APPLYING MARKET SYSTEMS DEVELOPMENT TO CHANGE CONSUMER BEHAVIOUR FOR HEALTHIER LIVES: LESSONS LEARNED FROM PSI

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Springfield worked with PSI several years ago during their adaption of market systems development to a variety of health market systems. We recently checked in with them to learn how that adaptation has gone.

Population Services International (PSI) recently celebrated fifty years of working to make it easier for all people to live healthier lives and plan the families they desire. It goes without saying that the world in 2020 is a different place than it was when PSI started in 1970, but one thing that has not changed is PSI's focus on consumer behaviour. Improved health outcomes are only possible if people adopt and sustain risk-reducing behaviours. What has changed is *how* the organisation works to enable people to live their healthiest lives. This learning brief explores PSI's journey – from the need to change its approach, to how change has taken place, to some of the lessons learned along the way.

Why change

Since its early days, PSI was distinctive because it tried to understand health care users as consumers served through markets. In many of the contexts in which it worked there were few, if any, options to work with existing private sector suppliers of health care goods and services to low-income populations. Thus, PSI's initial efforts to influence consumer health behaviour saw it play the role of a social marketer – in essence borrowing concepts and tools from commercial marketing and applying them to health problems. In practice, this often meant PSI managed the marketing, communications, and distribution of products like condoms and contraceptives, in addition to subsidising the cost to the consumer with international donor support.

However, as any systems advocate will tell you, market systems are complex and dynamic, and health care systems are no exception. As these market systems began to evolve and present different opportunities and challenges, it became clear that PSI would also need to adapt how it responded to ensure consumers continued to have access to information and goods and services that would enable them to practice healthy behaviours. Whilst different countries and contexts continued to have their particularities, several common changes in the market contexts in which PSI was working contributed to changing practices:

- A greater number of private suppliers emerged to provide health care goods and services in many of the contexts in which PSI had previously filled that gap directly.
- Donors, and PSI, began to question the sustainability of intervening directly to provide socially marketed goods and services.
- PSI increasingly confronted the limits of social marketing as field teams ran into constraints to consumer behaviour change beyond product development, adoption, and distribution.
- The aid market itself continued to be competitive and organisations like PSI needed to differentiate themselves as social marketing became the norm in a wide range of implementing organisations.

"10-20 years ago it was about individual behaviour change in a broken system. Now it's about changing the system around the individual."

In response to these changing market conditions, PSI began to evaluate how it needed to pivot in some health care market systems to best ensure low-income consumers had access to health care goods and services indefinitely.

How to change: from purposeful experimentation to organisational guidance

Responding to evolving contexts – with more emphasis on sustainability from donors and do-ers within PSI, more private sector providers, and a recognition that social marketing, while an important tool, was not always sufficient – PSI began to experiment with doing things differently.

Many of these early programmes required PSI to "zoom out" from its routine in-depth analysis of the drivers of individual behaviour to better understand barriers within the wider market system. PSI's sanitation work in Bihar, India is a good example of this. Instead of adopting the role of a social marketer of toilets, PSI first analysed the sanitation market – who was doing what, how they were doing it, and where the key bottlenecks were in the process. It found that challenges in consumer financing and supply-side logistics and distribution were keeping people from being able to practice better sanitation behaviour. By focusing on the wider market system obstacles – and opportunities – PSI was able facilitate a sanitation market that continues supplying toilets today.

Another example of purposeful experimentation came from a different health issue and context. The UNITAD-funded multi-country rapid diagnostic tests for malaria (mRDT) project, worked across five countries to create a market for private sector use of mRDTs. PSI implemented the project using different strategies in each of the five countries, with varying degrees of direct service delivery from PSI. A final evaluation found that *"It is probable that, if no additional market development activities take place, the markets in Kenya, Tanzania and Uganda will remain at their current levels while gains in Nigeria and Madagascar will reverse. PSI gradually changed its role over time in the Tanzanian and Kenyan markets by moving from direct distribution to support of other actors. This has increased the likelihood of market sustainability."*

At the same time as the organisation was building its capacity to "zoom out," and understand the broader environment that shaped consumers' behavioural choices, it was also "zooming in" to introduce new ways of designing activities. This was mainly by experimenting with the principles and processes encapsulated in human-centred design (HCD). Although the wider market system was changing, one of the ways in which PSI has operationalised its commitment to consumer -powered health care has been to keep the consumer at the centre, starting from analysis through implementation. Bringing the customer *into* the design process was considered to be an important addition to the PSI toolbox because, as one staff member put it, "*We thought that we were getting insights through the large surveys that we were doing, but this was just one point in time and took years so* [information] *was not current."* Rather, having a process that allowed for rapid insights into consumer behaviour gave PSI the right information at the right time to design more effective activities as its role in the market continued to evolve.

As PSI adopted different but complementary approaches to design for increasingly complex programmes, it recognised that it needed more internal guidance and capacity to understand and implement beyond its core competence of social marketing. With funding from supportive board members, and championed by an internal team, PSI created the Keystone Design Framework.

"We've moved from individual, to social, to market behaviour change. Keystone connects all these together."

Keystone offers organisational guidance on how to diagnose, decide, design, and deliver health programmes in a range of contexts for solutions beyond social marketing. Launched internally in 2018, it is now available to external organisations under a creative commons license. Key staff have been trained and a cadre of support staff exists to help design new programmes or troubleshoot existing ones.

Insights gained along the way

Keystone builds on the changing practices PSI had been adopting in response to a changing aid and implementation environment. It was not developed in a vacuum but built on the lessons learnt over nearly a decade. Most PSI staff have had experience using the framework, from business development teams at headquarters to field staff designing new programmes or changing course during an existing programme. Much has been learned along the way, from tactical and operational feedback about the framework itself to more strategic reflections for PSI as an organisation, which are explored briefly below.

Asking different questions leads to different answers: PSI's has always conducted analysis to inform its interventions, but prior to incorporating the principles and approaches encapsulated in Keystone, these questions tended to explore how PSI could increase sales of a particular product or service. What Keystone

nudges PSI to do now, however, is to begin with a different question – how you maximise public health impact for a particular market – and *then* figure out what role PSI should play?

More players' behaviours need to change to sustain customer behaviour change: PSI has not abandoned its core mission of working to change customer behaviour to enable better health outcomes. However, the laser focus on individual behaviour that shaped PSI's early interventions often assumed failure to use a good or service correctly was caused by individual opportunity, ability, and motivation. The inclusion of more rigorous systems diagnosis within Keystone has led PSI to widen its focus to include both private and public market actors' behaviour *as a means* of influencing consumer behaviour.

"Keystone provides a practical way of designing for sustainability from the beginning, not just the end of a project."

Operationalising sustainability: With the shift from the Millennium Development Goals to the Sustainable Development Goals, donors began to emphasise, at least on paper, more sustainable programming. Practitioners do not need more endless debates on the meaning of sustainability, but rather practical tools to operationalise it. Simply thinking through "who will do and who will pay" for the functions necessary to ensure customers have ongoing access to information, goods, and services has helped PSI programme for sustainability in practice. For example, thinking about "Who will do?" and "Who will pay?" helped PSI leadership advocate for a more mixed approach to malaria case management at the global level, influencing the World Health Organisation's guidance on private sector participation in malaria control.

Conclusion

Fifty years on, PSI remains committed to working towards better health outcomes. It now recognises that that will only happen with sustained behaviour change of public agencies, private firms, and individuals. PSI has also realised that it needed to change its own behaviour to ensure its approach is as effective as it can be in evolving markets. This journey has not been without its bumps. PSI encountered tensions in articulating its changing role in evolving markets; it had to balance opportunities to design more sophisticated programmes for donors with higher risk appetites with the pressures of conventional business development; and it had to communicate its evolving role internally and externally. Keystone does not replace the extensive health expertise required to tackle persistent global health challenges, but brings together PSI's understanding of diseases, the drivers of individual behaviour, and how those drivers are shaped by constraints beyond the individual. As PSI works to place the consumer at the centre of stronger health systems, helps to bring innovations to scale, and amplifies the work of other actors Keystone provides a common language and due diligence process for designing and delivering health programmes so that more people in more places can live healthier lives.