

# CASE STUDY 11

## The challenges of using social marketing in India: the case of HIV/AIDS prevention

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In India, 5.7 million adults and children were estimated to be living with HIV/AIDS in 2005, an increase from 5.3 million in 2003. The number of adults and children who died due to HIV/AIDS during the same period was in the range of 270 000-680 000 (UNAIDS, 2006). The primary driver of the epidemic is heterosexual activities between commercial sex workers (CSWs) and their male clients, including truck drivers and migrant workers, who then spread it to their housewives and/or lovers.

Since the mid-1990s, there has been a strong effort to create awareness and promote behaviours that would prevent HIV/AIDS infection and stem the epidemic. Since a cure to HIV is expensive, long and not completely effective, preventing the infection is a superior option. Due to these reasons, HIV/AIDS efforts have been more or less on the preventive end. However, social marketers have faced numerous problems and challenges in this effort. This report discusses the key problems and challenges that social marketers have faced while addressing male groups such as truck drivers, migrant workers, youths and men from the general population; these are categorized into individual factors, the immediate environment and the wider environment.

Several individual characteristics pose challenges to social marketers. Approximately 55% of the entire Indian population is not aware of HIV/AIDS (Chattopadhyay and McKaig, 2004). Due to both the lack of discussion about sexual matters and the lack of sex education in the society, male groups do not have the proper knowledge about what causes, prevents and cures AIDS. For example, several male groups also believe that condoms should be used only when having sex with a CSW and not with a trusted friend or good-looking person. Even among those who are aware, regular condom use remains low (Chattopadhyay and McKaig, 2004). There are numerous reasons for this.

First, condoms are considered to interfere with sexual pleasure. Second, the hard, unpredictable and risk-prone lifestyle creates a sense of helplessness and, combined with acculturated fatalism, high-risk groups such as truck drivers, migrant workers and slum youths lack the motivation to practise safe sexual and drug use. Third, they continue to deny the severity and the susceptibility to HIV/AIDS and thus avoid paying attention to

prevention campaigns. Instead, they consider others to be more susceptible to HIV infection. Rural youths, for example, consider it to be an urban problem, street children believe it to be an adult problem and housewives think it affects only men, while men from the general population believe truck drivers and migrant workers are at risk. Men do not readily perceive the preventive benefits of condoms, since these benefits are not immediate and are never obvious - making it difficult to promote safe sex practices (Singhal and Rogers, 2003).

Fourth, being a patriarchal society, Indian men impose their manhood by discouraging women to wear condoms (Chattopadhyay and McKaig, 2004), thus exposing housewives and CSWs to risks of HIV infection (Singhal and Rogers, 2003). CSWs fear that insistence on condom usage could result in loss of clientele and monetary gains (Chattopadhyay and McKaig, 2004). Even if male groups are aware and convinced about condom use, their distribution has been far from effective. Condoms are still largely sold in urban areas, through chemist shops and not through mainstream retail outlets, which limits consumer access to condoms. The availability is especially low in critical areas such as brothels in Mumbai. Retailers also avoid displaying condoms prominently.

Other than poor condom usage, the issue of prejudice against people living with HIV/AIDS (PLWHs) also poses challenges to social marketers. PLWHs experience severe discrimination at the workplace, by the community and many times by their own families. Being a moralistic society (Singhal and Rogers, 2003), Indians in general believe that people who get infected indulge due to immoral behaviours and deserve this penalty. Thus, high-risk individuals are not willing to test themselves for HIV and/or to declare themselves as HIV-positive due to fear of discrimination and rejection (Singhal and Rogers, 2003). This has resulted in underreporting of HIV prevalence in India (Solomon *et al.*, 2004).

Existing stigma against PLWHs and the discomfort with sexual matters creates an unfavourable environment for social marketing campaigns. For example, the Balbir Pasha Campaign in Mumbai - which aimed to create awareness that, although men may have sex with only one CSW, she may have numerous regulars - was criticized for its frankness ('bringing the bedroom into the living room'), thus negatively impacting on its effectiveness.

In addition to individual and societal barriers, the wider environment also presents its own set of challenges. The geographical and population size as well as socio-cultural and economic diversity, combined with lack of resources, makes the task of conducting HIV/AIDS prevention efforts in India very difficult (Solomon *et al.*, 2004). India supports 16% of the world's population over 3.3% of the total land area (Observer Research Foundation, 2001-02). However, the resources do not match the population size. A substantial amount of the population lives in absolute poverty and one-quarter of the population cannot afford an adequate diet (Solomon *et al.*, 2004). Although in recent years the economy has grown rapidly and poverty has been reduced (Dhongde, 2004), the growth has been uneven. Rich states such as Maharashtra and Tamil Nadu, which have witnessed an economic

boom, attract migrant workers leaving their wives behind in rural areas, thus attracting CSWs and the resulting HIV/ AIDS epidemic.

Lack of resources also influences the state of health care in India. According to a report by the Confederation of Indian Industry-McKinsey (2002-03), only 15% of the total population is covered by any form of insurance. Furthermore, government spending on health care is low (0.9% of GDP), resulting in poor infrastructure. India has 1.5 beds and 1.2 registered physicians per 1000 people as compared to 4.3 and 1.8 in countries like China and Brazil respectively. In addition to poor coverage and infrastructure, the purchasing of health care is inefficient (because 60% of health care delivery is financed by out-of-pocket spending) and the delivery of health care is undertaken mostly by the private sector, which puts a financial burden on the individual seeking medical aid. These factors limit the extent of government coverage and negatively impact health outcomes - for example, the majority of PLWHs lack access to anti-retrovirals and other forms of medical support (Singhal and Rogers, 2003).

Other macro factors such as illiteracy, socio-cultural diversity and corruption also create barriers to HIV/AIDS prevention efforts. India is struggling to achieve a respectable literacy rate, currently standing at 52% (Observer Research Foundation, 2001-02). The female literacy rate of 39% is alarming, since it is inversely related to fertility rates, population growth rates and other important social indicators (Sharma, 2000). India is a hugely diverse country with long-standing traditions - for example, 24 languages are spoken by at least a million people (Solomon *et al.*, 2004), combined with numerous religious practices and lifestyles. It is difficult to create campaigns that can address a sizeable group in any part of the country. India also suffers from widespread corruption at all levels of government. In the past, these corrupt practices have created distrust towards any government contraceptive social marketing campaigns among Indian consumers.

Government efforts have also suffered from other weaknesses (Chattopadhyay and McKaig, 2004). By denying the existence of the HIV/AIDS epidemic, the government and the country lost valuable time and opportunity to address the problem in its early stages. Furthermore, the government has tended to centralize campaign management, thus creating huge bureaucracy, inefficiency and stifling of individual efforts (Singhal and Rogers, 2003). The current government prevention policy also lacks clarity on how to reduce socio-cultural barriers and increase acceptance of condoms. Adman Alyque Padamsee provides an example:

'The government condom, Nirodh, acted as a deterrent to sex, because as soon as you thought of Nirodh, you lost your erection! If you lose your erection, you can't put on a condom. The logic is simple, but nobody seemed to have stumbled upon it. So I said, "How can the male think of the condom as a pleasure enhancer?" Nobody wants to sit down to a sumptuous meal, and then be told that you have to take medicine before it kills your appetite.'

(Mazzarella, 2003, p. 65)

NGOs, on the other hand, have lacked the expertise and the resources to develop effective campaigns, since they rely on both in-house marketing

programmes and donated commodities (Armand, 2003). This is reflected in a variety of ways. For example, NGOs in India, especially those funded by the Department for International Development (DFID), failed to develop a strategic approach, lacked knowledge about secondary audiences, failed to sensitize the community to gain general support, and used limited numbers of media materials and creative abilities. Campaigns have also been criticized for their emphasis on knowledge rather than behaviour change, for failing to use peer educators as outreach workers (Singhal and Rogers, 2003) and for poor choice of media. Finally, the materials lack research rigour, since they were not adequately pre-tested or evaluated. In response to these weaknesses, attempts have been made to partner with commercial enterprises to market contraceptives (Armand, 2003). While these campaigns may have been effective in the short term, once the partnership contract ended, commercial partners have tended to revert back to their earlier practices to increase prices, reduce the distribution coverage and focus on the higher income sections of society.

In conclusion, even if male groups are aware of benefits, critical individual and societal barriers discourage them from practising safe sex. Wider environmental factors also pose challenges that intertwine with the individual and societal barriers, and present a very messy situation for social marketers. This case study has tried to illustrate that unless these real-world complexities are recognized and worked upon, social marketers will not succeed in their HIV/AIDS prevention efforts in India.

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## Lessons learned

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1. The current case demonstrates that health cannot be viewed solely in terms of individual behaviour; it also needs to be considered in terms of broader social and environmental factors. Without a doubt, social marketers working in the field of HIV/AIDS in India need to examine how individual, societal and wider environmental factors contribute to this epidemic.
2. The government of India is a major player in addressing the HIV/AIDS problem. This case shows that not only is it necessary for key government officials to acknowledge the serious health issue of HIV/AIDS in India, but the centralized campaign management also needs to be addressed. Clarity should also be established in the government prevention policy with regards to addressing the socio-cultural barriers that play a key role in the acceptance of condom use.
3. As outlined in the case, previous HIV /AIDS prevention efforts in India have not used basic social marketing principles such as clear behavioural goals, consumer orientation and research to guide programme planning and implementation.

## Case study questions

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1. Q: What is the primary driver for the spread of HIV/AIDS in India?  
A: The primary driver of the HIV/AIDS epidemic in India is heterosexual activities among commercial sex workers and their male clients, who are often truck drivers and migrant workers, who then spread HIV to their housewives and/or lovers.
2. Q: Describe three individual factors that contribute to the spread of HIV/AIDS in India.  
A: (i) Inhibitions about discussing sex. (ii) Negative attitudes to condoms. (iii) Prejudice towards people living with HIV/AIDS.
3. Q: Describe three challenges from the wider environment that contribute to the spread of HIV/AIDS in India.  
A: (i) Financial burden on individuals seeking medical aid due to a large monopoly of privatized health care. (ii) Alarming low literacy rates, which are inversely related to a variety of social indicators. (iii) Diversity of the culture in India in terms of language, religious practices and lifestyles, making it difficult to design wide-reaching prevention campaigns.