
POSITIONING SOCIAL MARKETING AS A PLANNING PROCESS FOR HEALTH EDUCATION

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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.

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, p.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 understood 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 recog-

nize “competition,” can not rightfully be called social marketing (Andreasen).

A recent review of “marketing” as it is represented in “health promotion” literature suggests that elements 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.

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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 (Figure 1) 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 Andraesen (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.

Figure 1. McKenzie & Smeltzer’s Generalized Model

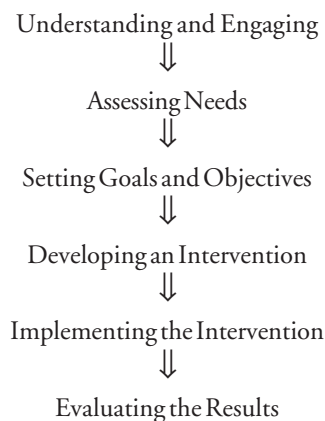


Table 1. Comparison of Planning Models Used in Social Marketing

Neiger & Thackeray 1998 (SMART Model)	Bryant 1998	Andreasen 1995	Walsh et al. 1993	Lefebvre & Flora 1988	Weinreich 1999
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	Pretesting
Channel Analysis	Program Monitoring & Revision	Pretesting Program Elements		Strategy	Implementation
Develop Materials & Pretest	Program Evaluation	Monitoring & Evaluation		Process Tracking	Evaluation & Feedback
Implementation					
Evaluation					

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.

DIFFERENCES 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.

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HEALTH EDUCATION RESPONSIBILITY AND COMPETENCY ADDRESSED

Responsibility II - Planning Effective Health Education Programs

Competency E - Develop health education programs using social marketing principles.

Sub-competency 3 - Design a marketing plan to promote health education.