HEALTH BEHAVIOR AND HEALTH EDUCATION

Theory, Research, and Practice

4TH EDITION

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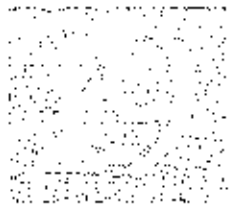
CHAPTER



SOCIAL MARKETING

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KEY POINTS

This chapter will

- Define social marketing, its basic principles, and how they can be applied within a strategic health communication framework.
- Link commonly used theories of health communication and health behavior to the effective practice of social marketing.
- Describe the uses of research in designing, monitoring, and evaluating social marketing programs.
- Provide examples of social marketing programs that illustrate how principles and processes can come together to achieve behavioral and social change.

In the more than half a century since Wiebe (1951–1952) posed his famous question—"Why can't you sell brotherhood like soap?"—the concept of social marketing has had enormous appeal for health promotion and social change programs, in part, because it evokes the image of ubiquitous and successful commercial advertising. The reality, however, is complicated. Not only is commercial marketing, of which advertising is an important component, a highly sophisticated and complex undertaking, it is also hugely expensive (albeit not always successful). Marketers of soap typically have much

larger budgets than marketers of brotherhood, as well as much larger infrastructures dedicated primarily to the marketing function. They also are most often focused on selling a specific brand rather than generating demand for a product category. Nevertheless, key perspectives, principles, and tactics adapted from commercial marketing for social change programs can improve the strategic value of health communication and increase the likelihood that people will make healthy behavioral choices.

The influence of social marketing perspectives has been such that, in the early twenty-first century, most health promotion programs that operate at scale use multiple, mutually reinforcing tactics, including some aspects of social marketing. So what distinguishes social marketing from other health promotion and health communication approaches? And why should one consider social marketing as a strategy for influencing health behavior? The rest of this chapter will address these questions, starting with a definition of *social marketing*.

DEFINITION OF SOCIAL MARKETING

Some of the earliest applications of social marketing may have occurred in the field of public health, specifically family planning campaigns in India in the 1960s (Harvey, 1999). But the term itself is usually attributed to Kotler and Zaltman (1971), who defined it as "a social influence technology involving the design, implementation and control of programs aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters" (Kotler and Roberto, 1989). Since then, it has evolved through widespread application and extensive scholarship. Journals, Web sites, textbooks, institutes, university courses, and funding from the nonprofit sector and from foreign assistance donors continue to drive this evolution.

Andreasen's definition continues to be one of the clearest and most concise summaries of social marketing's essential features: "Social marketing is 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, 1994; emphasis added). These three highlighted aspects—the use of a marketing perspective to influence behavior for individual and social good—lie at the heart of all social marketing efforts. The focus on outcomes that improve personal and social welfare is the primary distinction between social and commercial marketing.

To the features noted by Andreasen (1994) and Maibach and colleagues (2002), we add another one, derived from Bagozzi (1974, 1978) and Rothschild (1999): the mutual fulfillment of self-interest through voluntary exchange. *Voluntary exchange,* from a consumer's point of view, means that interaction fulfills some felt need or desire, the perceived cost—social, economic, physical—of which does not outweigh the perceived gain. In economic terms, the return on investment (ROI)—the need or desire fulfilled at some expense—is judged to be net positive. *Voluntary exchange,* from the marketers' point of view, means providing a good or service that is also in *their* best interest—that is, not provided at a loss. In commercial settings this means that the cost of providing and promoting a product or service is more than offset by what consumers pay in exchange for it. In the case of social marketing, consumers and

marketers presumably share the same goal, namely increasing benefits to society as a whole, so the ROI is a combined sum of consumer and marketer costs and benefits. This way of calculating ROI can be problematic for marketing organizations and funding agencies. Because the marketing organization operates as an agent of the public-at-large, it may tolerate a financial loss if the larger social benefit to society is judged to offset institutional costs.

It is likely that debate over the definitions of social marketing will continue, but it seems clear that social marketing as an approach to social and behavioral change is here to stay. The Centers for Disease Control and Prevention (CDC) has thrown its institutional weight behind social marketing for health in the form of a new National Center for Health Marketing, which their Web site describes as an approach that "draws from traditional marketing theories and principles and adds science-based strategies to prevention, health promotion and health protection" (Bernhardt, 2006; Centers for Disease Control and Prevention, 2007).

A summary of some key distinctions between social and commercial marketing and health education in general is provided in Table 19.1.

TABLE 19.1. Comparisons Between Social Marketing, Commercial Marketing, and Health Education.

	Social Marketing	Commercial Marketing	Health Education
Primary Locus of Benefit	Individuals Social and political leaders Professionals Society at large	Marketing organization Producer of marketed goods	Individuals
Types of Outcomes	Behaviors that increase personal and social welfare Knowledge, attitudes, norms, values, and consumer self-image addressed to the extent that they inform behavioral decisions Gratifications more likely to be delayed Benefits tend to be longer term	Purchasing behaviors Attitudes toward & image of product Consumer self-image Norms and values addressed to the extent that they affect purchases Gratifications may be more immediate Benefits tend to be shorter term	Knowledge Attitudes Skills Practice of skills

TABLE 19.1. Comparisons Between Social Marketing, Commercial Marketing, and Health Education, Cont'd.

	Social Marketing	Commercial Marketing	Health Education
Characteristics of Audiences	Tend to be less affluent, more diverse, more in need of social services, harder to reach Audience typically segmented by psychographic attributes and relationship or involvement with product	Tend to be more affluent, more connected to media, easier to reach Audience typically segmented by psychographic and demographic attributes and relationship or involvement with product	Tend to be less well-educated with regard to featured health issues Audience segmented by education or skill level
Voluntary Exchange	Includes weighing of economic and non-economic social costs and benefits More emphasis on non-monetary exchange Costs of marketing organizations usually subsidized Expectation that information about the social product is complete and that choices are fully informed	More emphasis on monetary exchange May include weighing of social costs and benefits, mostly for consumer Expectation that information about the commercial product is true, but biased in favor of the product	Education sometimes mandated (non-voluntary), sometimes volitional "Value" of content usually determined by educators
Market Perspective	Products tend to be less tangible and more complex Competition tends to be more varied and less tangible Economic factors (for example, purchasing power) tend to be less important	Products tend to be more tangible Competition tends to be more tangible and categorical Economic factors (for example, purchasing power) tend to be more important	Economic factors tend to be less important except as they affect health literacy or ability to process information

BASIC PRINCIPLES OF SOCIAL MARKETING

What are some of the basic principles that have made social marketing popular and effective as a health promotion strategy? In this section, we describe five principles: (1) focusing on behavioral outcomes, (2) prioritizing consumers' rather than marketers' benefits, (3) maintaining an ecological perspective, (4) developing a strategic "marketing mix" of communication elements according to the Four Ps, and (5) using audience segmentation to identify meaningful differences among consumers that affect their responses to the product or service being offered.

Focusing on Behavior

Whereas in earlier eras social "products" were defined broadly to include ideas (for example, family planning, environmental conservation, cardiovascular health), attitudes (for example, preference for small family size, approval of recycling, fear of heart disease), services (for example, family planning clinics, recycling centers, health clubs) and behaviors (for example, use of hormonal contraceptives, recycling glass bottles, thrice-weekly vigorous exercise), Andreasen (1994, 2006) and others argue that the proper objective of social marketing is to influence behavior. It is not enough to promote products or services; people must obtain and use them. In the commercial world, soft drink manufacturers would fail if their business goal was merely to promote awareness of or positive attitudes toward their products; consumers must act to purchase them. Yet, in most cases, the marketing organization is indifferent as to how the product is used or if it is used at all, as long as this does not negatively affect future sales; it doesn't matter if a customer drinks the beer or pours it down the drain, as long as he buys it again. In social marketing, the *use* of the product is of much greater importance because the use usually confers the benefit. A condom marketing campaign would have to be judged unsuccessful, even if millions of condoms were distributed, if they were not used as they were meant to be—to prevent disease and pregnancy. In other words, the focus on behavior is inextricably linked to the second principle—consumer benefit.

Prioritizing Consumer Benefits

A general dimension of communication campaigns—*locus of benefit* (Rogers and Storey, 1987)—refers to whether successful achievement of program objectives primarily benefits the program designers, in this case the marketing organization or the program audience. Social marketing programs properly focus on the benefit of the consumer and not on the benefit of the organization marketing the product or the service. Although consumers *may* benefit from commercial advertising and marketing campaigns, an important focus also includes the benefit for the producers of consumer goods and their stockholders. In contrast, social marketing campaigns benefit members of the audience or society-at-large in the form of better health or a cleaner and more stable environment. For example, little if any direct benefit may accrue to the designers of a health campaign in a government agency if consumers change their

health behavior, except in the sense that a healthier populace means a lower burden of disease and fewer demands on public health resources.

Maintaining a Market Perspective

Another principle of social marketing that sets it apart from other forms of purposive communication is the concept of the market itself. First, a market perspective implies adoption of a *consumer orientation*; that is, markets revolve around consumer needs and desires and the ways in which decisions are made to satisfy those needs. Second, the functioning of markets is dependent on the *communication of information* about available products, what they cost, how they can be used, what benefits they provide, and where to obtain them. Third, promoted products always face *competition* for the consumer's attention and resources in a dynamic marketplace of ideas, priorities, and choices. Therefore, marketing communication explicitly acknowledges the environment within which decisions are made and develops strategies to increase the desirability or perceived relative value of particular decisions within that context, so that the product can compete favorably with consumers' other options.

Some social marketing approaches (Andreasen, 2006) refer to strategies addressing different levels of communication in terms of an *upstream* focus on infrastructural change (such as policy or regulatory change) or a *downstream* focus on individual change (such as knowledge, attitudes, or practices). Often, upstream and downstream strategies need to be coordinated in order to change upstream structural conditions that pose downstream barriers to individual change. Paisley (1989), for example, described the interrelated "Three Es: of public communication campaign strategy: Engineering, Enforcement, and Education. The upstream engineering of safety features such as seat belts and airbags into automobiles helps prevent traffic accident injuries. But engineering approaches must be supported by the upstream enforcement of seatbelt laws, as well as the downstream education of the public about those laws, about the penalties that can result from noncompliance, and about the effectiveness of seat belts in reducing death and injury.

Determining Marketing Mix with the Four Ps

Another distinguishing characteristic of social marketing approaches is consideration of the proper marketing mix (or combination of strategic elements), often described in terms of the "Four Ps:" Product, Price, Place, and Promotion. These are closely interwoven in an effective strategy, but each draws attention to different aspects of the market environment.

Product. Rather than thinking of products as physical objects (for example, antiretroviral AIDS drugs, hygiene products, seat belts, recycling centers), marketers think of them as a constellation of benefits that can be offered to consumers to make using those products (behaviors) enticing. To identify the most important bundle of benefits to offer, social marketers conduct research to understand the current behav-

iors of consumer groups and how a new or alternative behavior can be made more attractive or valuable. For example, consider a campaign to make it easier for restaurant patrons to identify and choose healthier foods on the menu. By labeling such menu items as "heart healthy" or "light" to distinguish them from other choices, the perceived package of benefits associated with a particular food choice is enhanced ("the Greek salad not only looks tasty, it has lower fat content"). The attributes or benefits that define a product in the mind of the consumer may be physical, economic, social, psychological, or some combination thereof.

Price. *Price* refers to the perceived costs or barriers associated with the product being offered and is an essential aspect of the voluntary exchange dynamic. Costs can be monetary, social, or psychological. Will maintaining a low-fat diet cost more in terms of monthly food expenditures? Will a program of exercise cut into time spent with family or friends? Will trying to reduce alcohol consumption result in higher levels of stress? Consumers weigh the perceived costs of a behavior against its perceived benefits, sometimes casually and sometimes with great care and attention, before making a decision to purchase a product or adopt a behavior (see Chapter Three). Social marketers try to set an attractive price or influence the perceived cost-benefit ratio in order to tip the balance in favor of the promoted behavior.

Consider a campaign to increase the practice among backyard poultry farmers in Indonesia of caging their chickens to prevent the birds and people who work with them from becoming infected with the H5N1 virus that causes avian influenza. Free ranging of chickens is generally cheaper than keeping birds caged because it costs less to feed them and because building cages, although not highly expensive, requires some investment of time and materials. But in a country where the H5N1 virus is endemic in wild birds, where laws allow the culling of entire poultry flocks if infection is suspected, and where roughly 80 percent of the people who contracted the virus from their chickens died as a result, it may be wise to keep one's chickens separated from other people's flocks, from contact with wild birds, and from contact with one's family and neighbors. Therefore, social marketing efforts in Indonesia promote, among other things, low-cost caging using local materials as a behavior that not only protects the farmer's economic investment in her chickens but protects her health and the health of her family as well. By encouraging the use of local materials such as split bamboo rather than more expensive wire fencing, the anticipated price of caging is lowered, thereby making the marketing offer appear more affordable. Furthermore, by pairing the idea of lower cost with the desirable benefits of protecting one's investment and the health of one's family, the cost-benefit ratio associated with the behavior is more favorable.

Place. *Place* refers to where the consumer is reached with the product and information about it and where the voluntary exchange takes place. Distribution channels for the product being promoted (if there is a physical object to be used, such as oral contraceptives, exercise equipment, diet aids, water purification compounds, or vaccines) or for information about how to enact the promoted behavioral product must be chosen to maximize the convenience of the "buying" experience for the consumer.

Convenience may include such things as the product's location in physical or virtual space, the times at which it is available, and the time and effort it takes to find and access the product. In the case of commercial products, place might include a retail outlet, door-to-door delivery through outreach workers (or sales force), and nontraditional social networks. Products, services, and the opportunities to take action must be placed in outlets that intended consumer groups patronize and must be located conveniently within those outlets to maximize attention and favorable comparison with other product or service options.

For example, the placement of condom vending machines and messages about the prevention of sexually transmitted diseases in the restrooms of nightclubs, gas stations, and twenty-four-hour convenience stores increases the likelihood that the idea of, as well as the means to practice, safer sex will be available at a convenient place and at a time of elevated risk for some consumers. Or consider the *Mindset* satellite broadcasting system in South Africa that delivers information about antiretroviral drugs, treatment adherence, and other health topics directly to television monitors in the waiting rooms of health clinics (Mindset, 2007).

A multitude of placement options are available to social marketers, from point-of-purchase opportunities (like the condom vending machine example or in-store signage or packaging labels that provide nutritional content information about food products), to Web-based delivery, advertisements in popular entertainment programs or magazines, local and national broadcast media, interpersonal channels in the community or at service delivery sites, message placement at public sporting or holiday events, outdoor media, direct mail, and telemarketing. In short, any placement options may be considered, with the choice being determined by up-to-date information about which ones reach and are used by the greatest numbers of the intended audience. The growth of Internet technologies has dramatically expanded the virtual space within which consumers can access and choose from a nearly unlimited range of products and personalize the purchasing experience. This, in turn, extends the lifetime of product placement and the "long tail" (Anderson, 2006) of profit or social benefit.

The importance of place was discussed by Maibach, Abroms, and Marosits (2007), who describe the social marketing perspective in terms of a social ecological "people and places" framework that situates audiences and choices within geographical, economic, and cultural spaces that determine access to, and relevance and value of, the product. The "people and places" perspective highlights the importance of a situated behavioral approach to social marketing. This requires a thorough understanding, obtained through systematic research, of the individual-level factors (such as outcome expectancy, self-efficacy, motivations, demographic characteristics, social relationships, media habits, skill levels, and emotions), as well as the characteristics of the place within which decisions are made (such as availability of products and services, physical features of the environment, social structures, laws and regulations, and the content of the symbolic environment provided by mediated and interpersonal communication).

Promotion. *Promotion* refers to the communication and messaging elements of a social marketing program, to the forms and content of information provided and the ways in which they are formatted, sequenced, reinforced, and complemented by other elements of the marketing mix. Promotional strategies typically provide information about the other Ps, such as the salient features of the product and the costs and benefits the consumer can expect, how barriers to product use can be overcome or minimized, where the product can be obtained or practiced, and so on.

Different consumer groups may respond better to one promotional strategy than to another. For example, high-sensation-seeking teenagers may respond better to anti-marijuana messages that feature dramatic depictions of drug use consequences than to messages that emphasize health statistics or social disapproval of drug use (Palmgreen and others, 2007). Whatever the issue may be, promotional approaches must be selected to correspond with audience preferences and information processing styles. An enormous catalog of message strategies is available to chose from, including the use of emotional or rational appeals, one-sided or two-sided messages, the use of humor, visual or graphic presentations versus more text-based presentations, interactive messages delivered through electronic media or through live events in a community, mass appeal versus highly tailored individualized messages, messages that emphasize social values or norms versus messages that emphasize individual benefits or purely personal considerations, and many others. (For additional discussion of message strategies, see Chapter Sixteen).

Using Audience Segmentation

The principle of audience segmentation refers to the identification of relatively homogeneous subgroups and the development of marketing strategies customized to the unique characteristics of each subgroup. Different subgroups require different strategies because they may value different benefits associated with a product, prioritize price considerations differently, seek and obtain product information or social support for behavior change through different channels, and respond more readily to some kinds of message strategies than others.

Consider an adolescent reproductive health campaign focused on reducing teenage pregnancy. Teenagers are a diverse group of people representing many different socioeconomic, cultural, geographical, psychographic, and age cohorts. Within the age range of fourteen to eighteen years, for example, some individuals are sexually active and some are not, suggesting that different products and different promotional strategies are necessary to meet different needs. Some might argue that sexual abstinence messages are appropriate for all teenagers, yet for those who are already sexually active, educating about contraceptive use may be essential, whereas for those who are not sexually active, encouraging continued abstinence may be appropriate. Therefore, an audience segmentation strategy for teenage pregnancy prevention, based on sexual activity status, might focus on condom use for teens who are sexually active and delay of sexual debut for teens who are not sexually active. Each product

would have its own bundle of benefits, product and message placement, description of costs and benefits, and promotional strategy (perhaps using different types of role models) appropriate for the target audience.

THE ROLE OF SOCIAL MARKETING WITHIN A STRATEGIC COMMUNICATION FRAMEWORK

Ideal marketing strategies do not just implore people to change, but they help them make appropriate health decisions by fostering healthy, engaged communities and effective health care delivery systems, supported by enlightened health policy. This is not a new idea. As early as the late 1950s, the World Health Organization pushed efforts to define health and well-being away from a narrow disease-prevention perspective to, "a state of complete mental, physical, and social well-being and not merely the absence the disease" (World Health Organization, 1958). The problem with these earlier models is that they made no explicit mention of communication, even though many of the influence pathways implied in the model (for example, via education or family processes) would be impossible without communication.

Consistent with this view, social marketing communication must be grounded in underlying social, political, and economic conditions, which together define the market. In all societies, health communication occurs within three principal domains: (1) the social political environment, (2) health service delivery systems, and (3) among individuals within communities (United States Agency for International Development, 2001; Storey, Figueroa, and Kincaid, 2005). Communication within these domains motivates and facilitates a variety of changes in audiences and institutions over time. In turn, these changes facilitate behavioral outcomes that make the environment more supportive of healthy practices, improve the performance of health services, and improve the likelihood of preventive health practices. Changes in behavioral outcomes at the different levels reinforce each other, resulting in improved health status at the population level. To the extent that these changes are durable, improved health outcomes can be sustained. (For more discussion of how communication works at the three levels, see Chapter Sixteen.)

Obviously, not all levels of the market environment will be engaged in every social marketing program, but within this larger framework, specific social marketing approaches can be selected, depending on the type of product, the nature of demand, and the factors that constrain behavior. We can think of these as *product-driven* approaches, *consumer- or demand-driven* approaches, and *market-driven* approaches.

Product-Driven Approaches

Product-driven approaches naturally focus on the first of the Four Ps—product—and aim to increase its appeal and differentiate it positively from alternatives. Product differentiation is often accomplished through the promotional practice of *branding*. In commercial marketing, branding creates a product category and associates it with desirable product attributes. *Coca-Cola* soft drinks, *Shell* petroleum products, *Nike*

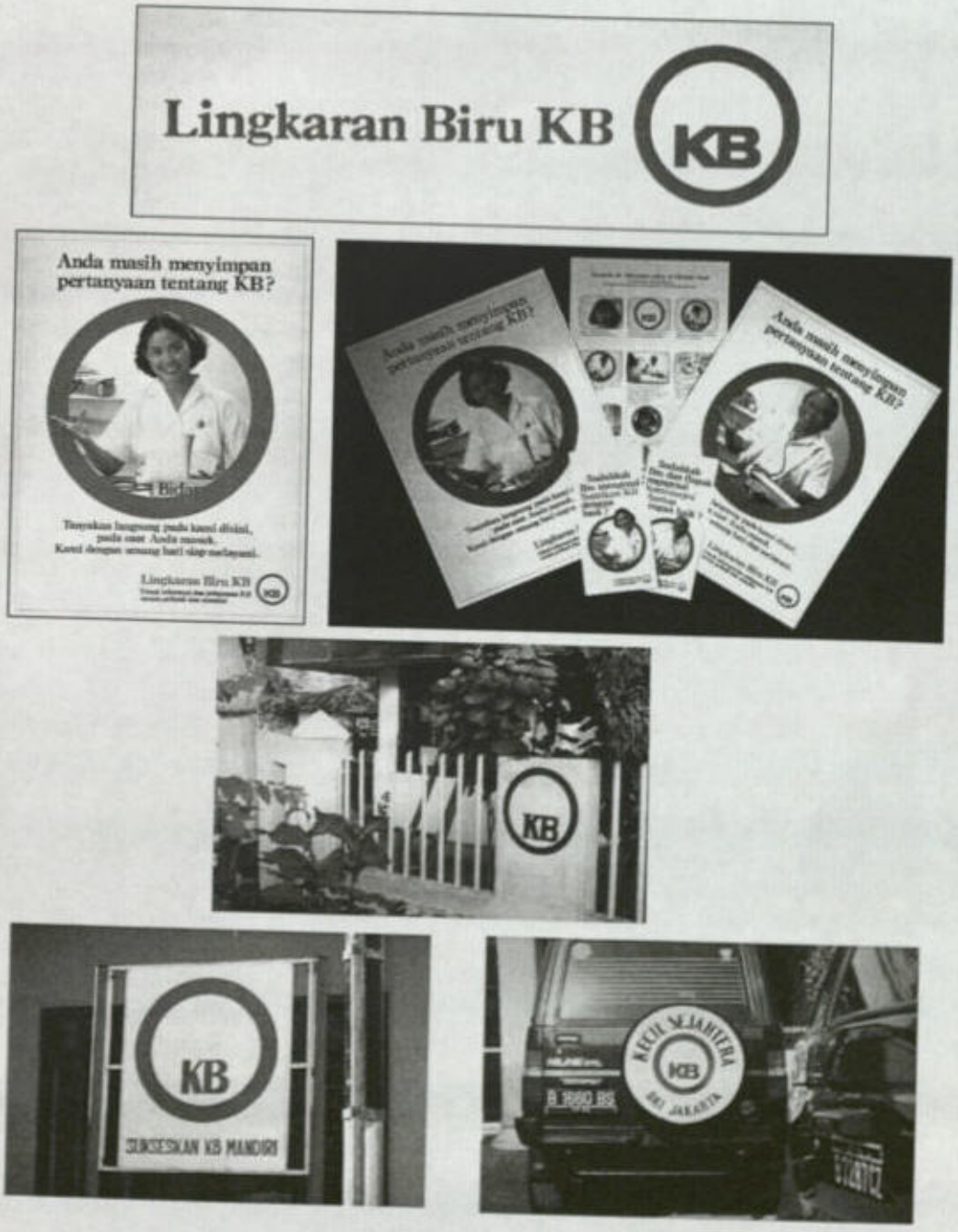
athletic gear, the *International Committee of the Red Cross, Smokey Bear,* and (unfortunately), *Marlboro* cigarettes are just some examples of popular, internationally recognized brands. Marketers offer such products with a consistent bundle of promised benefits (for example, good times, reliable quality, social status, compassion, environmental protection, good taste). Consumers come to expect those benefits and return to the products again and again in anticipation of predictable outcomes. Social marketers use similar branding tactics.

For example, Indonesia's highly successful 1988 national family planning program originally introduced the Blue Circle (*Lingkaran Biru*; see Figure 19.1) as the brand image for services provided by private sector doctors and midwives. This original program, focused in urban areas, was designed to expand family planning services into the private sector in recognition of changing economics and the need to shift responsibility for family planning from the government to the people. The program was designed under the umbrella of *KB Mandiri*—an expression of "individual self sufficiency and personal choice." Two years later, the Blue Circle was extended to an array of private sector contraceptive products (Piotrow, Kincaid, Rimón, and Rinehart, 1997; Mize and Robey, 2006). Eventually, the Blue Circle was featured in an enormous variety of ways: with the letters KB (*Keluarga Berencana* or family planning) inside to denote the concept of "making your own choice" about contraception; as signs indicating hospitals, clinics, pharmacies, and other facilities where contraceptive services and supplies were available; on contraceptive packaging; on posters, billboards, and televised public service announcements promoting health care providers who offered value-added Blue Circle services; on car wheel covers, and as decoration on village gates to indicate the community's support for families choosing to practice family planning. Even old tires were painted blue and mounted on fence posts lining country roads.

The use of Blue Circle branding was part of an integrated national social marketing campaign at a time when Indonesia was trying to move from subsidizing supply-side approaches to focusing on demand generation. The campaign helped break through old beliefs that family planning was the responsibility of and belonged to the government, by repositioning family planning as a personal choice and social norm, and fueled the rise in the use of modern contraceptive methods from 23 percent of married women in 1977 to nearly 60 percent in 2006 (Mize and Robey, 2006). Not only did the contraceptive prevalence rate increase, but the share of the private sector in 2003 increased to 65 percent, with 95 percent of hormonal contraceptive users paying market price for their supplies, whether they bought them from public or private sector sources (Rimón, Negrette, and Storey, 2006).

Consumer-Driven Approaches

Consumer-driven approaches go beyond pushing the product itself to building demand for the product, so that maintaining behavioral momentum shifts from the marketing organization to consumers. Such approaches may be more sustainable than product-driven ones, due to the nonprofit nature of social marketing. In commercial



Images: courtesy of the Media/Materials Clearinghouse at Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs

FIGURE 19.1. The Blue Circle (Indonesia).

marketing programs, the more product sold, the greater the profit and ROI for the marketing organization. But in social marketing programs where products are often subsidized or free, the greater the success, the more it costs the marketing organization to provide the product.

One strategy for achieving and sustaining consumer demand is to target social norms (Haines, 1998; Linkenbach, 1999). This approach is based on the theory that much behavior is influenced by perceptions of what is "normal" or "typical" and the perceived sanctions or rewards that result from deviating from or complying with those norms (Perkins and Berkowitz, 1986; Cialdini and Goldstein, 2004). Unfortunately, the misperception of norms, even among one's peers, is common, especially when the behaviors are less publicly visible, as in the case of taboo or illegal behaviors like sex or drug use, or visible behaviors like alcohol use. Perception usually trumps reality, so if a teenager believes that the majority of his peers smoke marijuana, then he is more likely to try it himself. If a married woman believes that few of her peers use contraception, she is less likely to seek family planning services or methods for herself. Social norms marketing can be used to inform people about the actual frequency of behaviors among groups they care about, in order to create salient social pressure. Or a program might even introduce and promote a new norm and reinforce its practice by creating visible symbols in the environment, increasing perceived social support (Kincaid, 2004).

Consider again the example of the family planning program in Indonesia. In a departure from traditional social marketing of condoms or oral contraceptives, the National Family Planning Coordinating Board chose to focus on making small family size a new social norm with the introduction of the theme "*Dua anak cukup*" (Two Children Are Enough) (Mize and Robey, 2006), with the use of contraception being promoted as a way to achieve that goal. National campaigns facilitated family planning practice by providing a full range of branded products and services from which couples could choose, at first primarily through government health service outlets, then later through Blue Circle private sector hospitals, clinics, pharmacies, and health service providers. Almost nonstop national and local campaigns during the 1980s and 1990s contributed to a rapid increase in the contraceptive prevalence rate, as noted earlier, and to a drop in the total fertility rate from 5.6 to 2.6 average number of births in a woman's lifetime between 1971 and 2006 (BPS and ORC Macro, 2003). By the late 1990s, family planning and small family size had become so deeply engrained that even the economic crisis and political instability that Indonesia suffered from 1998 to 2002 had little effect on contraceptive use rates, even though commodities became more expensive and harder to obtain (Storey and Schoemaker, 2006; Frankenberg, Sikoki, and Suriastini, 2003).

Market-Driven Approaches

An extension of consumer-driven (or demand-driven) approaches are market-driven ones. Consumer demand operates in a world of options, where behavioral choices are made in light of other possibilities, many of which have their own champions and

promoters. For example, responsible consumption of alcoholic beverages, especially around holiday periods, competes with the allure of drinking portrayed in a flood of seasonal advertising that emphasizes the social benefits and camaraderie of alcohol consumption. Does *not* drinking with friends mean a less active and fulfilling social life?

A market-driven approach to responsible drinking must position its product (one aspect of which is alcohol-free social interaction) as an attractive alternative to the competition. Accordingly, a growing number of communities in the United States sponsor "First Night" events on New Year's Eve—a time when alcohol abuse is common. For example, the City of Williamsburg, a popular history-themed tourist destination in Virginia, hosts and heavily promotes a celebration of the performing arts every New Year's Eve. In 2007, members of the public could purchase a single ticket that allowed entrance to more than sixty venues offering all types of performances from classical, folk, and popular music to dances, drama, and art shows as alternatives to public events, clubs, restaurants, and bars where alcohol is served.

THE ROLE OF THEORY AND RESEARCH IN SOCIAL MARKETING

The Use of Theory

Many theories are available to guide the planning and evaluation of social marketing programs (for more extensive discussion of health behavior theories, see Parts Two and Three in this book). In this chapter, we highlight four health behavior theories that are commonly used in large international health interventions: (1) the Integrated Model of Behavioral Prediction (Kasprzyk, Montano, and Fishbein, 2001; Fishbein and Yzer, 2003; see Chapter Four), which focuses primarily on cognitive or rational processes around decision making; (2) the *extended parallel processing model* (Witte, 1994), sometimes referred to as fear or threat management theory, which focuses on emotional response and its effects on motivations and behavior and is particularly relevant for some health issues like HIV/AIDS or avian influenza prevention; (3) *observational (or social) learning theory* (Bandura, 1986; see Chapter Eight), which focuses on how people learn to behave by observing others; and (4) *diffusion of innovations* (Rogers, 2003; see Chapter Fourteen)—in some ways the most "social" of these theories, which focuses on the flow of information about a new product or practice within the social environment (for example, neighborhoods and networks) and how these influence access to information and response to it.

Key ideas and applications of these four theories in social marketing research and design are summarized in Table 19.2.

Such theories offer insights into characteristics of a product that may be of interest to consumers and that can be confirmed through formative research. For example, the adoption of a new behavior tends to be more rapid if it (1) is perceived to have a relative advantage over current behavior, (2) is compatible with one's daily routine, sociocultural values, and priorities, (3) does not seem overly complex to adopt or practice, (4) can be tried without great risk before committing to it, and (5) can be observed in action to see what outcomes others experience before trying it oneself (Rogers, 2003). By evaluating the perceived characteristics of a product among potential consumers,

TABLE 19.2. Applications of Major Theories and Research in Social Marketing.

Theoretical Framework	Applications of Framework		
	Identify Motives for Action	Identify Message Strategies	Identify Target Audiences
Reasoned Action/ Planned Behavior	What are the advantages (benefits) and disadvantages (costs), both personal and social, of a health behavior?	Change beliefs about and evaluations of consequences (costs and benefits) of action Change perceptions of subjective norms Change motivations to comply with subjective norms	Define primary audiences (those who would benefit from attitude change) Define secondary audiences (significant others of those to be influenced)
Extended Parallel Processing Model	To what extent is the health issue thought to pose a serious and personal threat (costs of inaction)? To what extent are proposed actions perceived to be effective (response efficacy or benefit of action)? How do people perceive their ability to enact the behavior (personal efficacy)?	Create messages that increase understanding of the threat and explain or demonstrate how responses can effectively reduce the threat Create messages that explain how to do the recommended response Explain how to overcome barriers to recommended response	Segment audiences into categories representing levels of perceived threat and efficacy
Observational Learning	What perceived personal and social incentives or reinforcements (benefits) affect learning and action? What perceived personal and social barriers (costs) affect learning and action?	Provide models of effective action that are appealing and compelling Encourage rehearsal and trial of the behavior Provide feedback and reinforcement for behavioral attempts Provide incentives for performance of the proposed behavior	Define primary audiences (those who would benefit from attitude change) Define secondary audiences (potential role models and advocates)

TABLE 19.2. Applications of Major Theories and Research in Social Marketing, Cont'd.

Theoretical Framework	Applications of Framework		
	Identify Motives for Action	Identify Message Strategies	Identify Target Audiences
Diffusion of Innovations	How do members of the audience perceive the behavioral innovation? What relative advantage (benefits) does it offer? How complex or risky is it (costs)? Can consequences (costs and benefits) of the behavior be observed? Is the behavior compatible with current practices (costs)? What social influences or networks exist in the environment that encourage or discourage the action (social costs and benefits)?	Show and explain the benefits of the proposed action Explain how to do it in simple terms Show how new behavior fits with or grows out of current practices Encourage those who already practice the behavior to advocate it to others	Segment audience according to perceptions of the behavior Target people who are key network members (opinion leaders)

marketers can determine which positive perceptions to reinforce and which negative perceptions to change through their message strategy.

Theory, too, can help social marketers segment audiences in meaningful ways. For example, the Extended Parallel Processing Model (EPPM) describes the interaction between emotion (perceived threat) and rationality (perceived efficacy) in behavioral decision making (Witte, 1994). Splitting each of these dimensions into low and high categories creates a 2 × 2 typology of audience segments. Consider the backyard poultry farmer in Indonesia again, who has heard that mortality is high among humans infected with the avian influenza virus. If the farmer believes that avian flu poses a real and present threat to his health (higher fear) but feels confident that the use of protective equipment and hygienic poultry handling practices are both effective and feasible (higher efficacy), he is more likely to take protective action, compared to another farmer who is neither concerned about the disease (lower fear) nor is confident in the proposed solutions or in his ability to implement them

(lower efficacy). A communication strategy for the lower fear/lower efficacy segment might focus on raising realistic risk perceptions and educating about or modeling possible actions that are known to mitigate the threat. For the higher fear/higher efficacy segment, a communication strategy might focus simply on cueing them to action during the season when avian flu outbreaks are more likely to occur. Multiple audience segments may be addressed within an integrated marketing strategy through the use of multiple models representing distinct segments, tailored persuasive strategies, or personalized channels of communication (Kalyanaraman and Sundar, 2006).

Various stage theories of behavior change are also applied widely to market health behaviors in general (Prochaska and DiClemente, 1992; see Chapter Five), family planning (Piotrow, Kincaid, Rimon, and Rinehart, 1997), fertility behavior (Coale and Watkins, 1986; Kincaid, 2000; Lesthaeghe and Vanderhoeft, 1998), and attitude change (McGuire, 1989). These are often also used to identify different segments of the overall audience who may be at different stages; some are barely aware of a health issue while others are knowledgeable and capable of responding but lack motivation to act, requiring strategies tailored to the needs of each group.

The Use of Research

Because consumer decision making and behavior are complex and situational, systematic investigation into the conditions and dynamics of targeted behaviors, rather than inspired guesswork, helps validate program planning decisions and increases the likelihood that social marketing programs will succeed. Because research plays an essential role across the entire lifespan of a social marketing program, researchers should be involved in program planning from the beginning, rather than brought in only at the end to evaluate outcomes.

During the design phase of a program, research helps planners determine the prevalence of the problem overall and among specific sub-audiences; select audiences to target in order to achieve maximum individual and social benefit; identify the unique communication needs, media habits, and preferences of the different audience segments; catalog the social, cultural, and structural/environmental factors that positively or negatively influence behavior; and identify sources of personal influence over the behavior of intended audience members. At a more structural level, research helps identify organizations and social structures that influence the intended audiences and might be engaged to support the program and be available as communication and media channels.

Concept testing and pretesting are essential research steps in the design process that help planners explore the Four Ps and determine an optimum marketing mix. What attributes of a product are valued? What perceived costs are associated with the desired behavior? Where can or must the exchange take place and how can it be made most convenient? What promotional strategies, formats, presentations, and placement channels will reach and appeal to targeted audiences and are likely to motivate the desired behaviors?

During implementation, research helps track progress by providing answers to such questions as these: Is the program being implemented as designed? Are activities and materials reaching the audience? What is the level of exposure within the intended audience? Is the timing of activities and message distribution going as planned? Is the program beginning to have an impact? Does the program need adjustment and fine-tuning at midcourse?

Finally, *during the evaluation phase* of the program, research helps determine how well a program met its objectives. It can explain why a program was effective (or not), including the effects of different activities on different audience segments. Did anything change during the program? What did the program contribute to those changes? Which parts of the program explain the most change? How much did it cost to achieve specific outcomes or effects? Which parts of the program should be continued or strengthened?

INTERNATIONAL AND DOMESTIC (U.S.) SOCIAL MARKETING EXPERIENCES

In this section, we profile two health communication programs from a social marketing perspective: the integrated Communication for Healthy Living (CHL) family health program in Upper Egypt and the Red Ribbon Question Mark (RRQ) HIV-testing promotion program in Baltimore, Maryland, USA. We describe how each program reflects the five principles of social marketing (focus on behavior, not products; focus on consumer benefits; maintain an ecological market perspective; optimize market mix through the use of the Four Ps, and audience segmentation), as well as how each effectively used theory and research to guide decision making. We also describe some of the impact data from each program to illustrate how social marketing programs can be evaluated.

Case Study 1: Communication for Healthy Living, 2002–2009 (Egypt)

Communication for Healthy Living (CHL) is a seven-year integrated health communication program in Egypt, funded by the United States Agency for International Development (USAID). Begun in 2002, CHL builds on 25+ years of USAID-supported partnership between Egypt's Ministry of Health and Population (MOHP) and the Ministry of Information-State Information Services (MOI-SIS).

Focus on Behavior. Because funding for the project prioritizes family planning as an outcome, contraceptive use is a primary behavioral goal. However, CHL positions contraceptive use within a larger array of family health behaviors, using marriage as an entry point for the communication strategy. Newlywed couples immediately face health issues related to reproduction, including the decision to have children right away or to delay the first pregnancy. When the first pregnancy does occur, new behaviors become relevant: protecting the prenatal health of the mother and the fetus,

preparing for a safe delivery, and delivery itself with the assistance of a doctor or trained midwife. After delivery, immediate postpartum care for the mother and postnatal care for the infant, initiation of breastfeeding, and postpartum initiation of contraceptive use to delay a subsequent pregnancy become relevant, followed by infant feeding practices and immunization. Then, as the family matures, other lifestyle practices assume greater importance. Routinely washing hands and preventing infectious diseases such as hepatitis, HIV/AIDS, and avian influenza are examples; exercise, smoking, and the avoidance of secondhand smoke are others.

CHL publicizes the availability of health services and promotes the purchase and use of health products such as oral contraceptives, hand soap, feminine hygiene products, and disposable syringes but positions these as products that can be used to achieve behavioral goals, not as consumer products per se.

Focus on Consumer Benefit. The signature theme that brands all CHL messages and activities is "*Sahetak Sarwetak*" (Your Health is Your Wealth). Achieving and maintaining one's own health and that of one's family is the overall benefit communicated to target audiences, but each of the lifestage behaviors is described in terms of the benefits it conveys: better maternal and child health as a result of longer spacing between births, improved mental and physical development of infants through immunization and breastfeeding, reduced risk of cardiovascular disease and cancer through avoidance of secondhand smoke, and so on. Each of these behaviors is positioned as an informed choice that people make in order to protect their greatest asset—good health—a deeply held value that emerged strongly in pre-campaign formative research.

Maintain a Market Perspective. CHL reflects a market perspective in several ways, most notably through its private sector pharmacy initiative, known as *Isaal Istashir* (Ask-Consult). As of mid-2007, Ask-Consult had built a national network of 16,000 private sector neighborhood pharmacists who associate with the project in order to improve the level of the services and products they provide and to increase their sales. As donor funds begin to phase out, a small membership fee will help support branding and generic marketing of Ask-Consult services and products, as well as members' access to customer service and health information materials and training. The signature campaign invites consumers to "ask and consult" for family health information and appropriate products where they see the Ask-Consult logo.

Ask-Consult competes for consumer attention through national television advertising, public relations activities, point-of-sale promotions, direct mail, and contests. Messages promote positive behaviors and appropriate health products for family planning, safe injection, hygiene, and maternal and child health. By expanding and supporting this network, CHL attempts to affect the market structure itself by improving access to and quality of local sources of information and health care products people need in order to protect their greatest asset—their family's health.

Beyond the Ask-Consult initiative, CHL also works with potential competitors for consumer attention and advertising expenditures by leveraging the support of

health industry manufacturers. CHL has attracted corporate partners such as Procter & Gamble, Shering, Organon, Vodafone, and Durex, who participate in and fund activities such as pharmacy contests, distribution of health information and promotional materials, direct corporate support of training and events, product promotions, and prizes at public events and on health-related television game shows.

Focus on the Four Ps.

Product. As noted earlier, CHL products are a set of lifestage-appropriate behaviors bundled together under the *Sahetak Sarwetak* umbrella. Together, the individual benefits of family planning, maternal and child health, and healthy lifestyle practices add up to a lifetime of family health and well-being but are broken down into manageably small but concrete actions that can be taken at various points in time. Associating each behavior with a particular lifestage also makes it easier to contextualize. For example, less than half of Egyptian women first use contraceptives after the birth of their first child, even though delaying the second pregnancy has health benefits for both the mother and the newborn child. CHL messages position this decision in the context of pressures newlyweds face from in-laws to have more children, the economic pressures that more children create, and the health benefits of a longer time between pregnancies.

Price. CHL attempts to reduce the real and perceived cost of everyday health behaviors, in part by increasing access to quality health information and products at conveniently located local pharmacies. Messaging also attempts to explain the negative costs associated with inaction (for example, failing to protect pregnant women and infants from secondhand smoke can result in lower birthweight and lower growth rates) in order to influence the perceived cost-benefit ratio.

Place. Outreach activities promoting healthy lifestyles and behaviors include community events, home visits, contests, and birth preparedness and infant feeding classes at public health clinics. Print materials covering priority health messages for both health service providers and clients are distributed nationwide to 5000+ public sector clinics, private sector pharmacies, a network of nongovernmental organizations (NGOs), and in birthing hospitals along with product sampling packs for new mothers.

Promotion. CHL messaging is extremely varied and tailored to different audience segments and different topics. On issues where baseline knowledge is limited, messages are more informational. For example, many Egyptians purchase medical supplies such as syringes from pharmacies and take them to hospitals when they need treatment because such commodities are sometimes in short supply. Few people know about the link between hepatitis C infection and the reuse of syringes, so CHL messages on this topic feature pharmacists explaining the importance of using disposable syringes to prevent the transmission of blood-borne diseases. In the case of avian influenza, television and radio spots clearly model simple behaviors that people can take (for example, avoiding wild birds, regular hand washing, hygienic handling of poultry for

Metro ads:
Your health...your wealth

Flyer:
Women's
hygiene

Safe injection posters

Ask-
Consult
Logo

TV
spots:
Low
parity
FP use

Avian flu

Enter-
Educate
Events

TV spots: Birth spacing

Images: courtesy of the Media/Materials Clearinghouse and Photoshare at Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs

FIGURE 19.2. Communication for Healthy Living (Egypt).

food, thorough cooking of poultry and eggs). And entertainment-education events and media programming embed health messages within game shows, children's shows like *Alam Simsim* (the Egyptian Sesame Street), and wedding celebrations to maximize attention and emotional appeal. Some examples of CHL messages are provided in Figure 19.2.

The messages were spread through multiple channels, including national and regional TV, radio, and the press, as well as telephone hotlines, the Internet, performing arts, publicity events, community meetings, home visits, and clinic-based counseling. CHL cultivates relationships with print, TV, and radio journalists to encourage accurate and timely reporting of health news supporting the national health agenda. Large-scale publicity events, such as regional "Newlywed Celebrations" for hundreds of local couples and guests, receive extensive national media coverage. Press inserts on special topics are produced for national distribution in popular magazines. Popular television game shows are used to reach a national audience of 15 million with information for newlywed couples to help them get their families off to a good start. Finally, various interactive media are used, such as national telephone hotlines on HIV/AIDS and avian influenza, a CHL Web site, and an online database of health communication materials in Arabic and English (http://www.healthcom-egypt.info).

Audience Segmentation. CHL segments its audience primarily by lifestage, as well as by urban-rural differences and gender. Newlywed couples are a primary target audience, as are pregnant women, postpartum and breastfeeding women, couples with one or two children, and children between the ages of four and six years. As noted earlier, key behaviors are associated with each family lifestage and promoted to the appropriate audience segment. In addition, different versions of the same television spot are tailored, for example, to rural audiences and urban audiences with the featured characters reflecting appropriate dress, language, and other cultural characteristics but delivering the same message about birth spacing.

Use of Theory and Research. CHL research was comprehensive and systematic. During the design phases of CHL, in-depth audience segmentation and trend analysis were conducted using publicly available Egyptian Demographic and Health Survey data (MOHP and ORC Macro, 1995, 2000, 2003, 2005) and commercially available pharmaceutical marketing and media monitoring data. After the program launched in 2002, CHL continued to mobilize a diverse set of data sources, some specially commissioned and some publicly available. These data provided trend indicators at a national level, while commissioned national surveys in 2005 and 2006 (Communication for Healthy Living, 2005, 2006a) measured national exposure and response to specific CHL messages among adult audience segments. The commissioned surveys were able to include measures of key theoretical constructs such as social norms, perceived threat and efficacy, and perceived benefits of specific behaviors, as well as measures of various knowledge, attitudes, and self-reported behaviors related to CHL health issues. Commercially purchased data on media ratings and pharmaceutical sales helped the project track the reach of CHL's mass media offerings and the impact of the Ask-Consult

promotions. Finally, NGOs working as outreach partners at the community level in focal project areas collected extensive monitoring data on maternal and child health, including infant birth weights, immunization coverage, and malnutrition.

According to PARC Media Monitoring reports, CHL TV spots reached an estimated 32 million adults between the ages of fifteen and forty-nine in 2004 (Communication for Healthy Living, 2006b). A national health communication survey, fielded in August 2005, found recognition and recall of *Sahetak Sarwetak* to be 67 percent and of Ask-Consult to be 70 percent (Communication for Healthy Living, 2005). The same survey in 2006 found that 71 percent of Egyptian adults over the age of fifteen had initiated at least one new behavior to protect themselves from avian influenza as a result of a national campaign coordinated by CHL and that the mean number of protective behaviors increased with the number of CHL messages recalled (Communication for Healthy Living, 2006a). Other national survey data showed that the use of contraception after the birth of the first child increased from 35 percent of married women in 2000 to 50 percent in 2005 (MOHP and ORC Macro, 2000, 2005). Finally, 2005 monitoring data at the village level showed that the percentage of malnourished infants in focal villages had declined from 26 percent to 16 percent (Communication for Healthy Living, 2006b).

The CHL project will continue at least through 2009. Due to the extensive involvement of stakeholder organizations from the highest levels of government, the public sector, and private sector service delivery systems and civil society at the community level, it is likely that many parts of the program will be sustained beyond the end of the current phase of donor funding.

Case Study 2: Red Ribbon Question Mark HIV-Testing Campaign 1999–2003 (Baltimore, Maryland)

The Red Ribbon Question Mark (RRQ) campaign in Baltimore, Maryland was a four-year HIV-testing promotion program, funded by the Maryland AIDS Administration (MAA) and the state Department of Health and Mental Hygiene. Its ultimate goal was to reduce HIV infection rates in Baltimore City, where African Americans, twenty-five to forty-four years old, are at particularly high risk. The CDC estimate that at least 25 percent of HIV-infected individuals in the Unites States are unaware of their positive serostatus (Centers for Disease Control, 2003), and from this it is estimated that Baltimore could have over four thousand undiagnosed HIV-positive individuals.

Focus on Behavior. The behavioral goals of the RRQ campaign were to increase HIV testing in Baltimore City by 10 percent during the intervention period; to encourage at-risk individuals to seek out services by raising awareness and creating a supportive environment, and to motivate prenatal caregivers to encourage HIV testing among their clients.

Focus on Consumer Benefits. Although increased HIV testing would benefit public health in general, the campaign focused primarily on the benefits individuals would

gain from knowing their HIV status under the banner "Live Long. Live Strong. Get Tested. Get Treatment." In the case of pregnant women who test negative, the benefits include peace of mind that their children would be born free of HIV. To counteract fears of testing positive, the described benefits also include access to treatments that reduce the risk of mother-to-child transmission and increase a woman's own chances of living a normal life and surviving to care for her child. For men, the benefits included access to treatment (if someone tests positive) that can increase vitality and allow a return to normal life as long as the treatment regimen is followed.

Maintaining a Market Perspective. It was important for the RRQ to operate within the context of the African American culture and community structure. This meant working closely with faith-based organizations, popular local media, and annual community events that provided access to audiences that are stigmatized, marginalized, and fearful of the consequences of knowing their HIV status. The campaign also acknowledged the critical role of communication processes within the community—not just information delivery—about HIV testing, testing and treatment facilities, and the positive consequences of treatment in supporting decisions to seek testing. By providing information about testing, treatment, and support options, the campaign sought to affect market conditions by reducing physical and psychological barriers to testing and increasing incentives for someone to come forward to be tested.

Focus on the Four Ps.

Product. As in all good social marketing programs, the main product in the RRQ was a behavior and the benefits associated with it: getting an HIV test and the hope for a healthier life that is possible for HIV-positive individuals who get treatment. A number of other associated actions, such as calling an HIV-testing hotline, contacting referral networks, communicating with health workers about HIV testing, and more open public discussion with family and friends about HIV/AIDS and testing also were promoted to increase knowledge about testing and treatment.

Place. The RRQ used a wide variety of distribution points to deliver information and to encourage and support testing. Hotlines, outreach events, and HIV-testing centers provided clients with ways to contact testing services and access information about testing. The campaign promoted the United Way's "First Call for Help" telephone referral hotline and featured the number prominently on campaign advertisements and giveaways. In addition, the campaign tapped into local community outreach activities such as health fairs, heritage festivals, church events, and block parties that offered opportunities for broad community participation. Radio station 92Q, the most popular local station among African Americans in Baltimore, aired spots and announcements featuring the campaign slogan and sponsored events such as the 92Q Stone Soul Picnic, attended by over 100,000 people annually, where materials, referrals, and on-site testing were available.

Price. The campaign attempted to reduce the perceived material and psychological costs of getting tested by facilitating access to testing facilities and to counseling, in-

creasing the acceptability of public discussion of testing and treatment, and reducing stigma associated with HIV/AIDS by creating a more supportive social environment within communities and community organizations. In addition, by emphasizing the health benefits of treatment for people who test positive for HIV, the cost-benefit ratio of the marketing offer and of the voluntary exchange was enhanced.

Promotion. Posters on buses and in subways, outdoor billboards, direct mail to health care providers about how to talk with patients about voluntary HIV testing, additional posters in health facilities and community centers, and radio and television advertising all delivered messages citywide but with concentrated distribution in three postal zones with the highest HIV infection rates. Over 550,000 promotional items, such as calendars, coffee mugs, T-shirts, and lapel pins with messages were distributed to service providers, their clients, and members of the target populations.

The campaign slogan ("Live Long. Live Strong. Get Tested. Get Treatment.") was designed to reduce the anxiety and stigma common in the African American community, which pose major barriers to testing and treatment. Messages addressing pregnant women who may not be aware that mother-to-child transmission can be reduced with proper treatment showed pictures of a mother and baby with such captions as, "HIV is one thing you don't have to pass along to your baby," "My baby's healthy. I'm glad I got tested for HIV," and "What kind of mother could give her baby HIV? An untested one." Other ads spoke directly to African American men who might be skeptical or fearful of being tested for HIV. One ad showed a basketball player with the caption, "11 years with HIV. And he can still dunk in your face," indicating that being infected does not mean a death sentence. The campaign logo—a red ribbon in the shape of a question mark—immediately evoked recall of the almost universally recognized red ribbon AIDS-prevention symbol, but with a twist that made it unique and easily associated with testing to resolve the question of one's HIV status (see examples of campaign materials in Figure 19.3).

Audience Segmentation. Three main audience segments were targeted by the campaign: (1) women of childbearing age, (2) their at-risk male partners, and (3) prenatal caregivers and service providers. Messaging for each group, as described earlier, was developed on the basis of focus group research that revealed unique sources of concern or skepticism about testing or, in the case of service providers, uncertainty about how to broach the subject and discuss testing and treatment with their patients. Because a significant proportion of at-risk women speak Spanish, some materials were produced in Spanish and featured Hispanic women.

Use of Theory and Research. As noted earlier, valuable insights were gathered during focus group discussions with health care providers, community members, and individuals at risk for HIV infection; these insights were used to develop messages that reflected the ethnic background and identity of the neighborhoods in Baltimore most affected by HIV/AIDS. Resulting message concepts were pretested for comprehension, appeal, and emotional impact in additional focus groups with representatives of the primary audience segments.

Images: courtesy of the Media/Materials Clearinghouse at Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs

FIGURE 19.3. Red Ribbon Question Mark Campaign (Baltimore, Md.).

Message strategies drew on elements of the integrative model of behavioral prediction (Kasprzyk, Montano, and Fishbein, 2001; Fishbein and Yzer, 2003) regarding the weighing of beliefs about the consequences of an action, in this case what could happen as a result of HIV testing and the determination of one's HIV status. It also drew on elements of social learning theory (Bandura, 1986, 1997) related to learning from modeled behavior to help determine what types of models would most likely be appealing to the targeted audiences.

Results of the campaign were assessed using a variety of data sources. Call logs from the United Way "First Call for Help" hotline showed that the average monthly number of calls increased to fifteen times what they were in the three months prior to the campaign. Sixty-two percent of callers cited the RRQ messages as the reason for their call.

Questions about RRQ message recall, knowledge of HIV testing, and discussion of testing with others were purchased on random sample commercial omnibus surveys conducted by WB&A/MarketTrak in 2002 and 2003 (n = 306 male and female heads of households, age eighteen to fifty, in the Baltimore metropolitan area). Results in 2003 showed 88 percent recall of at least one RRQ message, while the percentage of respondents who reported talking to friends or family about HIV testing increased from 29 percent in 2002 to 59 percent in 2003.

In addition, the Maryland AIDS Administration (MAA) provided RRQ researchers with clinical data about HIV infection rates and testing rates. These data indicated that between 2001 and 2003, HIV testing increased by 61 percent throughout the City of Baltimore and by 68 percent in the campaign's three targeted postal zones, compared to the previous three-year period. Data also indicated a reversal in HIV infection rates. From 1994 to 1999, HIV infections increased by 35 percent annually in the targeted postal zones. However, during the first three years of the campaign, from 1999 to 2002, the MAA reported that the rate of new HIV cases declined by 24 percentage points, representing approximately 619 new HIV cases averted.

SUMMARY

This chapter has introduced the reader to the core principles and some examples of the social marketing of health behaviors. Social marketing should not be considered—any more than other approaches described in this book—as a panacea for overcoming public health challenges. Nevertheless, in its systematic approach to understanding and strategically responding to audience characteristics and the context or market structure surrounding behavioral decisions, social marketing offers powerful guidelines for communication planning.

More than some other approaches at least, social marketing draws our attention to factors beyond individual behavior change and toward ways that communication can affect the market structure itself through policy (fluoridation of water, iodization of salt), legislative (seat-belt use), and social normative (reduced HIV/AIDS stigma) change, thereby facilitating voluntary exchange and the uptake of beneficial health behaviors. Even so, social marketing strategies necessarily work backwards from the existing needs and conditions of consumers' lives to reduce barriers to beneficial behavior. In both commercial and social marketing, it is sometimes necessary to build or create value, but in social marketing it is always important to identify and fulfill demand. The social marketing perspective also demands that planners seek the optimum marketing mix or balance among the "Four Ps." Creating appealing messages about the product is important, but this must be filtered through considerations of the cost-benefit ratio, where the exchange is likely to take place, and what forces compete against the product for attention and resources.

One of the enduring appeals of social marketing is its family resemblance to commercial advertising, which is both widely loathed and widely admired. This resemblance should not be discounted or rejected with the best of high-minded intentions. Commercial advertising can be highly imaginative and often has its finger on the pulse of popular culture. So, although creativity and cultural resonance may not be enough-by themselves—to sell brotherhood or achieve other highly desirable social improvements, their combination with the systematic application of the social marketing principles described in this chapter may be.

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