An integrative model for social marketing

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Abstract

Purpose – Social marketing has evolved differently in the developing and developed worlds, at times leading to different emphases on what social marketing thought and practice entail. This paper aims to document what those differences have been and provide an integrative framework to guide social marketers in working with significant social and health issues.

Design/methodology/approach – An integration of views about social marketing is proposed that is focused on the core roles of audience benefits; analysis of behavioral determinants, context and consequences; the use of positioning, brand and personality in marketing strategy development; and use of the four elements of the marketing mix to tailor offerings, realign prices, increase access and opportunities; and communicate these in an evolving media environment.

Findings – Ideas about branding and positioning, core strategic social marketing concerns, have been better understood and practiced in developing country settings. Social marketing in developing countries has focused much more on products and services, with a concomitant interest in pricing and distribution systems. In developed countries, social marketing has too often taken the 1P route of using persuasive communications for behavior change. The integrative framework calls for an expansion of social marketing to product and service development and delivery, using incentives and other behavioral economic concepts as part of the price element, and extending place as both an access and opportunity idea for behaviors, products and services.

Practical implications – The framework pulls together social marketing ideas and practices from the diversity of settings in which they have been developed and allows practitioners and academics to use a common set of concepts to think about and design social marketing programs. The model also gives social marketers more latitude in how to use price and place in the design of programs. Finally, it also provides a platform for how we approach social change and public health in the years ahead through market-based reform.

Originality/value – Five challenges to social marketing are identified – achieving equity, influence of social networks on behaviors, critical marketing, sustainability, scalability and the need for comprehensive programs – that may serve to focus and coalesce social marketing research and practice around the world.

Keywords Marketing, Social change, Entrepreneurialism, Innovation, Social marketing, Communication

Paper type Viewpoint

Though largely ignored by textbooks (Andreasen, 1995; Donovan and Henley, 2003; Kotler and Lee, 2008), the field of social marketing has developed on two independent tracks over the past 40 years. These tracks correspond to the contexts in which social marketing has evolved: its earliest and primary use in developing countries to foster the use of various health-related products and services (Harvey, 1999; Manoff, 1985) and its application in developed world contexts to reduce behavioral risk factors for diseases (c.f. Fine, 1981; Lefebvre and Flora, 1988; Walsh *et al.*, 1993; though it also true that behaviors, products and service might be addressed by some projects in either context). And even though non-governmental organizations (NGOs) and donors from developed countries have largely funded and devised social marketing activities in developing countries, these activities have been independent their domestic colleagues and work.

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When these two worlds do come together, there is surprise and alarm that the basic tenets of social marketing each holds dear are seemingly not shared. One group will fault the other for not being "pure" marketing ("Where are your products?"); in response, the charge is made that one is not being "progressive" ("Where is your behavior change?"). Indeed, "what are we marketing?" is a fundamental issue in this debate.

An early definition of social marketing described it as using marketing principles to influence the acceptability of social ideas (Kotler and Zaltman, 1971); contemporary writers define it as a method to influence the voluntary behavior of target audiences (Andreasen, 1995; Donovan and Henley, 2003; Kotler and Lee, 2008). Yet, Manoff (1985), one of the leading social marketers in the developing world, stated that it may include introduction of new products (e.g. oral rehydration salts), the modification of existing ones (e.g. iodized salt) and the promotion of structural change in existing institutions (e.g. food stamps, hospital practices). And the US Agency for International Development, one of the major donors for social marketing projects to address an assortment of health problems in the developing world, has recently written:

> Social marketing is the use of commercial marketing techniques to achieve a social objective. Social marketers combine product, price, place, and promotion to maximize product use by specific population groups. In the health arena, social marketing programs in the developing world traditionally have focused on increasing the availability and use of health products, such as contraceptives or insecticide-treated nets (United States Agency for International Development, n.d.).

What observers and practitioners of social marketing do not realize is that the majority of financial support for social marketing programs across the world is done by government and international aid organizations that define social marketing by whether it is tied to the development of more efficient and responsive promotion and distribution systems of socially beneficial products and services (DFID Health Systems Resource Centre, 2003; United Nations Population Fund, 2002; United States Agency for International Development, 2009). Walsh *et al.* (1993) noted that the earliest social marketing interventions emerged in the international development field, partly in response to the frustration of donors with the slow pace of diffusion of clinic-based family planning services. They and other reviewers (Harvey, 1999; Meadley *et al.*, 2003) have pointed to the Nirodh condom project in India in 1967, as the first attempt to incorporate marketing practices of consumer research and segmentation, branding, advertising and promotion, pricing and product distribution strategies (including partnerships with private sector retailers such as pharmacies) to generate awareness, demand and use of contraceptive products and services. Along with its expansion to other national family planning programs, social marketing was quickly adopted among practitioners in the child survival and maternal health fields, with oral rehydration products to combat the effects of diarrheal diseases becoming a major emphasis (Manoff, 1985). When the HIV epidemic emerged, social marketing was seen as a ready-made tool for the distribution of both behavior change messages (abstinence, fidelity and safe sex) and barrier methods to prevent disease transmission (Meadley *et al.*, 2003).

In developed countries, the pioneering applications of social marketing were first seen in the 1980s by the National High Blood Pressure Education Program of the National Heart, Lung and Blood Institute (NHLBI; Ward, 1984), the Stanford five city project and the Pawtucket heart health program, two community demonstration projects to reduce cardiovascular disease morbidity and mortality also funded by the NHLBI

(Lefebvre and Flora, 1988), and the "Quit for Life" program in New South Wales, Australia (Egger *et al.*, 1983). Very rapidly, social marketing was adopted by other agencies working on public health issues (notably the Center for Substance Abuse Prevention and the Office of Cancer Communications at the National Cancer Institute in the USA, the Victorian Health Promotion Foundation in Australia; the Health Sponsorship Council in New Zealand; and the National Social Marketing Centre in the UK) as well as by a growing number of state and local agencies working primarily in chronic disease prevention, transportation safety and substance abuse. The centers for disease control and prevention also became a proponent of social marketing (Kroger *et al.*, 1997; Roper, 1993; Wong *et al.*, 2004). One may wonder if the presence of a more developed and vibrant private sector and marketplace obviated the need for social marketers in these contexts to focus on health-related products and services.

Progress in applying social marketing to public health and social issues

The field of family planning and reproductive health has been a major focus of social marketing efforts around the world. However, significant attention has also been given to maternal and child health, control of diarrheal diseases, increasing the demand and access to quality health services, HIV/AIDS prevention and malaria control. The social marketing of products, in particular condoms for both family planning and HIV prevention, oral rehydration products for diarrheal diseases, and bednets for malaria control has typically been done by setting prices that are usually heavily subsidized by the program sponsors or donors (though in the past few years free distribution of products by social marketing organizations has also been done). Because of this approach to product sales and purchases, these social marketers have become the strongest advocates and practitioners of brands, pricing strategies and distribution networks as core elements of the social marketing approach. In addition, international social marketing organizations have led the development of an approach to services marketing known as social franchising. In the prototype for family planning services, social franchising supports long-term contraceptive methods and broader reproductive health care and seeks to involve the participation of trained health providers. Networks of providers, or franchisees, are service producers in the clinic franchise system; they create standardized services under a franchise name. The result is a network of service providers offering a uniform set of services at predefined costs and quality of care (Stephenson *et al.*, 2004).

So pervasive is this approach to social marketing that has often been defined as the distribution and promotion of commodities (family planning products, condoms, bednets) at subsidized price (Nugent and Knaul, 2006). Indeed, for many donors, practitioners and critics of the social marketing approach in developing countries, the price of products and services is a crucial element of the marketing mix. There is also a shared concern among these stakeholders about the effect of pricing strategies on program reach, product or service usage rates, and its impact on equity and social justice. For example, the social marketing of bednets for malaria control in rural Zambia resulted in improvements in knowledge, access and self-efficacy, yet, there was little change in net use among the lowest SES group, and among non-users, 92 per cent reported price as being the most significant barrier (Agha *et al.*, 2007). The authors concluded that the costs of bednets would have to be significantly lower than the already highly subsidized cost to improve use among the poorest people in the country

and that complimentary strategies to achieve 100 per cent coverage and use are necessary (Lengeler and deSavigny, 2007). Other people look at these and other data (Fegan *et al.*, 2007; Mathanga *et al.*, 2005) and call for the elimination of social marketing altogether because of its failure to meet the needs of the poor (Kyama and McNeil, 2007).

In reviewing the evidence for the effectiveness of 65 social marketing programs in five health areas across the developing world, Chapman *et al.* (2005) concluded:

> The social marketing evidence base is growing rapidly and is almost exclusively related to HIV/AIDS, maternal and child health, malaria in the general population, and family planning and reproductive health. In terms of the impact of social marketing on health status, interventions to prevent malaria have the broadest and most conclusive evidence base. In terms of the impact of social marketing on behavior change, the evidence base is large in the area of HIV/AIDS and family planning/reproductive health for product use and maternal and child health, reproductive health and family planning and HIV/AIDS for non-product-related behaviors. Evidence for changes in opportunity, ability and motivation constructs was found for social marketing programs in the area of HIV/AIDS, family planning and reproductive health and maternal and child health.

In contrast to the experience in developing countries, social marketing in developed markets has tended to focus on the prevention and reduction of risk behaviors for chronic diseases and the use of addictive substances (notably tobacco and illicit drugs). Just as the strong support of various donor agencies for a social marketing approach emphasizes access to health-related products and services in developing countries, the focus on risk behaviors and communication and education approaches to their amelioration in developed contexts can be attributable to the priorities and philosophies of the governments that fund them. As a result, and guided by the determinants of these diseases, social marketers have made behavior change their default option or major outcome of interest, putting behavior ahead of product and services in the marketing mix. This has led, in too many cases in our estimation, to the use of persuasive communications and other elements of health communication to achieve these ends and a lack of attention to developing products and services to address public health needs.

What is social marketing?

We have been focused on the differences among social marking practice in developing and developed world contexts. We also are aware that there is a growing appreciation of the need to bridge these differences and also express the full potential of social marketing activities. In the next section, we offer a model that integrates the two perspectives.

In its most elemental form, social marketing is the application of marketing principles and techniques to foster social change or improvement – whether that change is related to public health challenges, injury prevention (Smith, 2006), environmental issues (Maibach, 1993), transportation demand management (McGovern, 2005) or other social needs. The National Social Marketing Centre (n.d.) uses similar language in its definition of social marketing as "the systematic application of marketing concepts and techniques, to achieve specific behavioural goals, for a social or public good." In this definition, they choose we have already seen other authors do, to elevate behavior change as the ultimate goal of all social marketing programs; a decision we do not contest, but which speaks more to social marketing and public health professionals than to the broader world.

From this shared passion of using marketing to address social improvement goals, two distinguishing elements of an integrated social marketing approach are suggested.

Social marketing is focused on people, their wants and needs, aspirations, lifestyle, freedom of choice. All marketing activities begin with a focus on understanding people – their wants and needs, aspirations, lifestyle and choices. However, we also must recognize that a focus on people is not the exclusive province of social marketing, and may in fact provide us common ground to adopt the ideas and approaches of other professionals who start from our shared premise – it is the people first (design thinking is but one recent addition to this tableau, Brown, 2008; Brown and Wyatt, 2010). Yet, it does become a defining and attractive feature for other professionals. For example, Ling *et al.* (1992) noted that conducting research that seeks to understand people on their terms, developing insights into how social benefits and individual needs and realities can be mutually accommodated, and fashioning programs that blend an objective or social perspective with a consumer-centric approach resonates with public health philosophies and approach. These overlapping values and approach are likely one reason social marketing has been so readily embraced by these professionals.

Social marketing aims for aggregated behavior change – priority segments of the population or markets, not individuals, are the focus of programs. Social marketing is one of the few intervention strategies that explicitly reject the "clinical model" or education approach for public health or population-level change. Indeed, it was the challenge of creating large-scale behavior change programs in countries (India) and in communities (Lefebvre and Flora, 1988) that led to its development and adoption across the globe. As a population or social change methodology, social marketing must be based on theoretical models that guide the selection of the most relevant determinants, priority groups, objectives, interventions and evaluations for scalable behavior change such as theories of diffusion of innovations, social networks, community assets, political economics and social capital. Unfortunately, the vast majority of programs continue to be developed from individual models of change (Lefebvre, 2001) that constrain our ability to design interventions for scale. When one looks at the success of international social marketing programs in their ability to achieve scale and impact on a national level, one hypothesis for their success may be that markets, not individuals, are their focus for analysis, planning and implementation.

The social marketing idea

With these core principles in mind, an integrated social marketing model has four inter-related tasks that revolve around an identified benefit for a target market or priority segment of the population (Figure 1). Tailoring these four tasks to the unique benefit of the market is what distinguishes social marketing from health communication, community based, education, economic and advocacy efforts aimed at social change.

The audience benefit

Benefits exist in the mind of the audience, consumer or user (Sutton *et al.*, 1995). They are not tangible things, though tangible items (iPod), the service experience (Starbucks) and the behavior being proscribed (rebellion against tobacco industry manipulation by the truth® campaign) can sometimes capture the essence of a benefit if carefully designed. Benefits tap into and satisfy an underlying motivation of groups of people (or segments); these benefits are not health, a cleaner environment, access to services or even money.

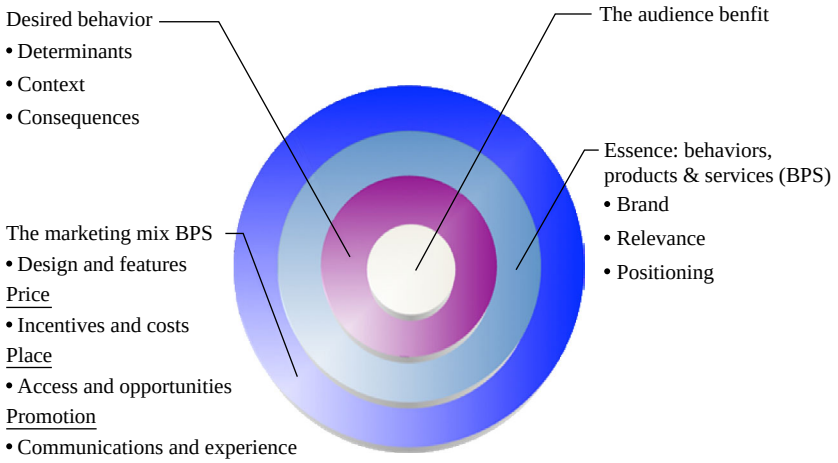

Figure 1.
The integrated social marketing idea

For example, Kaufman (2010) reports on the energy and climate project in Kansas that seeks to reduce residents' use of fossil fuels. The insight by the leader of this project was to not focus on climate change as the reason to change consumption behaviors: "why not identify issues that motivated them instead of getting stuck on something that did not?":

> Invoking the notion of thrift, she set out to persuade towns to compete with one another to become more energy-efficient. She worked with civic leaders to embrace green jobs as a way of shoring up or rescuing their communities. And she spoke with local ministers about "creation care," the obligation of Christians to act as stewards of the world that God gave them, even creating a sermon bank with talking points they could download. Relatively little was said about climate.

The results to date note a savings of more than 6 million kWh during the program's first year. In addition, the installation of permanent energy saving measures such as interruptible thermostats and more efficient air conditioning contributed an additional 7 million kWh annual savings. The winning town in the community challenge reduced its energy consumption by 5.5 per cent compared with a control community that did not participate in the challenge (Fuller *et al.*, 2010).

On a similar theme about the importance of personally relevant benefits, Rangan *et al.* (1996) identified that for many social marketing programs, the lack of short term, concrete benefits that accrue to an individual as a consequence of their actions is a major barrier to success. The lack of these types of benefits often differentiates social marketing programs from their commercial counterparts. Then, they point out, there is the added issue that the community may oppose the change being advocated by the social marketing program (for example, family planning, efforts to reduce deforestation or energy use, sex education for STD/HIV prevention in schools). The authors recommended that different forms of social marketing will be required dependent upon whether the costs to individuals were perceived as falling on a continuum of high to low, and where tangible benefits were seen as accruing more to individuals or whether they were intangible and of benefit to the larger social good. An excellent example of this trade-off and its implications for programs and policy is the analysis by Teklehaimanot *et al.* (2007) of whether the distribution of malaria nets is for the protection of individuals in which individuals

are seen as responsible for their purchase and use or whether the large-scale use of nets conveys a "herd protection" – social good – that argues for public sector financing and distribution to all.

Target behavior

Another hallmark of social marketing has been its focus on population-based behavior change. This behavior change might be product adoption and use, accessing services or adopting health protective/preventive behaviors. In the past, some social marketing programs in developing countries were content to report unit sales and visits. However, squarely placing behavior change as the outcome of interest has enormous implications for program design as focus and accountability moves from productivity and efficiency metrics to consumer response, use and satisfaction.

As shown in the Figure 1, there are three sets of questions about the target behavior that program designers must address – the precise nature of those questions will vary depending on the theoretical perspective they bring to the task. For instance, a review of the most commonly used theories and models in 497 health education/health promotion articles over a two-year period found that the health belief model, social cognitive theory, theory of reasoned action, community organization, stages of change and social marketing were the most frequent cited ones when any were mentioned at all (Glanz *et al.*, 1997, p. 29). This small number of theories and models may place major constraints on what social marketing programs focus on (e.g. behaviors or social structures), their assumptions of underlying determinants (e.g. beliefs, intentions, self-efficacy, social determinants, social norms) and important outcomes (e.g. behavior versus policy change). What the social marketing approach embraces is understanding the determinants, context and consequences of current behaviors, and desired ones, from the point-of-view (POV) of the audience – not from any one or set of theories and models. How this triad of determinants, context and consequences are conceptualized and operationalized by social marketers needs to include social and community variables, some of which may fall under the rubric of context (poverty, housing conditions, literacy, the quality of built and natural environments, social capital, working conditions, public policies and community assets) – a context not only to understand, but also to target for change. There has been a bias towards changing individuals in social marketing programs (whether through education, exchanges or policy); we need to become more aware of the possibility that we may often confront contexts or markets that require changing to improve social conditions, not the people themselves.

Finally, the consequences of current and alternative behaviors need to be assessed. What intrinsic, social and other rewards, modulators and punishments exist or can be created to enable people to move to healthier and more productive lives? Applied behavioral analysis, growing out of the operant conditioning learning model, has espoused this view for decades. Economists point to monetary rewards and penalties as one of the more important policy levers in influencing behavior change. Behavioral economics has emerged as a blending of these two POV (Kagel and Winkler, 1972) and today has gained the attention of policymakers and the public through several best-selling books (Levitt and Dubner, 2005; Thaler and Sunstein, 2008). Insights into how current behaviors are maintained, and how we shape and design healthier or more socially beneficial ones, need to reflect our understanding of these dynamics in people's everyday lives and be explicitly incorporated into social marketing programs.

The marketing mix

Behaviors, products and services

It has become clear to social marketers that products and services can be necessary, but not sufficient, conditions to improve health (e.g. condoms for HIV prevention, bednets for malaria control). What is crucial is that people must use these products and services (e.g. family planning, HIV testing and counseling centers, prenatal clinics) and change behaviors to impact morbidity and mortality. We are not satisfied with sales figures, visits, products distributed, reach, exposure and other measures of process – behavioral outcomes define success. Health and social outcomes then follow.

Behavior change is an incremental process that must start with people's current realities and the suggested behaviors must be relevant to their lives – not a theory or research finding. Thus, while programs may have desired behavioral outcomes, helping people get to that point may mean designing programs that focus on shaping, or targeting incremental, behaviors (Sutton *et al.*, 1995). For example, while consistent use of a condom in high-risk situations may be an objective for an HIV prevention program, depending on the audience the incremental behavioral steps might include seeking out and getting one, negotiating with a partner to use it and then correctly using it. When thinking about HIV prevention more broadly, other behavioral steps include getting tested for HIV, being faithful to a partner, abstaining from sex and getting prophylactic treatment if pregnant and HIV positive to prevent HIV transmission to the infant. The important point that social marketing brings to this discussion is that the behaviors we focus on should be ones that the people we work with agree are relevant, possible and they believe they are able to do in their daily lives (not just as part of a research protocol). If not, then we need to back up and work on earlier steps in the behavior change process.

Social marketers, especially in developed countries, must also recognize that access to affordable products and services may have a significant impact on people's abilities to engage in certain types of behaviors. These access and price issues may range from how information is retrieved and displayed on the internet for people with low health literacy skills, to whether clean water or point-of-use treatment products are available to survivors of natural disasters.

Whether it is a behavior in the chain of steps to the ultimate target behavior, or a product or service offering that supports or enables behavior change, the ideas of branding, personality (image or tone) and positioning come into strategic play (Evans and Hastings, 2008). Explicit here is the need to understand the competition, whether it is other organizations, interests and programs or competing behaviors (doing one thing versus another). Branding is not the logo, theme song and tagline of an organization or agency, the campaign or a program; it is what the behavior, program and sponsor mean to the people. An exemplar of this approach is rare international's species conservation programs that use a threatened species for image and communication purposes, but have national pride as the brand that supports behavior and conservation objectives (Boss, 2008).

All social marketers need to embrace the development and marketing of products and services that lead to or support behavior change as part of their core competencies. These products and services might not be developed by the usual social marketing organizations, but instead by social entrepreneurs or for-profit companies (Pilloton, 2009). How to position and market the social benefits of these products and services to

priority groups is the strength social marketers can bring to these offerings. These products and services likewise need to be thought about in terms of how their use and the experiences they create for people reinforce or inhibit healthier choices and facilitate or impede access and opportunities to practice them (Brown, 2008).

The unique and shared needs among members of our priority population groups are often the basis for segmentation, or the division of large heterogeneous markets into smaller ones that facilitate behavior change efforts. These smaller markets share certain characteristics in common, and it is these characteristics that dictate a specific mix of marketing elements tailored for them. This tailoring extends beyond communications (Kreuter *et al.*, 2000) to include the features and benefits of the target behaviors, products and services; prices; places or distribution points; and promotional or communication elements (see below for further discussion of each of these). However, what Yankelovich and Meer (2006) observed in the commercial marketing field is equally valid for social marketing:

> Market segmentation has become narrowly focused on the needs of advertising, which it serves mainly by populating commercials with characters that viewers can identify with – the marketing equivalent of central casting [...] The idea was to broaden the use of segmentation so that it could inform not just advertising but also product innovation, pricing, choice of distribution channels, and the like.

We need to value segmentation beyond the "casting call" for images and voices and think about it as it can impact behavior offerings, product and service design, benefits offered and distribution strategies.

Price

Social marketing has taken the idea of price beyond monetary ones to include psychological, social, geographic and other rewards and punishments for everyday behaviors (Lefebvre and Flora, 1988). Economists and marketers view price not just as costs, but as incentive opportunities as well (Fiszbein and Schady, 2009; Haveman, 2010). As a simple example: a woman in a rural village is not likely to take her sick child to a health clinic, even if the cost for services is nominal, if it takes her five hours each way to reach it and return home, robs her of the ten hours of earning power she may have, and risks the social alienation that may follow if her child is discovered – her worst fear – to be HIV positive. An exclusive focus on just monetary costs limits programs and leads to marketing myopia as much as would a focus on only psychological, social or physical barriers. If we understand the consequences of behavior and behavior change, then we can begin to judge the salience of various levels and types of prices for current and alternative behaviors from the audience POV. We then have the chance to develop programs that realign incentives and costs for products, services and behaviors that resonate with people and lead to better outcomes.

The explicit adoption of incentive pricing is seen in programs that are testing the use of conditional cash transfers (CCTs) in Latin America, southeast Asia, South Africa, Washington, District of Columbia and New York city (Fiszbein and Schady, 2009). The premise of CCT programs is to transfer cash, generally to poor households, on the condition that those households make specific investments in their children. Among the behaviors that are being investigated by these programs are ones that improve health and nutrition such as require periodic checkups, growth monitoring and vaccinations for children less than five years of age; perinatal care for mothers and

attendance by mothers at periodic health information talks. Education is another major focus of these CCTs, and the behaviors these programs focus on include school enrollment, attendance on 80-85 per cent of school days and some measure of academic performance. Other types of incentive programs that have been used to promote behavior change include ones for smoking cessation (Hey and Perera, 2008) and the use of children's booster seats in motor vehicles (Ehiri *et al.*, 2006).

Realigning incentives and costs means more the simply trying to convince people to use a new set of variables and weights in their personal calculation of risks and benefits of acting in certain ways. Realignment also means adjusting the environment, policies and marketplace whenever possible to shift power to the individual to have freedom to choose and to exercise basic human rights. We need to start asking ourselves questions like: where do inequities in health status stem from? Is income generation a prerequisite for health improvement in impoverished communities? How do we facilitate making markets work for the poor and vulnerable? The evolution of marketing for social change will have to expand beyond individual choices to markets and societies and how they shape the benefits, opportunities and choices that are available to various groups of people.

Place

Access to health-promoting products and services can be the large gap between wanting to engage in a healthier lifestyle and being able to do it (how do we place opportunity within an arm's reach of desire?). Equally important, especially to the behavior change-minded social marketer, is creating access and opportunities to perform healthier behavioral alternatives – or not practice the unhealthier ones. Clean indoor air laws clearly address the latter issue, while increasing the availability of fresh fruits and vegetables, having more safe places to be physically active and offering healthier options in restaurants and fast service establishments are examples of improving access and opportunities to engage in healthy behaviors.

Whether people successfully adopt new behaviors and use health promotion products and services revolves around creating opportunities and access for them to try, practice and sustain them. Social marketing must take distribution systems, in all their forms and expressions, as seriously – if not more so – as the messages and creative products it produces. People do not just think or choose their way to try new behaviors, products or services – they must have access to the information they need to make informed choices in ways, places and times that literacy, cultural and other considerations should inform.

It is the role of place or distribution that lies at the heart of concerns over inequities in health status and social justice. Viswanath and Kreuter (2007) argue that communication inequalities among social groups may act as a significant deterrent to obtaining and processing information; using the information to make prevention, treatment and survivorship-related decisions; and in establishing relationships with providers – all of which impact prevention and treatment outcomes. Marketers should be especially attentive to these possible untoward effects of the distribution of communication activities and also more active in designing efforts to address existing inequalities and preventing future ones.

Promotion

Communicating these behaviors, products and services, incentives, and opportunities to priority markets has become mired in old, linear communication models of

source-message-channel-receiver (or inoculation models). Any program that knows its market and has tailored its offerings to the characteristics and contexts of it will have products, services, behaviors and communications that are appropriate for their literacy level and cultural background. However, the cultural and technological revolutions, we are experiencing in communications (e.g. social and mobile media, interactive web sites) must lead to the adoption of modern communication models to frame our thinking and activities that include the ideas of social networks and dynamic, reciprocal communication patterns (Lefebvre, 2007). These innovations also force us to think about how to surround people with our programs and messages and provide them with multiple opportunities to be exposed to behaviors, products, services and communications in order to lead to behavior change (Lefebvre *et al.*, 1999; Resnicow and Page, 2007).

An under-appreciated aspect of communication theory that supports marketing, and especially the creation and change of markets and policies, is agenda-setting theory: how to develop and marshal support for public policy initiatives among policymakers, the media, opinion leaders and the general public. These public policy initiatives can set the context for the offering of new or expanded products and services or change the context in which unhealthy behaviors may have been supported and/or healthy behaviors made difficult. Media advocacy and social marketing, while favoring different tactics, both focus (or should) on broader population change objectives that alter the 4P context (the environment or marketplace) in which behavior occurs. Signs of this overlap become clear as one considers the use of demarketing strategies by many tobacco control policy initiatives that focus on increasing the price of tobacco, restricting access and sales, removing opportunities to smoke, banning various promotions and advertising activities, and increasing access and opportunities for smoking cessation services (Shiu *et al.*, 2009). Too few social marketing efforts expand beyond 1P marketing efforts that favor communication tactics and vehicles – public service announcements, posters, pamphlets, public relations, entertainment-education, social and mobile media. Promotions (communications) need to work with the other 3Ps in an integrated way across individual, organization and policy levels to increase the likelihood that a high percentage of people in our priority audience engage in healthier and socially beneficial behaviors.

The common challenges for social marketing

We have identified six challenges that are applicable to social marketing across the globe. These challenges include:

(1) equity;
(2) social networks as determinants of behaviors;
(3) critical marketing;
(4) sustainability;
(5) scalability; and
(6) comprehensive programming or the total market approach (TMA).

The first challenge is striving for equity in health status among all people. Marketers who work for public health and social change must embrace the philosophy that equity in health status and social justice is an integral part of their work. Donovan and Henley (2003) included the United Nations Charter for Humans Rights as part of their introduction to social marketing. In the developing world markets, we are beginning to see the ability to

reach and improve the health status of the poor as a common evaluation question for these programs. In the developed world, the reduction or elimination of health disparities is part of the drive towards health equity. What social marketing research and practice can advance as a core issue is how we can improve our ability, and that of society, to address equity and justice through the conscious and deliberate use of marketing.

A second major challenge social change programs face, and we believe social marketers may be in a strong position to tackle, is the shifting frame of determinants from individuals to networks and communities. In three major areas of interest for public health officials and social marketers – HIV prevention (Adimora *et al.*, 2007; Mah and Halperin, 2008), obesity (Christakis and Fowler, 2007) and tobacco use (Christakis and Fowler, 2008) – the role of social networks in disease transmission and the prevalence of risk behaviors is creating new opportunities for both concepts and practices that are larger than the usual frame of individuals. Where this trend may go in the next few years is an open question, but this is one area where we see the blending of social media and mobile marketing techniques that exploit these networking phenomenon (e.g. Facebook and other social network sites) with more typical social marketing paradigms as a fertile one for exploration and discovery (Lefebvre, 2009).

Countering the pervasive influence of commercial marketing practices has been termed "critical marketing." Hastings and Saren (2003) have put forth the argument that social marketing, with its unique nature of having insights into both the public health and commercial sectors, means that they can contribute to broader social goals by:

- identifying how marketing practices influence behaviors for both individual and social harm and good;
- by analyzing the market forces in play, suggest solutions to improve benefits and reduce costs to both; and then
- lead efforts to harness the power of markets to benefit society.

They propose that social marketing should concern itself not with just behavior change, but also with the analysis of the social consequences of marketing policies, decisions and activities. This approach holds promise across many global health issues including tobacco use, obesity and global warming. Moving social marketing into public policy analysis and discourse through critical marketing studies is a vital element for the continued vibrancy and relevance of the field to our stakeholders.

The sustainability of public health programs is one of the more important topics in both the health promotion (Swerissen and Crisp, 2004) and social marketing literatures. Lefebvre (1989) formulated a social marketing approach to sustainability of community-based heart disease prevention programs that consisted of a portfolio analysis of offerings to assess the relative strengths and weaknesses of programs to achieve long-term maintenance in the community when grant funding ended. This analysis led to decision-making processes and the development of product- and service-specific marketing plans. Bryant *et al.* (2000) and McKenzie-Mohr and Smith (1999) have also examined the sustainability of programs in the context of community-based social marketing and stress the desire for community participation and ownership from the beginning of the program planning process to optimize long-term success. Yet, sustainability remains an illusive quality for social change programs of all types – not just social marketing ones. How we can think about sustainability as a marketing problem, whether it requires new ways for us to think about our business models for social

marketing (instead of being so dependent on government and NGO grants and contracts), and if changing markets should become a core sustainability strategy has received little attention or debate among the broader community of social marketers. We could be leaders in developing models that are responsive to local conditions and economies, rather than ceding them to social entrepreneurs and marketers focused on the base of the pyramid (Lefebvre, 2008).

Social marketing must confront the challenge of scaling up programs that have been shown to be effective in promoting health and other social causes in pilot and demonstration projects or larger efficacy and effectiveness. As one step in this direction, social marketing may offer many different stakeholders a methodology to systematically develop dissemination efforts of all kinds. Maibach *et al.* (2006) propose that marketing of evidence-based programs can start by conducting consumer research with prospective adopters, building sustainable distribution methods and improving the access of prospective users to programs that are easily implemented.

As one example, The Global HIV Prevention Working Group (2007) noted with concern: "Despite the extraordinary potential of available prevention strategies, most people at risk of HIV infection have little or no access to basic prevention tools." They cite that despite what is known about HIV prevention and what works, only 9 per cent of risky sex acts worldwide are undertaken while using a condom, and the global supply of condoms is millions short of what is needed. Only 12 per cent of men and 10 per cent of women in the most heavily affected countries of sub-Saharan Africa know their HIV status. About 11 per cent of HIV-infected pregnant women in low- and middle-income countries receive antiretroviral prophylaxis; and prevention services reach only 9 per cent of men who have sex with men, 8 per cent of injection drug users and under 20 per cent of sex workers.

Our challenge, whether it is in HIV prevention, the prevention of childhood obesity or any other social issue, is to apply the evidence-base of diffusion research to social marketing programs to both spread adoption and increase the scale of successful programs. To do so, researchers and their funders must appreciate that developing and testing programs meant to achieve scale at the community or national level need to be designed with that intention and not always be focused on answering circumscribed questions addressed by controlled experimental designs that offer little chance of replication in the field.

The TMA has emerged to counter the possible negative impact of social marketing programs that offer subsidized products and services on private sector development as well as to articulate clear exit strategies (independence from donor subsidies, Pollard, 2006). TMA offers social marketers across the globe a model that can bridge, and even coalesce, the gaps between the public, NGO and private sectors in offering health programs, products and services. The TMA to the delivery of commodities and services within low-income countries sets out to establish equitable, efficient, sustainable and affordable markets for health commodities and services across all populations. Its objectives are to ensure subsidies are targeted to those who are most in need of them, that the very poor are equitably served, and that sustainable commercial markets are created. It establishes clearly defined market segmentation strategies within which each player in the supply chain works to enhance demand and effectively target supply across the total market – the public sector, the NGO/community sector and the commercial sector, and across all donors (Pollard, 2006).

We suggest that the TMA model should receive more attention in social marketing and among pubic and social planners. It embraces the idea that markets for socially beneficial goods and services do exist in some form in all settings, and recognizes the realities that poor and vulnerable populations must be protected from market failures. Some of these failures may stem from externalities where added social benefits may favor some goods and services over others; poverty where the willingness to pay and markets for heath promotion and protection goods and services may not exist; the designation of merit goods that society believes should be available to all people; the availability of information about the need and benefits for products and services; and gender inequalities that will impact the ability of women to have access to and fully participate in the marketplace (Lefebvre, 2008). TMA and similar ideas challenge social marketers to think more about the marketplace, rather than individuals, as they analyze problems, propose solutions and implement and evaluate actions.

Conclusions

The parallel evolution of social marketing thought and practice has made it difficult for social marketers around the world to share a common perspective on addressing pressing human and social needs that, in turn, makes the diffusion of innovations and best practices difficult. It also keeps social marketers fractured and unable to coalesce around important professional issues and move the field forward as a unitary force.

We have attempted here to highlight where those different paths have taken social marketing and where, in the past few years, they have begun to converge. We see the common agreements on the unwavering focus on the consumer and social change outcomes. There are also central themes that social marketers use in their practice that include audience benefits as a core offering of social marketing programs; utilizing audience research to understand the determinants, context and consequences of behavior; and fashioning products, services and behaviors that are positioned to meet the unique needs of segmented priority markets. Social marketers also share a commitment to using the marketing mix to design products, services and behaviors; realign incentives and costs; improve access and opportunities; and communicate in a multiplicity of ways – all of which are relevant and responsive to the people they serve. Finally, the challenges noted here can serve as opportunities for the field to collaborate and collectively advocate for the importance of social marketing to societies with the desire to move towards a healthier, more just, and more engaged people.

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