ESSENTIAL COMPONENTS OF A GRADUATE SOCIAL MARKETING CURRICULUM FOR HEALTH EDUCATORS: A DELPHI STUDY

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

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BY

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Date

To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Audrey M. Whitright entitled "Essential Components of a Graduate Social Marketing Curriculum for Health Educators: A Delphi Study." I have examined the final copy of this dissertation for form and content and recommend it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Health Studies.

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DEDICATION

This research is dedicated to the members of my dissertation committee, Dr. Mary Shaw-Perry, Dr. William Cissell, and Dr. Derrell Bulls. All gave freely of their time and energy to guide me through this process. Dr. Shaw-Perry especially has been my mentor and friend from the beginning. I also dedicate this achievement to my mother, Sybilla Miller, and my late husband, Patrick G. Whitright, who started me on this path, believed in me, and gave me the will to accomplish what I thought was impossible.

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ABSTRACT

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ESSENTIAL COMPONENTS OF A GRADUATE

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This study identifies essential components of a social marketing curriculum for health promotion/health education professionals in a graduate public health program to enable them to develop the knowledge and skills necessary to design, implement, and evaluate a successful social marketing campaign. Four research questions were addressed: 1) Why should social marketing courses be offered in graduate health/public health programs of study? 2) What are the benefits to health educators or other health care practitioners of offering social marketing courses in graduate health/public health programs of study? 3) What knowledge and skills are required for designing, implementing, and evaluating a social marketing campaign? and 4) What are the essential components of a social marketing course in a health/public health curriculum that will prepare health educators/professionals to perform social marketing campaigns?

The investigator has concluded, based on the study results and existing literature, that social marketing courses should be offered in graduate public health programs because health promotion/health education professionals should be expected to know

social marketing, since it provides a systematic approach to problem analysis and program development. In addition, social marketing is a good fit with other health behavior theories and teaches audience segmentation allowing the health educator to more precisely design a program or intervention to reach specific populations. Furthermore, social marketing provides useful skills, tools, and techniques for influencing behavior change and teaches effective communication skills beneficial to program planning and implementation. And finally, the results of this study present 33 knowledge and skill elements deemed important for health promotion/health education professionals and 27 essential components of a social marketing curriculum in a graduate public health or health education program.

Additional conclusions, which are in junction with those previously noted by other social marketers and health educators alike, include the following: 1) there exists a lack of adequate programs of study for non-profit or social marketing, 2) social marketing should be taught either in collaboration with an affiliated business school or as an interdisciplinary approach, 3) there should be development of a core curriculum in social marketing for health educators and other health care professionals.

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CHAPTER I

INTRODUCTION

Rationale

Social marketing has become a popular method for delivering health education messages and designing health promotion campaigns (McDermott, 2000). Given the many uses and benefits of social marketing, it is important for health care/education professionals to acquire knowledge and skills that promote the use of social marketing in health promotion programs (Carroll, 1986). However, social marketing courses in professional preparation programs for health educators and other public health professionals are extremely rare. This lack of professional courses may be due to several contributing factors such as the slow acceptance of social marketing as a behavior change technique, a lack of understanding of the value of social marketing to health care professionals, a feeling of a "conflict of interests" among health educators regarding the use of marketing, or simply no room in already existing curriculums (Hazel-Ford, Sarvela, Wright, and Gimenez, 1993; McDermott, 2000).

But, given the recent surge in the popularity of social marketing in the health fields, if health educators are going to use social marketing they should have more than just a basic knowledge of the subject. One would not expect a surgeon to practice without a complete and thorough knowledge of surgical techniques, so why should health educators be expected to use social marketing as a tool for improving health communications, services, and/or programs without the proper knowledge and skills?

Professional preparation programs for health professionals responsible for designing and delivering health programs and services for diverse consumers should include social marketing courses in the curriculum.

The probability of health promotion and/or health educators producing successful programs with meaningful outcomes is more likely to increase, if these health professionals have the knowledge and skills to apply social marketing principles and techniques in the design of health programs, interventions, and services.

Statement of the Problem

Social marketing, and its potential for changing behavior and addressing social issues, has been discussed in health education literature for over twenty years (Hazel-Ford et al., 1993). The original concept of social marketing began with an article by G. D. Wiebe in the 1950s and was elaborated upon by the work of Kotler, Levy and Zaltman in the 1970s. However, the actual practice of social marketing within a health care related field dates back to the 1960s with applications in family planning. Since that time the efficacy of social marketing as a health education tool has been clearly demonstrated by the enormous success of social marketing campaigns over the years (Andreasen, 2002).

Understandably, the broad success of social marketing campaigns has stimulated a strong interest among health care professionals resulting in an increased demand for instruction in utilizing social marketing as a tool to improve the effectiveness of health promotion programs (Novelli, 1990). From the early 1980s faculty members in the allied health fields have acknowledged the impending need to include health care/social marketing in their curriculums (Carroll, 1986). Currently however, very few courses in

social marketing exist in health care related curriculums. Typically social marketing is mentioned within the content of existing courses and insufficient instruction is offered to provide health educators with a clear understanding of the principles and skills necessary to conduct a successful social marketing campaign. McDermott concludes that, "when a social marketing campaign fails it most likely is due to a lack of understanding and experience by the user" (2000).

Statement of the Purpose

The purpose of this study was to identify the essential components of a social marketing curriculum for health care/education professionals in a graduate health/public health program to enable them to develop the knowledge and skills necessary to design, implement, and evaluate a successful social marketing campaign.

Importance of the Study

When utilized appropriately, social marketing has the potential to be a particularly valuable tool for producing significant behavior change in both individuals and society in general. The probability of health educators producing successful programs and meaningful outcomes is more likely to increase with a thorough understanding of social marketing principles and techniques. Currently most health educators must either rely on marketing professionals, who may not understand the nuances of the health care field, or hope that their own limited instruction in social marketing will be adequate to conduct a successful social marketing campaign. Regrettably, neither option is satisfactory.

Recently on the social marketing online forum established by Alan Andreasen (a noted author and expert in social marketing) and the Social Marketing Institute, a lengthy

discussion took place regarding the need for higher education curricula and/or programs in social marketing. The discussion included the need for a PhD program in non-profit marketing and the inclusion of social marketing courses in health profession curricula. The application of social marketing principles in health promotion can increase positive program outcomes through the use of community-based approaches that include members of the target audience in the planning process. As an added bonus, the use of social marketing techniques can deliver cost reductions in program implementation (Andreasen, 2000). This study sought to identify the essential components of a social marketing curricula for health care/education professionals from the perspectives of practicing health educators and social marketers.

Research Questions

The following questions were addressed within this study:

1. Why should social marketing courses be offered in graduate health/public health programs of study?
2. What are the benefits to health educators or other health care practitioners of offering social marketing courses in graduate health/public health programs of study?
3. What knowledge and skills are required for designing, implementing, and evaluating a social marketing campaign?
4. What are the essential components of a social marketing course in a health/public health curriculum that will prepare health educators/professionals to perform social marketing campaigns?

Delimitations

The study was delimited by the following:

1. The panel of experts (15 minimum) was composed of practicing health educators or other health professionals and practicing social marketers selected from associations within the health education and social marketing arenas.
2. The literature review was limited to that which is available to the principal investigator and published in the English language.
3. The questions were presented to the panel of experts through three rounds for consensus.
4. The panel answered a brief screening criteria questionnaire.

Limitations

The study was limited by the following:

1. Only experts (15 minimum) nominated by editors of professional journals in social marketing and health education or directors of professional associations and institutes associated with health education programs within the United States were eligible for participation.
2. Only nominees willing to converse via e-mail were selected as participants.

Assumptions

For the purpose of this study, the following was assumed:

1. Nominated experts were eligible for inclusion in the study.
2. The participants answered honestly without personal bias or agendas.

3. The participants kept in mind the best interests of health educators and health care professionals and their educational needs.
4. Selected participants had an interest in the topic.

Definition of the Terms

The following terms were defined for the purpose of this study:

1. Social marketing: "The application of commercial marketing concepts and tools to programs designed to influence the voluntary behavior of target audiences where the primary objective is to improve the welfare of the target audiences and/or the society of which they are a part" (Andreasen, 1994).
2. Essential components: important requisite parts that when combined comprise a meaningful comprehensive understanding of the discipline.
3. Health care/education professional: any practicing degreed and/or licensed professional dealing with the physical or mental health, education, or well being of individuals or society.
4. Graduate health/public health programs: graduate programs of study beyond a four year bachelor degree in any health care oriented field.
5. Social marketers: marketing professionals who employ the techniques of commercial marketing for marketing non-profit, health care, or socially beneficial products and issues.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter provides a review of the literature on topics related to this study. The chapter discusses the following topics: 1) definition and principles of social marketing; 2) current methods of social marketing training for health education professionals; 3) and the use of social marketing techniques by health care education professionals.

Definition and Principles of Social Marketing

Social marketing, as used by health educators, is a systematic approach for planning and implementing programs to bring about social change by creating and maintaining exchanges where the benefits outweigh the perceived "costs" (Social Marketing Institute, 2003; Kotler and Levy, 1969; Kotler and Roberto, 1989). Social marketing is derived from consumer marketing which utilizes exchange theory and consumer behavior theories to determine the reasons why people behave the way they do. Exchange theory, developed in the 70s by Richard Bagozzi, assumes that people are rational and attempt to maximize rewards and minimize punishments, and in addition that people have resources that can be exchanged for other resources (Andreasen, 2000).

In the case of social marketing, exchange theory is expanded into "social exchange theory" which assumes that people seek social gratification or rewards through social interaction with others and that an individual may not receive rewards from the person to whom he gave but expects others to fulfill their obligations to a particular group

or society (Abercrombie, Hill, and Turner, 1994). Social exchange theory includes transactions that involve intangible costs and benefits and third party transactions such as a donation to a charitable cause where the ultimate "consumer" is not the contributor.

The intangible aspects of social marketing challenges social marketers and health professionals with inducing audiences to undertake actions for which the payoff is either long term or elusive. Social marketing utilizes incentives and persuasion to motivate consumers to participate in program activities. In addition, social marketing employs the marketing concepts of market segmentation, consumer research, product concept development and testing, directed communication, and exchange theory in order to maximize the target population's response. Market segmentation allows health educators to tailor programs to serve a very specific target group.

Social marketing combines the fundamental methods of changing health behavior, (education, persuasion, behavior modification, and social influences) and in addition includes a customer orientation approach. A customer orientation approach is one that combines research of consumer behaviors necessary for planning and implementing programs, cost-effectiveness design, use of the Four P's (*product* – both tangible and intangible product offerings, *price* - all costs of participating in a program whether it is money, time, or anything else that the person values, *place* - time and location of an activity or program, and *promotion* - all the various appropriate methods and mediums available) in intervention implementation, and awareness of the "competition" (Andreasen, 1995; Coreil, Bryant, and Henderson, 2000).

Techniques used in social marketing include "backward" marketing research to reduce the cost of research, an in-depth interviewing technique to aid in better understanding of foreign cultural behaviors, and the use of community-based approaches for the development and implementation of interventions which involve members of the target audience in the planning process (Andreasen, 2000).

Social marketing offers public health professionals an effective approach for developing programs to promote healthy behaviors (McDermott 2000). A sponsoring agency typically pursues a social change goal in the belief that the change will contribute to the individuals' or society's best interests. In summation, social marketing is distinguished from other program planning models by its use of the marketing conceptual framework which includes exchange theory, the four P's (price, product, place, promotion), a consumer orientation, reliance on formative research to understand consumer's desires and needs, segmentation of populations, careful selection of target audiences, and continuous monitoring and revision of program tactics (Coreil et al. 2000).

Current Methods of Training in Social Marketing

Currently, the most widely used method of obtaining training and education in social marketing is by way of highly condensed formats offered sporadically through workshops and seminars. Unfortunately these workshops and seminars are not accredited courses for college credit, licensure or specialization. Only a few established programs of social marketing exist in higher education.

The most notable program offered at the university level is an 18 credit graduate certificate award in social marketing taught at the National Center for Social Marketing at the University of South Florida (USF) in Tampa, Florida. Two universities in Canada offer a "partial" program in social marketing. At Carleton University in Ottawa, Canada the marketing department provides a professional certificate in Public Sector and Non-profit Marketing which includes a course in social marketing (Christine Jackson, Carleton University). At the University of Lethbridge in Alberta, Canada the marketing department offers an MSc in Management where a person could major in marketing and specialize in social marketing (Michael Basil, University of Lethbridge). One other university in the United States, Duke University in North Carolina, offers some social marketing in its non-profit management program. (Penny P. Smith – SocMktg-list-serv).

Some higher education institutions do include a course in social marketing or non-profit marketing, or include a section on social marketing within another course curriculum (Livermore and Guseman 1987). These include the University of New Mexico course in "The Use of Medicine and Technology for Community Organizing" (Paul Nathanson - SocMktg list-serv), the University of California at Riverside Master's of Health Education program (Linda Rohret – SocMktg list-serv), the University of Montreal interdisciplinary course developed jointly by Faculty of Medicine and the School of Business Administration for the MBA Health program, and the Department of Marketing at the University of Strathclyde, Glasgow Scotland.

Another method for health educators to learn social marketing is from websites on the internet. The best sites include the following: the Center for Social Marketing at the

University of Strathclyde, Glasgow Scotland; the Social Marketing Institute sponsored by Dr. Alan Andreasen and the University of Georgetown; the Center for Socially Responsible Marketing at the University of Lethbridge, Alberta , Canada; the Social Marketing Network; Best Start Inc.(which publishes the *Social Marketing Quarterly* journal); Weinreich Communications; Sutton Social Marketing; and the Porter-Novelli agency website. These are just a few of the many excellent websites devoted to social marketing.

Professional journals and organizations also offer opportunities to learn about social marketing through journal articles, websites, conferences, and continuing education workshops. The Society for Public Health Educators (SOPHE) has a Special Interests Group (SIG) in Social Marketing and Health Communications for its members and also provides a Resource Guide for additional information on social marketing. Another excellent resource is the CDCynergy-Social Marketing Edition: Using Social Marketing Planning Tools to Address Public Health Issues (a CD_ROM program) and the APHA Sponsored Continuing Education Institute's training for using the CDCynergy program.

Finally, there exist several excellent books written by experts in the field that health educators can use as social marketing resources. A few of these books include: *Hands-On Social Marketing: A Step-by-Step Guide* by Nedra Kline Weinreich; *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment* by Alan R. Andreasen; *Social Marketing* by Philip Kotler;

Fostering Sustainable Behavior: An Introduction to Community-Based Social Marketing by Doug McKenzie-Mohr and William Smith; *Promoting Health in Multicultural Populations: A Handbook for Practitioners* by Robert M. Huff and Michael V. Kline and *Social Marketing: Improving the Quality of Life* by Philip Kotler, Ned Roberto, and Nancy Lee.

Use of Social Marketing by Health Care/Education Professionals

McDermott (2000) has speculated that health professionals are suspicious of marketing because they feel that the term marketing implies using unethical coercive techniques to get people to do or buy something against their will. He feels that because marketing is often confused with advertising and selling, which is viewed as being manipulative and self-serving, it conjures up an image of "mind control" that is distasteful to health professionals. Furthermore, the opposition to social marketing by some health professionals may also stem from the health professionals' view of social marketing as a threat to their identity and as an intruder into their domain (McDermott 2000).

Most health professionals tend to view themselves a part of a "social service culture set" whose mission is to provide basic health and social services. Because they see their work as beneficial, humanitarian and philanthropic, they tend to overlook inefficiencies (Andreasen, 2000). Whereas marketing, being part of the "corporate culture set," takes a more "business-like" approach and seeks to improve efficiency and effectiveness. To the social service culture set the strictly business approach makes marketing appear heartless, uncaring, and at times even immoral (Andreasen, 2000).

This clash of cultures results in a seemingly "natural" conflict of interests that precludes the use of business concepts and techniques in the health care professions (Andreasen 2000). However, according to Kotler and Levy (1969) two concepts of marketing exist, one of which is harmonious with the beliefs and culture set of health care professionals.

The first concept of marketing, as a technique for selling, influencing, and persuading, is often seen as a treacherous scheme for coercing people into buying or accepting things or ideas that they either don't want or that are bad for them. This negative perception of this concept leads to misguided thinking that marketing is immoral and self-seeking and thereby not acceptable for nonprofits who seek to help people.

The second and less commonly perceived of the two concepts is the use of marketing methods to sensitively serve and satisfy human needs. The key to this concept is the emphasis on the "customers' needs." Clearly, the second concept is more harmonious with the beliefs and culture set of health care/education professionals. Although social marketing employs both concepts, the main focus is on the second concept and the ultimate goal is behavior change for the benefit of individuals and society. So, actually, social marketing is a blending of the two cultures.

Social marketing is used by health care/education professionals for planning, communication, and implementation of countless health and social benefit programs. Case examples of the use and effectiveness of social marketing by health care/education professionals is so widespread and overwhelming that discussion will be limited to several that are representative of the many various uses of social marketing.

In the arena of HIV/AIDS prevention, social marketing has been shown to be effective in increasing the purchase and/or use of condoms in developing third world countries and other areas where the costs can be prohibitive (Shelton and Johnston, 2001; Potts, 2001). In a study by N. Price, the author states that it is evident that low-income groups are sensitive to condom price increases and that condom social marketing programs (CSMPs) appear to be addressing the constraints to access (Price, 2001). When CSMPs improve access to condoms, use of condoms also tends to increase. In a study of condom use related to a CSMP that provided free condoms to low income people in Louisiana the results showed that use increased from 28 to 36 percent among African American women and from 40 to 54 percent among African American men.; Cohen et al., 1999).

Social marketing has also been used in programs to educate people, especially teens and hard to reach populations, about HIV/AIDS and to change related attitudes and behaviors. Mizzuno et al. used social marketing to increase the exposure of "hard to reach" teens to an HIV prevention project in Sacramento, California known as "Teens Stopping AIDS" (Mizuno et al., 2002). Lamptey and Price (1998) explored the possibilities of enhancing HIV prevention efforts with social marketing principles and feel that opportunities exist to reduce sexual risk through behavior change interventions utilizing these principles. Dearing et al. (1996) studied HIV prevention programs targeted at unique populations using diffusion of innovations and social marketing and found that the principles of social marketing were used more frequently and with greater success than diffusion of innovations. The authors' research emphasizes the particular importance

of audience analysis in designing programs. William W. Darrow (1997) found that social marketing, community level interventions, and interventions grounded in theories of behavior change to be most promising for STD health education provided there are sufficient resources to support the interventions.

Social marketing has been used successfully in health education programs through campaigns to reduce college student drug use and alcohol consumption. A social marketing campaign on a large southwestern university campus resulted in a 29 percent decrease in binge drinking rates over a three-year period (Glider et al., 2001). The Higher Education Center uses social marketing to educate students and correct misperceptions about college student drinking habits that has resulted in decreased drinking on campus (Higher Education Center, 2003). Finally, a study by Jones and Rossiter showed that principles of social marketing, specifically branding, targeting, positioning and media use, could be successfully used to "sell" good behaviors and counteract abuse of drugs and alcohol by teens (Jones and Rossiter, 2002).

Social marketing has been used frequently to promote breast cancer screenings. A particular case example is that of the "Florida Cares For Women" campaign. The campaign used social marketing to uncover the motivators and barriers to breast cancer screening and increase the number of women using screening services in Florida. The four Ps and consumer research served as a guide to developing core strategies and products used in this very successful campaign (Brown, Bryant, and Forthofer, 2000).

Another case study used the application of social marketing principles and concepts to successfully educate the population and increase the levels of childhood

immunization in Australia (Carroll and VanVeen, 2002). This campaign recognizes the key role of social marketing formative research to ascertain the "costs" or "price" associated with immunization and identifying the "benefits" to parents of paying these costs.

The Center for Disease Control (CDC) and National Institutes of Health have used social marketing in several education programs. The National Diabetes Education Program is specifically targeted to Hispanics to provide clear accurate information about prevention and control of diabetes (Social Marketing Institute, 2003). The CDC also funds many STD education programs. Research by DeJong et al. (1996) advocates, based on social marketing formative research used to identify opportunities for and barriers to enhancing STD patient education, that the CDC alter service priorities toward improvements in health communication and education.

Another study by Albrecht and Bryant (1996) focuses on the use of several segmentation targeting techniques, tools of social marketing, for identifying meaningful target groups. In their study they cite examples of use of these segmentation strategies from the Texas Women, Infants and Children Program's Comprehensive Social Marketing Program to identify important barriers to enrollment in the WIC program.

Summary

A summary of the literature can best be stated in a report by Neiger et al. in which a review of the health promotion literature shows that despite numerous successful social marketing campaigns, social marketing elements associated with health promotion interventions lack an integration of marketing components and an overarching marketing

plan that predisposes the intervention to a less successful outcome. Neiger states that "while social marketing is flourishing and having significant impact on health promotion, the current understanding and utilization of social marketing in changing behaviors fails to grasp the comprehensive nature of marketing" and "while the diffusion of social marketing is prolific, the quality of knowledge that accompanies that spread appears to be inadequate."

CHAPTER III

METHODOLOGY

This chapter describes the Delphi method, sampling, and procedures used for this study. The instrumentation, data collection , and data analysis are also explained in detail.

Delphi Method

The Delphi Method was employed to survey a panel of experts to address the research questions. The Delphi process is a recognized technique that brings with it some rigor that strengthens the validity of the results considerably. The Delphi process provides an interactive communication structure that prohibits direct communication between the principal investigator and among the panel of experts. This method of indirect contact helps to prevent some of the problems associated with social interaction processes and contaminations that can occur in a group situation. These problems include interjection of interviewer bias in direct or telephone interviews, or in the case of a focus group the desire to fit in and agree with a group's opinions or fear of rebuff when professing a different opinion. The goal of the Delphi process is to systematically facilitate the communication that takes place through a reiterative process of asking questions, undertaking analysis, and providing feedback (Dailey, 1990; Sweigert and Schabacker, 1974).

In this case the Delphi method was employed to question experts in the fields of social marketing and health care/education in order to reach a consensus of opinions

regarding the essential components of a social marketing curriculum. Initially qualitative, open-ended questions were asked and from the analysis of those responses additional rounds of questions were distributed to the panel for consideration and response.

Sampling

Several techniques were employed to solicit participants for the Delphi panel including a non-probability purposive sampling technique. Nominations were solicited from the editors of prestigious journals in health education and social marketing. Editors from the following journals were asked to submit the names of three nominees for consideration as panel experts for the study: the Journal of Health Communication, American Journal of Health Behavior, Health Education & Behavior (formerly Health Education Quarterly), Health Promotion Practice, International Electronic Journal of Health Education, Health Communication, American Journal of Health Education, Health Education Research, American Journal of Health Studies, American Journal of Public Health, Journal of Community Health, and Social Marketing Quarterly. A total of 24 requests for nominations were sent out and 34 nominations were returned of which five agreed to participate as panel members.

In addition, panel experts were sought through the Social Marketing Institute, the Society for Public Health Education's (SOPHE) Social Marketing/Health Communications Special Interest Group (SM/HC SIG), American Alliance for Health, Physical Education, Recreation & Dance, AAHPERD, American Association for Health Education (AAHE), American Public Health Association (APHA), and the American

School Health Association (ASHA). A total of 16 requests for nominations were sent out and 27 nominations were returned of which three agreed to participate as panel members. However, two of the three participants were duplicates of the five mentioned above, bringing the total number of participants to six.

Additional methods of recruiting participants were then employed which included soliciting members of the following associations or memberships to participate or to nominate others to participate: 1) SOPHE chapter presidents and delegates from every state; 2) members of the social marketing list_serv; 3) well-known social marketing and health education authors; 4) guest lecturers for the upcoming social marketing conference at the University of Southern Florida in June 2004; 5) schools of public health or health sciences faculty; and 6) the Council on Education for Public Health. A total of one hundred and thirty-six requests for nominations were sent out of which 23 agreed to participate as panel members. However, seven of these were duplicates of the six mentioned above, bringing the total number of participants to 22, making this final recruitment method with six sources the most productive.

Therefore, to the original one 177 requests for participants and/or nominations, another 63 nominations were added bringing the total number of requests for participants to 240. Originally 22 people agreed to participate giving a response rate of exactly eleven percent. However, of the 22 people who initially agreed to participate only 17 actually participated putting the actual response rate at seven percent. This low response rate may be due to the following: those solicited 1) being unfamiliar with social marketing and not feeling they are "expert" enough to participate; 2) perceiving themselves to have a lack

of knowledge about social marketing and therefore lack of interest in participating; 3) being very busy at the time of year in which recruitment occurred and simply did not have the time to participate (many responses gave this reason); or 4) being reluctant to open unfamiliar email or attachments due to the proliferation of spam emails and emailed viruses (approximately 50 percent of the requests were made via email because postal addresses were unavailable).

Protection of Human Participants

The risks associated with this study included 1) loss of anonymity and confidentiality, 2) fear of loss of anonymity, and 3) loss of time. The participants of this study could have experienced a fear of negative repercussions from their peers and anxiety associated with offering honest opinions about specific programs of study if their identities could have been exposed. For this reason the Delphi method was employed to minimize the opportunity for participants to know the identity of other participants and also to minimize the possibility of interaction among the participants. In addition the principal investigator was not able to link the participants' responses with the identity of the participants and a faculty support person was employed to act as a monitor between the participants and the principal investigator. Finally, all responses were reported as aggregate thereby ensuring anonymity and confidentiality.

Specific steps taken to assure anonymity and confidentiality include the following:

1. The names of the editors who submitted the names of nominees were not associated with the nominees. The nominees were not told who had nominated them for participation in the study.
2. Consent forms and all questionnaires were sent to and kept by the faculty support person, Carolyn Rozier, PhD. Return correspondence from the nominees was mailed to the faculty support person instead of to the principal investigator. The faculty support person assigned codes to the nominees and the principal investigator was not informed of the identities associated with the codes.
3. The participants were sent individual e-mails addressed only to them with no carbon copies or blind copies created. Each e-mail was sent from the faculty support person's e-mail address only. Upon receipt of a potential panel member's e-mail address the faculty support person created a code for each participant known only to her and not revealed to the principal investigator to maintain anonymity. All e-mail correspondence to and from the participants were routed through the faculty support person's e-mail address and were coded before being sent to the principal investigator.
4. The coded responses were saved in a password protected directory on one local hard drive and filed by study rounds one, two, and three. Only the principal investigator had the password. The principal investigator sent each round of questions to the faculty support person who then sent them on to the participants. Printed copies of all correspondence, with names removed, were kept in a locked cabinet in a secure location accessible only by the principal investigator.

5. At no time was there any discussion between the principal investigator and the nominees or participants regarding the study responses. In addition, there was no direct correspondence among the editors, nominees, or participants that was initiated by this study or its researchers.

To minimize loss of time the principal investigator kept the number of questions to a reasonable number so that each round of questions would not exceed a one hour response time. In addition, the principal investigator requested that responses be made via e-mail so that the participants could respond directly on the e-mailed attachment sent to them by using the reply function.

Data Collection Procedures

The participants received a consent form, by either US mail or email, and a brief screening criteria questionnaire that determined eligibility to participate as an expert panel member. Even though asked to return the consent form to the faculty support person, a few participants did in fact return the signed consent form to the principal investigator. However, because the consent form was separate from the study questions the principal investigator still could not connect specific responses to participants.

The participants were also required to agree to correspond via e-mail to be included in this study. Upon receipt of the consent forms, the first round of questions was distributed to the selected panel members via e-mail. Once the panel of experts had been composed the first round of questions were e-mailed to the participants. After analysis of each round, the questions were revised according to the feedback received and the next

round of questions were composed and distributed. The participants did not interact face-to-face with the principal investigator or other participants.

After all responses from a round were received and analyzed by the principal investigator, the responses were synthesized and the next round of questions was sent out via e-mail for response.

Instrumentation

The initial qualifying questionnaire included a brief demographic profile section which asked the participants about their age, gender, ethnicity, educational background, profession, number of years in the profession, and experience with social marketing (see Appendix C).

Round One Question Development

The questions for Round One were based on the initial four research questions (see Chapter I, page 4). The Round One questions were reviewed for validity by the advisory committee and after making some revisions the committee approved eleven questions for Round One (see Appendix D). These questions were all open ended questions for the purpose of obtaining qualitative commentary from the panel members with the ultimate goal of achieving a consensus of their opinions.

Round Two Question Development

The Round One responses were reviewed, abbreviated, and placed into categories or themes. A total of 127 questions for Round Two emerged from these categories or themes. The panel members were asked to respond to these 127 questions using a 5-point Likert scale to determine consensus of agreement (see Appendix E). The first 55

questions of Round Two were derived from questions 1-6, 8, and 9 of Round One.

Questions 56-67 were derived from question 10 from Round One regarding the important instructional needs for social marketing. The participants were asked to respond to a 5-point Likert scale indicating their level of agreement with each statement to determine consensus.

Questions 68-100 were derived from question 7 of Round One. The panelists were given a list of knowledge/skills necessary for designing, implementing, and evaluating social marketing programs that had been assigned to one or more of three categories (designing, implementing, and evaluating) by the principal investigator. The participants were asked to respond to a 5-point Likert scale indicating their level of agreement with each statement to determine consensus of agreement.

Finally, questions 101-127 were derived from question 11 from Round One concerning the essential components of a social marketing curriculum. Again the participants were asked to respond to a 5-point Likert scale indicating their level of agreement with each statement to determine consensus of agreement..

The questions in Round Two are color coded as to which question from Round One each question is derived. For example, in Round Two, questions numbered 1-13 are color coded pink and refer back to question number one of Round One, questions numbered 14-24 are color coded light orange and refer back to question 2 from Round One, and so on according to the color coding table found at the top of the Round Two questions in Appendix E.

Round Three Question Development

For Round Three the same questions from Round Two were used but the method of response was changed based on the consensus of the responses from Round Two. Consensus (either "agreed" or "disagreed") was determined for all but 9 of the 128 questions. For those questions from Round Two for which consensus was "undetermined" (questions 10,13,19,20,24,29,54,94) the same questions (except question 94) were asked but with a 7-point Likert scale response. A larger point scale was used to expand the range of choices and generate a greater likelihood that agreement when it occurred would be clearly recognized (see Appendices E and F).

Next the panel members were asked to rank order the instructional needs in social marketing for health education professionals (questions 56-67 from Round Two, a total of twelve questions) from 1 to 12 with 1 being the most important and 12 being the least important.

The response method for questions 68-100 from Round Two was changed in Round Three. Where previously the panel members were asked to indicate agreement they were now asked to place the knowledge/skills necessary for social marketing programs into **their** choices of the three categories of designing, implementing, and evaluating.

Finally, in Round Three for questions 101-127 the panel members were asked to place the essential components of a social marketing curriculum for a professional preparation program in health education into one or more of six teaching/learning

modules that included theory, principles, research, planning, implementation, and evaluation.

Data Analysis

In general, all the questions were nominal data and frequencies were used for all data analysis. Even the rank ordered questions were determined by frequency of responses to each statement.

Round One Analysis

Round One was analyzed by reviewing each response and determining emerging or recurring themes and categories which were then addressed in a question format in Round Two.

Round Two Analysis

The responses to all of the questions in Round Two were level of agreement to a 5- point Likert scale (disagree, somewhat disagree, somewhat agree, agree, and strongly agree). The frequencies were calculated for each of the five choices for each question. Consensus of agreement, either ***"disagreed"*** or ***"agreed,"*** was determined by examining the frequencies (percent) of the "top two" choices (4. *agree* and *5. strongly agree*) and the "bottom two" choices (1. *disagree* and 2. *somewhat disagree*). The percentages of these two groups were combined and were deemed to have reached consensus if the total was greater than 60%.

The value of the middle choice (3. *somewhat agree*) was only considered as ***"agreed"*** consensus when the total of the "bottom two" was less than 40% and the combined total of the middle choice and the "top two" was >60%.

Any question that did not have consensus was deemed to be ***"undetermined"*** when neither the "bottom two" choices or the combined total of the middle choice and the "top two" choices were not greater than 60%. The ***"undetermined"*** questions were repeated in Round Three with a 7-point response scale.

Round Three Analysis

The frequencies for each of the seven choices on the 7-point Likert scale were calculated and the determination of consensus in Round Three for the "undetermined" questions from Round Two (questions 10,13,19,20,24,29,54,55) were more clearly defined. The larger total of the ***"agreed"*** (combined percentage totals of numbers 5. *somewhat agree*, 6. *agree*, and 7. *strongly agree*) or ***"disagreed"*** (combined percentage totals of 1. *strongly disagree*, 2. *disagree*, and 3. *somewhat disagree*) side of the spectrum determined consensus for the first eight questions.

The ranked order of the twelve statements concerning the instructional needs in social marketing for health education professionals (questions 56-67 from Round Two) was determined by highest frequency of response for each of the 12 ranked statements.

The remaining questions in Round Three were evaluated based on highest frequency response to each question. There was no "agreed" or "disagreed consensus to be determined in these remaining questions. The frequencies simply indicated the placement of the statements about knowledge/skills and the essential components into categories.

Summary

This study employed the Delphi method to survey a panel of experts to address the research questions. Several sampling techniques were employed to solicit participants for the Delphi panel including a non-probability purposive sampling technique and direct solicitation of known experts in social marketing and health professions. Ultimately a panel of 22 experts materialized of which seventeen panelists actually participated. Use of the Delphi method minimized the possibility of interaction among the participants thereby reducing the fears of negative repercussions from peers and anxiety associated with lose of anonymity. Eligibility of the participants was determined by a brief screening criteria questionnaire. The questions for Round One were based on the initial four research questions and the questions for the subsequent rounds were derived from the previous rounds' responses. All of the questions produced responses of a nominal data type and frequencies were used for data analysis.

CHAPTER IV

RESULTS

The purpose of this study was to determine the essential components of a social marketing curriculum for graduate health education students by seeking the opinions of a panel of experts using the Delphi Method. This chapter presents the demographic characteristics of the panel and the results of their responses to three rounds of questions.

Demographic Characteristics of the Panelists

The panel participants were asked to answer seven questions pertaining to their demographic characteristics and professional experience in social marketing (see Appendix C). Initially, 21 nominees agreed to participate in this study and returned their consent forms and screening criteria/participant information questionnaire. Of these, 17 actually participated in the study and only their demographic characteristics were included in the results.

Most of the panelists were over 46 years of age, eight males and nine females participated, and all were college graduates (Tables 1, 2 and 3).

Table 1: Age

Age range	Number N=17	Frequency (%)
36-45 years	1	6
46-55	9	53
56-65	7	41

Table 2: Gender

Gender	Number N=17	Frequency (%)
Male	8	47
Female	9	53

Most of the panelists' highest degrees are PhD degrees (70%), two have master's degrees (12%), and only two did not have graduate degrees in some field (12%). Five panelists have MPH degrees of which four also had doctoral degrees. Three panelists have an MBA degree and two of these also have a doctoral degree. Only one member of the panel had the CHES certificate (see Table 3).

Table 3: Education

Highest Degree	Number N=17	Frequency (%)
Bachelor's Degree	2	12
MPH	1	6
MBA	1	6
PhD (4 MPH and 2 MBA)	12	70
EDD (MA Communication)	1	6

Most of the panelists were college professors (76%), two work for a Federal government agency utilizing social marketing projects, one is a private social marketing consultant, and one works for a private health care industry. The panelists have worked in their professions from 5 to 33 years and only three have not had any experience in social marketing (see Appendix C).

Round One

In Round One the panelists were asked to respond to 11 questions using a narrative format. As stated in Chapter III the questions for Round One were derived from the four research questions and were reviewed for validity and approved by the Advisory Committee (see Appendix D). All seventeen panelists responded to Round One. The following is a summary of the panelists' responses to each question.

Question 1: Describe your current knowledge of the principles and concepts of social marketing?

Many of the participants (9) stated that although they had never utilized social marketing they did have a basic understanding of the concepts and principles and expressed knowledge of diffusion theory and marketing theory. Five of the panelists have either participated in social marketing efforts or are current practitioners. Two of these have been practicing social marketers for well over twenty years. Four of the panelists teach social marketing at the university level and one panelist simply rated his/her knowledge as "high."

Question 2: How would you describe your colleagues' knowledge of social marketing principles and concepts?

Most of the panelists felt that their colleagues' knowledge of social marketing was "weak," "minimal," or "varied" depending on their education and experience. Some felt that their colleagues thought of social marketing and marketing in general as "communication" such as usage of different types of media (brochures, posters, etc.). Two panelists felt that their colleagues missed the concept of using social marketing for changing health behaviors and the "uniqueness that sets social marketing apart from commercial marketing." Two panelists expressed the following:

> Those who are teaching social marketing are knowledgeable, followed by those working in large agencies such as CDC and NIH. It goes downhill from there. I find most people working in communications firms on social marketing projects are focused primarily (even exclusively) on only on of our tools . . . communications . . .and overlook tangible objects and services and incentives and convenient access to behavior change.

> Most public health practitioners have a limited understanding of SM principles and framework. Many equate SM with the use of media for public health messaging and miss much of the rest of the framework. Many are unclear how SM differs from social advertising, health communication campaigns, public relations, and other tangential frameworks.

Question 3: How confident do you feel about your knowledge of social marketing principles and concepts compared to your colleagues'?

In general the panelists felt "very" confident in their knowledge of social marketing principles.

Question 4: Describe how much instruction in social marketing principles and concepts you received in your professional preparation curriculum.

Only one panelist had taken an introductory course on social marketing principles while none of the others had a formal social marketing course. However, three panelists had taken marketing courses for their business degrees.

Question 5: Describe how much instruction in social marketing principles and concepts you received in your continuing education/professional development.

Although four panelists state that they have had no continuing education instruction in social marketing one of these four did state that he/she participates in an annual conference on social marketing. The other panelists reported learning social marketing either by being self-taught through books and professional publications, by attending conferences and workshops, or through contacts with other social marketing professionals and the social marketing list-serv. Only one

panelist reported attending a 3-hour graduate class from USF in Tampa. The following statements reflect the panelists' responses in general:

> I am largely self-taught, using available professional publications, list servs, and through contracting with SM professionals to design and conduct campaigns. SM training is limited in this state and covers only the most basic aspects of the field. There is little continuing ed available for regular practitioners at the middle or advanced levels.
>
> I have attended at least four national conferences on the subject. I have read most of the 10 or so books written on the subject.
>
> I have attended various presentations, conferences, and have read various articles. All told, probably about 25 hour's worth of time.

Question 6: What do you feel are the most important instructional needs in social marketing for health education professionals?

In general the panelists seem to agree on the following elements as required for instruction in social marketing:

- Basic theory and principles of social marketing
- Practical applications - developing and implementing real projects
- Skill development
- Message development

Comments included the following:

> Social marketing works best when it is best taught using both case studies and working on real projects in the community while following a course of study. Marketing is learned best when developing and implementing real projects and focuses less on theoretical education. Also having practitioners involved in the education process is crucial in teaching a discipline like social marketing
>
> It needs to be a semester or quarter long course. Not a special session or a special week or a special day on the subject. [It requires] a good textbook

on the subject (which is available) needs to be used. Students need to develop a social marketing plan as a part of their course requirement.

Overall, I think all health ed professionals should know the basics. However, those who plan to use social marketing need substantial instruction and experience.

Social marketing works best when it is taught using both case studies and working on real projects in the community while following a course of study. Marketing is learned best when developing and implementing real projects and focuses less on theoretical education. Also having practitioners involved in the education process is crucial in teaching a discipline like social marketing.

Question 7: What social marketing knowledge and skills do you feel are required for designing, implementing, and evaluating social marketing campaigns?

In general the panelists seem to agree on the following elements as required for designing, implementing, and evaluating social marketing efforts:

- Basic theories; marketing, health behavior, consumer, behavior change, exchange
- Research methods: formative, qualitative, quantitative, interview techniques,
- Message design: communication channels
- Consumer orientation: audience segmentation
- Program design: strategy development, needs assessment, cultural sensitivity, use of the 4Ps
- Evaluation: program, process, monitoring outcomes
- Budgeting, finance, and administrative planning

Specific comments included the following:

> First I think there is a real need to understand the differences between social marketing and health education models, they are quite different. Secondly understanding how social marketing can only be effective so long as it is part of an overall health promotion program and cannot be a on-off strategy. It is different from public education and other communication/health education strategies in that its ultimate goal is to influence and change behavior, not just to increase knowledge and/or change attitudes. Most health educators mistake marketing with promotion and lack understanding that social marketing deals with 4Ps. Obviously skills/knowledge with marketing research, integrated marketing communications, consumer behavior etc. are key.
>
> A strong consumer orientation is needed for all stages of the marketing process, which implies having good knowledge and skills in analyzing social or health problems, segmenting and learning about audiences (research), and using behavior change theory and empirical data to think about people and their behavior. For designing social marketing programs, people need skills and knowledge in behavior change theory and practice, communication, developing, conducting, and interpreting formative research (preferably both qualitative and quantitative), audience segmentation and profiling, strategy development, working with partners and with contractors. The skill I see missing the most is that of conceptualizing what information is needed to develop a social marketing strategy and then using data for strategy development once it's collected. For evaluation, someone would need knowledge and skills in program evaluation and research methods, especially quantitative.
>
> Multiple perspectives on problem definition – various theoretical perspectives. Focus on objectives. Use of the 4Ps in an integrated manner. Program evaluation skills (not epidemiology). Sensitive to working in partnerships and good interpersonal skills. Developing informative process evaluation systems (and not simply bean counting).
>
> Design – formative research methods with practice in application, theories of effective message design as well as practice application, working with outside contractors, budgeting and planning, segmentation theory and practice, channel analysis – theory and practice. Implementation – the notion of "threshold level of resources", the cyclical learning aspects of refining the campaign with tracking, monitoring and examining reach, acceptance and effects of the campaign. Evaluation – I believe that, while there are unique aspects of evaluating SM campaigns, such as determining the effects of media campaigns, a good evaluation course should prepare

health educators for how to do this without having huge separate evaluation components. I believe the design and implementation phases of SM are the more unique parts of the framework.

Question 8: Why should social marketing courses be offered in health educator and health care professions programs?

The panelists agree that social marketing can be an invaluable tool for health educators. Their comments included the following:

To effectively compete with other conflicting health communication messages.

Increasingly important and effective method of promotion.

Because it is a tool that affects most of the information individuals receive. Therefore health professionals should be able to interpret, assess and use social marketing, as well as use it to educate clients/patients.

They will often end up in roles with front line responsibilities to influence public behavior. Social marketing is the discipline to assist them. It provides tools to influence this voluntary behavior.

Social marketing campaigns are important to increase awareness, knowledge as well as behavior of the chosen population and to integrate social marketing research into policy change, health promotion, and program development.

The SM framework is only one tool of many for health educators, but it contains at least three unique points of emphasis that can be extremely valuable for the profession. First, the framework demands that the health educator examine his/her own perspective and separate it from that of the audience. Health professionals of all stripes tend to be "health fascists" and the SM "consumer focus", if truly adopted, provides necessary balance. Secondly, the segmentation process forces the health educator to resist the typical temptation in public health to "be all things to all people," and to identify clearly the audience of interest and to specify that audience beyond the usual (age, race, gender, income) factors. Finally, channel analysis continues the "consumer focus" thread by forcing the health educator to examine appropriate venues for distribution that are acceptable and credible to the audience.

Question 9: What would be the benefits to health educators or other health care practitioners of offering social marketing courses in a health education curriculum?

The majority of the panelists felt that social marketing provides another "tool" available to health educators. They felt that learning social marketing would help students perform better in their professions. Some specific comments include the following:

> SM is an extremely popular framework and health educators will be expected to be familiar with this tool. SM also works well with many other theories and models of behavior change, so allows for more "nuanced" approach to complex campaigns. SM also provides a planning model that is less complicated and demanding that the Green-Kreuter model, thus, more likely to be used.
>
> To be able to use social marketing to reach and educate their clients/patients, communities. Extremely important in health promotion, disease prevention, as well as to educate clients/patients on how to interpret social marketing when taking decisions about health and lifestyle.
>
> A knowledge of social marketing would help the students in these classes do a better job of behavior management after they graduate and begin their careers.
>
> It would give them more of a consumer perspective. It would ensure that they actually understand what social marketing is and have some sense of how to do it. A big problem in the field is that people call anything with focus groups in it a social marketing program.
>
> The benefit of this training would be to keep health educators on the "cutting edge" of new developments in field of health behavior.

Question 10: Where in a graduate health education curriculum should social marketing be taught?

Several of the panelists felt that social marketing should be taught in conjunction with other health education courses such as program planning or promotion although it is unclear if they mean as either a stand-alone course or as a actual component of another

course. Three panelists did specify that it should be a stand-alone course. A few panelists felt that it should come early in the curriculum while a couple panelists expressed that it should be later in the curriculum after the student has a "firm foundation" and has achieved other required skills. Specific comments include the following:

> SM could be taught in conjunction with either the basic "change" models or along with the "planning" models, though I think it would be better if students already had most of the change models under their belt before learning SM. From my perspective, SM is more of a planning framework.
>
> ...it should certainly be integrated with any curriculum dealing with Health Promotion as social marketing should be part of a larger overall Health Promotion program.
>
> ...after some research methods courses or it would be difficult to really grasp concepts. Also, after a basic marketing principles course at the graduate level

Question 11: What are the essential components of a social marketing curriculum for a professional preparation program in health education?

Essential components expressed by many of the panelists include:

- Various theories (health, learning, social change, diffusion)
- Principles of marketing or social marketing (segmentation, 4 Ps)
- Research methods (formative, marketing, quantitative)
- Communication skills (interviewing, needs assessment, message design, advertising)
- Evaluation skills (for all phases)

Of note is one panelist's observation that the essential components should include the historical development and current philosophical perspectives of social marketing. Some of the panelists' comments included the following:

Stressing the similarities between commercial marketing strategies and social marketing strategies. Understanding the unique differences, such as public policy decisions, population base, associated public costs, and how organizations can work together to get things done.

Historical development of SM, current philosophical perspective, practical framework and contested issues among SM professionals; comparison and contrast of SM with other models; examples of SM campaigns, applications and critiques; formative research- theory and skills development, channel analysis, segmentation skills, message design – theory and applications, real world constraints (cost, time, etc.) and ethical considerations.

What social marketing is, the principles, the theory behind it, and what a consumer orientation is. How social marketers look at the world. Then, all the steps in the social marketing process – describe the problem, identify audiences, do formative research, develop strategies to address all the 4P's (not just the promotion one) and pretest, implement, monitor and evaluate.

Please see Appendix D for a complete listing of all of the panelists' comments on all of the questions from Round One.

Round Two

As stated in Chapter III, the responses from Round One were reviewed, abbreviated, and placed into categories or themes. A total of 127 questions emerged from these categories/themes for Round Two. The panel members were asked to respond to these 127 questions using a 5-point Likert scale to determine consensus of agreement (see Appendix E).

As stated in Chapter III the questions in Round One were color coded to indicate which questions in Round Two were derived from the questions in Round One (Table 4).

Table 4: Questions from Round One Color Coding:

Consensus of agreement, either ***"disagreed"*** (Table 5, colored blue in Appendix E) or ***"agreed,"*** (Table 6, colored pink in Appendix E) was determined by examining the frequencies (percent) of the "top two" choices (4. *agree* and *5. strongly agree*) and the "bottom two" choices (1. *disagree* and 2. *somewhat disagree*). The percentages of these two groups were combined and were deemed to have reached consensus if the total was greater than 60%.

The value of the middle choice (3. *somewhat agree*) was only considered as ***"agreed"*** consensus (Table 7, colored light orange in Appendix E) when the total of the "bottom two" was less than 40% and the combined total of the middle choice and the "top two" was >60%.

Any question that did not have consensus was deemed to be ***"undetermined"*** when neither the "bottom two" choices or the combined total of the middle choice and the "top two" choices were not greater than 60% (Table 8, colored yellow in Appendix E). The ***"undetermined"*** questions were repeated in Round Three with a 7-point response scale.

There were a total of six ***"disagreed"*** consensus questions (Table 5) in which the panelists indicated that the majority (question 3, 94%) of them have used social marketing, that they (question 4, 87%) have greater than "minimal" knowledge of social marketing, that they do not teach a social marketing course at either the undergraduate (question 6, 75%) or graduate (question 7, 62%) level, that most (question 12, 63%) of their knowledge of social marketing is not confined to theory, and they did not (question 33, 88%) learn social marketing in a graduate program.

Table 5: Disagreed Consensus Questions

Disagreed consensus ("bottom two" >60%)	
Ques #	*Percentage*
3	94
4	87
6	75
7	62
12	63
33	88

There were a total of 86 ***"agreed"*** consensus questions where 56 questions had a total percentage of the "top two" greater than 60% and 34 questions had the total of the "top two" plus the middle choice greater than 60% (Tables 6 and 7). The majority of the panelists indicated that they have a "good" basic knowledge (question 1, 87%) of social marketing, they have experience (question 2, 75%) implementing social marketing campaigns, they consider their knowledge (question 5, 62%) of social marketing to be high, they teach social marketing workshops or seminars (question 8, 69%), their knowledge of social marketing comes from being self-taught (question 9, 68%), they participate in social marketing conferences (question 11, 62%), their colleagues knowledge of social marketing was varied (question 16, 62%), they considered their colleagues knowledge of social marketing to be weak (question 14, 75%), their colleagues did not understand the differences between commercial and social marketing (question 15, 75%), many of their colleagues focused on the communication aspects of social marketing (question 17, 94%), their colleagues who teach social marketing are very knowledgeable (question 18, 68%), their colleagues think of social marketing as "advertising" (question 21, 68%), they themselves have more knowledge about social

marketing than their colleagues (question 22, 75%), their colleagues are keenly aware of the need for social marketing in implementing interventions (question 23, 64%) and they felt more confident about their knowledge of social marketing when compared to their colleagues (question 25, 69%).

Table 6: Agreed Consensus Questions

Agreed Consensus ("top two" >60%)					
Ques #	*Percentage*	*Ques #*	*Percentage*	*Ques #*	*Percentage*
1	87	56	87	92	68
2	75	57	100	95	60
5	62	59	94	98	62
16	62	60	87	99	75
18	68	61	88	100	88
22	75	62	94	101	100
25	69	65	75	102	75
26	68	66	87	104	69
27	81	67	63	106	100
31	69	68	81	107	100
32	81	72	63	108	93
36	63	73	75	109	94
37	87	74	81	110	94
38	88	75	74	111	69
39	94	76	69	115	94
40	75	77	69	117	74
41	75	79	63	118	87
42	94	80	62	119	94
43	81	81	68	120	100
44	87	82	81	121	69
45	87	83	88	122	69
46	62	84	81	123	81
47	69	85	69	124	81
48	72	87	69	125	81
51	69	88	81	126	79
53	62	90	68	127	69

Also, the majority of the panelists reported that they did not receive instruction in social marketing in their professional preparation curriculum (question 26, 68%), they learned social marketing "on the job" (question 27, 81%), they had received instruction in commercial marketing (question 28, 66%), they learned a great deal about social marketing through continuing education (question 30, 63%), learned about social

marketing from attending conferences/seminars/workshops (question 31, 69%), they learned about social marketing from reading articles (question 32, 81%), they felt that training in social marketing is limited (question 34, 69%), they were self taught in social marketing (question 35, 87%), they felt that continuing education for social marketing was very limited (question 36, 63%), they felt that social marketing provides a effective approach for program planning (question 37, 87%), that social marketing increases awareness of health issues (question 38, 88%), and that social marketing is an effective method of health promotion (question 39, 94%).

In addition, the panelists' responses indicated that social marketing teaches the health educator how to segment audiences (question 40, 75%), it offers insights into commercial marketing which promotes unhealthy behaviors (question 41, 75%), that social marketing teaches the health educator how to separate his/her perspective from the consumers' (question 42, 94%), that it provides the health educator with skills and tools useful for influencing behavior change (question 43, 81%), that social marketing provides tools for effective interventions (question 44, 87%), that it provides a systematic approach to problem analysis and program development (question 45, 87%), that health educators will be expected to know social marketing (question 46, 62%), social marketing is a good fit with health behavior theories (question 47, 69%), social marketing teaches effective and cost efficient communication (question 48, 72%), that social marketing should be taught as a stand alone course (question 49, 62%), that social marketing should be taught within other health education courses (question 50, 81%), social marketing should be taught early in the curriculum (question 51, 69%), that it

should be taught in conjunction with other health education behavior change models (question 52, 66%), and that social marketing should be taught as part of a course in program planning (question 53, 62%).

Table 7: Agreed Consensus Questions with the "*Middle Choice*" Included

Agreed Consensus
("bottom two" <40% and "top two" + middle choice >60%)

Ques #	*Percentage (bottom two) / (mid + top two)*	*Ques #*	*Percentage (bottom two) / (mid + top two)*
8	31 / 69	64	12 / 88
9	32 / 68	69	25 / 75
11	38 / 62	70	19 / 81
14	25 / 75	71	13 / 87
15	25 / 75	78	12 / 88
17	6 / 94	86	13 / 87
21	32 / 68	89	37 / 63
23	36 / 64	91	19 / 81
28	34 / 66	93	19 / 81
30	37 / 63	96	19 / 81
34	31 / 69	97	13 / 87
35	13 / 87	103	19 / 81
49	38 / 62	105	6 / 94
50	19 / 81	112	31 / 69
52	34 / 66	113	23 / 77
58	25 / 75	114	6 / 94
63	31 / 69	116	31 / 69

The panelists agreed that the following were important instructional needs in social marketing for health educators: basic theory and principles (question 56, 87%), practical applications (question 57, 100%), diffusion theory (question 58, 75%), market segmentation (question 59, 94%), designing, implementing, and evaluating social marketing programs (question 60, 87%), formative research methods (question 61, 88%), developing a marketing plan (question 62, 94%), less emphasis on message development, advertising, and communication (question 63, 69%), understanding the differences between social marketing and health promotion (question 64, 88%), instruction in social marketing should be more than just one course (question 65, 75%), case studies of

applied examples in a variety of settings (question 66, 87%), and understanding the impact (benefits) of using social marketing on intervention outcomes (question 67, 63%).

Additionally the majority of the panelists (questions 68-100 except question 94, greater than 60%) felt that the following knowledge and skills were necessary for designing, implementing and evaluating social marketing programs: basic theory of social marketing, diffusion theory, exchange theory, health behavior theories, behavior change theory, practical applications, audience/market segmentation and profiling, formative research methods, problem definition, needs assessment, understanding competition, strategy development (appropriate use of data collected), message design, monitoring behavioral outcomes, developing communication channels, program design (4 Ps, objectives, goals), program evaluation, cultural awareness/sensitivity, interpersonal skills (communication, working with others and contractors), finance/budgeting, developing a consumer orientation, recruiting corporate support, understanding process, outcome and impact measures and how they differ, effective facilitator skills, report writing and summation of analysis, interpreting data (qualitative and quantitative), distribution planning, intercept interviewing, public relations, administrative planning, understanding consumer behavior, and oral and written communication.

Finally, the panelists agreed that the following were essential components required for a social marketing curriculum for health educators (questions 101-127, all greater than 60%): social marketing theory, exchange theory, diffusion theory, health behavior theories, theories of social and population health change, practical applications (practicum/special project/field study), case studies/review of best practices, principles of

social marketing, social marketing concepts, consumer orientation, contested issues and ethics, history of social marketing, integration with organizations/agencies, comparisons (other methods/models/commercial marketing), formative research methods of social marketing, advanced marketing research methods, consumer behavior, steps in the social marketing process, program (campaign) planning (development), implementation, and evaluation, market segmentation, needs assessment, integrated marketing promotions, process and program evaluation, message development/advertising/communications, channel analysis, strategic marketing for non-profits or service marketing, and monitoring interventions.

There were nine questions that fell into the ***"undetermined"*** category where neither the "bottom two" choices or the combined total of the middle choice and the "top two" choices were not greater than 60% (Table 8). As stated earlier, these questions were repeated in Round Three with a 7-point Likert scale. The following were the "undetermined" questions: "I am extensively published in social marketing" (question 10), "I need more social marketing evaluation skills" (question 13), "Most of my colleagues understand the basics of social marketing" (question 19), "My colleagues do not have the knowledge or ability for the application of social marketing" (question 20), "My colleagues have an excellent understanding of the principles and application of social marketing" (question 24), "I did not receive any instruction in commercial marketing" (question 29), "Social marketing should be part of a course in foundations and methodology" (question 54), "Social marketing should be offered as an elective or support course" (question 55), and under knowledge/skills necessary for designing,

implementing, and evaluating social marketing programs there was no agreement on question number 94 "Graphic design skills."

Table 8: Undetermined Question

Undetermined
(neither "bottom two" or "mid+ top" >60%)

Ques #	*Percentage (bottom two) / mid+top two)*
10	50 / 50
13	43 / 57
19	50 / 50
20	50 / 50
24	44 / 56
29	49 / 51
54	55 / 45
55	49 / 51
94	44 / 56

Round Three

There were four parts to Round Three: 1) the panelists were asked to respond to the ***"undetermined"*** questions from Round Two using a 7-point Likert scale this time instead of a 5-point scale; 2) the panelists were asked to rank order the instructional needs in social marketing for health professionals; 3) the panelists were asked to place the knowledge/skills into categories; and 4) the panelists were asked to also place the essential components into categories (see Appendix F).

Since question number 94 was one of the knowledge/skills deemed necessary for designing, implementing, and evaluating social marketing programs it was not included in the 7-point Likert scale questions. The questions that fell into the ***"agreed"*** consensus (combined percentage totals of numbers 5. *somewhat agree*, 6. *agree*, and 7. *strongly agree*) of the 7-point Likert scale included the following: "I need more social marketing evaluation skills" (question 13, 68%), "I did not receive any instruction in commercial

marketing" (question 29, 56%), "Social marketing should be part of a course in foundations and methodology" (question 54, 68%), and "Social marketing should be offered as an elective or support course" (question 55, 56%).

The ***"disagreed"*** consensus (combined percentage totals of 1. *strongly disagree*, 2. *disagree*, and 3. *somewhat disagree*) of the 7-point Likert scale included the following: "I am extensively published in social marketing" (question 10, 62%), "Most of my colleagues understand the basics of social marketing" (question 19, 62%), "My colleagues do not have the knowledge or ability for the application of social marketing" (question 20, 60%), "My colleagues have an excellent understanding of the principles and application of social marketing" (question 24, 57%). Point number 4. *neither agree nor disagree* was not included in either the ***"agreed"*** or the ***"disagreed"*** consensus (Table 9).

Table 9: Round Three Agreed and Disagreed Consensus Questions

Disagreed		Agreed	
Question #	**Percent**	**Question #**	**Percent**
10	62	13	68
19	57	29	56
20	60	54	68
24	57	55	56

The second part of Round Three asked the panelists to rank order the 12 identified instructional needs of social marketing for health education professionals. Basic theory and principles of marketing were overwhelmingly (75%) ranked as the most important instructional need. Thirty-one percent of the panelists ranked designing, implementing and evaluating social marketing programs as second most important; market

segmentation as third most important; and developing a marketing plan as fourth most important instructional needs (Table 10).

Table 10: Rank Order of Instructional Needs

Instructional Needs in Social Marketing for Health Education Professionals	Rank	Percent
Basic theory and principles of marketing (social marketing)	1	75
Designing, implementing, & evaluating social marketing programs	2	31
Market segmentation	3	31
Developing a marketing plan	4	31
Formative research methods of social marketing	5	25
Practical applications, instruction in social marketing should include "hands-on" experience	6	19
Understanding the differences between social marketing and health promotion/communication	7	19
Case studies of applies examples in a variety of settings	8	19
Understanding of the impact (benefits) of using social marketing on intervention outcomes	9	31
Instruction in social marketing should be more than just one course	10	25
Less emphasis on message development, advertising, & communication	11	31
Diffusion theory	12	31

Diffusion theory was felt to be the least important instructional need and in addition the panelists felt that less emphasis should be placed on message development, advertising and communication.

The third part of Round Three instructed the panelists to place the identified knowledge and skills necessary for social marketing programs into four categories; designing, implementing, evaluating, or not required. The panelists were allowed to place each item into more than one category so the totals for each item were typically greater than 100 percent. The highest percentages for each item placed them into the categories indicated in Table 11.

Table 11: Knowledge/Skills Necessary for Designing, Implementing, and Evaluating Social Marketing Programs.

Designing	Implementing	Evaluating
Basic theory of social marketing	Practical applications	Monitoring behavioral outcomes
Diffusion theory	Developing communication channels	Program evaluation
Health behavior theories	Interpersonal skills (communication, working with others and contractors)	Understanding process, outcome, & impact measures and how they differ
Behavior change theory	Effective facilitator skills	Report writing, summation of analysis
Audience/market segmentation and profiling	Art and layout, graphic design skills	Interpreting data (qualitative and quantitative)
Formative research methods (qualitative & quantitative)	Public relations	
Problem definition		
Needs assessment		
Understanding competition		
Strategy development (appropriate use of data collected)	Strategy development (appropriate use of data collected)	
Message design		
Program design (4 Ps, objectives, goals)		
Finance/budgeting		
Developing a consumer orientation		
Recruiting corporate support		
Cultural awareness/sensitivity	Cultural awareness/sensitivity	
Distribution planning		
Intercept interviewing		
Administrative planning		
Understanding consumer behavior		
Oral and written communication		

Items in the designing category that received a percentage of 100 included basic theory, health behavior theories, understanding competition, and understanding consumer behavior. In the implementing category only one item, developing communication channels, received 100 percent. Although no single item in the evaluating category received 100 percent, three items did reach 94 percent; monitoring behavioral outcomes, program evaluation, and interpreting data. Two items tied for positioning in both the designing and implementing categories; strategy development and cultural

awareness/sensitivity. The highest percentages of items that were placed in the "not required" category (all at only 38%) included developing communication channels, art and layout, and public relations.

The last part of Round Three asked the panelists to place the identified essential components of a social marketing curriculum into the appropriate teaching/learning modules provided. The modules included theory, principles, research, planning, implementation, evaluation, and "not essential." Again, the panelists were allowed to place each item into one or more of the categories (Table 12).

Table 12: Teaching/Learning Modules for the Essential Components of a Social Marketing Curriculum

Theory	Principles	Research	Planning	Implementation	Evaluation
Social marketing theory	Principles/intro to social marketing	Formative research methods of social marketing	Case studies/review of best practices	Practical applications (practicum/special project/field study)	Process and program evaluation
Exchange theory	Social marketing concepts	Advanced marketing research methods	Integration with organizations/agencies	Integrated marketing promotions	Monitoring interventions
Diffusion theory	Consumer orientation		Program planning implementation, and evaluation		
Health behavior theories	Contested issues/ethics		Market segmentation		
Theories of social and population health change	History of social marketing		Needs assessment		
Comparisons (other methods/models/ commercial marketing)	Comparisons (other methods/models/commercial marketing)		Strategic marketing for non-profits or service marketing		
Consumer behavior	Steps in the social marketing process		Steps in the social marketing process	Steps in the social marketing process	
	Strategic marketing for non-profits or service marketing		Message development/advertising/communications		
			Channel analysis		

Only two items achieved a rating of 100 percent from the panelists in the theory category; health behavior theories, and theories of social and population health change.

The components were placed into the appropriate modules based on their highest percentage, of which most (89%) of them were higher than 56 percent with only two at 50 percent (history of social marketing, and integration with organizations/agencies), and only one below 50 percent, the lowest one (strategic marketing for non-profits or service marketing) at 44 percent (see Appendix F for more detail).

Summary

The results from Round One established the expertise of the panelists and provided rich detail about the panelists' thoughts on social marketing curriculum and professional programs for health educators. Round Two quantified the panelists' perceptions and gave a clear picture of where the panelists agreed or disagreed on certain aspects of a social marketing curriculum. Finally Round Three more distinctly refined the panelists' responses leading to the conclusions presented in Chapter V.

CHAPTER V

CONCLUSION AND RECOMMENDATIONS

This chapter presents the principal investigator's conclusions based on the study results and existing literature regarding 1) the panelists' knowledge of and instruction in social marketing; 2) the need for and benefits of social marketing (Research Questions 1 and 2); 3) the knowledge and skills required for social marketing (Research Question 3); and 4) the essential components of a graduate social marketing curriculum for health educators (Research Question 4). The chapter concludes with a review of the conclusions from a social marketing conference and four recommendations by the principal investigator based on the results of this study.

The Panelists' Knowledge and Instruction

The majority of the panelists, comprised of both social marketing and health education experts, were generally knowledgeable about social marketing and felt confident that their knowledge and experiences with social marketing were more extensive than that of their colleagues. Most had learned social marketing "on the job" and did not have much formal training in their professional preparation curriculum. They learned social marketing from attending seminars and workshops or from reading books and articles. They felt that social marketing training and continuing education opportunities are limited and recognized a need for more advanced training for successful implementation of interventions.

According to the rank ordered results, the panel felt that the four most important instructional needs in social marketing for health education professionals were 1) basic theory and principles; 2) designing, implementing, and evaluating social marketing programs; 3) market segmentation; and 4) developing a marketing plan. However, when compared to the consensus frequencies, practical applications or "hands on" experience appeared to be the most important with a combined ***"agreed"*** percentage of 100 with market segmentation and developing a marketing plan following at 94 percent each. Based on these results and the strength of the panelists' comments from Round One, theory and principles of social marketing and practical applications or case studies appear to actually be the most important instructional needs for health care professionals.

As far as where in a health education curriculum social marketing should be taught there were no clearly significantly strong convictions established by the panel. The results of this issue, question 10 from Round One, although determined to be ***"agreed"*** leaves one without a firm belief as to whether social marketing should be a "stand-alone" course or taught as part of other health education courses such as foundations or program planning. This principal investigator firmly believes, based on this study and more so on the literature researched, that social marketing would be best learned as a required element of a health education curriculum as a "stand-alone" course. The skills and techniques of social marketing should be learned separately and distinguished from health promotions which tend to confuse social marketing with advertising.

The Need for Social Marketing: Research Questions 1 and 2

Research Question 1: Why should social marketing courses be offered in graduate health/public health programs of study?

This research question became question number 8 in Round One and was expanded to questions 37 through 43 in Round Two. Because the panel reached an "agreed" consensus in Round Two for each of these questions they were not repeated in Round Three. An overwhelming majority (the frequency percentages ranged from 75 to 94) of the panelists agreed that social marketing should be offered in a graduate health program for the following reasons: 1) social marketing teaches audience segmentation which allows the health educator to more precisely design a program or intervention to reach specific populations of interest; 2) social marketing provides the health educator with useful skills/tools/techniques for influencing behavior change; and 3) social marketing encourages the health educator to view health program offerings from the consumers' viewpoint and consider the commercial marketing "competition" to making healthy choices. These results are in accord with the literature and this investigator concludes that social marketing is beyond doubt vital in a health educator's professional preparation program of study.

Research Question 2: What are the benefits to health educators or other health care practitioners of offering social marketing courses in graduate health/public health programs of study?

This research question became question 9 in Round One and was expanded to questions 44 through 48 in Round Two. Because the panel reached an "agreed"

consensus in Round Two for each of these questions they were not repeated in Round Three. The panelists agreed that health educators would benefit from learning social marketing for these reasons: 1) health educators will be expected to know social marketing; 2) social marketing provides a systematic approach to problem analysis and program development; 3) social marketing is a good fit with other health behavior theories; and 4) social marketing teaches effective, efficient communication skills. Given the overwhelming success and current interest in utilizing social marketing for health education programs and interventions, this investigator agrees that the benefits of health educators learning social marketing are substantial. Furthermore, the benefits would be expounded when taught early in a graduate program of study and not in the current "hit or miss" fashion of infrequent, short burst of learning offered through continuing education via workshops, conferences, or seminars.

Knowledge and Skills Required: Research Question 3

Research Question 3: What knowledge and skills are required for designing, implementing, and evaluating a social marketing campaign?

This research question became question number 7 in Round One and was expanded to questions 68 through 100 in Round Two. Only one question in this group, number 94 (art, layout, and graphic design skills), did not achieve "agreed" consensus in Round Two (the frequency cut off point for "agreed" consensus was 60% and this question had a frequency percentage of 56%). In Round Three the panelists placed each knowledge/skill element into designing, implementing, and evaluating categories. The

panelists were allowed to place each item into one or more categories so the total percentage across categories does not equal 100 percent (see Appendix F).

The placing of these items into categories held few surprises. Question number 94 mentioned above, was placed in the "implementing" category and along with two other items (developing communication channels and public relations) received the highest scores for items the panelist placed in the "not required" category. However, 100 percent of the panelists placed "developing communication skills" in the implementing category and 56 percent also placed "public relations" in the same category. Three other items (practical applications, interpersonal skills, and effective facilitator skills) were most frequently placed in the implementing category with two others (strategy development and cultural awareness/sensitivity) tied for placement in the designing and implementing categories. These two items had the only ties among all of the 33 items.

Most of the remaining items were placed by the panelists in the designing category most frequently with only five items (monitoring behavioral outcomes; program evaluation; understanding process, outcome, and impact measures; report writing and summation of analysis; and interpreting data) having the highest percentage placement in the evaluating category (see Appendix F).

From this variety of placement by the panelists we see that the identified knowledge and skills are important and necessary for health educators in more than one area of program planning. While some of these skills may be attained in other curriculums or experiences, there are many which are more specific to social marketing, or marketing in general, such as marketing theory, understanding competition, channels

of distribution or communication, consumer orientation, public relations, and consumer behavior. We see that social marketing has much to offer the health educator and should therefore be carefully considered for inclusion in health education programs of study.

Essential Components: Research Question 4

Research Question 4: What are the essential components of a social marketing course in a health/public health curriculum that will prepare health educators/professionals to perform social marketing campaigns?

This research question became question number 11 in Round One and was expanded to questions 101 through 127 in Round Two. The panel reached an "agreed" consensus in Round Two for each of these questions and in Round Three the panelists placed each essential component into teaching/learning modules (see Appendix F).

Again the panelists were given the opportunity to place these items into more than one category with the choice of also placing an item into a "not essential" category. The highest percentage for any item in this "not essential" category was only 25 percent for question number 126 (strategic marketing for non-profits or service marketing). There were only nine other items that also received placement in this category with percentages from 6 to 19 percent. So we see that very few of these items were deemed to be "not essential" and even the ones that were placed in this category only received minimal percentages.

In Appendix F, you will notice that the highest percentage for each component is colored pink with the next closest percentage, over 50 percent, is colored light orange. Only question number 126 did not show a high percentage of greater than 50 percent. The

high percentage for this question was only 44 percent and there was a tie between the modules of "principles" and "planning." This lack of a percentage higher than 50 percent may well be another indicator that this item should be considered a "not essential" component and removed from the list.

Conclusions from a Social Marketing Conference

In 1996 sixty-five professionals in the social marketing field attended a "consensus conference." In addition to validating the concepts used in social marketing, the conference attendees identified several barriers to successful social marketing. One of the significant barriers identified was an "inadequately trained workforce."

A few of the attendees commented on the lack of adequate programs of study for non-profit or social marketing {Walter Wymer, Assoc Professor of Marketing Management, CNU; Trent Stamp, Executive Director, Charity Navigator} and some felt that social marketing studies should be included in schools of public health or social work {Mike Newton-Ward, UNC-CH; Michael L. Rothschild, Emeritus Professor, School of Business, University of Wisconsin; Joe Roccisano, MBA}.

Many of these experts in social marketing expressed that collaboration with an affiliated business school might be a workable approach since social marketing did not attract new faculty as a career track at that time {R. Craig Lefebvre, PhD, Managing Director, Health Communications and Social Marketing; Deborah Trombley, MPH, Minnesota Dept of Health; Susan D. Kirby, Kirby Marketing Solutions, Inc.} and collaboration provided an excellent opportunity to bring together "the best of both worlds into a strong program."

Then again, others saw the first step to be the development of a core curriculum for those wishing to enter the profession {Bill Novelli} and accordingly, the conference attendees recommended that "the profession needs to train individuals adequately by offering appropriate degrees in social marketing and developing professional education opportunities..." (Maibach and Shenker, 1997) and this investigator agrees with this recommendation.

Recommendations

My first recommendation for health educators is that all health education students, in particular the graduate students, should learn social marketing. Graduate students are more likely to be in leadership roles due to their greater experience and most likely have already been working in the field. They will be the lead or key personnel when planning programs or interventions and need to be as well as informed as possible about the benefits of using social marketing techniques. Health educators deserve to learn more than the basic theories and principles of social marketing. They should examine case studies and at best have the opportunity to participate in a real social marketing campaign.

My second recommendation is that social marketing should be taught as a stand alone course. Too often social marketing is confused with advertising, communication, or sales. In a stand alone course the student will have more time and opportunity to devote to really learning what social marketing is all about and how the strategies and techniques can help them improve programs and outcomes. Naturally, the curriculum should include topics such as principles of marketing, the history of marketing in healthcare, research

methods, needs analysis, planning and implementation of a social marketing campaign, and practical examples of successful social marketing campaigns related to healthcare.

Next, social marketing should be taught by a social marketing practitioner who is also educated in the fields of marketing and health education. Only a person with this greater depth of knowledge and understanding can teach health educators the differences between social marketing, health promotion, and commercial marketing.

In addition, social marketing should be taught by means of an interdisciplinary approach. The combined efforts, experiences, and knowledge that a diverse faculty brings will enhance the learning experience and magnify the level of understanding. This recommendation echoes the recommendations given by Susan Carroll (1986) nearly twenty years ago. What Carroll proposed as a solution to teaching social marketing to health educators was the seemingly ideal approach of a multidisciplinary nonprofit or social marketing course taught at the graduate level. I concur with Carroll who expressed the belief that such a course would require someone educated, skilled, and experienced in both business marketing and health promotion concepts.

Finally I would like to say that this study only touches the surface. The next logical step is to survey the existing health education programs to determine why social marketing has not been included in the current curriculums. We now know that social marketers and practicing health education experts see a place in education for social marketing and many questions need to be asked. These questions include: 1) What is the role of social marketing in health education? 2) Should social marketing be offered to

health education students? and 3) How and where can social marketing fit into a health education program?

Conclusion

The inclusion of social marketing in the health educators' arsenal requires a modification of professional preparation curricula. Professional health education programs should develop social marketing courses with common essential components to provide future practitioners the knowledge and skills necessary to apply social marketing principles. Further, post-graduates need to have access to appropriate in-service and continuing education opportunities in social marketing for continued professional development (Neiger, Thackeray, Barnes, and McKenzie, 2003).

Undoubtedly the future of social marketing includes a future in professional health education programs. It seems highly likely that social marketing principles will become common elements of both professional preparation and continuing professional development curricula. However, the form in which this occurs is likely to vary, whether taught in one or two dedicated courses, integrated throughout several courses in a curriculum, or as the dominate focus of a specific program.

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APPENDICES

APPENDIX A
Nomination Letter

~ Date ~

Dear Director or Editor:

As a person with access to numerous practicing health care/education or social marketing professionals, you are invited to contribute to a nation wide Delphi study, which will attempt to identify the essential components of a social marketing curriculum for health educators in a graduate program of study. Please take a few minutes to nominate experts who, in your opinion, could contribute meaningful information on this topic. Your nominations will not be associated with you and the nominees will not have knowledge of who nominated them for this study.

Nominees must meet the following criteria: 1) currently practicing or teaching in social marketing, health education, or other health care profession capacity, and 2) are recognized by their peers and have a good working knowledge of the formal educational process in social marketing, health education, or other health care professions. Participation in this study will be voluntary and each participant will be required to sign a letter of consent.

Nominate as many individuals as you feel meet these criteria, self-nominations are acceptable. Please provide as much information as you can regarding a nominee's full name, credentials, address, telephone number, and e-mail address. Nominees who are selected for inclusion in this study will be invited to accept or decline participation on a panel of experts to assist in the development of a consensus document by responding to a series of questionnaires.

Nominations will be accepted through February 10, 2004 and may be sent in the enclosed self-addressed, stamped envelope, or may be transmitted electronically to the following: e-mail to Audrey Whitright at marie0127@earthlink.net.

Thank you for your participation in this phase of an exciting and important attempt to assess the need for social marketing courses in health education programs. Please do not hesitate to contact me for further information if necessary.

Sincerely,

Audrey Whitright, MBA
Principal Investigator
940-566-5889

Mary Shaw-Perry, Ph.D., CHES
Research Co-Advisor
812-856-6782

William Cissell, Ph.D., CHES
Research Co-Advisor
214-689-6618

Department of Health Studies, Texas Woman's University, Denton, TX

APPENDIX B

Prospective Panel Member Letter

Dear Prospective Panel Member,

You have been nominated to participate as a panel member of a Delphi Group on determining the essential components of a graduate social marketing curriculum for health educators. You have been identified as an expert who can contribute valuable information regarding social marketing and health education. The study is being conducted by Audrey Whitright as partial fulfillment of the requirements for a Ph.D. in Health Studies at Texas Woman's University and will be conducted in three rounds of questions.

Nomination requests were sent to directors of professional associations and institutes, and editors of journals associated with health education programs and social marketing within the United States. A nomination form was attached to the letter requesting nominations. Multiple nominations were encouraged from each source. Non-probability purposive sampling was used to identify and invite prospective panel members to participate in this Delphi process.

Should you decide to participate, please sign and return the consent form detailing your involvement in the study, the time commitments, and security procedures and the brief questionnaire attached. The study will require about six hours of your time over the three rounds of questions.

You may accept this nomination by completing and mailing the consent form and screening criteria questionnaire in the stamped addressed envelope provided. Should you have any questions regarding the study you may call either phone number listed below.

Thank you for your consideration,

Audrey Whitright, MBA
Principal Investigator

1505 Paco Trail
Denton, TX 76209

(940) 566-5889
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Mary Shaw-Perry, Ph.D., CHES
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(812) 856-6782

William Cissell, Ph.D., CHES
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214-689-6618

APPENDIX C

Consent Form and Qualifying Questions and Responses

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Essential Components of a Graduate Social Marketing Curriculum for Health Educators: A Delphi Study

Investigator: Audrey Whitright, MBA 940/566-5889
Research Co-Advisor: Mary Shaw-Perry, PhD 812/856-6782
Research Co-Advisor: William Cissell, PhD 214/689-6618

You are being asked to participate in a research study for Ms. Whitright's doctoral dissertation at Texas Woman's University. The purpose of this research is to determine the essential components of a social marketing curriculum for graduate students of a health education program of study. The principal investigator will use a Delphi Process to gain consensus among experts in the field about the essential components of a social marketing curriculum.

As an expert, you will be asked for your opinions on the subject. The study will be conducted by e-mail and each participant will be unaware of the identity of the other participants. The panel of experts will be composed of practicing health educators or other health professionals and practicing social marketers selected from associations within the health education and social marketing arenas. The panel will answer a brief screening criteria questionnaire on educational background, current profession, number of years in the profession, and experience with social marketing campaigns. Only experts nominated by editors of professional journals in social marketing and health education or directors of professional associations and institutes associated with health education programs within the United States will be eligible for participation. Only nominees willing to converse via e-mail will be selected as participants due to time constraints and ease of merging data via word processing software.

The results from each round will be compiled by the principal investigator and submitted to the group for further clarification and acceptance. The study will conclude at the end of the third round of polling the panel of experts. The results of the Delphi rounds will be used to make recommendations for the design, implementation, and evaluation of a curriculum in social marketing to be included in programs of study for health educators and other health care professionals.

The risks associated with this study include 1. loss of anonymity and confidentiality, 2. fear of loss of anonymity, and 3. loss of time. Steps taken to address these risks include:

1. Loss of anonymity and confidentiality:
Confidentiality will be protected to the extent that is allowed by law. The principal

investigator will not be able to link the participants' responses with the identity of the participants. All responses will be reported as aggregate thereby ensuring anonymity and confidentiality. Participants could experience anxiety associated with offering honest opinions about specific programs of study.

Consent forms and all questionnaires will be sent to and kept by the faculty support person, Carolyn Rozier, PhD. Participants will be sent individual e-mails addressed only to them with no carbon copies or blind copies created. Each e-mail will be sent from the faculty support person's e-mail address only. Upon receipt of a potential panel member's e-mail address the faculty support person will create a code for each participant known only to her and not revealed to the principal investigator to maintain anonymity. All e-mail correspondence to and from the participants will be routed through the faculty support person's e-mail address and will be coded before being sent to the principal investigator.

The coded responses will be saved in a password protected directory on one local hard drive and filed by study rounds one, two, and three. Only the principal investigator will have the password. Printed copies of all correspondence, with names removed, will be kept in a locked cabinet in a secure location accessible only by the principal investigator.

2. Fear of loss of anonymity:
Participants could experience fear of loss of anonymity associated with offering honest opinions about specific programs of study. Participants might fear negative repercussions from peers if they offer honest commentaries to the posed questions. The Delphi Process will be employed to minimize the opportunity for participants to know the identity of other participants and also to minimize the possibility of interaction among the participants.

3. Loss of time:
To minimize loss of time the principal investigator will keep the number of questions to a reasonable number so that each round of questions should not exceed a one hour response time. In addition, the principal investigator is requesting that responses be made via e-mail so that the participants can respond directly on the e-mailed attachment sent to them by using the reply function.

The polling of the experts will be via e-mail and the original data collected from each panel member will be destroyed after the study is published. It is anticipated that the data will be published for thesis, books, and/or journals. However, names or other identifying information will not be included in any publication. Participants could experience anxiety from offering their opinion to a group of their peers. The Delphi Process will be employed to minimize the involvement of participants with each other.

If you have any questions about the research study you should ask the researchers: their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Office of Research & Grants Administration at 940-898-3377 or e-mail IRB@TWU.EDU.

The researchers will try to prevent any problem that could occur because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation in the study is voluntary and you may discontinue your participation in the study at any time without penalty. The only direct benefit of this study to you is that at the completion of the study, a summary of the results will be mailed to you upon request. You will be given a copy of this dated and signed consent form to keep.

_____ _____

Signature of Participant Date

_____

E-mail Address (Required)

_____ *Check here if you would like to receive a summary of the results of this study and list below the address to which this summary should be sent.*

_____

Name

_____

Address

_____

City State Zip code

Please complete the following questionnaire and return with you signed consent form.

Screening Criteria and Participant Information Questionnaire

1. What is your age?
   _____ 20-25 _____ 46-55
   _____ 26-35 _____ 56-65
   _____ 36-45 _____ >65

2. What is your gender? _____male _____female

3. What is your ethnic background?
   _____ Caucasian
   _____ Hispanic
   _____ African-American
   _____ Asian
   _____ Other _____
   specify

4. Describe your educational background?

5. Describe your current profession.

6. How many years have you been in your current profession? _____

7. Please describe any education or experience you may have in social marketing or in conducting social marketing campaigns.

Screening Criteria and Participant Information Questionnaire

	Age	Gender	Ethnicity	Education	Profession	Years in Profession	Experience with Social Marketing
1	*46-55*	*Male*	*Caucasian*	*Grad-HE*	*Prof&Chair College of ED&Human Dev-Div of Health&Safety*	*33*	*20 yrs designed SM campaigns for worksite populations*
2	*46-55*	*Male*	*Caucasian*	*BS, MS Health Ed PhD Health ED*	*Prof Health Ed, S Illinois Univ*	*27*	*none*
3	*46-55*	*Male*	*Caucasian*	*BS- Bus Mgmnt MBA-Organizational Development PhD-Rehabilitation Counseling*	*College professor-School of Education Research Interest-Behavioral health (D+A, MA) problem prevention and health promotion*	*20*	*Worked in rehab to drug and alcohol problem prevention; positive youth development*
4	*56-65*	*Male*	*Caucasian*	*BS-economics MBA-Marketing PhD-business*	*Emeritus Prof-School of Bus, doing project work and writing in Soc Mktg*	*34-mktg&soc mktg 4-emeritus prof*	*25 yrs teaching mktg & soc mktg 20 yrs work in advertising agencies recent projects: NHTSA: drinking/driving NCI: reducing obesity*
5	*56-65*	*Female*	*Caucasian*	*EDD-Org Learning & Technology MA-Health Ed (community) BA-Psych*	*Health Education*	*29*	*I have developed and completed a few modest soc mktg campaigns on a mid to large US campus*
6	*46-55*	*Female*	*Caucasian*	*PhD-communication MA-communication MLS-library science*	*Communication team leader for a Federal government agency*	*5*	*Evaluated soc mktg programs for 8 years, taught courses at the masters level in soc mktg for 5 years, my current team uses a soc mktg approach to all our activities and has developed one national campaign*
7	*46-55*	*Female*	*Caucasian*	*PhD-Health Ed MPH-Community Hlth Ed Med-Guidance & Counseling*	*Univ Prof- Hlth Ed*	*20*	*Soc mktg is part of courses I presently teach. I use the principles in my job of coordinating the Academic Success Center. (1st year student assistance into university life program)*

	Age	Gender	Ethnicity	Education	Profession	Years in Profession	Experience with Social Marketing
8	*46-55*	*Male*	*Caucasian*	*BA-Psychology PhD-Clinical Psych Post Doc Fellowship 2yrs-Behaviorial Medicine*	*Soc Mktg Consultant*	*20*	*2years of applying marketing principles and practice to community, state, federal and international public health programs Conduct numerous soc mktg lectures and workshops. Publications in the field of soc mktg*
9	*36-45*	*Female*	*Caucasian*	*PhD-Hlth Ed MSEPH-PH Services BS/As- Dental Hygiene*	*Faculty member*	*17*	*Currently am Co-PI of the Florida Prevention Res Ctrthat uses community based prevention in mktg to encourage behavior change. Have received over $5mil in grants that have used soc mktg as a framework. Have been a part of several statewide soc mktg campaigns, consult with a Soc mktg firm, and have provided trainings to more than 6 state HD on soc mktg. Currently am co-chair of the Annual Soc Mktg & PH conference and have developed the only soc mktg &PH Grad Certificate Program in the US*
10	*56-65*	*Female*	*Caucasian*	*PhD*	*Professor*	*15*	*Designed multiple SM projects, teach graduate level courses in SM*
11	*56-65*	*Male*	*Caucasian*	*BA-Arts (public Administration)*	*Special Advisor and former Director of a Social Marketing Group in the Federal Health Dept in Canada*	*25*	*I have run virtually hundreds of social marketing campaigns over the past 25 years. I have also given many workshops as well as a University course involving social marketing (see bio attached to consent form)*

	Age	Gender	Ethnicity	Education	Profession	Years in Profession	Experience with Social Marketing
12	*46-55*	*Male*	*Caucasian*	*AD-Nursing* *BA- Psychology* *MPH- Social & Behavioral Sciences*	*Title: "Prevention Coordinator"* *I design and plan community-wide health promotion initiatives in the areas of violence prevention, alcohol misuse, tobacco use, physical activity and obesity prevention. This includes media campaigns, staff training, needs assessment, implementation strategies, and evaluation methods.*	*X*	*I designed and conducted a county-wide campaign to promote the safe storage of firearms using social marketing principles* *I have presented to public health professionals and students on the principles and uses of social marketing principles to plan and carry out health promotion campaigns* *I regularly consult with staff regarding the use of social marketing approaches to develop effective campaign strategies.*
13	*46-55*	*Male*	*Caucasian*	*Associate of Applied Science in Cardiopulmonary Technology* *Bachelor of Science in Interdisciplinary Studies Business and English* *Master of Science in Healthcare Administration* *Philosophy Doctorate in Health Education*	*Industry, Account Manager for Stereotaxis, Inc. manufacturer of a magnetic guidance system for cardiovascular guide wires and catheters.*	*30*	*None*

	Age	Gender	Ethnicity	Education	Profession	Years in Profession	Experience with Social Marketing
14	56-65	Female	Caucasian	BS-Education MBA-Marketing	Teach-adjunct faculty, 4 universities/SM Consult-state SM campaigns Author-2 books, 1 on SM, 1 on corporate social responsibility	11	Consulted on more than 100 SM campaigns
15	46-55	Female	Caucasian	PhD-Health Ed MPH-Maternal & Child Health BA-Health Administration	Director, research, & Sponsored Programs	7	Project director, strategies for change: a field guide to SM for School Health professionals
16	56-65	Female	Other	BSN-Nursing MPH-Health PhD-Health	School of Public Health faculty	17	Almost none
17	56-65	Female	Caucasian	MS, PhD-Health Ed BS- Home Ec Ed CHES	School of Public Health faculty Assistant Professor	5	Completed one 3 hour graduate course entitled "Introduction to SM" at Univ of So Florida. Assisted local health dept with a SM campaign for asthma awareness. Currently working in a group conducting formative research on obesity for TDH

APPENDIX D

Round One Questions and Responses

Round One Questions:

1. Describe your current knowledge of the principles and concepts of social marketing?
2. How would you describe your colleagues' knowledge of social marketing principles and concepts?
3. How confident do you feel about your knowledge of social marketing principles and concepts compared to your colleagues'?
4. Describe how much instruction in social marketing principles and concepts you received in your professional preparation curriculum.
5. Describe how much instruction in social marketing principles and concepts you received in your continuing education/professional development.
6. What do you feel are the most important instructional needs in social marketing for health education professionals?
7. What social marketing knowledge and skills do you feel are required for designing, implementing, and evaluating social marketing campaigns? (You may separate the skills needed for each category: designing, implementing, evaluating)
8. Why should social marketing courses be offered in health educator and health care professions programs?
9. What would be the benefits to health educators or other health care practitioners of offering social marketing courses in a health education curriculum?
10. Where in a graduate health education curriculum should social marketing be taught?
11. What are the essential components of a social marketing curriculum for a professional preparation program in health education?

Round One Responses

1. Describe your current knowledge of the principles and concepts of social marketing?			
1	I really do not think I have much formal social marketing knowledge. I do however rely heavily on diffusion theory and business marketing theory in my health education practice	**9**	My current knowledge is in the middle between nothing and expert. I would say that most of my knowledge is theory rather than experience in application.
2	Good understanding of principles, research methods, strategy development. Fair understanding of evaluation methods	**10**	Theoretically framed and used within the stage of change model. Need more skills in evaluation.
3	Moderate knowledge level based on self study and work on applied projects.	**11**	I have an introductory level knowledge of the principles and concepts.
4	My MBA and PhD are with majors in marketing. I was involved in starting one of the first social marketing courses while I was a student at Stanford, and then developed my own course at Wisconsin in the late 1970s. I come to social marketing from marketing I've also been employed at three advertising agencies sine 1970, have worked on several social marketing projects over the 6years, and have published extensively in the area.	**12**	As a practitioner for over 20 years and a professor who teaches social marketing at University, I am quite familiar with the principles and concepts of social marketing
5	I have been writing about and doing social marketing for many years, participate in major social marketing conferences, and I would rate it high.	**13**	Basic principles & foundational concepts
6	I know what it is, the components of social marketing, and have included it in my undergraduate program planning course.	**14**	I am very familiar with the framework and perspective of social marketing and have applied parts of the framework in several community campaigns. I have never had the resources or the time to apply the entire framework as intended.
7	High	**15**	Minimal, I have not had experience in social marketing. I have used the traditional approach to "selling" health care based on my product experience rather than the consumer needs.
8	I teach semester long courses in social marketing at 2 universities in our state. I also teach 5-10, 2 day workshops on social marketing every year. I teach a field school in social marketing at the University of South Florida. I have led seminars in social marketing at Cape Town University in South Africa and for the Health Promotion Board in Singapore.	**16**	Very basic
		17	My current knowledge is based on books and as well as experience with several SM campaigns

2. How would you describe your colleagues' knowledge of social marketing principles and concepts?			
1	Weak	**9**	Some are better than others…most have the theories and few have the ability for application or have applied the theories in real life exp.
2	Varied	**10**	Some strong skills and others just think of social marketing as brochures and posters
3	Varied based on education and experience. No adequate way to characterize colleagues as a group.	**11**	I believe that knowledge of social marketing principles and concepts exceeds that of my colleagues'.
4	It's not clear who you are referring to when you ask about my colleagues, as I've been retired from the university for almost 4 years. I'll assume that you mean my marketing department colleagues from before I retired. I feel that the principles and concepts of social marketing come from marketing, so they are all experts. What they lack is considering the uniquenesses that set social marketing apart from commercial marketing.	**12**	Most of my colleagues (except those who work in the marketing unit) are not social marketing experts, although have general understanding of marketing principles and concepts
5	There are some who understand many of the concepts and principles but many others who continue to learn	**13**	minimal
6	They have heard about it; about ½ could speak intelligently on it.	**14**	Most public health practitioners have a limited understanding of SM principles and framework. Many equate SM with the use of media for public health messaging and miss much of the rest of the framework. Many are unclear how SM differs from social advertising, health communication campaigns, public relations, and other tangential frameworks.
7	Low (although this depends on which colleagues you're considering – however, overall, the people I work with don't have a good understanding)	**15**	Minimal as well. We focus on the product we offer and try to fit the consumer into our concept of need.
8	Those who are teaching social marketing are knowledgeable, followed by those working in large agencies such as CDC and NIH. It goes downhill from there. I find most people working in communications firms on social marketing projects are focused primarily (even exclusively) on only on of our tools . . . communications . . .and overlook tangible objects and services and incentives and convenient access to behavior change.	**16**	Not sure
		17	Most have book knowledge but with little actual experience with a campaign form beginning to end.

3. How confident do you feel about your knowledge of social marketing principles and concepts compared to your colleagues'?			
1	I have a stronger interest and experience with social marketing	**9**	In the middle
2	Very confident	**10**	Pretty good
3	Generally good.	**11**	I am fairly confident about my knowledge compared to my colleagues.
4	Very confident	**12**	Very confidant that my expertise and knowledge of social marketing, including our marketing team, would be at a much higher level then my colleagues.
5	Very	**13**	Very confident regarding fundamentals
6	I would give myself a B-	**14**	I believe I have a much firmer grasp of the SM framework and principles than most of my colleagues in public health, especially since I have had more opportunity than most in my region to actually apply those principles to real world campaigns
7	Very	**15**	From an academic perspective I have a small amount more than my colleagues. At least I can state the objectives and principles of social marketing
8	Extremely confident.	**16**	
		17	Relatively confident.
4. Describe how much instruction in social marketing principles and concepts you received in your professional preparation curriculum.			
1	Weak. I also have a business degree which required a few marketing courses	**9**	Too long ago…was not in the literature or the textbooks
2	none	**10**	Never a full course- in connection with Stage of Change and Rogers diffusion of innovation
3	No formal education. Have health education degrees in 71, 74 & 79 before SM was on anyone's radar screen.	**11**	I have taken one formal class on the introduction of the social marketing principles and concepts and have read other information on my own.
4	I have an MBA and a PhD. In both, I majored in marketing; I also have a minor in psychology.	**12**	Over the years I have had the opportunity to work with some of the best social marketers in Canada and have participated in many courses, workshops and conferences . I also teach social marketing.
5	None, though courses in behavior change, communications and epidemiology helped get me started. It's been mostly on the job and lots of outside reading and thinking over the years.	**13**	none
6	I received none in my professional preparation	**14**	None
7	Minimal – I learned on the job	**15**	None as such. We approached curriculum design and implementation as a product centric element of education.
8	None. I have an MBA in marketing. There was only a few pages in a textbook about it. Everything I learned I learned from reading books and attending seminars.	**16**	Just mentioned
		17	None, while in my PhD program 20 years ago

5. Describe how much instruction in social marketing principles and concepts you received in your continuing education/professional development.			
1	None	**9**	10 hrs. through conferences and some workshop components
2	extensive	**10**	That's where I got most of the information/experience. Mostly regarding changing behavior re alcohol use/abuse on college campuses.
3	none	**11**	The class I took was a 3 hour graduate class for credit from USF in Tampa.
4	none	**12**	See number 4
5	None, though the Innovations in Social Marketing conference helps keep it fresh.	**13**	Self-taught.
6	I have attended various presentations, conferences, and have read various articles. All told, probably about 25 hour's worth of time.	**14**	I am largely self-taught, using available professional publications, list servs, and through contracting with SM professionals to design and conduct campaigns. SM training is limited in this state and covers only the most basic aspects of the field. There is little continuing ed available for regular practitioners at the middle or advanced levels.
7	Medium – mostly by attending conferences. Most of what I have learned is by doing and by teaching sm myself.	**15**	Very little as I am involved in a product that is the focus of our efforts.
8	I have attended at least four national conferences on the subject. I have read most of the 10 or so books written on the subject.	**16**	One presentation by an expert and one demonstration – total 1hr.
		17	Considerable

6. *What do you feel are the most important instructional needs in social marketing for health education professionals?*			
1	Basic theory and practical applications in diffusion theory, market segmentation, and assessing and matching client (consumer) needs.	**9**	Application of the theory to real life situations…community based or school based…
2	Basic principles of marketing approach – how it differs from health communication. "how to" conduct formative research, segment audiences, translate research into a marketing plan, etc.	**10**	Participation from the population in focus and evaluation.
3	Understanding and applying the process of designing, implementing and evaluating SM programs and processes.	**11**	I feel it is very important for health educators to have training in principles and concepts of social marketing and health communication.
4	I feel that most current instruction in social marketing focuses on message development, advertising, communications, education. These are components of marketing, but don't capture the essence of marketing. If we are to call ourselves marketers, we need to build on the large base of marketing thought that has evolved from economics, psychology, sociology, anthropology and other fields over the past 100 years. We need to teach marketing so that messages become a small part of the course work and not the central focus.	**12**	Social marketing works best when it is taught using both case studies and working on real projects in the community while following a course of study. Marketing is learned best when developing and implementing real projects and focuses less on theoretical education. Also having practitioners involved in the education process is crucial in teaching a discipline like social marketing
5	Understanding the difference between individual and population-based behavior change – that it requires a broader perspective in looking at change. Learning how to analyze a problem from a marketing perspective and then creating a marketing plan.	**13**	Comprehensive review of fundamental principles in order to craft educational messages for behavior change at the individual, group, and community level most effectively. Case studies of applied examples in a variety of settings and scale. Skill development related to various components integral to social marketing such as selecting target audiences, interviewing, etc.
6	Being aware of the major components; having examples to help explain.	**14**	Formative research methods (not just focus groups!), segmentation, channel analysis, message design
7	Not clear what you mean by this question. Overall, I think all health ed professionals should know the basics. However, those who plan to use social marketing need substantial instruction and experience.	**15**	To probe the depths to which an effective social marketing campaign can alter the course of a disease or health issue. As example, obesity among the youth of the US is beginning to feel the effects of a true social marketing campaign.
8	1. It needs to be a semester or quarter long course. Not a special session or a special week or a special day on the subject. 2. A good textbook on the subject (which is available) needs to be used. 3. Students need to develop a social marketing plan as a part of their course requirement.	**16**	Not sure
		17	Actual experience to be able to develop necessary skills and mindset

7. What social marketing knowledge and skills do you feel are required for designing, implementing, and evaluating social marketing campaigns?			
1	Basic theory and practical applications in diffusion theory, market segmentation, and assessing and matching client (consumer) needs.	**9**	D= understanding of theories and the population that you are working with I=skills to be an effective facilitator or creative enough to design the message dynamic E= what to evaluate and basic manipulation of numbers/words into a summary statement that can be used to make decisions.
2	Audience segmentation Understanding competition Exchange theory Health behavior theories Other theoretical approaches, e.g., community organizations Formative research methods –qual and quan Strategy development Monitoring behavioral outcomes Message design principles	**10**	Designing: art and layout background helpful. Group process to incorporate ideas from priority population Implementing: intercept interviews, working with printer and establishing a distribution plan Evaluation: intercept interviews and post distribution impact is important and difficult.
3	Needs assessment Communication channels Program design Program evaluation Cultural sensitivity/competence Budgeting	**11**	A health educator needs 1) training in qualitative research methods for the formative research required for social marketing campaigns, 2) training in health communication evaluation; 3) training in cultural awareness/sensitivity; 4) training in public relation area; and 5) training in financial/budget/administrative planning.
4	Campaigns need to be based on a knowledge of marketing. I'd look at an intro marketing text, or at a good social marketing text (e.g. Andreasen). This might be seen as a flippant response, but a detailed response would fill several textbooks.	**12**	First I think there is a real need to understand the differences between social marketing and health education models, they are quite different. Secondly understanding how social marketing can only be effective so long as it is part of an overall health promotion program and cannot be a on-off strategy. It is different from public education and other communication/health education strategies in that its ultimate goal is to influence and change behavior, not just to increase knowledge and/or change attitudes. Most health educators mistake marketing with promotion and lack understanding that social marketing deals with 4Ps. Obviously skills/knowledge with marketing research, integrated marketing communications, consumer behavior etc. are key.
5	Multiple perspectives on problem definition – various theoretical perspectives. Focus on objectives. Use of the 4Ps in an integrated manner. Program evaluation skills (not epidemiology). Sensitive to working in partnerships and good interpersonal skills. Developing informative process evaluation systems (and not simply bean counting).	**13**	Knowledge of various strategies for obtaining formative information; interview skills, decision trees for selecting primary & secondary target audiences; fundamental evaluation skills, instrument construction for surveys and questionnaires, group process skills, knowledge of various media channels, cultural competency, oral and written communication skills

7. What social marketing knowledge and skills do you feel are required for designing, implementing, and evaluating social marketing campaigns?			
6	I'm not really sure.	**14**	Design – formative research methods with practice in application, theories of effective message design as well as practice application, working with outside contractors, budgeting and planning, segmentation theory and practice, channel analysis – theory and practice Implementation – the notion of "threshold level of resources", the cyclical learning aspects of refining the campaign with tracking, monitoring and examining reach, acceptance and effects of the campaign. Evaluation – I believe that, while there are unique aspects of evaluating SM campaigns, such as determining the effects of media campaigns, a good evaluation course should prepare health educators for how to do this without having huge separate evaluation components. I believe the design and implementation phases of SM are the more unique parts of the framework.
7	A strong consumer orientation is needed for all stages of the marketing process, which implies having good knowledge and skills in analyzing social or health problems, segmenting and learning about audiences (research), and using behavior change theory and empirical data to think about people and their behavior. For designing social marketing programs, people need skills and knowledge in behavior change theory and practice, communication, developing, conducting, and interpreting formative research (preferably both qualitative and quantitative), audience segmentation and profiling, strategy development, working with partners and with contractors. The skill I see missing the most is that of conceptualizing what information is needed to develop a sm strategy and then using data for strategy development once it's collected.	**15**	All three areas must be managed through an understanding of the fundamentals of commercial marketing, product, price, place and promotion. Understanding why and how these four "P's" influence success will provide insight into how they can be employed by social marketing strategies.
8	Designing: *Research skills *Familiarity, understanding and respect for the other 3Ps: Product, Price, Place that I think are often critical to behavior change Implementing: *Budgeting *Finding corporate support Evaluating: *Research skills *Understanding that this gets "cast in concrete" when setting goals for a campaign *Understanding the distinctions between process measures, outcome measures and impact measures	**16**	Not sure
		17	Research – both qualitative and quantitative – that allows you to ask and answer MARKETING questions, not epi questions.

8. Why should social marketing courses be offered in health educator and health care professions programs?			
1	Health education and promotion are the social marketing of health	**9**	Our goal is to assist, facilitate individual change and to encourage environmental changes that support individuals…it is part of who and what we do
2	Social marketing is an effective approach for planning programs. While not the only approach, it is one that health educators should be able to use. They also need to know when it is appropriate and inappropriate	**10**	Increasingly important and effective method of promotion
3	To effectively compete with other conflicting health communication messages	**11**	Social marketing campaigns are important to increase awareness, knowledge as well as behavior of the chosen population and to integrate social marketing research into policy change, health promotion, and program development.
4	Because a knowledge of social marketing would help the students in these classes do a better job of behavior management after they graduate and begin their careers.	**12**	I think it is important that health educators and health professionals understand social marketing so that they are better able to work with social marketing colleagues in a **big organization**. If they are presently working in a small organization/ company NGO etc. they would be able to develop and implement social marketing initiatives.
5	See # 7 above	**13**	Technique is useful to help understand the perspectives of others and offers insight into commercial marketing used to promote unhealthy behaviors.
6	I feel that most current instruction in social marketing focuses on message development, advertising, communications, education. These are components of marketing, but don't capture the essence of marketing. If we are to call ourselves marketers, we need to build on the large base of marketing thought that has evolved from economics, psychology, sociology, anthropology and other fields over the past 100 years. We need to teach marketing so that messages become a small part of the course work and not the central focus.	**14**	The SM framework is only one tool of many for health educators, but it contains at least three unique points of emphasis that can be extremely valuable for the profession. First, the framework demands that the health educator examine his/her own perspective and separate it from that of the audience. Health professionals of all stripes tend to be "health fascists" and the SM "consumer focus", if truly adopted, provides necessary balance. Secondly, the segmentation process forces the health educator to resist the typical temptation in public health to "be all things to all people", and to identify clearly the audience of interest and to specify that audience beyond the usual (age, race, gender, income) factors. Finally, channel analysis continues the "consumer focus" thread by forcing the health educator to examine appropriate venues for distribution that are acceptable and credible to the audience.
7	See # 7 above	**15**	Health care: 14% of GNP; Obesity; life style illness; population density; quality of life; aging population; poverty; scarce resources ….. ETC!
8	They will often end up in roles with front line responsibilities to influence public behavior. Social marketing is the discipline to assist them. It provides tools to influence this voluntary behavior.	**16**	Because it is a tool that affects most of the information individuals receive. Therefore health professionals should be able to interpret, assess and use social marketing, as well as use it to educate clients/patients.
		17	To provide a basic understanding of marketing principles so they can be smarter when developing programs and materials

9. What would be the benefits to health educators or other health care practitioners of offering social marketing courses in a health education curriculum?			
1	Social marketing is fundamental to health promotion and education (You can think of social marketing as good health education / teaching)	**9**	Better prepared students…
2	To determine when it is appropriate to use To be able to manage or coordinate a social marketing program	**10**	Another tool
3	Effective and cost effective communication/SM programs tailored to diverse audiences	**11**	The benefit of this training would be to keep health educators on the "cutting edge" of new developments in field of health behavior
4	A knowledge of social marketing would help the students in these classes do a better job of behavior management after they graduate and begin their careers.	**12**	See 8
5	Maybe none if they don't have a perspective to effect social change. If they do, it will put a lot of tools in their box. It also provides a systematic approach to problem analysis and program development that is relatively straightforward.	**13**	Expands tools available for health promotion. Social marketing is another communication tool.
6	The science of social marketing provides pretty good evidence of the strategies needed to market an item. There are also plenty of examples in the profession that has used social marketing.	**14**	Seems to be the same as #8? SM is an extremely popular framework and health educators will be expected to be familiar with this tool. SM also works well with many other theories and models of behavior change, so allows for more "nuanced" approach to complex campaigns. SM also provides a planning model that is less complicated and demanding that the Green-Kreuter model, thus, more likely to be used.
7	It would give them more of a consumer perspective. It would ensure that they actually understand what social marketing is and have some sense of how to do it. A big problem in the field is that people call anything with focus groups in it a social marketing program.	**15**	It would provide the appropriate vehicle to get out the wonderful messages health educators spend their lives acquiring.
8	They would be more skilled at developing strategies that are: *Customer-oriented *Utilize all 4Ps *Realistic goals and campaign measures	**16**	To be able to use social marketing to reach and educate their clients/patients, communities. Extremely important in health promotion, disease prevention, as well as to educate clients/patients on how to interpret social marketing when taking decisions about health and lifestyle.
		17	No answer

10. Where in a graduate health education curriculum should social marketing be taught?			
1	Courses in program design, planning, development and implementation	**9**	Should be part of several courses so that the skills to design, implement and evaluate have been covered: foundations, evaluation, methods, research
2	As a support course or elective at the MPH level	**10**	In promotion courses or separate
3	Health education methodology or Health education planning	**11**	Social marketing should be taught after a student has a firm foundation in health education and had achieved skills in design, implementing, and evaluating programs.
4	I've never been associated with a health education curriculum, so it is hard to answer. I'd teach it early enough so that when students get to their final projects, they can incorporate social marketing.	**12**	I have very little knowledge with the health education curriculum so cannot respond . However, it should certainly be integrated with any curriculum dealing with Health Promotion as social marketing should be part of a larger overall Health Promotion program.
5	Immediately, for the obvious reasons.	**13**	Could be offered in program planning or administration or as a stand alone course depending on desired depth of coverage.
6	Program Planning course	**14**	SM could be taught in conjunction with either the basic "change" models or along with the "planning" models, though I think it would be better if students already had most of the change models under their belt before learning SM. From my perspective, SM is more of a planning framework.
7	Do you mean, at what point? Probably second semester and beyond.	**15**	Toward the end as context is as critical as content.
8	It should be a stand-alone course.	**16**	Core course area
		17	Not sure what you mean, but it should at least be an elective; Probably after some research methods courses OR it would be difficult to really grasp concepts. Also, after a basic marketing principles course at the graduate level

11. What are the essential components of a social marketing curriculum for a professional preparation program in health education?			
1	Basic theory and practical applications in diffusion theory, market segmentation, and assessing and matching client (consumer) needs.	**9**	Knowledge of health theories and learning theories, ability to conduct a needs assessment, creativity, communication skills, ability to evaluate effectiveness.
2	1. Introduction to Social Marketing 2. Formative Research Methods in Social Marketing 3. Message Design 4. Strategic Marketing for Non-Profits or Service Marketing 5. Advanced Marketing Research Methods 6. Consumer Behavior 7. Evaluation of Social Marketing Interventions 8. Practicum or Special Project or Field Study 9. Marketing Management 10. Integrated Marketing Promotions	**10**	Review of best practices Getting to root causes in order to identify a clear message. Multi-step evaluation throughout the three phases
3	See # 7 above	**11**	At the very least an introductory course covering the principles (product, price, place, promotion, politics), concepts (exchange, competition) and steps (formative research, market testing, evaluation) of social marketing should be required. It would be best if the class were experiential learning.
4	I feel that most current instruction in social marketing focuses on message development, advertising, communications, education. These are components of marketing, but don't capture the essence of marketing. If we are to call ourselves marketers, we need to build on the large base of marketing thought that has evolved from economics, psychology, sociology, anthropology and other fields over the past 100 years. We need to teach marketing so that messages become a small part of the course work and not the central focus.	**12**	Most of my comments are in 7,
5	Concepts and techniques paired with on-going practicum that would last for two semesters. Process and program evaluation. Quantitative research methods. Theories of social and population health change.	**13**	Role of marketing in stimulating social change in general. Use of marketing in affecting individual behavior. Techniques and strategies of marketing research applied to health behavior.

11. What are the essential components of a social marketing curriculum for a professional preparation program in health education?			
6	I'm not really sure. As mentioned in my biography, I have very limited understanding of social marketing.	**14**	Historical development of SM, current philosophical perspective, practical framework and contested issues among SM professionals; comparison and contrast of SM with other models; examples of SM campaigns, applications and critiques; formative research-theory and skills development, channel analysis, segmentation skills, message design – theory and applications, real world constraints (cost, time, etc.) and ethical considerations.
7	What social marketing is, the principles, the theory behind it, and what a consumer orientation is. How social marketers look at the world. Then, all the steps in the social marketing process – describe the problem, identify audiences, do formative research, develop strategies to address all the 4P's (not just the promotion one) and pretest, implement, monitor and evaluate. Most of these are covered in the major social marketing texts, or in the CDCynergy for Social Marketing that has just been announced on the social marketing listserv.	**15**	Stressing the similarities between commercial marketing strategies and social marketing strategies. Understanding the unique differences, such as public policy decisions, population base, associated public costs, and how organizations can work together to get things done.
8	*Theory *Principles *Campaign Planning Model. Students should develop a draft campaign	**16**	D/K
		17	No Answer

APPENDIX E

Round Two Questions and Responses

Responses to Round Two Questions

Questions from Round One color coding:

1	2	3	4	5	6	7	8	9	10	11

Consensus color coding:

AGREED	AGREED w/mid point	DISAGREED	UNDETERMINED

The figures in the boxes below are the response percentages for each choice

	Question	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
1	I have a good "basic" knowledge of social marketing principles and concepts	0%	0%	13%	19%	68%
2	I have experience implementing social marketing campaigns	13	6	6	25	50
3	I have never used social marketing	88	6	0	6	0
4	I have a very minimal knowledge of social marketing	81	6	13	0	0
5	I consider my knowledge of social marketing to be "high"	6	19	13	19	43
6	I teach social marketing in undergraduate courses	62	13	0	6	19
7	I teach social marketing in graduate courses	25	37	13	0	19
8	I teach social marketing in workshops or seminars	25	6	13	6	50
9	My knowledge of social marketing comes solely from "self study"	32	0	31	31	6
10	I am extensively published in social marketing	37	13	18	13	19
11	I participate in social marketing conferences	19	19	6	6	50
12	Most of my knowledge in social marketing is theory	32	31	31	0	6
13	I need more social marketing evaluation skills	6	37	25	19	13
14	I consider my colleagues knowledge of social marketing to be 'weak'	6	19	37	19	19
15	My colleagues do not understand the differences between commercial marketing and social marketing	19	6	25	37	13
16	My colleagues' knowledge of social marketing is varied from very little to being able to speak intelligently on the subject	0	19	19	31	31
17	Many of my colleagues only focus on the "communication" aspects of social marketing	6	0	44	6	44
18	My colleagues who teach social marketing are very knowledgeable on the subject	6	13	13	43	25

	Question	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
19	Most of my colleagues understand the basics of social marketing	13	37	38	6	6
20	My colleagues do not have the knowledge or ability for the application of social marketing	0	50	38	6	6
21	My colleagues think of social marketing as "advertising"	19	13	37	31	0
22	I have a greater knowledge of social marketing than my colleagues	0	6	19	44	31
23	My colleagues are keenly aware of the need for social marketing for successful implementation of interventions	7	29	29	21	14
24	My colleagues have an excellent understanding of the principles and application of social marketing	19	25	25	31	0
25	I am very confident about my knowledge of social marketing compared to my colleagues'	6	6	19	25	44
26	I did not receive any instruction in social marketing in my professional preparation curriculum	19	13	0	13	55
27	I learned social marketing "on the job"	0	6	13	56	25
28	I received instruction in commercial marketing	27	7	7	39	20
29	I did not receive any instruction in social marketing in my continuing education/professional development	24	25	13	13	25
30	I have learned a great deal about social marketing in my continuing education/professional development	13	24	25	19	19
31	I learned much about social marketing from attending conferences/seminars/workshops	19	6	6	44	25
32	I have learned much about social marketing from reading articles	0	0	19	38	43
33	I learned social marketing in a graduate program	82	6	0	6	6
34	Training in social marketing is limited	6	25	19	19	31
35	I am "self-taught" in social marketing	13	0	37	31	19
36	Continuing education in social marketing at the mid to advanced levels is limited	6	6	25	32	31
37	Social marketing provides an effective approach for program planning/development when used appropriately	0	0	13	19	68
38	Social marketing can increase awareness (of health issues)	0	6	6	19	69
39	Social marketing is an effective method of health promotion useful for opposing the "competition's message	0	0	6	25	69

	Question	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
40	Social marketing teaches the health educator how to segment the audience and tailor the intervention to a specific population	0	0	25	13	62
41	Social marketing offers insights into commercial marketing which promotes unhealthy behaviors	0	0	25	25	50
42	Social marketing teaches the health educator to separate his/her perspective from the consumers	0	0	6	31	63
43	Social marketing will provide the health educator with skills and tools useful for influencing voluntary behavior change	0	0	19	13	68
44	Social marketing provides the health educator with more tools for effective interventions	0	0	13	13	74
45	Social marketing provides a systematic approach to problem analysis and program development	0	0	13	31	56
46	Health educators will be expected to know social marketing	0	19	19	37	25
47	Social marketing is a good fit with other health behavior theories	6	0	25	38	31
48	Social marketing teaches effective and cost efficient communication	0	14	14	36	36
49	Social marketing should be taught as a "stand alone" course	13	25	6	13	43
50	Social marketing should be taught within other courses in health education	13	6	25	19	37
51	Social marketing should be taught early (as in immediately) in a graduate health education curriculum	0	0	31	44	25
52	Social marketing should be taught in conjunction with health education behavior change models	0	34	33	20	13
53	Social marketing should be taught as part of a course in program planning (design, implementation, evaluation)	0	19	19	43	19
54	Social marketing should be part of a course in foundations and methodology	6	49	19	13	13
55	Social marketing should be offered as an elective or support course	24	25	25	13	13

	The most important instructional needs in social marketing for health education professionals are the following:	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
56	Basic theory and principles of marketing (social marketing)	0	0	13	38	49
57	Practical applications, instruction in social marketing should include "hands-on" experience	0	0	0	44	56
58	Diffusion theory	0	25	43	19	13
59	Market segmentation	0	0	6	13	81
60	Designing, implementing, & evaluating social marketing programs	0	0	13	25	62
61	Formative research methods of social marketing	0	6	6	31	57
62	Developing a marketing plan	0	0	6	38	56
63	Less emphasis on message development, advertising, & communication	6	25	31	19	19
64	Understanding the differences between social marketing and health promotion/communication	6	6	31	13	44
65	Instruction in social marketing should be more than just one course	0	19	6	25	50
66	Case studies of applied examples in a variety of settings	0	0	13	38	49
67	Understanding of the impact (benefits) of using social marketing on intervention outcomes	0	6	31	38	25

		The knowledge/skills listed below are necessary for (1) designing, (2) implementing and (3) evaluating social marketing programs. In general the skills apply to all three areas but may be more specific to one particular area as indicated by the numbers on the left.	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
68	1	Basic theory of social marketing	0	6	13	31	50
69	1	Diffusion theory	6	19	43	13	19
70	1	Exchange theory	6	13	31	13	37
71	1	Health behavior theories	0	13	37	19	31
72	1	Behavior change theory	6	6	25	32	31
73	1,2	Practical applications	0	6	19	44	31
74	1	Audience/market segmentation and profiling	6	0	13	38	43
75	1,2	Formative research methods (qualitative & quantitative, conceptualizing what data is needed, instrument construction, interviewing, etc.)	0	13	13	19	55
76	1	Problem definition	0	6	25	38	31
77	1	Needs assessment	6	6	19	38	31
78	1	Understanding competition	6	6	38	6	44
79	1	Strategy development (appropriate use of data collected)	6	6	25	13	50
80	1	Message design	13	6	19	25	37
81	3	Monitoring behavioral outcomes	0	19	13	31	37
82	1,2	Developing communication channels	0	6	13	25	56
83	1	Program design (4 Ps, objectives, goals)	6	6	0	25	63
84	3	Program evaluation	6	0	13	25	56
85	1,2	Cultural awareness/sensitivity	0	6	25	44	25
86	1,2 3	Interpersonal skills (communication, working with others and contractors)	0	13	31	25	31
87	1,2	Finance/budgeting	6	0	25	50	19
88	1,2 3	Developing a consumer orientation	0	6	13	25	56
89	2	Recruiting corporate support	13	24	25	19	19
90	3	Understanding process, outcome, & impact measures and how they differ	0	19	13	49	19
91	2	Effective facilitator skills	6	13	37	25	19

		The knowledge/skills listed below are necessary for (1) designing, (2) implementing and (3) evaluating social marketing programs. In general the skills apply to all three areas but may be more specific to one particular area as indicated by the numbers on the left.	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
92	3	Report writing, summation of analysis	0	13	19	37	31
93	3	Interpreting data (qualitative and quantitative)	6	13	25	13	43
94	1,2	Art and layout, graphic design skills	19	25	31	19	6
95	1,2	Distribution planning	0	20	20	47	13
96	2,3	Intercept interviewing	0	19	50	25	6
97	1,2 3	Public relations	0	13	37	25	25
98	1	Administrative planning	0	19	19	49	13
99	1	Understanding consumer behavior	6	6	13	44	31
100	1,2 3	Oral and written communication	0	6	6	50	38

	The essential components of a social marketing curriculum for a professional preparation program in health education should include the following:	1. disagree	2. somewhat disagree	3. somewhat agree	4. agree	5. strongly agree
101	Social marketing theory	0	0	0	31	69
102	Exchange theory	0	6	19	13	62
103	Diffusion theory	0	19	25	31	25
104	Health behavior theories	0	6	25	31	38
105	Theories of social and population health change	0	6	38	31	25
106	Practical applications (practicum/special project/field study)	0	0	0	25	75
107	Case studies/review of best practices	0	0	0	44	56
108	Principles/intro to social marketing	0	0	7	20	73
109	Social marketing concepts	0	0	6	19	75
110	Consumer orientation	0	0	6	19	75
111	Contested issues/ethics	0	0	31	31	38
112	History of social marketing	0	31	25	31	13
113	Integration with organizations/agencies	0	23	47	15	15
114	Comparisons (other methods/models/commercial marketing)	0	6	37	38	19
115	Formative research methods of social marketing	0	6	0	38	56
116	Advanced marketing research methods	0	31	13	25	31
117	Consumer behavior	0	13	13	31	43
118	Steps in the social marketing process	0	0	13	31	56
119	Program (campaign) planning (development), implementation, and evaluation	0	0	6	25	69
120	Market segmentation	0	0	0	19	81
121	Needs assessment	0	6	25	44	25
122	Integrated marketing promotions	0	6	25	44	25
123	Process and program evaluation	0	6	13	56	25
124	Message development/advertising/communications	0	6	13	43	38
125	Channel analysis	0	0	19	31	50
126	Strategic marketing for non-profits or service marketing	0	0	21	50	29
127	Monitoring interventions	0	6	25	44	25

APPENDIX F

Round Three Questions and Responses

Round Three Questions and Results

Q#	Question	1. Strongly disagree	2. Disagree	3. Somewhat disagree	4. Neither agree nor disagree	5. Somewhat agree	6. Agree	7. Strongly agree
10	I am extensively published in social marketing	43	13	6	0	13	6	19
13	I need more social marketing evaluation skills	0	19	0	13	37	25	6
19	Most of my colleagues understand the basics of social marketing	6	25	31	0	25	13	0
20	My colleagues do not have the knowledge or ability for the application of social marketing	0	27	33	0	27	13	0
24	My colleagues have an excellent understanding of the principles and application of social marketing	13	13	31	6	31	6	0
29	I did not receive any instruction in social marketing in my continuing education/professional development	6	19	19	0	6	31	19
54	Social marketing should be part of a course in foundations and methodology	0	0	19	13	6	43	19
55	Social marketing should be offered as an elective or support course	0	19	19	6	6	25	25

Q#	Please rank the following instructional needs in social marketing for health education professionals from 1 to 12 with 1 being the most important and 12 being the least important.	Rank	Percent
56	Basic theory and principles of marketing (social marketing)	1	75
57	Practical applications, instruction in social marketing should include "hands-on" experience	6	19
58	Diffusion theory	12	31
59	Market segmentation	3	31
60	Designing, implementing, & evaluating social marketing programs	2	31
61	Formative research methods of social marketing	5	25
62	Developing a marketing plan	4	31
63	Less emphasis on message development, advertising, & communication	11	31
64	Understanding the differences between social marketing and health promotion/communication	7	19
65	Instruction in social marketing should be more than just one course	10	25
66	Case studies of applies examples in a variety of settings	8	19
67	Understanding of the impact (benefits) of using social marketing on intervention outcomes	9	31

Q#	Please place the following knowledge/skills necessary for designing, implementing, and evaluating social marketing programs into the three categories to the right by checking the appropriate box(es). You may choose to place an item into one or more categories. If you believe the item is not necessary for any of the three areas listed please check "not required."	1. Designing	2. Implementing	3. Evaluating	4. Not Required
68	Basic theory of social marketing	100	56	56	0
69	Diffusion theory	88	56	63	6
70	Exchange theory	88	44	44	6
71	Health behavior theories	100	44	56	0
72	Behavior change theory	94	44	56	6
73	Practical applications	69	75	63	6
74	Audience/market segmentation and profiling	94	56	63	0
75	Formative research methods (qualitative & quantitative)	81	25	50	6
76	Problem definition	94	25	19	6
77	Needs assessment	88	13	19	13
78	Understanding competition	100	50	44	0
79	Strategy development (appropriate use of data collected)	63	63	38	0
80	Message design	81	69	31	0
81	Monitoring behavioral outcomes	38	44	94	6
82	Developing communication channels	75	100	44	38
83	Program design (4 Ps, objectives, goals)	88	44	31	6
84	Program evaluation	44	44	94	6
85	Cultural awareness/sensitivity	88	88	50	0
86	Interpersonal skills (communication, working with others and contractors)	50	88	38	6
87	Finance/budgeting	88	63	50	6
88	Developing a consumer orientation	94	56	25	6
89	Recruiting corporate support	56	44	13	31
90	Understanding process, outcome, & impact measures and how they differ	56	38	88	6
91	Effective facilitator skills	31	75	19	25
92	Report writing, summation of analysis	38	19	81	13
93	Interpreting data (qualitative and quantitative)	44	19	94	6
94	Art and layout, graphic design skills	25	50	19	38
95	Distribution planning	63	44	6	19
96	Intercept interviewing	56	31	31	25
97	Public relations	44	56	13	38
98	Administrative planning	69	50	38	25
99	Understanding consumer behavior	100	38	38	0
100	Oral and written communication	81	75	75	6

Q#	Please place the following essential components of a social marketing curriculum for a professional preparation program in health education into the appropriate teaching/learning module(s). You may place an item into one or more modules. If you believe that an item is absolutely not essential please check the box labeled "not essential."	1. theory	2. principles	3. research	4. planning	5. implemen-tation	6. evaluation	7. not essential
101	Social marketing theory	88	56	38	44	31	38	0
102	Exchange theory	94	44	38	31	19	13	6
103	Diffusion theory	88	38	38	38	19	13	13
104	Health behavior theories	100	44	38	38	19	19	0
105	Theories of social and population health change	100	38	31	31	19	13	0
106	Practical applications (practicum/special project/field study)	13	31	38	63	75	50	0
107	Case studies/review of best practices	25	50	50	75	50	50	0
108	Principles/intro to social marketing	56	69	25	38	25	13	0
109	Social marketing concepts	44	56	25	38	19	13	0
110	Consumer orientation	44	56	19	38	19	19	0
111	Contested issues/ethics	44	63	19	38	19	6	0
112	History of social marketing	44	50	6	13	13	6	13
113	Integration with organizations/agencies	25	38	13	50	44	13	19
114	Comparisons (other methods/models/commercial marketing)	56	56	31	19	19	25	6
115	Formative research methods of social marketing	25	25	88	31	19	25	6
116	Advanced marketing research methods	13	13	75	25	13	31	19
117	Consumer behavior	69	50	50	38	25	13	0
118	Steps in the social marketing process	50	56	31	56	56	31	0
119	Program (campaign) planning (development), implementation, and evaluation	25	31	50	81	63	50	0
120	Market segmentation	44	44	50	75	31	25	0
121	Needs assessment	31	31	63	75	25	31	0
122	Integrated marketing promotions	31	31	25	56	69	13	0
123	Process and program evaluation	25	25	25	19	44	81	0
124	Message development/advertising/communications	25	31	19	81	63	13	6
125	Channel analysis	19	19	13	63	31	13	13
126	Strategic marketing for non-profits or service marketing	38	44	25	44	25	19	25
127	Monitoring interventions	19	19	25	44	56	75	0