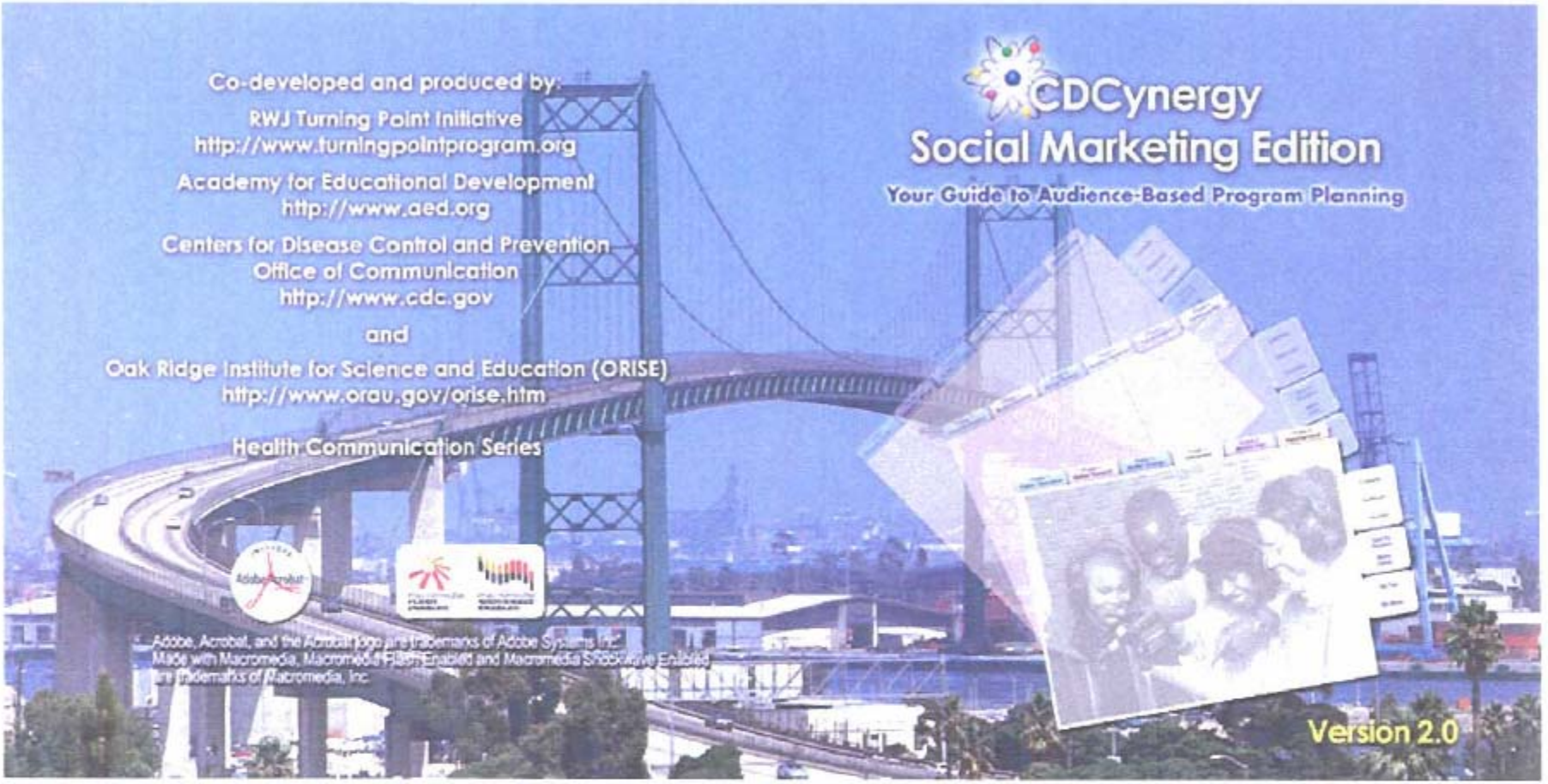

CDCynergy:

Step-by-Step Guidance for Applying Social Marketing Systematically to Public Health Programs

CDCynergy Social Marketing Version 2 Workshop

Participant Materials

The materials in this packet will help you focus on application of social marketing principles and concepts. By the end of the workshop you will have seen and learned how to use the major features of the CDCynergy CD. After the workshop you will need to take time on your own to become more familiar with the details of a comprehensive best practices of this health promotion planning and evaluation tool and all the 700+ resources on the CD.

Agenda for CDCynergy Social Marketing Version 2.0 Workshop	
Time	**Activity**
8:00 – 8:15	**Introduction**
8:15 – 8:25	**Install Software and Check Computer Operation**
8:25 – 8:30	**Take Pre-Test**
8:30 – 9:00	**Getting Started** • Overview of Social Marketing – Social Marketing 101 PowerPoint • Get to Know Social Marketing Key Phrases and Terms Exercise • View Christopher Cooke Video
9:00 – 9:30	**Phase 1: Problem Description** • Identify Potential Audiences • Identify Models of Behavior Change and Best Practices
9:30 – 9:40	**Social Marketing Jeopardy**
9:40 – 10:10	**Phase 2: Market Research** • Define Research Questions • Develop market Research Plan • Conduct and Analyze Research
10:10 – 10:30	**Break**
10:30 – 10:50	**A Real World Example** • Changing Behaviors to Prevent Yersinia Enterocolitica
10:50 – 11:30	**Exercise – Work with My Plan** • Record Problem Description, Potential Audiences, Research Questions
11:30 – 12:15	**Phase 3: Market Strategy** • Select Audience Segments • Define Current and Desired Behavior • Establish Behavior Change Goals • Select Interventions
12:15 – 1:15	**Lunch**
1:15 – 1:30	**Social Marketing Jeopardy**
1:30 – 2:00	**Phase 4: Interventions** • Establish SMART Objectives • Write Program Plan for Interventions • Pretest, Pilot Test
2:00 – 3:00	**Exercise – May Plan and My Model**
3:00 – 3:30	**Phase 5: Monitor Plan** • Identify Program Elements to Monitor • Select Evaluation Questions • Determine How Information with be Gathers
3:30 – 3:45	**Break**
3:45 – 4:15	**Phase 6: Implementation** • Prepare for Launch • Execute/Monitor Intervention • Execute/Monitor Monitoring • Modify
4:15 – 4:30	**Exercise – Navigating Phases 5 & 6**
4:30 – 5:00	**Wrap-Up** • Discuss Most Valuable Places • Review of Index, Glossary, How to Use • Don't Leave Without Asking • Evaluation

Instructions for Installing *CDCynergy-SOC*

1. Insert the CD-ROM into your CD-ROM drive.
2. Click "Install CDCynergy-SOC to my hard drive."
3. Click "OK" to save the program to your C:/ drive in the Program Files folder. You will see a dialogue box with the heading "Copying files, please wait..."

Note to user: You may select another drive to save the program by clicking the down arrow under "Drives." Once you've chosen the appropriate drive, you may make a new folder by clicking "New," typing in the new folder name and clicking "OK." Then click "OK" again to start saving the program.

4. From now on, you will be able to run the program by double clicking the icon on your desktop labeled "*CDCynergy-SOC*."
5. You will want to check your settings to be sure you can run the program fully; follow the instructions on page 4 of this workbook. At the bottom of the opening page, click "Computer Settings Guide." Follow the instructions on your screen. If you do not have an Internet connection, install any needed software from the CD-ROM by following the instructions on your screen. This will not work on Apple® computers.

Additional copies of the CD-ROM are available at cost plus shipping and handling. To order more copies, go to:

www.tangibledata.com/CDCynergy-SOC

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Instructions for Running *CDCynergy-SOC* from the Hard Drive

1. Install the CD-ROM onto your hard drive using directions on previous page.
2. From your desktop, double-click on the "CDCynergy-SOC" Icon.
3. Click "Yes" to start running *CDCynergy-SOC*. The program runs using your Internet browser (Microsoft Internet Explorer or Netscape Navigator).
4. *CDCynergy-SOC* requires your computer to have certain software in order for all its features to run properly. Check that you have the necessary software on your computer to run CDCynergy-SOC.
5. At the bottom of the opening page, click "Computer Settings Guide." Follow the instructions on your screen.
6. If you do not have an Internet connection, install any needed software from the CD-ROM by following the instructions on your screen.

Note to users of Windows XP: *CDCynergy-SOC* relies heavily on the use of pop up windows. To allow the program to run properly on your computer, you will need to modify your set up. To make this modification please follow the following steps:

- From the Start menu, select "Control Panel", **OR**
- From within the Internet Explorer, select "Tools" – then,
- Select "Internet Options"
- Select the tab labelled "Advanced"
- Scroll down to the section labeled "Security"
- Make sure there is a check or an "x" in these two boxes:
  i. Allow active content from CDs to run on my computer
  ii. Allow active content to run in files on my computer
- Select "Apply"
- Select "OK"

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Instructions for Running CDCynergy from the CD-ROM

1. Insert the CD into your CD Drive
2. CD should start automatically. Click “Run” from the CDs dialogue box.
3. Click “Yes” to start running CDCynergy. The program runs using your internet browser.
4. CDCynergy requires your computer to have certain software in order for all its features to run properly. Check that you have the software on you computer to run CDCynergy.
5. At the bottom of the opening page, click “Computer Settings Guide.” Follow the instructions on your screen.
6. If you do not have an internet connection, install any needed software from the CD by following theinstructions from your screen.

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- Select Apply”
- Select “OK”

Key Windows on the CD-ROM

Instructions for viewing the *Introduction to Social Marketing* window

You can access several items from the main (blue) window that help orient you to the social marketing program planning process.

How to check your computer set-up to optimize your CDCynergy-SOC experience

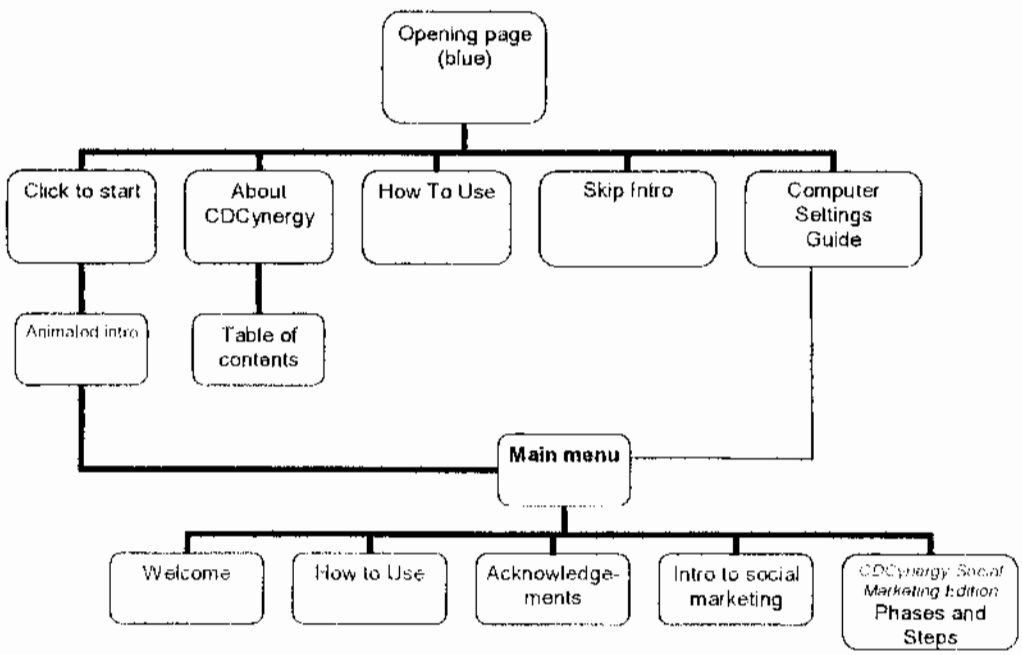
1. From the opening page, click on **Computer Settings Guide,** located at the bottom-center of the screen
2. Read and follow steps 1-8.
3. All necessary software to run and use CDCynergy-SOC is included on the CD-ROM.
4. When finished click on the **CDCynergy Social Marketing Edition** hyperlink and you will be brought back to the opening page.

Instructions to access an overview of the CD-ROM

1. From the opening page, click on ***Click to Start***.
2. Click ***Skip*** if you would like to skip the slide show that starts to play. You will see the Main Menu.
3. From the Main Menu click ***How to Use***.

Instructions for viewing *Introduction to Social Marketing* window

1. From the opening page, click on ***Click to Start***.
2. Click ***Skip*** if you would like to skip the slide show that starts to play. You will see the Main Menu.
3. From the Main Menu click ***Introduction to Social Marketing***. A window will open with 6 features that will help orient you to CDCynergy-SOC Version 2.0 and Social Marketing.
4. Including a 6-minute video Introduction to Social Marketing featuring Alan Andreasen.
5. To view the video, click on the first bulleted link, *"Introduction to Social Marketing."*



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Workshop Pre-test

1. Of the following, please mark the *5 P's* of the *social marketing mix* with an 'X'.
   a. ____ Perseverance
   b. ____ Place
   c. ____ People
   d. ____ Product
   e. ____ Policy
   f. ____ Penalty
   g. ____ Price
   h. ____ Presentation
   i. ____ Promotion

2. When using social marketing to change healthcare practices, whose wants and needs should be the focus of an intervention or communication strategy?

   a. ____Policy Makers
   b. ____Providers
   c. ____Program Funders
   d. ____Audience

3. List three key concepts in social marketing (other than the *5 P's*):

   a. _____

   b. _____

   c. _____

True or False:

4. _____ Competition always exists.

5. _____ Marketing is a message based, promotion only approach.

6. Please list the six phases of best practice social marketing:

   (1) _____ (2) _____

   (3) _____ (4) _____

   (5) _____ (6) _____

7. What do you consider to be the "marketing" part of social marketing?

_____

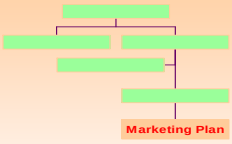
Turning Point

Social Marketing Overview

Turning Point

First Things First!

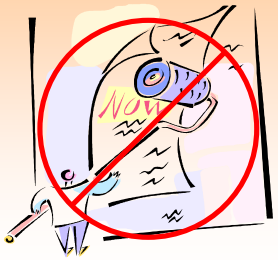
- You can't have a marketing plan without an overall plan!



- Communication activities should support your overall goals!

First Things First!

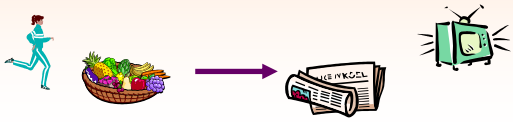
- Don't think media first!



First Things First!

- Start with your audience first!


- Then think message, then channel.



First Things First!

- Work with professionals.

First Things First!

- Use formative research…
  - Every time…
    - For every project…
      - ***Really!***


First Things First!

- Apply best practices!

Simplified Definition

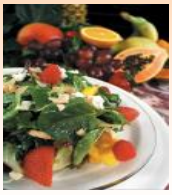
Social Marketing is the coordinated activities that comprise a program to make a certain behaviors

- **Fun**
  "Are the consequences of behavior both real and rewarding for me?"
- **Easy**
  "Can I do it? Am I capable?"
- **Popular**
  "What do the people I care about want me to do?"

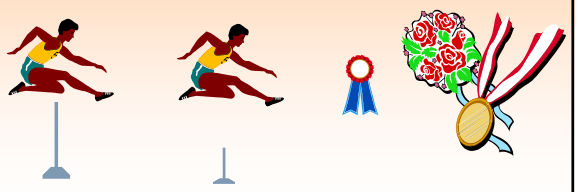
Warning!

Messages Alone ≠ Marketing!

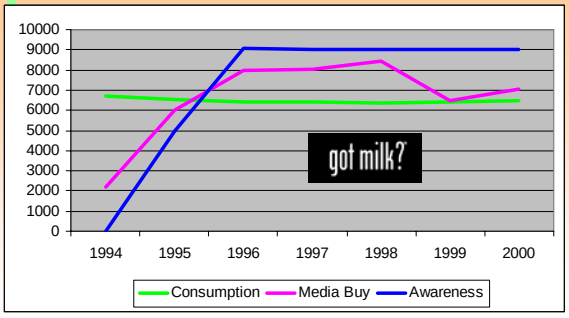
≠



Marketing is *more* about lowering barriers and increasing benefits!



Got Behavior Change?



What is Marketing About?

It's about <u>Behavior</u>

- Brushing your teeth
- Recycling
- Putting your baby in a car seat
- Voting
- Eating eight servings of fruits and vegetables each day

What is Marketing About?

It's about <u>People</u>

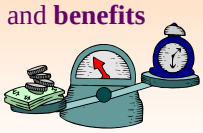
Not everybody!

Specific groups of people . . .

What is Marketing About?

It's about <u>Understanding Why People Do What They Do</u>

People weigh the **costs** and **benefits** of behaviors



People behave in ways that benefit them

. . .So, What Affects Behavior?

External

- Policies
- Access
- Skills
- Actual consequences
- Cultural beliefs and values

. . .So, What Affects Behavior?

Internal

- Knowledge and beliefs
- Attitudes
- Perceived risk
- Perceived consequences
- Self efficacy

What is Marketing About?

It's about Decreasing Barriers & Increasing Benefits of Behavior

Brushing your teeth
bubble gum flavors & fewer dental visits!

Recycling
curbside pick-up & reduced utility bill for a month

Putting your baby in a car seat
providing seat to new parents before they leave the hospital at free or low cost; lessons in proper use

How Does Marketing Do This?

It's about the "4 Ps"

Product
Price
Place
Promotion

Marketing "Strategies" *--What are We Offering*

(Product)

- The **behavior** we want people to do
- The **"bundle of benefits"** that people tell us are important to them (may not be health-related)
- **Tangible services and products** to make the behavior easier to do

Marketing "Strategies" *Barriers/Benefits*

(Price)

Anything that lowers barriers, reduces "costs," makes it easier, emphasizes benefits:

- Activities
- Policy changes
- Messages
- Outreach
- Services and opportunities

Marketing "Strategies"
Where we Offer It
(Place)

Placing services, products and activities at places or times that

- people are *likely to be thinking* about the problem/issues
- are *convenient* for people
- they are *likely to see/hear* the information
- where they *will act*

Marketing "Strategies"
Providing Information
(Promotion)

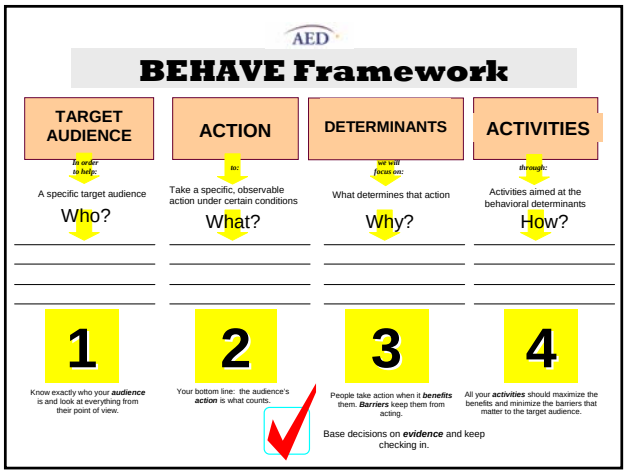
Presenting information in a way that

- is *memorable*
- *stands-out* from competing messages
- is *repeated* again, and again, and again
- has a *"call to action"*
- *respects culture*
- is in a *place* and at a *time* they will notice

Marketing "Strategies"
Providing Information
(Promotion)

Examples:

- News stories
- Letters to the editor
- PSAs
- Brochures
- Word-of-mouth/face-to-face
- Education sessions



An Example

What is Marketing About?

It's about Behavior

- Brushing your teeth
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- Putting your baby in a car seat
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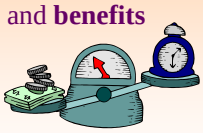


People behave in ways that benefit them

<u>. . .So, What Affects Behavior?</u>

External

- Policies
- **Access**--toothbrushes and toothpaste made available
- **Skills**--outreach visits to schools and recreation centers to teach kids and parents
- **Actual Consequences**--flavored toothpaste tastes good; kids tell about successful dentist visits with no cavities or fillings!
- **Cultural Beliefs and Values** --parental support and modeling

. . .So, What Affects Behavior?

Internal

- **Knowledge and Beliefs**--teaching through outreach visits
- **Attitudes**--stories from kids who brush successfully
- **Perceived Risk**
- **Perceived Consequences**--stories from other kids and from outreach worker
- Self Efficacy

What is Marketing About?

It's about Decreasing Barriers & Increasing Benefits of Behavior

Decreasing Barriers

- Bubble gum flavors of toothpaste
- Toothbrush and toothpaste made available
- Correct brushing skills taught through fun games

Promoting Benefits

- Fewer dental visits; no drilling or pain (kids)
- Less monetary costs; happier kids (parents)

The 4 P Strategies

Product

- Correct tooth brushing
- Flavored toothpaste; outreach classes
- Fewer cavities = no drills & less money!

Price

- Flavored toothpaste; toothbrushes available
- Outreach classes
- Kids who brush tell their class mates its great not to have cavities

The 4 P Strategies

Place

- School classes
- Recreation centers

Promotion

- Outreach classes
- Teaching materials for kids and parents
- Letter to parents about the class

What Are the Benefits of Using Social Marketing?

Provides a 360 view of the issue

Develops culturally appropriate interventions

Involves those affected by the issue

Enables effective use of resources

What Are the Benefits of Using Social Marketing?

It offers coordinated, multiple intervention tactics!

It can be used for “downstream” and “upstream” change

Social Marketing: A Mindset

- ✓ Think behavior change
- ✓ Know your audience-motivations, what is important to them, fears, hopes, values
- ✓ Think benefits and costs of behavior
- ✓ When/Where in right frame of mind
- ✓ When/Where is right place & time

"With social marketing, you can have some truly improved outcomes. Because it is evidence-based—based on what works—you have more effective use of resources."

-Leah Devlin, DDS, MPH
State Health Director

Social Marketing Key Terms Exercise

Draw a line from key terms to each term's definition.

Barriers	Four domains of influence to consider when planning intervention activities for reaching a target audience from multiple perspectives Product, Price, Place, Promotion.
Benefits	Advantages that the audience identifies which may or may not be directly associated with a behavior.
Competition	The behaviors and related benefits that the target audience are accustomed to or may prefer over the behavior you are promoting.
Determinants of behavior	Hindrances to desired behavior change that are identified by the audience.
4 Ps of marketing	Factors that influence an individual s actions or behaviors. Behavioral science theories and models list determinants.
Market strategy	The concept that people compare the costs and benefits (See Barriers and Benefits) of performing a behavior before actually doing it.
Target audience	Four domains of influence to consider when planning intervention activities for reaching a target audience from multiple perspectives Product, Price, Place, Promotion.
Exchange	Place is where and when the target audience 1) will perform the desired behavior, 2) will access program products/services or 3) is thinking about your health or safety issue.
4 Ps of marketing	Research designed to enhance your understanding of the target audience s characteristics, attitudes, beliefs, values, behaviors, determinants, benefits and barriers.
Market research	A guiding plan of action for your entire social marketing program.
Promotion	The group(s) of individuals that your social marketing program seeks to reach and influence.
Place	Product refers to: 1) the desired behavior and associated benefits you are asking the audience to do; 2) tangible objects or services that facilitate behavior change.
Price	Price refers to the costs barriers the audience members face in making the desired behavior change.
Product	One of the 4 Ps of marketing. Includes the communication messages, materials, channels and activities that will effectively reach your.

CDCynergy Social Marketing Edition	
Process Steps	
Phase 1: Problem Description	
Step 1.1	Write a problem statement.
Step 1.2	List and map the causes of the health problem.
Step 1.3	Identify potential audiences.
Step 1.4	Identify models of behavior change and best practices.
Step 1.5	Form your strategy team.
Step 1.6	Conduct a SWOT analysis.
Phase 2: Market Research	
Step 2.1	Define your research questions.
Step 2.2	Develop a market research plan.
Step 2.3	Conduct and analyze market research.
Step 2.4	Summarize research results.
Phase 3: Marketing Strategy	
Step 3.1	Select your target audience segment(s).
Step 3.2	Define current and desired behaviors for each audience segment.
Step 3.3	Describe the benefits you will offer.
Step 3.4	Write your behavior change goal(s).
Step 3.5	Select the intervention(s) you will develop for your program.
Step 3.6	Write the goal for each intervention.
Phase 4: Interventions	
Step 4.1	Select members and assign roles for your planning team.
Step 4.2	Write specific, measurable objectives for each intervention activity.
Step 4.3	Write a program plan, including timeline and budget, for each intervention.

Step 4.3a	Plan new or improved services.
Step 4.3b	Develop or adapt a product.
Step 4.3c	Plan a strategy for policy change.
Step 4.3d	Plan communication intervention/promotion activities.
Step 4.4	Pretest, pilot test, and revise as needed.
Step 4.5	Summarize your program plan and review the factors that can affect it.
Step 4.6	Confirm plans with stakeholders.
Phase 5: Evaluation	
Step 5.1	Identify program elements to monitor.
Step 5.2	Select the key evaluation questions.
Step 5.3	Determine how the information will be gathered.
Step 5.4	Develop a data analysis and reporting plan.
Phase 6: Implementation	
Step 6.1	Prepare for launch.
Step 6.2	Execute and manage intervention components.
Step 6.3	Execute and manage the monitoring and evaluation plans.
Step 6.4	Modify intervention activities, as feedback indicates.

My Plan

Use this template to record the information pertinent to each step of the planning process. Select the step you are currently working by holding the Control key and clicking on the corresponding link from the list below to go to the appropriate location in MyPlan. **Note:** Once completed, the instructions and guiding questions can be deleted to save space if you wish.

To create a table of key program decisions about Target Audience, Behavior Change, Exchange/Benefits, Strategy, Intervention Activities and Tactics, use the **HAWC Model** document.

Phase 1- Problem Description

Phase 2- Market Research

Phase 3- Market Strategy

Phase 4- Interventions

Phase 5- Evaluation

Phase 6- Implementation

Phase 1: Problem Description

Step 1.1- Write a problem statement

a. Guiding questions:

- What should be occurring? (desired behavior)
- What is occurring? (problem)
- Who is affected and to what degree?
- What could happen if the problem isn't addressed?

b. Outcome of this step:

Statement of the problem to be addressed.

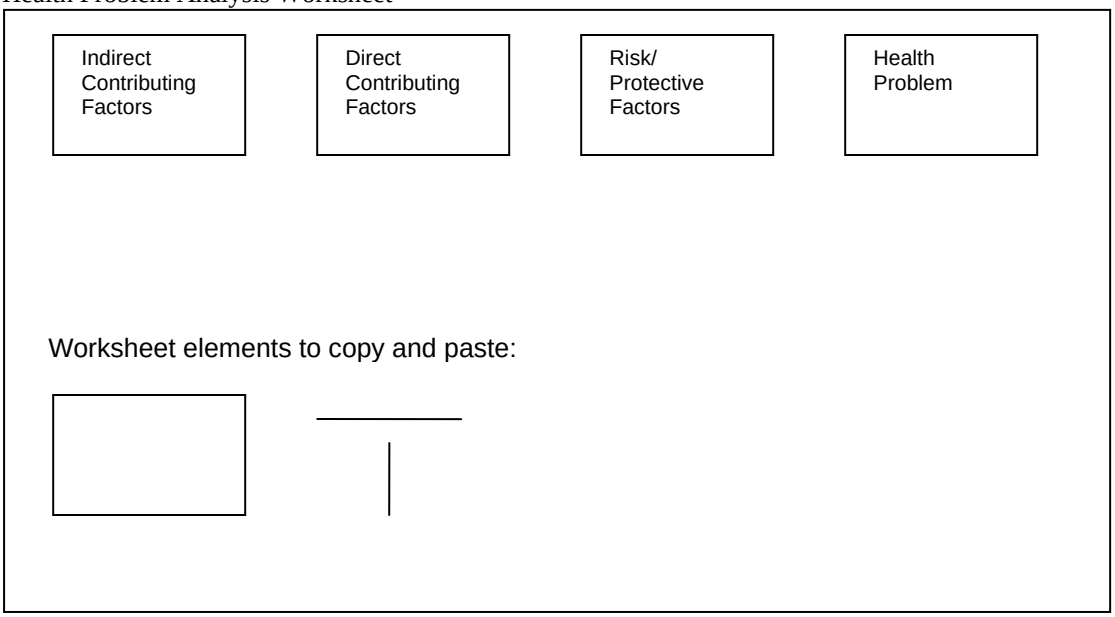
Step 1.2- List and map the causes of the health problem

a. Guiding questions:

- What are the causes of the health problem?
  - Direct
  - Indirect
- What are the risk factors?
- What are the protective factors?

b. Worksheet:

Health Problem Analysis Worksheet



c. Outcome of this step:

List of health problem causes categorized as direct and indirect, and as risk and protective factors organized in a logical sequence.

Step 1.3- Identify potential audiences

a. Guiding questions:

- Who is most affected by the problem?
- Who is most likely to change their behavior?
- Who is most feasible to reach?
- What are the key secondary audiences?

b. Outcome of this step:

A summary of the theories and best practices you want to use.

Step 1.4- Identify the models of behavior change and best practices

a. Guiding questions:

- Which theories appear to have determinants of behavior that match the causal factors you identified in Step 1.3 and why?
- What has worked with similar audiences in the past based on your review of other programs?

b. Outcome of this step:

A summary of the theories and best practices that you will use.

Step 1.5- Form your strategy team

a. Guiding questions:

- What are the required roles?
- Who can help with financial and political issues within the organization?

- Who are the external partners most critical to get on board?
- What organizational structure will be used?
- What communications approaches will be used?

b. Worksheet:

Team Member	Affiliation	Role
Decision-making process:		
Communication process:		

c. Outcome of this step:

The names of your team members, their affiliations, and their roles and brief descriptions of your communication and decision-making processes

Step 1.6- Conduct a SWOT analysis

a. Guiding questions:

- How relevant is the problem to your organization's mission/goals?
- Where does the problem fit in your organization's priorities?
- What knowledge is available to ameliorate the problem, and do you have access to that information?
- What is the state of relevant technology?
- Are the human, technical and financial resources you need to address the problem available?
- What activities can you do in-house?
- What activities will you need to contract for, and what challenges are presented by the contracting process?
- What work is already underway to address the problem, and who is doing that work?
- What gaps exist?
- What political support and resistance surround the problem?
- What organizations or activities that affect the problem indirectly (that work "upstream" in your health problem analysis could be potential partners?
- Are there ethical concerns associated with any of the possible interventions?

b. Worksheet:

SWOT worksheet

Factors/Variables	Internal	External
Positive	Strengths	Opportunities
Negative	Weaknesses	Threats

c. Outcome of this step:

The strengths, weaknesses, opportunities and threats identified, along with any ethical barriers to adopting particular interventions in your community. Also, a summary of eliminated approaches and ones that appear to be more attractive based on the SWOT analysis.

Phase 2- Market Research

Step 2.1- Define your research questions

a. Guiding questions:

- What gaps or assumptions are there in your Phase 1 analysis?
- What questions are suggested by the theory (ies) of behavior change you are choosing for guidance?
- What questions do you have about applying best practice to your specific target audience and situation?

b. Outcome of this step:

List of research questions

Step 2.2- Develop a market research plan

a. Guiding questions:

- Which of the research questions developed in Step 2.1 can be answered using secondary sources and which ones require collecting new (primary) data
- Will you be using qualitative or quantitative methods to answer your primary research questions and if so which ones specifically?

b. Outcome of this step:

Market Research Plan

Step 2.3- Conduct and analyze market research

a. Guiding questions:

- Who will carry out each major components of the market research plan you crafted in the previous step?
- What are their roles and responsibilities?
- If needed, who will be the lead researcher?
- How will you tabulate and analyze the data?

b. Outcome of this step:

Market research analysis

Step 2.4- Summarize research results

a. Market research results summary worksheet:

Executive Summary	
Introduction	
Methodology	
Results	
Conclusions and Recommendations	

b. Outcome of this step:

Market research results summary

Phase 3- Market Strategy

Step 3.1- Select your target audience segments

a. Guiding questions:

For each of the potential segments, answer the following questions using information from your research findings:

- What are their aspirations?
- What are the benefits of the target behavior valued?
- What are the competitive behaviors practiced?
- What information channels are used?
- What is their level of readiness for change?

Which segments that have the following?

- Perceived benefits that are easy to build into an exchange
- Competing behaviors against which you can "win"
- The largest number of people reachable at the smallest cost
- The greatest readiness to change

- Based on the characteristics and concerns of secondary audiences (influentials) in your Phase 2 research, does the amount of influence they have merit devoting program resources to reaching them as a distinct audience segment?

b. Outcome of this step:

List of primary and secondary target audience segments refined from the list created in Step 1.2 using the results of the research done in Phase 2.

Step 3.2- Define current and desired behaviors for each audience segment

a. Guiding questions:

- What behaviors are the audience segments you have chosen currently engaged in?
- Which of these behaviors could be changed in the short-run?
- Is it likely to change them with a little more incentive? If audience members take the desired action, will it make a tangible difference in achieving your overall program goal?

To narrow your list down to the final priorities, answer these questions about the following factors for each audience/behavior pair:

Risk

- Is the target audience segment currently practicing risky or unhealthy behaviors?
- How serious is the risk?

Impact

- Does the new (desired) behavior reduce risk?
- Will addressing this audience/behavior have a useful, lasting impact on the problem?
- How effective will the proposed behavior be at reducing overall negative outcomes or improving positive ones?
- Is the audience/behavior being effectively addressed by anyone else?

Behavioral Feasibility

- Is the audience likely to adopt the behavior? Is the current behavior seen as a problem? How ingrained or "rewarding" are the current or competing behaviors?
- How costly is it (time, effort, resources) for the audience segment to perform the behavior?

- How complex is the behavior (does it involve few or several elements)?
- How frequently must the behavior be performed?
- How compatible is the proposed behavior with the audience's current practices (is the behavior socially approved)?
- Are there major barriers to engaging in the desired behavior? What information, skills, resources and/or access must the audience segment acquire to overcome the barriers and make the desired behavior change?
- Are there at least some members of the segment ("doers") who manage to do the desired behavior? Do they have unusual characteristics?

Resource Feasibility

- How effectively can we reach this audience segment given our available resources?
- How effectively can we influence their behaviors given our available resources?
- Can this audience/behavior be addressed within the timeframe of the initiative or does it require an ongoing effort?

Political Feasibility

- Will the community (or other important stakeholders) support this audience/behavioral objective?
- Does your organization support the choice?

b. Worksheet:

Utilize the interactive Health Intervention Comparison Wizard provided for this step in CDCynergy.

c. Outcome of this step:

Descriptions of current and desired behaviors for each audience segment

Step 3.3- Describe the benefits you will offer

a. Guiding questions:

- What do your audience research findings show that the target audience wants?
- What do audience members say they value the most?
- What are you are asking them to do?
- What they'll get in return?
- Does the exchange you are proposing meet the following criteria?
- Easy-to-irresistible to accept ?
- Maximizes the benefits they will get for adopting a behavior?
- Minimizes any barriers that might deter them?

b. Worksheet:

Exchange Worksheet

Audience member gives:	**Audience member gets:**
Social Marketer gets:	

c. Outcome of this step:

Description of the benefits that will be offered.

Step 3.4- Write your behavior change goal

a. Guiding questions:

- Who?
- Will do what?
- Under what conditions?
- In exchange for?

b. Outcome of this step:

Behavior change goal write-up

Step 3.5- Select the intervention(s) you will develop for your program

a. Guiding questions:

- What interventions do you propose to develop?

- Communication about facts and benefits
- Providing or improving a service
- Developing or adapting a product
- Changing policy through advocacy and community mobilization to reduce barriers to service

b. Outcome of this step:

List of interventions to be developed

Step 3.6- Write the goal for each intervention

a. Guiding questions:

- How will each intervention work to influence the audience to adopt the new behavior?

b. Outcome of this step:

Description of in goals for the interventions

Phase 4- Interventions

Step 4.1- Select members and assign roles for your planning team.

a. Guiding questions:

- Should your current team's composition be supplemented or reconfigured to incorporate the intervention planning skills contacts or other resources needed for this phase that your current strategy team lacks?

- What additional representation do you need on your team in terms of groups that you want to reach, and technical, managerial, and creative expertise?

b. Outcome of this step:

List of planning team members and descriptions of their roles.

Step 4.2- Write specific, measurable objectives for each intervention activity.

a. Guiding questions:

What are the short-term, intermediate and long-term outcome objectives for each intervention goal that you set in Phase 3?

b. Outcome of this step:

The short-term, intermediate and long-term outcome objectives for each intervention goal.

Step 4.3- Write a program plan, including timeline and budget, for each intervention.

a. Guiding questions:

- What are the activities, timing, scope and quality of each intervention and the size and nature of the target audience that will be exposed to it?

b. Outcome of this step:

The delivery/reach objectives, timeline and budget for each intervention

Step 4.4- Pretest, pilot test, and revise as needed.

a. Guiding questions:

- What is your plan to create and test your concepts, products, distribution channels, materials and messages?
- What are the revisions that will be made based on the testing of the items above?

b. Outcome of this step:

Testing plan and recommended revisions based on the outcomes of the testing.

Step 4.5- Summarize your program plan and review the factors that can affect it.

a. Guiding questions:

- What are the factors that can affect your program plan?

b. Outcome of this step:

List of the factors that can affect your program plan.

Step 4.6- Confirm plans with stakeholders.

a. Guiding questions:

- Do your stakeholders support your intervention plans?
- Have you secured stakeholder agreements?

b. Outcome of this step:

Secured stakeholder buy-in and support.

Phase 5- Evaluation

Step 5.1- Identify program elements to monitor.

a. Guiding questions:

- Which program elements will you monitor?

b. Outcome of this step:

List of program elements to monitor

Step 5.2- Select the key evaluation questions.

a. Guiding questions:

- What evaluation questions will you address?

b. Outcome of this step:

List of evaluation questions.

Step 5.3- Determine how the information will be gathered.

a. Guiding questions:

- What information sources and data collection methods will you use for monitoring and evaluation?
- What evaluation research design will be used?

b. Outcome of this step:

Description of information sources, data collections methods and research design.

Step 5.4- Develop a data analysis and reporting plan.

a. Guiding questions:

- How will the data for each monitoring and evaluation question will be coded, summarized and analyzed?
- How will conclusions be justified?
- How will stakeholders both inside and outside the agency will be kept informed about the monitoring and evaluation activities?
- When will the monitoring and evaluation activities be implemented and how will they be timed in relation to program implementation?
- How will the costs of monitoring and evaluation be presented?
  How will the monitoring and evaluation data will be reported?
- What are your monitoring and evaluation timelines and budgets?

b. Outcome of this step:

A data analysis and reporting plan

Phase 6- Implementation

Step 6.1- Prepare for launch.

a. Guiding questions:

- Have you received organizational clearance for use of program materials?
- What level of quality can you can afford to produce them in the amounts needed to support your program activities?
- If you plan to issue requests for proposals (RFPs) have the been prepared and what is your schedule for issuing and reviewing them?
- Have you hired new staff or consultants as your program plan requires?
- Have you trained your staff to prepare them for the launch of your intervention activities?

- Do you need a plan for rolling out different intervention components at different times?

b. Outcome of this step:

Launch preparations and plan.

Step 6.2- Execute and manage intervention components.

a. Guiding questions:

- When is your launch date and how will you manage and publicize it?
- How will you managing program activities and personnel?
- What will be your approach to taking advantage of unforeseen opportunities that arise and integrating lessons learned?

b. Outcome of this step:

Execution and ongoing management of intervention components.

Step 6.3- Execute and manage the monitoring and evaluation plans.

a. Guiding questions:

- What is the ongoing status of your program progress, monitoring and evaluation activities, feedback and lessons learned?

b. Outcome of this step:

Summary of monitoring and evaluation results.

Step 6.4- **Modify intervention activities, as feedback indicates.**

a. Guiding questions:

- What modifications are needed to the interventions based on the results of your monitoring and evaluation activities?

b. Outcome of this step:

Recommendations for modifications to intervention activities.

S.M.A.R.T. Behavior Change Outcome Objectives

Step 4.2: Write specific, measurable objectives for each intervention activity.

Outcome objectives specify the kind and amount of change you expect to achieve for a specific population within a given time frame for each intervention.

You have already identified desired program outcomes and written related goals, which may have been grouped in short-term, intermediate and long-term categories. For example, your short-term goal may be increasing awareness, your intermediate goal may be changing attitudes, norms and behavioral intentions, and your long-term goals may be changing behavior and improving health status. Behavior change can be an intermediate or long-term goal, depending on the circumstances and how behavior is defined.

Remind yourself that social marketing seeks behavior change:

- to improve the personal welfare of members of the target audience, and
- to benefit society more broadly.

This implies that every aspect of planning should begin at the end—the desired behavior—and work backward to achieve the behavioral goal.

So, begin with an outcome objective that quantifies the desired behavior change.

Then estimate the amount of change that would be necessary in what each target segment thinks, feels, knows, intends, and does to reach the ultimate behavioral objective.

For the outcome and each of its determinants, specify:

- Who specifically will be affected?
- What will change?
- How much change will occur?
- By when?

Develop SMART Outcome Objectives

Make sure your outcome objectives are "SMART."

- Specific
- Measurable
- Achievable
- Relevant
- Time-specific

Examples of SMART outcome objectives are:

- Short term: Increase the proportion of high school youth who report that they believe the tobacco industry deliberately uses advertising to get young people to start smoking from 20 percent in January to 60 percent in September.

- Intermediate: Decrease the proportion of high school youth who report trying a cigarette in the last 30 days from 30 percent in 2002 to 20 percent in 2004.
- Long-term: Decrease the number of smoking related premature births beginning in 2006.

*Dig deeper into the **SMART** concept.*

- Objectives should be ***specific***. Explicitly state what you want to happen, where and to whom as a result of your intervention.
    - **S**pecific objective: At least 90 percent of county schools will institute campus-wide no-smoking policies by 2004.
    - Non-specific objective: To stop teens from smoking.

- Objectives should be ***measurable***. This means you must identify the current, or baseline, value and the level or amount of change that is expected. Your funders will insist on measurements. Measurable objectives will guide evaluation design, allowing you to track progress, document success or know where interventions aren't progressing as planned.
    - **M**easurable Objective: To increase fruit and vegetable consumption among workers in Montgomery Hospital (the target audience) by 50 percent by June 2003.
    - Non-measurable objective: To ensure that the workers in Montgomery Hospital eat more fruit.

- Objectives should be ***achievable*** and realistic. Especially when you aim to change chronic, addictive behaviors (e.g., overeating, smoking), you may have to settle for small steps in a long process. If you overreach, your target audience may turn away completely. Besides, your realism reflects on your credibility. You cannot save the world with any intervention. But you can make the world a better place in a very concrete, albeit incremental, way.
    - **A**chievable objective: To reduce marijuana use by youth age 14-16 in Iowa by 5 percent by December 2004.
    - Non-achievable objective: To stop youth from using marijuana.

- Objectives must be ***relevant***, i.e., logically related to your overall goals. Check with your target audience to ensure that what you hope to achieve in the short run will get you where you want to be in the long run.
    - **R**elevant objective: Developing pictorial instructions that can be understood at low reading levels to improve patient compliance with "Back to Sleep" recommendations among people with low literacy by 10 percent in the next six months.
    - Irrelevant objective (or not relevant enough): To improve patient compliance among people with low literacy by teaching adults to read better.

- Objectives should be ***time-specific***. Your interventions are limited in time and space. While you always hope and plan for permanent change, you must be realistic

about when to measure the effect that you can achieve. Your funders, partners, and policymakers will want a report within a realistic time frame. Identify the end point of your intervention and the points along the way at which you'll measure progress. If you have the resources, you could learn a lot about the permanency of your behavior change and the durability of your intervention by measuring change at a distant point in the future.

- **T**ime-specific objective: To reduce the proportion of adults in the U.S. who smoke to 12 percent by 2010 (a specific goal of Healthy People 2010).
- Non-time-specific objective: To reduce the proportion of adults in the U.S. who smoke to 12 percent.

Step 4.2

Write specific, measurable objectives for each intervention activity. Outcome objectives convey specifically how much your program must accomplish to be considered successful. Specific, quantified outcome objectives provide the evaluator with standards against which to judge the effects of various intervention activities. Your evaluator can help you set realistic objectives, thus helping to build in a positive evaluation result.

Reach Your Target Audiences:
Program Exposure and Gross Rating Points

The following text emphasizes the importance of having an adequate exposure or reach of your marketing messages to influence health behaviors. Explained below is Gross Rating Points (GRP) which is the marketing technique used to estimate, measure and evaluate exposure to your marketing messages. Much of the text comes from Phase 5: Evaluation. The transcript from a video in the phase is included. Gross Rating Points (GRP) is a commercial marketing tool rarely used by health promotion professionals. Health Promotion Operations will develop this tool for your use. Definitions follow the video transcript.

Determine Needed Exposure to Achieve Behavior Change Outcomes

Three successful social marketing programs (VERB, Wheeling Walks, National Highway Traffic Safety Administration) had goals to have target audience members exposed to marketing messages about six to nine times per week from at least two or three forms of media (channels). This should also be at least 115 GRPs per week. *A program goal should be to have enough exposure to have between 75% and 90% of the target audience be able to recall the messages if asked a year after the social marketing campaign begins.*

With over 90% recall hearing about the campaign after one year Wheeling Walks had an outcome of a 23% increase in the number of walkers. With a 74% recall of VERB campaign messages VERB had 25% more engagement in free-time physical activity. The NHTSA "Click It or Ticket" program consists of high visibility enforcement with an intense flurry of paid advertising and publicity about enforcement creates the heightened awareness and actual behavioral change we need to save lives. Seat belt use increased from 71% in 2000 to 82% in 2005.

Step 5.2: Select the key evaluation questions.

What To Do

Evaluation is the effort to find out what effect your program is having – whether it is reaching its objectives. Outcome evaluation studies are usually limited to specific periods in the life of a program. These studies try to link program activities to:

- **short-term outcomes**, such as who was **aware of a program** during its evaluation period
- mid-term outcomes, such as which determinants of behavior were changed
- long-term outcomes, such as the intended (and unintended) effects a program had on behavior and health problems

How to Do It

Derive evaluation questions from My Model

In *My Model*, you:

- described a sequence of steps in a behavior change process
- explained how the program is supposed to work, linking program activities to the target audience outcomes you hope to achieve
- **quantified program delivery/reach and outcome objectives**

Convert these logic model elements into evaluation questions

A basic evaluation question is

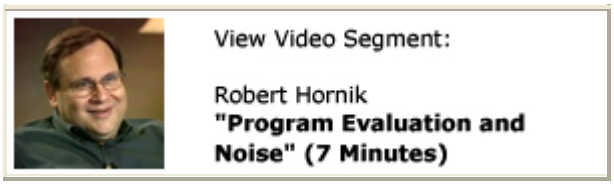
- **were *exposure levels* adequate to make a measurable difference?**

Adapt the question to your program content.

For example, if your program were designed to increase use of a [health behavior] among a target audience, you might ask whether:

- your ads reached enough of the target audience to detect an effect of the expected size at the level of statistical power afforded by your sample size

The extent of program exposure or "noise" is a particularly important evaluation consideration in Social Marketing.



Robert Hornik on "Program Evaluation and Noise" (Transcript)

The basic argument is that many communication programs -- many social marketing programs, particularly communication programs -- have focused on providing knowledge, providing ideas on the assumption that that's all it took to get people to change. They'd learn something new, "Ah! That's a good idea. I'll do it." And, of course, that rarely works. People are really rarely in that situation. So you can contrast two models of effect. One is a model which says, "I tell them. They learn it. They do it." The other is to say, "Behaviors are well-ensconced. They've got lots of supports, lots of reasons why people do them. And if you want to get behavior changed, it's going to take a long time."

At a simple level, it's just the amount of exposure that a program achieves. There is the number of times the message is heard and through the number through lots of channels. So it's making lots of noise means getting repeated exposure to your messages.

The program noise says, "It's an important issue. You really ought to pay attention to this." You hear it lots of times from lots of sources, and maybe at some point you begin to think it's true; and that's really the argument for program noise is when you have a situation where new knowledge isn't enough. But you really need to change social norms. You really need to change the way people think about it and get people to pay more attention to an issue, then that's the point at which repeated exposure may really matter. There's another argument for exposure, though, as well, which is our audiences are constantly changing. Think about the problem with immunization. People need to know about kids immunization when their kids are of the age to immunize. But every six months there are a whole bunch of new kids that are born. If you do it just once, you're not likely to reach those audiences that begin to come of age.

One of the things that multiple exposures may do is engender more social discussion. That is, you hear it. I don't, but because you hear it repeatedly you say, "This must be an important issue. I'll make it a topic of my social discussion." I'll talk about smoking or I'll talk about AIDS. Maybe if you heard it

only rarely, you might not want to talk about it probably; it doesn't become okay. I think that's real important for HIV, and that is it became acceptable to talk about condoms in public, which in an earlier period it simply wasn't. So the fact of repetition legitimates talking about something, which probably wouldn't come from single exposures even the people that were convinced about the truth of it.

I think the issue is that most programs fail when they fail, not because their messages are bad or they didn't understand their environment so well; it's that they never got enough exposure to matter. That is, they said, “Oh, we'll get this on the air because they'll give us contributed time.” And nobody ever sees the message. In my experience, it's probably the best single predictor of whether a program's successful or not. That is, how much exposure it got. And, in fact, I looked at a full range of programs and I think many of the well-known programs that have not been so successful have largely been not successful because they just didn't get enough exposure to matter. Given the background noise that was already there, they didn't add anything new. So one argument for measuring exposure is that it's the area of failure most often; and so really knowing whether or not you're actually getting to the audience, whether they recognize your message, whether they remember it or not seems to be an absolute minimum condition for deciding if a program's going to work. And lots of times it doesn't for just that reason.

there are whole classes of evaluation methods which are helped by being able to show that those were exposed. In fact, in those that were not exposed, we're showing the outcome that you wanted. That is, they're more likely to breast feed because we are going after it. They're more likely to do physical activity, if that's what you're going after, than people who were not so exposed. And although there are some problems with trying to evaluate things with simple associations between exposure and outcome, so there are good statistical methods we are trying to control for possible other characteristics that might have mattered. So being able to show not only how much exposure you've got -- which is a minimum condition for a successful program -- but also trying to show that exposure is associated both with intermediate outcomes -- mediating things like changes of knowledge, but also associated with behavior change in the end -- is a real important thing. So I think exposure is a crucial thing to measure and to do seriously.

In terms of how to measure exposure, there's a whole range of good methods. I think there are some methods which you can use which are independent of the individual's reports; that is, gross rating points for example or other sorts of external measures of how much exposure was achieved. But then there are lots of ways of measuring it directly with people. The most common ways certainly are asking people if they recall specific messages, again trying to make sure that they are not just making it up, that they're not claiming exposure when they really didn't get it. A typical way is to ask about false messages as well as true messages and answer correct for the fact that somebody will remember false messages.

If you were operating under the model which says, “This is behavior that's well-ensconced. This is behavior that people have been doing for a while; it's not going to be so easy to change,” you have to have quite reasonable expectations about how fast it's going to change relative to the amount of exposure you're providing. And so some people, well, you not going to get direct trade-off with every additional ad, you’re going to get that much more change; still there’s an argument which says, “For behaviors that are hard to change, that people hold dear, it's going to take a long time.” So I guess the real important issue in terms of evaluation when you think about a program noise model, what you're really saying is you're assuming that this is going to be a hard behavior to change. You're going to have to do lots of things and go through lots of channels, which means you'll need to have a reasonable expectation for how long it's going to take to get all those channels working, to get institutions to change, to get social networks to operate to try to say, “This is a new behavior.” That's not going to happen instantly and, therefore, probably the most important thing is to have patience. I realize often funders don't have patience. That is, they have very quick expectations: but typically with a program that has this model underpinning it, you have to expect slow change. Think about the smoking interventions. It's true that there's some decent evidence over a couple of years for Florida

or for the national campaign suggesting we've had effects; but in some level you go back to the extraordinary decline in smoking behavior that's present in the United States, and it happened at the rate of 2 percent a year. Many evaluations wouldn't even be able to detect that change without extremely large samples. But, yet, that was really a social movement change; it took a long time to take place. You had lots of aspects that were changing, but eventually it did produce very substantive change. You have to be ready to wait.

Formative Research
Process Evaluation
Outcome Evaluation
Resources & Reports

Gross Rating Points

Reach, frequency, and their product—gross rating points (GRP)—are all means of estimating exposure of an audience to advertising. Reach is defined as the proportion of the target audience that has an opportunity to be exposed to the ad, based on knowledge of the media consumption patterns of the target population and the advertising purchased. Frequency is the number of times an average target audience member is estimated to have an opportunity to view the advertisement in a given time period, usually weekly or monthly. Multiplying reach times frequency produces the measure GRP, the customary unit used by the advertising industry to measure estimated exposure to advertising. Although estimates of audience reach are used to make decisions about which programs or channels to include in a media buy plan, most ad agencies use estimates of GRPs to build an effective and efficient media buy plan.

Media monitoring companies make parallel projections of audience size (based on census data and other sources) for all media, and GRP estimates are calculated accordingly. GRPs are estimates of averages. For example, a reach of 80% means that 80% of a target audience composed of average individuals is believed to have had the opportunity to view the advertising; it is not an estimate of whether any particular individual did or did not see the advertising. Because GRPs are the product of reach and frequency estimates, a GRP estimate reflects many different possible exposure patterns. For example, if 10% of a population could be reached five times in a week, the weekly GRPs for that advertisement would be 50 (10 x 5); if 50% of the population could be reached once in a week the GRPs would also be 50 (50 x 1).

GRPs are calculated for each advertisement in each medium, and the GRPs for all exposure opportunities are summed. In some cases, estimation procedures are used to eliminate duplication of reach estimates, for example, if it is expected that one segment of a population will be reached by multiple television channels with the same advertisement.

My Model

TARGET AUDIENCE	**In order to help this specific target audience:** ***(Steps 1.3, 3.1, 3.2)*** ▪ (start text here) ▪ (start text here) ▪ (start text here)
BEHAVIOR CHANGE	**Do this specific behavior:** ***(Steps 3.2, 3.4)*** ▪ (start text here) ▪ (start text here) ▪ (start text here)
EXCHANGE/ BENEFITS	**We will offer these benefits that the audience wants:** ***(Step 3.3)*** ▪ (start text here) ▪ (start text here) ▪ (start text here)
STRATEGY	**And lower these barriers, address these 'Ps':** ***(Steps 3.5, 4.3, 4.3a-d)*** ▪ (start text here) ▪ (start text here) ▪ (start text here)

Through these intervention activities and tactics:

Behavior Change Goals ***(Step 3.4)***	*Activities and Tactics* ***(Steps 3.5, 4.3 a-d)***	*Program Delivery & Reach Objectives* ***(Steps 4.2, 4.5)***	*Outcome Objectives* ***(Steps 4.2, 5.1)***	*Resources Needed* ***(Steps 4.3, 6.1)***
Start text here	Start text here	Start text here	Start text here	Start text here

TARGET AUDIENCE. In order to help this specific target audience:
Grandmothers and others in the community who prepare chitlins for the holidays while caring for grandchildren or other youth

BEHAVIOR CHANGE. Do this specific behavior:
Disseminating the program's message to primary target audience members within their sphere of influence

EXCHANGE/BENEFITS. We will offer these benefits that the audience wants:
This might have been phrased: Being able to contribute to the health of children in the community.

STRATEGY. And lower these barriers, address these 'Ps':
Primary:

Barrier	Product	Price	Place	Promotion
Change from traditional technique Perceived change in taste Extra 5 minutes of up-front work		Using community members to endorse pre-boiling Cooking demonstration and taste testing for community members. Demonstration also showed that later cooking time was decreased.	Grocery store point of sale reaching chitterlings purchasers Church newsletter/bulletin inserts Physician offices, hospitals, county clinics, WIC waiting rooms	Community leaders, Office of Minority Health, physicians and clergy in community churches disseminate information on preboiling.

Through these intervention activities and tactics:				
Activities and Tactics	*Behavior Change Goals*	*Program Delivery & Reach Objectives*	*Outcome Objectives*	*Resources Needed*
Cooking demonstrations Dissemination of materials explaining pre-boiling	Pre-boil chitlins for five minutes before cleaning and cooking.	Planners might have written these and similar objectives: *Example of a short-term delivery and reach objective* By December 31, 1996, 10% of African American churches in metropolitan Atlanta will distribute the bulletin insert on four consecutive Sundays. *Example of a long-term delivery and reach objective* By December 31, 1996, 15% of African American grandmothers who prepare chitterlings for the winter holiday season will attend to the message four times that they should pre-boil the chitterlings for five minutes.	By December 31, 1996, 10% of African American grandmothers who prepare chitterlings for the winter holiday season will pre-boil their chitlins for five minutes before cooking.	$25,000 was budgeted for the campaign

My Model

TARGET AUDIENCE	**In order to help this specific target audience:** ▪ Community Leaders and gatekeepers ▪ (start text here) ▪ (start text here)
BEHAVIOR CHANGE	**Do this specific behavior:** ▪ Disseminating the program's messages to primary target audience members within their sphere of influence ▪ (start text here) ▪ (start text here)
EXCHANGE/ BENEFITS	**We will offer these benefits that the audience wants:** ▪ Having a sense of contributing to the well-being of their community by keeping the children healthy ▪ (start text here) ▪ (start text here)
STRATEGY	**And lower these barriers, address these 'Ps':** ▪ Barriers: None identified, however, difficulty in disseminating information and lack of time could be barriers ▪ Product: Appealing to this audience's sense of giving back to the community ▪ Price: Time to make available already prepared materials. ▪ Place: Churches ▪ Promotion: use already prepared materials

Through these intervention activities and tactics:				
Behavior Change Goals	*Activities and Tactics*	*Program Delivery & Reach Objectives*	*Outcome Objectives*	*Resources Needed*
Activities include face-to-face meetings between community leaders, public health officials and staff from the state office of minority health	Disseminating the program's message to primary target audience members within their sphere of influence	By December 31, 2007 10% of African American churches in the metropolitan Atlanta will distribute the bulletin insert on four consecutive Sundays.	By December 31, 2007 10% of African American churches in the metropolitan Atlanta will distribute the bulletin insert on four consecutive Sundays.	$25,000 for the campaign staff and materials
Trainings on distributing materials				List of community leaders and contact information

TARGET AUDIENCE. In order to help this specific target audience:
Health care providers
Physicians
County clinic nurses
WIC nutritionists
Hospital infection control nurses and epidemiologists

BEHAVIOR CHANGE. Do this specific behavior:
Take exposure history and culture for possible YE cases

Disseminate prevention message

EXCHANGE/BENEFITS. We will offer these benefits that the audience wants:
This might have been phrased: increasing your awareness of a new health threat; having an impact on this serious health problem.

STRATEGY. And lower these barriers, address these 'Ps':
Secondary: HC providers

Barrier	Product	Price	Place	Promotion
None identified. However, difficulty in disseminating information and lack of time could have been barriers	Could have been: Appealing to this audience's sense being a good clinician; having an evidence-based, easy to use intervention to offer.	Could have been: Making available already prepared materials.	This could have been at provider offices.	Cover letter Medical fact sheets Presentations In person/phone to address questions

Through these intervention activities and tactics:				
Activities and Tactics	*Behavior Change Goals*	*Program Delivery & Reach Objectives*	*Outcome Objectives*	*Resources Needed*
Activities might have included: face-to-face meetings between community leaders, public health officials and staff from the state office of minority health.; trainings on distributing materials.	Take exposure history and culture for YE inappropriate cases Disseminate prevention message	Planners might have written these and similar objectives: *e* By December 31, 1996, 50% of health clinic and emergency providers seeing African American Children with severe diarrheal disease will ask history questions asking about chitlins preparation, and distribute cooking information.	Planners might have written these and similar objectives: *Example of a short-term delivery and reach objective* By December 31, 1996, 10% of African American churches in metropolitan Atlanta will distribute the bulletin insert on four consecutive Sundays	$25,000 was budgeted for the campaign An example of other resources needed might have been: Lists of who community leaders were; entrée to contact them.

Most Valuable Places

Nifty things I found on the CD ROM I want to remember.

HELP! I can't find it.

. . . and other questions I want answered

Workshop Post-test

1. Of the following, please mark the *5 P's* of the *social marketing mix* with an 'X'.
   a. ____ Perseverance
   b. ____ Place
   c. ____ People
   d. ____ Product
   e. ____ Policy
   f. ____ Penalty
   g. ____ Price
   h. ____ Presentation
   i. ____ Promotion

2. When using social marketing to change healthcare practices, whose wants and needs should be the focus of an intervention or communication strategy?

   a. ____Policy Makers
   b. ____Providers
   c. ____Program Funders
   d. ____Audience

3. List three key concepts in social marketing (other than the *5 P's*):

   a. _____

   b. _____

   c. _____

True or False:

4. _____ Competition always exists.

5. ___ Marketing is a message based, promotion only approach.

6. Please list the six phases of best practice social marketing:

   (1) _____ (2) _____

   (3) _____ (4) _____

   (5) _____ (6) _____

7. What do you consider to be the "marketing" part of social marketing?

_____

Tur[redacted]nt

Workshop Evaluation

These items ask you to rate both the quality of the course and how having the information might impact planning your interventions and communications. Please circle the number closest to the statement that represents your beliefs.

The information presented in this course...

1.	**will** help me do my job	1	2	3	4	5	will **not** help me do my job
2.	has **increased** my knowledge of the social marketing planning process	1	2	3	4	5	has **not** increased my knowledge of the social marketing planning process
3.	will **weaken** my working relationship with partners	1	2	3	4	5	will **strengthen** my working relationships with partners
4.	will make doing my job **harder**	1	2	3	4	5	will make my job **easier**
5.	**weakens** the confidence I have in my ability to plan interventions and communications using social marketing	1	2	3	4	5	**Strengthens** the confidence I have in my ability to plan interventions and communications using social marketing
6.	will **not** help me make strategic decisions	1	2	3	4	5	**will** help me make strategic decisions
7.	will **add** to my credibility with my boss and my peers	1	2	3	4	5	**will** help me plan effective interventions and communications
8.	will **not** help me plan effective interventions and communications	1	2	3	4	5	**will** help me plan effective interventions and communications

This course...

9.	had **too much** information in it	1	2	3	4	5	had **too little** information in it
10.	**had** the information I was looking for	1	2	3	4	5	**did not have** the information I was looking for
11.	was **well-organized**	1	2	3	4	5	was **chaotic**

Turning Point

Workshop Evaluation, continued

The next set of questions ask a bit more about the course.

		Poor	Fair	Average	Good	Excellent
12.	The quality of the information presented	1	2	3	4	5
13.	The time allotted during class to assk and discuss questions	1	2	3	4	5
14.	The speed at which the materials were covered	1	2	3	4	5
15.	The skill of the instructor at presenting	1	2	3	4	5
16.	The usefulness of the small group approach to completing activities	1	2	3	4	5
17.	The organization of the materials and topics presented	1	2	3	4	5
18.	The facilities and equipment	1	2	3	4	5
19.	The quality of printed materials	1	2	3	4	5
20.	The order of topics and activities	1	2	3	4	5
21.	The length of the training	1	2	3	4	5

22. A significant learning for me was...

23. A surprise for me was...

24. Some changes I would suggest are...

Tur[redacted]nt

Workshop Evaluation, continued

Feedback for the Instructors

Please circle a number in each row that represents your opinion

		Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A
1.	Presented information in a clear and organized manner.	1	2	3	4	5	-
2.	Accurately explained technical terms and issues.	1	2	3	4	5	-
3.	Answered questions fully.	1	2	3	4	5	-
4.	Created a comfortable atmosphere that encouraged participation.	1	2	3	4	5	-
5.	Gave helpful feedback to trainees during activities.	1	2	3	4	5	-
6.	Reviewed key points.	1	2	3	4	5	-
7.	Demonstrated good facilitation skills.	1	2	3	4	5	-
8.	Adhered to time schedule.	1	2	3	4	5	-

Comments:

Thank You!

Tur[redacted]nt

Social Marketing Resources
–A Quick Look!

CDCynergy-Social Marketing Edition Version 2

CD ROM-based software to help you plan, implement and evaluate social marketing initiatives. Contains over 700 resources, such as consultant videos, best practice case studies, templates and journal articles. Purchase on-line at: http://www.tangibledata.com/CDCynergy-SOC

Web Resources

The Social Marketing Place	http://social-marketing.com/
The Social Marketing Place Blog	http://www.social-marketing.com/blog/
Social Marketing National Excellence Collaborative, Robert Wood Johnson Turning Point grant	http://www.turningpointprogram.org/Pages/socialmkt.html
Social Marketing Institute	http://www.social-marketing.org/
The Social Marketing Network, Health Canada	http://www.hc-sc.gc.ca/ahc-asc/activit/marketsoc/socmar-hcsc/index_e.html
On Social Marketing and Social Change (The Social Marketing Blog)	craig.lefebvre@gmail.com http://socialmarketing.blogs.com/
Social Marketing Wetpaint/Wiki Site	http://socialmarketing.wetpaint.com/

Books

Social Marketing in the 21st Century. Alan Andreasen. Thousand Oaks, CA: Sage Publications. 2006.
Social Marketing: Improving the Quality of Life. Philip Kotler, Ned Roberto, Nancy Lee. Thousand Oaks, CA: Sage Publications. 2002.
Hands-On Social Marketing: a step-by-step guide. Nedra Kline Weinreich. Thousand Oaks, CA: Sage Publications. 1999.
Marketing in the Public Sector: A Roadmap for Improved Performance. Philip Kotler, Nancy Lee. Upper Saddle River, NJ: Wharton School Publishing. 2007.
Marketing Public Health. Michael Siegel, Lynne Donner. Gaithersburg, MD: Aspen Publishers, Inc. 1998.

Social Marketing List Serve *(Subscribe to this, if you don't do anything else!)*

The list serve is a forum for talking about social marketing research, practice, and teaching via e-mail. It was founded by Alan Andreasen at Georgetown University, one of the leaders in the area of social marketing. People participate from across the United States and many other countries and represent a variety of disciplines.

To subscribe, send an e-mail message to:
LISTPROC@LISTPROC.GEORGETOWN.EDU

In the body of the message write:
subscribe SOC-MKTG (your name)

and type your actual name in place of “your name.”

Journals

Social Marketing Quarterly
Taylor and Francis
325 Chestnut Street, Suite 800
Philadelphia, PA 19106
Subscription: $34.00/year
http://www.tandf.co.uk/journals/titles/15245004.html

Journal of Health Communication
Taylor and Francis
325 Chestnut Street, Suite 800
Philadelphia, PA 19106
Subscription: $164.00/year
http://www.tandf.co.uk/journals/titles/10810730.html

Conference Opportunities

1) *Social Marketing in Public Health Annual Conference*
June 20-27, 2007, Clearwater Beach, FL

Contact:
Bobbi Rose, Continuing Professional Education
University of South Florida College of Public Health
813-974-9684 *e-mail:* **brose@health.usf.edu**

To view and download registration information go to:
http://www.cme.hsc.usf.edu/coph/smph/index.html

To view and download materials from previous conferences go to:
http://www.cme.hsc.usf.edu/coph/smph/presentations.html

GRP and Other Marketing Terms Definitions and Resources

Gross rating points is a measure of estimated exposure to advertising. Reach is defined as the proportion of the target audience that has an opportunity to be exposed to the ad. Frequency is the number of times an average target audience member is estimated to have an opportunity to view the advertisement in a given time period, usually weekly or monthly. Multiplying reach times frequency produces the GRP measure. Because GRPs are the product of reach and frequency estimates, a GRP estimate reflects many different possible exposure patterns. For example, if 10% of a population could be reached five times in a week, the weekly GRPs for that advertisement would be 50 (10 x 5); if 50% of the population could be reached once in a week, the GRPs would also be 50 (50 x 1).

Wong F, Huhman M, Heitzler C, Asbury L, Bretthauer-Mueller R, McCarthy S, et al. VERB™ — a social marketing campaign to increase physical activity among youth. Prev Chronic Dis [serial online] 2004 Jul [*date cited*]. Available from: URL: http://www.cdc.gov/pcd/issues/2004/jul/04_0043.htm

Definitions and References

Gross Rating Points

Gross Rating Points (**GRP**) measure the total volume of delivery of your message to your target audience. It is equal to the percent Reach to your target audience times the Frequency of exposure. To arrive at your total Gross Rating Points, add the individual ratings for each media vehicle you are using. You may also get GRP by dividing your gross Impressions by the population base and multiplying the answer by 100.

How Stuff Works. http://money.howstuffworks.com/marketing-tools.htm

Gross Rating Point (GRP)

1. Sum of all rating points over a specific time period or over the course of a media plan; sometimes called *homes per rating point.* The rating of a show represents the percentage of people (or households) tuned in to a television program as compared to the number of television sets in the particular television universe (geographical location). Each rating point is equal to 1%. If a show has a rating of 7 that means that 7% of all persons (or households) who have a television were tuned in to that show (whether the other televisions were turned on or not). If there are two shows on a particular station during a particular time period, and the first show has a rating of 7 and the other a rating of 10, then the GRPs for that time period equal 17.

Media planners use gross rating points as a method of designing a media schedule in an attempt to deliver a maximum number of GRPs at minimum cost. In this instance, GRPs are calculated by multiplying the total reach (the unduplicated audience) of the schedule by the frequency (average amount of exposures) of the insertion in the proposed schedule. The gross rating points then will represent the product of reach and frequency and will express the "gross" duplicated percentage of audience that will be reached by the proposed plan. (It is important to note that GRPs are a percentage. Therefore, if a given market has 1000 television households, each GRP represents 10 viewing households, whereas in a market of 10,000 television households, each GRP represents 100 viewing households. Thus, the largest amount of GRPs does not necessarily mean the largest audience.)

2. In outdoor advertising, percentage of the population that passes an outdoor advertising structure on a daily basis. GRPs are the same as showings.

Answers.com. http://www.answers.com/topic/gross-rating-point

Reach x Frequency = GRPs

If you "reach" 70% of the population 3 times in a week, you are said to have bought 210 GRPs. 70 x 3 = 210. Two hundred GRPs a week is thought to be a reasonable media weight for a sustaining campaign in a total market. If you're introducing a new brand, or running a big sale this weekend, you might buy 300 to 500 GRPs in radio alone, or in radio plus some other media.

Burkhard Works
http://www.burkhardworks.com/Radio_Advertising_Costs.htm

Media Report Viewer

- Reach (%)
    - The number of people exposed to at least one issue in a schedule (as a percentage of the target).
- Average Frequency
    - The average number of issues read by each person in the target market who have been exposed to at least one issue in the schedule.
- Gross Impressions
    - This is the total opportunities to see the campaign or schedule. For example, if a schedule reaches 100 people (i.e. the reach), and the average frequency (i.e. the average number of times a person will see the campaign or schedule) is 6; then the Gross Impressions, or Gross Opportunities to See (as it may be called), will be 600 (ie the reach multiplied by average frequency).
- GRPs Gross Rating Points:
    - These are the Gross Impressions expressed as a percentage of the target market. Therefore, if the Gross Impressions are 600 and the population of the target is 1200, then the GRPs are 50.
- Reach
    - For any schedule, the number of people in the target market exposed to the schedule.
- Total cost
    - The total cost of advertising of a particular schedule.
- Scheduled insertions
    - The total number of insertions in the schedule.
- Number of vehicles
    - The number of titles with at least one insertion in the schedule.
- CPT
    - Whether this is Cost Per Thousand Reach or Cost Per Thousand Gross Impressions, it is the total cost of the schedule divided by either the Reach or the Gross Impressions expressed in thousands.

http://www.tgi.hu/choices3/User%20Guide%20to%20Media%20Report%20Viewer.pdf

Frequency The number of times an average individual has the opportunity to be exposed to an advertising message during a defined period of time. Frequency in outdoor usually refers to the calendar month since this time period coincides with standard contract practices.

Gross Rating Points - GRP The total number of impressions delivered by a media schedule, expressed as a percentage of the population. GRP's for Outdoor generally refer to the daily effective circulation generated by poster panels divided by the market population. Often used interchangeably with "showing". One rating point represents a circulation equal to 1% of the market population.

Impressions This is a term used by media to describe and quantify the number of individuals who have an "opportunity" to see an AD in a given amount of time. See CPM. TruckAds® "Impressions Calculator" can help you determine the CPM's for your truckside advertising campaign. See CPM Calculator.

TruckAds.com
http://www.truckads.com/industry_definitions.htm

http://www.truckads.com/cpm_advertising_impressions_calculator.htm

Gross Rating Points (GRP) - GRPs represent the number of impression opportunities, expressed as a percent of the population of a specific market normally quoted on a daily basis. Gross Rating Points (GRP) - The total ratings of all television shown in a given advertising schedule during a given time period (usually four weeks). Program Rating x # of Announcements = GRPs

Tobacco Documents Online. Ness Motley Documents. Advertising/Marketing Glossary
http://tobaccodocuments.org/ness/21.html

Ratings 101
Neilson Media
http://www.nielsenmedia.com/ratings101.htm

"Click It or Ticket"
National Highway Traffic Safety Administration, Traffic Safety Marketing
http://trafficsafetymarketing.gov/
http://www.buckleupamerica.org/index.htm

Exel-lent Marketing Formulas
Add-in tool for Excel. Trial Version is available. Calculates GRP and about 30 other marketing measures.
http://www.exel-lentmarketingformulas.com/

CHANGING TRADITIONS: PREVENTING ILLNESS ASSOCIATED WITH CHITTERLINGS

E. Anne Peterson and Jane E. Koehler

Social marketing of theory-based interventions should have greater impact on targeted populations than non-theory-based, non-targeted interventions (Andreasen). This paper presents a theory-based evaluation of a public health problem and the design and implementation of an intervention using social marketing strategies.

In 1989, a severe form of diarrhea in African-American infants caused by the bacterium *Yersinia enterocolitica (YE)* was first associated with preparation of chitterlings (pork intestines or chitlins) in the home (Lee 1990). An informational intervention, including flyers and short lectures, was designed for dissemination through Women Infant and Children (WIC) clinics each November and December in metro Atlanta (MMWR). The intervention emphasized hand washing and protection of children from exposure to chitterlings. The trend in numbers of cases was followed at one hospital, our sentinel hospital, that regularly cultures stools for *YE* bacteria in all cases of diarrhea. Data collected during 1996 by the Georgia Department of Human resources (GA-DHR) showed that yearly winter peaks of cases were continuing despite the WIC-based intervention.

In August 1996 it was decided to try a social marketing approach to prevent the next holiday outbreak of chitterlings-associated *YE* diarrhea cases. Formative research included literature reviews, community focus groups, and interviews. The literature reviews included medical, epidemiological, microbiological, and agricultural (pig/pork) studies. Phone and personal interviews were conducted with pork producers and with food safety experts at the United States Department of Agriculture (USDA), the Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention (CDC).

Community focus groups and interviews were conducted at a retirement center, a clinic waiting room, a grocery store, and churches. Preparation and hygiene practices, cultural views of chitterlings preparation, and age-related handling practices were elicited. Participants were informed about the annual outbreaks and the literature review findings and then were asked to discuss 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. These hygiene breaks varied but were evident in each preparation story. Two specific preparation methods with potential for preventing disease transmission were identified during the focus groups and interviews: 1) wash chitterlings in low concentration of bleach-water during the hours of cleaning and 2) briefly pre-boil chitterlings before cleaning. These potential interventions were evaluated in home cleaning and cooking trials and by laboratory culture studies. Barriers to acceptance of the interventions were assessed via follow-up phone interviews.

The home cleaning and cooking trials confirmed observations from the formative research. Perfect hygiene was very difficult (impossible) to maintain, even when awareness of disease-causing bacteria in chitterlings was high. Pre-boiled chitterlings were found to be easier and faster to clean than raw chitterlings.

A microbiological study was done of levels of *YE* bacteria present in different commercially available preparations of chitterlings and in chitterlings samples taken after implementing the two preparation interventions. The commercially available chitterlings varied in the amount of bacteria found, but all kinds carried some risk of exposure. (Pre-cooked chitterlings, which are available commercially, were not tested because they are 3-5 times as expensive as other types and were unacceptable in taste and texture to focus group participants.) The first potential intervention, bleached chitterlings, were not consistently lower in bacterial counts than the chitterlings from which they were taken. The second potential intervention, home pre-boiled chitterlings, grew no bacteria of any kind in any of the samples and met the necessary health criteria of killing bacteria in the chitterlings. Pre-boiling removed the potential of transmission in the refrigerator and around the kitchen during and after the cleaning process. Because of this confirmed efficacy and community origin and acceptability, the intervention chosen for dissemination was "Pre-boil your chitterlings for 5 minutes before cleaning and cooking as usual".

From the formative research and follow-up interviews a behavioral theory evaluation was done(Glanz), primarily based on the Health Belief Model (HBM). Perceived threat was almost non-existent. While chitterlings were acknowledged as "dirty" and with potential for disease transmission (one "doesn't eat just anybody's chitterlings" because they might not be safe), most interviewees did not have any experience or knowledge of *YE* diarrhea. This is probably due to the fact that the incubation period is long (Lee 1991) and the exposure is environmental rather than direct (the cases are small children who did not eat chitterlings). There are strong cultural traditions surrounding chitterlings preparation. This is a holiday food with preparation practices and recipes passed down through the generations. Interventions changing traditional practices suggested from outside the community are unlikely to be accepted. Perceived self-efficacy, in maintaining meticulous hygiene, is high among older women despite reported hygiene breaks and a distinct generation gap in hygiene practices and self-efficacy in chitterling preparation is described by both older and younger focus group participants. In contrast, perceived self-efficacy is low, with external locus of control, for prevention of diarrhea in small children.

The primary intervention, the innovation to be diffused (Table 1), was the pre-boil message to be targeted to the chitterling preparers: older African-American women who prepare chitterlings and who, as grandmothers, are often care givers for infants. The design of materials for this target audience again was based heavily on the HBM, cognizant also that the materials would need to move the target audience through the Stages of Change model from precontemplative to action in order for the initiative to be effective. Perceived threat was addressed in describing the outbreaks and demographics of cases. Perceived severity was included by case description of symptom severity and hospitalization rates; one infant death had occurred during a previous outbreak. Barriers identified during the formative research were addressed with specific pieces of information to overcome each of the major barriers. A major barrier to trying the pre-boil innovation was the expectation that boiling chitterlings before cleaning would "boil in the dirt" and change the taste. Perhaps for the first time in a nutritional intervention, a taste test was done which showed home pre-boiled chitterlings to be indistinguishable from usual preparation methods. As a holiday food, it was important that home cooking of chitterlings could still be part of the holiday preparation and that the preparation method came from traditions already being practiced by the community. Implicit modeling by community grandmothers as the acknowledged source of the intervention and collaboration with the Office of Minority Affairs gave more "ownership" of the intervention to the community. Previous intervention messages had suggested removing children from the home during the entire time that chitterlings were

being prepared - a matter of many hours. The pre-boil message required their removal only for the five minutes of pre-boiling and kitchen clean-up. The safety of the children (health benefit) now did not have to weighed against the barrier of finding alternative child care for extended periods of time (Multiattribute Utility {MAU} Theory). A secondary (non-health) benefit of pre-boiling was that it made cleaning both easier and twice as fast. Once tried, this secondary gain was expected to maintain the acceptability of the innovation. Self-efficacy in the new procedure was encouraged by very simple step-by-step instructions on flyers and brochures.

The promotional materials designed for diffusing the innovation included flyers, cartoon flyers, cartoon stickers, brochures, a case story, public service announcements, news releases and television news features. In planning the diffusion of these materials, it became clear we had two other target audiences as well: Health Care Providers and a heterogeneous group of "Gatekeeper /Community Leaders" (Table 1). The desired actions (product), barriers, and benefits (price), promotion and place (Lefebvre) were different for these groups than for chitterlings preparers and so additional materials were designed to address these two target audiences: sub-group specific cover letters, a medical fact sheet, and personal and/or phone presentations to decision makers. For example, the action desired for church leaders was willingness to hand out materials to the congregation. Working from the Health Belief Model, the cover letter explained the susceptibility and potential severity of the problem and the ease (lack of barriers) and benefit of the proposed intervention.

Table 1: Summary of Target Segments and Focused Interventions

TARGET POPULATION	PRODUCT	PRICE	PROMOTION	PLACE
Chitterlings preparers Primarily older African-American women in metro Atlanta	**Message** Pre-boil chitterlings before cleaning	**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	**Cartoon Flyers** Walk-by eye-catching **Flyer/bulletin insert** Short read: problem & community solution **Brochure** Full info for interested readers **News release** PSA: Public service announcements Newspaper articles Radio talk show TV news spots Focus on new problem with a simple community solution	**Grocery stores** Point of sale reaches chitterlings purchasers **Churches** Targets church goers. Churches trusted source **Health Care providers** Doctors, hospitals, county clinics, WIC Waiting rooms **Media** Targeted: Gospel station talk show

TARGET POPULATION	PRODUCT	PRICE	PROMOTION	PLACE
Community leaders / gatekeepers Heterogeneous group having authority to allow dissemination of information	Allow and encourage message dissemination to target group within their sphere of influence	**Perceived barriers** Extra work Potential political or economic repercussion **Perceived benefits** Image of promoting safety of children DHR did most of follow-up work	**Cover letters** for each sub group **News release** **Medical fact sheets** **Samples of brochures &flyers** Can evaluate what they are being asked to distribute **Presentation** In person/phone to address questions	**Grocers' associations & large chains** Point of sale distribution **Church Associations** Posting, bulletin insert, pulpit announcements **Media** Timely awareness of preventable health
Health Care providers Private doctors County clinic nurses & environmentalists WIC nutritionists Hospital infection control nurses & epidemiologists	To take exposure history and culture for *YE* in appropriate cases Disseminate prevention message	**Perceived barriers:** Requires awareness & asking about chitterling exposure Extra cultures & cost **Perceived benefits:** Correctly diagnosis *YE* Earlier treatment *YE* Simple prevention message	**Cover letter** **Medical fact sheets News release** **Samples of brochures &flyers** Distribution to their patient population **Presentations** In person/phone to address questions	**Work place /office** From supervisors State Epidemiologist Research investigator Emphasis on new, well documented medical information and timeliness of prevention issues

Pastors and church leaders had to make their own judgement as to whether they perceived their own congregation as matching the described population at risk.

Over a one and a half month period, from mid-November to the end of December, the promotion was implemented through the locations listed in the table. Penetration of the market increased week by week as gatekeepers gave permission and facilitated dissemination of the promotion. The efficacy of the project was limited by several factors: less than adequate time to fully design and pilot each of the materials, late and incomplete penetration of the market (at least one high risk market refused to post flyers), and the immensity of moving a target population from pre-contemplation to action in a short time frame.

It was expected that health care providers would increase their efforts to find and diagnose cases of diarrhea in response to the message targeted for them and we would see an apparent increase of cases (increased reporting). If the community implemented the intervention, they would reduce their exposure to the bacteria and reduce the true number of cases of severe diarrhea in small children. The number of cases reported in our sentinel hospital was followed to evaluate the impact of the intervention (surveillance) and would be the balance of the two competing factors. The outbreak season begins in November but our intervention didn't begin until mid-November. Cases exposed before mid-November would begin to get sick through the end of

November and be diagnosed at the beginning of December. The period of intervention effect would then be expected to begin in mid- December 1996. Compared to 1995/96 the number of cases prior to intervention effect was slightly higher this year, especially noticeable was the Thanksgiving peak (at the beginning of December). However, post intervention there is no Christmas peak, as there was the last year, and the number of cases was lower during this period (11 cases) than for the same weeks last year (16 cases), despite increased surveillance by doctors. While the decrease is not statistically significant, these are suggestive of some intervention effect.

Feedback from the target audiences was anecdotal. Gatekeepers and health care providers for the most part approved and helped promote dissemination of the intervention. They included: two grocery retail associations, several large chain grocery stores, a number of African-American clergy associations, and the major pediatric hospitals. Two of three stores surveyed had flyers posted next to the chitterlings. All the hospitals pre-approved distribution of brochures and distribution was verified at four of six medical centers. Several clinics and two churches requested extra copies of the materials. Some negative feedback came from mid-level health care workers who believed that the stated case demographics were racist. Over 90 percent of ascertained Atlanta cases are in the African-American population and the intervention materials identified African Americans as the target group. The primary target was receptive to the intervention message - returning to a clinic in one instance to get more brochures for family members in other states. The only negative response received from the community was a woman unmoved by the results of the taste test, who was convinced that the taste would change and refused to try pre-boiling.

This social marketing approach to a food related health problem was well received and results suggest effectiveness greater than previous non-targeted interventions. Project objectives were met in that new information, both microbiological and behavioral, was obtained, on transmission and potential interventions. The message was designed for (addressed specific barriers and benefits) and was liked by the primary target audience. Implementation of the intervention was widespread and done at low cost, despite the short time frame for assessment and innovation design (three months from formative research to beginning of the outbreak season) and late market penetration. While modest, this apparent success in the pilot intervention is encouraging. Expansion of this program to include rural (including white) target audiences statewide is planned.

REFERENCES

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Glanz Karen, Lewis FM, Rimer BK eds, Health Behavior and Health Education: Theory and Practice, Jossey-Bass Health Publishers, San Francisco, 1990.

Lee L, Gerber R, Lonsway D et al *Yersinia enterocolitica 0:3* Infections in Infants and Children Associated with Household Preparation of Chitterlings, NEJM April 1990; 322:(14),984-987.

Lee L, Taylor J, Carter G, et al, *Yersinia enterocolitica 0:3*: An Emerging Cause of Pediatric Gastroenteritis in the United States, J Infectious Diseases 1991; 163:660-663.

Lefebvre C, Flora JA, Social marketing and public health intervention, Health Education Quarterly 1988; 15(3): 299-315.

Yersinia enterocolitica Infections during the holidays in Black Families - Georgia, Topics in Minority Health MMWR Nov 1990, vol39,#45, 821.

Social Marketing CDCynergy:
A Primer for Managers and Supervisors

Introduction:

Your staff will be using this planning tool to develop a social marketing program. In doing so, they may apply principles and processes different from those usually used in your department. They will be asking certain critical questions of the research data, and making decisions based on specific criteria. They need your input and support and adequate resources to use this tool successfully and to mount an effective social marketing program. In turn, you must ensure that the directions taken and decisions made comply with your department's objectives and priorities, and that there is clear accountability for the resources used and results delivered.

This Supervisor primer aims to help you by:

- Briefly describing the purpose and steps of each of the planning tool's six phases
- Alerting you to key points in the process where your involvement may be necessary to
  – provide input and/or resources,
  - review rationale and approve recommendations/ decisions, and to
  - support strategic direction and tactics
- Pointing out important differences between the social marketing approach and program planning processes you may be using currently
- Cueing you with questions to ask and items to consider or pay attention to at key points in the planning process

The intent is to help you be an engaged, informed, and efficient social marketing consumer and manager.

Phase One: Describe Problem

At the outset of this process, your staff will develop a description of the health problem to be addressed and a compelling rationale for the program. These are to be based on a thorough review of the available data, the current literature on behavioral theory and best practices of programs addressing similar problems. Through a Strengths/Weaknesses/Opportunities/Threats (SWOT) analysis, your staff will identify factors that can affect the program being developed. Finally, your staff will propose a strategy team, probably comprised of staff, partners, and stakeholders, to help develop and promote the program.

Much of this will feel very familiar to you, but there may be one or two important differences.

What's Different?

- Behavior change, not epidemiology, will be at the center of your program. The problem description should reflect which behaviors are contributing to the problem and which proposed behaviors will be promoted as the solution.
- The problem statement should be informed by theories of behavior and how change occurs. This requires that your staff consider factors that influence behavior, or behavioral determinants. Sometimes, these may be expressed in terms of benefits and barriers.
- Factors "upstream" in the causal chain from the problem and associated behaviors may be considered.

How You Can Help:

- Confirm that the problem description and rationale fit your department's current priorities. It is essential that your staff have your endorsement and support for the problem they've chosen to tackle.
- Determine that the data presented are complete and support the problem analysis.
- Ensure that the SWOT analysis is complete and identified factors are defensible.
- Review the proposed strategy team for serious omissions or political sensitivities.
- Clarify who else must review and approve key elements of this program at various points, and help with a plan for expediting such review and approval.

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Phase Two: Conduct Market Research

Social marketing depends on a deep understanding of the consumer. That is why you conduct *market* or *consumer* research. In this phase, your staff will learn what makes your target audience tick; what makes audience subgroups or *segments* alike and different from one another. This research aims to get inside your consumer's head, understanding what s/he wants in exchange for what your program wants her/him to do, and what s/he struggles with in order to engage in that behavior. The objective of the research is to determine: how to cluster your target audience into useful segments, which target audience

segments are most ready to change their behavior, and what they want or need most in order to do that.

What's Different?

- Dividing the audience into segments: Your research aims to identify which members of your target audience are more likely to adopt the desired behavior, and important similarities and/or differences among them. These answers will set up the strategy development.
- Identifying competing behaviors: The safer, healthier behavior you want to promote is competing with innumerable other choices your target audience can make, including the risky behavior they may be performing now. To be effective, your strategy must make your proposed behavior at least as attractive as the alternatives, or you will fall short of your objectives.
- A focus on benefits and barriers: People do things because they get benefits in return. Barriers make it harder for people to act. Your research must uncover which benefits the target audience wants more and which barriers they struggle with most. Your strategy depends on this.
- Distinguishing Doers from Non-doers: One way to determine which benefits or barriers most influence a population's behavior is to compare those who do the behavior (Doers) with those who don't (Non-doers). The key is to look at how they are different, rather than the same; those factors will be the key clues to behavior change.

How You Can Help:

- Most importantly, allocate available resources for this critical phase of the process.
- Make sure that timelines and roles and responsibilities seem clear and reasonable.
- Confirm that any required review/clearance and/or procurement mechanisms are clear and in place.
- Review the research report to look for the following:
    - What most distinguishes between key audience segments?
    - Which target audiences appear most ready to change? And why?
    - What benefits and barriers do target audiences ascribe to the desired and

competing behaviors?
- What appear to be attractive exchanges for the respective audience segments?

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Phase Three: Create a Marketing Strategy

This is the centerpiece of your social marketing program: articulating what you are setting out to achieve and how you'll do it. Based on the research findings, your staff members begin by selecting a target audience segment and the desired behavior to be promoted. Then they will specify the benefits the target audience will receive for doing that behavior. These must be benefits the target audience really cares about and that your program can actually offer. Your staff may also specify key barriers that the program will help the target audience overcome in order to perform the desired behavior.

What's Different?

- Targeting some, not all. As noted above, your strategy likely will focus on the largest audience segments that are more ready to change. This focus enables you to tailor what you are offering uniquely to the defined target audience, which improves efficiency and effectiveness. But it means your program will not be reaching everyone equally, an outcome that sometimes presents political difficulties.
- Audience profiles. These are rich descriptions of your target audiences, designed to give planners a textured, research-driven picture of whom your program is setting out to reach and influence.
- Exchange – creating an offering, not a message. Your program must offer the target audience meaningful benefits in exchange for adopting the desired behavior. This offering must be clear, readily available and appealing to your audience.
- Interventions that address key determinants. It is likely that the strategy you review will contain a mix of interventions. Each one should clearly address one of the identified behavioral determinants, with an emphasis on key benefits and barriers.
- Finally, your research may indicate that existing programs/services need improvement or replacement because they don't reach the right audience or because

they fail to meet key audience needs. This may ruffle feathers, but keep in mind the clients you are trying to serve.

How You Can Help:

- Most importantly, confirm available budget and other needed resources for the program.
- Review the rationale behind the selection of the target audience, desired behavior, and behavioral goal.
- Review the intervention mix and the respective objectives:
    - Is it clear how each intervention either adds value or reduces costs to the target audience?
    - Is it clear what each intervention is intended to do and how it affects the desired change?
    - Taken together, will the overall mix of interventions reach enough of the target audience often enough to have the desired impact?
    - Is the overall mix feasible for your staff to develop, launch and manage? If not, is it clear how others will be involved? Is that kind of involvement appropriate and feasible?

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Phase Four: Plan the Intervention

This phase involves developing interventions and tactics in four possible areas – new or improved products or services, staff training, policy change, and communication. Your staff will likely be quite familiar with these processes and considerations. They involve keeping on strategy, ensuring that each intervention addresses the respective target benefit or barrier, is accessible and appropriate for the target audience, and is ready to go when it needs to be. Your staff will develop a plan, timeline and budget for each of the proposed interventions. They will highlight where key partners and stakeholders are needed and how to engage them. At the end of this phase, you should be able to review a comprehensive workplan, describing and tying together all the pieces.

What's Different?

Keep focused on the target audience. The program is for

the audience, not the implementers. If your staff members become strongly invested in a particular approach, get suspicious. Ask them how they know this is what the audience wants.

- Delivery, reach and outcome objectives. The intervention components of the overall plan must reach enough of your target audience and must deliver what they want and need in order to make an evident impact.
- Interaction between interventions: You want repeated exposure to your products, services and messages. Plan for reinforcement and repetition.
- Better to do a few things very well, than more things insufficiently.

How You Can Help:

- Review the overall workplan:
  - Are the respective objectives of each activity clear, feasible and on-strategy?
  - Are roles and responsibilities clear and feasible?
  - Do timelines and budgets appear reasonable and fit your departmental schedules?
  - Are necessary review/clearance and procurement mechanisms clear and in place?
- Review rationale and technical content for proposed modifications/improvements:
  - Does each of the proposed activities support the overall strategy? Do they clearly offer the benefits sought be the target audience? Do they lower or remove key barriers?
  - Have the activities been pretested and revised based on the findings?

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Phase Five: Plan Monitoring and Evaluation

During this phase, your staff will determine what information needs to be collected, how the information will be gathered and how the data analysis and reporting will take place. Social marketing is based on an iterative design model, so monitoring data are used to both ensure the program is being

implemented as planned and to examine whether your strategy and tactics are suitable or may need tweaking. Your staff also will put a proverbial finger in the wind to consider if environmental factors (policies, economic conditions, new programs, structural change or improvement, etc.) have changed in ways that affect your program.

Your staff also will design a research plan to evaluate the effects or outcomes of the social marketing program. This will involve examining whether:

- Desired effects were achieved
- Observed effects can be attributed to what your program did
- The underlying logic of the intervention and its relationship to desired effects are sound

As you know, good program evaluations are highly prized by policy-makers and funders, but rarely paid for. These evaluations can be modest or extensive, but should be designed to maximize the available resources. So at an early point in this process, you will want to check in with your staff to discuss their resource needs and what you can make available for these purposes.

What's Different?

Gather data to understand "How we are doing" so the program can be adjusted and improved. Your target audience's exposure, recall and opinion are primary concerns here.

You will assess indicators that reflect the behavior change objectives that were set, rather than the ultimate epidemiology or the morbidity / mortality objective. For example, the evaluation design might examine changes in audience perceptions of consequences, or self-efficacy, to performing the desired behavior.

How You Can Help:

- Review identified program indicators. Are they clearly linked to the respective intervention objectives? Will they satisfy your departmental accountability requirements?
- Review the monitoring and evaluation plan. Are roles and responsibilities clear? Do timelines and budgets appear reasonable and fit your departmental schedules?
- Keep in mind that inconsistent evaluation results often result from:
    - Using the wrong intervention (targeting the wrong behavior or wrong determinant of behavior);

- Poor implementation of a good intervention (poor execution, not reaching enough people, wrong target audience);
- Measurement problems (impact of secular events); and/or
- Unrealistic expectations from the outset.

Be sure to discuss these issues with your staff.

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Phase Six: Implement the Intervention and Evaluation

Finally, after all the planning, your staff is ready to implement the program and the evaluation. This phase walks them through steps for launching the program; producing materials; procuring needed services; sequencing, managing and coordinating the respective interventions; staying on strategy; fielding the evaluation; capturing and disseminating findings and lessons learned; and modifying activities as warranted.

For the most part, your staff will be familiar with these concepts and procedures. However, they may need your support in sticking to the identified strategy while the interventions have adequate time to unfold and reach its intended target audiences. Not fully implementing the program plan is one sure way to produce mediocre results. At the same time, your monitoring plan should be alerting you to any issues that require urgent attention or modification. Staying on top of important stakeholder and partner perspectives and concerns is an important function during this phase.

What's Different?

- Monitoring data driven mid-course corrections, as appropriate. Your staff must feel comfortable making necessary adjustments to the strategy and tactics if they learn that something's not working. You should be brought in to review and approve any proposed changes, and defend them as needed.

How You Can Help:

- Establish an appropriate schedule of project updates – both technical and financial.
- Help your staff to stick to the strategy. This may entail either giving them a buffer from external pressure, or questioning sudden opportunistic departures from the strategy or program plan.

- Monitor the perspectives and concerns of partners and stakeholders. Are partners pleased with the program's direction and progress? Are stakeholders apprised and supportive of the project and its accomplishments?

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Social Marketing CDCynergy: Key Points and Considerations

Phase 1: Describe Problem

Points in Process	*Ask/Consider This:*
Review problem description and rationale	• Does this fit with current departmental priorities? • Are the relevant data presented? Do the data support the problem analysis?
Review composition of strategy team	• Does the team fit well together? Does it fit with your department? • Are there any political sensitivities? Anyone missing?
Review SWOT analysis	• Any there any red flags? • Are there any serious omissions?

Phase 2: Conduct Market Research

Points in Process	*Ask/Consider This:*
Review research plan	• Confirm available resources • Are roles and responsibilities clear? • Do the timelines and budgets appear reasonable and fit your departmental schedules? • Are necessary review/clearance and procurement mechanisms clear and in place?

Review research report	• Can you answer the following:
	  ○ What most distinguishes between key audience segments?
	  ○ Which target audiences appear most ready to change? And why?
	  ○ What benefits and barriers do target audiences ascribe to the desired and competing behaviors?
	  ○ What appear to be attractive

	exchanges for the respective audience segments?

Phase 3: Create Marketing Strategy

Points in Process	*Ask/Consider This:*
Review identified target audience(s) and behavior(s)	• Is the rationale (research and logic) behind the selections clear and sound?
Review behavioral goal (this is what your social marketing program aims to achieve)	• Will achieving this goal have a sufficient impact on the original problem described? • Does the goal seem feasible?
Allocate available budget and other resources for the program	• Is the effort sufficiently well-funded to reach enough of the target audience to achieve your behavioral goal?
Review the intervention mix and respective objectives	• Is it clear how each intervention either adds value (offers more desired benefits) or reduces costs (lowers a relevant barrier) to the target audience? Are these benefits and barriers supported by the research findings? • Is it clear what each intervention is intended to do and how it affects the desired change? • Taken together, will the overall mix of interventions reach enough of the target audience often enough to have the desired impact? • Is the overall mix feasible for your department to develop, launch and manage? If not, is it clear how others will be involved? Is that kind of involvement appropriate and feasible?

Phase 4: Plan the Intervention

Points in Process	*Ask/Consider This:*
Review selection of new or improved services or products	• Is the rationale behind the modifications/ improvements clearly and convincingly presented? Is it clear how/why the target audience will respond better? • Does each of the activities support the overall strategy? • Are the respective development processes, materials, delivery channels and partner roles clear and feasible? • Is the plan for pretesting the new or improved products or services clear and

	feasible?
Review proposed staff training plan	• Is the rationale and approach for staff training clear and feasible • Confirm budget and other resources for the staff training
Review proposed policies to be enacted or changed	• Is the rationale clearly and convincingly presented? Does it support the overall strategy? • Is there a clear approach for achieving the policy change? • Are there red flags to be aware of?
Review the communication plan	• Are respective audiences, benefits and messages clear and supported by prior research? • Does each of the activities support the overall strategy? • Are the respective materials, delivery channels and partner roles clear and feasible? • Is the plan for pretesting the messages and materials clear and feasible?
Review the work plan	• Are roles and responsibilities clear? • Do the timelines and budgets appear reasonable and fit your departmental schedules? • Are necessary review/clearance and procurement mechanisms clear and in place?

Phase 5: Plan Program Monitoring and Evaluation

Points in Process	*Ask/Consider This:*
Review identified program indicators	• Are they clearly linked to intervention objectives? • Will they satisfy your departmental reporting and/or accountability requirements?
Review monitoring and evaluation plan	• Are roles and responsibilities clear? • Do the timelines and budgets appear reasonable and fit your departmental schedules?

Phase 6: Implement Interventions and Evaluation

Points in Process	*Ask/Consider This:*
Establish schedule of project updates – both technical and financial	• Has the overall strategy changed at all? If so, why? • Are there any external (policy or

		environmental) or internal factors or issues that may adversely affect the strategy or its implementation? • Are audience exposure and/or service delivery levels in line with projections? • Is spending in line with projections? Are there any issues to be addressed?
	Monitor perspectives of partners and stakeholders	• Are partners pleased with direction and progress? • Are key stakeholders (particularly those who approve ongoing budget allocations) apprised and supportive of the project and its accomplishments?

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