

2 Second in a series of Turning Point
resources on social marketing



Social Marketing and Public Health Lessons from the Field

A Guide to Social Marketing

from the Social Marketing
National Excellence Collaborative



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May 2003

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About Turning Point and the Social Marketing National Excellence Collaborative







Turning Point, started in 1997, is an initiative of The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation. Its mission is to transform and strengthen the public health system in the United States by making it more community-based and collaborative.

The Turning Point Initiative established the Social Marketing National Excellence Collaborative to promote the application of social marketing principles and practices to improve public health across the nation. The Collaborative's membership includes six states (Illinois, Maine, Minnesota, New York, North Carolina, and Virginia) and two national organizations: the Centers for Disease Control and Prevention (CDC) and the Association of State and Territorial Health Officials (ASTHO).

The mission of the Collaborative is to provide national leadership to achieve integration of social marketing as a routine part of public health practice at all levels. A major goal of the Collaborative is to provide state and local health professionals with the skills and tools needed to effectively apply social marketing research and practice to public health issues within their communities. *Lessons from the Field* is one of the tools developed to help state, local, and not-for-profit professionals apply social marketing to public health issues.

For more information on Turning Point and on other tools developed by the Social Marketing National Excellence Collaborative, please go to the Web site, www.turningpointprogram.org.

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Introduction



Social Marketing: It's Effective, Efficient, and Proven

Social marketing can enhance the effectiveness of our efforts to protect and improve public health. Using marketing to conduct public health improvement campaigns can help clarify what we want to accomplish and can help us be more productive with limited public health resources. The goal of this document is to make that task easier.



Practical Information You Can Share with Others

This guide provides examples of how social marketing strategies have been and can be applied to everyday public health challenges.

Because marketing has often been confused with advertising or promotion-only efforts, health professionals will benefit from understanding the key principles and marketing tools (the 5 Ps, see pages 8-10) involved in a social marketing approach. The examples listed here have been selected to illustrate the key concepts of marketing and to document to what extent these principles have been applied in the cases presented.

It should be noted that these cases are not intended to be perceived as “best practices,” and not all of them were originally evaluated for outcome effectiveness. The cases have been evaluated to determine to what degree each case applied the key principles of marketing. Some of the cases suggest how a marketing orientation can improve program outcomes. All of the cases offer good reasons why we should more often use the principles, techniques, and tools of marketing when addressing issues of public health.

Currently, the execution of social marketing programs in public health is dominated by message-based, promotion-only strategies. To most effectively integrate social marketing into the disciplines encompassed by public health, it is critical to have a strong understanding of each field. This guide is designed to give readers a good head start on learning about the social marketing field and its application to health issues.

For a deeper understanding of social marketing we encourage you to consult the resources and references listed on pages 3-5 and in the bibliography.



How to Use This Guide

If you are a novice, begin by focusing on the core concepts and how they are applied. Then scan the case studies to see how diverse perspectives have come together. If you are familiar with social marketing, you might prefer to scan the core concepts as a refresher and focus more strongly on the case studies. If you're an advanced user, you may simply wish to use this guide as a resource for situations in which you have to teach others about social marketing. In those situations, the case studies and the core concepts are very useful tools for teaching.

Resources



Centers for Disease Control and Prevention

CDC sponsors local social marketing campaigns on a demonstration basis as well as some large national campaigns (see, for example, www.cdc.gov/youthcampaign/verbCampaign.htm). Several of the campaigns make materials available for local adaptation; the current campaigns are listed at: www.cdc.gov/communication/campaigns.htm.

Some of the CDC campaigns incorporate aspects of a CDC “brand,” *Prevention Marketing*, in which local community members actually direct the planning of a social marketing program. A 1996 manual entitled *Applying Prevention Marketing* provides easy-to-read instructions, tips, and resources on topics including coalition building, social marketing, research and evaluation, and media relations. It is available from the National Prevention Information Network at www.cdcnpi.org or 1-800-458-5231. A detailed example of Prevention Marketing is provided at the following Web site: www.cdc.gov/hiv/projects/pmi.



Social Marketing Quarterly

This peer-reviewed journal contains national and international research studies, articles on social marketing theory and applications, abstracts of articles from other journals, reviews, curricula, and commentary. It also lists conferences, jobs, service, and program updates. For more information on the *Social Marketing Quarterly*, you can contact:

Best Start Social Marketing
4809 E. Busch Blvd, Suite 104
Tampa, FL 33617
813-971-2119

Or visit them on the Web at www.beststartinc.org/



Novartis Foundation

For a concise introductory read, see: *A Short Course in Social Marketing*, on the Web site of the Novartis Foundation for Sustainable Development:

www.foundationnovartis.com/social_marketing.htm



The Social Marketing Institute

Subtitled *Advancing the Science and Practice of Social Marketing*, the Web site of the Social Marketing Institute (SMI) is a key connecting point for the profession. SMI offers a growing collection of “success stories,” job listings and articles, listings of conferences and events related to social marketing. Its list of related Web sites and the discussions available through the social marketing listserv provide quick access to a broad, deep array of expertise and insights.

Social Marketing Institute
1825 Connecticut Avenue NW, Suite S-852
Washington, DC 20009
www.social-marketing.org/



Health Canada's Social Marketing Network

This Web site offers a rich set of resources, including case studies and updates on Canadian social marketing initiatives, conferences, papers, and the online tutorial *Best Practices and Prospects for Social Marketing in Public Health*, by François Lagarde.

www.hc-sc.gc.ca/hppb/socialmarketing/



Fostering Sustainable Behavior

Fostering Sustainable Behavior is the title of a Web site and the book that it contains, subtitled *An Introduction to Community-Based Social Marketing*. The Web site consists of an online guide for designing and evaluating programs, searchable databases of graphics, **case studies**, articles, and a discussion forum. A "Quick Reference" section offers practical tools for designing, implementing, and evaluating social marketing strategies.

www.cbsm.com



Tools of Change

This Web site is subtitled *Proven Methods for Promoting Health and Environmental Citizenship*. Detailed case studies from the U.S. and Canada provide examples of how specific community-based social marketing (cbsm) tools have been used for public health and environmental tasks in various settings. Its *Introduction and Site Guides for Health Promoters* and separate *Introduction and Site Guide for Social Marketers* "connect the dots" between these two fields. Co-sponsored by Health Canada, Environment Canada, Natural Resources Canada, Cullbridge Marketing and Communications, NRTEE, and the Federation of Canadian Municipalities.

www.toolsofchange.com/



Innovations in Social Marketing Conference

This annual conference brings together invited academicians and selected practitioners at the local, state, national, and international levels. Oral and poster presentations address topics ranging from corporate partnerships and knowledge dissemination via the Internet to the use of census data and cause branding for social change.

<http://smgproj.bu.edu/smg/ism2001/>



The Communication Initiative

This Web site is a window to theory and practice in international communication, behavior, and sustainable development strategies. Social marketing and public health are among the top priorities addressed by slide presentations describing models, change theories, and evaluation strategies. The site lists training programs, conferences, job listings, consultants, online forums, listservs, and updates from around the world.

www.comminit.com/



The Social Marketing in Public Health Conference

Held annually in or near Tampa, Florida, this training conference is sponsored by the Department of Community and Family Health, College of Public Health at the University of South Florida and CDC.

For conference registration information, call 813-974-6695.



The University of South Florida, Florida Prevention Research Center at Social Marketing in Public Health Field School

A carefully crafted selection of courses offered in an intensive four- to seven-day format. These "Field Schools" are organized specifically for motivated students and busy professionals to acquire skills in an intense, but exciting and highly interactive format, with some of the leading instructors in Social Marketing. Courses may be taken for USF-Graduate-credit-semester hours (toward an 18-hour graduate certificate in Social Marketing or other related graduate degree), or not-for-credit, and carry continuing education units for Certified Health Education Specialists, nurses, and registered dietitians.

These courses are scheduled before and after the Annual Social Marketing in Public Health Conference, held annually in June, and most recently, during a full week of Field School held in January (beginning 2003).

Field School information can be obtained at www.hsc.usf.edu/publichealth/conted/calendar.html.

Chapter 1: Social Marketing Defined



What Is Social Marketing

There is more than one way to define social marketing but there are three components that are essential to any definition. First is the role of marketing techniques—which necessitate putting the primary audience or target audience (aka “customer”) at the center of every decision. Second is that the focus of the endeavor is on voluntary behavior change. Third, but not least, is that the behavior change is for the benefit of an individual, group, or population, not for profit or commercial gain. Three of the most established and widely accepted definitions of social marketing are:

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviors of target audiences in order to improve their personal welfare and that of their society. (*Alan Andreasen, Georgetown University, 1995*)

“Social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole.” (*Philip Kotler, Ned Roberto, Nancy Lee, 2002*)

Social marketing is “...A process for influencing human behavior on a large scale, using marketing principles for the purpose of societal benefit rather than commercial profit.” (*W. Smith, Academy for Educational Development*)

Like other health planning strategies and models, social marketing draws on behavioral research. Some features of social marketing, such as identifying a target audience, are not unique to social marketing. For example, the widely used PRECEDE-PROCEED model developed by Green and Kreuter at the CDC also emphasizes the need to understand target audiences. Other features used in social marketing will also be familiar. However, the way these features are employed and application of the three key components described above distinguish social marketing from other approaches.



Key Social Marketing Terms

Audience segmentation

A distinguishing feature of the social marketing approach, audience segmentation is the identification and process of selecting small groups of individuals for which uniquely appropriate programs and interventions can be designed. A single behavior can result from different attributes or circumstances among varying groups of individuals. The audience segments are therefore grouped together based on shared characteristics and attributes that are linked to the behavior, such as values, knowledge, culture, behavioral determinants, opinions, beliefs, personality, and the channels that can be used to communicate with them effectively.

Barriers

Often discussed in the context of Price, barriers are hindrances to the desired behavior change as identified by the audience. These may be factors external or internal to audience members themselves (e.g., lack of proper health care facilities and the belief that fate causes illness and one cannot alter fate). See discussion of Price, below.

Benefits

Often discussed in the context of Product, benefits are advantages that the audience identifies which may or may not be directly associated with a behavior, and can be framed as the positive results, feelings, attributes, etc. that the audience will obtain from the desired behavior change. Benefits are what you offer to the audience in exchange for the new behavior. It's "what's in it for them." For example, mothers (audience) will create a loving bond with their newborns (benefit) when they breast-feed for at least six weeks (behavior).

Competition

A distinguishing feature of the social marketing approach, competition is the behaviors and related benefits that the target audiences are accustomed to or may prefer over the behavior you are promoting. The competition may also include the organizations and persons who offer or promote alternatives to the desired behavior. Imagine, for example, where we would be today without paying attention to the tobacco industry as a competitive force against tobacco control efforts. Keeping tabs on your competition, addressing your competition's key strategies, and realizing that there is always competition for the health issue/behavior you are promoting are essential in a true social marketing approach (Andreasen, 1995).

Determinants of behavior

Factors (either internal or external to the individual) that influence an individual's actions or behaviors. Behavioral science theories and models list various determinants. For example, "degree of readiness to change" is a determinant within the Transtheoretical Model/Stages of Change. Examples of determinants from other theories/models include locus of control, self-efficacy, and perceived risk.

Exchange

A distinguishing feature of the social marketing approach, exchange is the concept that people adopt/reject or maintain a new behavior in return for benefits that they believe outweigh the costs of that behavior. Apply this concept by offering the audience benefits they want in return for making the desired behavior change. For example, giving a teen audience segment a sense of being cool, "in," and accepted by their peers if in return they become or remain drug-free adolescents.

5 Ps of social marketing

Four domains of influence adopted from commercial marketing plus a fifth added as a result of the public context in which social marketing occurs. These domains or factors, as they are referred to throughout most of this document, are important to consider when planning intervention activities for reaching a target audience from multiple perspectives—Product, Price, Place, Promotion, and Policy. These terms are defined on pages 9 and 10.

Market research

Research designed to enhance understanding of the target audience's characteristics, attitudes, beliefs, values, behaviors, determinants, benefits, and barriers to behavior change. The results of this research are used to create a strategy for social marketing programs. Also called formative, consumer or audience research. Other types of market research include tracking and evaluation.

Market strategy

A guiding plan of action for your entire social marketing program, market strategy encompasses the specific target audience segment(s) and influencing audiences, the specific desired behavior change goal, the benefits you will offer, and the marketing intervention tools (5 Ps) that will influence or support behavior change. The marketing strategy must remain flexible and able to change in response to audience feedback and ongoing evaluation.

Place

One of the original 4 Ps of marketing. The component that invites consideration of where and when the target audience will perform the desired behavior or access program products/services so that it is convenient and pleasant to do so. For example, an intervention may include offering immunizations in a neighborhood or mobile clinic.

Price

One of the original 4 Ps of marketing. The component that invites planning interventions that use incentives and disincentives (they may be monetary such as rebates/discounts or non-monetary such as recognition) to minimize the costs or barriers the audience members face in making the desired behavior change (financial, emotional, psychological, or time costs). For example, training mothers in techniques (a service or product) like pumping breast milk before going out to a public venue, as a method for reducing embarrassment (a cost or barrier) about breast-feeding in public.

Product

One of the original 4 Ps of marketing. The component that includes interventions, objects, or services that support or facilitate behavior change. Examples include a journal to plan and track weekly exercise activities or a hotline that parents can call with questions about drugs. May also refer to the desired behavior or benefits that a social marketing program offers.

"In social marketing, our product is what we are selling, the desired behavior and the associated benefits of the behavior. It also includes any tangible objects and services developed to support and facilitate the target audience's behavior change."

Phillip Kotler, Ned Roberto, and Nancy Lee. *Social Marketing: Improving the Quality of Life*. Second Edition. Thousand Oaks, Ca: Sage Publications. 2002. p. 195)

Promotion

One of the original 4 Ps of marketing. This component includes the communication messages, messengers, materials, channels, and activities that will effectively reach your audience to promote the benefits of the behavior change as well as the Product, Price, Place, and Policy factors of a program. Messages may be delivered through public relations, advertising, print materials, small-group or one-on-one activities (mentoring, counseling, workshops, demonstrations, presentations), and other media.

Policy

The “5th P” in social marketing. This component leads to consideration of stimulating changes in policy and rules as a component of a social marketing plan (e.g., to accomplish environmental changes that support changes in individual behavior). It is essential that changes in these arenas support voluntary behavior change and not be coercive or punish “bad” behavior. Further, policy by itself is not social marketing. An example of a policy that facilitates voluntary change is a school district policy that supports students in adopting healthier nutrition behaviors by adding juice, water, fruit, and other healthful food choices to school food service plans and vending machines.

Target audience

The primary audience or priority population that your social marketing program seeks to reach and influence. This group is a selected portion (or segment) of a larger population that is directly affected by the health problem. It is their behavior one seeks to change through the marketing plan. Many marketing plans include communication with and activities targeting secondary audiences that then influence the decisions of the target/priority/or primary audience.

Chapter 2: Introduction to the Case Studies

All of the following case studies have been presented in different forms elsewhere, ranging from refereed journals to conference proceedings and Web sites of such reputable sources as the Centers for Disease Control and Prevention in the U.S., Health Canada, and the Social Marketing Institute. The original authors of the presentations were invited to review and update these case studies.

Social marketing is more than a message-based approach; it integrates the marketing mix of the 5 Ps (Product, Price, Place, Promotion, and Policy factors) as well as the exchange and competition factors with the outcome of behavior change. We did not include case studies or projects that called themselves social marketing but which relied on more traditional information and education–message-driven strategies based on the theory that changes in information and attitude will result in changes in behavior.

Though few of the case studies in this guide apply all of the social marketing factors with equal strength, each of the cases selected here illustrates particular factors with unusual clarity. In addition to the core social marketing factors listed below, the case studies describe relatively inexpensive approaches, the integration of qualitative and quantitative methods in evaluation, the utility of behavioral science theory in social marketing, and the often-sobering length of time required to bring about population-level social change.



Reviewing the Case Studies

In reviewing the cases, we asked the question “How well does the case address...?” each of the following factors:

How well does the case...?

| | |
|---------------------------|--|
| Audience | Identify, segment, and analyze target markets, audiences, and stakeholders they want to affect? Profile (understand) each group? Identify benefits for each target audience? |
| Formative Research | Identify existing needs, wants, benefits, barriers, and other Price, Place, Promotion, and Policy factors relevant to the Product factors, behaviors, and services of interest? |
| Behavior | Identify specific behaviors to be addressed by target audiences? Understand the epidemiological, sociological, cultural, economic, and political context related to the behavior of interest? Present a clear link between the causes of the undesirable behavior and the possible social marketing intervention elements? |
| Product | Identify and position the behaviors, services, programs, or objects to satisfy the needs and wants of the target audiences? Offer benefits consumers truly desire? |

| | |
|----------------------|--|
| | How well does the case...? |
| Price | Address the economic, social, geographic, and other costs? Identify perceived costs and barriers (disincentives) and audience-specific benefits including monetary and non-monetary incentives into the development of all 5 Ps? |
| Place | Identify and select Product delivery locations that enable access to behavior for specific audiences? Create programs that make it easier to practice behaviors of interest? Give consumers information where they are in the right frame of mind to listen, remember, and act? |
| Promotion | Tailor messages, channels of communication and strategies to reach, inform, persuade, remind and reward target populations? Select spokespersons (messengers) who are perceived as trustworthy? |
| Policy | Consider the impact of the current environment and rules that influence the ability of the target audience to adopt/reject/maintain the targeted behavior? Identify and address policy changes that need to be adopted and will facilitate the desired behavior change? |
| Competition | Identify competitive threats and build Products, Pricing, Place, Promotional, or Policy strategies to address the competition? |
| Evaluation: | |
| Process | Use a regular feedback loop from audiences to make changes in the 5 Ps when the data indicate that a change would improve results? Track audience response and make changes as necessary? Track programmatic efforts to assure the program is taking place as intended? |
| Impact | Track intermediate measures of success (e.g., intermediate behaviors, and attitudes that lead to behaviors of interest) to determine if there is progress toward the specified outcomes? |
| Outcomes | Identify appropriate outcome measures and collect data to determine if they accomplished what they intended? Provide realistic outcome measures realistic given the breadth of the health problem, the behavior, and the program resources? *Note: Outcomes can be health behaviors, policy behaviors, or health outcomes. |
| Marketing Mix | Combine the 5 Ps into a cohesive and comprehensive program that best addresses the needs, wants, and desires of the target audiences while creating sufficient stimulus to achieve program goals? |



Social Marketing Strengths at a Glance

Rating Scheme

The rating grid printed below appears at the beginning of each case. It summarizes the reviewers' assessments of the published information about each case. To make the rating grid easier to read in one brief visual, we abbreviated some of the marketing factors included in the assessment. Following the grid are the full labels each factor assessed:

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 2 | 3 | 1 | 3 | 1 | 3 | 2 | 1 |

- Aud. - Audience
- Beh. - Behavior
- Prod. - Product
- Price
- Pla. - Place
- Promo. - Promotion
- Comp. - Competition
- For. - Formative research
- Proc. - Process evaluation
- Imp./Outc. - Impact or Outcome evaluation (this is sometimes referred to as program effects)

Each principle of marketing was scored on a scale from 1-3, with 3 representing "a strong application, describing, or addressing that principle," based on the reviewers' assessments. A score of 1 is equivalent to "weakly applying, addressing, or describing a specific principle." The exceptions are the "audience" and "behavior" factors. These are scored with an "X" when an audience was described or a behavior was defined, otherwise that cell was left blank. Note that formative research is grouped with evaluation but is actually the first thing one does in a social marketing endeavor and is addressed first in each of the case studies.

Chapter 3: The Case Studies



Case Study 1

Sacramento PMI: Community Members Reducing HIV Risk

In Brief: In 1993, the Centers for Disease Control and Prevention (CDC) funded the five-site Prevention Marketing Initiative (PMI) Demonstration project to explore the usefulness of social marketing techniques for preventing HIV among young people. Community-led coalitions in each PMI site organized and began formative research in 1994. In the Sacramento site, coalition members chose sexually active 14- to 18-year-olds in zip codes with high sexually transmitted disease (STD) and pregnancy rates as their target audience. They identified condom carrying and consistent condom use with all partners in all situations as the behaviors they wanted to promote. Their *Teens Stopping AIDS* campaign included radio spots, print ads on the sides of buses, print and promotional materials that included branded condoms, an informational phone line, skill-building workshops, and peer outreach. Outcome evaluation showed that both the campaign as a whole and the workshops as a stand-alone intervention achieved the behavioral goals of the campaign.

Reference: Kennedy, M.G., Mizuno, Y., Seals, B.F., Myllyluoma, J., & Weeks-Norton, K. (2000). Increasing condom use among adolescents with coalition-based social marketing. *AIDS*, 14, 1809-1818.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 3 |

Each principle of marketing was scored on a scale from 1-3, with 3 representing "a strong degree of applying, describing, or addressing that principle, based on the reviewers' assessments".

Background

In the early 1990s, scientists estimated that the numbers of HIV infections were stabilizing in some groups of Americans, but were still rising in people under 25 years of age. Apparently, mass media AIDS education approaches had been relatively ineffective with young people. CDC thought that social marketing was a promising alternative, and funded the Academy for Educational Development to provide technical assistance in social marketing to five local communities around the country. The project was funded for a five-year period in the hope that it would generate lessons that could be shared nationally.

To increase the likelihood that the PMI programs would be acceptable to the local communities, to benefit from the knowledge that local community members have about their own young people, to build local skill in using social marketing, and to encourage long-term program sustainability, the PMI programs were actually planned and conducted by coalitions of local community members. The coalitions were made up of youth service professionals, parents, AIDS service providers, and other concerned adults, as well as young people themselves.

CDC also funded and oversaw a multi-pronged outcome evaluation of PMI. The most extensive evaluation was conducted in the Sacramento site, and it is this site's program that is described below. Information about all the sites is available from the PMI Web site: www.cdc.gov/hiv/projects/pmi.

Formative Research

Interviews with 40 key informants, 24 focus groups with teens and their parents, and reviews of scientific literature on adolescent sexual risk behavior were conducted in Sacramento. An epidemiological profile was assembled, as well as an environmental profile with condom sales data, local youth-serving program lists, school enrollment rates, and drug and juvenile justice data.

Target Audience(s)

The target audience was sexually active youths aged 14-18 who had tried condoms and used them inconsistently and who were from 15 high-risk zip codes. The selection of this target audience reflected several considerations that emerged during formative research:

- The 15 zip codes were the ones with the highest rates of sexually transmitted infections (STI) among teens.
- The Sacramento area was extremely ethnically diverse, with a large farmworker population in which dozens of Latin American and Asian/Pacific Islander ethnic groups were represented. Segmentation according to language preference was not considered feasible.
- Local epidemiological data suggested that Whites, Hispanics, and Blacks all had relatively high rates of STI (although the specific infections differed by ethnicity), so the coalition chose not to segment according to ethnicity, either.
- National survey data indicated that many sexually active teens had used a condom at least once, and local focus group data were consistent with this finding.
- Youths aged 14-18 were accessible through high schools.
- California State Youth Risk Behavior Survey (YRBS) data showed that a substantial percentage of 14-year-olds had initiated sexual activity.
- To justify having all the program's resources dedicated to it, the target segment needed to be as large as possible.
- Targeting teens who were already sexually active increased social service agency support for condom promotion.
- Teens at highest risk (e.g., young men who had sex with men) did not necessarily report identifying as gay at this age, and could be reached with non-stigmatizing messages targeting a sexually active teen audience.

- Teens who had tried condoms were considered “ready for action” in terms of the Transtheoretical Model/Stages of Change. Marketers might call them “low-hanging fruit” and urge targeting this psychographic segment to maximize return on program investment.

Parents were considered an important secondary audience, both because they could reinforce messages and because their opposition to the program could threaten its survival.

Target Behavior(s)

The behavior of using condoms consistently with all partners in all situations reflected additional research findings:

- National studies had shown that condom use was less likely with main or steady partners than with casual partners.
- Focus group participants and national data indicated that situations such as drug or alcohol use, unplanned sex, or use of other contraceptives were barriers to condom use.

The behavior of carrying condoms was also targeted because:

- Carrying condoms made their use much more likely, and
- Carrying condoms could be encouraged through promoting a carrying *norm*—a behavioral determinant that mass media is likely to be able to effect.

Product(s)

The branded product was a “package” of safer sex behaviors and cool, altruistic associations. The benefits were defined by the target audience and health behavior change theory as “the desire to be popular” and “the desire to be one of the crowd (normative).”

Price

Teens Stopping AIDS condoms and workshops were free. The psychological costs of condom carrying and use were reduced by teaching condom use and negotiation skills. The benefits were promoted heavily in the promotional and workshop materials. The barriers to carrying and using a condom were also addressed in subsequent promotional, workshop, and hotline information kits. These same benefits and barriers were addressed by the keyring condom give-aways, which helped reinforce the attitude that carrying a condom was normative and popular. The keyrings also reduced the price of “not having a condom handy” by facilitating easy and convenient access to condoms.

Place

Focus group data had indicated that teens found condoms widely accessible in convenience stores, grocery stores, and the like; the problem was having one handy in the heat of the moment. Teens were encouraged to have a “handy plan.” Carrying condoms was made more convenient by distributing key chains that held a condom. The school system did not allow PMI skill-building workshops on the premises but they did put up posters providing the hotline, which in turn, provided workshop information. Workshops were held in places that teens considered cool, like a youth hostel in the downtown pedestrian mall.

Promotion

Consistent messages with a positive and sometimes playful tone were promoted through multiple channels (radio, print ads including posters on the sides of buses, workshops, and peer outreach). The radio spots were on stations with the highest teen listenership, at times of days when most teens tuned in. Preliminary data from the evaluation survey indicated that boys and girls who used condoms used them for different reasons; thereafter, radio PSAs were tailored for boys or girls. The spot for girls depicted girls beginning to carry condoms because one of their friends did, while the spot for boys depicted a boy agreeing to use a condom because his girlfriend asked him to do so. Professional acting talent was used in the PSAs to ensure production quality. The PSAs were aired in two-week barrages and then rested so that teens would not begin to tune them out. The *Teens Stopping AIDS* brand was part of a promotional strategy that encouraged teens themselves to reinforce campaign messages.

A *Teens Stopping AIDS* logo in a grunge font was used on all promotional materials to brand and unify the campaign. The logo included a mark with no predetermined meaning; it was thought that the mark would take on meaning as the brand became identifiable, and it was emblazoned on key chains, t-shirts, and temporary tattoos. Branded condoms were distributed as part of special event promotions (e.g., give-aways at concerts); the condom packages carried other information such as the informational hotline phone number. The hotline described “cool” workshops where teens and their friends could talk about sex and HIV. The hotline also had special information messages for parents. At conveniently located workshops, teens got a cue card with three messages that they could use to talk about condoms with their friends, and workshop participants pledged to reach out to three friends with those messages. Teens had input into all materials development and testing. Workshop instructors had experience working with young people.

Evaluation

Process Evaluation

Advertising spots were purchased, so there were good records of the number and placements of ads. Radio stations and bus companies were able to estimate the number of young people exposed to their channels; it was estimated that at least 70 percent of the target audience had been exposed. The number of teens attending workshops was tracked, allowing the locations to be changed to maximize attendance. Workshops were monitored by observers with checklists to make sure that there was fidelity to the planned curriculum. The numbers of condoms and other promotional materials distributed were tracked, as were calls to the hotline. It was even possible to get information about which phone messages were chosen from the hotline informational options offered.

Impact/Outcome Evaluation

Both qualitative and quantitative evaluation measures were used. The interview-based case studies described in the special issue of the *Social Marketing Quarterly* devoted to PMI (vol. VI, number 1, published in March 2000) provided a qualitative account of the experiences and learnings of the coalition members. The case studies also indicated that nothing else that took place in Sacramento during the *Teens Stopping AIDS* campaign could have accounted for the gains in protective behavior that were observed in survey data.

The skill-building workshops were evaluated by means of an experimental design with a control group and a one-month follow-up of workshop participants. Significant increases in protective behaviors and their determinants were found among workshop participants. Finally, a random sample survey of 1,402 teens in the 15 zip code target area in Sacramento showed that there was a significant association between the number of channels through which a teen had been exposed to PMI on the one hand and condom use at last sex with a main partner, condom carrying, and several psychosocial determinants of condom use on the other—a dose effect of the type that has been observed in other successful social marketing programs. By the end of the program, 70 percent of surveyed adolescents reported exposure to PMI through at least one channel. There was a national trend in the direction of increased condom use among teens while the *Teens Stopping AIDS* campaign was underway. However, condom use with a main partner increased twice as much in Sacramento in one year as condom use with all partners (an easier behavioral goal) increased over a two-year period in the rest of the country. Reassuringly, neither the survey nor the workshop evaluations found that exposure to PMI increased sexual activity levels.

Program Cost

In addition to receiving national technical assistance, much of it in the form of face-to-face trainings from AED professionals who would travel to California from Washington, DC, Sacramento PMI received approximately \$250,000 per year from CDC. It is reasonable to use the upper end of the range of estimated lifetime costs of treatment for HIV when someone is infected as an adolescent, and the upper end of a widely cited estimate is \$200,000. This means that the program would be cost-saving if it averted two cases of HIV. The Sacramento site funding was used to hire a local staff director and other staff and to conduct local activities including formative research, the development and duplication of promotional materials and, ultimately, mounting the campaigns. Outcome evaluation expenses were covered or provided in-kind by CDC. The program could be considered cost effective if it prevented six individuals in Sacramento from becoming infected with HIV (\$250,000 per year in direct costs vs. \$200,000 per person infected with HIV over the five-year project period). While it is not possible to know exactly how many HIV infections were avoided, the increased rate of condom use among the target audience suggests that it is reasonable to believe that the program was cost effective.

Comment

The PMI sites enjoyed unusually high levels of resources during the federal demonstration period. The Sacramento PMI has been sustained exclusively through state and local funding since 1998. Local funders and stakeholders may appreciate the fact that *Teens Stopping AIDS* has been refreshed several times to retain the attention of Sacramento teens and remain relevant to them. For example, a radio soap opera has been added to the marketing mix. Because the program was shown to be successful in its original form, additional formal evaluation has not been conducted. However, the monitoring of service levels, service quality, and audience feedback is an ongoing staff function.

The Sacramento PMI staff director who managed the program for the last several years of the demonstration period is now employed by the California State Department of Health to provide technical assistance in social marketing to community-based organizations around the state. This resource can be viewed as a dividend of the investment CDC made in PMI.



Case Study 2

Changing Traditions: Preventing Illness Associated with Chitterlings

In Brief: In August 1996, health officials in metropolitan Atlanta, Georgia, decided to use a social marketing approach to prevent the next holiday outbreak of diarrhea cases associated with preparation of chitterlings (pork intestines; chitlins) by African American women. Formative research identified the source of transmission to be breaks in sanitation during preparation. After culture tests confirmed the safety of the potential interventions, a culturally appropriate and “low-cost” intervention was designed around the message: *“Pre-boil your chitterlings for five minutes before cleaning and cooking as usual.”*

Despite the short lead time (August to November) and relatively low budget, the project generated positive results. Targeting women who prepared chitterlings, community gatekeepers and health care providers, the project documented greater awareness and actual reductions in diarrhea cases during the winter holiday season.

Reference: This case study has been adapted from a presentation by Peterson, E.A. & Koehler, J.E. (1997). 1997 *Innovations in Social Marketing Conference Proceedings*, 4-8.

| Social Marketing Strengths at a Glance | | | | | | | | | |
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| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 3 | 3 | 3 | 2 | 3 | 2 | 2 |

Background

In 1989 a severe form of diarrhea in African American infants in Georgia caused by the bacterium *Yersinia enterocolitica* (YE) was first associated with home preparation of chitterlings (pork intestines or chitlins). Each November and December after that, Women, Infants, and Children (WIC) clinics offered flyers and short lectures emphasizing handwashing and protecting children from exposure to chitterlings. But data collected at one hospital in 1996 showed that yearly winter peaks of cases continued despite the WIC-based intervention.

Strong cultural traditions surround the preparation of chitterlings, with holiday preparation recipes passed down through the generations. A potential barrier to changing chitterlings preparation behavior was the fear that boiling would “boil in the dirt” and affect the taste. A taste test showed that not to be the case.

Collaborating with the Office of Minority Affairs helped reach many of the African American gatekeeper audiences. This collaboration also helped to identify African American grandmothers as the appropriate source for the intervention. The grandmothers who participated in formative research developed the chitterlings cleaning method for their peers. Having the grandmothers (as messengers) model how to pre-boil chitterlings was thought to make the new preparation method easier to accept within the community.

Formative Research

Research included literature reviews, community focus groups, and interviews. Phone and personal interviews were conducted with pork producers and food safety experts at the United States Department of Agriculture (USDA), Food and Drug Administration (FDA), and Centers for Disease Control and Prevention (CDC).

Focus groups and individual interviews were conducted at a retirement center, a clinic waiting room, grocery stores, and churches. After being informed about the annual outbreak and findings from the literature review, focus groups discussed two questions: “How do you think the bacteria are being transmitted to the small babies?” and “What could we do to prevent this transmission?”

The women themselves identified hygiene breaks, either during refrigeration or during the long hours of cleaning the chitterlings, as the likely method of transmission to children. Both interventions were evaluated in home cleaning and cooking trials and laboratory studies. Barriers to acceptance of the interventions were assessed via follow-up phone interviews.

It was this formative research that provided the key to identifying the more appropriate target group for the intervention. Historical outreach had been focused toward mothers, however, the formative research identified grandmothers as the cohort who make the chitterlings, provide child care, and teach their daughters how to cook.

Target Audience(s)

Previous interventions had been aimed at children’s mothers, using participation in the WIC program as a channel for communication. The formative research and conversations with the African American community suggested that grandmothers were more frequently the chitterlings preparers and would serve as a role model to younger women for future preparation. Thus, the primary target audience was women who prepare chitterlings—older African American women who, as grandmothers, are often also caregivers for infants.

Secondary audiences were identified as community leaders/gatekeepers such as pastors and church leaders, retail grocery associations, chain grocery stores, major pediatric hospitals, and health care providers.

Target Behavior(s)

Two preparation methods with potential for preventing disease transmission were identified and compared to traditional preparation methods:

1. Wash chitterlings in low concentration of bleach-water during the 6-8 hours of cleaning.
2. Briefly pre-boil chitterlings before cleaning.

Findings of the preparation comparison showed that bleach rinsing of chitterlings was inconsistent in reducing bacteria. Pre-boiling chitterlings showed complete killing of all bacteria and offered the advantage of making chitterlings easier and faster to clean. Subsequent taste tests showed that pre-boiling did not affect the taste appeal. The behavior intervention selected was summarized in the instruction: *“Pre-boil your chitterlings for five minutes before cleaning and cooking as usual.”*

Product(s), Price, Place, and Promotion

The authors summarized the marketing mix in the following chart:

| Target Population | Product(s) | Price | Promotion | Place |
|---|--|--|--|---|
| <p>Chitterlings preparers Primarily older African-American women in metro Atlanta</p> | <p>Messages Pre-boil chitterlings before cleaning</p> | <p>Perceived Barriers Change from traditional technique; Perceived change in taste; Extra 5 minutes of up-front work; Perceived Benefit Community ownership as source of technique; Taste test showed no change in taste; Faster/easier overall; Safer for children; Child care issues avoided</p> | <p>Cartoon & flyers Flyer/bulletin insert Short read: problem and community solution Brochure Full info for interested readers News release Public service announcements (PSAs) Newspaper articles Radio talk shows TV news spots Focus on new problem with a simple solution</p> | <p>Grocery stores Point of sale reaching chitterlings purchasers Churches Targets church goes Churches trusted source Health care providers Physicians, hospitals, county clinics, WIC waiting rooms Media Targeted: gospel station talk show</p> |
| <p>Community leaders, gatekeepers Heterogeneous group having authority to allow dissemination of information</p> | <p>Encourage message dissemination to target group within their spheres of influence</p> | <p>Perceived barriers: Extra work; Potential political or economic repercussion; Perceived benefits: Image of promoting safety of children; DHR did most of follow-up work</p> | <p>Cover letters for each sub-group; News release; Medical fact sheets; Samples of brochures; Can evaluate what they are asked to distribute; Presentation in person/phone to address questions</p> | <p>Grocers' association and large chains Point of sale distribution Church associations Posting, pulpit announcements, bulletin inserts Media Timely awareness of preventable health problem</p> |
| <p>Health care providers Physicians County clinic nurses WIC nutritionists Hospital infection control nurses and epidemiologists</p> | <p>Take exposure history and culture for YE in appropriate cases; Disseminate prevention message</p> | <p>Perceived barriers: Requires awareness and asking about chitterling exposure; Extra cultures and cost; Perceived benefits: Correct diagnosis YE; Earlier treatment YE; Simple prevention message</p> | <p>Cover letter; Medical fact sheets; News release; Samples of brochures and flyers; Distribution to patients; Presentations; In person/phone to address questions</p> | <p>Work place/office; State epidemiologist; Research investigator; Emphasis on new, well-documented medical information and timeliness of prevention issues</p> |

Evaluation

Process Evaluation

Project objectives were met. New microbiological and behavioral information was obtained on transmission and potential interventions. The key messages addressed specific barriers and benefits and were liked by the primary target audience. Implementation was widespread and accomplished at a low cost, despite the three-month time frame for assessment, design, and late market penetration. Feedback from target audiences was anecdotal. Gatekeepers and health care professionals for the most part approved and helped distribute information. Several locations requested extra copies of literature.

Impact/Outcome Evaluation

It was expected that health care providers would increase their efforts to find and diagnose cases of diarrhea in response to the messages targeted for them and there would be an apparent increase of cases reported. Compared to the previous year, the number of cases prior to the intervention effect was slightly higher, especially around Thanksgiving. Post intervention, however, there was no Christmas peak as there had been the previous year. The number of cases in the year of the project (11) was lower than during the same weeks of the previous year (16) despite increased surveillance. While the changes were not statistically significant, they were suggestive of some intervention effect. "Each subsequent year the intervention was repeated, the number of cases decreased. One year they did not do the intervention, the numbers went back up." (Peterson, at the Turning Point Meeting. 5/01)

Program Cost

"Implementation of the intervention was widespread and done at low %cost..." Dr. Peterson estimated the total cost including staff time was "less than \$25,000." A variety of print materials (flyers, bulletins, brochures, fact sheets, cartoon stickers) were developed and distributed through local grocery stores, churches, and social groups. Mass media messages (talk shows, TV news, and PSAs) also carried a large portion of the promotion load.

Comment

This case demonstrates the practical wisdom of applying social marketing strategies to health challenges. Although the project was relatively inexpensive, it achieved notable results because of careful attention to the needs, wants, attitudes, and habits of the target audiences. One note: the fact that members of target audiences "like" an intervention or behavioral product does not always ensure adoption. Satisfactory responses sometimes occur whether people state that they like something or not. The short time between project start-up and the actual interventions may have impaired the results somewhat, but the realities of public health are not always conveniently situated in a health department or marketers' calendar. It is also worth noting that this project received the Novelli Award at the Innovations in Social Marketing Conference held in December 2002.



Case Study 3

Street Vendors and Food Safety: A Community-Building Example

In Brief: In the late 1990s, Mexican American street vendors were selling uninspected food products to 1500 daily customers in Oakland’s ethnically diverse Fruitvale neighborhood. Enforcement of city health and safety codes and street vending ordinances was ineffective. A coalition of vendors identified a source for new, affordable, code-compliant carts; a communal kitchen where food could be inspected; and entrepreneurial funding. The endeavor included changes in vending ordinances and enforcement. Lessons from the experience have been applied countywide as a model for participatory community approaches to addressing public health issues.

The Alameda County Public Health Department’s response to these challenges took place through its Community Health Team. The responses exemplified the department’s change in orientation from a provider of prevention services to a catalyst promoting community-driven public health by incorporating social marketing concepts.

Reference: This case study was originally presented as a poster at the American Public Health Association meeting in 1999 by Jeffrey Brown, Division Director, Community Health Services, Alameda County Health Department, 1000 Broadway, Suite 5000, Oakland, CA 94607. 510-208-5901. jbrown@co.alameda.ca.us.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 3 | 2 | 2 | 1 | 2 | 1 | 3 |

Background

Preparing and selling their food in fairly traditional ways, Mexican American street vendors in the Fruitvale neighborhood of Oakland, California, were out of compliance with local health and safety codes. They prepared the food in their homes where it could not be inspected, sold the food in carts that did not meet required health and safety standards, and violated a city ordinance prohibiting street vending. Prior to this project, health department enforcement resulted more often in the vendors moving to other locations than it did in correction of the health and safety problems.

Target Audience(s)

In Fruitvale, the target audiences and stakeholders included:

- Street food vendors
- Street vendors’ customers
- Spanish-speaking community influencers
- Alameda County Public Health Department, Environmental Services Division personnel
- Municipal and private sector small business advocates

Target Behavior(s)

The following behaviors were targeted regarding street vendors in Fruitvale:

- Improved sanitation and safety in food preparation and vending
- Compliance with safety and health standards in construction and maintenance of food carts
- Reduced conflict events regarding enforcement
- More participatory (and by definition, more culturally competent) community decision making on health issues

Community Health Teams (CHTs) worked in partnership with local communities and vendors to assess and meet the needs of each neighborhood while ensuring the delivery of mandated services.

Product(s)

Centralized Food Preparation Center

With technical assistance from county staff, the vendors formed a legal cooperative, pooled their resources and secured a small, closed-down restaurant and converted it into a communal kitchen, which is still in use today.

Guaranteed Code-Compliant Carts

Instead of being able to build their own carts, vendors were to purchase them from manufacturers who would guarantee their health code compliance. The county also helped locate sources for these code-compliant carts. The city's One-Stop Capital Shop was very interested, and willing to assist the vendors with long-term, low-interest loans for the carts and to build out a commercial kitchen.

Benefits

- Fewer citations and less conflict over health and safety violations
- Shared expenses for communal kitchen
- Identified lower priced carts that were up to code, through contacts in the Mexican Consulate and a trip to industrial Tijuana
- Improved street vendors' image in the community through the use of approved food vending carts rather than old grocery carts

Price

Barriers

- Inconvenience: Instead of being allowed to prepare their food products at home with no inspection, they moved to a centralized food preparation facility.
- Money: Instead of being able to build their own carts, vendors were to purchase them from a manufacturer who could guarantee they were up to code.
- Long-term Debt: Available long-term, low-interest loans to buy new carts through the city's One-Stop Capital Shop was seen by vendors as undesirable when compared to outright ownership of their carts.

According to Brown, the vendors valued their independence, and saw even low-interest loans as undesirable. Though the carts they ultimately purchased were not as high quality as the first (county-identified) manufacturer would have provided, the reduced cost and ownership without loans was far more valuable to the vendors.

Place

The most fundamental issue addressing the Place factor was making it easier and more convenient for food vendors to comply with county health codes. This was achieved primarily through the development of a permanent communal kitchen. This activity addressed the vendors' ability to more easily and conveniently provide safer food.

Promotion

The vast majority of both the Fruitvale and countywide Promotion effort was through word of mouth—listening, processing community and health department staff input, identifying challenges and possible solutions, and finding and nurturing partnerships. In Fruitvale, it took the form of community meetings with residents, vendors, and business organizations to address issues and work together to solve problems.

A new partnership between the health department and a local organization, the Community Health Academy, helped facilitate communication. Other promotion included:

- Technical assistance to organize 28 vendors into a cooperative organization
- Assistance in securing a temporary communal kitchen where food could be inspected, and city funds for establishing a permanent communal facility

Policy

Efforts to address Policy included:

- Funding and technical assistance to finance business development (“One-Stop Capital Shop;” Enhanced Enterprise Zone funds) and to help locate sources for affordable code-compliant food carts
- Collaborative community advocacy to revise city ordinances to allow street vending

Evaluation

Impact/Outcome Evaluation

The Fruitvale Food Vendors' initiative resulted in several positive outcomes:

- The city reversed its prohibition of food vending on public property (precooked hot food and cold food only).
- Fewer violations of health and safety codes in the preparation and sales of food by street vendors.
- Improved, code-compliant carts.
- Stabilization of 28 small family-run businesses supporting more than 100 family members.
- Retention of local small businesses valued by the community.

The standardized, code-compliant cart had additional positive impacts/outcomes:

- Improved street vendors' image in the community through the use of approved food vending carts rather than old grocery carts
- Increased business for street vendors because of improved image and use of standardized code compliant carts

Project Cost

The street vendor project received a \$15,000 planning grant from a private source that paid for professional vending cart design, consultation with a U.S. cart manufacturer, hiring of a business consultant with expertise in cooperative formation, travel costs to identify and negotiate an agreement with a cart manufacturer, and telephone costs. Some of the grant funds were also used on commercial kitchen design; however, the vendors opted to refurbish a closed restaurant rather than build out a commercial kitchen from scratch.

Comment

Behind this case is an evolving county health department as it shifted from, in 1994, an organizational image as a provider of personal prevention services to, in 1999, a department emphasizing its role as a problem solver and service provider in cooperation with the communities it serves. For more information about the transformation of the health department, contact the project coordinator listed at the beginning of the case.



Case Study 4

Florida Cares for Women: A Social Marketing Approach to Breast Cancer Screening

In Brief: This project used a social marketing approach to increase the number of uninsured and underinsured women aged 50 and older using low-cost breast cancer screening services at their local health department. A strong emphasis on formative research helped identify and segment target audiences, tailor behavior objectives for women in each category, and take into account the beliefs, values, and behaviors of women in each target group. Audience characteristics guided the development of the multifaceted marketing mix and the coordinated implementation in three pilot sites. Television, radio, print publicity, distribution of educational materials, and use of professional and community channels were combined with pricing strategies and local convenience to promote the benefits of yearly screening.

Reference: McCormack Brown, K., Bryant, C.A., Forthofer, M.S., Perrin, K.M., Quinn, G.P., Wolper, M., & Lindenberger, J.H. (2000). Florida Cares for Women social marketing campaign: A case study. *American Journal of Health Behavior*, 24(1), 44-52.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
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| X | X | 3 | 3 | 2 | 3 | N/A | 2 | N/A | N/A |

Background

Breast cancer is an urgent health concern in the state of Florida, which ranked third highest of any state for breast cancer incidence and mortality at the time of this project. In 1999, the ACS estimated that 11,900 women in Florida would be diagnosed with the disease, and 2,900 would die.

The high incidence of breast cancer in Florida can be partly attributed to aging demographics. The ACS estimated that nearly 1.9 million women in Florida were over age 60 in the year of this campaign, the age bracket in which 65 percent of all breast cancers occur. Many of these cancer deaths could have been prevented through routine, high quality mammography screening. Breast cancer mortality can be reduced by as much as 30 percent through clinical breast examinations and screening mammograms for women aged 49 years and older. Unfortunately, breast cancer screening is still underutilized.

Formative Research

Qualitative and quantitative research methods were used to better understand women's perceptions of mammograms. Objectives of the research were to:

- Identify the factors that motivate economically disadvantaged women to be screened
- Identify the factors that deter economically disadvantaged women from being screened

- Identify effective information channels and spokesperson(s) for promoting breast cancer screening among economically disadvantaged women in Florida.

Formative research included six focus groups, eight in-depth interviews, and a survey of 2,373 women from eight randomly selected counties of the 20 counties funded for free and low-cost screening. A 52-item survey in English or Spanish was administered through face-to-face, mail, and telephone interviews. During campaign development, three concepts were created and pretested with the target audience. Two that tested well: *“Get a mammogram once a year”* and *“Get a mammogram for peace of mind”* were combined into one message for the final copy.

Target Audience(s)

Women over age 50 who do not have health insurance coverage for mammograms and have not been screened at recommended intervals. Within this group, women who had been screened in the past, but were not being screened annually, were selected as the primary target audience.

Target Behavior(s)

Increase utilization of low-cost or no-cost breast cancer screening services at local health departments (LHDs).

Product(s)

According to the authors, the Product for this program was “peace of mind” obtained through annual screenings.

Price

The primary issue in addressing the Price factor of this program was the monetary cost or disincentive of getting a mammogram. To address this, no-cost or low-cost mammograms were made available through the LHD. A toll-free number at the LHD was provided for women to schedule an appointment for affordable screening services available in their community. The pricing strategy intended to lower the perceived costs and/or make them more acceptable to patients (potential “consumers”).

Other factors that influenced whether or not women sought annual screening were:

- Insurance for annual screening
- Physician referral
- Belief that mammograms are effective
- Discount coupon

Factors most likely to deter women from screening were:

- Lack of physician referral
- Belief that mammograms are painful
- Lack of time to get a mammogram

The Pricing strategy in this program attempted to decrease barriers and disincentives, while the strength of the Product factor increased benefits (peace of mind and the potential for early detection).

Place

Qualitative data in formative research confirmed two key aspects relating to the Place factor:

- Women wanted screening delivered in convenient places.
- The screening services needed to be provided in a pleasant atmosphere that was safe and staffed by people who were caring and nurturing.

Consequently the program planners recommended that health departments improve mammography service environments to improve the caring, nurturing, safe, or convenient attributes of the mammography facilities.

Promotion

The *Florida Cares for Women* marketing plan included recommendations for project coordination, professional training, and support focusing on encouraging physician referral, public information, and public relations; consumer education, community organization, and outreach; local service delivery and policy and legislative changes. Specialized information kits for community organizers and religious organizations were distributed. The communication plan included these guidelines:

Tone: Factual, upbeat, respectful, and nurturing

Appeal: Peace of mind, early detection successes

Spokesperson: Cancer survivor and female physician

Conceptual: Woman's desire for a caring community; latest health information; avoid a welfare image/stigma associated with low/no cost health services

Media: 30 second TV commercial, 60 second radio announcement

Other Materials: Educational pamphlets and poster; postcard-size coupons could also be used as envelope stuffers and distributed through physicians' offices

Distribution Channels: Women's health care provider, health departments, and other locations that women over age 50 frequented

Evaluation

Funding was not available to evaluate the campaign fully for this study. However, the team contracted with Best Start Social Marketing to develop *Florida Cares for Women* and made the following recommendations for evaluation:

Process Evaluation

Track phone calls to the pilot site toll-free numbers to identify characteristics of women who responded to campaign messages. Keep field notes to document how well various programs and agencies implemented campaign guidelines, recommendations, and challenges.

Impact Evaluation

Document if women followed through on scheduled appointments, their satisfaction with the experience, and intentions about future screenings.

Outcome Evaluation

Follow up to determine if participants seek and get a second mammography exam a year later. It was expected that health care providers would increase their efforts to find and screen women in the target group, and that women exposed to the marketing program would be more likely to have another breast screening within the next year.

Comment

This case study clearly demonstrates core concepts of social marketing, building on previous work about audience characteristics by two of the authors. Campaign strategies were developed based on thorough quantitative and qualitative research in all aspects of the marketing mix of the Product, Price, Promotion, and Place factors. While the conceptual and formative research parts of the article are very clear on all of the aspects of a successful marketing mix, the implementation section deals primarily with the execution and evaluation of the Promotion factor. There is little information on how the Place factor strategy was executed using the research collected during formative evaluation, and the Product factor execution is primarily described as message delivery about services made available through the campaign. This case was published in 2000, thus little information is available as yet on results—process, impact, or outcome evaluation.



Case Study 5

A Social Marketing Campaign to Promote Low-fat Milk Consumption in an Inner-City Latino Community

In Brief: This campaign promoted the use of low-fat milk instead of whole milk in a low-income Latino community in the Washington Heights-Inwood neighborhood of New York City. Designed for implementation through a community-based cardiovascular disease (CVD) prevention agency, the campaign increased demand for low-fat milk by building support for healthy diet choices through community groups, media, and the school district.

Reference: Wechsler, H. & Wernick, S.M. (1992). A social marketing campaign to promote low-fat milk consumption in an inner-city Latino community. *Public Health Reports*, 107(2), 202-207.

See also: Wechsler, H., Bash, C.E., Zybert, P., & Shea, S. (1998). Promoting the selection of low-fat milk in elementary school cafeterias in an inner-city Latino community: Evaluation of an intervention. *American Journal of Public Health*, 88(3), 427-433.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 2 | 3 | 3 | 2 | 2 | 3 | 2 |

Background

Washington Heights-Inwood, on the northern tip of Manhattan, had a population of 200,000 in 1992, the majority of whom were low-income Latinos, many of them from the Dominican Republic. Cardiovascular diseases (CVD) including heart disease (leading to heart attacks) and cerebrovascular disease (cause of strokes) accounted for approximately 39 percent of all deaths in the community.

Nationally, cardiovascular disease is responsible for almost as many deaths as all other causes combined. High saturated fat content in food consumption is one of the leading behavioral risk factors for CVD. Since coronary atherosclerosis begins in childhood and is affected by high blood cholesterol, reducing the intake of total fat, saturated fat, and dietary cholesterol among children is an important strategy for reducing CVD later in life.

Although dairy products provide many important elements in a balanced diet, the products have been identified as leading contributors to high fat intake among children and adults. A national survey of children 1-5 years old found that nearly 40 percent of their saturated fat intake came from milk products. Between 1970 and 1990 the national trend was that whole milk sales dropped by almost 50 percent and lower fat milk sales increased by more than 400 percent and skim milk sales by more than 100 percent. However, several studies showed that Latinos were more likely to use whole milk than low-fat milk.

A study in Washington Heights-Inwood found that whole milk was the single largest source of saturated fat in children's diets, contributing 44 percent of total reported saturated fat consumption. Substituting 1% low-fat milk for whole milk was calculated to reduce the percentage of calories consumed in the form of saturated fat by 25 percent. A major barrier to increasing consumption of low-fat milk in Washington Heights-Inwood was its limited availability. Preschools, after-school centers, and *bodegas* (small "corner" grocery stores) generally did not offer low-fat milk.

Formative Research

A telephone survey of 54 child care centers, senior citizen centers, after-school programs, and non-public schools found that 46 of them (85 percent) served only whole milk or almost exclusively whole milk before this study. Public schools were not included because they were required by their participation in the National School Lunch Program to offer both low-fat and whole milk.

Target Audience(s)

Latino mothers of children between the ages of 2 and 12 years old were identified as the primary target group. This group was selected because mothers usually purchased their families' food, and their children were believed to drink large quantities of whole milk. Institutional providers of food to children (such as day care, preschools, elementary schools, after-school programs) were considered secondary audiences.

Target Behavior(s)

The purpose of the campaign was to increase consumption of low-fat milk among low-income Latinos, especially those with young children. To accomplish this outcome the project planners assumed they would have to make people aware of low-fat milk and the benefits of drinking it. The target behaviors were:

- Increase the primary target audience's purchase of low-fat milk, instead of whole milk
- Increase secondary target audiences stocking and serving of low-fat milk to be at least equal to the amount of whole milk stocked and served

Product(s)

Benefits of drinking low-fat milk were positioned as an attractive, tasty, and competitively priced alternative to whole milk. This augmented the behavioral products.

Benefits

The benefits discussion of this article does not directly state that the researchers inquired about audience-perceived benefits; rather they focused on myths and untrue facts about low-fat milk. They imply that focusing on the health benefits for children after age two was considered valuable by the target audience. Benefits for serving institutions were implied to be increased or stable sales.

Price

Barriers

The perceived additional monetary cost of a milk product that (might not be liked) was strong among the target audience. Therefore, a discounting strategy was employed to make the monetary price of the product more attractive to the primary target audiences. To this end, managers at 23 local supermarkets and bodegas redeemed bilingual coupons good for 25 cents off each purchase of low-fat milk. Over 10,000 coupons were distributed through churches, schools, mailings, and taste tests on the street.

In addition to the monetary cost, there were concerns about taste and appearance. Members of the target audience reported beliefs that low-fat milk was just whole milk with water added, while the thickness of whole milk was a sign of newfound prosperity for many immigrants.

Serving institutions were primarily concerned about potential difficulty selling, or low use of low-fat milk in the target community. These barriers were addressed through the local promotion of coupons and local taste tests, both designed to increase sales and the use of low-fat milk. The taste tests were primarily designed to overcome the perception that low-fat milk did not taste as good or was not as thick as whole milk.

Place

By focusing on popular neighborhood locations for promotion, free distribution, and sale of low-fat milk (e.g., through preschools, after-school centers, and *bodegas*), the Place factor of this campaign capitalized on cultural values and on easy and convenient access to low-fat milk, both of which strengthened receptivity to both the information and the product.

Promotion

Instead of stressing the negative concept of eliminating an acceptable product (whole milk), the primary message emphasized the positive concept of substituting (providing, selling, buying, and serving) low-fat milk.

The following strategies were used to stimulate consumer demand:

Print

- Hundreds of color posters were placed at 62 locations.
- 25,000 one-page flyers used similar distribution channels: churches, schools, preschools, adult education programs, community service programs, and stores.
- A total of 600 flyers were mailed to women aged 18-44 who had participated in previous agency programs.
- 15,000 were sent through elementary schools to parents.
- 1,200 were passed out on the street

Personal Selling

- Small group presentations with taste tests of low-fat milk were provided to 514 people at 14 organizations.
- Taste tests were also provided in two popular neighborhood locations and outside six schools at 3 P.M., when mothers came to pick up their children. More than 1,000 people tasted low-fat milk; most of them for the first time.

Promotional Events

- Educational activities in schools, such as the Healthy Heart Carnival, with games called “The Wheel of Cholesterol,” “Healthywood Squares,” “Nutrition Label Lotto,” and “Fish for Foods Your Heart Will Love.”
- A short video promoting low-fat milk was shown in schools, at community events, and on cable television.

Mass Media

- Press releases and public service announcements promoted the campaign on Spanish language radio stations, cable television, and newspapers.
- Eight long articles with photos covered the campaign in five newspapers with a circulation of more than 190,000.

Community Based

- Low-fat milk label collection contests were organized to activate community organizations to educate their members.
- Ten organizations participated in order to win prizes: a VCR and a radio.

The second stage of the campaign’s Promotion factor marketed the practice of institutions offering and serving low-fat milk.

- A one-page “Rationale for Serving Low-Fat Milk at Schools and Pre-Schools” and supporting information was distributed through a meeting of the community Early Childhood Coalition, to school principals, child care center directors, and community organizations serving only whole milk.

Evaluation

Process Evaluation

Discount coupons were color- and number-coded to allow for an analysis of which distribution channels were most effective. About 200 coupons out of over 10,000 were redeemed for a 2 percent redemption rate, which is comparable to many commercial coupon redemptions. About 25,000 flyers were distributed through a wide variety of appropriate community outlets and low-fat milk posters were placed in over 62 key locations. More than 1,000 local residents participated in the Low-Fat Milk Taste Test and were overwhelmingly positive about the taste. Public relations techniques yielded over 750,000 impressions in print and local broadcast mass media.

Impact/Outcome Evaluation

Within one year, the project convinced seven institutions to offer low-fat milk only to nearly 1,200 children each day: four day-care or preschools, two after-school programs and a parochial school. Changes among the primary target audience had not been formally measured at the time of article publication, but their marketing work was ongoing and plans to more formally measure sales and consumption were underway.

Program Costs

Costs of the campaign were minimal because of volunteer labor and other in-kind contributions (such as staff time and telephone charges). Low-fat milk, cookies, and contest prizes were donated by businesses. Out-of-pocket costs were under \$3,500—primarily for printing of coupons, posters, flyers, and magnets; miscellaneous supplies; payment to stores for redeemed coupons; and mailing expenses.

Comment

Further study: The Washington Heights-Inwood community study set the stage for a later study using social marketing strategies to promote the drinking of low-fat milk at lunchtime in six elementary schools in the same neighborhood. This second study (1998, see reference section at the beginning of this case study) used a more comprehensive array of social marketing strategies ranging from product positioning (offering both 1% low-fat in addition to whole milk), facilitation of product trials (taste tests), “teaser” and point-of-purchase advertising, sales promotion incentives (contests with prizes), promotional magnets, and persuasion through entertainment. Tallies of discarded milk cartons in the intervention schools showed an increase in low-fat milk consumption from 25 percent of all milk consumed up to 57 percent. The estimated cost of the intervention in the second study was \$2.25 per student.



Case Study 6

Project LEAN: A National Social Marketing Campaign

In Brief: The Henry J. Kaiser Family Foundation started the national program of Project LEAN (Low-Fat Eating for America Now) in 1987 with the goal of reducing dietary fat consumption to 30 percent of total calories. The overall goals were to promote dietary change among persons, reinforce the change through organizations, and facilitate the change in settings where people make food choices.

Using public service advertising, publicity, and point-of-purchase programs to stimulate consumer demand for and increase the availability of low-fat foods in the marketplace, the campaign generated local campaigns in 13 states by 1993, partnerships from 34 organizations, and 300,000 calls to a toll-free number.

Reference: This case study is compiled from information published in Samuels, S.E. (1993). Project LEAN—lessons learned from a national social marketing campaign. *Public Health Reports*, 108(1), 45-53.

National LEAN Campaign Contact:
Peggy Agron, Executive Director. PAgron@dhs.ca.gov.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 2 | 2 | 3 | 3 | 1 | 2 | 3 | 2 |

Background

In 1987 the Henry J. Kaiser Family Foundation approved \$3.5 million to develop and implement a national social marketing campaign in the U.S. The first 18 months were devoted to planning and developing community and industry campaigns which became fully operational in fall 1989. National activities were implemented with the support of a nationwide coalition of participating organizations called Partners for Better Health. In 1991 the foundation awarded funds to the National Center for Nutrition and Dietetics, the education arm of the American Dietetic Association, to continue to operate Project LEAN.

A guiding assumption: "Because nutrition is uniquely positioned between the commercial marketplace and the public health sector, this type of effort requires a coordinated approach among government, industry, and voluntary sectors. A clear and consistent public health message needs to be conveyed and reinforced throughout the commercial marketplace." (Samuels, 1993, p.46)

The campaign started with three primary goals:

- To accelerate the trend to reduce dietary fat consumption from 37 percent of calories from fat to less than 30 percent
- To increase availability and accessibility of low-fat foods in supermarkets, restaurants, school and worksite cafeterias, and vending machines
- To promote collaboration among national organizations, including partners and community organizations, around low-fat program strategies and messages

Formative Research

Consumer research and ten Project LEAN focus groups suggested that consumers found it difficult to change their eating habits without detailed knowledge about how to select and prepare low-fat alternatives within a balanced diet. A Gallup survey found that the public's knowledge about nutrition was difficult to translate into food choices.

Target Audience(s)

Identification of target audiences was facilitated by the involvement of organizational partners whose membership and missions targeted primary and secondary audience groups, including:

Primary Audiences

- Consumers: Members of the general public

Secondary Audiences

- Physicians: family physicians, pediatricians, preventive medicine physicians, medical students, African American physicians, medical school faculty, oncologists, internists
- Food industry: food marketers, fisheries, purveyors of fresh fruits and vegetables, turkey, processed food, sugar, restaurant food, and school food
- Health organizations: advocacy and service groups interested in cancer and diabetes, wellness, public health (health departments), aging, and minority health
- Education field: home economics teachers and students, teachers' union members

Target Behavior(s)

The primary behaviors of interest were:

- Increased consumption of low-fat foods among consumers
- Additional consumer calls to a national hotline for more information, recipe flyers, etc.
- Additional partner members producing collaborative events and common messages to promote low-fat food consumption
- Industry partners developing and distributing low-fat recipes and presenting food-cooking demonstrations
- Increased trial behaviors by grocery store customers resulting from point-of-purchase displays featuring low-fat foods
- Increased access to low-fat foods through increased offerings by retailers, grocery stores, and restaurants

Product(s)

Strictly speaking, the Product factors marketed in this campaign were foods with lower fat content.

Benefits

There was little discussion of the research on perceived benefits of eating low-fat foods. The authors implied that the benefits would be decreased risk of cardiovascular diseases. However the benefits analysis for the primary and secondary audience groups was not well developed.

Price

Barriers

Focus group research found that consumers' motivation and willingness to make dietary changes were affected by convenience, lifelong habits, and taste. Consumers also said they were wary of new warnings about food and had reached their limit on dietary changes they were willing to make. The research-documented lag between awareness of the links between diet and chronic disease and behavior change suggested that the "price" (e.g., being able to buy, prepare, and enjoy) of making such changes would have to be low if this campaign were to succeed.

Among the secondary audience groups, the barriers to their target behaviors were primarily:

- Logistical—producing two lines of low-fat and high-fat foods
- Technical—developing good tasting low-fat recipes
- Sales—selling low-fat foods when the public is neither aware of the benefits nor motivated to purchase them

Promotion

Although the most visible part of the campaign's Promotion strategy relied on media messages, the strategies also involved intermediary spokespersons, face-to-face presentations through food industry groups, professional associations, and corporate and government organizations. A working group of prominent chefs and food journalists worked together to create marketable concepts for low-fat recipes and cooking techniques. The products and strategies used to promote selection and preparation of low-fat foods included recipe books, training of food and health professionals, medical care providers, health educators, and consumers.

Working with the Advertising Council, the media ran Project LEAN public service announcements and print ads with a value of more than \$36 million in one year before discontinuing the campaign. Media advertising was stopped because of the high expense of producing and reissuing the ads and the heavy response which they generated. Hotline costs associated with answering calls and fulfilling information requests exceeded \$300,000 per year.

There was a coordinated public relations campaign aimed at newspapers, national magazines, television and radio news, talk, and entertainment media. Between October 1989 and June 1990 they documented 291 articles referring to the campaign in media reaching 35 million readers and 27 million viewers and listeners. Among the highest profile exposures were through *Good Morning America* on network television and *Better Homes & Gardens* magazine.

Place

Through close work with the food industry, retailers, grocery stores, and restaurants Project LEAN sought to increase supply and distribution of tasty low-fat foods through these outlets. The collaboration with the food industry sought to increase low-fat food consumption by increasing the convenience and availability of low-fat foods at aforementioned food outlets.

Evaluation

Process Evaluation

Because of the heavy use of media and partnerships, monitoring the placement and reach of Project LEAN public service ads was critical. The Advertising Council compiled data on media usage from several sources including Broadcast Advertiser Reports (BAR). According to BAR, PSAs were aired primarily during daytime hours, with high usage of cable television. Project LEAN advertising usage ranked 15th among the Advertising Council's 40 campaigns during the same period. TV networks and PSAs reached more than 50 percent of households in the target areas during the first year of the campaign. Over 2,800 radio stations used Project LEAN radio spots. Newspapers with a total circulation of at least 16.5 million readers carried the print ads.

A 1993 national process evaluation was scheduled to analyze program operations and interventions in supermarkets, restaurants, schools, and worksites.

Impact/Outcome Evaluation

More than 34 national organizations joined the Project LEAN collaboration on common messages and events, collectively contributing more than \$354,000 dollars to the media outreach effort. The hotline received more than 300,000 consumer calls during the first 12 months. Chefs have developed and distributed ethnic-specific recipe books and a handbook to teach other chefs how to cook better tasting low-fat food.

Foundation-funded local sites were expected to evaluate the consumer impact of its point-of-purchase program. A post-grant measurement was scheduled to measure the extent of program institutionalization in health departments and commercial food outlets. The outcomes of these measures were not reported in this 1993 article.

Comment

While the study outlined the evaluation research used to measure progress toward some goals (such as increased collaboration), it did not describe others (such as measuring the program's success at decreasing dietary fat intake), and this affected the evaluation ratings. While good competitive analysis was done on the barriers of eating low-fat food, little was described about the benefits of eating low-fat food, and this affected the score for competition.

The author of this journal article listed lessons learned, summarized below, which can provide excellent guidance to other public health social marketing campaigns:

- Advertising and public health professionals come at these tasks with very different approaches. The creative strategies of ad agencies may be difficult to "sell" to all members of a partnership.
- Well-placed publicity, not public service advertising, may work best for national nutrition social marketing.

- Media monitoring and tracking must be built into the program to allow for modifications of messages and media channels. (Note: At the time of this article PSA tracking systems could not produce reports quickly enough for such campaigns. More effective strategies are now available.)
- National campaign strategies and materials have important benefits for state and local programs, and vice versa.
- Credible spokespersons strengthen the message. In this case, food professionals translated nutrition messages to food messages and modeled skills for the public.
- Partnerships and collaborations with the private sector enhanced the campaign by bringing broader skills and expertise on food, preparation, nutrition, and marketing, as well as more credibility and access to target markets.



Case Study 7

Make More than a Living. Make a Difference: Recruitment and Retention of Long-Term Care Workers in Kenosha County, Wisconsin

In Brief: This six month campaign was designed to build a more positive image of long term care workers, stimulate increased applications and hiring, and enhance the retention rate of low-wage employees in a critical health industry of an urban area. The marketing mix included advocacy activities to increase salaries of LTC workers; a staff person to answer questions for applicants and guide them through the hiring process; a school-based outreach strategy to make it easier and more convenient to learn about and apply for LTC positions; supervisor training to increase LTC worker recognition and publicity; public service and paid media; training, direct mail, and systematic person-to-person contact designed to stimulate positive word of mouth. The initiative was renewed and expanded the next year.

Reference: Contact Barbara Wisnefski, Coordinator, Long Term Care Staffing Project, Kenosha County Job Center, 8600 Sheridan Road, P.O. Box 4248, Kenosha, WI 53141-4248. 262-697-4637.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 3 | 3 | 3 | 1 | 3 | 2 | 2 |

Background

Wisconsin has a recent history of inadequate staffing levels and high turnover in long-term care (LTC) associated with low wages, difficult working conditions, record-low unemployment rates in general, negative perceptions about the industry, and insufficient recognition and support from long-term care employers. As the demand for LTC services increases, the workload of currently employed staff and volunteers also increases. As one health agency director put it at the beginning of this project, "With limited staff, supervisors are often called upon to do direct service work themselves, and spend enormous numbers of hours recruiting, interviewing, orienting, and training new staff." Therefore, there is little remaining time left for supervisors to devote to staff development and meeting the basic needs of employees for recognition and support necessary in this high-stress environment.

In 1998, the Kenosha County Office on Aging and Disabilities convened a Long-Term Care Staffing Task Force of representatives from the public and private sector to assess the problem and take action. The Task Force decided to conduct a marketing-driven initiative to address this serious health care problem.

Formative Research

Focus groups with LTC agencies; in-depth interviews with current LTC workers, their patients' and clients' families, supervisors, and human resource personnel; and task force analysis of national data regarding the motivations of LTC workers contributed to the design of the campaign. An essay contest where LTC workers wrote about the rewards of caregiving contributed to the development of the overall theme and promotional materials.

Formative research also identified the following competitive issues:

- Higher wages and better benefits in easier jobs (emotionally and otherwise), even in the fast food industry
- Low public recognition of the importance and value of LTC workers, except among those directly affected
- Perceived lack of professional growth opportunities in the LTC field
- Unacknowledged competition among LTC providers

Target Audience(s)

- Management, supervisors, recruiters in LTC facilities, and agencies
- Individuals currently employed in retail, food service, or other jobs but not satisfied with their work and desiring non-tangible benefits (80-90 percent women; some men)
- Women in their late 40s, 50s, and 60s (homemakers) whose children are self-sufficient, who are looking for meaningful activity in the “empty” hours of the day, or who want to supplement their incomes. Demographic research identified a test market segment of 5,000 homes of older women in Kenosha County.
- Current LTC workers unsure about how long they might stay in the field
- Non-college-bound high school students examining job options after graduation
- Recent graduates looking for part-time work while they go to college

Target Behavior(s)

- Increased inquiries (calls to a central phone line) and applications for employment
- Improved retention and reduced turnover of current LTC workers
- Increased positive recognition and rewards for LTC workers, from the general public and from employers
- Increased employment referrals (including self-referrals) of potential LTC workers

Product(s)

Services and intangible Products developed to support and facilitate the target audience’s behavior change included:

- Improved image of LTC work and frontline workers
- Increased community awareness of the need for new workers and support of current workers
- Increased salaries of LTC workers

Price

Based on formative research, the Price factors involved in making a decision to avoid becoming a LTC worker were the costs of LTC employment itself—low pay and perceived lack of upward mobility. Equally important were price factors that are intangible: perceived poor reputation, perceived unpleasantness of the work, perceived lack of training and management support, and poor recognition for the value of LTC work. If the employers and general public do increase recognition and rewards for LTC workers, these rewards become a non-monetary component of the Pricing strategy.

Place

Place factors research indicated two ways to reach program goals.

1. Make it easier and more convenient for potential LTC workers to apply for jobs.
2. LTC Staffing Task Force outreach to the employer community and use existing channels for advocacy and training.

To address the first issue, a school-based outreach system was implemented to make it easier and more convenient for non-college bound students to apply for jobs. Also, the LTC Staffing Task Force implemented a centralized phone inquiry system staffed by a knowledgeable person to help applicants through the hiring process. To address the second issue, advocacy and training activities were organized and distributed through partners' work sites and other existing channels.

Promotion

Non-communication promotional strategies included:

- Funding for a staff person to answer questions for applicants and guide them through the hiring process
- A school-based outreach strategy to make it easier and more convenient to learn about and apply for LTC positions
- Supervisor training to increase LTC worker recognition, respect of the worker, and increasing worker responsibility (career ladders)

The overall message for the campaign was "*Make More Than a Living. Make a Difference...Be a Care Worker.*" Short profiles of current LTC workers who enjoyed their work were featured in various media, focusing on what they liked about the work and the conditions, and the importance of their role. Although paid advertisements and public service announcements were used, the most effective strategy, judging by response, was the mailing of a series of four postcards with LTC photos and profiles to 5,000 women at home, encouraging recipients to "*be a care worker*" and contact the task force for more information. Advertising specialties or incentives (notepads with the slogan, magnets), posters, and special events kept the slogan in the public eye and in front of target audiences.

Materials and promotional incentives were also distributed through partners' work sites and existing communication channels:

- LTC organizations—nursing homes, residential support agencies for people with disabilities
- Community-based rehabilitation centers

- Schools (high schools and college)—UW-Parkside, Gateway Technical and Community College
- Kenosha County Job Center
- Hispanic Center
- County and city government (social services, health departments, etc.)

Specific targeting of promotion activities is outlined in the table below.

| Audience | Promotion |
|------------------------------------|---|
| Long-term care employers | Mentor and communication training, Seminar on recognition and rewards, "Tuesday's Tips" local newsletter |
| Long-term care employees | Payroll inserts, employee bulletin board posters, continuing education assistance, recognition through employers, task force materials, "The Meaning of Caregiving" writing contest, newspaper articles and editorials, transit ads, radio, posters, church bulletin inserts, payroll inserts, notepads |
| Students | Materials used at school counselor recruitment for certified nursing assistant (CNA) courses at high school and community college |
| Recent retirees/widows, homemakers | Postcard mailings, articles in senior citizen newspaper, public service announcements, presentations at community events and associations, displays at public libraries and community centers |
| Retail/food service workers | Newspaper articles and editorials, postcards, transit ads, radio, posters |
| General public | Newspaper articles and editorials, two urban billboards, postcards, transit ads, radio, posters, church bulletin inserts |

Evaluation

Process Evaluation

Recruitment and retention data were provided by employers before and after the campaign. Detailed records were maintained regarding phone inquiries, referrals, follow-up, and placement.

Impact/Outcome Evaluation

- The Aging and Disability Resource Center received more than 120 phone inquiries about job possibilities resulting in close to 30 new hires.
- Of the nine employers who returned surveys before and after this project, seven had an increase in the retention rate—they kept their "seasoned" workers longer.
- After the project's first year, 102 LTC workers reported improvement in their attitude towards their job

Program Cost

The Task Force originally earmarked about \$30,000 for “media” and set aside other funds to hire Aging and Disability Resource Center staff to coordinate recruitment and support for employers and employees. After one year monetary costs totaled \$57,189: \$24,228 for media and strategy consultants, graphic design, trainers, and writers; \$15,887 for staff time; \$400 for training expenses; \$506 for subscriptions to a LTC newsletter; \$649 for supplies; \$5,191 for printing; \$1,923 for postage; and \$8,406 for paid advertising.

Comment

While county personnel had the wisdom to bring together many different stakeholders, they benefited from the design, media placement, and strategic skills of social marketers. The project made a significant marketing impact by segmenting audiences and tailoring materials to each target segment. Because paid and unpaid media provided such high visibility during the initiative, the Task Force was proud of its efforts and enthusiastically supported the initiative at their workplaces.

Perhaps the most valuable discovery in terms of Promotion was the effectiveness of the direct mailing of postcards to the homes of women in the target audience. While mass media messages competed with informational and advertising clutter and disappeared after the money ran out, the postcards accomplished two things:

- They caught women’s attention with compelling picture/stories.
- They had considerable staying power.

Many of the non-media approaches may have had a stronger impact in the long run than the mass media campaign itself. Key non-media elements of the initiative were:

- The hiring of an energetic former hairdresser with social work education and good human relations skills as the person who responded to inquiries about jobs
- Public and private employers sharing ideas and recruitment strategies
- Writing contests, employee recognition, and other word-of-mouth strategies that helped build ripple effects from the short, paid media exposure



Case Study 8

When Free Isn't Enough: Maine Breast and Cervical Health Program

In Brief: The Maine Breast and Cervical Health Program (MBCHP) is part of the National Breast and Cervical Cancer Early Detection Program. The program provides no-cost screenings to low-income women between the ages of 50 and 64. A social marketing project was initiated in September 1998 to identify ways to increase enrollment in the program. The project targeted women who called the MBCHP toll-free line but did not enroll in the program. Formative research indicated that these women frequently have moved beyond the Contemplation Stage but have not moved completely into the Action Stage. A small survey was developed, pretested, and disseminated to 125 women in the target population. Follow-up telephone interviews were conducted with volunteers from the mail survey. The formative research identified structural issues about the enrollment process that were the primary barriers, not lack of knowledge or information about the need for screening on the part of the target audience. Changes made in the enrollment process resulted in increased enrollment effectiveness.

For More Information: Call Anita Ruff at the Maine DHS Bureau of Health, Comprehensive Cancer Control Program, 207-287-5358 or email Anita.Ruff@maine.gov.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| 3 | 3 | 2 | 3 | N/A | 3 | 1 | 3 | 2 | 2 |

Background

The Maine Breast and Cervical Health Program (MBCHP) is part of the National Breast and Cervical Cancer Early Detection Program funded by the Centers for Disease Control and Prevention. The program provides no-cost screenings for breast and cervical cancer primarily to low-income women between the ages of 50 and 64. In its first five years the MBCHP screened over 5,000 women and was expected to screen 3,100 women each subsequent year. As a way to increase enrollment in the MBCHP, a social marketing project was initiated in 1998. The initial plans called for the project to increase enrollment by 350 women per year.

Formative Research

Initial planning identified three areas that could be barriers to women: enrollment, life issues, and knowledge/behavior. To address process and enrollment questions, a mail survey was developed, pretested, and disseminated to 125 women in the target population. Included in the survey were an incentive magnet and a prepaid postcard for those who were willing to talk more about their enrollment experiences. Two mailings of the survey were distributed with a 50 percent response rate. Of the 63 who responded, 14 (22 percent) returned postcards indicating their interest in talking with staff from the MBCHP. After the survey project, managers conducted individual interviews with the 14 women who returned postcards. The focus of the interview was to obtain personal and

behavioral information from members of the target audience, as well as to get more information on their experience with the MBCHP enrollment process. The interviews were conducted via telephone from January to February 2000.

Target Audience(s)

The project targeted eligible women who had called the MBCHP toll-free line but had not enrolled in the program. These were women who had moved beyond contemplating calling the hotline but had failed to complete the enrollment process and had not received the reduced-cost screening. Project managers felt that because they had demonstrated a willingness to consider screening services offered by the MBCHP, they could be effectively targeted using social marketing strategies.

Target Behavior(s)

The target behavior was for the eligible women who called the toll-free line to enroll in the MBCHP program and receive services.

Product(s)

Primary

Successful enrollment of eligible women in the Breast and Cervical Health Program and use of linked services (free screenings)

Secondary

Increase the number of women calling to learn more about the program and services

Benefit

Finding disease early and thereby improving survival—longer life

Price

Barriers

- Potential of finding cancer
- Pain or embarrassment during screening exam or procedure
- Lack of knowledge about how to actually enroll in the program

Financial

- Incentive coupons used to reduce monetary costs

Other Factors

The results of the survey indicated a lack of knowledge of the MBCHP enrollment process. Many women thought that they were enrolled in the MBCHP after they called the toll-free line and did not realize that there were additional steps in the enrollment process. Despite their belief that they understood the enrollment process, there was clear dissonance between their perceived knowledge and their actions. Overwhelmingly, 46 of 60 total respondents (76 percent) reported that they knew how to enroll in the program, with 28 (44 percent) of those calling a provider site to schedule an appointment. Of the 44 percent who called to schedule an appointment, 19 (67 percent) went to the provider site. While this is seemingly good, it is an indication of a breakdown in the enrollment process. They

were not receiving no-cost screenings for breast and cervical cancer. While they may have received the necessary screening services, it may have been at a cost to the women.

Place

Message

- To get screened appropriately for breast and cervical cancer

Placement

- Physician's office staff, Community Action Program Agencies
- Worksites, Churches

Promotion

- Country radio weekday afternoons
- TV and newspapers
- Word of mouth

The survey results also indicated that most of the women (71 percent) see a doctor yearly for a check up with 68 percent of the respondents having had a mammogram within the past five years. This suggested that women in the target population regularly see a physician, representing a potential place for an intervention to encourage women to call about screening.

Mid-Course Adjustments

- Changed the PSA content to reflect findings regarding the primary product.
- Changed timing and channels for PSAs to include weekday afternoon television and country-western radio stations.
- Adjusted communication (print and personal) with physician offices and their staff to more strongly emphasize the steps necessary to ensure successful enrollment for their patients.
- Implemented a one-year incentive program to increase the number of women being referred to the program by physicians and their office staff. Practices with the highest percentage of patients referred and enrolled were treated to a special luncheon.

Policy

Initial Policy

Prior to implementation of social marketing principles, during the formative research stage, the enrollment process was initiated by a primary care physician or an interested woman calling the toll-free number. If the woman was determined eligible for the program, hotline staff would mail the woman an enrollment form, which she was then expected to complete, sign, and return.

The first program policy adjustment came in 2000, the script used by hotline staff was rewritten to more clearly and effectively describe the enrollment process. Script and other program policy changes described above did not result in the level of change desired, the enrollment process itself was changed. The new enrollment process policy was implemented in the summer of 2001—hotline staff began to fill out the enrollment forms with the eligible women still on the phone. The staff-completed form was then mailed to the caller for verification, signature and return.

Along with the change to the enrollment process, a computer-based tracking system was created. The project computer system was programmed to generate a monthly report indicating which eligible callers returned their signed forms and which did not. Armed with the new reports, staff members were able to target the eligible women who had not returned the enrollment form and prevent them from slipping through the cracks.

Evaluation

Process Evaluation

External reviewers were consulted during survey development and pilot testing of surveys (individual and mailed). The response rate for surveys was measured along with program data (number of calls to the hotline, number of eligible callers, and subsequent number of women successfully enrolled). The data were reviewed quarterly.

Impact/Outcome Evaluation

During the year immediately following the redesign of program enrollment processes (October 2001 – September 2002), 1,241 of 1,306 program eligible callers were enrolled. Only 65 of the eligible women were unsuccessful in completing the enrollment, in contrast with 125 women who failed to complete the enrollment process during the year prior to implementation of the social marketing process.

In summation:

The number of callers to the hotline has increased. The number of eligible callers identified has increased. The number of eligible callers who have successfully enrolled has increased. The number of eligible callers who are unsuccessful in completing the enrollment process is half of what it was prior to the implementation of the social marketing process. The decline of unsuccessful enrollments of eligible women has occurred in the context of increased hotline calls and the number eligibles identified.

Comment

MBCHP staff members indicate that direct expenses for this social marketing process were less than \$1,000. There was a significant amount of staff time that went in to the formative research process. The formative research process and development of recommendations took approximately two years. However, the staff time committed to this effort would have been spent in some form of program planning. Therefore, the staff resources were not considered part of the budget. This case is an example of how state government can, with minimal cash expenditure, improve the effectiveness of an existing program by utilizing a social marketing approach to program planning and evaluation. In an environment where a social marketing approach is more prioritized by upper management, the work could probably be accomplished in a more timely fashion.



Case Study 9

Oregon’s Air Quality Public Education and Incentive Program

In Brief: In 1995, Portland, Oregon, did not meet the Environmental Protection Agency’s (EPA) “attainment” standards for carbon monoxide and ground level ozone (AKA, smog). The State’s Department of Environmental Quality used new products, partnerships, education, and incentives—non-regulatory approaches—to encourage voluntary change of behavior of Portland residents that could result in lower emissions of volatile organic compounds (VOCs) and reduce air pollution.

Reference: See www.toolsofchange.com/English/CaseStudies/ on the Tools of Change Web site cosponsored by Natural Resources Canada, Cullbridge Marketing and Communications, Environment Canada, Federation of Canadian Municipalities, Health Canada, and NRTEE; and www.cbsm.com, the Fostering Sustainable Behavior Web site, by Doug McKenzie-Mohr.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|--------------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 3 | 3 | 3 | 3 | 3 | N/A | 3 |

Background

In 1995, Portland, Oregon, did not meet the Environmental Protection Agency’s (EPA’s) “attainment” standards for carbon monoxide and ground level ozone (smog) set by the 1990 Clean Air Act. In response, Oregon’s Department of Environmental Quality (DEQ) initiated a strategic plan for reducing air pollution by 2 percent permanently, and reaching “attainment” levels of EPA standards by 2006. The Oregon DEQ effort called the Clean Air Action Day Program calls air pollution advisories for stagnant summer days, when sunlight and steamy temperatures simmer pollutants to form a rich and irritating ozone stew called smog.

Formative Research

Baseline data were generated through random phone surveys inquiring about households’ consumer spending habits, automobile and lawnmower use, and awareness of local air quality issues. The activities of the DEQ’s Air Quality Environmental Public Education and Incentive Program were piloted over a three-year period from 1995-1998.

Target Audience(s)

The target audiences were Portland, Oregon area businesses, their one million employees, and consumers in residential areas. An effort was made to ensure that each target audience benefited from participation and behavior change in ways that were meaningful to that audience.

Target Behavior(s)

The three primary behaviors of the Clean Air Action Day Program were to reduce automobile driving or use alternatives; reduce aerosol spray use; and avoid use of gas-powered mowers.

Other promoted behaviors included: reducing VOC emissions through improved car maintenance (tune-up, keep tires properly inflated) and encouraging the purchase of low/zero VOC paint and other products.

Product(s)

The tangible products of the DEQ's Air Quality Public Education and Incentive Program included:

- Consumer products containing low amounts of VOCs: zero VOC paint, non-aerosol hair sprays
- Car-sharing programs, reducing and combining non-work car trips
- "Car smart" recommendations geared toward simple ways to help improve air quality through basic car maintenance

This case is a good example of developing a combination of monetary and other kinds of incentives or benefits.

Price

Direct Financial Incentives to Consumers

- Discount coupons and prices on low/zero VOC products (such as paints and non-aerosol sprays)
- Lawnmower buyback rebates on push and electric lawnmowers

Non-Monetary Incentives

- Increasing social norms to reduce car trips, to avoid use of gas-powered mowers, and to reduce aerosol spray use
- Pollution advisories reinforced actions participants may have already been taking

Incentives to Businesses

- Consumer coupons could only be redeemed at partnering businesses guaranteeing some financial benefit from participation.
- Participating businesses increased their "community-friendly" reputations.
- Partners received complimentary full-page advertising space in the *Portland Business Journal* at the end of each ozone season (the summer).
- Employers received a certificate from Oregon's governor thanking them for participating.

Place

- Convenience of Place was addressed through operation of several non-regulatory programs concurrently. Consumer products were made available and highlighted with on-shelf cues (prompts) and information at high-traffic retail stores (paint, grocery, and department stores and home improvement centers).

- Car sharing was made easier with a neighborhood short-term auto rental service that provided cars within a several block walk of members.
- The lawnmower buyback promotion included demonstration of non-gas alternatives in a central community location. This increased visibility of the program and took advantage of an opportunity for modeling to provide vivid, personalized communication, minimizing barriers and reinforcing new social norms at the site where trade-ins for rebates on new lawnmowers were taking place.

Promotion

A combination of community partnerships with utilities, media, retail businesses, auto dealers, and heavy mass media advertising included:

- Clean Air Action Day air pollution advisories were issued by Oregon's Department of Environmental Quality (DEQ) for days when smog levels were in danger of reaching unhealthy levels. These advisories served to inform, persuade, and remind audiences. Clean Air Action Day involved more than 400 employers promoting pollution prevention ideas to their employees and consumers through signs and in-store announcements.
- Education information on grocery and department store bags, on buttons worn by employees, and at the shelves where products were stocked for purchase.
- A major chain department store paid for 60-second radio PSAs delivering similar messages on the hour. Six auto dealers participated in two cable TV ads highlighting "car smart" ideas and promoting lower-emissions vehicles.
- The lawnmower buyback program was advertised and promoted through "stuffers" included in utility bills, TV ads, and PSAs.
- Special events like the "lawnmower-a-thon" tested, demonstrated, and promoted alternatives to gas-powered mowers at neighborhood intersections.
- Pledge cards with incentives (video discounts) were available at Blockbuster video stores, and were also sent with utility bills reaching 600,000 customers.
- DEQ issued a press release to Clean Air Action Day partners about its positive EPA evaluation in 1997 and advertised successes in the newspaper.

Evaluation

Impact/Outcome Evaluation

Follow-up surveys were performed in a similar manner with an additional inquiry of resident's awareness of Portland's Air Quality Environmental Public Education and Incentive Program.

By 1998, Oregon achieved "attainment of EPA standards for carbon monoxide and smog." By 2000, more than half of Portland's residents were aware of Clean Air Action Day, the program's primary messages, and what to do if an advisory was issued. While increased numbers of residents used alternatives to single-person commuting, car sharing did not result in fewer vehicle miles traveled. Aside from regulated products, no measurable sales increases in low VOC products could be directly attributed to the education and incentive program. However, sales for zero VOC paint generally increased and a number of paint manufacturers discontinued sale of paints with high VOC emissions. More than 1600 gas-powered lawnmowers were removed from service in the first four

years before the lawnmower buyback program ended in 2000 when a partner utility company discontinued funding.

Program Cost

Approximately \$250,000/year with heavy community partnership and donation of in-kind support.

Comment

This is an excellent example of the value of broad-based partnerships, creative promotion, and use of the community-based social marketing tools of commitment, point-of-purchase prompts or cues, word-of-mouth, vivid and personalized communication, feedback, and financial incentives (see www.toolsofchange.com/).

Important lessons learned highlight the importance of sustainable change, and not expecting “too much, too fast.” In cultivating community and business partnerships, groups seeking change through social marketing must understand how the partnership benefits the self-interest of a business or group and promote that, with an end product that is a win-win situation. Portland’s DEQ recognized the importance of a *marketing mix*—how well a program works overall is often dependent on not relying on any one communication strategy or tool, but rather how communication and marketing tools are used in conjunction with one another. Repeating a message in a variety of different venues, through a variety of different media, serves to build and reinforce that message, creating a “strong foundation for knowledge of, and participation in, the programs.” Finally, of all the marketing methods, the Portland program found direct financial incentive to be the most effective in encouraging a change, noting that “people were much more willing to scrap their lawnmowers if they knew they would receive a \$50 coupon for an electric mower or push mower.”



Case Study 10

The National Women, Infants, and Children (WIC): Breast-feeding Promotion Program

In Brief: This comprehensive, national program was designed to promote breast-feeding among WIC participants and other economically disadvantaged families. Participant observation, in-depth interviews, and a survey were used to collect data from WIC participants, their family members, WIC employees, and other health providers. Knowledge about these target groups was used to identify products and behaviors to be targeted to specific audiences, pricing, promotional strategies and messages, placement of information about breast-feeding, and overall outcome goals.

By 2000, the program had been implemented in 54 of 88 WIC state, intertribal, or territorial organizations. Several state WIC agencies initiated their own program evaluations and collaboration steps for national program evaluation were underway.

Reference: Lindenberger, J.H. & Bryant, C.A. (2000). Promoting breast-feeding in the WIC program: A social marketing case study. *American Journal of Health Behavior*, 24(1), 53-60.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 2 | 3 | 2 | 3 | 2 | 3 | N/A | N/A |

Background

The WIC program was established in 1972 to provide economically disadvantaged women, infants, and young children with nutrition education, supplementary nutritious foods, and referrals to appropriate health and social services. WIC's popularity can be attributed to its emphasis on helping women achieve improved nutritional status and better pregnancy outcomes, and enabling children under five years of age to achieve their maximum potential for physical and cognitive growth.

Breast-feeding support, education, and promotion are all part of WIC's services. In fact, a portion of each state's WIC allocation is to be used specifically to support and encourage breast-feeding. Even so, WIC participants breast-feed their babies at lower rates than women in higher socioeconomic brackets. When this project began in 1995, 59.7 percent of infants in the United States were breast-fed in the hospital and 21.6 percent at 6 months. Only 46.6 percent of infants in WIC were breast-fed in the hospital, and 12.7 percent at six months.

As proposed to the U.S. Department of Agriculture, Food and Nutrition Service in 1995, this project was intended to capitalize on WIC's broad national reach to millions of women who were breast-feeding at a lower rate than the population as a whole.

Formative Research

- Participant observation in five pilot states
- 122 in-depth interviews with WIC participants; 62 in-depth interviews with WIC employees
- 12 focus-group interviews with WIC participants; one with health care providers
- 45 telephone interviews with secondary target audience members
- Survey of 292 WIC participants

The purposes of the formative research:

- To identify WIC participants' perceptions of breast-feeding and bottle-feeding
- To identify the factors that influence WIC participants' infant-feeding decisions
- To identify effective information channels and spokespersons for promoting breast-feeding among WIC participants
- To identify secondary and tertiary audiences' perceptions of breast-feeding
- To identify the factors that motivate and deter secondary and tertiary audiences from encouraging women to breast-feed

Target Audience(s)

The project's approach to segmenting target audiences was related to an aspect of the Price factor—the perceived costs (disadvantages) of breast-feeding over bottle feeding.

Primary Audience

Pregnant Anglo American, African American, and Hispanic American women enrolled in the WIC program or income eligible (i.e., income below 185 percent of the US poverty guidelines). Women in this group perceived breast-feeding as embarrassing; conflicting with work, school, and an active social life; and/or jeopardizing their relationships with spouses, boyfriends, and mothers. Women who doubted their abilities to adequately nourish their babies or nurse successfully were also targeted.

Secondary Audience

People who influence women in WIC—pregnant women's mothers, husbands or boyfriends, WIC nutritionists and clerical staff, and prenatal health care providers.

Tertiary Audience

The general public. Because social norms about breast-feeding, especially in public settings, have a strong influence over women's decisions about feeding their infants, the campaign also targeted the general public.

Nine states (Arkansas, California, Iowa, Mississippi, Nevada, New Jersey, New York, Ohio, and West Virginia) and the Chickasaw Nation were selected to serve as research and demonstration sites. Monitoring and evaluation identified two target groups that required materials and strategies tailored more specifically to their needs, wants, and environments:

- Prenatal health care providers working outside WIC
- Ethnic groups (especially Native Americans) which were not originally targeted

Target Behavior(s)

The four goals were:

1. Increase breast-feeding initiation rates
2. Increase breast-feeding duration rates among WIC participants
3. Increase referrals to WIC for breast-feeding support
4. Increase general public support for breast-feeding

Product(s)

The Product is breast-feeding and the emotional benefits associated with it. The project positioned breast-feeding as preferable to its competition—bottle feeding—emphasizing the emotional benefits to families and children rather than emphasizing the health benefits. The choice of benefits emphasized were identified during formative research.

Health benefits to the baby were emphasized less than emotional benefits because the formative research indicated the emotional benefit was more influential with target audiences.

Price

In addressing the Price factor, the campaign's marketing plan focused on ways to lower the psychological and social costs (barriers) or make them more acceptable. A key price-related tactic was a three-step counseling approach designed to teach health providers to identify patients' perceptions of breast-feeding's costs and help mothers develop ways to lower the costs most relevant to them personally. Key benefits discovered were the emotional bonding and connection with a new baby.

Place

The Place factor was addressed with a strategy focused on legislative advocacy and public and private-sector policy development to make workplaces and public settings more welcoming to women breast-feeding. Families make infant feeding decisions together and can be reached in a variety of places, including the home. Efforts to make workplaces, hospitals, and public settings more "breast-feeding-friendly" are also important.

The project used a wide variety of strategies to facilitate support for breast-feeding:

- Professional training: national training for WIC staff who would carry out the program at the state and local levels; training of nurses, physicians, and others
- Peer counselor programs
- Curriculum development
- Consumer information and education for face-to-face use in women's homes, where they could discuss breast-feeding with family members and friends
- Media advocacy and grassroots community advocacy

Promotion

The campaign slogan, *“Loving support makes breast-feeding work,”* and program materials emphasized the role family members, friends, and the public play in mothers’ willingness and ability to breast-feed. Many different locations (besides WIC) where women of childbearing age seek information about infant feeding were used for message distribution.

The original media campaign included:

- Three 30-second TV spots; two in English, one in Spanish
- Three 60-second radio spots; two in English, one in Spanish
- Outdoor advertising in English and Spanish
- Nine posters targeting the primary ethnic groups in WIC (English and Spanish)
- A WIC staff support kit pocket folder containing a motivational/information booklet, guides to breast-feeding resources, and promotion

Once it was determined that prenatal health care providers need specifically targeted support materials, the federal Maternal and Child Health Bureau funded a Physicians and Health Care Providers Breast-feeding Promotion Kit.

Evaluation

Impact/Outcome Evaluation

Implementation of at least some portion of the National WIC breast-feeding promotion program has occurred in 54 of 88 WIC state, intertribal, or territorial organizations. As of 2000, national funding for comprehensive evaluation had not been allocated by the federal government, but private-sector partners and states had taken practical steps to measure program effectiveness. Since the case was published, the authors have also received results from Mississippi and Iowa.

Comment

Social marketing core concepts were employed with great depth to guide, fine-tune, and continually adjust this campaign to respond to the characteristics of various target audiences. The “buy-in” of state WIC programs through their own funds, the building of local, state, and national partnerships, and the use of a private-sector social marketing organization as the distributor/clearinghouse of program materials helped minimize bureaucratic obstacles. The legislative and workplace advocacy to reduce physical barriers to breast-feeding in public and at work are excellent examples of thinking of the Place factor with a marketing mindset—making it easier, more convenient, and appropriate for women to find places to breast-feed.



Case Study 11

A Social Marketing Approach to Involving Afghan Immigrants in Community-Level Alcohol Problem Prevention

In Brief: A community level program to prevent alcohol-related problems in Hayward, California, through environmentally focused public health approaches, sought to involve a new population—Afghans who had recently immigrated from a culture where abstinence was prescribed in the Islamic law rooted in the Koran. The goal of the program was to determine what “value-based benefits”—protective factors from traditional Afghan culture—various members of the Afghan community could identify to encourage their involvement in preventing alcohol problems through environmental changes. Using in-depth interviews with key community informants and focus groups, the project identified promising channels of message dissemination, especially through community spokespersons.

Note: Social marketing is not considered an effective approach to treat addictive behaviors. However, it can be used successfully as a way to create an intervention for prevention of initiation, such as increased community involvement and policy changes, as was the focus in this case.

Reference: Cherry, L. & Redmond, S.P. (1994). A social marketing approach to involving Afghans in community-level alcohol problem prevention. *The Journal of Primary Prevention*, 14(4), 289-310.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 1 | 3 | 3 | 2 | 2 | 3 | N/A | N/A |

Background

After the Soviet Union invaded Afghanistan in 1979, large numbers of Afghans escaped to the United States. By 1992, nearly half of them lived in California, and more than 60 percent of those lived in the San Francisco Bay area. In 1992 approximately 400 students in the Hayward School District reportedly spoke Farsi—a Persian language spoken in some parts of Afghanistan.

Research in the early 1990s on health and cultural adjustment among refugees identified a number of factors relevant to Afghans as well as their peers from other Middle Eastern countries. Culture shock was associated with the lack of time for transition, language problems, perceived loss of status, the challenges of finding meaningful employment, anxiety about children absorbing new (American) values and behaviors, lack of social support, and ethnic bias.

According to the Holy Koran, alcohol is spiritually “dirty,” and contact with it is prohibited by God. Drinking alcohol is considered to be a sin as serious as gambling, idolatry, murder, and other crimes. The primary concerns about alcohol, from a religious standpoint, are based on the issues of health and loss of self-control.

While some Afghans drank in their homeland, especially after the Soviets invaded and brought vodka, the easy availability of alcohol in the U.S. was seen as a problem by interviewees in this study. The use of alcohol at social gatherings, particularly weddings, illustrated basic conflicts in values and behavior in the Afghan community in Hayward. Restaurant owners, banquet managers, and hosts were often expected to provide alcohol for guests. If they did not, many guests would bring their own alcohol and leave the event to get drunk.

In this article there was no description of implementation, execution or process, impact, or outcome evaluation. This case is primarily an example of marketing research methods and marketing thinking.

Formative Research

This entire project was intended to inform the designers of a community-based alcohol problem prevention program. The research could all be interpreted as formative.

The four research objectives were:

1. **To determine the extent to which alcohol may be creating problems for Afghans** who are now living in the greater Hayward area and who have a traditionally abstinent heritage. (For example, were traditional protections through religious and cultural restrictions about drinking alcohol breaking down? and if so, for whom?)
2. **To identify the kinds of alcohol-related problems that Afghans may be experiencing in this country** (e.g., alcoholism, drinking and driving, teen drinking, sales to minors, disruptions at social and cultural events, or other problems)
3. **To better understand how Afghans view causation of alcohol-related problems**, particularly alcoholism.
4. **To elicit viable prevention responses from the Afghan community itself.** Among the questions asked: If cultural protection from alcohol-related problems was being lost, how could it be restored, strengthened, and maintained? Who could be engaged in addressing these issues, and what resources would be needed?

Researchers interviewed the manager of a banquet hall, leaders of cultural groups and social service agencies, religious leaders, and educational administrators. Focus groups included university students, elementary school parents, participants in an Afghan health study, Afghan leaders identified by a social service agency, and citizens of diverse ages and walks of life.

During the formative research several specific environmental and policy changes were suggested to reduce alcohol consumption. These changes would likely follow building involvement in community planning and are as follows:

- Increase parent involvement and communication about cultural issues with youth
- Sell alcohol only in special stores, making access more difficult
- Sell alcohol only on the weekends
- Allow alcohol to be drunk only in homes and restaurants
- Restrict the number of hours that alcohol can be sold
- Raise the price of alcohol

This article does not report on the actual execution of those plans but does describe behaviors that are linked to access and social norms.

Target Audience(s)

Nearly 75 individuals participated in key informant interviews and focus groups which helped identify three target groups of men:

1. Afghans who were not adjusting well to the immigration experience, drinking to cope with the stresses of living in a different culture. This group included alcoholics aged 35-70.
2. "Those who are adjusting too well to the immigration experience," according to one focus group. Young people (teens as one subgroup and 20- to 35-year-olds) who older Afghans believe "don't care about religion and don't listen to anyone."
3. Afghans who drank in their homeland and continued to drink in the U.S., but whose drinking did not seem to create problems except for violations of Islamic law.

Target Behavior(s)

The ultimate goal was to reduce or eliminate alcohol consumption. The target behavior for this project, however, was to increase community involvement in crafting environmental and policy changes that would foster progress toward the larger goal.

The project consultant's approach to this task was based on "community organizing and empowerment principles through which special populations...are supported in identifying and responding to their unique situations." In this case, the unique situation pertained to preventing alcohol-related problems, many of which were associated with Afghan cultural and religious traditions in conflict with the access, norms, and social pressures of a U.S. community.

Health professionals and community members thought that the local community would need to become more involved in reducing access and imparting social norms consistent with reduced use of alcohol. But the first behavior of interest to the planners was to encourage the local community to become more involved in alcohol prevention efforts in their own communities. The specific behaviors that would indicate community involvement were not well defined.

Product(s)

The project defined the Product factor as "involvement with a community-level prevention program" to reduce drinking alcohol. There were no tangible products or services associated with this behavior change case.

Benefits

Two specific benefits of becoming more involved in community alcohol prevention were identified:

1. Community involvement would lead to an enhanced future for Afghan children by helping them adapt to a bicultural life.
2. More enjoyable social events (with less on-the-spot conflict) when community standards for alcohol behavior are defined and enforced by all.

Price

Barriers

Because of the strong prohibitions against alcohol consumption in the Koran, merely admitting that alcohol was a problem suggested a high psychological price for Afghan adults, especially to join a community effort to reduce alcohol consumption. Being involved in prevention meant admitting that life in the U.S. was significantly different from their lives in Afghanistan; often in violation of previously strong taboos. The fear of gossip within the Afghan community also served as a barrier to parents who had a difficult time coping with their children's behaviors.

Place

Place took on two meanings in this case. One set of Place factors related to encouraging Afghan involvement in their communities. This Place factor was addressed by working with local community leaders to take educational and advocacy programs directly to the community at times and places that were considered easy and convenient.

The second set of Place factors was focused on policy changes to support the long-term behavior goal of reducing alcohol consumption in the local community and included a number of tactics that would limit the places and times when liquor was available.

Promotion

Two promotional strategies to encourage community and parental involvement were recommended by interviewees and focus groups:

- Bilingual television programs (in Farsi and English) on cable TV
- Community gatherings

Three videotapes were produced:

- One to educate parents about the social expectations and educational environments faced by their children in the U.S.
- One discussing the anxiety and discomfort created within the Afghan community when social gatherings were disrupted by drinking alcohol
- One to examine the cultural conflicts, misconceptions and confusion reported by younger Afghans about the idea that living in a "free country" meant the absence of rules or standards of behavior

Evaluation

No process, impact, or outcome evaluation data were reported in the journal article on this project.

Comment

Competition for the project included several other culturally related behaviors that affected the information-gathering process: the reluctance to discuss the topic itself in public and the custom for side conversations to occur within group meetings. An equally fundamental issue identified in the study derived from the new (U.S.) environment where the responsibilities of living in a “free country” often became evident only when Afghan youth were punished for violations of often unspoken rules and expectations. Translation was apparently a significant challenge in this endeavor.

From a social marketing perspective, this article describes the formative research process and the development of some portions of a marketing Plan, but does not describe the implementation or evaluation of the subsequent project. Secondly, the description of behaviors is somewhat muddy and goes back and forth between community involvement behaviors (which are not clearly defined) and reduced alcohol consumption within the Afghan community of interest. Readers would be advised to separate the two behaviors clearly and develop separate marketing Plans for each or define the community involvement behavior as an intermediary step to achieving the health behavior of interest (reduced alcohol consumption). Further complicating matters, there is the question: “When does alcohol use become an addictive behavior?”



Case Study 12. STOP IT NOW! VERMONT: An Innovative Social Marketing Approach to Preventing Child Sexual Abuse

In Brief: The purpose of this project was to introduce a public health approach to child sexual abuse prevention. Previous prevention programs focused on children and how to prevent their victimization, or how to report the abuse after the abuse occurred. This program introduced a new approach that focused on adults and how to prevent the perpetration of child sexual abuse.

In 1992, Stop It Now! began formative research with each of their target audiences: adult abusers, those at risk to abuse, their friends and families, and the parents of youth with sexual behavior problems. For abusers and those at risk to abuse, the behavior goals of the program were to increase the number of sexual abusers—and those at risk to abuse—who self-identify, call for help, and proceed through the system, getting effective sex offender specific treatment. For their friends and families and the parents of youth with sexual behavior problems, the behavior goals of the program were to ask questions in situations where there was concern about sexual behaviors, confront precursor behaviors that are warning signs of possible sexual abuse, and report abuse when it is uncovered.

The authors asked, “Can social marketing tools be used on an issue that people don’t even want to talk about?” The process and outcome evaluation data showed that perpetration prevention is feasible, people will reach out for help, and some sexual abusers and those at risk to abuse will step forward to help.

References: Tabachnick, J. (1997). An innovative social marketing approach to preventing child sexual abuse. *Innovations in Social Marketing '97 Conference Proceedings*, 87-92.

Tabachnick, J. & Dawson, E. (2000, November/December). Stop It Now! Vermont: A Four Year Program Evaluation, 1995-1999. *Offender Programs Report*, 1 (4), 49.

Reference contact: STOP IT NOW! 495 Haydenville, MA 01039. 413-268-3096.

| Social Marketing Strengths at a Glance | | | | | | | | | |
|--|------|-------|-----------------------------------|------|-------|-------|------------|-------|------------|
| Aud. | Beh. | Prod. | Price (benefits - barriers) | Pla. | Promo | Comp. | Evaluation | | |
| | | | | | | | For. | Proc. | Imp./Outc. |
| X | X | 3 | 3 | 2 | 3 | 1 | 3 | 2 | 3 |

Background

Since the early 1980s, activists—primarily survivors—have raised awareness of child sexual abuse through sharing personal stories of trauma. By the mid-80s, research studies indicated that one in four to five girls, and one in seven to ten boys will be sexually abused before the age of eighteen. In response, innovative prevention programs were developed for children, and coordinated response teams were piloted throughout the United States to address the increased reporting of child sexual abuse. By the mid-90s legislation was introduced that focused on increased tracking, control and punishment of the sex offender. However, it was not until 1995 that the American Medical Association called sexual abuse a “silent violent epidemic.” The AMA’s press conference announce-

ment provided the framework for a new public health approach to child sexual abuse prevention.

Formative Research

From 1992 to 1995 researchers held focus groups, administered in-depth interviews/questionnaires, and engaged in dialogues with abusers who were in prison and in treatment programs. Socio-demographic characteristics, psychological profiles, and behavior characteristics of the target audiences were collected.

In doing their research, Stop It Now! asked their target audiences traditional marketing questions, and the following:

- What would they want to know or hear in order to stop their abusive behaviors or intervene in a potential abuse situation
- When would they listen to such a message
- From whom they would have most likely heard and accepted this kind of message

Formative research with imprisoned sex abusers proved invaluable to the program design. These findings included:

- Targeted focus groups indicated they would listen to someone like themselves who had similar experiences. Spokespeople should include abusers, those at risk to abuse, their families, and the parents of youth with sexual behavior problems.
- Everyone wanted a message of hope from someone who had learned how to control these destructive behaviors. They wanted to know that healing was possible for those who experienced the trauma of sexual abuse. They said that they needed to understand that “their lives would be forever changed by confronting the situation...but it would also be a better life for everyone in the long run.”
- Respondents continually described the need to talk specifically and directly about the subject. They wanted someone to speak about what was really happening in their lives and to say out loud the words that no one, including themselves, were able to say.
- Most revealed that they could not find adequate constructive information in the public sphere about this issue. They wanted to know why “no one ever talked about the stuff that made them uncomfortable.” Much of what was discussed by the focus groups and interviews with target audiences became the basis for new information generated about the warning signs or risk factors for abusing behaviors.

Target Audience(s)

Previous research indicated children were abused by people they knew and trusted thus it was determined that adults are responsible parties and should be the audience.

With the prevention focus of Stop It Now!, the target audiences were identified as:

- Adult sexual abusers
- People at risk for abusing
- Friends and families of each of these groups
- The parents of youth with sexual behavior problems

Target Behavior(s)

For abusers and people at risk for abusing, the target behaviors are:

- Increased self-identification
- Calling a toll-free helpline for information and referrals
- Using existing treatment programs
- Accessing support systems for abusers and their families

For friends and families of abusers, for friends and families of those at risk for abusing, and for parents of youth with sexual behavior problems, the target behaviors are:

- Questioning sexualized behaviors or inappropriate boundaries within the family
- Increased efficacy in confronting abusing behaviors
- Calling a toll-free helpline for information and referrals

Product(s)

Stop It Now! initiated the first helpline (888-PREVENT) in the country for abusers, those at risk to abuse, their friends and families as well as the parents of youth with sexual behavior problems. To do so, the organization created a referral system and resource manual for treatment providers who specialize in this issue, as well as the protocol to interface with the legal system if a crime had taken place.

Price

Price was considered to be one of the major issues of the campaign. The Price for “reporting a family member, especially if you are unsure whether abuse has occurred” was considered too high for most families. Therapists and physicians are mandated to report child sexual abuse. As a result, Price issues were linked with social stigma and fear of punishment. Without confidentiality and resources to help, the cost to the abuser or to the family member seeking help are extremely high. The Price includes his or her family’s ability to stay together, maintaining individual or family reputation, securing or keeping a job or other sources of family income, and holding any position in their community. Conversely, abusers who self-reported believed the costs of ignoring the problem were too high.

Place

Based on formative research, the information gathered from victim families indicated that police or child protective services were particularly frightening points of access. Stop It Now! created an easier point of access through the toll-free helpline and other information sources (e.g., Web site, brochures, etc.). The confidential helpline addressed the issue of Place to the extent that it eliminated or reduced the risk to individuals and families seeking information and referrals. The ease of access to phone and in-person mental health assistance is a good example of using the Place factor to make a behavior easy to access and perform.

For the abuser audience, the Place factor for getting help and hearing from “others like me” was also addressed through the hotline, confidential mental health help, and the Web site. The program staff spent over two years developing a protocol to help abusers step forward into the legal system and seek help without the threat

of mandatory reporting and prosecution. Protocol development included examination and approval by all district attorneys and Vermont's Attorney General. This policy strategy introduced innovation and created key changes in the Place factor that made it easier and less restrictive for abusers to seek help on their own.

Promotion

The program used a combination of media and community action strategies to reach the public. Media was used to increase awareness and knowledge of the issue. The tools included radio and television public service announcements, bus transportation signs, posters, radio talk shows, press conferences and press releases, op-ed pieces, feature stories, and letter-to-the-editor campaigns.

Community action strategies were utilized to bring the messages in the form of one-on-one interactions to families with members at risk to abuse. The most effective forums were public dialogues between recovering sexual abusers, survivors of abuse, and family members, about the need for prevention. These community events served multiple purposes, such as empowering those who experienced trauma to voice what they have learned, putting a human face on the issue so that others can see that this could happen in any family, and modeling how families can talk about this very difficult issue. Although the stories were about situations where abuse had occurred, their focus was to emphasize the multiple opportunities for adult intervention prior to the abuse occurring. These dialogues were supported by brochures that depicted simple, easy-to-understand warning signs or risk factors for perpetration, which were not available in any other literature at the time.

Evaluation

To evaluate the program, Stop It Now! commissioned Market Street Research (MSR) of Northampton, Massachusetts, to conduct a random digit-dial telephone survey of knowledge, attitudes, and beliefs toward child sexual abuse. Surveys of 200 Vermonters were conducted in 1995, 1997, and 1999 with a margin of error of 4.2 percent to 6.9 percent. MSR also monitored public opinions through a survey of key stakeholders in Vermont. These data points were supplemented by data collected through helpline tracking, a survey of clinicians working with sex offenders (coordinated by the Vermont Center for the Prevention and Treatment of Sexual Abusers), and through tracking coverage in the media, newsletters, the Internet, and other outlets.

Process Evaluation

The MSR evaluation measured the program's efficiency—the ability of staff to get the information and messages out to the target audiences. Staff secured approximately \$100,000 of in-kind contributions for the media campaign. These donations included the development of free television public service announcements and free air time as well, free radio public service announcements, and free placement of posters on the buses in the largest city in Vermont. Staff contacted media outlets to secure free airtime and to approximate the amount of airtime during which the messages were delivered. The process evaluation also tracked the contributions and credibility offered by an active collaborative of key individuals and organizations throughout Vermont. Much of what was accomplished could not have been done without the support of these key organizations and national leaders. The organizations included the OUR House, the Pre-Sentence Alternative Program, Prevent Child Abuse Vermont, the Safer Society Foundation, Inc., the Vermont Center for the Prevention and Treatment of Sexual Abuse, and Vermont Educational Associates.

Impact/Outcome Evaluation

Amazingly, the program documented 118 cases of abuser self-disclosure of sexual abuse (e.g., a report by an abuser with no similar report made by the victim) in the first four years of the program. The majority of these were from adolescents with parental support provided. Prior to the Stop It Now! pilot, there were virtually no incidences of abusers self-disclosing their abuse in Vermont.

Evaluation also measured changes in attitudes and behaviors—what staff considered the program effectiveness. Due to the difficulty in measuring the impact of prevention programming, Stop It Now! utilized key indicators to measure success. After four years, the program demonstrated four indicators of awareness and change: the ability to talk about child sexual abuse increased by 40 percent (from 44.5 percent in 1995 to 84.8 percent in 1999); Vermonters' awareness of child sexual abuse as a problem reached a peak of 78 percent; and an increase in the number of Vermonters who recognized that abusers live in their communities (67 percent in 1995 to 73.7 percent in 1999).

The campaign also found that adults will call for help. During the first four years, the helpline received 657 calls. Of those who called, 15 percent were abusers; 50 percent were calls from people who knew the abuser and/or the victim; and 32 percent of callers were men (much more than the average of 10 percent male callers reported by other helplines in Vermont). Of the calls from friends and family, 72.3 percent were from immediate family members of the abuser and/or the victim.

The 5th P: Policy

Policy had a significant role in Stop It Now! Program success. The program staff spent more than two years developing a protocol to help abusers step forward into the legal system and seek help without the threat of mandatory reporting and prosecution. Protocol development included examination and approval by all district attorneys and Vermont's attorney general. This policy strategy introduced innovation and created key changes in the system that were necessary in order for the project to proceed.

In evaluating policy, the Stop It Now! program currently focuses on the potential implications for primary prevention. In retrospect, original Stop It Now! staff (traditional MBA-trained marketers) have reported feeling as though they did not adequately consider the impact of emerging policies and particularly the impact of policy as a source of competition for their product. New legislation during the first four years of the Stop It Now! program included initiatives such as community notification, chemical castration, and civil commitment (only the first actually became law). Publicity surrounding all of these legislative initiatives added significant costs and little benefit to those who may consider seeking help for themselves or someone in their family. This issue of policy as competition was particularly evident during the first six months of the program. The number of callers to the helpline who identified themselves as abusers, or at risk to abuse, dropped from a high of 65 percent in fall 1995 down to zero in spring 1996 after the publicity of Megan's Law (the national community notification statute) hit Vermont. The Stop It Now! program's response was to be patient, and in time the percentage of self-identifying abuser calls to the helpline recovered to a steady 15 percent.

Program Cost

The program was funded by individual donors and private foundation support and piloted in the state of Vermont. No government funds were used in the development of this public health approach. Funding for the entire project in Vermont was approximately \$60,000 per year in direct costs with additional in-kind contributions from the media for ads and public service announcements and from Market Street Research, an independent evaluation firm, for an additional \$120,000 per year. The entire budget was close to \$180,000 annually.

Comments

Secondary Target Audiences: Although the primary audiences were clearly identified and considerable formative research done, the nonprofit Stop It Now! program had secondary audiences that were not researched. For example, by relying on in-kind media donations of PSA time, the PSA spots had to appeal to TV and radio station's and periodical's marketing standards. The first Stop It Now! advertisement, which was directed at and tested very well with abusers, read: "Two years ago, I would have been turned on by this picture," with a picture of two children in the ad. The radio stations and magazines refused to give any free space for a number of reasons, one of which was that they did not want their listeners or readers to think that sex offenders liked the programs. However, advertisements directed at bystanders (families, friends, etc.) were openly accepted by these same media outlets, even the harsher slogans developed by ad agencies, "Mommy told me to save myself for someone special. Daddy told me he was..."

Growth of Stop It Now!:

Stop It Now! has collaborated with other organizations to develop programs with the Joseph J. Peters Institute in Philadelphia, with Project Pathfinder, Inc. in Minnesota, with the Lucy Faithfull Foundation in the United Kingdom, and with Prevent Child Abuse Georgia in Georgia. The impact of policy strategies and policy as competition has been demonstrated by the dramatic differences in acceptance of the program and approach in each of these pilot areas.

To learn more about these programs, contact: Joan Tabachnick at STOP IT NOW!
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Bibliography



A

- Aaker, D.A. (1991). *Managing Brand Equity: Capitalizing on the Value of a Brand Name*. New York, NY: Free Press.
- Abrams, B. (1996). *The Observational Research Handbook: Understanding How Consumers Live with Your Product*. Lincolnwood, IL: NTC.
- Albrecht, T.L. (1997). Defining social marketing: 25 years later. *Social Marketing Quarterly*, 3(3-4), 21-23.
- Albrecht, T.L. & Bryant, C. (1996). Advances in segmentation modeling for health communication and social marketing campaigns. *Journal of Health Communication*, 1(1), 65-80.
- Alden, D. & Tietje, B. (1998). Social marketing and consumer sales promotion: A test of emerging theory on promotion effectiveness for 'maintenance stage' consumers. *Social Marketing Quarterly*, 4(4), 83-92.
- Andreasen, A.R. (1982). Non-profits: Check your attention to customers. *Harvard Business Review*, 60(3), 105-110.
- Andreasen, A.R. (1993). Presidential address: A social marketing research agenda for consumer behavior researchers. In M. Rothschild and L. McAlister (Eds.), *Advances in Consumer Research*, 20 (pp. 1-6), Conference proceedings, Association for Consumer Research.
- Andreasen, A.R. (1995). *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment*. San Francisco, CA: Jossey-Bass.
- Andreasen, A.R. (2002). *Marketing Research that Won't Break the Bank: A Practical Guide to Getting the Information You Need*. San Francisco, CA: Jossey-Bass.
- Atkin, C., & Wallack, L. (1990). *Mass Communication and Public Health*. Newbury Park, CA: Sage.



B

- Babbie, E.R. (1998). *The Practice of Social Research*. New York: Wadsworth Publishing.
- Bagozzi, R.P. (1979). Toward a formal theory of marketing exchange, In O.C. Ferrell, S.W. Brown, & C.W. Lamb (Eds.), *Conceptual and Theoretical Developments in Marketing* (pp. 431-447). Chicago, IL: American Marketing Association.
- Balch, G.I., & Sutton, S.M. (1997). Keep me posted: A plea for practical evaluation. In M.E. Goldberg, M. Fishbein, & S.E. Middlestadt (Eds.), *Social Marketing: Theoretical and Practical Perspectives* (pp. 61-74). Mahwah, NJ: Lawrence Erlbaum Associates.
- Blattberg, R.C., & Neslin, S.A. (1990). *Sales Promotion: Concepts, Methods, and Strategies*. Englewood Cliffs, NJ: Prentice Hall.
- Braus, P. (1995, November). Selling good behavior. *American Demographics*, 60-64.

Brehony, K.A., Fredericksen, L.W., & Solomon, L.J. (1984). Marketing principles and behavioral medicine: An overview. In L.W. Fredericksen, L.J. Solomon, & K.A. Brehony (Eds.), *Marketing Health Behavior: Principles, Techniques, and Applications* (pp. 3-22). New York, NY: Plenum.



C

Centers for Disease Control and Prevention. (2003). CDCynergy-Social Marketing [Computer software]. Atlanta, GA.

Chakravorty, B. (1996). Product substitution for social marketing of behavior change: A conceptualization. *Social Marketing Quarterly*, 3(2), 5-13.

Cherry, L. & Redmond, S.P. (1994). A social marketing approach to involving Afghans in community-level alcohol problem prevention. *The Journal of Primary Prevention*, 14(4), 289-310.

Churchill, G.A. (1995). *Marketing Research: Methodological Foundations*. Fort Worth, FL: Dryden.

Ciszewski, R.L. & Harvey, P.D. (1994). The effect of price increases on contraceptive sales in Bangladesh. *Journal of Biosocial Science*, 26(1), 25-35.

Coreil, J. & Mull, D. (1988). Introduction: Anthropological studies of diarrheal illness. *Social Science and Medicine*, 27(1), 1-3.



D

Dahl, D.W., Gorn, G.J., & Weinberg, C.B. (1997). Marketing, safer sex, and condom acquisition. In M.E. Goldberg, M. Fishbein, & S.E. Middlestadt (Eds.), *Social Marketing: Theoretical and Practical Perspectives* (pp. 169-185). Mahwah, NJ: Lawrence Erlbaum Associates.

Davies, J. & Agha, S. (1997). Contraceptive social marketing in Pakistan: A new system for assessing the impact of price increases on condom sales and consumption in a low-resource setting. *1997 Innovations in Social Marketing: Conference Proceedings* (pp. 11-15).

Debus, M. (1988). *Handbook for Excellence in Focus Group Research*. The Association for Educational Development.

DeLozier, M.W. (1976). *The Marketing Communication Process*. New York, NY: McGraw-Hill.



F

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

Frank, R.F., Massy, W.F., & Wind, Y. (1972). *Market Segmentation*. Englewood Cliffs, NJ: Prentice-Hall.

Fredinger, F. (1999). Using market research to influence environmental policies to promote physical activity. Conference Abstracts of Ninth Annual Social Marketing Conference in Public Health. *Social Marketing Quarterly*, 5(4), 80-81.

Fox, K.F.A. & Kotler, P. (1980-81). Reducing cigarette smoking: An opportunity for social marketing? *Journal of Health Care Marketing*, 1(1), 8-17.



G

Gemunden, H.G. (1985). Perceived risk and information search: A systematic meta-analysis of the empirical evidence. *International Journal of Research in Marketing*, 2, 79-100.



H

Harvey, P.D. (1997). Advertising affordable contraceptives: The social marketing experience. In M.E. Goldberg, M. Fishbein, & S.E. Middlestadt (Eds.), *Social Marketing: Theoretical and Practical Perspectives* (pp. 147-168). Mahwah, NJ: Lawrence Erlbaum Associates.

Harvey, P. (1998). Product advertising versus ideas advertising (summary of remarks). *Social Marketing Quarterly*, 4(4), 32-34.

Hastings, G.B. & Elliot, E.B. (1993). Social marketing practice in traffic safety. In OECD Scientific Expert Group (Eds.), *Marketing of Traffic Safety* (pp. 35-53). Paris, France: Organisation for Economic Co-operation and Development.



K

Kennedy, M.G., Mizuno, Y., Seals, B.F., Myllyluoma, J., & Weeks-Norton, K. (2000). Increasing condom use among adolescents with coalition-based social marketing. *AIDS*, 14, 1809-1818.

Kotler, P. (1975). *Marketing for Nonprofit Organizations*. Englewood Cliffs, NJ: Prentice Hall.

Kotler, P. (1988). *Principles of Marketing*. Englewood Cliffs, NJ: Prentice Hall.

Kotler, P. (1997). *Marketing Management: Analysis, Planning, Implementation, and Control*. Upper Saddle River, NJ: Prentice Hall.

Kotler, P. & Levy, S. (1969). Broadening the concept of marketing. *Journal of Marketing*, 33, 10-15.

Kotler, P. & Levy, S. (1971). Demarketing, yes, demarketing. *Harvard Business Review*, 49(6) 74-80.

Kotler, P. & Roberto, E.L. (1989). *Social Marketing: Strategies for Changing Public Behavior*. New York, NY: Free Press.

Kotler, P., Roberto, N., & Lee, N. (2002). *Social Marketing: Improving the Quality of Life*. Second Edition. Thousand Oaks, CA: Sage Publications.

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



L

Lazarsfeld, P. F., & Merton, R.K. (1949). Mass communication, popular taste, and organized social action. In W. Schramm (Ed.), *Mass Communication* (pp. 459-80). Urbana-Champaign, IL: University of Illinois.

Lindenberger, J. H. & Bryant, C. A. (2000). Promoting breast-feeding in the WIC program: A social marketing case study. *American Journal of Health Behavior*, 24(1), 53-60.

Loos, G.P. (1995). Foldback analysis: A method to reduce bias in behavioral health research conducted in cross-cultural settings. *Qualitative Inquiry*, 1(4), 465-480.

Lovelock, C.H. & Weinberg, C.B. (1984). *Marketing for Public and Non-Profit Managers*. New York, NY: John Wiley & Sons.

Lefebvre, R.C. (1996). Benefits and barriers to conducting research in social marketing. *The second conference on social marketing: Advancing empirical work in social marketing*, (In the discussion section titled, "Recent developments in theory and practice").



M

Mayer, J.P., Taylor, J.R., & Thrush, J.C., (1990). Exploratory cluster analysis of behavioral risks for chronic disease and injury: Implications for tailoring health promotion services. *Journal of Community Health*, 15(6), 377-389.

McCarthy, E.J. (1968). *Basic Marketing: A Managerial Approach*. Homewood, IL: Irwin.

McCormack Brown, K., Bryant, C.A., Forthofer, M.S., Perrin, K.M., Quinn, G.P., Wolper, M., & Lindenberger, J.H. (2000). Florida Cares for Women social marketing campaign: A case study. *American Journal of Health Behavior*, 24(1), 44-52.

McKenzie-Mohr, D. *Fostering Sustainable Behavior*. www.cbsm.com.

Mehrabian, A. (1972). *Nonverbal Communication*. Chicago, IL: Aldine Publishing.



N

Novelli, W.D. (1984). Developing marketing programs. In L.W. Fredericksen, L.J. Solomon, & K.A. Brehony (Eds.). *Marketing* Lindenberger, J. H. & Bryant, C. A. (2000). Promoting breast-feeding in the WIC program: A social marketing case study. *American Journal of Health Behavior*, 24(1), 53-60. *Health Behavior: Principles, Techniques, and Applications* (pp. 59-89). New York: Plenum.



P

Pealer, L.M. & Weiler, R.M. (2000). Research notes—Web-based health survey research: A primer. *American Journal of Health Behavior*, 24(1), 69-72.

Peterson, E.A. & Koehler, J.E. (1997). 1997 *Innovations in Social Marketing Conference Proceedings*, 4-8.

Prochaska, J.O. & DiClemente, C.C. (1986). *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones/Irwin.



R

Ray, M. (1982). *Advertising and Communication Management*. Englewood Cliffs, NJ: Prentice Hall.

Rimal, R.N. & Flora, J.A. (1997). Interactive technology attributes in health promotion. In R.L. Street, W.R. Gold, & T. Manning (Eds.), *Health Promotion and Interactive Technology: Theoretical Applications and Future Directions* (pp. 19-39). Mahwah, NJ: Lawrence Erlbaum Associates.

Rothschild, M.L. (1999). Carrots, sticks, and promises: A conceptual framework for the behavior management of public health and social issues, *Journal of Marketing*, 63.



S

Salazar, B. (1999). Pretesting. Conference Abstracts of Ninth Annual Social Marketing Conference in Public Health. *Social Marketing Quarterly*, 5(4), 119-120.

Samuels, S.E. (1993). Project LEAN—lessons learned from a national social marketing campaign. *Public Health Reports*, 108(1), 45-53.

Shimp, T.A. (1997). *Advertising, Promotion, and Supplemental Aspects of Integrated Marketing Communications*. New York, NY: Harcourt Brace.

Siegel, M. & Doner, L. (1998). *Marketing Public Health: Strategies to Promote Social Change*. Gaithersburg, MD: Aspen.

Smith, W.A. (1991). Organizing large-scale interventions for sexually transmitted disease prevention. In J.N. Wasserheit, S.O. Aral, K.K. Holmes, & P.J. Hitchcock, *Research Issues in Human Behavior and Sexually Transmitted Diseases in the AIDS Era* (chapter 13). Washington DC: American Society for Microbiology.

Smith, W.A. (1997). Social marketing: Beyond the nostalgia. In M.E. Goldberg, M. Fishbein, & S.E. Middlestadt (Eds.), *Social Marketing: Theoretical and Practical Perspectives* (pp. 21-28). Mahwah, NJ: Lawrence Erlbaum Associates.

Social Marketing Quarterly, vol. VI, number 1, March 2000.

Sternthal, B. & Craig, C.S. (1974). Fear appeals; revisited and revised. *Journal of Consumer Research*, 3, 23-34.

Street, R.L. & Rimal, R.N. (1997). Health Promotion and interactive technology: A conceptual Foundation, In R.L. Street, W.R. Gold, & T. Manning (Eds.), *Health Promotion and Interactive Technology: Theoretical Applications and Future Directions* (pp. 1-18). Mahwah, NJ: Lawrence Erlbaum Associates.



T

Tabachnick, J. (1997). An innovative social marketing approach to preventing child sexual abuse. *Innovations in Social Marketing '97 Conference Proceedings*, 87-92.

Tabachnick, J. & Dawson, E. (2000, November/December). Stop It Now! Vermont: A four year program evaluation, 1995-1999. *Offender programs Report*, 1 (4), 49.

Tools of Change. www.toolsofchange.com/English/CaseStudies/. Co-sponsored by Natural Resources Canada, Cullbridge Marketing and Communications, Environment Canada, Federation of Canadian Municipalities, Health Canada, and NRTEE.

Turow, J. (1997). *Breaking Up America: Advertisers and the Media World*. Chicago, IL: The University of Chicago Press.



W

Wechsler, H., Bash, C.E., Zyburt, P., & Shea, S. (1998). Promoting the selection of low-fat milk in elementary school cafeterias in an inner-city Latino community: Evaluation of an intervention. *American Journal of Public Health*, 88(3), 427-433.

Wechsler, H., & Wernick, S.M. (1992). A social marketing campaign to promote low-fat milk consumption in an inner-city Latino community. *Public Health Reports*, 107(2), 202-207.

Weinberg, C.B. & Ritchie, R.J.B. (1999). Cooperation, competition and social marketing. *Social Marketing Quarterly*, 5(3), 117-126.

Weinreich, N.K. (1996). A more perfect union: Integrating quantitative and qualitative methods in social marketing research. *Social Marketing Quarterly*, 3(1), 53-58.

Weinreich, N.K. (1999). *Social Marketing Library* (online resource). Retrieved January 10, 2001 from the World Wide Web: www.social-marketing.com/library.html.

Weinreich, N.K. (1999). *Hands on Social Marketing: A Step-by-Step Guide*, Thousand Oaks, CA: Sage Publications

Williams, J.E., Flora, J.A. (1995). Health behavior segmentation and campaign planning to reduce cardiovascular disease risk among Hispanics. *Health Education Quarterly*, 21(1), 36-48.

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