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Edited by Jeff French

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The case for social marketing in public health

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Author(s): Jeff French
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Social Marketing seeks to develop and integrate marketing concepts with other approaches to influence behaviour that benefits individuals and communities for the greater social good.

Social Marketing practice is guided by ethical principles. It seeks to integrate research, best practice, theory, audience and partnership insight, to inform the delivery of competition sensitive and segmented social change programmes that are effective, efficient, equitable and sustainable.

Global definition of social marketing endorsed by the Boards of the International Social Marketing Association, European Social Marketing Association, and Australian Association of Social Marketing, October 2013

Learning points

This chapter:

- reviews key macro societal drivers of change and development, together with the impetus these are adding to the application of social marketing by public health agencies and practitioners around the world;
- explores the need for a new citizen-focused approach to addressing health challenges and reviews the characteristics of effective practice;
- explores the rationale and arguments for why social marketing has become a key tool for public health agencies and professionals.

Introduction to the case for social marketing in public health

It is a fact that every big health challenge facing governments around the world contains significant behavioural elements. Infection control, family planning, drug misuse, sanitation, smoking, obesity, alcohol misuse, and infection control all involve the need for people to behave in ways that will promote or protect their health. In addition to influencing individuals' behaviour, most public health programmes aim to influence organizational and often professional behaviour. Influencing behaviour, as we will explore in chapter six, can be achieved in many different ways, but one thing is constant: the need for systematic planning and delivery based on the widest set of evidence and intelligence available.

The world has experienced unprecedented improvements in health over the last 50 years (UN, 2015) but there is much still to be done. In the developing world we face the ongoing threats of infectious disease and child mortality and new threats from the rise in chronic disease (WHO, 2015a) and climate change (Stern, 2007). We also face huge economic and social challenges associated with persistent and growing inequalities between regions and countries and within countries (WHO, 2008). At an individual level, a personal sense of self-worth and the search for meaning act on the mental and physical health of millions of people (WHO, 2010); these are both contributory factors to and consequences of this complex web of challenges (Australian Public Service Commission, 2007).

Despite these challenges it needs to be remembered that at a global population level a fantastic amount of progress is being made in improving health and well-being. In large part this success has been brought about through the application of more evidence-based practice (WHO, 2015b) and user insight-informed programmes about how to influence behaviour and how to construct, deliver, and evaluate public health programmes to influence behaviour.

In parallel with these developments, data shows that in many countries questions relating to the legitimacy of state intervention to influence people's lives are growing (Ipsos MORI, 2010), together with calls for state intervention to be limited because it often breeds dependence (Acemoglu and Robinson, 2012) and sometimes even encourages people to behave in ways that are not good for them or society as a whole (Murray, 2006).

Given the rapidly evolving health threats and opportunities faced by the world and the equally rapidly changing relationship between states and the people they seek to govern and protect, this chapter explores how and why social marketing is becoming regarded as a standard approach to public health practice. It argues that citizens' views and wants should be given more prominence in the selection, planning, and delivery of all public health programmes. Such a change means that governments and their public health agencies will increasingly look to enhance traditional public health tools to bring about behaviour change such as legislation, taxation, and information giving with other types and forms of intervention—see chapters five and six—that are focused more on encouraging, engaging, and enabling people to act to improve their own health and the well-being of others.

The growth of global paternalistic healthism

In most health policy over the last 20 years, the word 'health' denotes not merely the absence of disease but also well-being and social justice. Health has also been promoted as a fundamental 'human right' at least since the 1978 World Health Organization (WHO) Alma-Ata Declaration (WHO, 1978). WHO has argued that this 'right to health' can only be realized through the combined and coordinated action of all social and economic sectors. This is a reasonable proposition supported by a wealth of insights and evidence from many academic and practice fields.

Health has been described as an emergent capacity arising from the integrated effects of somatic, social, economic, and cultural activity. It is not something that can be attained solely from health sector-directed expenditure or attempts to get people to live healthy lives (Wilkinson and Marmot, 2003). If we accept that health is determined by such factors, the development of better health will need whole-system solutions (French and Gordon, 2015). Such solutions, however, depend on how the system is conceived and the role of state-sponsored public health within

this. There are very different views about the answers to these questions among public health practitioners and between governments, the commercial sector, and citizens.

WHO and many public health practitioners have, for over 30 years, argued that prevention and treatment of disease should be viewed by all governments as their primary duty. In so doing, the avoidance and treatment of disease is positioned as the driving force and the ultimate goal of the world's economic and political systems. Smith et al. (2003) have advocated that health actually constitutes the most important form of 'global health good'. Conceived in this way public health represents a radical left-of-centre position, calling for no less than a global, political, and economic reorientation of society as proposed by Marmot (2008).

For those public health practitioners who hold such views, the main goal of society is not seen as the promotion of individual freedom, collective prosperity, or the accumulation of wealth and personal independence but medically defined health status. Many public health practitioners view markets and capitalism as a key part of the problem rather than part of the solution to improving health. This antagonism towards markets runs deep—for example, the refusal to tax high-sugar or fatty foods or the failure to restrict tobacco advertising by governments is often criticized by public health practitioners, even though such measures often have a disproportionate economic effect on the poorest in society. Politicians, on the other hand, often view with increased frustration the constant criticism from public health professionals and recommendations that they view as being at least partly ideologically motivated.

Public health conceived in this way has been criticized by Armstrong (1983; 1993; 1995), Fitzpatrick (2001), and others as representing the ever-expanding medicalization of life. Kurtz (1987) has also argued that health has become the 'new religion' and public health workers are the new puritanical priests offering punishment for the 'bad' life and rewards for the 'good' healthy life.

This 'collective paternalistic' stance stands in stark contrast to how health promotion is perceived by most governments. Minkler (1989) believes that health promotion and public health are predominantly viewed as being largely about protection from infectious diseases, encouraging behavioural change. Traditionally, governments use an intervention mix of law, education, and service provision to improve health. They are also responsible for developing regulated markets to act as an engine for collective and individual prosperity and increased well-being. This clear clash of ideological positions between most governments and the paternalistic collectivist stance supported by many public health professionals sits at the heart of the current theoretical and practical antagonism between public health advocates and many administrations. Kelly and Charlton (1995) agree with the proposition outlined above that public health has become a left-of-centre political campaign in which health is viewed as a moral right. Peterson and Lupton (1996) have

further criticized public health as a source of moral regulation and consequent state-sponsored control of individual freedoms. Stevenson and Burke (1991) are also critical of health promotion, arguing that it seeks to weaken and depoliticize action for social equality by turning what is a political and economic struggle into a technical professionally led intervention.

It could be argued that public health then sits at a crossroads. It could continue to hold to a position that simultaneously emphasizes that health promotion and protection is the pre-eminent responsibility of the state and that public health practitioners hold the body of expertise and the moral authority that can deliver this goal. Alternatively, public health practitioners can assume a less ideological position and a more technically focused role based on what is known about how to influence health behaviour, drawn from a broad range of science and experience, and position public health through the application of social marketing principles as a field dedicated to working with and through citizens to achieve collectively agreed social objectives defined by citizens and their representatives.

Acknowledgement that governments cannot do it alone

Creating an environment of maximum choice for the majority requires the coordinated application of all policy tools to influence the behaviour of individuals, organizations, and markets. In this way, we can shift to a more balanced view of the locus of power, to what Rothschild (2001) calls the 'apparent power' of government to the 'actual power' of individuals. We need to recognize the fact that both governments and individuals have power and responsibilities; public health strategy must explicitly acknowledge this. In this regard, Kickbusch et al. (2005) have emphasized the need in public health for co-production of solutions to complex social issues and challenges.

Liberal democracy and regulated free market economies are generally recognized as forces for social good (Roberts, 1985; Fukuyama, 1992). These complex systems, with all their benefits, problems, and complexities, are the reality for many and an aspiration for more and more of the world's population. There is also increasing recognition that the power of civil society, the private sector, the non-governmental organization (NGO) sector, and the thousands of community groups and civil associations represents and has always represented the main bedrock of success in building better lives for people. Civil society provides more health and social care than the state, informs and educates more children and adults, creates more employment than the state, and provides the myriad of social networks that nurture and develop citizens. The well-being of society is intertwined then with the well-being of individuals, their social networks, cultures, and the confidence and resources they have to choose and create the kinds of lives they want, often using markets to drive prosperity and improved life chances. As we explore in chapter ten, the private sector and NGO sector have a vital part to play in tackling almost all of the big health challenges that the world faces. These sectors' reach, expertise, and deep understanding of people needs to be harnessed in a far more coordinated way (Box 1.1).

Box 1.1 Case study: evidence-based demand creation and advocacy interventions for voluntary medical male circumcision scale-up in Zimbabwe

Karin Hatzold, Kumbirai Chatora, Noah Taruberekera, Webster Mavhu, Munyaradzi Mapingure

Aims

Zimbabwe is among the countries most affected by HIV and AIDS. In 2015, HIV prevalence among adults was estimated at 15% (UNAIDS, 2013). The Government of Zimbabwe adopted voluntary medical male circumcision (VMMC) as an HIV prevention intervention in 2009 following WHO's recommendation that countries with generalized HIV epidemics and a low prevalence of male circumcision progressively expand access to safe VMMC (National AIDS Council, 2011; CSO and Macro International, 2007; WHO and UNAIDS, 2007).

Despite scale-up of service provision by Population Services International (PSI), uptake of VMMC was slow. By September 2013, only 170,000 men had been circumcised against a five-year target of 1.27 million (MOHCC, 2014). In 2013 PSI/Zimbabwe launched a campaign using mass media and interpersonal communication to generate greater demand for VMMC services.

Behavioural objectives and target group

The campaign targeted two groups of men, segmented by age: adolescents (15–24 years) and adults (25–49 years). Its objectives were to increase men's uptake of VMMC services by addressing barriers and dispelling myths and misconceptions about the procedure.

Customer orientation

Male circumcision prevalence prior to the start of the VMMC programme was one of the lowest in the Southern African region, at 10.3%, since only minority ethnic groups practice circumcision traditionally (CSO and Macro International, 2007). Thus, a priority of the social marketing campaign was to distinguish VMMC for HIV prevention and its health benefits from the traditional practice. PSI also needed to understand personal barriers and motivators for VMMC uptake among the target audiences.

Social offering

VMMC provides a range of health and social benefits to the individual. In addition to a 60% risk reduction in heterosexually acquired HIV infection (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007), VMMC reduces the risk of sexually transmitted infection (Weiss et al., 2006) and penile cancer in men (Auvert et al., 2009), improves genital hygiene, and is believed by many to increase sexual appeal and performance (Bailey et al., 1999; Mattson et al., 2008) (Figure **1.1**).

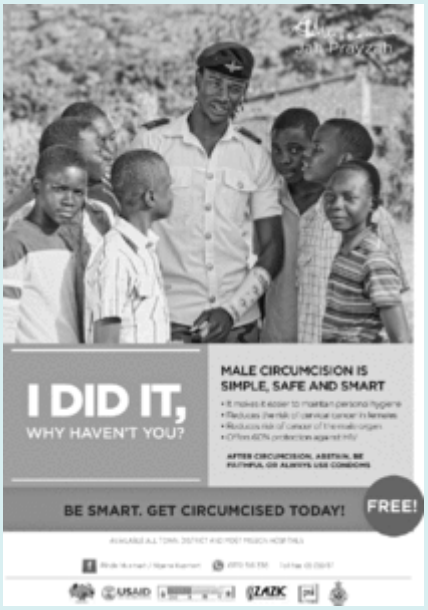

Figure 1.1
Example of promotional material used in the ‘I’m Doing It’ programme.
Reproduced by kind permission of PSI Zimbabwe.

Furthermore, VMMC reduces the risk of human papillomavirus transmission and consequently the risk of cervical cancer in female partners of circumcised men (Auvert et al., 2009). Impact modelling demonstrated that Zimbabwe’s VMMC programme could avert 212,000 new HIV infections by 2025 and save the country more than $1 billion in health expenditures related to HIV treatment (MOHCC, 2014; Njeuhmeli et al., 2011).

Target audience engagement and exchange

While HIV prevention is often cited as a reason for getting circumcised, men seem mainly motivated by non-HIV-related factors. To increase acceptance of the service, PSI positioned VMMC as a lifestyle choice rather than only for HIV prevention.

The campaign offered information about the procedure to address fears of experiencing pain, complications, and a difficult healing period. Because fear of receiving an HIV-positive test result especially prevented older, sexually active men from getting circumcised, the campaign also clarified that HIV testing was not a prerequisite for male circumcision (Hatzold et al., 2014; Mavhu et al., 2011; Westercamp and Bailey, 2007).

To address the issue of perceived threat to masculinity and to capitalize on the importance of social support, the campaign featured women. Since women are likely to influence their partners' decision to get circumcised, even if covertly (Lanham et al., 2012), testimonials were used. These featured women discussing how they had supported their partners and how they themselves had benefited from male circumcision. Messages also highlighted VMMC's role in improving men's hygiene and sexual appeal to women.

Another way the campaign leveraged the importance of social support was by tailoring messages for adolescents that presented VMMC as fashionable and leading to success, and as a lifestyle choice for 'smart' men. Peer groups also worked with youths to improve their attitudes towards VMMC.

Competition analysis

VMMC is a one-time, highly effective intervention with substantial prevention against HIV. No other HIV intervention currently available provides this permanence of effect. Condoms, microbicides, pre-exposure prophylaxis, and HIV treatment all require considerable adherence to realize the desired effectiveness (Reed et al., 2012).

Audience insight and segmentation

PSI conducted quantitative and qualitative research to inform the VMMC communications and marketing strategy. It was clear from the data that the target age groups expressed strong attitudes towards VMMC and were motivated by different factors. Study findings suggested that demand-creation messages needed to be tailored for different age groups. Older men were motivated by the promise of improved hygiene, enhanced sexual performance, and the opportunity to set an example for the community. Younger men were influenced by peers' attitudes and behaviours and by role models, such as popular musicians who took up VMMC to advocate for the programme.

Integrated intervention mix

Campaigns were implemented during school holidays with intensified service delivery as well as community mobilization before and during breaks, combined with mass media. VMMC services were offered in clinics located close to schools and other places where young people congregate.

Longer media formats, such as radio and television programmes, were used to engage with the target audiences. Satisfied clients were featured and answered general questions, while doctors and

nurses provided technical information about the procedure plus its associated health and HIV prevention benefits.

Community-level activities reinforced mass media messages. Younger and older men and women were trained at the community level to promote VMMC among peers through small group discussions and edutainment.

Systematic planning

The success of the campaign was based on intensive formative research, which guided the marketing planning process. Consistent messaging through multichannel mass media and interpersonal communication was supported by intensive advocacy featuring public celebrities and politicians who encouraged men to 'lead by example'. Intensified demand creation was coupled with VMMC service expansion and rapid scale-up.

Results and learning

Between 2011 and 2014, uptake of male circumcision among males more than quadrupled and the 'smart campaign' became a popular synonym for VMMC in Zimbabwe.

Marketing approaches to public health are becoming increasingly recognized as more effective strategies for translating knowledge and awareness in the population to action. Although many men may understand the benefits of VMMC, they require a different intervention to support their personal decision to get circumcised. Rather than a 'product-driven' or an 'expert-driven' programme, VMMC demand-generation strategies must address consumers' values and needs, their anxieties towards the service, and develop messaging that positions VMMC as responsive to consumers' emotive and functional needs (Lefebvre and Flora, 1988).

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The new citizen-informed public health model

There is always a tension when setting out the goals of social programmes between aiming high and being realistic about what can be achieved. However, it is the case that we have succeeded in many parts of the world in generating a belief and reality that people can make their own history. As Anthony Giddens (1991) has pointed out, in the developed world ours is the first mass generation to view life as other than just the playing-out of fate; we have become the lead actor in the film of our own lives and are able to determine what happens to us to a larger extent than has ever been possible before.

This shift in emphasis for an increasing number of people away from just a daily struggle to survive towards a situation where they are increasingly seeking higher levels of self-understanding, satisfaction, and happiness is a huge social triumph. A profound consequence of this achievement is

that the notion that your fate is determined by structural or mystic forces outside your control is being increasingly seen as untrue and even offensive to more and more people. With regard to factors outside individuals' control, Corrigan (2004) has argued that there is a danger when public health becomes too focused on the macrosocial and economic determinants of health to the exclusion of other explanations. Corrigan argues that an over-focus on health determinants can attempt to explain too much and leaves no dialectic for the importance of individual agency. The concept that the determinants of health should be the principle focus of public health has to be reconsidered in the light of the fact that we now live in a world of consumption—a place where more people are able to have many more 'consumption experiences', or choices, than were available in previous eras. People enjoy consumption and the sense of being in control that it brings them. In these circumstances determining factors make a less powerful impact, and the concept of external determining factors is itself also less acceptable to many people. Public health cannot stand outside this world of consumption experience. As LeGrand (2007) argues, there are four basic factors that underpin any type of public services including public health services:

1. trust—where professionals are just trusted to deliver high-quality services;
2. targets and performance management—where workers are directed to deliver by a higher authority who sets the targets and measures performance;
3. voice—where users are given a chance to say what they think about the service;
4. the 'invisible hand' of choice and competition.

LeGrand further argues that although all of these factors have their strengths and weaknesses, approaches to public health service delivery that incorporate substantive elements of choice and competition have the best prospect of delivering services that make a positive contribution to people's lives. LeGrand sets out extensive evidence that systems driven by choice and competition are not only more efficient and responsive but also better at providing people who have less voice and economic advantage with better services. It is also true that poor people want choice just as much as the better off and stand to derive just as much if not more benefit from systems set up to emphasize these features. In short, there is a need for what Osborne and Gaebler (1992) argued for in their seminal work *Reinventing government*: 'customer-driven government'. This means services and interventions being informed by data about citizens' views and needs and by a desire to meet these needs, as opposed to aims and objectives identified by professional elites driving the system. As Halpern et al. (2004) state:

> Ultimately, this is not just about the government and its agencies learning a few extra techniques to ‘make people eat their greens’. Rather it is about helping individuals and communities to help themselves. A more sophisticated approach enables governments to do this in ways which command greater public engagement and therefore greater effectiveness.

In this situation, state approaches to behavioural change that emphasize telling people what to do, or restricting behaviour by the force of law, can be doomed to failure unless they have the popular support of the vast majority of citizens. People now need to be engaged, listened to, and helped to change—not just forced, nudged, or hectored into change. It is also worth noting that as people become more empowered they trust governments and state organizations less and become more resistant to what they perceive as interference by governments (OLR, 2002; Ipsos MORI, 2010). Halpern et al. (2004) have suggested that there is a case for moving towards what they call the ‘full co-production’ model, in which citizens are engaged in the design, implementation, and evaluation of policy and practice.

We do, of course, know that those with more power and resources can have more control over their experiences and also have more choices. These disparities in choice and control are some of the key reasons for health inequalities (Wilkinson and Marmot, 2003). However, less choice and less power are not the same as no choice and no power. It is also well understood that setting up choice or market systems is usually the most efficient way to distribute resources, provided they are set up in such a way to address the risk that those with more resources and capacity may seek to gain a disproportionate share or access to such resources or services (Giddens, 2003; Lent and Arend, 2004).

The fact of increasingly empowered citizens has huge implications for state-sponsored public health interventions intent on making the world a better place and improving health. It means that a focus on enabling and empowering people to do the right thing for themselves and others is increasingly a key part of the way forward. This requires services and interventions driven by a desire to meet citizens’ needs and not needs defined solely by experts.

Many public health behavioural change interventions are based on evidence derived from published studies and analysis of demographic, service uptake, and epidemiological data. This information is vital but not always sufficient to develop effective behavioural interventions. In contrast, the commercial sector invests heavily in market research to understand people’s motivations, needs, wants, fears, and aspirations about why they would purchase goods or services, or what goods and services they feel they need or would like. Public health and other forms of public sector interventions need to enhance their understanding of the target group’s motivations if they are going to be able to develop more effective programmes. It should be remembered also that by target

groups we mean not only individuals but also social groups, organizations, policy-makers, and politicians, all of whom may be the target of a social marketing-informed public health programme.

A key driver for a more user-focused approach to tackling population health behavioural challenges is essentially a public sector version of a switch from a product- or service-focused approach to a citizen-focused strategy. This switch in emphasis drives most successful for-profit organizations and many not-for-profit organizations that rely on user or donor support. An increasingly empowered and demanding citizenry represents a triumph rather than a problem for governments. This shift in power and expectation demands that governments and their institutions demonstrate that they are adding value to the lives of the people that they serve. Given this perception by the public, one of the challenges facing governments is to set out more clearly what value they are creating for the people they serve.

Moore (1995) and Kelly et al. (2002) have identified the concept of public value as having three dimensions: outcomes, the delivery of services, and trust. Kelly et al. (2002) also argue that public value only exists if people are willing to give something up in return for the service they get, such as granting coercive powers to the state in return for security and protection. This ‘exchange’ is a key feature of social marketing and requires reciprocal actions on the part of both the state and citizens; it is often called the ‘social contract’. The state is required to understand citizens’ perspectives on the nature and value of these trade-offs, and citizens are required to accept limitations on behaviour for the collective good. In a world where public value will be measured and used by citizens to assess government and public sector performance, we require new approaches to understand both citizens and what they are prepared to exchange for different behaviour and change programmes that make changing behaviour easy and, where possible, rewarding for people. This change in emphasis sits at the heart of this book and at the heart of social marketing.

There is a case then for governments and those concerned with promoting health to move away from a purely ‘expert-defined’, systems-focused, mechanistic ‘product’ approach to change and service delivery and towards a social marketing approach that places more emphasis on the citizen user and co-producer. The focus of such a new model is set out in Figure **1.2**. In this new approach views, beliefs, and suggestions from citizens are key streams of intelligence that are used alongside epidemiology, demographics, and intervention evidence to inform public health policy and strategy development and programme delivery.

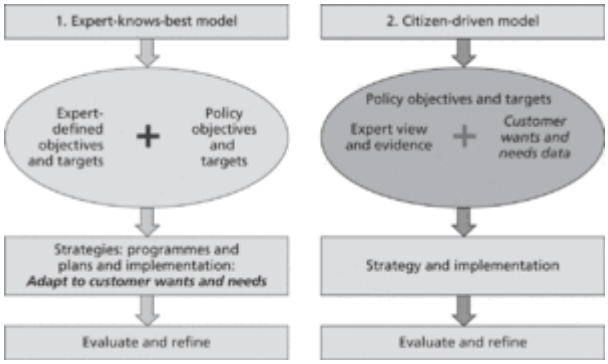

Figure 1.2
Expert-knows-best versus citizen-informed model.
Source: data from Moore MH. *Creating public value—strategic management in government*. Cambridge, MA: Harvard University Press, Copyright © 1995 by the President and Fellows of Harvard College; and Kelly G, Mulgan G, and Muers S. *Creating public value. An analytical framework for public sector reform*. London: Prime Ministers Strategy Unit, Cabinet Office, Copyright © 2002 Crown Copyright, http://webarchive.nationalarchives.gov.uk/20100416132449/http:/www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/public_value2.pdf, accessed 01 May 2016.

The development of such a citizen-informed model of service delivery and improvement in public health, through the rigorous application of social marketing, can result in public service organizations that are more motivated, progressive, ambitious, and constantly striving to improve services, not for the sake of managers or policy-makers but for the benefit of the service users.

If such an approach was universally applied, it would soon become clear to citizens that the public health providers were seeking to provide them with the kinds of help they need and in ways that were most convenient for them. Health improvement interventions would be developed and delivered from a perspective of listening and understanding, and not telling and selling. Public health would be characterized by responsiveness and dedicated to satisfying people’s health needs.

Social marketing adding value to a citizen-informed approach to public health

As argued so far in this chapter, most health issues stem from a combination of personal choice, environmental factors, cultural factors, and economic factors. Personal choices about issues such as healthy eating are played out against a background of many powerful influences on individual behaviour. As we will explore in chapter six, there is evidence from many disciplines that people do not always act in a logical way. This fact has led some to argue for an approach that uses non-rational appeals and design to influence health behaviour (Thaler and

Sunstein, 2008), which is known as ‘libertarian paternalism’ (Sunstein and Thaler, 2003). Liberal paternalism seeks a middle ground between a state-dominated coercive paternalistic approach that appeals to logic to drive social change and a more liberal approach that emphasizes free choice and the power of the market.

Although social marketing employs a lot of what Thaler and Sunstein (2008) call ‘nudges’, it goes beyond nudges to include interventions that people value both cogitatively and emotionally—see chapters two and six for more on this issue. Social marketing is a set of principles and concepts that are largely ideologically neutral. It can be used to inform paternalistic policy, libertarian paternalism, and a laissez-faire approach to promoting health. Social marketing is, however, rooted in the democratic tradition as it constantly seeks a mandate for action from the target groups it aims to help in the form of insights gained from market research and the market testing of potential interventions.

Due to the close ideological match between social marketing and liberal democratic imperatives it is probable that social marketing will increasingly be selected by governments as a preferred public health intervention and strategy development approach. Social marketing is a highly systematic approach to health improvement that sets out unambiguous success criteria in terms of behaviour change. In this respect, social marketing stands in stark contrast to many health promotion interventions which demonstrate weak planning systems and poor evaluation. Social marketing will also be attractive to governments because of its emphasis on developing deep customer insight, choice, and population segmentation to develop interventions that can respond to a diversity of needs.

As mentioned above and explored further in chapter two, a central concept of social marketing is that of ‘exchange’. Exchange recognizes that if people are going to change their behaviour or collectively work for social improvement they need to believe that the reward for such action is worth the price paid, in terms of the effort they need to put in, the time it will take, and other cost factors. This implies that any offers developed by those intent on assisting people to live healthier lives need to be developed on the basis of a deep understanding of the views, motivations, and barriers encountered by target audiences.

Does social marketing work?

Notwithstanding the very real issues of proving cause and effect that are explored in chapters four and five, over the last 40 years a growing and compelling body of evidence has been developing about the effectiveness of social marketing. This has been reviewed by organizations such as the Centers for Disease Control and Prevention in the USA (CDC, 2007; 2011) and the European Centre for Disease Prevention and Control (French and Apfel, 2014), both of which have endorsed the application of social marketing as an effective approach to delivering behavioural influence programmes. Social marketing has also been endorsed by a number of governments including the UK, Canada, America, Australia, India, and Bangladesh. There are also many social marketing conferences every year around the world, a number of academic institutions that teach and research in the field of social marketing, a growing number of academic journals such as *The Social Marketing Journal* and *Social Marketing Quarterly*, and a growing number of national and regional professional associations. Details of most of these developments and resources can be found at the International Social Marketing Association website: http://www.i-socialmarketing.org/.

Conclusion

Over many years public health has developed impressive data-gathering systems related to mortality, morbidity, and health sector utilization. However, we have invested much less time and effort in developing methodologies to generate deep understanding of the wants, fears, needs, motivations, and barriers people face that either enhance or detract from their ability to live healthy lives. In short, we are fantastic at counting the sick and the dead but much less adept at understanding the living. The fundamental shift set out in this chapter and the rest of this book is from an approach through which solutions are derived principally by public health specialists and policy experts utilizing limited forms of evidence and data towards a more inclusive model that is also influenced by a deep contextual understanding of what target audiences know, believe, value, and say will help them, supported by a deep understanding of the science, methodologies, and technologies that can be applied to develop deliver and evaluate more successful public health programmes.

This fundamental shift includes the coordinated use of all forms of intervention that will help and enable people to adopt and sustain health behaviours to prevent disease, promote wellness, and reduce the impact of both infectious and chronic diseases. This chapter has explored why social marketing is a natural fit with modern evidence and data-informed social policy. Social marketing's focus on measurable returns on investment and respectful co-production of solutions with citizens is an approach that many governments and public health organizations are trying to bring about. Social marketing is also attractive to governments

and public health organizations because of its emphasis on deep citizen insight and population segmentation, enabling the development of interventions that can respond to a broad diversity of needs of specific subgroups within increasingly diverse communities in many countries.

At a time of declining trust in civic institutions, fragmentation of society, and rising consumerism, social marketing also offers a systematic and systemic approach for tackling many of the key health behavioural challenges faced by societies around the world. Social marketing offers a transparent methodology that embraces the reality of markets, choice, and mutual responsibility and balances the rights and responsibilities of individuals and of wider society. Authentic social marketing is not about telling people what to do or coercing them into doing it, but is the process of understanding what will help people make choices and take action that will lead them to healthier lives. In short, those who seek to serve the public and make the world a healthier place have to learn how to make positive life choices the easy and desired choices.

In the coming years, it is highly probable that social marketing will become part of the standard operating systems for governments and all public health organizations, and among for-profit and not-for-profit organizations concerned with promoting health, as advocated by WHO (2012) and the US Department of Health and Human Services (2010). This is because social marketing works, it can be shown to work, and it is a deeply democratic and empowering approach to health promotion and disease reduction. Social marketing as we have seen in this chapter is also well matched to the sophisticated cultural, social, and political environment of the twenty-first century. Public health specialists, health promoters and educators, and health policy planners will all need to invest time and effort in developing their understanding of social marketing's principles so that they can become champions for the communities they serve. It is our hope that this book makes a small contribution to bringing this about.

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