Introduction

India, Pakistan and Bangladesh share more than boundaries; they also share a similar heritage and history. The partition of the British Indian Empire led to the creation of Pakistan and India, which gained independence on 14 August 1947 and 15 August 1947, respectively. India is the seventh largest country in the world and covers an area of approximately 3.3 million km$^2$. The country is rightly called a sub-continent and is comprised of a multi-ethnic, multi-religious and multi-lingual society. It is made up of 28 states and seven union territories, each with their own culture and official languages — even though Hindi and English are the official languages of the country, 22 official languages are recognised by the constitution of India (Ministry of Law and Justice, 2014).

Pakistan is the 36th largest country in the world with an area of approximately 803,940 km$^2$. The official language is Urdu, but other languages are also spoken here, with Punjabi spoken by 48 per cent of the population. In terms of administration, the country is divided into four provinces and four federal territories (World facts and figures — Pakistan, 2014). Officially known as the Islamic Republic of Pakistan, the World Bank describes the country as having ‘important strategic endowments and development potential’ due to its strategic geographic location between South Asia, Central Asia, China and the Middle East (World Bank, 2014c).

Bangladesh seceded from Pakistan and became independent on 26 March 1971. It covers an area of 144,000 km$^2$ and the official language is Bangla. Since its independence, the country has made impressive improvements in human development, especially with regards to advancing women’s and children’s health (UNDP, 2014b). Highlighting the progress made by the country, the UN Secretary-General Ban Ki-moon said: ‘risen from great hardship to build a thriving economy, a vibrant civil society and a dynamic future’ (UN News Centre, 2011). All three countries are members of the South Asian Association for Regional Cooperation (SAARC).

Learning objectives

After reading this chapter, you should be able to:

- understand the importance of social marketing and comprehend the challenges and barriers to social marketing campaigns in India, Pakistan and Bangladesh;
• demonstrate how to organise and manage social marketing in different parts of this region; and
• appreciate the application of the concepts of social marketing and marketing mix in a case study.

Challenges

One of the major challenges faced by all three countries is poverty. For example, if we look at India, it is a country of contradictions. In the 67 years since its independence from the British on 15 August 1947, India has seen tremendous growth and human development. The Indian economy is the world’s eleventh largest by nominal GDP and fourth largest economy in purchasing power parity terms (PPP) (IMF, 2013; World Bank, 2014a). Several Indians are now among the richest in the World (Forbes, 2014). However, despite this impressive economic growth and wealth creation, there are huge disparities in human development. Thirty-seven per cent of India’s population (about 410 million people) falls below the poverty line, which translates to roughly one-third of the world’s poor (World Bank, 2014b).

Human development in Pakistan has also become a critical concern for sustainable economic growth especially in the light of the high infant and under-fives mortality rates in the country. Of interest, perhaps, for the current discussion, is that the country is currently ranked as one of the lowest spenders on education and health in the region (at about 2 per cent of GDP) (World Bank, 2014c). However, on the bright side, Pakistan has made impressive reductions in poverty rates, which currently stands at an estimated 17.2 per cent in 2007/08 as compared to around 34.5 per cent in 2001/02. Of the three countries, Bangladesh has an impressive track record in terms of growth and development with poverty reduction in both urban as well as rural areas, with nearly a third moving out of poverty since 1992. However, around 47 million people are still below the poverty line and Bangladesh remains one of the most densely populated countries in the world (World Bank, 2014d).

Poverty is closely related to the fast population growth experienced by all three countries. Soon after Independence, the Indian government recognised their country’s ‘population problem’, which was seen as an impediment to the country’s development. Consequently the government launched a family planning programme supported by various international organisations. In fact, social marketing was first introduced in India in the 1960s to tackle this ‘problem’. However, experts are quite divided on the success rates of social marketing campaigns targeted at tackling this problem. This is highlighted by the fact that despite impressive improvements in food production, the country has still not been able to meet the nutritional needs of the growing population (Hopper, 1999). With a population of 1.21 billion (as on 1 March 2011) and growing at an average of 1.64 per cent annually, it is the second most populous country in the world after China (623.7 million males and 586.4 million females) (Govt. of India website, 2014). Pakistan has a population of 179.2 million and a population growth rate of 1.69 per cent (World Bank, 2012b), while Bangladesh has a population of 154.7 million and a population growth rate of
1.19 per cent. Pakistan and Bangladesh have the world’s sixth and eighth largest populations in the world, respectively (World Bank, 2012c). They are also among the world’s most densely populated countries. Figure 8.1 shows the population growth rate across the three countries.

Among the other major social challenges facing the three countries are the HIV/AIDS epidemic (UNDP, 2014a). According to the World Bank, there are 2.40 million HIV infected Indians are living with HIV. Although recent studies show a declining trend, the epidemic still remains one of the major issues of concern, and government efforts are focused on preventing new infections (World Bank, 2012a). The threat of AIDS/HIV facing Pakistan was highlighted by Rodrigo and Rajapakse (2009), who reported that although most of the South Asian countries are in the low HIV prevalence category, the numbers are increasing in Pakistan. Of the diagnosed cases, males predominate (87 per cent), with most belonging to the 20–40 age group. (Husain & Shaikh, 2005; UNAIDS, 2002). Bangladesh has managed to contain the HIV/AIDS epidemic in the country and the reasons for relatively low levels is believed to be due to their ‘HIV prevention programs targeting high risk groups backed by a state-of-the-art surveillance system’ (World Bank, 2012d).

Among all the challenges faced by these three countries, the unsustainable population growth remains one the biggest areas of concern. It affects and is related to a number of other social issues as well. The HIV/AIDS epidemic is also another major challenge facing all three countries. This chapter will thus focus on the contraception and family planning as well as HIV/AIDS social marketing programmes in these three countries. We will first take a brief look at the history of social marketing in these countries and then examine some of the major issues and challenges faced by various social marketing campaigns.

![Figure 8.1 Population growth rate.](image)

*Source:* Based on World Bank data (Google, 2014).
Social marketing in India

Most scholars agree that the first documented use of social marketing — employing marketing theories, tools and techniques to address social issues — was in India in 1964, when a marketing plan to promote family planning was proposed by the Indian Institute of Management (IIM), Calcutta. Targeted primarily at married couples, the proposal called on the private sector ‘to consider ways of extending the distribution of contraceptive services, especially the condom, through commercial channels’ (Chandy et al., 1965, p. 7). Their objective was to make their preferred contraceptive product, condoms, a normal household item.

The IIM model was considered the most viable for delivering family planning (Harvey, 2008). The social marketing of contraceptives was subsequently implemented as part of the national family planning programme. To meet the growing demand of condoms, the Ministry of Health and Family Welfare set up HLL Lifecare Limited (HLL), then called Hindustan Latex Limited, in the south Indian state of Kerala, for the production of condoms. Their first plant was built at Peroorkada in Trivandrum (now Thiruvananthapuram), with technical help from Okamoto Industries of Japan. Nirodh condoms were officially launched by the government in 1968. Two more plants were added at Trivandrum and Belgaum in 1985. The company is now one of the world’s largest manufacturers of condoms, with an annual production of around 800 million pieces (as of December 2012). Besides Nirodh, other brands include Zaroor, Masti and the upmarket Moods. Subsequently, the social marketing of marketing planning continued with other contraception methods and products. Mala D — an oral contraceptive pill brand available over the counter without a prescription — was launched in 1987.

The early 1990s saw the launch of numerous Social Marketing Organisations (SMOs), which were involved in the implementation of social marketing programmes with funding from government and other organisations. HLL Lifecare Limited has established itself as the leading SMO in the country. Other leading SMOs in India today include Hindustan Latex Family Planning Promotion Trust (HLFPPT) (promoted by HLL Lifecare Limited), Population Services International, India (PSI) and Population Health Services, India (PHSI), among others. Under the Ministry of Health and Family Welfare, India’s government-led contraceptive social marketing programme is now the largest in the world (Deshpande, Balakrishnan, Bhanot, & Dham, 2011), and has recognised social marketing as key to ‘providing accessible and affordable contraceptive products’ (FHI 360, 2011).

However, despite the fact that the population growth rates in India have slowed down, they are nowhere near the Indian government’s targets, and according to the French National Institute for Demographic Studies (INED), India will overtake China as the world’s most populous nation by 2050 (Pison, 2013). So what happened?
Social marketing in Pakistan

A review of literature reveals that several studies on social marketing in Pakistan have focused on the HIV/AIDS issue. Studies looking at the implementation of social marketing to contain the threat of HIV/AIDS in Pakistan observed that non-governmental organisations (NGOs) in Pakistan provide information and free access to condoms and clean needles. A case in point is Greenstar Social Marketing Pakistan, a non-profit NGO. They use the franchising model and are one of the first health franchisers in the world. Targeting the low-income and non-users, they use a ‘total market approach which has different price points for each segment of the population’ (Bhattacharyya et al., 2010). Greenstar targets truck drivers in Karachi, the capital of Pakistan, providing HIV counselling services and condoms, as well as medical treatment facilities for the drivers (Husain & Shaikh, 2005). Their marketing campaign to promote their brand of condoms, called Touch condoms, involved ads on TV, newspapers, posters and billboards, and the organisation was praised for communicating their message openly in a country where a conservative approach is commonly used when communicating topics considered culturally ‘sensitive’ (Butt, 2009).

Highlighting the importance of social marketing, Husain and Shaikh (2005) emphasise the importance of preventive strategies, which are culturally acceptable. According to them:

these strategies must logically address the known mechanisms of spread and should integrate biomedical and behavioural approaches. However, the application of a single isolated strategy will undermine the purpose of a preventive programme by laying stress on one aspect of complicated human behaviour.

(Husain & Shaikh, 2005, p. 294)

Similarly, Qureshi and Shaikh (2006) highlighted the need to address cultural misconceptions and societal barriers, which had an impact on healthy behaviour in Pakistan. They emphasised the importance of using social marketing in motivating low-income and high-risk groups, which were susceptible to the myths, fallacies and misconceptions pertaining to health. One of their recommendations was the setting up of ‘health promotion committees’ at village levels to reduce these myths and fallacies. They also highlighted the successful implementation of social marketing strategies to promote the use of iodised salt (Qureshi & Shaikh, 2006).

Several papers have also looked at the use of social marketing of insecticide-treated mosquito nets in Pakistan (Howard et al., 2003; Qazi & Shaikh, 2006; Rowland et al., 2002). It was found that Howard et al. (2003) did not really talk about social marketing, but merely pointed out that subsidies for the nets should be targeted at the most poor, who could not afford the nets. Looking at condom social marketing campaigns, Harvey (1994) pointed out that one of the most successful countries was Pakistan (looking at sales of condoms), differentiating it from Bangladesh, which had a long-established, multi-method, heavily subsidised government programme. This was because in Pakistan, competition from other methods
was considered minimal. A study undertaken to evaluate the effectiveness of the 2009 marketing communication campaign on thematic condom indicated that approximately 15 per cent of urban married men were aware of Touch condom advertising. The study further found that the advertising campaign led to greater degree of discussion on family planning, condom use and an improved perception of the effectiveness of condom use (Agha & Beaudoin, 2012). This indicates a promising possibility of adopting advertising to educate the public on contraceptive and other important health issues. Husain and Shaikh (2005) point out that the public sector is also actively involved in the process including advertisements in both the electronic and print media; however, much of the initiative and in this field appears to be led by the NGOs.

**Social marketing in Bangladesh**

As mentioned earlier, Bangladesh has been quite successful in improving the social conditions in the country as compared to its two neighbours. A lot of the credit goes to the effectively run social marketing campaigns. Schellstede and Ciszewski (1984) analysed the success of the Social Marketing Project (SMP), which was managed by Population Services International (PSI). This contraceptive and family planning programme was launched on a national scale in 1975.

A few studies have also looked at the social marketing of oral contraceptives and it was revealed that most of the users were higher in socioeconomic terms. They had higher educational qualifications and were more affluent (Boone, Farley, & Samuel, 1984; Davies, Mitra, & Schellstede, 1986) than users of socially marketed condoms (Ciszewski & Harvey, 1994).

With funding from the Global Fund, the organisation Save the Children used drop-in centres to increase condom use by female sex workers (FSWs) in Bangladesh. Save the Children provided free condoms, education, counselling and testing services besides sexually transmitted infection (STI) clinics and general health services. A survey in 2012 found that condom use increased tremendously from 66.7 per cent to 95.5 per cent, from 2008 to 2012 (Hossain, Sultana, Amin, & Siddiqua, 2013). Hossain et al. (2013) concluded that strong motivational support and peer education would help to keep up this high rate of condom use among FSWs. This was essential to prevent the spread of HIV.

Among the various NGOs involved in social marketing in Bangladesh, one organisation that stands out is the Social Marketing Company (SMC) which was established in 1974 as a Family Planning Social Marketing Project under an agreement between the Bangladesh government, Population Services International (PSI), a US-based NGO and USAID. The SMC later became a company with a voluntary board of directors in 1990 (SMC, 2014a). It is now the largest and one of the most successful privately managed not-for-profit organisations for a single country in the world. Besides focusing on family planning and maternal and child health, they are also involved in the prevention of sexually transmitted diseases (STDs)/AIDS as well as education programmes. The SMC began addressing the issues of STDs and HIV/AIDS in 1995 by targeting high-risk populations, in particular the FSWs.
The SMC story is really impressive and the organisation is moving towards 100 per cent self-reliance with independence from donations, due to their social franchise model comprising of a private sector network of branded providers (Gonsalkorale, 2010). Later, we will examine the successful BlueStar Programme, which was launched in June 1998.

Looking at the Bangladesh experience, what has emerged is the importance of community-based approaches and partnerships in implementation of social marketing campaigns. El Arifeen et al. (2013) have identified three distinctive strategies that have resulted in improved health service coverage and outcomes in Bangladesh, which are:

1. experimentation with community-based approaches to health service delivery;
2. experimentation with partnerships for health service delivery; and
3. early adoption of innovations.

According to El Arifeen et al., these approaches were responsible for the success of a number of high-priority programmes in Bangladesh and have evolved over time to meet the different challenges.

The state of the art in social marketing: India, Pakistan and Bangladesh

Challenges and barriers to social marketing campaigns in India

Given the diversity of India, barriers to effective social marketing are bound to vary from region to region and also between urban and rural areas. The following are some specific challenges and barriers, focusing specifically on the contraceptive social marketing campaigns.

Effects of coercive policies

India has the unsavoury distinction of being one of only two countries where coercion has been used in family planning programmes (the other being China). With increasing pressure from international organisations, in 1975 the then Prime Minister of India, Indira Gandhi, introduced a national population policy. Some overzealous states instituted forced sterilisations, which resulted in 8.3 million sterilisations in 1976–7 against a forecasted 4.3 million (Veron, 2006). This led to widespread resentment, especially among the poorer sections of society and minorities targeted. Largely due to the unpopularity of the forced sterilisations, the Congress Party was defeated at the elections in 1977 and this ended the population policy. Although successive governments made several efforts to make the family planning campaigns friendlier, this has damaged the credibility of government organisations and anybody involved in family planning programmes. It has also undoubtedly hurt social marketing campaigns and it will take a long time to regain the trust of the people. This underlines the importance of instituting voluntary
family planning programmes, if we want to have sustainable population control. As highlighted by Connelly (2008), there are other factors that are more effective than coercion in the long run. Connelly noted that birth rates fell as women became more educated and had more rights. This means that family planning programmes would be more effective and sustainable where women had a choice.

**Selling-focused approaches**

A look at the various population control social marketing campaigns reveals that these campaigns are still focused on selling; they are product-focused approaches. These information-intensive campaigns focus on informing, making use of intensive media advertising and printed materials. We are now talking about the need to build long-term customer relationships (Rust, Moorman, & Bhalla, 2010) and the consumer-centred approach, where positive social change is the main objective, rather than fiscal targets. It is essential to remember that in this approach, the consumer is an active participant and partner in the whole process of behaviour change.

**Barriers to contraceptive social marketing**

A study by the Urban Health Initiative (UHI) (2010) identified four main barriers to effective social marketing of contraceptives in the North Indian state of Uttar Pradesh. The barriers were:

1. lack of convenient access to retail outlets for the poor;
2. lack of incentive for retailers to stock and sell the socially marketed brands because of lower profits;
3. lack of up-to-date information among many pharmacists and chemists about contraceptive methods, which meant that they were unable to provide guidance to women about their safety and efficacy; and
4. unfavourable impressions about condoms among men. This was probably the only internal barrier and related to embarrassment while buying condoms, decrease in sexual pleasure or belief that condom use indicated a lack of trust.

The UHI reported two programmes: Innovations in Family Planning Services Project II (IFPS II) and Sadhan Social Marketing Network. Both programmes focused on increasing the use of birth-spacing (i.e. the time interval from one child’s birth date until the next child’s birth date) methods, especially condoms and pills, for family planning.

**Challenges and barriers to social marketing campaigns in Pakistan**

Although specific targeted strategies such as counselling services provided by Greenstar HIV to truck drivers have been proven successful, these are quite restricted. Promoting preventive activities within the general population was the most challenging issue (Husain & Shaikh, 2005). This may be due to the fact that organisations involved in sexual health campaigns are too culturally sensitive and thus do not get their message across effectively. As Butt (2009) has pointed out,
‘Organisations involved in the field of reproductive and sexual health are guilty of being too conservative in their approach and appear to place a higher value on our comfort levels rather than the clarity of their message.’

Agha (2010) also highlighted the importance of convincing other family members, especially husbands and mothers-in-law. In fact, it was revealed that support of family planning use by in-laws was the strongest determinant of a woman’s intentions to use contraceptive methods. Agha (2010) pointed out that one of the biggest challenges was the fear that IUDs and sterilisation would make women sterile and harm their wombs, and therefore recommended that these concerns should be addressed using social marketing.

**Challenges and barriers to social marketing campaigns in Bangladesh**

Schellstede and Ciszewski (1984) highlighted some of the issues facing contraceptive and family planning programmes, especially the fact that like Pakistan, Bangladesh had a religious (Islamic) and conservative society. It was realised from the start that in order to be effective, the campaign needed to be more explicit, especially in the advertising of contraceptives. The importance of husbands in implementing family planning programmes was also highlighted in another study, particularly with regard to ‘obtaining supplies from the commercial sector and acting as instructors’ (Davies et al., 1986). This was similar to the results of the study in Pakistan (Agha, 2010). Here Agha (2010) pointed out the dominant role that men play in communication networks.

However, the main challenge facing Bangladesh is sustaining the successes achieved in health service coverage and health outcomes. As identified by El Arifeen et al. (2013), a key challenge is the provision of training, support and supervision of the largely unregulated community-level workers. For a lot of poor people in the country, these workers are the ‘first line of care’. El Arifeen et al. point out that the government needs to ‘clearly define its roles as a policy maker, regulator and implementer if Bangladesh is to meet these future challenges’ (El Arifeen et al., 2013, p. 2022).

**New research directions**

McKenzie-Mohr (2000) highlights the advantages of community-based social marketing as opposed to information-intensive programmes in fostering sustainable behaviour. According to him, media advertising can be effective in creating awareness and understanding of issues, but are limited in their ability to foster behaviour change. The foundation of community-based social marketing is the uncovering of and understanding the perceived barriers that prevent people from engaging in the desired behaviour. It has been observed that social marketing is instrumental in changing the ‘health behaviour of individual citizens’ (Hastings, MacFadyen, & Anderson, 2000).
Practising social marketing: IIM contraceptive social marketing campaign proposal in India

As an example of the application of the chapter topic in action/practice, we examine the marketing mix analysis of the IIM contraceptive social marketing campaign proposal in India. We analyse the proposal using the ‘four Ps’ of marketing — product, price, place and promotion — as a social marketing framework.

**Product**

The IIM recommended focusing on high-quality and well-packaged condoms. Branding was considered important and the IIM recommended branding the condoms using a term familiar to Indians, and thus Nirodh, meaning protection, was born. Initially the condoms were imported and subsidised by the government. Branding was essential in order to position the condom as a higher-quality product and to appeal to consumers more than the generic no name products.

**Price**

It should be remembered that when *Nirodh* was launched, the Government of India were already distributing condoms free of charge. The commercially available brands were much costlier, which priced them out of the hands of poorer consumers. The IIM recommended an affordable retail price of Rs. 0.30 (approximately £0.003) for a packet of six condoms, or Rs. 0.50 each, which would be subsidised by the government and distributed through commercial channels. This was about 85 per cent lower than the commercial prices at that time (e.g. the 1960s). There is also a body of literature that shows that lower prices for socially marketed products does lead to increased uptake among low-income sections of society. The opposite holds true as well (*Price, 2001*). The IIM came to this price based on an estimated average consumption of six condoms per month per family. Their rationale for charging a price was that this would cover wholesale and retail selling costs as well as some costs of their promotions. It would also eliminate the additional need to maintain inventories. Although the IIM did not highlight it, products distributed free are often perceived by consumers as low in quality. Thus costing them at an affordable price resulted in a higher perceived quality than giving them away for free would achieve.

**Place**

Regarding the distribution channels, the IIM estimated that more than 200,000 outlets would be required in urban areas, with a further 200,000 relatively large shops in rural areas. They highlighted the importance of *kiranas* (or dry grocers, e.g. grocery stores selling non-perishable, unrefrigerated packaged products), as these were
the local shops where most of the household shopping was done (Chandy et al., 1965, p. 7). The intimate knowledge of kirana shopkeepers and their friendly social relationships was considered highly important.

**Promotion**

Finally, the IIM proposed an increase of the family planning promotional activities by at least 20 times in terms of the scale (and range) in order to facilitate the social marketing strategy’s success. This was to be carried out by a massive government-led national campaign to promote various family planning programmes and methods. Interestingly, they recommended that about 10 per cent should go to promotions of the condoms in retail outlets, and about five per cent should go directly to promoting the use of condoms. The use of mass media and print was highlighted.

**Practice case study: the BlueStar Programme**

One of the most successful programmes launched by the Social Marketing Company (SMC) of Bangladesh was the BlueStar Programme (BSP). This programme was launched in June 1998 and used the social franchise model comprising of a private sector network of branded providers, in order to increase the utilisation of public health services. This was done by using community-based private health providers to improve the quality, awareness, accessibility and affordability of these services.

**BlueStar providers**

There are non-formal private health practitioners who are recruited based on set criteria and trained by the SMC. The providers agree to deliver a defined package of services. They also keep detailed records, which are sent to the SMC. Although only graduate providers were initially accepted, non-graduate medical practitioners have been accepted since 2000. The SMC currently has 4,000 providers nationally. According to the SMC, each of these providers serves an average of 200 patients per week, which includes 80 per cent women and approximately 14 per cent were children. A programme evaluation study of 1,379 private sector health service providers indicated that the knowledge level of BlueStar providers was significantly higher than that of non-BlueStar providers with regard to contraception, including knowledge of side effects (SMC, 2014b).

**Segmentation and targeting**

The SMC markets a variety of contraceptives under its family planning programme. Each of these products is positioned differently and targeted at different price
segments. For example, the SMC launched its branded injectable contraceptive SOMA-JECT in March 2003. This was positioned as a high quality contraceptive and targeted at low and middle-income families. The number of administrations of SOMA-JECT in 2013 was 1,236,747, compared to 8,500 in the first year of marketing in 1999.

**User satisfaction**

According to the Bangladesh Demographic and Health Survey (BDHS) in 2008, four out of ten modern contraceptive users, six out of ten condom users and two out of ten injectable users reported that they used SMC brands. The SMC have also reportedly captured 81 per cent share of the condom and 90 per cent of the oral contraceptive pill retail market (sources: CHMI, 2014; Gonsalkorale, 2010; SMC, 2014b).

**Further investigation**

Social marketing has a long history in India, Pakistan and Bangladesh. The contraceptive and family planning social marketing campaigns have had some successes — with the lowering of population growth rates. Clearly there are some barriers, which are hampering the campaigns. The model proposed by the IIM in India has been analysed using the marketing mix. We believe that it is crucial to systematically identify, understand and then eliminate the barriers to the desired sustainable behaviour changes, namely the adoption of contraceptives described in this chapter.

Future studies need to focus on appropriate evaluation methods and approaches. Here are some key questions/projects that require further investigation:

1. Would be accurate to say that social marketing campaigns in these three countries are still very much selling focused and there needs to be a move towards a more consumer-centric approach?
2. Are the campaigns focusing too much on meeting family planning targets? For example, targets such as number of condoms distributed, etc., which are easier to meet compared to the complexities associated with measuring and evaluating large-scale behaviour changes.
3. Husain and Shaikh (2005) emphasised the importance adopting specific and culturally acceptable strategies (in the context of HIV/AIDS programmes). However, the question is that whether organisations in these countries are too conservative in their approach — as Butt (2009) puts it, ‘going for the whole nudge nudge wink wink approach’. By being too culturally sensitive, is there a risk of diluting the message that the organisations are trying to communicate?
4. Looking at the various social marketing campaigns in these three countries, it appears that some of the most successful ones are those led by private NGOs (Pakistan) while others are spearheaded or strongly supported by the government (Bangladesh) and government linked companies (India). What are the factors for their successes while other efforts failed?
References


