	Operational Guideline	
TITLE: Social Marketing for Health Communication		
APPROVED BY: PPH Communications subcommittee	DATE Aug. 2015	PAGE 1

1.0 PURPOSE

To guide processes for use of social marketing for health communication by service areas and staff.

2.0 SCOPE & GOAL

Applicable to all Public Health (PH) staff working within the Winnipeg Regional Health Authority.

3.0 DEFINITIONS

3.1. **Social media** is an emerging and evolving term. For the purpose of this guideline, social media refers to online media that start conversations, encourage people to pass them on to others, and find ways to travel on their own (Balance Interactive, 2011). These online platforms allow for the public publication of messages and conversations. Examples of social media include Facebook, Twitter, and YouTube.

3.2. **Social marketing** is the "application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreasen, in Storey, Saffitz, & Rimón, 2008, 436). Its goal is to 'sell' a particular behaviour to a particular audience in order to either solve a particular problem or to confer a particular benefit (Grier & Bryant, in Langford & Panter-Brick, 2013).

4.0 BACKGROUND

Social marketing is one of the strategies that can be employed by PH programs and staff to achieve particular health communication goals. All existing WRHA policies apply to social marketing, including, but not limited to, those policies that deal with privacy, computer/internet usage, misuse of company resources, respectful workplace, confidentiality, industry relationships, information, and data security.

5.0 PROCEDURE

5.1. Early Planning

5.1.1. Determine whether the issue in question is appropriate for social marketing.

5.1.2. Identify populations affected by the issue and prioritize population segments for intervention.

5.1.3. The way the issue is framed should not inadvertently reinforce negative stereotypes or exacerbate stigma for already-stigmatized populations.

5.1.4. Prioritize and select measurable behaviors, organizational practices, environments, and/or policies to influence (Lefebvre, 2013).

5.1.5. As early in the process as possible, mobilize an internal Approvals Group, and convene a multi-agency Advisory Group composed of some combination of stakeholders, partners, and intended audience members.

5.1.6. It may be helpful to develop a logic model clearly identifying the activities being undertaken and the particular outcomes to be achieved.

5.2. Design

5.2.1. A professional marketing company may be contracted to manage or assist with the design and implementation, including media placement of campaign materials and evaluation.

5.2.2. Plan the intervention according to the 'Social marketing benchmark criteria' (Stead et al., in MacDonald et al., 2012):

5.2.2.1. Change: The intervention aims to change behaviour, organizational practices, environments, and/or policies; and uses specific, measurable, behavioural objectives. This should be pre-determined and not delegated to a marketing company. The intervention and plan should be based on an analysis and synthesis of theories, models and frameworks that describe the issue and its possible solutions (Lefebvre, 2013).

5.2.2.2. Consumer orientation: The intervention is based on consumer experiences, needs, values, benefits, and an understanding of the alternatives. This can be accomplished both through review of existing literature and incorporating the perspectives of the intended audience (e.g., advisory group, ad hoc via focus groups).

5.2.2.3. Segmentation and targeting: Incorporate evidence to inform practices for the particular segment of the population being targeted.

5.2.2.4. Marketing strategies and tools: Test strategies (e.g., concepts and approaches) and tools (products services and messages) with prioritized stakeholders (Lefebvre, 2013). Tools may include conventional marketing media (posters, billboards, radio, Internet, social media), but consideration should also be given to alternative means of reaching the intended population such as community events and sponsorships. French-language materials should effectively engage the intended audience(s). Recognize that static media (posters, billboards, website) may be visible after the campaign period; specific dates or events

should generally be avoided in favour of directing the audience to more dynamic media.

5.2.2.5. Exchange: The intervention encourages the audience to engage or not engage in a behaviour in exchange for some benefit. The literature on message framing should be consulted when designing the campaign (see Garcia-Retamero & Cokely, 2012; Rothman et al., 2006). In general, episodic behaviours are best promoted by spurring a person to immediate action through highlighting the negative outcomes of *not* performing the behaviour. Conversely, longer-term 'prevention' behaviours are best promoted by reinforcing the positive outcomes of performing the behaviour. For examples: this campaign (http://www.gayhealthnetwork.ie/assets/files/pdfs/campaigns/A4_Poster_4_Condom_Dublin(1).pdf) highlights the protective benefits of condom use (a prevention behaviour), while this one (http://adsoftheworld.com/media/print/one_life_couch) highlights negative consequences to spur a person to seek HIV testing. Especially in the case of 'negative' framing, care should be taken that a particular approach does not exacerbate other problems (e.g., reinforcing stigma, creating hysteria, etc.).

5.2.2.6. Competition: The intervention should include strategies to remove or minimise forces that interfere with the promoted behaviour. This is particularly important so that the campaign does not exacerbate inequities (see Niederdeppe et al., 2008). Strategies may include collaboration with specific communities, the provision of free or low-cost supplies, and changes in the built and/or policy environments.

5.3. Designing Implementation

5.3.1. Consider the labour required of the PH service area, WRHA supports (e.g., Communications), and paid contractors (e.g., the marketing company, couriers). Particularly when multi-media materials such as free supplies, handouts, posters, are disseminated to community venues this may require greater labour than anticipated.

5.3.2. When other systems such as education or acute care are involved as partners, ensure sufficient time for support and appropriate level of leadership engagement (e.g., Director-level).

5.3.3. Community-area staff may be a valuable resource for connecting with community venues, schools, etc. If they are to be used, ensure:

5.3.3.1. That time of year is considered (e.g., not interfering with flu clinics, other annual commitments).
5.3.3.2. That management is properly briefed and agreeable to the commitment of staff resources.
5.3.3.3. That an assertive briefing/engagement process is used. Ideally, this entails a presentation session to staff at their office, or to multiple groups at a convenient location. Avoid only mass emails.

5.3.4. If time permits, consider engaging with community-area PH teams to solicit feedback on localized strategies for displaying and distributing materials for maximum impact. For example, WRHA Primary Care Program can coordinate distribution to community health agencies and primary care locations, etc.

5.3.5. To ensure broader reach, include nonprofit agencies (women's centres, youth centres, neighbourhood resource centres, etc.), agency alliances, and businesses in the dissemination of materials.

5.4. Evaluation

5.4.1. If a logic model was developed, the activities and outcomes identified may be used to generate indicators appropriate for the purposes of evaluation.

5.4.2. A process evaluation should be compiled by PH staff, detailing
5.4.2.1. the activities undertaken,
5.4.2.2. deviations from existing guidelines, evidence-informed practices, and rationale,
5.4.2.3. public responses or feedback (including media coverage), and
5.4.2.4. feedback from any staff who assisted in the roll-out (e.g., using an online survey tool).

5.4.3. An outcome evaluation may be carried out internally or facilitated by an external marketing company or agency with expertise in evaluation, especially if there are complex methodologies and large sample sizes.

5.4.4. All social marketing campaigns, including those of short duration or scope, must aim to produce some change or a difference from the baseline (e.g., 14-16 year olds not having the same rates of STI as previous cohorts of 14-16 year olds) as an outcome.

5.4.5. Appropriate outcome evaluation criteria include:
5.4.5.1. Impact (e.g., attitude change, behaviour change)
5.4.5.2. Acceptability (engagement with/opinion of the campaign by the intended audience)
5.4.5.3. Reach/equity

5.4.5.4. Sustainability
5.4.5.5. Cost-effectiveness

5.4.6. Research ethics approval may be sought prior to the collection of data from the public, if the campaign is felt to be of potential interest to other jurisdictions and/or academics, and/or if publication of evaluation results is anticipated.

5.4.7. Evaluation results should be communicated to relevant stakeholders, communities, agencies and groups (Lefebvre, 2013).

6.0 VALIDATION

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6.6. Niederdeppe, J., X. Kuang, B. Crock, and A. Skelton (2008). Media campaigns to promote smoking cessation among socioeconomically disadvantaged populations: What we know, what do we need to learn, and what should we do now? *Social Science & Medicine* 67, 1343-1355.

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