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Selling Health: Hindustan Lever Limited and the Soap Market

Introduction

In the category of infectious diseases, only acute respiratory infections and AIDS kill more people per year than diarrhea, which accounts for 2.2 million deaths annually.[1]

India contributes to 30% of all diarrhea deaths in the world.[2]

These statistics outline the pervasiveness of diarrheal disease in the developing world and the tremendous toll it takes on the public health, especially among the poor and children. In India alone, 19.2% of the children suffer from diarrhea.[3] At the same time, the preventive measures and cures are relatively simple: access to safe water and sanitation facilities and instruction on better hygiene practices. Yet, in spite of the efforts of NGOs, developmental agencies and governments, the problem persists. So what is a viable solution?

THE INNOVATION. . .

The paradox of diarrheal disease is that the solution is known and inexpensive, but it is difficult to reach and educate the poor about the need to wash hands with soap. Hindustan Lever Limited (HLL), the largest soap seller in India, created a unique approach to public-private partnership as a solution, as well as made this public health issue an integral part of their business.

This document traces the efforts of HLL, the Indian subsidiary of Unilever, in combating the social health issue of diarrheal disease through innovative methods of marketing a common consumer good--soap.

This report was written by Mindy Murch and Kate Reeder, under the supervision of Professor C.K.Prahalad. The reports are intended to be catalysts for discussion and are not intended to illustrate effective or ineffective strategies.

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DIARRHEAL DISEASE

Globally, diarrheal disease accounts for more than 2.2 million deaths annually.[4] Children are particularly susceptible due to loss of liquids and dehydration from diarrhea. UNICEF estimates that one child dies every 30 seconds from diarrheal disease,[5] making it the second-greatest infectious killer of children in the world today.[6] India is by no means immune to the problem of diarrheal disease. National surveys estimate that almost 10% of the population suffers from diarrheal disease at any given time,[7] resulting in an estimated 660,000 diarrhea-related deaths per year in India.[8]

What causes diarrheal disease?

Research has proven that human excreta is the main source of diarrheal pathogens.[9] A lack of adequate sanitation facilities for disposal of excreta and poor hygiene practices results in the diarrheal disease pathogens being carried throughout the human environment. There are four key ways in which pathogens are transmitted: through drinking water, from flies and insects, physical contact with dirt and from human hands.[10] Flies landing on excreta can carry pathogens to food or surfaces used to prepare food, and feet may track waste into the home. However, "hands are the main vector of diarrheal pathogens, transferring them from surface to surface and person to person."[11] Yuri Jain, at HLL, describes daily life in India, "Hands feed a child, hands prepare food and in an Indian context people don't typically use knives and forks…everything is done with your hands, so that's a transmission mechanism."[12] There is weaker evidence that hands are also a main pathway for the transmission for Acute Respiratory Track infections (ARI).[13] Statistics show that at any given time, over 6% of the population suffers from ARI.[14]

A lack of sanitation facilities is widespread throughout India. The majority of India's population is poor, with approximately 83% of the population (885 million people) earning a median household income of less than 2000 rupees ($43) per month.[15] Almost 35% of the country is living below the poverty line.[16,17] Moreover, less than 29% of the Indian population has access to modern sanitation facilities, and 64% of the population uses the bush or fields as toilets.[18] The number diverges widely by urban and rural populations. As of 2000, 27.7% of India's more than one billion people live in urban areas, while 73.3% live in rural areas.[19] A 1999 sanitation report from WHO/UNICEF revealed that in rural areas, only 16.8% of the Indian population use a flush toilet, pit or latrine, and 81.1% have no facility and use the bush or fields as toilets.[20] The same report stated that 60.9% of urban Indians own a flush toilet, pit toilet or latrine, and 19.3% have no facility or use the bush or fields as toilets. Handwash habits also differ in urban and rural areas. Twenty-six percent of urban Indians (173 million) and 74% of rural Indians (492 million) do not wash their hands with soap every day.[21]

Handwash as a preventive measure

Research on preventive behaviors for diarrheal disease shows that washing hands with soap could significantly reduce incidences of infection. In 1988, research conducted by the World Health Organization showed that washing hands with soap reduced diarrhea attacks by 48%.[22] A recent evidence review by Valerie Curtis and the London School of Hygiene and Tropical Medicine found handwashing

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with soap could cut diarrheal disease by 42% to 46%.[23] Changing behavior to increase the frequency of handwash is "theoretically capable of stopping most or all transmission of the infectious agents" from diarrheal diseases.[24] Washing hands also could be effective in reducing the spread of ARI.[25]

Currently, handwash and soap usage is low among most of the Indian population. Although the penetration of soap in Indian households is actually very high, with 95% of Indian households owning soap, 665 million Indians do not use soap every day. Of these, 26% are urban Indians (173 million) and 74% are rural Indians (492 million).[26] Only 30% of the population uses soap everyday.[27] Others use substitute products such as clay, ash or mud. The International Scientific Forum on Home Hygiene: Rural Study found that after defecating and before and after every meal, 62% of the population used water plus ash/mud, 24% used water alone and only 14% used soap and water.[28]

The need for behavior change

If a solution to diarrheal disease is simply washing hands with soap, why is this problem still stunningly pervasive? Historically, this issue has been approached as a public health issue that could be solved through large infrastructure projects, a timely and costly proposition for governments in developing countries. In addition, three other reasons are ascribed for the persistent incidence of diarrhea.[29] First, the disease fell into the multiple domains of Ministries of Public Health, Water or Environment. However, no group ever assumed full responsibility for the disease. Second, attention has been focused on "hot" issues such as HIV that command more public attention, leaving diarrheal disease to be "championed by no one." Third, behavior programs to address diarrheal disease are difficult to design and implement, and are "more complex and problematic than expected."

Changes in consumer beliefs and behavior are especially difficult to engineer in India. First, a deep understanding of the current practices, motivations and hindrances preventing the use of soap and handwashing is required. This understanding is difficult to obtain in a country dominated by local cultures. India's one billion citizens are spread across 25 states and seven union territories. They speak more than 15 official languages and 325 different dialects, many of which are so different they are only understandable to those in a small geographic area.[30] Second, messages on health and hygiene to create behavior change are difficult to communicate to dispersed populations. Many rural parts of India are "media dark" areas, where citizens have little to no access to mass media channels.[31] Only 22% of the population has a TV, and only 43% has a radio.[32] This lack of a mass communication venue adds complexities and costs to education campaigns, requiring targeted messages distributed through unconventional means.

A public health issue in the private realm

Given these complexities in developing and delivering an effective behavioral change campaign, a multinational soap manufacturer (MNC) may be better equipped to reach Indians with health messages to reduce diarrheal disease. This behavior stems out of the belief that water or other substitute products clean as well as soap. Yuri Jain at HLL explains, "We should really think about why a lot of these public programs haven't been as effective as they could have been. When put into the context of handwash and water, a lot of it actually involves changing consumer behavior and that's the crux of the matter. You have

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a way of doing it, and you change the way of doing it. And who is better placed at changing habits than a large company."[33] MNC's may be in the best position, with the following unique capabilities, to take on the challenge of combating diarrheal disease:

- Deep experience in conducting and analyzing consumer research to identify behaviors and trigger points for behavioral change.
- Marketing expertise to craft communication messages and direct contact programs that can bring about behavioral change.
- Strong brands that can serve as routes for driving behavioral change riding on their consumer equity.
- Experience in adapting their products and messages to meet local conditions, cultures and traditions.
- Vast distribution networks to deliver products to consumers even in the most rural settings.
- Experience in sharing lessons learned and transferring best practices to increase the efficiency and effectiveness of their operations on a large scale.
- Accountability for achieving results by carefully evaluating investment in projects to ensure success.
- Global reach, with the ability to touch customers in many countries with similar messages and products, and quickly scale projects from local initiatives to regional and global endeavors.

Finally, MNCs sell soap, a product which can address diarrhea, and have a built-in incentive to successfully create the required behavioral changes.

Hindustan Lever Limited

HLL is the largest soap and detergent manufacturer in India, with $2.4 billion in sales, 40% of which is from Soaps and Detergents.[34] In recent years, the CEO's increasing focus on differentiating HLL's products based on a health platform has pushed employees to delve deeper into consumers' needs and behaviors in an effort to find opportunities to make their products become imperative to a family's health and safety. One means of making this connection was the tie between diarrheal disease prevention and HLL soap products. Yuri Jain, a General Manager at HLL, explains, "When you ask yourself how do you break the transmission of disease with hands, you come up with handwashing with soap. And that clearly suggests there is great business imperative for us to try…to make that happen because we are the largest manufacturer of soap. If people start washing their hands with soap more often, the consumption will go up and there is an impact on market size."[35] This clearly could be a "win-win" solution for both the BOP consumers and the company.

Not only would this focus on increasing the demand for soap benefit HLL, but it also could benefit Unilever in other parts of the world. In developed countries, the soap market is reaching a point of saturation. However, in developing markets, the opportunity for growth still exists. The opportunity to increase the size of market lies in increasing the frequency of use in India and other developing nations. Moreover, this opportunity to grow sales through health messages exists beyond the soap market and could be used to address other public health issues.

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The largest soap manufacturer in India

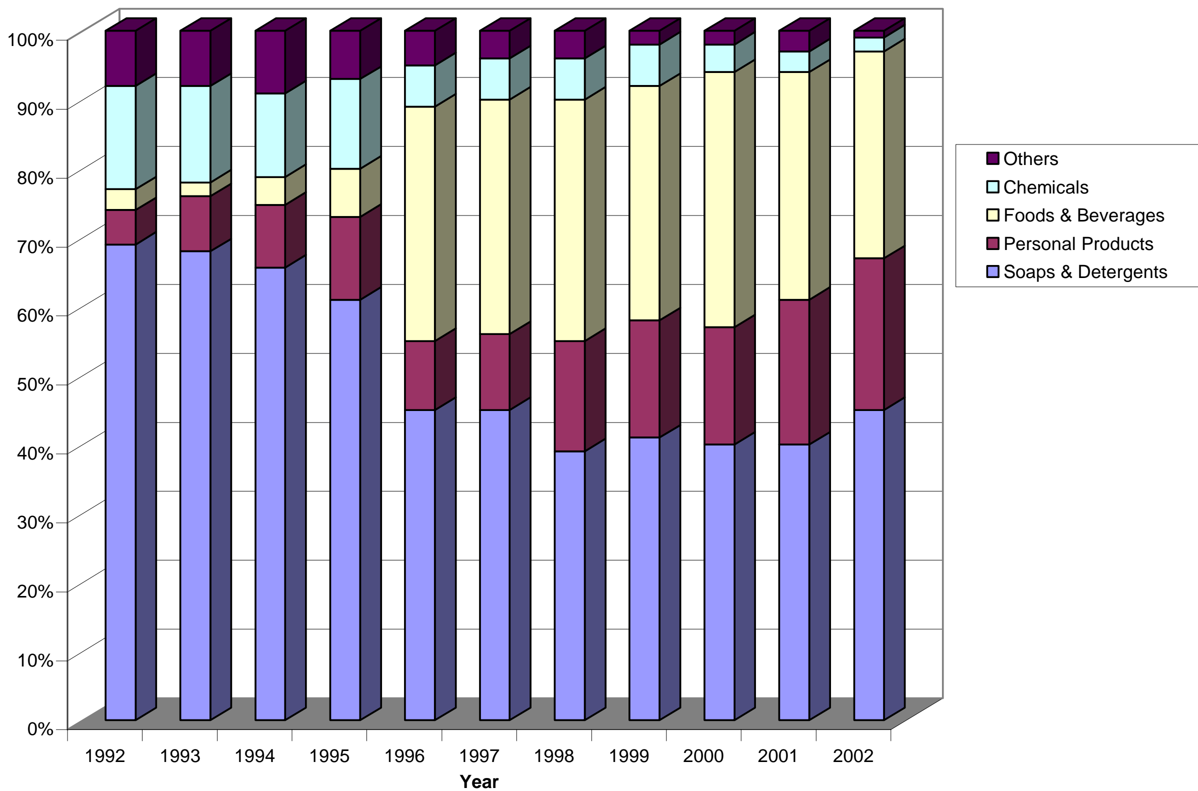
HLL's mission outlines a broad philosophy of serving all Indians, across the wealthy and poor, rural and urban spectrums:

Our purpose at Hindustan Lever is to meet the everyday needs of people everywhere – to anticipate the aspirations of our consumers and customers and to respond creatively and competitively with branded products and services, which raise the quality of life.

Our deep roots in local cultures and markets around the world are our unparalleled inheritance and the foundation for our future growth. We will bring our wealth of knowledge and international expertise to the service of local customers.

To meet the needs of such a large and diverse country, HLL has four key Profit Centres, delivering over 1000 SKUs through its 30 plus "power" brands. The largest Profit Centre is Soaps & Detergents, followed by Foods & Beverages, Personal Products and Specialty Chemicals (see Figure 1).

Figure 1: HLL Net Sales, 1992-2002[36]



HLL's ability to reach the masses

HLL has built superior R&D, distribution and marketing capabilities to effectively deliver its goods across both urban and rural India. HLL employs more than 100 scientists to develop new consumer goods and pioneer efficiencies in manufacturing. Its investment in R&D resources is returned in cost savings and the ability to price goods affordably to mass markets.

HLL also has assembled the manufacturing and distribution capabilities to provide its products to India. Products are manufactured in almost 100 locations throughout the country. From factories, the products move through a network of central depots to almost 7,500 "redistribution stockists." The stockists work through wholesalers or retailers to sell into three million outlets located in 3,768 cities and towns in urban India, and in one million outlets in 627,000 villages throughout rural India.[37] Currently HLL reaches into all villages with more than 2,000 people and continues to expand its market reach through innovative direct sales programs to distribute products to rural areas. For example, an initiative called Project Shakti employs women to occupy a nontraditional role in commerce, selling HLL's products in their villages. Another initiative, Project Streamline, creates "Star Sellers" to sell an array of HLL products into rural areas.

In order to understand consumer behavior along the socioeconomic spectrum, HLL invests a significant potion of its earnings on consumer research and marketing to better position its products in mass markets. Large expenditures on both mass and direct marketing campaigns have made HLL brands such as Lifebuoy soap, Wheel detergent and Fair and Lovely soap household names across India. HLL also invests in nontraditional and grassroots marketing efforts to reach rural and poor consumers.

HLL's formula is working

HLL's financial performance reflects its success in effectively creating, marketing and selling its brands. HLL has achieved solid growth with net sales increasing from less than $500 million to over $2.5 billion in the last 10 years (see Figure 2). This growth is due to growing market share as well as acquisitions and mergers.

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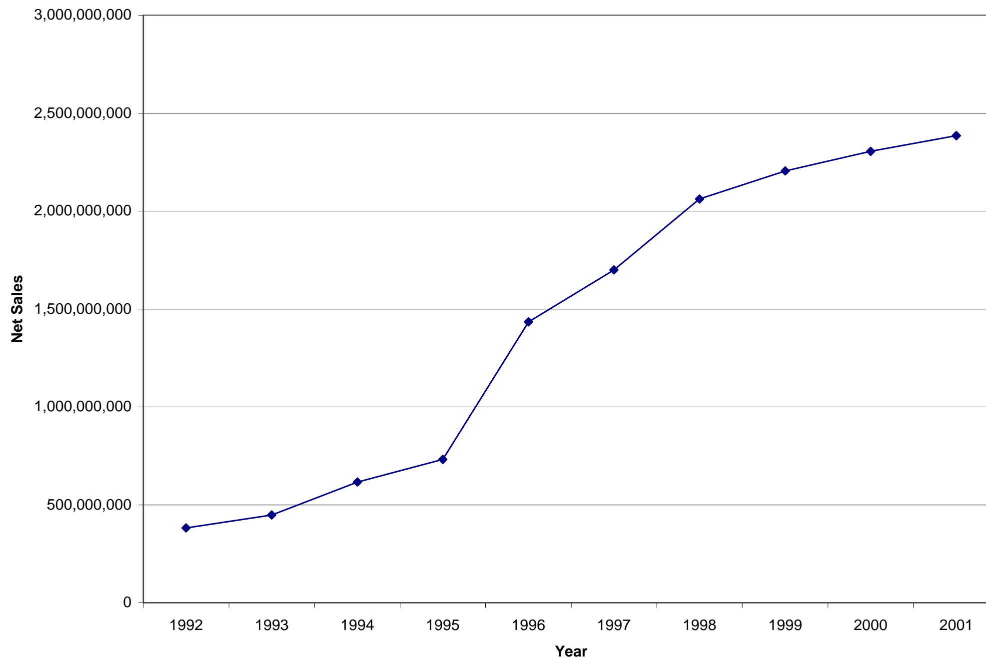
Figure 2: HLL Net Sales, 1992-2001[38]



In 2001, net sales were up over 2000, and net profits increased by over 25% despite an overall economic slowdown in India."[39]

BUSINESS OPPORTUNITY THROUGH HEALTH

The global soap market is increasingly saturated with products, while developing markets hold greater promise for growth opportunities. Currently, the majority of Indian consumers have soap in their homes, but usage is low since consumers don't associate washing hands with soap as a method for preventing disease. Also, beauty messages dominate ideas about the primary use of toilet soap, and daily washing with soap is not considered necessary for beauty by the Indian consumer. The opening in the competitive landscape, therefore, is to shift the positioning of soap from a beauty platform to a beauty and health platform as a means of increasing consumers' frequency of use.

The worldwide soap market

The worldwide soap market in 2000 was US$88.2 billion, and is dominated by a few major global players including Unilever, Procter and Gamble, Colgate Palmolive and Johnson & Johnson. The top 10-industry leaders account for 55% of total soap market (see Table 1).

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Table 1: Value of Soap Market Held by Top 10 Players[40]

POSITION	COMPANY	% OF WORLD MARKET
1	Unilever	10.07
2	Procter & Gamble	7.41
3	Gillette Group	7.66
4	Colgate Palmolive	4.5
5	Johnson & Johnson	4.45
6	Shiseido	4.32
7	Estee Lauder	4.21
8	Revlon	3.42
9	Wella	2.27
10	Henkel	2.27

At the global scale, however, developed markets are becoming saturated. Market growth has been mainly attributed to new product developments and extensions into anti-bacterial and moisturizing products, liquid and shower soaps, and products "focusing on added value and convenience."[41] These markets are expected to tighten in the next few years due to increased price competition and consolidation between soap manufacturers, leaving multi-nationals to seek out new markets in developing countries.[42]

Unilever as a whole is expecting developing markets to comprise approximately 50% of its sales over the next 10 years.[43] In emerging markets, the majority of consumers typically buy fewer soap products at lower costs than in the developed world. However, consumers in emerging markets are becoming increasingly value sensitive in their purchases.[44] This is in part due to growing middle classes and increasing customer aspirations in many countries brought on by the globalization of media messages.

Soap in India

Currently, HLL accounts for 60% of all soap sales in India. Other large competitors include Nirma, with 11% of the market, Godrej Soaps with 6.2% and Johnson & Johnson with 1.6%.[45] Only 5% of all soaps come from the small-scale sector. The market is subdivided into several segments, including discount, popular, premium and super premium, with the discount segment currently the largest segment in India.

The large unmet consumer need

Given these trends in the Indian soap market, HLL determined it needed to deliver more than beauty benefits and economy. Therefore, HLL focused on three value propositions: economy, beauty and health. Harpreet-Singh Tibbs, Activation Manager for the Lifebuoy brand, describes the connection: "If you establish why health is important or why soaps can contribute to reducing germ incidents and perhaps save [consumers] medical bills through long-term associations, I think you have a winner right there."[46] Moreover, health is a meaningful message to consumers across socioeconomic spectrums. As described by Yuri Jain from HLL: "What is hygiene? It's a large, unmet consumer need."[47] Promoting this message

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presents a large opportunity to help prevent diarrheal disease, but also leverage health messages as a means of growing sales. Leveraging these new value-drivers, HLL sought opportunities to utilize its products, distribution network and marketing skills and position itself as a "local multinational" to increase its reach and depth into the soap market in India.

Leverage Health Messages through the Global Public-Private Partnership for Handwashing with Soap

HLL and a public/private partnership

HLL sought out initiatives that connect the use of soap to health and hygiene behaviors, including handwashing. In fall 2000, as part of its research centered around handwash, HLL learned of a public-private partnership (PPP) being developed between the World Bank, the Water and Sanitation program, the London School of Hygiene and Tropical Medicine, UNICEF, USAID and the Environmental Health Project. The PPP envisioned a large-scale handwashing intervention that used lessons learned from pilot projects to promote the approach at a global level. They entitled the initiative the Global Public-Private Partnership for Handwashing with Soap (later to become Health in Your Hands—A Public Private Partnership).

The structure for the program was based upon the successful Central American Handwashing Initiative, a public-private partnership that united four private corporations (La Popular, Colgate-Palmolive, Unisola (Unilever) and Punto Rojo), the USAID and UNICEF.[48] Before the program was initaited, diarrheal disease caused "19% of under five mortalities in Honduras, 23% in Nicaragua, 20% in El Salvador and 45% in Guatemala." The Initiative developed hand wash education messages that each private partner incorporated into its own marketing campaigns. The handwashing program resulted in a "30% increase in hygienic handwashing behavior in mothers, and an estimated 1,287,000 fewer days of diarrhea per year for children under five years of age in the two lowest socioeconomic groups."

Although the Global Public-Private Partnership for Handwashing with Soap would be similar to the Central American Handwashing Initiative, this campaign would be non-branded and open to all interested parties. The PPP envisioned reaching 29 million people, the entire population of Kerala, in three years. This type of initiative was well aligned with HLL's corporate goals of helping to improve the health of a nation. HLL also learned that the Kerala state government (the southernmost state in India) and the government of Ghana (two markets in which Unilever had a strong presence) were interested in piloting the initiative. Therefore HLL committed to the Kerala pilot, and as an early player, was able to help shape the program design and recruit other industry participants.[49]

Partners

In order to create a pilot of this scale, the PPP needed to leverage the specific competencies of each partner (see Figure 3 from the Water and Sanitation Program). First, the program needed scientific credibility and leadership in understanding the fundamentals of handwash on health and hygiene. Therefore, Dr. Valerie Curtis from the London School of Hygiene and Tropical Medicine teamed with the Centers for Disease

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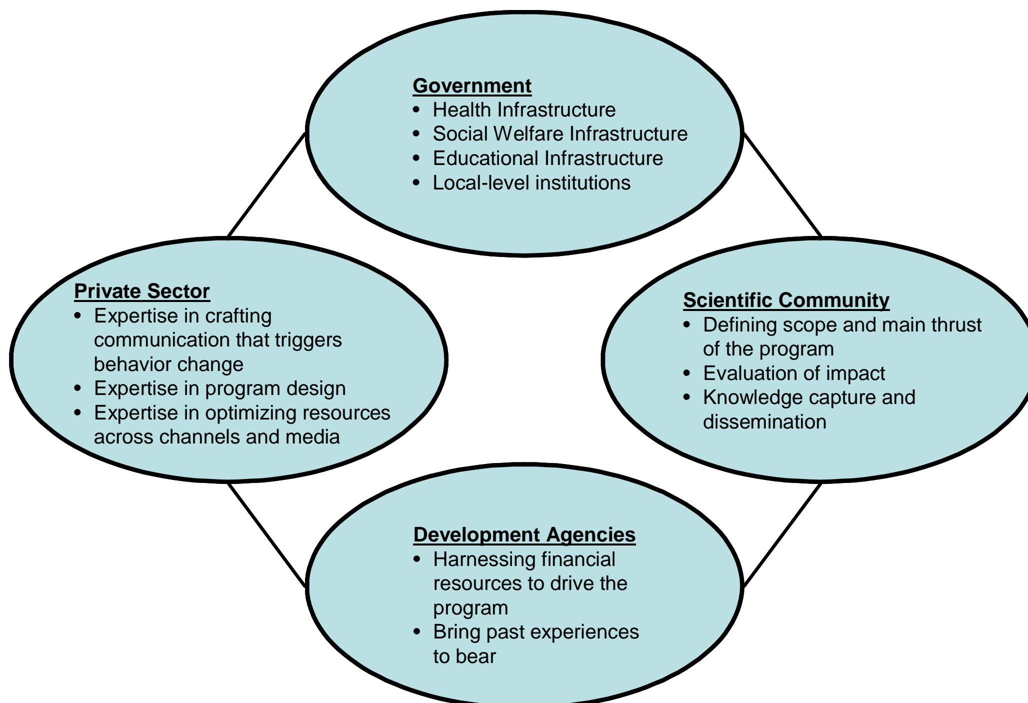
Control and the Environmental Health Project (USA) to provide credibility regarding the science-based foundation of the program and the monitoring and evaluation functions. This team would help determine the effectiveness of the handwashing campaign in terms of changed behaviors and monetary costs and would disseminate best practices and lessons learned to all participants. Second, the PPP needed expertise in behavior change and marketing. HLL and the private sector members held vast amounts of consumer behavior research as well as significant expertise in program design and communication methodologies in both mass and direct contact media.

Third, in order to reach the entire population with handwash communications, the PPP needed government support to utilize existing infrastructure channels, such as schools and clinics, as a way to minimize costs and maximize direct contacts. The government of Kerala viewed this initiative as a welcome alternative to costly infrastructure projects and offered ready access via the governmental machinery. Yuri Jain described the impact of the PPP being able to work through government channels, "…as a company--as Lifebuoy or as HLL--we can only do so much, we can only cover X number of villages. But [in Kerala] we have the entire government at our disposal…We have 10,000 schools, 20,0000 social worker centers, 6,000 health centers. We have scale. You multiply that by 30, you get India. When you multiply that by 10, you have the whole world. So it's huge."[50] Finally, this initiative required funding. The World Bank, in particular the Bank-Netherlands Water Partnership, U.S. Agency for International Development, UNICEF and the Water and Sanitation Program were needed to provide resource inputs and craft funding packages. They also had a network of employees experienced in administering large-scale programs. The final funding package was envisioned to leverage a combination of funding from the development agencies, the Kerala government and the private sector.

Figure 3: PPP Handwash Participants and Roles[51]



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In return for these contributions, each player also expected certain outcomes. The health sector and development agencies sought to leverage additional resources and expertise in designing and implementing education campaigns. The Kerala government sought a less-costly solution over large infrastructure projects as a means of reducing diarrheal disease. It also could benefit from the communication expertise of the multinationals. And the private sector sought growth in the soap market, increased market reach and visibility, and recognition as a corporate citizen. With the players in line, the PPP hired the Indian Market Research Bureau to conduct studies on handwashing habits in Kerala.

The Kerala program

Kerala is a well-developed state in India. It has a population of 29 million and a 100% literacy rate. Sanitation coverage in Kerala is 51.36% in urban areas and 44% in rural areas.[52] Despite higher levels of education and sanitation access, research studies in Kerala found that only 42% of mothers used soap after using the toilet, 25% used soap after cleaning up a child, 11% used soap before eating and 10% used soap before preparing food.[53] The Kerala results also showed those who did not wash with soap were five times more likely to have diarrhea than those who washed with soap.

Based on this data, the PPP designed a program that tried to link the handwash initiative to life changing events or times when new behaviors are most likely to be adopted (such as the arrival of a new baby or vaccination).[54] The complete program was to include four main pieces: a mass media campaign, a direct contact campaign, evaluation and communications development. The first piece was a direct contact program for women when they visited health or social service institutions. The PPP also designed a direct contact program in schools consisting of four health hygiene education days per year and the creation of a mandatory lunchtime hand washing program for children ages 6 to11. Finally, the plan included a mass media campaign. The media campaign was to be generic with no company logos.

Calculations for Kerala suggested that through this program, "70% of households would be reached 43 times a year via mass media, and 35% of households would be reached nine times a year through the Direct Contact program."[55] The initial cost estimate for Kerala was a little over $10 million spread over three years to cover the whole state. Per person costs were estimated to be $.10 per year.[56] Program administrators estimated that savings in healthcare costs would cover total program costs after two years.

The Indian government agreed to fund the mass media campaign, while the Kerala government and UNICEF agreed to pay for the direct contact program.[57] The World Health Organization took charge of the evaluation function, and the private sector agreed to fund the communications research and message development. This allocation of costs among partners allowed each party to achieve a larger objective while only bearing a portion of the costs each year. The private sector committed to take on one-third of total program costs. These costs were further divided among all participating companies (primarily HLL, P&G and Colgate-Palmolive). HLL agreed to bear the majority of the private sector costs, since it is the largest player in the market. However, this funding model may change. In total, HLL planned to contribute almost $776,000 per year (15% of total program costs) or $.027 per head per year.[58]

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Table 2: Percentage Contribution per Partner[59]

PARTICIPANT	PERCENTAGE OF COSTS
Government of India	37%
Government of Kerala/Unicef	29%
World Health Organization	4%
Private Sector	30%
Total	100%

With firm plans in place for global expansion, program design and implementation plans progressed until spring 2002, when nonprofit groups and political opponents started speaking out against the initiative in Kerala. Environmental and anti-globalization activist Dr. Vedana Shiva, Director of the Research Foundation for Science, Technology and Natural Resource Policy, wrote, "Kerala has the highest access to safe water, highest knowledge of prevention of diarrhea because of high female literacy and local health practices such as use of jeera water and high use of fluids during diarrhea. The World Bank project is an insult to Kerala's knowledge regarding health and hygiene. It is in fact Kerala from where cleanliness and hygiene should be exported to the rest of the world. People of Kerala do not need a World Bank loan for being taught cleanliness."[60]

Others accused the Kerala government of side-stepping the real problem: proper toilets and sanitation facilities.[61] This opposition soon spread to politicians such as Mr. V. S. Achuthanandan, leader of the opposition in the State Assembly, who began speaking out against the initiative.[62] The criticism generated by adverse press began to hinder the PPP's efforts. The World Bank asked the Government of Kerala to respond to the criticism, but the state refused. Meanwhile, the state cabinet had not yet approved the proposal, bringing the initiative to a standstill. Final negotiations for the effort are under way, but as an alternative, the PPP has downsized the initiative from $10 million over three years to $2 million for one year[63] and begun to discuss options of moving the initiative to other states in India.[64]

Despite these hold-ups, the PPP and HLL are having successes in other parts of the world. The official launch of the Ghana campaign was in August 2003 and work is well underway in Senegal, Peru, China and Nepal. In each country, the program of work will include a similar direct contact/mass media mix, but will be tailored to the individual country's demographics and cultures.

HLL and the PPP

HLL saw the opportunity to benefit from the PPP, whose aim was to "to stimulate demand for soap through education campaigns." This initiative would leverage each partner's capabilities and expertise in order to serve the public good and expand the market for soap. However, the problems in Kerala highlighted the complexities and possible downsides of working with numerous partners. Public and international organizations, especially such modern-day political lightening rods as the World Bank, are susceptible to public criticism. The process of building trust and accommodating multiple agendas also can slow down project implementation.

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Leveraging Health Messages for Lifebuoy Brand

At the same time HLL was trying to expand the soap market through the PPP, one of its oldest and most successful soap products, Lifebuoy, was losing topline growth at the rate of 15% to 20% per year, starting in 1999.[65] The Lifebuoy brand team was trying to determine appropriate next steps to revive the ailing brand, and began to look toward handwash. As a means of countering sales declines, the Lifebuoy brand looked to HLL's work on the PPP for new methods of attracting and winning customers.

The history of Lifebuoy

The Lever Brothers Company created Lifebuoy in 1894 by mixing residue from the manufacturing process for Sunlight detergent with red coloring and cresylic acid to create a strong soap. From the beginning, HLL linked the bright red color and sanitary carbolic smell to "healthy clean." Beginning in the 1960s, the brand messages were reinforced through the use of a "sports idiom" in Lifebuoy's advertising. An active and energetic sports player needed a strong, effective soap to get truly clean. The Lifebuoy jingle played behind a team sports vignette, "Lifebuoy hai jahan tandurusti hai wahan" or "There's Lifebuoy wherever there is health!" HLL marketed the soap to the Indian male, 18-45 years old, with a medium household income of less than 2000 rupees per month or approximately $47. This person was a semi-literate farmer or construction laborer living in a town of 100,000 or less.[66] By 1986, sales exceeded 100,000 tons with 70% of the brand's volume coming from rural areas. By 1992, Lifebuoy sales surpassed sales of any other soap in India.

Beginning in the 1980s, the cheaply priced beauty bar segment began to eat into Lifebuoy profits. As described by Harpreet-Singh Tibbs, Activation Manager for the brand, "We kept saying health, health, health. And over time, health became synonymous with the base level of cleaning. Every soap over time started speaking about basic health plus something. And the net result was that we were thought to be at the base level of protection. So our health offering became less attractive."[67] He went on to explain that the carbolic fragrance was also outdated, since younger generations and women showed preference for more floral-type fragrances. At the same time, the enormous brand equity associated with the 107-year old Lifebuoy name, especially in rural India, was something the company could not afford to lose.

Brand revitalization on a health platform

Therefore, the Lifebuoy team decided to revisit its mission. HLL Chairman Manvinder Singh Banga advocated the creation of new opportunities for soap: "If Lifebuoy stands for improving health and is all about germ kill, why it is only a soap, why not a shampoo, talcum powder and so on. Then you begin to think about the ways in which the brand can interface and touch the consumer throughout the day; how can that brand touch the consumer? Today we're only touching the consumer when he or she had a bath, but when you begin to think about it in this framework, you say where are the possible inroads of germs into your day, and where can Lifebuoy play a role? So you get a whole set of growth opportunities that emerge."[68] With this direction, the marketing team created a new vision and mission for the brand, relevant to all Indians:

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Making a billion Indians feel safe and secure wherever they are by focusing on their health and hygiene needs.

The team decided to leverage the historical brand platform of health by tying soap usage to the eradication of family health problems. HLL also linked the data demonstrating how soap can help eliminate common health problems, such as diarrhea, to Lifebuoy, finding that members of families often experience stomach infections (diarrhea), eye infections and infected sores. As described by Yuri Jain, this results in a significant loss of time and disposable income for an Indian family: "Every time a diarrheal episode takes place, and for a poor family this could be two to six times a year, there are treatment costs, there are medicine costs, there are doctor costs. And so there is a spectrum of savings that is amassed."[69] The team also changed the target audience from men to entire families, in order to expand its audience for the health message and to cater to the increased influence of women on household purchases. HLL hoped this revitalized health platform would create relevance for the new Lifebuoy target consumers and reassure existing customers that it was still health soap.

Product, cost and marketing strategy

To address the health needs of one billion Indians, the team created a reformulation that was relevant, accessible and affordable to the mass market. HLL replaced the carbolic smell with a more fragrant smell to better appeal to families and women. The team also changed the manufacturing process from "hard" soap production to milled soap production, a change that made Lifebuoy longer-lasting and produced more lather.[70] It's new positioning was now targeted at the entire family's health.

In addition to these changes, HLL wanted to ensure it could differentiate its product on a health platform. The team decided to add Triclosan, a common anti-bacterial agent, to strengthen the antibacterial power of the soap. In Europe and the U.S., Triclosan has been the center of the anti-bacterial controversy. Dr. Laura McMurray at Tufts University School of Medicine found evidence that bacteria could develop resistance to Triclosan and propel the creation of more dangerous forms of bacteria.[71] Despite these criticisms, HLL felt the use of an anti-bacterial agent was critical in producing the health impact of eradicating and preventing germ regrowth. They named the ingredient Active-B as a cue to the consumer that Lifebuoy provided additional health benefits over other soaps.

The team also had to ensure Lifebuoy was still affordable to its consumers. HLL Chairman Manvinder Singh Banga explained: "Lifebuoy is priced to be affordable to the masses…Very often in business you find that people do cost-plus pricing. They figure out what their cost is and then they add a margin and figure that's their selling price. What we have learned is that when you deal with mass markets, you can't work like that. You have to start by saying I'm going to offer this benefit, let's say its germ kill. Let's say its Lifebuoy. You have to work out what people are going to pay. That's my price. Now what's my target margin? And that gives you your target cost—or a challenge cost. Then you have to create a business model that delivers that challenge cost."[72]

The Lifebuoy team had invested from its own profits to reformulate the product, and incurred increased production costs from the addition of the Triclosin ingredient. Therefore, the Lifebuoy team reconfigured the product's price and mix to meet the cost challenge and create a viable model to deliver a low-cost mass-market soap. The team determined the product changes and extra germ-kill ingredient did create additional "value for money" and increased the price from 8.50 to 9.50 rupees. Moreover, the

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change from a "hard" soap production process to a milled soap process created a longer-lasting bar, allowing the team to deliver the same value in a smaller size. The milled soap process was already employed for production of most other HLL soap brands, so the learning curve for adopting the change was minimal, and the changeover was implemented in less than one week.[73] Gurpreet Kohil, a senior product development manager at HLL, recounts this change, "We also engineered [the new Lifebuoy] in such a way that it did not contribute a significant amount on costs either on us or consumers. We changed the mix, the pack size mix, from 150 grams to 125 gram. But it lasts just as long."“[74] The team also developed a 60-gram bar priced at 4.50 rupees for consumers who were not able to afford the 9.50-rupee bar.

The team next developed a new series of commercials that linked Lifebuoy to the prevention of diarrhea, eye infections and infections of cuts and wounds. These commercials would reach customers through mass media channels. However, rural customers, who comprised 70% of Lifebuoy sales, often lived in areas without access to mass media. Therefore, HLL needed a special method for reaching its rural customer-base.

New Communication Channels: Multi-Contact Programs & Swasthya Chetna

Health messages and the rural consumer

In order to reach its rural consumers, HLL had to first understand rural behaviors and preferences. HLL researched hygiene and handwashing practices and the trigger points for using soap. HLL found that while attention to cleanliness has been increasing over time, most customers still associate cleanliness with the absence of dirt as opposed to the eradication of bacteria. For example, focus group and observational interview participants in rural areas often described their hands as being dirty if they were sticky, oily, discolored or smelled badly. However, if their hands looked and felt clean, then consumers considered their hands to be clean. Through this research, HLL determined the trigger for a consumer to wash his or her hands was to remove unpleasant contaminants, not to kill germs that cause infections. They also found this perception of "visual clean is safe clean" leads to infrequent handwashing and limited use of soap.

Focus group research showed similar results in that only five of 13 people washed their hands before eating, and only 10 of 18 washed their hands before preparing food.[75] Moreover, if consumers did wash their hands, they most often used water or a proxy product for soap such as mud or ash. The same study found that after handling cow dung, five of seven interviewees rinsed their hands with water, one washed with mud and one used soap. Consumers were not using soap because they did not believe they were dirty or did not perceive that soap had added benefits over water or other materials. Therefore, HLL decided it would have to educate customers on germs and the consequences of germs on health in order to increase soap usage as a means of deterring bacterial infection.

HLL teamed up with the rural India outreach arm of Ogilvy & Mather to design a behavioral-change education campaign focused on uniting the health attributes of Lifebuoy soap with health messages of germ eradication. First, HLL and Ogilvy & Mather brainstormed a way to communicate the negative effects of "invisible" germs in an easily understandable and relevant message to the rural consumer. They also decided to highlight the unique attribute of Lifebuoy soap, Active-B. HLL, and Ogilvy & Mather outlined the following key messages:

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- Invisible germs are everywhere.
- Germs cause diseases common to rural families including painful stomach, eye and skin infections.
- Lifebuoy soap with Active B can protect you from germs.
- Wash your hands with Lifebuoy soap to prevent infection.

HLL next embarked on the creation of a comprehensive program aimed at reaching all members in a rural village to create a sustained behavioral change. Harpreet-Singh Tibbs explains, "If it's going to multiple contacts, it has to be low cost. It has to be a scalable and sustainable program. It has to be interactive because you're trying to get a behavioral change. And the cost of reaching out to villages in rural India is very, very expensive. I can't keep doing that for ages. So I need to ensure I get the community to own up to this program and get this movement going for ages. And therefore community participation is very important."[76]

HLL titled the program Lifebuoy Swasthya Chetna or Lifebuoy Glowing Health. HLL hoped to change the trigger for washing hands from "visual clean is safe clean" to a social convention of frequent handwashing.

Program design: low cost, scalable and sustainable

Although the HLL and Ogilvy & Mather team believed this program could effectively change rural consumer behavior, it also was projected to be costly. Initial plans called for four-person teams, two from HLL and two from Olgilvy & Mather, to travel in vans equipped with audiovisual equipment, flip charts, interactive games and the germ glow demo. Costs were estimated to be approximately 4,000 rupees or $87 per visit.[77] These initial expenses proved too costly for the program to scale as needed, especially given the initiative was funded out of the Lifebuoy marketing budget. Therefore, the team created guiding premises for the model: It needed to be low-cost, scalable and sustainable.

In order to maximize expenditures on the program to both HLL and communities, the team decided to hire facilitators from local regions who knew local dialects and could utilize local forms of transportation. In addition, they eliminated the use of costly audio visual-equipment and used only low-cost props. These measures helped reduce costs from an estimated 4,000 to 800 rupees per visit (from roughly $87 to $17).[78]

Moreover, because the program could not be rolled out across the entire country at once, HLL systematically chose areas to target with the new program (see Table 3). In this way, HLL maximized its reach to new customers as well as reassured old customers that the new Lifebuoy formulation was better than the old formulation. First, HLL looked at per capita consumption per state and chose states that had a strong loyalty to the Lifebuoy brand. HLL found that Lifebuoy had solid brand equity in Maharasthra, Bihar, Uttar Pradesh, Karnataka, Jharkhand, Madhya Pradesh, West Bengal, Chhatisgarh and Orissa. Next HLL reviewed district data to determine what states had high numbers of infrequent soap users as well as states that contributed a high share to total Lifebuoy sales. HLL then cross-referenced this data against media status (HLL wanted to leverage the direct media contact in areas that were not accessible by mass communication means). Finally HLL selected those villages with middle schools so it could gain entrée to the community via the local school system. Harpreet-Singh Tibbs of HLL explained the rationale behind this selection, "Principal audiences are the middle school

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children, ages 7-13. Through them, they are the carriers of change for us. Through them we are reaching out to the mothers, the elders and their parents, because [the students] are the ones who are the most educated in the family."[79]

Table 3: Selection Criteria for Villages for Swasthya Chetna Initiative[80]

Process Sheet	Filters	Outputs	Stated Objective
1. State Selection	Lifebuoy rural share and contribution to total LB shares	States with high share and contribution were selected	Identify states to increase Lifebuoy consumption
2. SCRs (districts) Selection	% Infrequent soap users and soap users' potential	SCRs with high infrequent soap users and high soap contribution were selected	Identify potential SCRs to increase frequency of soap usage
	Lifebuoy share of SCRs and their contribution to total LB sale	High Lifebuoy shares were selected	Increase LB consumption
3. District Selection	Lifebuoy share at district level	Districts with more than 10% share were selected	Increase LB consumption
	Media status	Media grey and dark (less than 50% media reach) were selected	Reach those unreachable through mass means
4. Village Selections	2-5K villages with middle schools	Shortlisted 9000 villages with middle schools	Reach target audience mother and children

In the end, the Lifebuoy Team selected 10,000 villages in nine states where HLL stood to gain the most market share as well as educate the most needy communities. This targeted method of selecting villages allowed the Lifebuoy team to capitalize on high-growth regions by providing a direct multiple-contact program that could bring about a life-long behavioral change, with hope of leading to a life-long increase in soap consumption.

Through Ogilvy & Mather, HLL hired 127 two-person teams to reach an estimated 40 million people in the first year alone. Due to the low cost and ease of implementation, they expanded the program to 70-80 million people in the second year. The program currently employs 310 teams and estimates the program is reaching 30-40% of the rural population in targeted states. HLL also works to ensure its products are distributed and available in these sites in order to ensure it benefits from sales generated by the program. Currently, HLL has reached out to almost 30% of the population in these rural areas.[81]

Creating behavior change

The development of Swasthya Chetna relied upon a structured communication process for creating behavioral change:

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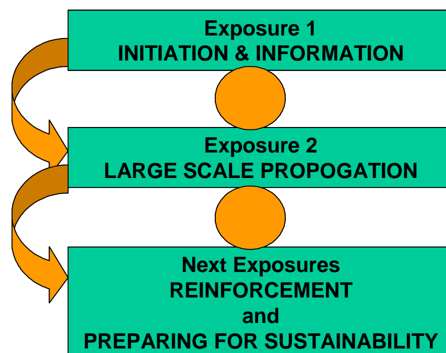
Figure 4: Behavior Change Methodology[82]



Each exposure relies upon five key communication tactics: education, involvement, shock, reiteration and reward. These elements were structured into each Lifebuoy Swasthya Chetna visit.

Contact 1: School and Village Presentation

The first contact session targets school children ages 5 to 13 and their parents. To begin, the Lifebuoy Swasthya Chetna team presents an interactive flip chart story of Raju, a young schoolboy who uses soap to stay healthy. Through this presentation, the children learn about germs and how they cause stomach, eye and wound infections. They also learn how soap can reduce infection, and about the five most important times to use soap: after going to the bathroom, before eating, after eating, to bathe and after playing.

Throughout the session, they also learn about the health benefits of Lifebuoy soap. As explained by Harpreet-Singh Tibbs, "In the communication we are just speaking about the category of soaps. We are advocating soap usage, we're not advocating Lifebuoy. But the branding, the element that we put around it, are all branded with Lifebuoy. We actually categorize the soaps as health soaps, because they work better than regular soaps. Health soaps are the ones that actually have active ingredients in them that are twice as effective in preventing germs."[83] To impress upon the students the effectiveness of Lifebuoy soap, the facilitators introduce the Lifebuoy Hero, an action character that eradicates germs. The facilitators invite students to share what they have learned in front of their classmates and present them with awards of Lifebuoy soap for correct answers.

Next, the facilitators demonstrate that invisible germs exist and can be eliminated through the use of soap. To convince people that "visual clean is NOT safe clean," the HLL team developed a glow germ demonstration kit, comprised of a bottle of talcum powder, a black light and black viewing box. The talcum powder represents germs and how they are affected by soap. The talcum powder is applied to the hands of two separate participants. One participant then washes her hands using water while the other uses both soap and water. Once immersed in water, the talcum powder disappears, so both pairs of hands appear to be visually clean. However, when both participants' hands are then placed in the black viewing box under the black light, the participant who only used water will have many spots of talcum powder residue on her hands compared to the participant who used soap. This innovative demonstration proves to the rural consumer that "visual clean is NOT safe clean," but rather washing with soap helps eradicate bacteria and germs.

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Following the glow germ demonstration, the children reiterate the importance of washing by embarking on a parade around their village. Led by the HLL facilitators, the children chant “Swastya Chetna” and “Lifebuoy helps keeps germs away” to raise visibility of the initiative and reinforce prior learnings. Finally, the students are given health message stencils about the benefits of Lifebuoy with which to decorate their villages. The children stencil an estimated 200 messages around the village such as “After defecation, use Lifebuoy” or “Before eating, use Lifebuoy” or “Have a bath with Lifebuoy and keep germs away.”

At the end of the day, the facilitators tell the students they will return in two to three months for a community-owned program of skits and presentations by students. They work with the local schoolteacher to assign students to skits. This mandates that students work on health issues until the next visit. It also gets parents excited about the prospect of their children presenting in front of the entire village. Finally, facilitators institute a wrapper-redemption program in which students who collect three, four or five Lifebuoy wrappers before the next visit receive prizes such as small radios or games. The wrapper redemption program is meant to increase soap usage in homes as well as benefit Lifebuoy sales.

After school is out, the facilitators meet with the village elders to share similar health and hygiene messages. Elders are often influential parties in guiding village behavior; therefore, education of these individuals early in the process was determined to be a key part of the initiative gaining credibility.

Contact 2: Lifebuoy Village Health Day

Day 2 is aimed at children ages 5-13 and their parents and begins with a health camp. HLL brings a village doctor to speak to participants about the importance of washing with soap. Moreover, the facilitators measure students’ height and weight to determine if they fall within healthy norms. Because more than 52% of Indian children under four suffer from malnutrition,[84] HLL gives “Healthy Child” awards to those in the normal range as a method of helping parents understand healthy heights and weights.

In the evening, the children present their health skits and poems to the community as a way to reiterate messages and gain community involvement in the handwashing campaign. During this time, HLL also communicates to the community the messages about germs and germ eradication, repeats the glow germ demonstration and provides awards for the best presenters.

Contact 3: Diarrhea Management Workshop

The third visit is geared toward young mothers and pregnant women who may not have been involved in the community presentation put on by older school children. During this session, the facilitators present on the dangers of diarrhea, how it is spread, how it can be prevented and how it can be treated. They also perform preliminary health checks for the women.

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Contact 4: Launch of the Lifebuoy Health Club

On the fourth visit, the HLL facilitators announce the formation of a health club that will include activities around hygiene and keeping the village clean. The facilitators will return four to six more times to run health club sessions to maintain active engagement in health and hygiene issues. The club is anticipated to grow through a quarterly newsletter and the Lifebuoy Club activity calendar.

HLL and Lifebuoy Swasthya Chetna

Though the excitement surrounding the program is great, the sales benefits are difficult to quantify. In large part, HLL has undertaken this initiative based upon faith that it would have long-term impacts on India's health and the market. Initial data, being collected almost two years after the launch, is just now being reviewed to measure the return on investment and effectiveness of the pilot. Fortunately, the data indicates the program has resulted in a sustained behavior change. To date, the wrapper redemption program has had a 30% response rate, but little other concrete information on monetary benefits to HLL exists. Harpreet-Singh Tibbs explains, "Lifebuoy last year grew by 30%. It's grown across states, across regions. It's very difficult to say what proportion of that can be attributed to this program. But in the geography in which we have this program, Lifebuoy has grown in sales."

Given that initial indications are favorable, HLL also is planning to roll out the initiative in Bangladesh this year with expectations to move to additional countries in the near future. Moreover, the Public Private Partnership Kerala initiative has borrowed the Swasthya Chetna format for its school visits (although Kerala will only be instituting a three-contact program and will not be participating in the wrapper-redemption program). The ability for other units of Unilever to leverage these findings demonstrates the program is transferable and scalable to other markets, countries and venues.

Conclusion

> The promise of health is relevant universally.
> –Govind Rajan, HLL[85]

What does HLL gain from marketing public health messages about soap?

Differentiating soap products on the platform of health takes advantage of an opening in the competitive landscape for soap. Providing affordable health soap to the poor achieves both product differentiation for a mass-market soap and taps into an opportunity for growth through increased usage. In India, soap is perceived as a beauty product, rather than a preventive health measure. Also, many consumers believe a "visual clean is a safe clean," and either don't use soap to wash their hands, use soap infrequently or use cheaper substitute products which they believe deliver the same benefits. HLL, through its innovative communication campaigns, has been able to link the use of soap to a promise of health as a means of creating behavioral change, and thus increasing sales of its low-cost, mass-market soap. Health is a

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valuable commodity for the poor and to HLL. By associating Lifebuoy's increased usage with health, HLL can build new habits involving its brand and build loyalty from a group of customers new to the category. A health benefit also creates a higher perceived "value for money," increasing a customer's willingness to pay. By raising consumers' level of understanding about illness prevention, HLL is participating in a program that will have a meaningful impact on the Indian population's well-being and fulfill its corporate purpose to "raise the quality of life."

This opportunity for brand differentiation based on health does not just exist in India or in the soap market alone. A snapshot of the world's population, increasingly divided between rich and poor consumers, in developed and developing countries, shows that almost 90% of the world's anticipated population growth (from 6.2 billion to 9.1 billion in the next 50 years) will occur in developing markets.[86] Twenty percent alone will occur in India. PPPs are starting to work in these untapped markets, yet a huge opportunity still exists for multi-nationals to spread health messages to other developing countries through branded campaigns.

Moreover, wealthier populations also could benefit from health and hygiene messages. Statistics from the World Bank found that the when the Indian population was evenly divided into five socioeconomic quintiles, incidence of diarrheal disease was similar across the quintiles (see Table 4). This suggests a lack of adequate sanitation facilities in poor and rural populations may not be the primary factor in the spread of diarrheal disease. Handwash habits may be similar across populations, which suggests an opportunity to reach out with direct contact campaigns to all socioeconomic populations in order to transform handwash behavior and greatly increase the frequency of handwash and soap sales.

Table 4: Incidence of Diarrhea by Socio-Economic Quintiles[87]

PREVALENCE OF DIARRHEA (% ILL IN THE PRECEDING 2 WEEKS)	POOREST	SECOND	MIDDLE	FOURTH	RICHEST	POPULATION AVERAGE
Total	10.2	10.4	10.2	10.1	8.5	9.9
Urban	4.9	12.0	9.0	9.5	8.0	
Rural	10.3	10.2	10.4	10.3	10.2	

This opportunity also may exist in developed nations. The *Economist* reported that in England, fewer than one-half of British mothers washed their hands after changing their children's diapers.[88] By reinforcing health messages to low-use populations, multinationals stand to benefit globally.

In addition to reaching low-use population, multinationals have an opportunity to provide solutions for other health problems of the poor. The growing populations in developing countries are at risk from many of the same basic health issues stemming from poverty and its accompaniments of poor sanitation infrastructure, lack of access to health resources and inability to buy affordable preventive measures. By creating affordable products that meet basic needs like preventing disease, multinationals could capitalize on large untapped markets. And according to HLL, the poor can be just as discriminating as the rich when it comes to brand consciousness. Keki Dadiseth of Hindustan Lever is quoted in a Fast Company article, "Everybody wants brands. And there are a lot more poor people in the world than rich people. To be a global business and to have a global market share, you have to participate in all segments."[89] As HLL builds brand equity around its ability to offer a better quality of life through health, it will find ways to scale its lessons learned from the soap market to other product offerings and markets around the world.

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Methods for increasing market sales

To date, HLL has helped create two initiatives to spread health and hygiene messages and expand the soap market. Are there lessons that can be drawn from the first few years of working in these different models? Are these programs scalable, low-cost and impactful?

Scalability: Both the PPP and Swasthya Chetna initiatives aim to reach large populations in short timeframes. The PPP is initially reaching a smaller number of people than the PPP; it aims to reach 49 million people in its first year of operation whereas Swasthya Chetna will reach 70-80 million people by the end of this year (see
Table 5).

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Table 5: Comparison between the PPP and Swasthya Chetna

	Health in Your Hands	Lifebuoy Swasthya Chetna
HLL Visibility	Not branded	Branded
Scope	Whole population, all segments	Targeted population Rural Media dark Strong Lifebuoy brand support Low per capita soap consumption Middle school for program access
Methods	4 contacts with school children Daily contact with school hand wash X contacts with social work and health care system	7 contacts with school children 1 contact with community 1 contact with young mothers
Partners	Local government health care system Local government school system Developmental agencies Other MNCs	Local government school system
Total Program Costs (In India)		
2002	$ 3,493,333.33	$ 695,652.17
2003 (Revised due to Kerala slowdown)	$ 2,000,000.00	$ 1,252,173.91
Program Costs per Head		
2002	$ 0.120	$ 0.017
2003	$ 0.069	$ 0.018
HLL Total Program Costs (Revised)	$ 444,444.44	$ 1,252,173.91
HLL Costs per Head (Revised)	$ 0.015	$ 0.018
Scalability		
2001	1st meeting	Preparation
2002	Preparation	India (9 states) 40m in 10,000 villages
2003	Total: 49.2m Ghana (20.2m) Maybe Kerala (29m) Preparation for Senegal, Peru, Nepal, China	Total: 100m India (9 states) 70m in 18,000 villages Preparation for Bangladesh
2004	Total: Senegal 9.9m Peru 26.7m Nepal 23.9m China 1.28b Each continent to learn cultural lessons and spread to each region	Total: India (11 states) 100m Bangladesh (number TBD) Each HLL office to learn from best practices and spread it to that region
Benefits	Scales quickly Can contribute money to those campaigns where HLL is strongest Slightly lower costs per head	Branded Targeted to largest growth segment Fewer partners, so can start-up more quickly
Disadvantages	Not using HLL name or brand names Complications may occur due to many partners (i.e., slower pace in Kerala)	Scaling out of brand profits, so spreading to fewer countries Slightly higher cost per head

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Moreover, Swasthya Chetna has been able to design and implement its program more quickly—it already operates in nine Indian states whereas the PPP is still in planning stages in Kerala. At the same time, the network and resources of the PPP have allowed it to immediately expand globally with project planning already underway in five other nations, including China, the world's most populous country. This is a much greater scale than Swasthya Chetna's planned expansion to Bangladesh. In addition, the PPP is targeting all socioeconomic groups in the population, meaning that it could potentially have a greater effect on overall soap market sales than the Swasthya Chetna campaign that is targeted to Lifebuoy's main customer segment.

Impact on Behavior Change and Soap Sales: While scalability seems to be greater with the PPP, direct benefits to corporate sales lie with Swasthya Chetna. Through strategic selection of villages, Swasthya Chetna has maximized use of limited funds to reach targeted demographics to increase Lifebuoy sales. This not only results in cost savings and efficiencies, but also may be more effective than an unbranded campaign in creating behavior change. Research shows that use of a brand can help strengthen the health messages being delivered by conveying quality, increasing consumer confidence and ensuring that messages are delivered in a non-patronizing or demeaning tone.[90] By reaching out to poor populations with strong brands and building habits involving their brands, HLL can create an unshakable hold on consumers' wallets. Conversely, the PPP seeks overall market sales, which may or may not directly benefit HLL.

At the same time, promotion of a branded product can leave the company open to criticism. Therefore, it's important the campaigns have a solid science-based foundation and are transparent. The Lifebuoy Swasthya Chetna campaign has done both. As explained by Harpreet-Singh Tibbs, "We're not shying away from the fact that Lifebuoy is going to benefit or we're trying to get soap consumption up. We're being up-front about it. But we're also telling them that we're doing something for the good of the community and its there for you to see yourself. And that's the reason we're actually going into schools and schools are giving us permission to go in. Because they believe that what we're saying is actually making sense…I'm trying to develop the category because I believe soaps can reduce diarrheal incidents by 40%. And if you believe its true, there's not reason why you should dispute this program."[91]

Developing the expertise to sell health

HLL will undoubtedly continue to evaluate the advantages and disadvantages of both programs to promote hygiene and soap usage as they move forward. To date, both the PPP and the branded direct marketing campaign have proved to be innovative and viable models for expanding markets while helping improve the quality of life for the poor. Both programs combine partnerships (the PPP with NGOs and governments and Swasthya Chetna with schools), health education campaigns and low-cost products in order to successfully translate improved hygiene behavior into increased sales in a scalable way.

A central challenge in "selling" health is the development of successful partnerships between private business and public health offices and organizations. Both groups need to invest together to create the market for a product. Private organizations contribute competencies around behavior change and delivery

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of low-cost products, while public organizations provide access to consumers, in effect the channels to deliver messages and extend product reach. Both groups are investing in and addressing a common problem, but are evaluated on producing two different results: NGOs and governments are interested in an increased quality of life, while private businesses seek increased earnings.

These different motivations produce an inherent tension in the public-private partnership model. This tension is apparent in the status of the highly publicized Global Handwashing Initiative PPP, where political roadblocks have slowed down the program and thus impacted HLL's plans to deliver health education and expand the soap market. Yet, these lessons have helped HLL to transfer knowledge from Global Handwashing Initiative PPP to improve its own branded health education program, Swasthya Chetna. Working with more localized partners, in this case village schools, HLL is rapidly scaling its program throughout rural India. By learning how to build partnerships and work in PPPs, even if toward seemingly different ends, HLL has gained a competitive advantage. HLL can leverage its experience accessing public health channels to sell products as health solutions, while increasing its market share both in India and abroad.

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