviour [21]. Thus, the stages of change theory helps in the design of messages that specifically target the client at every stage of the behaviour change process. For example, the segment of the clients at the early stages of change are informed of the availability of the packaged clinical preventive services, while those at the preparation and action stages need information on how to access and deal with matters related to the services. However, irrespective of the stage of change, messages are designed while considering the exchange the social marketing programme hopes to achieve. Social marketing programme hopes to exchange an undesirable behaviour with a desirable one, and is considered a success when both the social marketer and the clients are satisfied with the exchange. Experience has shown that immediate benefits resonates better with the audience than long term benefits [44], therefore the messages of the programme should emphasize the immediate benefits of clinical preventive services, even as the long term goal is a long and healthy life.

The theory of diffusion of innovation is used to determine the best communication channels for the messages of the social marketing programme [17,19]. The theory posits that different communication channels are effective at different stages of the innovation-decision process [19]. The mass media channels have been shown to be more important at the knowledge stage; while interpersonal channels are relatively more important at the persuasion stage. For the social marketing of clinical preventive services, mass media channels such as radio, television and newspapers can be used to create awareness among a large audience, of the availability of the services; while interpersonal channels that involve a face-to-face exchange between two or more individuals are used to deal with resistance or apathy to the uptake of the services. Interpersonal channels are so used because they provide a two-way exchange of information [14].

2.6. Place

This concerns the placement of the packaged clinical preventive services in places and time that are most convenient to clients. This is accomplished through the identification of the place and time the clients are most perceptive to the services. For example, the packaged services for children and adolescents can be made part of the school health services, while those for adults can be made part of the occupational health services. The timing of the delivery of the services can be around the birthday of the clients, or as part of the periodic occupational checks.

Poor access has been noted to be a major reason for the poor uptake of clinical preventive services in Nigeria [9]; and in view of the rising prevalence of non-communicable

diseases, it is increasingly been advocated that preventive services should be made universally available to all persons, irrespective of the place of residence or socio-economic status [45]. This means that the packaged clinical preventive services should not be restricted to hospitals, but delivered in primary health care facilities, with the active involvement of non-physician health workers [46]. The U.S. Preventive Services Task Force recommends that the clinical preventive services can be offered in primary care facilities either on its own, or as part of any other medical consultation, by non-physicians working with a protocol, and under the supervision of a physician [33,47]. The services can also be delivered outside health facilities, in community events and facilities where members of the community can conveniently access the services [48].

3. Conclusion

The poor uptake of clinical preventive services can be addressed with a social marketing programme, especially as those that truly need the services often do not access them. We believe that the framework we have proposed for the social marketing of the services in Nigeria would result in a significant uptake of the services, as achieved with the other health products and services that have been so marketed all over the world. We also believe that though the social marketing programme can be initiated by government and health professional organizations, the input of religious leaders is vital to the success of the programme, considering the religiosity of Nigerians, and the effects of religion on health seeking behaviour.

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