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“END SMART MODEL: A Social Marketing Approach for Tobacco Control”

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Introduction: Tobacco and India

1. Tobacco Introduced in India in 16th century by Portuguese traders.
2. India 3rd Largest producer & consumes of Tobacco.
3. Global capital of tobacco generated diseases, with over 40% of health problems due to tobacco
4. 1.3 million deaths, still 2.5 million new tobacco users every year. (Mostly 14-18 years of age)
5. World Health Organization has declared ‘Tobacco’ as on epidemic and it’s a Health Emergency.
Introduction

6. Annual cost $15.88 Bn
   (1,04,000 cr)

   Revenue $6.5 Bn
   (40,000 cr)

6. Loss of public money $9.3 Bn
   (64,000 cr)

7. Tobacco control initiative started an 1974, Law introduced in 2003, still tobacco uses 35 % of population.

8. To find a solution, there is a need for a fresh way of thinking and new ideas.

(Source: GATS, 2009-10)
Methodology

1. This exploratory and qualitative Research was conducted in Rajasthan State of India in 2014-2016.

2. Used 3 types of tools viz.,
   a) Focus Group Discussions.
   b) Survey of Stake holders. (Three Categories)
   c) Case studies of selected best practices from the field of ‘social marketing’ as well as ‘tobacco control’.
Methodology : 1. Focus Group

Professor
Doctors
Social Activists
Students
Politicians
Addicts
Entrepreneur
Methodology : 2. Survey

Mechanics and Supervisors in Automobile Workshop
### Methodology : 3. Case Studies

3a. The best practices in ‘Social Marketing’ included:

<table>
<thead>
<tr>
<th>Organization/Project</th>
<th>Description</th>
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<tr>
<td>Pulse Polio Immunization</td>
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<td>Social Marketing of Condom by USAID</td>
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<td>‘SULABH’ International Service Organization (Pay And Use Community Toilets)</td>
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<td>A Women Co-operative Bank - ‘SEWA BANK’</td>
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<td>‘SAVE GIRL CHILD’ Campaign In India</td>
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### Methodology: 3. Case Studies

3.b The best practices in ‘Tobacco Control’ included:

| **COMMIT** | ‘Community Intervention Trial for Smoking Cessation (COMMIT) model’ from USA. |
| **ASSIST** | ‘American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) Model’ by National Cancer Institute, USA |
| **CLeaR** | ‘Challenge Leadership and Result (CLeaR) Model’ for Excellence in Local Tobacco Control, Public Health, England (UK) |
| New York State Quit line, Buffalo, NY, USA | Bloomberg Initiative, (USA) that provided grants and support at Global Level. |
Survey Results: Major Findings

1. 95% of tobacco users want to quit tobacco. 66% wish to quit immediately and 29% within one year.
2. The most popular reasons for willingness to quit tobacco are:

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<tbody>
<tr>
<td><img src="image" alt="Cross" /></td>
<td><strong>Ist</strong>: Bad for health</td>
</tr>
<tr>
<td><img src="image" alt="Thumbs Down" /></td>
<td><strong>IInd</strong>: Disliked by Family</td>
</tr>
<tr>
<td><img src="image" alt="Currency Symbols" /></td>
<td><strong>IIId</strong>: Expensive Habit</td>
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Major Findings: Majority wants Ban

3. **90% of the all stakeholders recommended a complete ban on tobacco in India.** 79% People want the ban immediately or within one year.
Major Findings : Users want ban

4. Surprisingly 91% Tobacco users also want complete ban. 56% of them 'Strongly Recommended' the ban.

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Major Findings: What is more helpful?

5. For quitting tobacco voluntarily, top 3 measures selected by people on helpfulness are –

1st Complete treatment in de-addiction centre.
2nd Support from their families and friends.
3rd Face to face counseling with doctors.
Major Findings : Who is most influential?

6. The most influential persons ‘In a Family’ to force any addict to quit Tobacco are:
   a) ‘Mother’ - for unmarried young respondents.
   b) ‘Spouses’ - for married young respondents.
   c) ‘Daughters/Sons’ - for married elderly or middle-aged people.

7. The most influential persons ‘Outside Family’ to force any addict to quit Tobacco are: (in order of reducing influence)
   1\textsuperscript{st} : Friends/Colleagues
   2\textsuperscript{nd} : Doctor
   3\textsuperscript{rd} : Teachers
Major Findings: Poor awareness about helpline

8. 72% respondents were not aware about the existing 'Quit Tobacco Helpline' in Rajasthan State. Only 28% were aware about it, but only 14% knew the Helpline Number.

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Major Findings: Features of Helpline

9. The most preferred features in a ‘Tobacco Control Helpline’ required are:

a) **Referral** to the nearest De-addiction centers.
b) **Delivery** of medicine at home.
c) **Three-digit** number for handling complaints of violations of the Tobacco Act.
Major Findings: PRICE (Monetary)

10. 59% were willing to spend up to USD $15 (Rs 1000) per month for 3 months for getting de-addicted from tobacco. 26% could spend up to USD $30 (Rs. 2,000) per month.
Major Findings: PRICE (Non Monetary)

11. Majority of respondents were willing to spend 1-2 hours and travel average 3 kilometers every week to avail de-addiction services for 3 months.

TIME COST

1 to 2 HRS. PER WEEK

EFFORT COST

1 to 3 KMS. (upto 1.6 MILES) PER WEEK
Group Discussion: Major Hurdles

A. Major Findings:

1. Major Hurdles in tobacco eradication:
   a) Vested interests and nexus of politicians with tobacco industries and Lobbyists.
   b) Lack of involvement of all stakeholders.
   c) Poor implementation of Tobacco Control Law.
   d) Very mild penalties on violation of the Law.

2. Tobacco still an acceptable norm in the society. Must be made a “taboo”.

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Group Discussion : Major Points

3. Rampant surrogate advertising on all media, massive advertising and promotions at the “point of sales” (POS). It should be banned.

4. Ceiling and Licensing on Production and Sales of Tobacco is required.

5. Low budget for tobacco control vis-à-vis huge ad. Spent promotion of tobacco.
6. Grossly **inadequate Research**: No major impact on reducing the consumption.

7. **No Effective De-addiction Mechanism**: Absence of an effective and Quitlines de-addiction camps, Medicines for quitting are very costly.

8. **No Social Marketing Approach**: Absence of Community Participation in national tobacco control programme.
Group Discussion : Major Ponits

9. The basic mission must be ‘Tobacco Eradication’ instead of “Tobacco Control”.

10. Set up a ‘National Authority for Tobacco Eradication’ (NATE) as the apex body to control the program under the office of the Prime Minister with all necessary powers and budget.

11. Aggressive ‘top-down’ approach for reducing supplies and aggressive ‘bottom up’ approach for reducing demand.
Group Discussion : Major Ponits

12. Strict law against lobbying by politicians and tobacco industry. Heavy penalty on such violations.

13. Shifting the onus of the ‘health cost’ of tobacco generated diseases from public to tobacco manufacturers.

14. Raise Tax, implement uniform tax on all tobacco products including bidi (country made cigarette made from ‘Tendu’ leaves) in the entire country.
Group Discussion : Major Points

17. **100% dis-investment/withdrawal of Government investment from Tobacco industry.** Instead, Government investment should be made to fund establishment of ‘Quit Line’ in Public Private Partnership (PPP) mode in health sector.

18. **Apply professional branding and social marketing tools** to give a big boost to the acceptability of the programme.

19. **Engage celebrities, use social media,** boost activations & events and establish awards.
Group Discussion : Major Points

20. **Create IT enabled platforms,** website, app and service delivery mechanism for multiple stakeholders.

21. Rope in Corporate Social Responsibility (**CSR**) funding to the programme.
'END SMART' Model: A Social Marketing Approach for Tobacco Control

In 2014-16, a three-dimensional research work, with inputs from 60 tobacco control resource persons, 220 tobacco users and non-users with 10 best practiced case studies from all over the world, helped in building this new approach for tobacco eradication called 'END SMART'.
Descriptions of the Model

Every 6 Second Tobacco Kills someone in the World.

“END SMART”

1. The implementation the tobacco control program in many countries severely lacks participation by their “Communities”. Most of the major stakeholders (like Health Professionals, Teachers, even family members of Tobacco addicts) are not suitably engaged in the drive. As a result, the program becomes ineffective despite spending million of dollars and wasting decades of hard work.

2. Therefore, we need a “Social Marketing Approach” i.e. ‘END SMART Model’.
3. ‘The End Smart Model’ has been developed using the well-known “8 elements of Social Marketing”:

(i) Consumer orientation
(ii) Voluntary exchange
(iii) Segmentation
(iv) Formative Research
(v) Competition
(vi) Marketing mix
(vii) Tracking system
(viii) Management process.

They form the “Central Spine” of the model.
4. Above the ‘Central Spine’, there is “Supply” side of Tobacco, and below the Spine is “Consumption” side of Tobacco.

5. The application of the social marketing elements enhance the ‘Social Marketing Bandwidth’ of the tobacco control programme. The core of this approach is to increase this Bandwidth.

6. To reduce ‘Supply of Tobacco’ 3 organizational interventions are suggested:
   i. Enforcement of the Law.
   ii. NGO’s Whistle Blowing.
   iii. Decision Makers Accountability to public Health. (Acronym as END).
7. To reduce “consumption of tobacco” the model suggests 5 interventions:
1. Service Delivery
2. Mass Communication
3. Activation
4. Rehabilitation
5. Technology
   (Acronym as SMART).
8. To increase the bandwidth, each of the 8 Social Marketing elements must be applied to the ‘END’ interventions to push back the supply curve towards zero.

9. Similarly, these must also be applied on the ‘SMART’ interventions to push down the consumption curve towards zero.

10. Thus the ‘END SMART’ interventions, when backed by 8 elements of Social Marketing, will certainly reduce the ‘supply’ and ‘demand’ of tobacco and will pave the way for its complete eradication.
Specialties of the Model

(a) **Digital Platform**: This conceptual model can be developed as a mathematical model on a digital platform.

(b) **Base Line/End Line Survey Tool**: One can measure the existing “Social Marketing Bandwidth” of tobacco control programme of any district like a score sheet of a student for different subject.

(c) **Micro /Macro Planning Tool**: Every City can create its own suitable goals and plan for the program. Later micro plans of various cities can be clubbed to State and National levels.
Specialties of the Model

(d) **Multiple Utility:** It can be customized for other social programme viz. De-addiction from drugs and alcohol, spreading education, Promoting use of solar energy, global warming and even against “Terrorism”.

(e) **Replicability:** In any socio-economic / cultural group in any geographical area of the World for mass social changes.
Design Inspiration

The design of END SMART MODEL: design has been inspired from Balloon Angioplasty, which is a minimally invasive, endovascular procedure to widen narrow or obstructed arteries or veins of the heart.
“Social Marketing is a platform on which ordinary people with good intentions can do extra ordinary things for the good of people”.

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Thank you!

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