A Synopsis of Social Marketing
by Lynn MacFadyen, Martine Stead and Gerard Hastings (1999)

Introduction
The term social marketing was first coined by Kotler and Zaltman in 1971 to refer to the application of marketing to the solution of social and health problems. Marketing has been remarkably successful in encouraging people to buy products such as Coca Cola and Nike trainers, so, the argument runs, it can also encourage people to adopt behaviours that will enhance their own - and their fellow citizens' - lives.

Many social and health problems have behavioural causes: the spread of AIDS, traffic accidents and unwanted pregnancies are all the result of everyday, voluntary human activity. The most dramatic example of this is tobacco use, which kills one in two smokers (Peto 1994) - an estimated 6 million people in the UK alone since the health consequences were first established in the early 1950's. Social marketing provides a mechanism for tackling such problems by encouraging people to adopt healthier lifestyles.

However, health problems have a social, as well as an individual, dimension. This phenomenon is most clearly demonstrated by the epidemiological data which shows that poverty is one of the most consistent and basic predictors of ill-health in the UK (Smith 1997, Jarvis 1994, Marsh & MacKay, 1994), Europe (Whitehead & Diderichsen 1997), the USA (McCord & Freeman 1990, Pappas et al 1993) and the southern hemisphere (WHO 1995). The lack of opportunity, choice and empowerment it generates prevents people from adopting healthy lifestyles. Social marketing also has a great deal to offer here by influencing the behaviour, not just of the individual citizen, but also of policy makers and influential interest groups. Social marketers might target the media, organisations and policy and law makers.

Social marketing, like generic marketing, is not a theory in itself. Rather, it is a framework or structure that draws from many other bodies of knowledge such as psychology, sociology, anthropology and communications theory to understand how to influence people's behaviour (Kotler and Zaltman, 1971). Like generic marketing, social marketing offers a logical planning process involving consumer oriented research, marketing analysis, market segmentation, objective setting and the identification of strategies and tactics. It is based on the voluntary exchange of costs and benefits between two or more parties (Kotler and Zaltman, 1971). However, social marketing is more difficult than generic marketing. It involves changing intractable behaviours, in complex economic, social and political climates with often very limited resources (Lefebvre and Flora, 1988). Furthermore, while, for generic marketing the ultimate goal is to meet shareholder objectives, for the social marketer the bottom line is to meet society's desire to improve its citizens' quality of life. This is a much more ambitious - and more blurred - bottom line.

The Development of Social Marketing
Social marketing evolved in parallel with commercial marketing. During the late 1950s and early 1960s, marketing academics considered the potential and limitations of applying marketing to new arenas such as the political or social. For example, in 1951, Wiebe asked the question, "Can brotherhood be sold like soap?", and suggested

that the more a social change campaign mimicked that of a commercial marketing campaign, the greater the likelihood of its success.

To many, however, the idea of expanding the application of marketing to social causes was abhorrent. Luck (1974) objected on the grounds that replacing a tangible product with an idea or bundle of values threatened the economic exchange concept. Others feared the power of the marketing, misconceiving its potential for social control and propaganda (Laczniack et al 1979). Despite these concerns, the marketing concept was redefined to include the marketing of ideas and the consideration of its ethical implications.

The expansion of the marketing concept combined with a shift in public health policy towards disease prevention began to pave the way for the development of social marketing. During the 1960s, commercial marketing technologies began to be applied to health education campaigns in developing countries (Ling et al 1992, Manoff 1985). In 1971, Kotler and Zaltman published their seminal article in the Journal of Marketing *'Social marketing: an approach to planned social change'*. This was the first time the term "social marketing" had been used and is often heralded as its birth. They defined social marketing as *"the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution and marketing research."* (p5).

In practice, social marketing was being explored by a number of people at the same time, including Paul Bloom, Karen Fox, Dick Manoff, and Bill Novelli. Early examples of social marketing emerged during the 1960s as part of international development efforts in third world and developing countries (Manoff 1985, Walsh et al 1993). For example, family planning programs in Sri Lanka moved away from clinical approaches and examined the distribution of contraceptives through pharmacists and small shops (Population Services International 1977). They began to experiment with marketing techniques such as audience segmentation and mass communication. Similarly, oral rehydration projects in Africa began to take a more consumer oriented approach to programme development. Important initiatives in the developed world included the Stanford Heart Disease Prevention Program, the National High Blood Pressure Prevention Program, and the Pawtucket Heart Health Program (Farquar et al 1985, National Heart, Lung and Blood Institute 1973, Lefebvre 1987). While many of these early programs were primarily exercises in social communications, they were important for the inception of social marketing.

By the 1980s, academics were no longer asking *if* marketing should be applied to social issues, but rather *how* should this be done? During this period, practitioners shared their experiences and made suggestions for the development of social marketing theory and practice (Ling et al 1992). Fox and Kotler (1980) described the evolution of social advertising into social communications. Bloom (1980) explored the evaluation of social marketing projects and found that many studies were poorly designed and conducted. In 1981, Bloom and Novelli reviewed the first ten years of social marketing and advocated more research to dispel criticism that social marketing lacked rigour or theory. They identified a need for research to examine audience segmentation, choosing media channels and designing appeals, implementing long

term positioning strategies, and organisational and management issues (Bloom and Novelli, 1981).

Lefebvre and Flora (1988) and Hastings and Haywood (1991, 1994) then gave social marketing widespread exposure in the public health field, generating lively debates about its applicability and contribution. While social marketing was being practised in many countries by this time, the publication of these papers was followed by a widespread growth in its popularity (Lefebvre, 1996). Centres of expertise began to emerge, most notably at the College of Public Health at the University of South Florida, the Centre for Social Marketing at Strathclyde University in Scotland, and at Carleton University in Ottawa, Canada.

Defining Social Marketing

A social marketing campaign or programme contains the following elements: a consumer orientation (Lefebvre and Flora 1988, Lefebvre 1992b, Andreasen 1995), an exchange (Lefebvre and Flora 1988, Lefebvre 1996, Leathar and Hastings 1987, Smith 1997) and a long-term planning outlook (Andreasen 1995).

(i) A Consumer Orientation

Consumer orientation is probably the key element of all forms of marketing, distinguishing it from selling - and product - and expert-driven approaches (Kotler et al 1996). In social marketing, the consumer is assumed to be an active participant in the change process. The social marketer seeks to build a relationship with target consumers over time and their input is sought at all stages in the development of a programme through formative, process and evaluative research.

In short, the consumer centred approach of social marketing asks not *"what is wrong with these people, why won't they understand?"*, but, *"what is wrong with us? What don't we understand about our target audience?"*

(ii) An Exchange

Social marketing not only shares generic marketing's underlying philosophy of consumer orientation, but it also its key mechanism, exchange (Kotler and Zaltman 1971). While marketing principles can be applied to a new and diverse range of issues - services, education, high technology, political parties, social change - each with their own definitions and theories, the basic principle of exchange is at the core of each (Bagozzi 1975). Kotler and Zaltman (1971) argue that: "marketing does not occur unless there are two or more parties, each with something to exchange, and both able to carry out communications and distribution" (p4).

Exchange is defined as an exchange of resources or values between two or more parties with the expectation of some benefits. The motivation to become involved in an exchange is to satisfy needs (Houston and Gassenheimer, 1987). Exchange is easily understood as the exchange of goods for money, but can also be conceived in a variety of other ways: further education in return for fees; a vote in return for lower taxes; or immunisation in return for the peace of mind that one's child is protected from rubella.

Exchange in social marketing puts a key emphasis on **voluntary behaviour**. To facilitate voluntary exchanges social marketers have to offer people something that

they really want. For example, suppose that during the development of a programme to reduce teenage prevalence of sexually transmitted diseases (STDs) by encouraging condom use, research with the target finds that they are more concerned with pregnancy than STDs. The social marketer should consider highlighting the contraceptive benefits of condoms, rather than, or at least as well as, the disease prevention ones. In this way consumer research can identify the benefits which are associated with a particular behaviour change, thereby facilitating the voluntary exchange process.

(iii) Long-term Planning Approach
Like generic marketing, social marketing should have a long term outlook based on continuing programmes rather than one-off campaigns. It should be strategic rather than tactical. This is why the marketing planning function has been a consistent theme in social marketing definitions, from Kotler in 1971 to Andreasen in 1996.

The social marketing planning process is the same as in generic marketing. It starts and finishes with research, and research is conducted throughout to inform the development of the strategy. A situational analysis of the internal and external environment and of the consumer is conducted first. This assists in the segmentation of the market and the targeting strategy. Further research is needed to define the problem, to set objectives for the programme and to inform the formulation of the marketing strategy. The elements of the social marketing mix are then developed and pre-tested, before being implemented. Finally , the relative success of the plan is monitored and the outcome evaluated.

(iv) Moving Beyond the Individual Consumer
Social marketing seeks to influence the behaviour not only of individuals but also of groups, organisations and societies (eg. Hastings et al 1994c, Lawther & Lowry 1995, Lawther et al 1997, Murray & Douglas 1988). Levy and Zaltman (1975) suggest a sixfold classification of the types of change sought in social marketing, incorporating two dimensions of time (short term and long term) and three dimensions of level in society (micro, group, macro). In this way social marketing can influence not just individual consumers, but also the environment in which they operate (see Figure 1).

Figure 1: Types of social change, by time and level of society

	Micro level (individual consumer)	Group level (group or organisation)	Macro level (society)
Short term change EXAMPLE:	*Behaviour change* Attendance at stop-smoking clinic	*Change in norms Administrative change* Removal of tobacco advertising from outside a school	*Policy change* Banning of all forms of tobacco marketing
Long term change EXAMPLE:	*Lifestyle change*	*Organisational change* Deter retailers	*'Socio-cultural evolution'* Eradication of

	Smoking cessation	from selling cigarettes to minors	all tobacco-related disease

(Adapted from: Levy & Zaltman 1975)

Group and macro level change are important because they also impact on health and lifestyle decisions. For example, people's choices about taking up exercise may be limited by their income, local service provision or social mores. Macro-level factors can also have a more direct impact on health: for example, the presence of fluoride in the water (whether natural or artificial) can improve dental health, especially among children. This example demonstrates that there are many measures that can be taken to improve people's health without the individual citizen having to do anything at all. Better roads, reduced industrial pollution and improved safety standards on cars are similar examples.

Departures from Commercial Marketing
There are some important differences between social and commercial marketing. Specifically, in social marketing:

- the products tend to be more complex.
- demand is more varied.
- target groups are more challenging to reach.
- consumer involvement is more intense.
- the competition is more subtle and varied.

(i) The Products are More Complex
The marketing product has traditionally been conceived of as something tangible - a physical good which can be exchanged with the target market for a price and which can be manipulated in terms of characteristics such as packaging, name, physical attributes, positioning and so on. As marketing has extended its scope beyond physical goods, marketers have had to grapple with formulating product strategy for less tangible entities such as services (see Chapter 29 in this volume for a discussion of the characteristics of services; Woodruffe 1995). In social marketing, the product is extended even further from the tangible to encompass ideas, and behaviour change. Figure 2 illustrates the different types of social marketing product.

Figure 2: The social marketing product
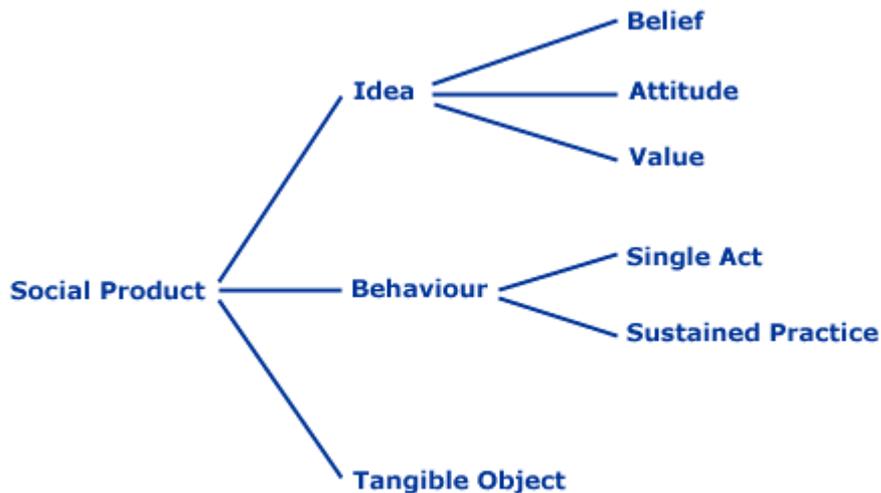
(Adapted from: Kotler & Roberto 1989)

This complexity makes social marketing products difficult to conceptualise. As a consequence, social marketers have a bigger task in defining exactly what their product is and the benefits associated with its use.

(ii) Varied Demand

Marketing cannot create needs but commercial marketers do manage to harness needs previously unknown for new product categories such as CDs, catalytic converters and "new" washing powders. Social marketers must not only uncover new demand, but in addition must frequently deal with *negative demand* when the target group is apathetic about or strongly resistant to a proposed behaviour change. Young recreational drug users, for instance, may see no problems with their current behaviour (Andreasen 1997). In these situations, social marketers must challenge entrenched attitudes and beliefs. Demarketing approaches may help here (Lawther et al 1997, Hastings et al 1998).

Rangun et al (1996) suggest a typology of the benefits associated with a behaviour change. The benefits may be: tangible, intangible, relevant to the individual or relevant to society. Demand is easier to generate where the benefits are both tangible and personally relevant. In those situations where the product benefits are intangible and relevant to society rather than the individual (as with CFCs in aerosols), social marketers must work much harder to generate a need for the product. This, they argue, is the hardest type of behaviour change, as the benefits are difficult to personalise and quantify.

(iii) Challenging Target Groups

Social marketers must often target groups who commercial marketers tend to ignore: the least accessible, hardest to reach and least likely to change their behaviour. For example, health agencies charged with improving population health status must, if they are to avoid widening health inequalities further in the general population (Whitehead 1992, Smith 1997), target their efforts at those groups with the poorest health and the most needs (Hastings et al 1998b). Far from being the most profitable market segments, these groups often constitute the least attractive ones: hardest to

reach, most resistant to changing health behaviour, most lacking in the psychological, social and practical resources necessary to make the change, most unresponsive to interventions to influence their behaviour and so on. This poses considerable challenges for segmentation and targeting.

(iv) Greater Consumer Involvement

Marketing traditionally divides products into high and low involvement categories, with the former comprising purchases for items such as cars or mortgages which are "expensive, bought infrequently, risky and highly self-expressive" (Kotler 1994) and the latter comprising items such as confectionery or cigarettes which are much more habitual. High involvement products typically command careful consideration by the consumer ('central processing') and demand detailed factual information from the marketer. Low involvement products are consumed much more passively, with very limited (or no) search and evaluation ('peripheral processing'), and simple advertising emphasising "visual symbols and imagery" (ibid) is called for.

Both the categorisation scheme - high and low - and its marketing implications need to be extended in social marketing. Social marketing frequently deals with products with which the consumer is very highly involved (complex lifestyle changes such as changing one's diet fall into this category). While high involvement can result in a motivated and attentive consumer, higher involvement may be associated with feelings of anxiety, guilt and denial which inhibit attempts to change. At the other extreme, social marketers might seek to stimulate change where there is very low or no involvement - for example, persuading Scots to save water.

(v) More Varied Competition

Social marketers, like their commercial counterparts, must be aware of their competition (Andreasen 1995). The most obvious source of competition in social marketing is the consumer's tendency to continue in his or her current behavioural patterns, especially when addiction is involved. Inertia is a very powerful competitor.

Other sources of competition involve alternative behaviours. For example, time spent donating blood is time which the consumer could spend doing other more enjoyable, more convenient and more personally beneficial activities.

Competitive organisations include other health promoters, educators or government organisations trying to use similar methods to reach their target audiences. For example, the typical doctor's surgery in the UK displays such a plethora of leaflets and posters that any one message or idea stands little chance of being noticed. Social marketers must then be innovative and careful not to overwhelm their target audience.

Finally, one of the most serious forms of competition comes from commercial marketing itself where this markets unhealthful or unsocial behaviours. The most obvious examples are the tobacco and alcohol industries.

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