

Health Communication and Social Marketing: Health Communication Campaigns That Include Mass Media and Health-Related Product Distribution

Task Force Finding and Rationale Statement

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Task Force Finding and Rationale Statement

Conceptual Basis

Health communication campaigns apply integrated strategies to deliver messages designed, directly or indirectly, to influence health behaviors of target audiences. Messages are communicated through various channels that can be categorized as mass media (e.g., television, radio, billboards); small media (e.g., brochures, posters); social media (e.g., Facebook®, Twitter®, web logs); or interpersonal communication (e.g., one-on-one or group education). Drawing on concepts from social marketing, a health communication campaign can be combined with other activities such as distribution of products to further influence health behaviors. The current review was devised to evaluate the effectiveness of the combination of health communication campaigns that meet specific criteria with the distribution of health-related products that also meet specific criteria.

Intervention Definition

This review evaluates the effectiveness of interventions that combine two components to increase the appropriate, repeated use of evidence-based, health-related products:

1. A health communication campaign that uses messages to increase awareness of, demand for, and appropriate use of the product. The messages must be delivered through multiple channels, one of which must be mass media, to provide multiple opportunities for exposure; and
2. Distribution of a health-related product, free of charge or at a reduced price (e.g., discount coupons), to reduce cost, access, and convenience-related barriers among targeted users.

Health-related products eligible for this review:

- Have been shown through an evidence-based process¹ to improve health-related outcomes (e.g., increased physical activity; smoking cessation; reductions in disease, injury, or death)
- Are tangible
- Are not a service (e.g., mammogram)
- Are not exclusively available through prescription or administration by a health professional (e.g., vaccination or prescribed medication)
- Require repeated use for desired health promotion and/or disease and injury prevention effects (e.g., using condoms, wearing helmets) rather than a one-time behavior (e.g., installing smoke alarms)
- Cannot be a specific food product (e.g., oatmeal) marketed as being “healthful”

Task Force Finding (December 2010)

Based on strong evidence of effectiveness for producing intended behavior changes, the Community Preventive Services Task Force recommends health communication campaigns that use multiple channels, one of which must be mass media, combined with the distribution of free or reduced-price health-related products (defined above).

The specific behaviors promoted in the included studies were the use of products that:

- Facilitate adoption and/or maintenance of health-promoting behaviors (i.e., increased physical activity through pedometer distribution combined with walking campaigns).
- Facilitate and/or help to sustain cessation of harmful behaviors (i.e., smoking cessation through free or reduced cost over-the-counter nicotine replacement therapy [OTC NRT]).

- Protect against behavior-related disease or injury (i.e., condoms, child safety seats, recreational safety helmets, sun-protection products).

Because results were positive across all of the six behaviors evaluated, these findings are likely to apply to a broader range of health-related products that meet the review's product eligibility criteria in the intervention definition. The effectiveness of interventions promoting the use of health-related products other than those distributed in the reviewed studies should be assessed to ensure applicability.

The systematic review focused only on interventions that included a mass media component; therefore, this recommendation is specific to such interventions. The results may or may not apply to campaigns that do not include a mass media component, which were outside of the scope of the review.

Rationale

This review (search period 1980 – 2009) included 25 study arms from 22 studies. Twenty study arms found that the intervention was associated with a median increase of 8.4 percentage points (interquartile interval [IQI]: 2.7 to 14.5 percentage points [pct pts]) in the proportion of people engaging in a healthful behavior related to use of the product distributed. Similar results were found for 5 studies with results that could not be expressed as percentage point changes. The studies reviewed also provided some evidence that combining product distribution with a health communication campaign results in greater behavior change than using a health communication campaign alone.

The goal of this review was to evaluate the effectiveness of an intervention process—the combination of a health communication campaign, including mass media, with health-related product distribution—for promoting the desired behavior change in the target audience. To serve this goal, eligibility criteria were developed to define a set of health-related products that, although unique, shared enough common characteristics to allow generalizability of the review's results to products with those common characteristics. Thus, the findings of this review may not generalize to health communication and distribution campaigns for products that do not meet these eligibility criteria (e.g., intangible services, products that require one-time use or installation to promote or protect health/prevent injury). This does not imply that such interventions are ineffective, but simply that their effects cannot be assessed based on the studies evaluated in this review.

Of the health-related products that met the inclusion criteria, 6 were represented in this review (i.e., child safety seats, condoms, pedometers, recreational safety helmets, OCT NRT, and sun-protection products). Several other eligible products were not represented (e.g., insect repellent, oral health products, and wrist and elbow pads) for a variety of reasons. These include: an eligible product may not have been identified for a literature search, no interventions distributing the product were found, the effectiveness of eligible interventions was not studied, or the studies did not assess the intervention effects on outcomes of interest. The most commonly evaluated interventions in the included studies were those that promoted the use of recreational safety helmets (10 study arms) and condoms (6 studies). Although the magnitude of intervention effects varied, favorable results were found for interventions promoting all of the evaluated products, with median effect estimates ranging from an increase of 4.0 pct pts for condom use (4 studies) to 10.0 pct pts for OCT NRT (3 studies). Overall, results were consistently favorable across products with various characteristics (e.g., reusable versus single-use products; inherently protective products versus those that facilitate behavior change; those that promote the adoption of healthful new behaviors and the cessation of risky behaviors) and across a wide range of baseline usage rates (median baseline usage rate of 9.7 pct pts [IQI: 5.1 to 18.2]). These results suggest that combining mass media health communication campaigns with distribution of any of a variety of health-

related products that meet the inclusion criteria specified above is likely to be effective in influencing the intended health behaviors.

The included communication campaigns disseminated their product-use messages through several different channels, which always included mass media (e.g., television, radio) and nearly always included small media (e.g., brochures, posters), over periods of time that ranged from one week to 36 months. Messages also were commonly disseminated via interpersonal communication (e.g., peer outreach, hotline numbers), community events (e.g., health fairs, festivals), and occasionally through social media (e.g., through social networking websites such as Facebook®). Some campaigns were accompanied by other activities such as provision of services (e.g., HIV testing, quitline counseling) or environmental changes (e.g., building walking trails). Results demonstrated effectiveness regardless of the number of distinct channel categories that disseminated the product-use message (e.g., mass media, small media, interpersonal communication).

A limited amount of information was available on several other potentially important aspects of the interventions, such as the intensity of the health communication campaigns (e.g., measures of audience reach and exposure to mass media campaigns) or the degree to which formative research or other social marketing practices were used to develop the communication campaign and product distribution strategies. The available evidence suggests that interventions using some application of social marketing principles had somewhat better results than those for which no such application was evident (median change of 9.6 versus 6.8 pct pts). Favorable results were found for interventions that included distribution of free products (median change of 5.6 pct pts) or discounted products (median change of 8.2 pct pts), with product prices ranging from \$11 to \$35. Results were also generally consistent across interventions with different distribution sites (e.g., community organizations, retail stores).

Data to evaluate differential effects of interventions across demographic groups also were limited, with particularly poor reporting on to the socioeconomic status of the target audiences. The reviewed studies evaluated the effectiveness of campaigns in a wide range of urban, rural, and suburban settings and in the U.S., Canada, Australia, Israel, and Belgium. The majority of the included campaigns were designed for specific audiences (e.g., children, African-American women, Latino men, and people at risk for HIV or AIDS). Across all campaigns, a wide variety of people were reached including males and females, children and adults, and people from different racial and ethnic groups. Favorable results were found for both community-wide interventions and those targeted to specific demographic groups. These findings suggest that if campaigns and products are appropriately selected and targeted, they should be generally applicable across demographic groups.

No significant harms related to the included campaigns were found, which may reflect, in part, their messaging about appropriate product use. Many campaigns had additional benefits, such as increasing other health behaviors and positively affecting populations not originally targeted by the campaign. The campaigns were often large and complex; as a result, some authors reported barriers to implementation of the intervention such as lack of community buy-in and the failure of partners to meet their commitments (e.g., retailers charging for products that were intended to be free).

Only two campaigns disseminated their messages using Internet or social media channels. Given today's rapidly changing media environment, the Internet and social media are gaining prominence in health promotion due to their strong potential for conveying targeted messages in a cost-effective manner. The availability of these options has the potential to make health communication campaigns with product distribution feasible for many organizations that

would have difficulty funding an intervention centered on traditional mass media channels. The assessment of effectiveness of product promotion and distribution interventions that use social media as a primary communication channel will be an important area for future research.

Finally, the lack of details about campaign design and execution in the published research studies limits the utility of the studies in two ways. Without the details, research synthesis methods can only answer a small number of questions about the effectiveness of the interventions. Other questions about the most effective ways to implement the interventions cannot be answered without more information about the campaign itself. The lack of these details also hinders the ability of others interested in implementing similar interventions to use them as a starting point for developing their own implementation strategies. At a minimum, authors should report on whether and how they applied social marketing benchmark criteria (i.e., consumer orientation, behavioral objectives, theory, insight, exchange, competition, segmentation, marketing mix), what formative research methods were used, decisions on targeting, and key details of the communication campaign (e.g., primary messages, number of channel repetitions, exposure to the messages, scheduling effects, impression data). Reporting available information on the cost of the intervention would also be useful for improving the ability to assess the cost effectiveness of combining product distribution with health communication campaigns.

¹ To be considered evidence-based, the product had to be shown to improve health or health behaviors in a peer-reviewed systematic review or in multiple rigorous studies.

Publications

Robinson MN, Tansil KA, Elder RW, Soler RE, Labre MP, Mercer SL, Eroglu D, Baur C, Lyon-Daniel K, Fridinger F, Sokler LA, Green LW, Miller T, Dearing JW, Evans WD, Snyder LB, Viswanath KK, Beistle DM, Chervin DD, Bernhardt JM, Rimer BK, and the Community Preventive Services Task Force. Mass media health communication campaigns combined with health-related product distribution: a Community Guide systematic review. *Am J Prev Med* 2014;47(3):360-71.

Jacob V, Chattopadhyay SK, Elder RW, Robinson MN, Tansil KA, Soler RE, Labre MP, Mercer SL, and the Community Preventive Services Task Force. Economics of mass media health campaigns with health-related product distribution: a Community Guide systematic review. *Am J Prev Med* 2014;47(3): 348-59.

Community Preventive Services Task Force. Combination of mass media health campaigns and health-related product distribution is recommended to improve healthy behaviors. *Am J Prev Med* 2014;47(3):372-4.

Disclaimer

The findings and conclusions on this page are those of the Community Preventive Services Task Force and do not necessarily represent those of CDC. Task Force evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information and options for decision makers and stakeholders to consider when determining which programs, services, and policies best meet the needs, preferences, available resources, and constraints of their constituents.

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