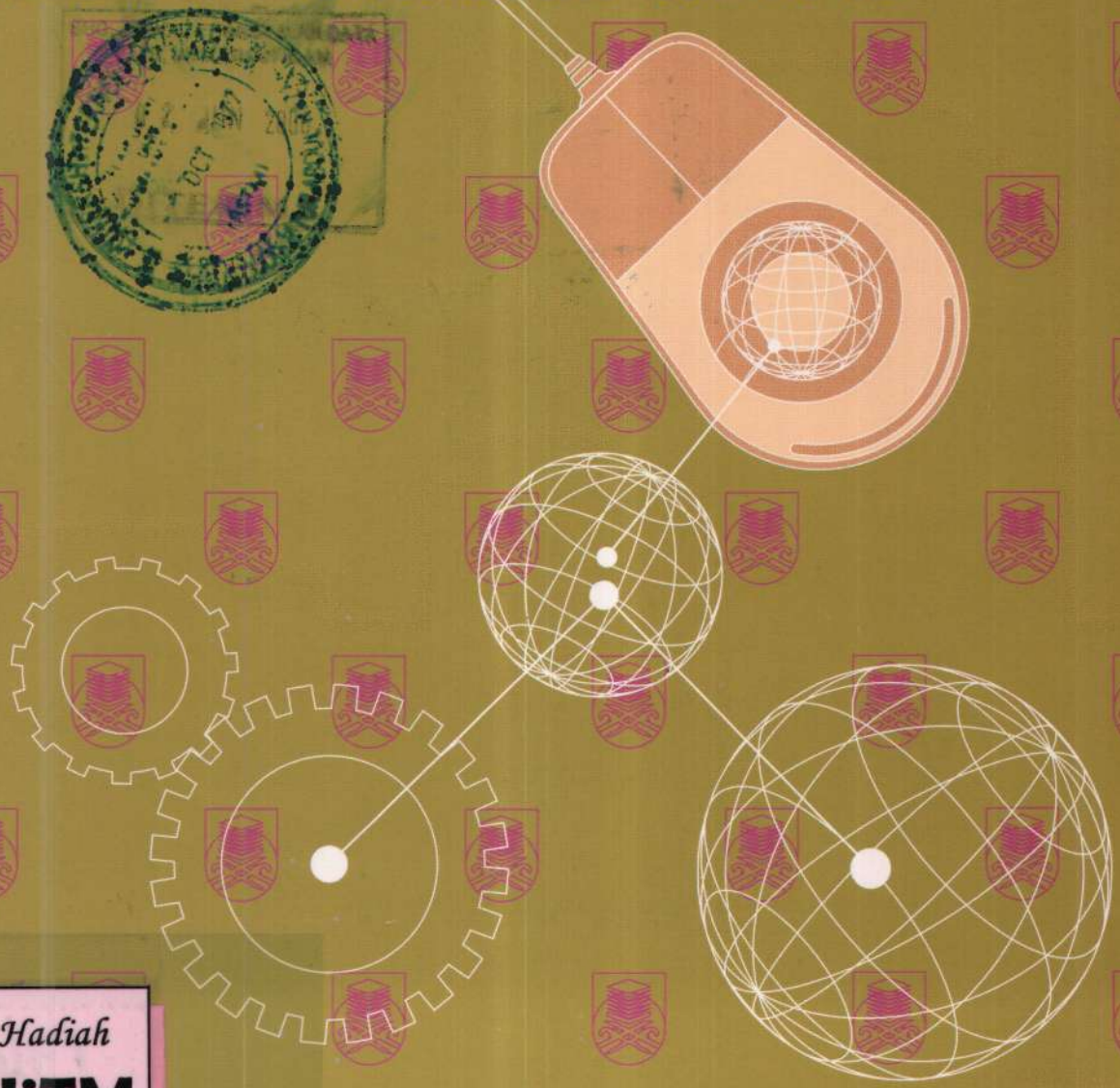
ESTEEM

ACADEMIC JOURNAL VOLUME 1. 2003 • ISSN: 1675-7939



Universiti Teknologi MARA Pulau Pinang

ESTEEM

Volume 1, December 2003

CONTENTS

The Role of Social Marketing in Health Education

Ismail Sualman
Universiti Teknologi MARA Pulau Pinang

Abstract

Abstract: While social marketing is flourishing, there appears to be confusion regarding what it is, what it can reasonably do, and how it should be applied to health education. Some confusion relates to a perception that social marketing is limited to narrow strategies, interventions, or theories. The purpose of this paper is to position social marketing as a systematic planning process similar to those used in health education. The paper describes why social marketing is a planning process, how it compares and contrasts to health education planning models, and how the social marketing planning framework may benefit health education practice.

Introduction

Public campaigns intended to influence the attitudes and behavior of society have existed in Western society since at least ancient Greece, when certain segments of society launched movements to free slaves. Since then, public communication campaigns have arisen to support a wide range of movements: from the expansion of suffrage to prohibition and the prevention of sexual abuse and harassment. In the later half of the 20th century, sociologists have termed the use of mass mediated communications designed to alter public attitudes and behaviour " public communication campaigns". Unlike two other widespread forms of mediated persuasive communication – commercial communications, which are designed to influence consumers to purchase goods and services, and political campaigns intended to affect voting behaviour – public communications campaigns are intended to alter social knowledge, attitude and behaviour outside these realms.
In Malaysia, one of the highest-profile and longest running campaigns has been the federal government's anti-tobacco effort, which began in the 1970s. Early campaigns, which focused on disseminating information on the health hazards of smoking, seem to have had success. With mounting scientific evidence on the health hazards of smoking, an ageing population placing increasing demands on the nation's health care system, and an escalating national debt, the Malaysian government renewed its anti-smoking efforts in the late 1980s. In 1988, the federal government passed the Tobacco Products Control Act, which banned all advertising of tobacco products in Malaysia. Around the same time, adopted an approach to public communications campaigns known as social marketing.

Social marketing has been used in varying degrees for over 30 years in international and domestic settings, with the primary intent to improve health and social conditions. It has been defined as, "the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreasen, 1995,7).

Although social marketing is increasingly recognized as a viable process, there appears to be considerable confusion regarding what social marketing is, what it can reasonably be expected to do, and how it should be performed. McDermott (2000) indicated that social marketing may be poorly under-

stood by most health educators, whereas Smith (2000) implied that similar confusion exists among social marketers themselves. Andreasen (1995) has claimed that what is often called social marketing is not really social marketing. For example, programs that do not focus on consumer behavior (i.e., that do not create strategies with the consumer in mind), that do not involve adequate market research (i.e. merely conducting a focus group is not adequate market research), that do not carefully segment the target audience, and that do not recognize "competition," can not rightfully be called social marketing (Andreasen).

A recent review of "marketing" as it is represented in "health promotion" literature suggests that dements of social marketing associated with health promotion interventions often lack an overarching marketing plan and that the integration of marketing components to make the process truly strategic is lacking (Hill, 2001). Reaction to this review by Lindenberger (2001) proposed that while social marketing is flourishing and having a significant impact on health promotion, the current understanding and utilization of social marketing in changing behaviors fail to grasp the comprehensive nature of marketing (e.g., being more than promotion). Furthermore, while the diffusion of social marketing is prolific, the quality of knowledge that accompanies that spread appears to be inadequate (Lindenberger, 2001).

The purpose of this paper is to position social marketing as a systematic planning process, describe how the social marketing process compares to and can complement traditional health education planning processes, address the potential benefits of using a social marketing planning approach, and discuss general implications for health education.

Social Marketing

Social marketing models, first articulated by Philip Kotler and based on commercial marketing practices, show that the consumer (target audience) should be the central focus for planning and conducting a program. The program's components focus on the:

- price—what the consumer must give up in order to receive the program's benefits. These "costs" may be intangible (e.g., changes in beliefs or habits) or tangible (e.g., money, time, or travel)
- product—what the program is trying to change within the target audience
- promotion— how the exchange is communicated (e.g., appeals used)
- place—what channels the program uses to reach the target audience (e.g., mass media, community, interpersonal)

The formulation of price, product, promotion, and place evolves from research with consumers to determine what benefits and "costs" they would consider acceptable, and how they might be reached. Lessons learned from social marketing stress the importance of understanding the target audience and designing strategies based on their wants and needs rather than what good health practice directs that they "should" do.

As we have seen, social marketing approaches to social change tend to include elements other than communication. (Or promotion, to use social marketing terminology) is merely one part of social marketing's strategy. Social advertising is simply the use of advertising media for a social purpose. Social marketing, on the other hand, deals with all for of the marketing variables: product, price place and promotion"(Solomon 1989,88) .In Kortler and Roberto's work there are example of simple diffusion, Complex diffusion. social learning approaches. Because Kotler and Roberto advocate approaches that focus on the needs and situation of the intended audience, their social marketing model sometimes resemble a systems approach, where the need to recognize and account for social and structural

issues is acute. Despite their advocacy of flexible and multi-faceted approaches, social marketing writers such as Kotler and Roberto, Solomon and Tanguay do not deviate significantly from the transmission model implicit in simply diffusion approaches when discussing the use of mass communication to promote social change.

Kotler and Roberto and others analyze mass media promotion within the transmission model as a "hierarchy of effects" that begins with awareness, moves through recall of the massage, to a favourable attitude toward the message and its subject, to the development of behavioural intentions through to acting on these intentions (Kotler and Roberto1989 191, Tanguay, 1992, 61-62) The first effect in the model, awareness of the communication promoting the social product, is simply the result of being exposed to the massage. Then follow recall, which according to Kother and Roberto, is based on the "copy execution" of the massage (Kotler and Roberto 1989,192). The next links in the effects 'chain' are the formation of favourable attitudes toward the social product, the formation of the intention to adopt it, and finally, behavioural change (Kother and Roberto 1989,191) However, how these effects occur is largely unexplained. While social marketing discussing the use of emotional versus rational appeals and urges research into the media habits of the target audience (Kotler and Roberto 1989,195-202), the books do not actually present explanatory criteria for what constitutes effective communication. In other words, there is discussion of the processes that move the target adopters though the chain of effects. While Kotler and Roberto suggest that the hierarchy of effects model itself answer the question "How does mass communication inform and persuade?" (Kotler and Roberto 1989,191) this is disingenuous. The model merely elaborates several stages of effect that culminate in behavioural change. Kotler and Roberto do not explain HOW communication works; they simply assert that it does, through a process.

It is important to note that Kotler and Roberto do not suggest that the diffusion of media message will necessarily achieve desired social change, although they argue that mass media campaigns can persuade and directly cause behavioural change by providing information (Kotler and Roberto1989, 9). Like complex diffusion approaches Kotler and Roberto advocate a multi-channel communication strategy consisting of mass communication, direct communication (e.g direct mail, telemarketing) and interpersonal communication. What separates social marketing from other diffusion approaches is that what is being communicated is conceived of as a product, rather than merely an invocate or invitation to adopt an attitude or behavior. As a product, it should offer a benefit to potential adopters. Consequently, the purpose of mass communication massage is "To convey the superiority of the social product in satisfying the target adopter's need"(Kother and Roberto 1989, 194). Thus, the persuasive mechanism of social marketing communication is ultimately one of rational self-interest: the desire behaviour is adopted because the audience number is convinced that it is in his or her best interest to do so.

Social Marketing As A Planning Process

Social marketing is best interpreted as an approach to strategic planning that places consumers at the core of data collection, program development, and program delivery (DHHS, 1999). Thackeray and Neiger (2000) have called social marketing a planning framework that is theory-driven and consumer focused. It has been defined by Schwartz as a "large-scale program planning process designed to influence the voluntary behavior of a specific audience segment" (as presented in Albrecht, 1997, p.23). Smith (2000) defined social marketing as a "process" for influencing human behavior on a large scale.

McKenzie and Smeltzer (2001) have proposed a Generalized Model for program planning in health education (see Figure 1). Most, if not all, health education planning models can be aligned to this Generalized Model. The Generalized Model is composed of the following steps: understanding and

engaging, needs assessment (including priority setting), development of goals and objectives, developing interventions, implementing interventions, and evaluating results. Based on the content of the Generalized Model, social marketing qualifies as a planning approach. For example, Table 1 presents prominent models or schematics associated with social marketing practice as reported in literature. Common elements in these models are highly consistent with the Generalized Model. To consider social marketing as something less than a multi-phased, systematic planning approach will likely jeopardize the potential quality and impact of related interventions

Social Marketing And Traditional Health Education Planning Models

There are several similarities, as well as key differences, in the planning processes associated with social marketing and health education. The Generalized Model as well as social marketing models presented in Table 1 will be used to compare the two planning approaches.

Similarities Between Social Marketing and Health Education Planning Approaches.

Both the Generalized Model and the social marketing models begin by acknowledging the unique characteristics of the population to be served, inherent opportunities and challenges, assessment of capacity, including budgets and potential partners, and at times, identification of preliminary areas of focus. This is labeled understanding and engaging in the Generalized Model, preliminary planning in the SMART model (Neiger & Thackeray, 1998), background analysis by Andreasen (1995), research and planning by Walsh, Rudd, Moeykens & Moloney, (1993), and planning by Weinreich (1999). This initial groundwork provides contextual information and a foundation for future planning activity.

Needs (and asset) assessments are common to both approaches. For example, what is classified specifically as needs assessment in the generalized model is labeled formative research, consumer analysis, market analysis, channel analysis, and consumer orientation in the social marketing models. Both approaches generally narrow the scope of activity by focusing on a single or limited number of priorities and by delimiting the scope of activity to appropriate audience segments. At the same time, audience assets are identified.

Development of goals and objectives, a hallmark of health education planning processes, is stated explicitly in the Generalized Model, but more implicitly in the social marketing models, with the exception of Andreasen (1995). After the development of program goals and objectives, both the Generalized Model and social marketing models address the development of appropriate interventions. Whereas the Generalized Model states "develop an intervention," social marketing models use terms such as, "develop materials" (SMART Model), "strategy formation" (Bryant, 1998), "strategy design" (Walsh et al., 1993), and "message and material development" (Weinreich, 1999). Tracking and evaluation are also common characteristics of both approaches. While implicit in both the Generalized Model and social marketing models, this involves formative and summative evaluation.

Difference Between Social Marketing And Health Education Planning Approaches

The elements that typically distinguish a social marketing planning approach from health education planning approaches are the same factors that may complement health education practice. These elements include, but are not limited to: a strong consumer focus; formative research; and attention to the market mix, exchange, positioning, and pre-testing. It is not argued here that health education is

devoid of these elements. Rather, it is suggested that social marketing planning efforts incorporate these elements significantly more often than traditional health education planning efforts.

The critical difference between planning approaches in social marketing and health education is a persistent focus on consumers. "Although customer-centered health education is not new, it is not always carried out by practitioners" (McDermott, 2000, p. 8). Social marketing is based on the fundamental principle that its practitioners must be aware of and responsive to the needs, preferences, and lifestyles of the consumer audience (Leveton, Mrazek, & Stoto, 1996). Too often, health educators limit their needs assessments to demographic and epidemiological data and create "top-down" (practitioner-driven) interventions in isolation, with relatively little or no input from prospective consumers (Thackeray & Neiger, 2000). Yet, to facilitate individual or community-based change, health education alone is insufficient, and marketing concepts must be applied with a stronger consumer orientation (Novelli, 1997).

The quantitative and qualitative processes of collecting audience data in social marketing constitute formative research, which, as defined by Bryant (1998), includes the segmentation process and identifying the wants and needs of the segment as well as factors that influence its behavior, including benefits, barriers, and readiness to change. Identifying the wants and needs of the target audience, as well as challenges, likes, dislikes, and fears related to a health problem and its determinants, is labeled consumer analysis in the SMART Model (Neiger & Thackeray, 1998), consumer orientation by Lefebvre and Flora (1988), and formative research by Bryant.).

Formative research is also defined broadly to include other factors related to an audience segment. For example, market analysis (see the SMART Model), in part, establishes the marketing mix. The marketing mix or 4 Ps, a hallmark of social marketing, includes product, price, place, and promotion. A product can include ideas and behavior changes (Flora, Schooler, & Pierson, 1997; Lefebvre & Flora, 1988), or something offered to the consumer to satisfy a want or need (Wilson & Olds, 1991). Examples may include educational programs, screenings, environmental changes, self-care programs, etc. Price is the barrier(s) or cost(s) that may prevent the consumer from taking action (Bloom & Novelli, 1981). Costs can include money, time, opportunity, energy (Kotler & Zaltman. 1971), social, behavioral, geographic, physical, structural, psychological factors (Flora et al.), and convenience or pleasure (Siegel & Doner, 1998).

Price considerations include the exchange theory. Exchange theory in marketing is defined as the transfer or trade of something of value between two parties (Flora et al., 1997). It can include giving up one behavior in exchange for something else (Hastings & Haywood, 1991). The exchange emphasis is on voluntary exchange (versus coercion), and should emphasize the benefits to the consumer by participating in the exchange (Lefebvre & Flora, 1988). Closely related to the concept of exchange is positioning. In social marketing, positioning is the process of showing key benefits of the product relative to the competition (Weinreich, 1999). Positioning allows consumers to clearly see exchange benefits.

Place is where the product can be obtained (Kotler & Zaltman, 1971). It involves identifying ways to reach the consumer (Hasting & Haywood, 1991) and make the product available to the consumer (Wilson & Olds, 1991). The place can also be considered where the consumer puts motivation into action (Kotler & Zaltman, 1971).

Promotion encompasses the communication strategies, tactics, and the means used to communicate with the consumer (Hastings & Haywood, 1991). It includes advertising, personal selling, publicity, sales, and promotion (Kotler & Zaltman, 1971). Channel analysis, explicitly labeled in two models in

Table 1, and implicitly in the others, is related to promotion. It involves selecting effective and efficient methods of reaching each audience segment, finding out where and how audience members get their information, and how to use appropriate channels to distribute a message, product, or program (Weinreich, 1999).

Once interventions are developed through formative research, social marketing pays close attention to pre-testing (see Table 1). Prior to the production of messages, materials, and full-scale program implementation, key elements including methods, communications, and strategies, are presented to members of the target audience, and feedback is received. Modifications are then made based on this feedback. Pre-testing ensures that the social marketer has developed program components reflective of, and in response to, audience needs, wants, and expectations.

Proposed Advantages and Benefits of the Social Marketing Planning Framework

The primary planning advantage that social marketing offers health education is a more conscientious focus on consumers and the infusion of strategies to conduct and interpret formative, or consumer research, including a better understanding of consumer motivational and resistance points (Walsh et al., 1993). Other potential advantages offered by social marketing, as outlined, involve assurance of market analysis, including attention to the marketing mix; channel analysis; exchange, positioning, and pre-testing.

Some evidence suggests that when used properly, social marketing results in the type of outcomes desired by health educators in all settings (Armstrong-Schellenberg et al., 1999; Bryant, Forthofer, McCormack-Brown, Alfonso, & Quinn, 2000; Cohen et al., 1999; Fisher, Ryan, Esacove, Bishofsky, & Wallis, 1996; Marcus et al., 1997; Neiger et al., 2001; Samuels, 1993; Thackeray, Neiger, Leonard, Ware, & Stoddard, 2002). Health education planning models, modified to reflect elements of social marketing with consumer needs at the core, may represent a more powerful planning approach that holds promise, based on reported literature, for better designed interventions and more successful outcomes.

Implications For Health Education

Health educators should not associate social marketing with quick fixes, gimmicks, or easy answers to complex and difficult behavioral or social challenges. Rather, health educators should view social marketing as a systematic, consumer-based planning process composed of actions consistent with traditional health education planning approaches. A narrow view of social marketing as a convenient theory tool, or communication strategy can lead to shortcuts in practice which further lead to criticisms of social marketing as a process and discipline.

A continued application and expansion of social marketing planning in health education will require a shift in professional preparation curricula. This will require the development of appropriate courses, which are not universal at the present time. Health education practitioners will also have to develop their capacity to apply social marketing planning principles. This will require the development of appropriate in-service and continuing education opportunities.

Social marketing offers an alternative, yet complementary planning approach that promotes the value of consumer input, a sense of democracy and participant empowerment. The body of literature related to social marketing and health education suggests that this may ultimately be more significant

in terms of community acceptance and change than traditional planning approaches driven by health promotion practitioners with much less focus and input from the target audience.

Conclusion

Social marketing approaches are based on an understanding of social change as positivistic, teleological progress. Within this view, social marketing theorists, exemplified by Kotler and Roberto, conceive campaign subjects as individuals who are, or should be, fundamentally motivated by reason. In social marketing approaches, social problems becomes re-articulated at the level of the individual-social change becomes merely the aggregate of many individual changes. Approaches to social marketing research and campaign design, meanwhile, tend to further abstract the individual form his or her social context in attempts to understand target groups as compilations of static individuals who possess a variety of demographic or attitudinal characteristics. Social marketing consists of attempts to develop a rational coherence between beliefs, attitudes and behaviour.

Table 1. Comparison of Planning Models Used in Social Marketing (McKenzie & Smeltzer's Generalized Model

Legend for Chart:

A - Neiger & Thackeray 1998 (SMART Model)
B - Bryant 1998
C - Andreasen 1995
D - Walsh et al. 1993
E - Lefebvre & Flora 1988
F - Weinreich 1999

A	B D F	C E
Preliminary Planning	Formative Research	Background Analysis
	Research & Planning	Consumer Orientation
	Planning	
Consumer Analysis	Strategy Formation	Marketing Mission
	Strategy Design Goals and Objectives	Audience Segmentation
	Message & Materials Development	
Market Analysis	Program Implementation	Marketing Organization, Procedures, Benchmarks, & Feedback Mechanisms

	Implementation & evaluation	Channel Analysis
	Pre testing	
Channel Analysis	Program Monitoring & Revision	Pre testing Program Elements
	Strategy	Implementation
Develop Materials & Pretest	Program Evaluation	Monitoring & Evaluation
	Process Tracking	
	Evaluation & Feedback	

References

Albrecht, T. L. (1997). *Defining social marketing: 25 years later. Social Marketing Quarterly, 3, 21-23.*

Andreasen, A. R. (1995). *Marketing social change. San Francisco, CA: Jossey-Bass.*

Armstrong-Schellenberg, J. R. M., Abdulla, S., Minja, H., Nathan, IL, Mukasa, O., Marchant, T., Mponda, H., Kikumbih, N., Lyimo, E., Manchester, T., Tanner, M., & Lengeler, C. (1999). *KINET: Asocial marketing programme of treated nets and net treatment for malaria control in Tanzania, with evaluation of child health and long-term survival, Transactions of the Royal Society of Tropical Medicine and Hygiene, 93, 225-231.*

Bloom, P. N., & Novelli, W. D. (1981). *Problems and challenges in social marketing. Journal of Marketing, 45, 79-88.*

Bryant, C.A. (1998, June). *Social marketing: A tool for excellence. Session presented at the eight annual Social Marketing in Public Health Conference, Clearwater Beach, FL.*

Bryant, C. A., Forthofer, M. S., McCormack-Brown, K., Alfonso, A. L., & Quinn, G. (2000). *A social marketing approach to increasing breast cancer screening rates. Journal of Health Education, 31, 320-328.*

Cohen, D. A., Farley; R. A., Bedimo-Etame, J.F., Scribner, R., Ward, W., Kendall, C., & Rice, J. (1999). *Implementation of condom social marketing in Louisiana, 1993 to 1996. American Journal of Public Health, 89, 204-208.*

Department Of Health And Human Services (1999). *Promoting physical activity: A guide for community action. Champaign, IL: Human Kinetics.*

Fisher, D. S., Ryan, R., Esacove, A. W., Bishofsky, S., Wallis, J. M., & Roffman, R.A. (1996). *The social marketing of Project ARIES: Overcoming challenges in recruiting gay and bisexual males for HIV prevention counseling. Journal of Homosexuality, 37,177-203.*

Flora, J. A., Schooler, C., & Pierson, R. M. (1997). *Effective health promotion among communities of color: The potential of social marketing. In M.E. Goldberg, M. Fishbein, & S.E. Middlestadt (Eds.), Social marketing. Theoretical and practical perspectives (pp. 353-373). Mahwah, NJ: Lawrence Erlbaum.*

Hastings, G., & Haywood, A. (1991) *Social marketing and communication in health promotion. Health Promotion International, 6, 135-145.*

Hill, R. (2001). *The marketing concept and health promotion: A survey and analysis of recent health promotion literature. Social Marketing Quarterly, 7, 29-53.*

Kotler, P., & Zaltman, G. (1971). *Social marketing: An approach to planned social change. Journal of Marketing, 35, 3-12.*

Lefebvre, R. C., & Flora, J. A. (1988). *Social marketing and public health intervention. Health Education Quarterly, 15, 299-315.*

Leveton, L., Mrazek, P., & Stoto, M. (1996). *Social marketing to adolescents and minority populations. Social Marketing Quarterly, 3, 6-23.*

Lindenberger, K. (2001). *Publishers Notes. Social Marketing Quarterly, 7, 2-3.*

Marcus, B. H., Emmons, K. M., Simkin-Silverman, L. R., Linnan, L. A., Taylor, E. IL, Bock, B. C., Roberts, M. B., Rossi, J. S., & ABRAMS, D. B. (1997). *Evaluation of motivationally tailored versus standard self-help physical activity interventions at the workplace. American Journal of Preventive Medicine, 15, 362-377.*

McKenzie, J. E, & Smeltzer, J. L. (2001). *Planning, implementing and evaluating health promotion programs: A primer. 3rd Edition. Boston, MA: Allyn and Bacon.*

McDermott, R.J. (2000). *Social marketing: A tool for health education. American Journal of Health Behavior, 24,6-10.*

Neiger, B. L., & Thackeray, IL (1998, May). *Social marketing: Making public health, sense. Paper presented at the annual meeting of the Utah Public Health Association, Provo, UT.*

Neiger, B. L., Thackeray, IL, Merrill, IL, Larsen, L., Chalkley, C., & Miner, K. (2001). *The impact of a social marketing campaign on the eat smart move smart initiative among public health employees. Social Marketing Quarterly, 7,10-28.*

Novelli, W. D. (1997). *Social marketing centerpiece: An interview with William D. Novelli. Social Marketing Quarterly, 3, 27-50.*

Samuels, S.E. (1993). *Project LEAN: Lessons learned from a national social marketing campaign. Public Health Reports, 108, 45-53.*

Siegel, M. & Doner, L. (1998). *Marketing public health. Strategies to promote social, change. Gaithersberg, MD: Aspen.*

Smith, W. A. (2000). *Social marketing: An evolving definition. American Journal of Health Behavior, 24,1117.*

Thackeray, R., & Neiger, B. L. (2000). *Establishing a relationship between behavior change theory and social marketing: Implications for health education. Journal of Health Education, 31, 331-335.*

Thackeray, R., Neiger, B. L., Leonard, H., Ware, J. & Stoddard, G. (2002). *Comparison of a 5 a Day social marketing intervention and school-based curriculum. American Journal of Health Studies, 18(1), 46-54.*

Walsh, D. C., Rudd, R. E., Moeykens, B. A., & Moloney T. W. (1993). *Social marketing for public health. Health Affairs, 12, 104-119.*

Weinreich, N. K. (1999). *Hands on social marketing: A step by step guide. Thousand Oaks, CA: Sage.*

Wilson, M .G., & Olds, R. S. (1991). *Application of the marketing mix to health promotion marketing. Journal of Health Education, 22, 254-259.*