PUBLIC HEALTH MANAGERS' PERSPECTIVES ON THE USE OF SOCIAL MARKETING AMONG PUBLIC HEALTH NURSES IN SASKATCHEWAN

KRISTIN KNIBBS

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PUBLIC HEALTH MANAGERS' PERSPECTIVES ON THE USE OF SOCIAL MARKETING AMONG PUBLIC HEALTH NURSES IN SASKATCHEWAN

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Kristin Knibbs

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ABSTRACT

Social marketing is a branch of health communication that has, over the last thirty years, become widely accepted in public health practice. By definition, "social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon behavior for the benefit of individuals, groups, or society as a whole" (Kotler, Roberto, & Lee, 2002, p. 5). Because social marketing is consumer focused and client centered, it is consistent with the accepted paradigm of health promotion in public health nursing. In Canada, population focused health promotion strategies, such as social marketing, are an integral part of the mandate of public health nurses (PHNs) (Community Health Nurses Association of Canada, 2003). Despite this mandate, a review of recent literature points to a misunderstanding and under-use of the strategy (McDermott, 2000; Quinn, Albrecht, Marshall, & Akintobi, 2005; Schoenfeld & MacDonald, 2002). Using a qualitative approach, the author of this study examined the use of social marketing among public health nurses from the perspective of public health managers in the province of Saskatchewan. Community based action research approach was used to identify enablers, barriers and strategies associated with social marketing use. In addition, a quantitative participant demographics questionnaire was employed to aid in the analysis of qualitative data. Two health regions were chosen for data collection sites as convenience samples in this study. Within these health regions, complete population sampling was employed. The total population group comprised of 19 public health managers. Of these, 12 directly managed, and 7 indirectly managed public health nurses. The total number of study participants was 11 of 12 direct

managers, representing 92% of that population.

Within focus group sessions, enablers and barriers to the use of social marketing were identified using nominal group process. Enablers included: BSN preparation, client centered and evidence-based practice, established community relationships, nature of health challenges, and support of nursing organizations. Barriers included: human resources, financial resources, familiarity with the strategy, and formal process to maintain momentum. Strategies for reinforcing enablers and overcoming barriers were also identified in group discussion. These included: a social marketing elective in health science, an increase in the number of PHNs and support staff, core funding for social marketing, in-service training, and a social marketing consultant. Ultimately, an increase in the awareness of social marketing among upper-level health management was identified as a necessary precursor to the successful implementation of all the identified strategies. Finally, the potential applicability of two theoretical models in explaining and/or predicting the influence of factors on public health nurses' use of social marketing in Saskatchewan was explored. The Diffusion of Innovation Model was proposed as a framework through which to examine the factors associated with social marketing use because of its inclusion of both individual and system level influences. It was determined that the Health Promotion Model was not the most appropriate model for this purpose, as it primarily focused on individual influences on behavior. This focus was inconsistent with the system level nature of factors identified by participants. It is the hope of the researcher that an understanding of the factors associated with social marketing use

among PHNs may facilitate its diffusion throughout public health in Saskatchewan. The resulting increase in social marketing campaigns could have significant potential for the promotion of health in this province.

This work is dedicated to my loving husband, Rob.
Your support and encouragement throughout this process
has meant more to me than you will ever know.

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CHAPTER ONE – INTRODUCTION

1.1 Background of Research Problem

Over the past three decades, health communication has become an integral strategy in public health practice. By definition, health communication is the development and delivery of media messages aimed at informing and influencing decisions that enhance health (Nelson, Brownson, Remington, & Parvanta, 2002). "When used appropriately, health communication can influence attitudes, perceptions, awareness, knowledge, and social norms, which all act as precursors to behavior change" (Barnes , Neiger, Lindsay, Thackeray, & Hill, 2001, p. 345). In addition, research on population health confirms that public health initiatives, such as health communication, have the potential to afford greater positive influence on the future health of Canadians than do improvements to the acute care system alone (Canadian Public Health Association, 1997).

Social marketing is one branch of health communication that has, over the last thirty years, become widely accepted in public health practice. The introduction of social marketing to academic literature occurred in 1971. Kotler and Zaltman bridged the gap between the traditional fields of consumer marketing and that of social change, defining

social marketing as " . . . the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving consideration of product planning, pricing, communication, distribution, and marketing research" (1971, p. 5). Throughout the 1980's several articles were written establishing social marketing as a discipline unto its own, with the first text book dedicated to the field published in 1989 by Kotler and Roberto. Since that time, Andreasen (1995, 2002, 2003) also made significant attempts to further the field of social marketing. By 1990, several academic programs had been established in the United States and abroad, and in 1994 *Social Marketing Quarterly*, a publication devoted to the discipline, was launched and continues to be published today (Kotler, Roberto, & Lee, 2002). By the end of the decade, The Social Marketing Institute was formed in Washington, DC. It currently hosts multiple conferences and seminars annually. Over the years, as the discipline has grown and matured, the definition of social marketing has also evolved. It is now commonly understood that social marketing is not about changing ideas, but about changing behavior (Andreasen, 2003). Today, one of the most widely accepted definitions of social marketing is as follows: "social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole" (Kotler et al., p. 5).

Social marketing was first implemented as a health promotion strategy in India by advocates of family planning (Andreasen, 2003). Since that time, documentation of successful attempts to positively influence behavior relating to a variety of health challenges has steadily increased. In the last three decades, many authors have published

articles on its use in a multitude of health promotion programs. Areas of influence have included, but are not limited to: sexual assault (Boehm & Itzhaky, 2004; Konradi & DeBruin, 2003), smoking (Carver, Reinert, Range, & Campbell, 2003; Hersey, Niederdeppe, Evans, Nonnemaker, Blahut, Holden, Messeri, & Lyndon Haviland, 2005; Klein, Graff Havens, & Carlson, 2005; Lowry, Hardy, Jordan, & Wayman, 2004; McAlister, Morrison, Hu, Meshack, Ramirez, Gallion, Rabius, & Huang, 2004; Straub, Hills, Thompson, & Moscicki, 2003; Tamir, Polachek, Zivlin, Amikam & Weinstein, 2001), alcohol and drug use (Blantari, Asiamah, Appiah, & Mock, 2005; Campbell, Fisher, Picciano, Orlando, Stephens, & Roffman, 2004; Clapp, Johnson, Voas, Lange, Shilington, & Russell, 2005; Glider, Midyett, Mills-Novoa, Johannessen, & Collins, 2001; Griffin & O'Cass, 2004; Hastings, Stead, & MacKintosh, 2002; Jack, Sangster Bouck, Beynon, Ciliska, & Lewis, 2005; Surkan, Dejong, Herr-Zaya, Rodriguez-Howard, & Fay, 2003; Yap, Wu, Liu, Ming, & Liang, 2002), breast health (Brown, Bryant, Forthofer, Perrin, Quinn, Wolper, & Lindenberger, 2000; Bryant, Forthofer, McCormack-Brown, Alfonso, & Quinn, 2000; Cohen, Dobson, & McGuire, 2000), breastfeeding (Brown, Poag, & Kasprzycki, 2001; Hughes, 1999; Lindenberger & Bryant, 2000), nutrition (Bryant, Lindenberger, Brown, Kent, Schreiber, Bustillo, & Walker Canright, 2001; Dutta-Bergman, 2003; Foerster, Gregson, Lane Beall, Hudes, Magnuson, Livingston, Davis, Block Joy, & Garbolino, 1998; Francis, Taylor & Williams Strickland, 2004; Morarjl Dharod, Perez-Escamilla, Bermudez-Millan, Segura-Perez, & Damio, 2004; Oglethorpe, 1995; Paxton, Wertheim, Pilawski, Durkin, & Holt, 2002; Warnick, Dearden, Slater, Butron, Lanata, & Huffman, 2004; Wechsler & Wernick, 1992; Young, Anderson, Beckstrom, Bellows, & Johnson, 2004), physical activity (Bauman, Madill,

Craig, & Salmon, 2004; Black, Blue, Kosmoski, & Coster, 2000; Edwards, 2004; Huhman, Potter, Wong, Banspach, Duke, & Heitzler, 2005; Peterson, Abraham, & Waterfield, 2005), and sexual health (Agha & Van Rossem, 2002; Boulay, Storey & Sood, 2002; Bull, Cohen, Ortiz, & Evans, 2002; Cohen, Farley, Bedimo-Etame, Scribner, Ward, Kendall, & Rice, 1999; Conner, Takahashi, Ortiz, Archuleta, Muniz, & Rodriguez, 2005; Futterman, Peralta, Rudy, Wolfson, Guttmacher, Smith Rogers, & The Project Access Team of the Adolescent Medicine HIV/AIDS Research Network, 2001; Gabler & Kropp, 2000; Hammett, Des Jarlais, Liu, Ngu, Duy Tung, Vu Hoang, Kieu Van, & Donghua, 2003; Hussain & Shaikh, 2005; Jacobs, Kambugu, Whitworth, Ochwo, Pool, Lwanga, Tifft, Lule, & Cutler, 2003; Meekers, 2000; Meekers & Richter, 2005; Mitchell, Tanner, & Raymond, 2004; Montoya, Kent, Rotblatt, McCright, Kerndt, & Klausner, 2005; Newman, Duan, Rudy, & Anton, 2004; Price, 2001; Vega & Roland, 2005; Wackett, 1998).

Social marketing is recognized for the unique perspective and opportunity it presents in health promotion. It ". . . can be distinguished from education approaches that emphasize knowledge as the primary determinant of human behavior and regulatory approaches that use law, sanction, and force to influence behavior" (Smith, 2000, p. 108). The end goal of social marketing is behavior change while encouraging individual freedom of choice. The consumer focused nature of social marketing also makes it highly consistent with the client centered paradigm of community health nursing.

Community health nurses represent a considerable proportion of practicing registered nurses. The Canadian Nurses' Association (2004) reports that in 2003, of the 241,342 registered nurses in Canada, 23,410 (9.7%) practiced in community health.

Saskatchewan statistics for the same year reveal an even stronger commitment to community health nursing. Of the 8,503 registered nurses practicing in Saskatchewan, 1,536 practiced in community health, representing 18.1% of the workforce (Canadian Institute of Health Information, 2004).

According to *The Canadian Community Health Nursing Standards of Practice* published by the Community Health Nurses Association of Canada (CHNAC) in 2003, community health nurses (CHNs) ". . . collaborate with individuals, families, groups, communities and populations in designing and implementing community development activities, health promotion and disease prevention strategies" (p. 1). The Community Health Nurses Association of Canada further asserts that a CHN "understands and uses social marketing . . . strategies to raise consciousness of health issues, place issues on the public agenda, shift social norms, and change behaviors if other enabling factors are present" (CHNAC, p. 11). Public health nurses (PHNs) practice under the umbrella of community health nursing, however, it is their focus on the health of populations that distinguishes their practice. Even though CHNs, such as home health nurses, while working with individuals and families may target many of the same health issues, the population scale on which PHNs work makes them ideal practitioners of social marketing in Saskatchewan (CHNAC). The Community Health Nurses Association of Canada is not the only organization advocating for a population health focus among PHNs. The standards of practice outlined by CHNAC have also been affirmed and endorsed by the Canadian Nurses' Association (Underwood, 2003). However, not all community health nursing academic organizations place the same level of importance on nurses' understanding of the strategy. In publications by the United States based Association of

Community Health Nursing Educators entitled *Essentials of Baccalaureate Nursing Education for Entry Level Community/Public Health Nursing* (2000a), and *Research Priorities for Public Health Nursing* (2000b), the authors made no mention of social marketing.

Though population health initiatives at the community and system levels, including social marketing, are clearly a mandate of PHNs, in a recent American study by Grumbach, Miller, Mertz, and Finocchio (2004), "results indicate that the population health focus of public health nursing is not reflected in the practice activities, management priorities, or educational preparation of public health nurses" (p. 266). They found that public health managers tended to rate intervention with large population sizes as less important than those at the individual and family level. In turn, PHNs were much more likely to intervene with individual clients than they were to target intervention at larger population groups (Grumbach et al.). The practice reality is that ". . . very few staff public health nurses reported frequently performing . . . community level interventions" (Grumbach et al., p. 269). This represents a considerable departure from the recommendation of the Canadian Public Health Association (1990) that the emphasis of PHNs' practice be on broader health promotion strategies at the population level. In 2001, the Canadian Public Health Association recommended that PHNs "make better use of strategies such as social marketing to focus attention on public health issues, using the media to promote awareness . . . and to strengthen people's abilities to positively influence their own health . . ." (p. 9). One year later, Schoenfeld and MacDonald (2002) found that 88.3% of Saskatchewan PHNs reported using appropriate social marketing strategies to encourage healthy lifestyles, but, only 35.6% of these nurses felt well

prepared for this role. It is important to note, however, that a limitation of the study identified by the authors was a lack common understanding of social marketing among participants. For example, some PHNs believed that an individual education session on breastfeeding constituted social marketing (B. Schoenfeld, personal communication, June 14, 2005). This concern is echoed in the non-research literature. McDermott (2000) asserted that social marketing is often poorly understood by even those who profess to practice it, making research findings derived from the sampling of this population potentially misleading.

It is difficult to accurately assess social marketing achievements in Saskatchewan. "Currently there is no mechanism in the system to document the results of strategies of comprehensive population health promotion approaches" (Saskatchewan Health, 2001, p. 5). Despite this, the anticipated need for public health nurses versed in social marketing is unlikely to wane. Societal trends and predicted needs of the heath care system indicate demands will continue to increase for health care professionals who can address the health needs of populations (Fisher Robertson, 2004). This argument is supported by the fact that public health nurses routinely address health concerns such as nutrition, sexual health, and substance abuse, which will be shown in the literature review of this thesis to respond successfully to social marketing programs.

1.2 Statement of Research Problem

There is a significant body of research literature that suggests social marketing is a highly effective health promotion strategy, yet very few social marketing campaigns have been published in Canada, and none in Saskatchewan. In addition, research strongly suggests that social marketing is often misunderstood by both PHNs and public health

managers (McDermott, 2000; Quinn, Albrecht, Marshall, & Akintobi, 2005; Schoenfeld & MacDonald, 2002). As a result, the following research problem was proposed:

When starting with a common knowledge base regarding the basic principles of social marketing, how do public health managers perceive enablers and barriers to the current and future use of social marketing among public health nurses in Saskatchewan? Are there mechanisms by which enablers can be strengthened and barriers overcome? In addition, what is the potential applicability of the Health Promotion Model and the Diffusion of Innovations Model in explaining and/or predicting the use of social marketing among PHNs?

1.3 Research Purpose

The purpose of this study was to explore enablers and barriers to the use of social marketing among public health nurses from the perspectives of public health managers. Strategies for reinforcing enablers and overcoming barriers were examined and the potential applicability of the Health Promotion Model and Diffusion of Innovation Model were explored.

1.4 Research Questions

The general question that guides this research is: From the perspectives of public health managers, what factors affect the use of social marketing within public health nursing in Saskatchewan? More specifically, the following questions were developed as a guide for this study: From the public health managers' perspectives,

1. What are the enablers to the use of social marketing strategies?
2. What are the barriers to the use of social marketing strategies?
3. How can identified enablers be reinforced?

4. How can identified barriers be overcome?
5. What is the potential applicability of the Health Promotion Model in explaining and/or predicting the influence of identified enablers and barriers on the use of social marketing?
6. What is the potential applicability of the Diffusion of Innovations Model in explaining and/or predicting the influence of identified enablers and barriers on the use of social marketing?

1.5 Relevance and Significance of Research

Despite the current and future roles PHNs play in social marketing, prior to this study, no Canadian research study has been undertaken expressly to identify the variables affecting PHNs' use of this health communication strategy. Of the articles reviewed, no studies addressed participants' understanding of social marketing strategies prior to collecting data on its use (Barnes et al., 2001; Chambers, Underwood, Halbert, Woodward, Heale, & Isaacs, 1994; Schoenfeld & MacDonald, 2002). According to McDermott (2000), social marketing is often misunderstood by practitioners, thus, research questioning practitioners regarding their use of the strategy could be misleading. The current study included an educational session on social marketing prior to data collection in order to increase the likelihood that perceptions of participants were based on a similar understanding of the health promotion strategy. The results of this study provide some of the knowledge necessary for evidence based decision making regarding the social marketing role PHNs play both in nursing practice and educational settings. Specifically, the information gathered may raise awareness and understanding of social marketing practices among public health nurses in Saskatchewan. These results have

potential implications for The Nursing Education Program of Saskatchewan and nursing organizations such as The Canadian Association of Schools of Nursing with respect to community health curricula at the baccalaureate level. Organizations such as the Canadian Public Health Association, Community Health Nurses Association of Canada, and Public Health Agency of Canada may find the data gathered helpful in relation to the social marketing role of PHNs. Finally, there exists significant implications for Saskatchewan public health managers in relation to their administrative support of social marketing initiatives and continuing education of practicing public health nurses.

CHAPTER TWO – LITERATURE REVIEW

The purpose of this literature review is to present current publications related to the practice of social marketing. Search engines from four separate fields of study were searched including: nursing (CINHAL & Cochrane Library), medicine (HealthStar & MedLine), psychology/sociology (PsychInfo, Social Science Citation Index, & Sociological Abstracts), and commerce (ABI Inform). Articles were limited to those published in the English language. No limitations were placed on the geographic location of the research or year of publication. In addition to this computer assisted search, a manual search of the following journals was completed for the years 1980-2006 (where available): *Canadian Journal of Public Health, Health Communication, Journal of Community Health Nursing, Journal of Health Communication, Public Health Nursing, Social Marketing Quarterly, and Public Health.* Finally, the reference pages of reviewed articles were searched for other relevant literature. Nine articles were retrieved using this process. All of the articles retrieved were reviewed and limited to those relevant to this thesis topic. Relevant literature is presented under three headings including: , non-research literature addressing social marketing, research articles employing a social marketing operational framework, and research articles addressing social marketing use in public health. In addition, a brief overview of two theoretical models will be presented.

2.1 Non-research Literature Addressing Social Marketing

There exists an abundance of scholarly literature establishing social marketing as a valuable health promotion strategy. Over the past decade, many authorities on social marketing have published articles and books related to the history of the strategy, including its current and future use. These authors have successfully defined the parameters of the field for both practitioners and researchers.

According to Kotler, et al. "social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups or society as a whole" (2002, p.5). It is the expectation of behavior change that is the most challenging aspect of the strategy. Social marketing relies on voluntary compliance rather than more coercive forms of influence, be it legal, economic, or social. As a result, the behavior change sought is often neither immediate nor guaranteed. In order to achieve this end, social marketing empoys traditional marketing principles, formerly reserved for the sale of commercial products. Once a challenge or problem is identified, market research is undertaken to explore the audience, environment, and even the behavior change process itself. This research leads to the identification of the target audience, who exhibit the highest probability of positive behavior change. In order to influence the desired behavior change, the marketing mix is employed, also known as the 4 P's of social marketing (product, price, place and promotion). First, the product, or desired behavior change, is "packaged" in a way most likely to resonate with the target audience. The price of the desired behavior change is then considered. In commercial marketing, price is traditionally synnonomous with monetary currency. In social marketing however, the

price can refer to any expense on the part of the target audience, be it financial, emotional, intellectual or otherwise. The place and promotion of the message refer to the location in which it will be presented and the media channel through which it will be disseminated (Kotler et al.). "The product is positioned to appeal to the desires of the target market to improve their health . . . more effectively than the competing behavior the target audience is currently practicing or considering" (Kotler et al., p.7). An implemented plan is then monitored, evaluated and modified as required.

Though there are certainly differences between the marketing of commercial products and marketing behavior change, there are also many similarities. These fundamental similarities include: a customer orientation, use of exchange theory, use of marketing research, segmentation of audiences, consideration of the 4 P's, and the evaluation of results (Kotler et al., 2002). "The most fundamental principle underlying marketing is to apply a customer orientation to understand what target audiences currently know, believe or do" (Kotler et al., p. 7). This same customer orientation has been employed in a variety of successful social marketing programs tailored to influence behavior change positively influencing health. Published studies in this area are detailed below.

Also noteworthy are a book, *Marketing Social Change* published in 1995, and two subsequent articles published in 2002 and 2003 by Andreasen. The author critically examines the history of social marketing as a discipline and, these works are frequently mentioned in the research literature as seminal works on the subject. Finally, Thackeray and Nieger (2000) were two of the first authors to expressly examine the relationship

between behavior change theory and social marketing theory, a perspective on which several subsequent research articles are based.

2.2 Research Articles Employing a Social Marketing Operational Framework

Over the past three decades, social marketing has been used as an operational framework in a variety of research fields. Many of these studies demonstrated its successful use in the shaping of public behavior to benefit health. Though a limited number of the articles reviewed did not explicitly define social marketing within the context of their study, the majority subscribed to definitions by either Andeasen (1995) or Kotler et al. (2002), both of which are consistent with the operation definition employed in this study. Although most authors provided their definition of social marketing, not all of the authors described their intervention process in adequate detail for its congruence with the accepted social marketing process to be evaluated. As a result, if the authors of the reviewed research articles stated their use of social marketing it was assumed that social marketing processes were in fact employed.

Research articles retrieved on health promotion using social marketing dated back to the early 1990's. However, of the articles retrieved, only 8 were published between the years 1990 and 2000, while 65 were published after the year 2000, and none were published before the year 1990. The geographic location of research was varied, with the majority of research being conducted in the United States and developing countries abroad. Only five published research studies were conducted in Canada. The 72 articles reviewed under this heading can be divided into eight main topics of study including: sexual assault, smoking, alcohol and drug use, breast health, breastfeeding, nutrition, physical activity, and sexual health.

2.2.1 Sexual Assault

Two separate studies employed social marketing to increase the use of reporting and examination services following sexual assault. Boehm and Itzhaky (2004), and Konradi and DeBruin (2003) both reported a reduction in the fear of victims reporting assault, an increased positive community dialogue on the subject, and a rise in the number of reports and victims seeking treatment as a result of exposure to a social marketing campaign.

2.2.2 Smoking

The use of social marketing as a health promotion strategy to reduce smoking rates has furnished mixed results. The majority of studies reported successful evaluation of social marketing campaigns (Carver et al., 2003; Hersey et al., 2005; Klein et al., 2005; Lowry et al., 2004; McAlister et al., 2004; Tamir et al., 2001). However, Straub et al. (2003) questioned the effectiveness of social marketing on adolescents' intentions to smoke. The authors stated that "although anti-tobacco advertising has a protective effect, it was unable to counteract the effects of pro-tobacco advertising in the same cohort" (Staub et al., p. 36).

2.2.3 Alcohol and Drug Use

The results of health promotion programs addressing alcohol and drug use using a social marketing focus have also varied. Surkan et al. (2003) reported the successful use of a social marketing radio campaign on parent-child communication about alcohol use. Glider et al. (2001) studied a population of university students in the United States. Following a three-year long social marketing media campaign aimed at reducing binge drinking, the authors documented a staggering 29.2 % reduction in binge drinking rates

(Glider et al). Clapp et al. (2005) conducted a quasi-experimental study on college aged alcohol consumption. Their findings indicated that the social marketing campaign successfully corrected students' misperceptions of drinking, and significantly reduced the incidence of driving under the influence of alcohol when compared to the control group (Clapp et al.). Griffin and O'Cass (2004) also reported the successful implementation of a social marketing approach to reduce college-age drinking. However, their study pointed specifically to the importance of the advertisement's believability for the intended audience. ". . . Individuals tend to have stronger attitudes against behaviors impacting on their health (e.g., drinking) when they have a high degree of believability in the information contained in the communication (e.g., advertisements)" (Griffin & O'Cass, p.142).

Hastings et al. (2002) were the only authors to report no change in behavior following a social marketing campaign on drug prevention. After a three-year social marketing intervention with 13 to 16 year old children in England aimed at reducing drug use, no measurable reduction in drug use among the target audience was found (Hastings et al.). It is worthy to note that the authors did not define social marketing for the purposes of their study, and it is therefore unclear if a definition consistent with that proposed in this thesis was used.

In addition to the above studies, four other articles outlined health promotion needs with regards to alcohol and drug use, and included recommendations for social marketing campaigns to be initiated (Blantari et al., 2005; Campbell et al., 2004; Jack et al., 2005; Yap et al., 2002).

2.2.4 Breast Health

The successful use of social marketing to promote breast screening in Glasgow was documented by Cohen et al. (2000). The authors reported up to a 13% increase in screening uptake in the geographic areas covered by the social marketing campaign (Cohen et al). The implementation of a second breast cancer screening social marketing program was discussed in two separate articles (Brown et al., 2000; Bryant et al., 2000). At the time of publication, the social marketing process had been used to successfully implement a health promotion campaign, but summative evaluation had not yet been completed.

2.2.5 Breastfeeding

Two separate studies in the United States aimed to increase the social acceptance of breastfeeding in public places through the use of a social marketing intervention. Hughes (1999) found that though the media intervention ". . . had minimal effect on changing attitudes of those who 'disapproved' of breastfeeding, . . . results suggest it did increase awareness of breastfeeding amongst . . . (the) community" (Hughes, p. 110). Brown et al. (2001) implemented a similar social marketing intervention however, at the time of publication no summative evaluation of the study had been completed. Finally, Lindenberger and Bryant (2000) used a social marketing campaign to increase breastfeeding rates among economically disadvantaged families in the United States. As with the previous study, at the time of publication no summative evaluation had been completed.

2.2.6 Nutrition

Several authors documented the successful use of social marketing strategy on a variety of nutrition related health concerns including: low-fat milk consumption (Wechsler & Wernick, 1992), nutrition program attendance (Bryant et al., 2001), multivitamin use (Warnick et al., 2004), food safety (Morarjl Dharod et al., 2004), fruit and vegetable consumption (Foerster et al., 1998), and dieting prevention (Paxton et al., 2002). All authors presented data demonstrating a measurable change in behavior in their target audience following the implementation of a social marketing program.

Young et al. (2004) had yet to evaluate the outcomes of their social marketing campaign, however, they described successful planning and implementation of a nutrition education initiative for pre-school aged children intended to support behavior change.

Also noteworthy are three studies in which data were gathered regarding nutrition issues including: infant feeding (Oglethorpe, 1995), food choices (Dutta-Bergman, 2003), and in-home nutrition education (Francis et al., 2004). All three articles included recommendations for social marketing campaigns to be initiated.

2.2.7 Physical Activity

Four separate studies examined the use of social marketing in the promotion of physical activity. Bauman et al. (2004), Huhman et al. (2005), Edwards (2004), and Peterson et al. (2005) found a significant increase in both the levels of physical activity awareness, and behavior following a social marketing campaign, the former three with adults, and the latter with children. In addition, Black et al. (2000) had only gathered data regarding their target audience in preparation for a social marketing campaign aimed at increasing physical activity among blue-collar employees.

2.2.8 Sexual Health

The most frequently studied health related behavior, sexual health, was reflected in nineteen separate studies. Eight studies reported positive behavior change as a result of a social marketing intervention. Montoya et al. (2005) described the use of a social marketing campaign to increase syphilis testing among gay and bisexual men. In the findings of their study the authors reported that ". . . campaign awareness was a significant correlate of having a syphilis test in the last six months" (Montoya et al., p. 395). Vega and Roland (2005) also studied a social marketing syphilis awareness campaign. In that study, "Preliminary results suggest 71 to 80% of men who have sex with men interviewed were aware of the campaign, and 45% to 53% of them reported they were tested due to the campaigns" (Vega & Roland, p. S30). In a similar study, social marketing was used to reduce the rates of Chlamydia Trachomatis infection among young adults in the Yukon (Wackett, 1998). Both an increase in knowledge and frequency of Chlamydia tests in the community were attributed to the social marketing campaign.

Two separate studies successfully used media messages to increase condom use in Louisiana and Zimbabwe respectively (Cohen et al., 1999; Meekers & Richter, 2005). In a previous study, Meekers (2000) utilized social marketing to promote adolescent reproductive health in Soweto, South Africa. "The findings indicate that the intervention increased young women's awareness of the risk of pregnancy, awareness that condoms are effective for pregnancy and HIV/AIDS prevention, awareness that other contraceptives are effective for pregnancy prevention, discussions about contraception, and increased the percentage of women who have used condoms" (Meekers, p. 73).

Jacobs et al. (2003) successfully used the social marketing of a pre-packaged treatment for men with urethral discharge in Africa as a possible means to treat sexually transmitted infections and prevent HIV transmission. Finally, Boulay et al. (2002) studied a family planning mass media campaign in Nepal. Specifically, the authors examined the effects of indirect exposure to social marketing interventions. In this study, indirect exposure was described as receiving information regarding the campaign second hand from family or friends. According to the authors, "indirect exposure was extensive; half of all respondents were indirectly exposed to the program's messages and the overall reach of the program increased from 50% to 75% when indirect exposure was considered" (Boulay et al., p. 379). In fact, indirect exposure to the social marketing campaign was more strongly associated with contraceptive use than was direct exposure (Boulay et al.).

Price (2001) studied the performance of social marketing in reaching underprivileged audiences in AIDS control programs. Price was the only author to identify a significant cost barrier to the use of social marketing campaigns for low income communities and organizations. He felt that though it may have merit, social marketing is often a strategy feasible only in communities with significant funding for health promotion.

Agha and Van Rossem (2002) studied the impact of various health promotion strategies on students' intentions to use the female condom in Tazania. They found that 6% of respondents had been exposed to peer education, another 6% had been given information from a health care provider, however an astounding 38% of respondents had been exposed to the social marketing campaign (Agha & Van Rossem). This finding highlights the potential exposure to large populations that social marketing can provide.

Four studies discussed the successful implementation of a social marketing campaign on sexual health promotion issues including: female condoms (Bull et al., 2002), and HIV prevention (Conner et al., 2005; Futterman et al., 2001; Hammett et al., 2003). In addition, several authors presented data collected on various target audiences and made recommendations for the implementation of social marketing strategies in the prevention of HIV (Husain & Shaikh, 2005; Newman et al., 2004), barriers to the purchasing of condoms (Gabler & Kropp, 2000), and sexual initiation (Mitchell et al., 2004).

2.2.9 Other

Several additional articles reported positive behavior change as a result of social marketing programs on health topics including: oral rehydration (Kenya, Gatiti, Muthami, Agwanda, Mwenesi, Katsivo, Omondi-Odhiambo, Surrow, Juma, Ellison, Cooper, & Van Andel, 1990), malaria control (Armstrong Schellenberg, Abdulla, Nathan, Mukasa, Marchant, Kikumbih, Mushi, Mponda, Minja, Mshinda, Tanner, & Lengeler, 2001; Nathan, Masanja, Mshinda, Shellenberg, de Savigny, Lengeler, Tanner, & Victora, 2004), diabetes (Almendarez, Boysun, & Clark, 2004), child safety restraints (Ebel, Koepsell, Bennett, & Rivara, 2003), gun safety (Meyer, Roberto, & Atkin, 2003), and stroke (Silver, Rubini, Black, & Hodgon, 2003). Petrella, Speechley, Kleinstiver, and Ruddy (2005) examined the impact of a social marketing media campaign on public awareness of hypertension. The authors found that "in the short-term, although (the) media awareness program increased the number of respondents claiming to have high BP and patient self-efficacy for BP control, this was not maintained" (Petrella et al., p. 270).

The remaining articles described the collection of data on a variety of health topics including: prenatal health education (McClintock, 1997), health promotion program access (Icard, Bourjolly, & Siddiqui, 2003), organ donation (Lwin, Williams, & Lan, 2002), and osteoporosis (Larkey, Hoelscher Day, Houtkooper, & Renger, 2003). In addition to presenting data on health promotion needs, all of the authors also included recommendations for social marketing campaigns to be initiated.

It is important to note that of all the articles reviewed in this category, only five articles were published in Canada, none in Saskatchewan. Topics included: stroke (Silver et al., 2003), sexual health (Wackett, 1998), physical activity (Bauman et al., 2004; Edwards, 2004), and alcohol use (Jack et al., 2005). This does not necessarily suggest that only five social marketing attempts have been made in Canada, but rather that there has been little publication of such attempts. Given that social marketing relies heavily on assessment of the target audience, it is essential that Canadian health promotion practitioners do not rely entirely on research from other geographic regions. If social marketing is to become a mainstream health promotion strategy in Canada, it is critical that this gap in published research be closed.

2.3 Research Articles Addressing Social Marketing Use in Public Health

Though the body of literature dedicated to social marketing is substantial, there has been limited research directed at the study of social marketers. Of the articles retrieved, the topic of social marketing practitioners was largely studied using a combination of descriptive and correlational designs. Nearly all samples were comprised of practicing public health nurses and participants were predominantly selected using random and convenience methods. Published studies can be divided into three main

themes including: factors associated with the use of social marketing strategies, public health nursing roles, and educational preparedness.

2.3.1 Factors Associated With the Use of Social Marketing Strategies

The first theme, factors associated with the use of social marketing strategies, was studied by Barnes et al. (2001), Fowler, Celebuski, Edgar, Kroger, and Ratzan (1999), Hoffman-Goez and Dwiggins (1998), and Quinn et al. (2005). These were the only authors to examine the practice of health communicators as a main focus of their research, and all four were completed in the United States.

Barnes et al. (2001) administered a questionnaire to health educators regarding their social marketing practices. They found a significant positive correlation between an individual's theoretical understanding of social marketing and their reported ability to implement the strategy. As well, those participants who reported using social marketing were significantly more likely to place higher value on the importance of the strategy in health promotion (Barnes et al.). Many respondents reported feeling well prepared for their role as social marketer. However, it is possible that selection bias resulted in an inaccurate representation of the total population of health communication practitioners since the sample was chosen from a convenience group of practitioners at a health communication conference.

Fowler et al. (1999) interviewed employers of health communication practitioners. Respondents rated the need for practitioners versed in program design and development, and research related to program materials, as highest priority. Baccalaureate level education was identified as necessary to perform several health communication responsibilities including health related public-administration and

information services. However, responsibilities such as fundraising and program research were identified as requiring graduate level education in a health communication field (Fowler et al.). Results of this study are limited by the small convenience sample chosen. As well, participants were questioned regarding their anticipated need for practitioners but results were not compared to current industry trends.

Hoffman-Goez and Dwiggins (1998) sampled the social marketing curricula of 52 American accredited graduate programs in public health. They found that very few programs made mention of health communication in their program's mission statement, and only 8% of programs identified health communication as a specialty track of their masters in public health degree. In addition, throughout all the curricula examined, only nine courses focused on social marketing and none of these included the application of social marketing in health promotion (Hoffman-Goez & Dwiggins).

Finally, Quinn et al. (2005) examined the marketing mindset required for health practitioners to undertake a social marketing campaign. Following the implementation of a social marketing education training program, participants were assembled in focus groups and administered questionnaires to assess the impact of the training. Specifically, participants were asked how their approach to public health had changed as a result of the training, which components of the training they found most valuable, and what barriers they met during implementation of social marketing following the training. The authors found that participants gained greater sensitivity and appreciation for the social marketing research process. They developed a new appreciation for research and the need for data in the planning phases of campaign development. Financial and human resources were identified as significant barriers to the use of social marketing. Participants reported that

these barriers exist largely because the majority of senior administrators have a limited understanding of social marketing. On the whole, "findings suggest that although participants gained greater sensitivity and appreciation for the social marketing research process, the major barrier to application in the workplace surrounded upper management" (Quinn et al., p.157).

2.3.2 Public Health Nursing Roles

The second theme, public health nursing roles, including social marketer, was studied by Chambers et al. (1994), Gebbie and Hwang (2000), MacDonald and Schoenfeld (2003), and Schoenfeld and MacDonald (2002). Chambers et al. utilized a questionnaire to examine information regarding the roles and qualifications of public health nurses in Ontario. Respondents reported their role as social marketer as likely to increase in the future. However, nurses also perceived themselves as less than prepared for this role (Chambers et al.). In the articles by Schoenfeld and MacDonald, and MacDonald and Schoenfeld, the authors discuss a replication of the study by Chambers et al., completed in Saskatchewan. Findings of the replication study were consistent with the original study with respect to the role of social marketer. In the study by Schoenfeld and MacDonald, greater than three quarters of public health nurses reported often acting in the role of social marketer, yet as few as 36% felt well prepared for the role. The study by Chambers et al. and subsequent replication study discussed in Schoenfeld and MacDonald and MacDonald and Schoenfeld were the only three Canadian articles in this theme retrieved during the course of the literature review. Since the same questionnaire was utilized, and social marketing represented only a small portion of the content, additional Canadian research is necessary to demonstrate the reliability of results. In

addition, a limitation of the questionnaire identified by the researcher was its failure to assess the nurse's understanding of the concept of social marketing (B. Schoenfeld, personal communication, June 14, 2005). As stated above, this concern is echoed in the scholarly literature (McDermott, 2000). Finally, Gebbie and Hwang utilized focus groups of key informants to ". . . identify the skills needed by practicing public health workers if they are to successfully fill roles in the current and emerging health system" (p. 716). One of the main skills identified was the ability to conduct population-based interventions such as social marketing (Gebbie & Hwang).

2.3.3 Educational Preparedness

The third theme, educational preparedness of public health nurses for their current and future practice roles, was studied by Bramadat, Chalmers, and Andrusyszyn (1996), Chalmers, Bramadat, and Andrusyszyn (1998), and Grumbach et al. (2004). In one study discussed in Bramadat et al. and Chalmers et al., the authors used an action research approach to examine the knowledge, skills, and experiences that nursing graduates require in community practice. Though the need for an increased skill level in population scale interventions was identified, no mention of health communication or social marketing was made. Grumbach et al. used a survey to investigate the practice activities, priorities and education of pubic health nurses in California. The authors reported that the " . . . population health focus of public health nursing is not reflected in the practice activities, management priorities, or educational preparation of public health nurses" (Grumbach et al., p. 266). The authors found that public health managers tended to rate intervention with large population sizes as less important than those at the individual and family level. In turn, public health nurses were much more likely to intervene with

individual clients than they were to target intervention at larger population groups. According to the authors, the reality in practice is that "very few staff public health nurses reported frequently performing . . . community level interventions" (Grumbach et al., p. 269). Every article in this theme identified expanding public health nursing roles as a significant issue, and called upon nursing educators to critically examine the community health nursing curricula designed to prepare graduates for practice (Bramadat et al., 1996; Chalmers et al., 1998; Grumbach et al., 2004).

There were several findings consistent across all three of the themes. A finding common to nearly all the studies reviewed was an anticipated increase in need for social marketers in the future (Chalmers et al., 1998; Chambers et al., 1994; Fowler et al., 1999; Schoenfeld & MacDonald, 2002). Though some revealed the need for additional practitioners, and others advocated for current PHNs' roles to expand, it is clearly articulated in the literature that social marketing is fast becoming an integral strategy in the health care system.

According to Fowler et al. (1999), to be most effective in the delivery of present and future social marketing interventions, practitioners must be prepared at the graduate level. This finding is consistent with those of Chambers et al. (1994) and Schoenfeld and MacDonald (2002) who both reported that public health nurses, most of whom had baccalaureate level education, felt poorly prepared to conduct interventions utilizing social marketing. In contrast, Barnes et al. (2001) found the majority of health communication practitioners felt well prepared for their role. This inconsistency may be attributable to the differences that exist between health care systems and educational

preparedness of participants. The former two studies were conducted in Canada among public health nurses, and the latter in the United States among public health educators.

Both Schoenfeld and MacDonald (2002), and Chambers et al. (1994) also reported in the findings from their studies that managers were likely to rate individual interventions as more important than those at the population level, such as social marketing. The relationship between the level of managerial support for the strategy and use of social marketing among front line staff was also documented by Grumbach et al. (2004).

In summary, there is consensus that social marketing is a valuable health promotion tool, however, strong evidence exists to suggest that its implementation by public health nurses brings forth challenges. Existing research indicates that social marketing is often misunderstood, and PHNs, as a collective, feel inadequately prepared educationally to effectively implement this health promotion strategy. Despite this, no published Canadian study has focused on determining what variables influence PHNs' use of social marketing.

2.4 Conceptual Framework

To date, no published research on social marketing has examined the use of a conceptual framework as a means to explain and/or predict the use of this health promotion strategy. Since this study drew on both the health and marketing fields, one model from each discipline was chosen as a launch point for analysis. The potential applicability of the Health Promotion Model and the Diffusion of Innovations Model in addressing the enablers and barriers to the use of social marketing among public health nurses in Saskatchewan will be examined in the findings chapter of this thesis.

2.4.1 Health Promotion Model

The Health Promotion Model is a middle range theory, introduced into nursing literature in 1982 by Nola Pender. Middle-range theories are the least abstract of the nursing theories, and characteristically include details specific to nursing practice (Marriner Tomey & Raile Alligood, 2002). The Health Promotion Model integrates "nursing and behavioral science perspectives on factors influencing health behaviors" (Pender, Murdaugh, & Parsons, 2006). Within this framework, eleven interrelated factors are used to explain and predict health behavior including: prior related behavior, personal factors, perceived benefits of action, perceived barriers to action, perceived self efficacy, activity related affect, interpersonal influences, situational influences, immediate competing demands, commitment to a plan of action, and health promoting behavior. These factors are further categorized under three main headings including: individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcome (Pender et al.) According to Pender et al., these factors are described as follows:

Individual Characteristics and Experiences

Prior Related Behavior – Research suggests that the best predictor of an individual's future behavior is the frequency of similar behavior. Previous behavior has a direct effect by developing habit strength, thus predisposing an individual to perform certain health behaviors. Behavior is also affected indirectly through perceptions of benefits, barriers, self-efficacy, and activity related effect. A positive or negative incident is accompanied by opinions and emotions related to the behavior which are retrieved when faced with a similar behavior choice .

Personal Factors – Any biological, psychological, or sociocultural personal factors may have predictive relevance in reference to a specific health behavior.

Behavior-Specific Cognitions and Affect

Perceived Benefits of Action – The likelihood of an individual engaging in a specific health behavior is directly related to the benefits they associate with that behavior. Individuals are most likely to invest time and energy into behaviors they deem to have a desirable benefit.

Perceived Barriers to Action – Perceived barriers consist of any concerns regarding availability, convenience, expense, difficulty, or time constraining nature of a particular behavior. Barriers may be real or imagined, and have significant potential to influence health behavior.

Perceived Self-Efficacy – Self efficacy refers to an individual's judgment of personal capability related to a particular course of action. Perception of competence will motivate an individual to engage in the behaviors in which they feel they are most likely to excel.

Activity Related Affect - All of the feeling states experienced prior to, during, and following a specific behavior, contribute to the activity related affect. The resultant feeling, positive or negative, will influence the likelihood of an individual repeating the behavior, or maintaining the behavior long term.

Interpersonal Influences – Behaviors, beliefs and attitudes of others contribute to influences such as norms, social support, and modeling, and play a key role in an individual's health behavior choices. Primary sources of interpersonal influences include: family, peers, and health care providers.

Situational Influences – The context in which a proposed behavior is expected to take place may impede or facilitate individual behavior choices. Situational influences may play an important role in the development of effective strategies for increasing acquisition and maintenance of health-related behaviors.

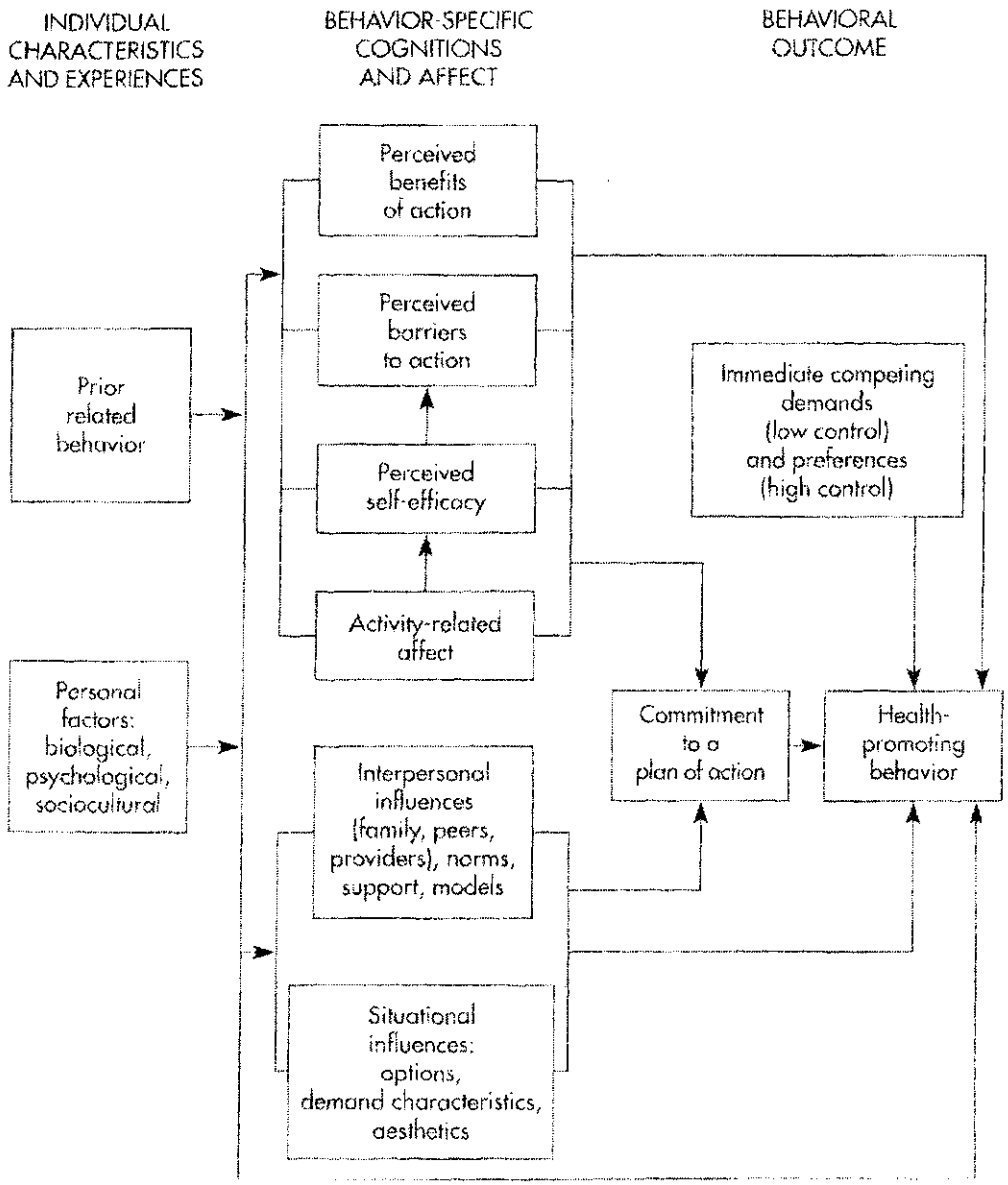
Behavioral Outcome

Immediate Competing Demands – Any behavior presented as an alternative course of action constitutes a competing demand. These alternative behaviors may have powerful reinforcing properties, making them difficult for an individual to resist.

Commitment to Action – The stronger an individual's commitment to a certain health behavior, the more likely they are to carry out the behavior choice. Strategies based on personal preferences and states of change aimed at reinforcing the health behavior choice are key to ensuring a successful outcome. Commitment alone may lead to "good intentions", but fall short of behavior change.

Health Related Behavior – The resulting behavior choice, be it positive or negative, constitutes the health related behavior. This behavior may be a one-time choice, an ongoing, or repeated behavior commitment (Pender et al., 2006).

Health Promotion Model



Taken from Pender et al. (2006, p. 50)

The Health Promotion Model is widely accepted as a theoretical model to explain and predict individual health related behavior (Pender et al., 2006). There is however, no published research on its use as a model to explain the health promotion behavior of health care professionals. The merit of the Health Promotion Model in explaining and/or predicting health promotion behavior of public health nurses, specifically in relation to their use of social marketing, will be explored in the discussion chapter of this thesis.

2.4.2 Diffusion of Innovation Model

The Diffusion of Innovation Model was developed by G.M. Rogers in the early 1970's. This model explains and predicts individuals' and societies' adoption of a new idea or product. According to Rogers, diffusion is defined as ". . . the process by which (1) an innovation (2) is communicated through certain channels (3) over time (4) among the members of a social system" (1995, p. 11) .

Innovation is defined as "an idea, practice or object that is perceived as new by an individual . . ." (Rogers, 1995, p.12). According to Rogers, it is inconsequential if an idea is ". . . 'objectively' new as measured by the lapse in time since its first use or discovery" (p. 12). An innovation may be an idea perceived to be new, or one that has been long understood, but not yet adopted (Rogers). In the Diffusion of Innovation Model, four distinct factors directly influence the rate of innovation adoption including: perceived attributes of the innovation, communication channels, social system, and innovation decision process (Rogers).

Perceived attributes of the innovation

It should not be assumed that all innovations are equivalent. Each new innovation possesses specific characteristics that influence its rate of adoption (Rogers, 1995). According to Rogers, these attributes include:

Relative advantage - The degree to which the innovation is perceived to supersede previous strategies will accelerate or decelerate the rate at which it is diffused.

Compatibility – The extent to which the innovation is consistent with existing values, past experiences, and individual needs will influence the rate at which it is diffused.

Complexity – The more difficult an innovation is to understand and use, the slower it will be to diffuse. Innovations that are simple to understand are adopted more readily than those that require the development of new skills or knowledge.

Triability – An innovation that may be experienced on a limited basis without complete commitment is more readily adopted than those that are not divisible. An innovation that may be trialed presents less uncertainty to the individual considering its adoption.

Observability – The more easily an individual may observe the results of an innovation's adoption, the more likely they are to adopt it (Rogers, 1995).

Communication channels

Communication channels are defined as any means by which messages concerning the innovation are communicated from one individual to another. This may be formal or informal, and can include mass media and interpersonal channels (Rogers, 1995).

Social System

The social system of diffusion refers to existing social constructs, beliefs, values, and ideas that will impact upon the likelihood and rate of innovation adoption. These systems may be formal or informal in nature, and may consist of peers, or individuals at varying levels of authority (Rogers, 1995).

Innovation Decision Process

The innovation-decision period is the length of time required for an individual or community to complete the innovation-decision process. The innovation decision process is composed of five steps including:

Knowledge – an understanding of the innovations existence or functioning

Persuasion – the formation of a favorable or unfavorable attitude towards an innovation

Decision – engagement in activities that lead to a choice to adopt or reject the innovation

Implementation – utilization of the innovation

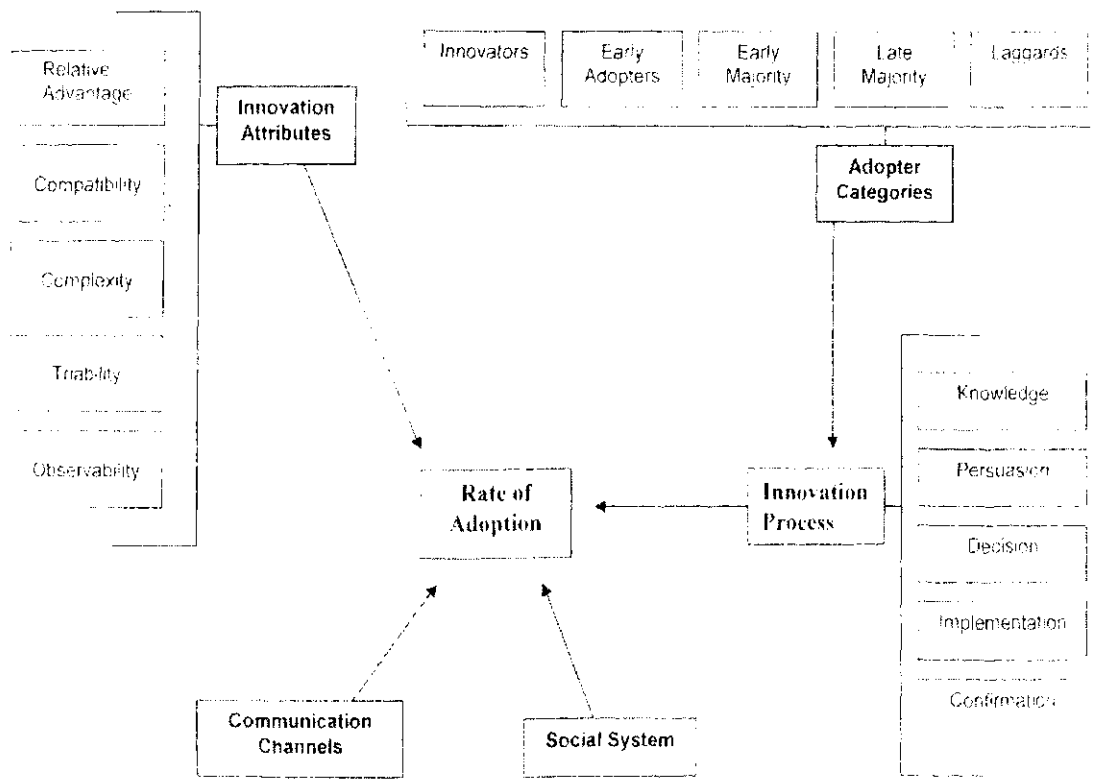
Confirmation – reinforcement of an innovation-decision that has already been made (Rogers, 1995)

The speed at which an individual completes these stages is in large part determined by their innovativeness, that is, the degree to which they are likely to adopt a new idea relative to other members of a system. Adopter categories include: innovators, early adopters, early majority, late majority, and laggards (Rogers, 1995).

Rate of Adoption

Individuals will differ in their acceptance of a new idea. The rate of adoption of an innovation refers to the time required for the idea to become widely accepted in a system. The majority of innovations have an S-shaped rate of adoption. Rapidly diffusing ideas will produce a steep curve, and slowly diffusing ideas a more gradual one (Rogers, 1995).

Diffusion of Innovation Model



Adapted from Rogers (1995)

The Diffusion of Innovation Model has been used successfully in promoting safe sexual practices, reducing smoking rates, and other health promotion initiatives (Rogers, 1995). Its merit in explaining and/or predicting the diffusion of health promotion strategies among public health nurses, specifically social marketing, will be explored in the discussion chapter of this thesis.

CHAPTER THREE - METHODOLOGY

3.1 Research Design

This study was completed using a qualitative action research methodology. Data was gethered in focus groups using nominal group process and group discussion methods. In addition, a quantitative survey was used to collect data related to participant demographics to aid in the interpretation of qualitative results (see Appendix A).

3.1.1 Action Research

This study employed an action research method, which is characterized by its emphasis on reciprocity between the researcher and the participants (Speziale & Carpenter, 2003). The goal of this method is full engagement and empowerment of all participants in the data collection process, for the purpose of bringing about measurable change (Speziale & Carpenter). In the case of this study, change has come in the form of increased knowledge regarding the use of social marketing. Unlike other research methods which attempt to formulate generalizable explanations, action research seeks local understanding specific to the participant group (Stringer & Genat, 2004). This method allows for the exploration of social and organizational complexities within which the issue is enmeshed. It also allows insight into the ways in which participants interpret

the issue from their own perspective, providing contextually rich information (Stringer & Genat).

Under the broad category of action research, a more specific method, community-based action research was employed. The most frequent application of community-based action research has been among practitioners, since the overall goal of this process is to address problems routinely faced in the workplace (Speziale & Carpenter, 2003). A level of technical collaboration was employed, that is, the researcher entered into a partnership with participants for data collection and analysis, while bringing with her pre-determined research questions (Speziale & Carpenter).

This research method was chosen for three reasons. First, in existing research, PHNs reported feeling disempowered in the workplace (Schoenfeld & MacDonald, 2002). Community-based action research empowers participants as an equal member in data collection (Speziale & Carpenter, 2003). Second, action research allowed for differences in the use of social marketing between health regions, by allowing for discussion specific to each site. Third, no existing research has outlined the enablers and barriers to the use of social marketing among PHNs. Community-based action research allowed for these factors to be generated in partnership with the participants, and not by the researcher alone.

3.2 Research Process

This study was completed in two phases. All participants participated in both phases of the study. The first phase consisted of an education session approximately three hours in length on the basic principles of social marketing. This education session was included in order to increase the likelihood that all participants had a common

understanding of the basic principles of social marketing prior to the second phase of data collection. The applicability of three existing social marketing training programs to this study were examined. The *Thinking Like a Marketer* training program developed by the National Training Collaborative (n.d.) for Social Marketing at the University of Florida is an online, self-directed learning module on social marketing. The program is targeted at individuals planning to implement a social marketing campaign, and includes the basic principles of the strategy in an easy to learn, step by step format. It was the online delivery of this program that made it incompatible with this study. The group format of educational sessions, and limited access to computer hardware and internet connections, made this module unrealistic to employ.

A second training program related to health communication developed by The Health Communication Unit at the University of Toronto was also considered. It would have been preferable to utilize a Canadian program, however, because of time limitations, it was important that the educational session in this study addressed only social marketing, and not health communication as a whole. For this reason, the Health Communication Unit module was not employed.

Finally, the Turning Point Program (n.d.) resources developed by the Turning Point Social Marketing National Excellence Collaborative were chosen for use in this study because they specifically target social marketing, and explained the strategy in basic terms. The education session consisted of a formal presentation and group activities utilizing resources including: *The Basics of Social Marketing, The Manager's Guide to Social Marketing*, and an accompanying CD ROM. Within the session, the basic principles and processes of social marketing were discussed. In addition,

participants were exposed to a variety of health related social marketing campaigns, and explored how each example campaign related back to the principles and processes previously discussed. The educational material was distributed to all participants in the form of a binder which they retained following their participation in the study. Permission was granted by Marleyse Borchard, a representative of the Turning Point Program, for the use of the above documents for the purposes of this study (see Appendix B).

The second phase of the study took the form of a focus group session. This discussion occurred within 1-14 days after the above mentioned education session. Carey defines a focus group as "a semi-structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic" (1994, p.226). According to Stevens (1996), "in focus groups, egalitarian cooperation rather than researcher control of group conversation is encouraged. The informality of group discussions, and the reduced power base of the researcher, encourages candidness and spontaneity for a depth of data that may not be achieved in more structured individual-interview formats" (p. 171). This empowerment of participants and reduced researcher control is consistent with community based action research (Speziale & Carpenter, 2003). Though Stevens cautioned regarding the limitations of focus group methodology, such as the emergence of unproductive controversy and individual participant dominance over the group, it was felt that given the research questions and participant group, these limitations could be mitigated.

Focus group data collection generally involves four types of exchange. First, individuals contribute their experiences and opinions regarding the research topic.

Second, the group as a whole identifies areas of both consensus and disparity. As a result, individual participants develop an increased consciousness regarding their own beliefs and experiences. Finally, as the focus group comes to a close, the participant group becomes more aware of the collective similarity of their experiences (Stevens, 1996). According to Stevens, this process is invaluable and sets focus group data collection apart from individual-interview techniques. "The experiences shared by peers can lessen group members' inhibitions in disclosing feelings and opinions and bring to individuals' minds details of their experiences that they may have overlooked, forgotten, or thought too idiosyncratic to be defensible" (Stevens, p.172).

It is not only study participants who interact in focus group data collection, the facilitator also plays a key role. "Ideally, a focus-group facilitator gently draws group members into the conversation, listens carefully, encourages the conversation to flow naturally with a minimum of interruptions, subtly guides the proceedings when necessary, is comfortable with displays of emotion, welcomes diversity of opinion, and remains nonauthoritarian and nonjudgemental" (Stevens, 1996, p. 171).

Within the focus group session, nominal group process was employed to identify enablers and barriers to the use of social marketing among public health nurses in Saskatchewan. Though social marketing use has been documented in a variety of specific clinical areas, participants only discussed social marketing in general terms as it related to public health. This may have resulted, in part, from a small participant group and limited amount of time for discussion of the issue.

In nominal group process, participants are guided by the researcher in a focused discussion session (Dunham, 1998) (see Appendix C). This method was chosen because

it allows participants the opportunity for group discussion, while maintaining the confidentiality of their individual contributions (Dunham). First, participants were asked to individually write down a list of enablers and a list of barriers to the use of social marketing. Answers were then combined on a list visible to the whole group. Once complete, participants had the opportunity to remove any redundancies and to add any additional responses. This process resulted in a group generated list. Participants were then asked to individually assign a number (between 1 and 5) to each group answer indicating its level of importance. The same level of importance may have been assigned to as many answers as the participant wished. Rankings were collected from all participants and aggregated. The product of this exercise was a list of enablers and barriers identified by the group, and categorized by their level of importance in the opinion of participants. A fundamental tenant of community-based action research is flexibility on the part of the researcher to adapt the data collection process to meet the needs of the participants (Ulin, Robinson, & Tolley, 2002). As a result, in one data collection site, nominal group process was not followed for the identification of barriers. Following the identification of enablers using this process, the participant group requested that they be allowed to generate the list of barriers as a collective, citing their comfort with group discussion methods. The researcher complied, as the change in process was deemed unlikely to impact upon the study results. No resulting impact was noted during data analysis.

Following the identification of enablers and barriers, group discussion was moderated by the researcher using a list of guiding questions (see Appendix D). The number of questions posed was limited to three to ensure participants were able to

respond fully within the time allotted. According to Carey (1995), "the number of questions posed in a session should not exceed 4 or 5. If many questions are planned, no depth can be explored and the session functions as an oral questionnaire for multiple subjects" (p. 491). The procedural guidelines for managing focus group discussion outlined by Ulin et al. (2002) were utilized as a guide for facilitation. The intent of the group discussion was to identify possible strategies to strengthen identified enablers and overcome identified barriers. The focus group sessions ranged between two and three hours in length. In each case, the researcher facilitated discussion until saturation within the group had occurred. That is, once participant responses ceased to reveal new information, and the participants felt they had fully articulated their views, the focus group was closed. All dialogue was audio tape-recorded and transcribed verbatim. Group generated written material was collected, for the purpose of analysis. In addition to audio recordings, the researcher also documented participant nonverbal expression in written notes. Following each session, notes were reviewed immediately by the researcher to ensure their completeness and accuracy.

It was imperative that the researcher's interpretation of transcripts accurately reflected the intents of participants. Therefore, following the preliminary analysis of data by the researcher, all participants were contacted once, on an individual basis, at their convenience, to review the aggregated, coded group findings and offer further validation or clarification.

In addition to the qualitative data collection above, each participant was asked to complete a short written questionnaire regarding participant demographics (see Appendix A). This background information was collected to aid in the interpretation of findings by

highlighting the contextual differences and similarities of participants. The findings of this data analysis will be presented in the findings chapter of this thesis.

3.3 Identification of Sample and Setting

3.3.1 Sample Criteria

The research sample included public health nursing managers from two health regions in Saskatchewan. Each of the health regions included a combination of large urban, small urban and rural public health departments. For the purposes of this study, a public health manager was defined as an individual responsible for the direct or indirect supervision of public health nurses. The health regions studied were sampled using convenience methods. However, within the selected health regions, total population sampling was employed. That is, every public health manager within the two chosen health regions was invited to participate. Potential participants were identified by the General Manager of Public Health Services in their respective health region and given a letter of invitation in either print or electronic form (see Appendix E). The invitation letter clearly indicated their right to decline participation with no consequence, and provided the researcher's contact information for those who wished to participate.

Public health managers were chosen as the sample group for this study because previous research pointed to the level of managerial support as a significant contributor to PHNs' use of social marketing (Chambers et al., 1994; Grumbach et al., 2004; Schoenfeld & MacDonald, 2002). As a result, it was seen as valuable to identify the public health manager's perspective on social marketing among PNHs. Public health managers are also intermediary between front line PHNs and the administrative level responsible for policy development and budgetary planning. The author acknowledges

that additional research on the perspective of PHNs themselves would be valuable. However, it was felt that the expansion of the sample group to include both PHNs and their managers was out of the scope of this study.

3.3.2 Setting

Both phases of this study were conducted in the public health offices of the respective health regions. In order to protect the rights of participants, both groups were given the option to participate in a location off-site, however both declined. Following the educational and focus group sessions in each location, participants were contacted once to review preliminary findings. This contact was made via telephone or email at the participants' convenience.

3.4 Data Analysis

Given the nature of the proposed data collection, data analysis was done using two separate methods. The use of nominal group process resulted in an aggregated ranked list of enablers and barriers to the use of social marketing as identified by the participants. By nature of this process, analysis was done in large part by participants as a working process throughout the first half of the focus group session. As previously stated, the change of group process in relation to the identification of barriers in one of the sites was not found to impact upon the results of this study.

In the second half of focus group sessions, the discussion was facilitated by the researcher using guiding questions regarding strategies to strengthen enablers and strategies to overcome barriers to the use of social marketing. Group discussion was recorded, transcribed verbatim, and analyzed using content analysis methods. In content analysis, inferences are made by systematically and objectively examining transcribed

discussion (Stemler, 2001). In effect, all data relating to the identification of enablers, barriers and strategies were derived from the participant group's written information and transcribed discussion. None of the above were identified prior to data analysis. Findings were examined under the general headings of identified enablers and barriers to social marketing. Specifically, each participant response was coded with a word or phrase that represented the general message of their statement. Codes were reviewed and adapted until they accurately refleted participant responses without omission, while avoiding any redundancies. Though this process was lead by the researcher, however, input was saught from both the thesis committee and study participants. As previously discussed, any clarification offered was added to the aggregated data.

3.5 Definition of Research Terms

For this study, the following operational definitions were employed:

Community Health Nurse was defined as:

A registered nurse who meets the CHNAC definition of community health nurse as follows: "a nurse whose practice specialty promotes the health of individuals, families, communities, and populations, and an environment that supports health. The practice of community health nurses combines nursing theory and knowledge, social sciences and public health science with primary health care (CHNAC, 2003, p. 3) AND is currently employed within a health region in Saskatchewan.

Public Health Nurse is defined as:

A registered nurse who meets the CHNAC definition of public health nurse as follows: "a community health nurse synthesizes knowledge from public health science, primary health care (including the determinants of health), nursing science, and theory

and knowledge of the social sciences to promote, protect, and preserve the health of populations" (CHNAC, 2003, p. 3) AND is currently employed within a health region in Saskatchewan.

Public Health Manager is defined as:

Any person who has responsibility for the direct or indirect supervision of public health nurse(s) working within a health region in Saskatchewan.

Health Communication is defined as:

The development and delivery of media messages aimed at informing and influencing decisions that enhance health (Nelson et al., 2002).

Social Marketing is defined as:

" . . . the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon behavior for the benefit of individuals, groups, or society as a whole" (Kotler et al., 2002, p. 5).

3.6 Identification of Assumptions

Given the knowledge that public health units vary significantly in their structure and internal culture across Canada, it is critical that the context within which PHNs practice be considered when examining their use of social marketing. For this reason, the following assumptions have been applied to the proposed study:

1. Findings may not be generalizable to all nurse managers.
2. Findings may not be generalizable to all public health units across Saskatchewan or Canada

3.7 Explication of Researcher's Beliefs

By virtue of her education and experience, the researcher entered into this study with preconceived notions regarding social marketing as a discipline, and the role of public health nursing in Saskatchewan. The researcher has identified these beliefs in order that they may be set aside in an effort to maintain the highest possible level of objectivity.

The researcher is a registered nurse in the province of Saskatchewan with four years experience in public health. As such, she has worked directly with population groups and health concerns with which social marketing has the potential to positively influence health behavior. It is the belief of the researcher that social marketing strategies are underused in public health services. In addition, previous to this study the researcher independently studied various textbooks and academic journals on the subject, increasing both her understanding of social marketing, and her appreciation for its potential in health promotion.

3.8 Trustworthiness in Qualitative Research

Trustworthiness refers to the rigor of the research study. It is a measure of the extent to which the findings accurately represent the topic of study. In qualitative research, trustworthiness is established using four separate criteria including: credibility, dependability, transferability, and confirmability (Ulin et al., 2005).

3.8.1 Credibility

The credibility of research refers to the plausibility, integrity, and accuracy of the study findings (Stringer & Genat, 2004). In assuring credibility, it is critical that steps be taken to minimize the risk of the researcher's own viewpoints influencing the study

findings (Stringer & Genat). In this study credibility was enhanced using a variety of methods.

A prolonged engagement with participants allowed for the development of rapport. This trusting relationship enabled the researcher to explore a relatively deeper understanding of the topic from the participants' perspectives. According to Stringer and Genat (2004) it is this relationship with qualitative research participants that ensures a more sophisticated understanding of participant context compared with the superficial purposeful information often given to strangers. Over the course of the education session, focus group, and follow up, an average of eight hours was spent with each participant in a combination of group settings and individual interaction.

Member checks are a key requirement in the establishment of the credibility of a study (Stringer & Genat, 2004). To reduce the risk of misinterpretation of findings, participants were involved in the data analysis process. Each participant was requested to review preliminary findings in order ensure that the interpretations of the researcher were congruent with the participant intents.

Peer debriefing occurred throughout the research process with a thesis committee comprised of three experienced researchers. Two members of the committee were professors of nursing with extensive experience in public health nursing research and one was a professor of commerce with extensive experience in health marketing research.

The explication of the researcher's beliefs was completed prior to data collection. The researcher's education and past experience contributed to preconceived notions regarding the topic of study. In an effort to maintain the highest possible level of objectivity, these beliefs were identified and bracketed.

Finally, triangulation, or the use of multiple methods of data collection, was employed. All focus group sessions were tape recorded and transcribed verbatim, written material generated by participants during focus group sessions was collected, and field notes were used to provide a context for participant contributions.

3.8.2 Transferability

Transferability refers to the likelihood that results may be applied to contexts other than the researched setting (Stringer & Genat, 2004). Unlike quantitative research, the primary goal of qualitative inquiry is not the generalizability of results. However, it is the hope of the researcher that the results may have implications for health regions beyond those included in this study. A detailed description of the context and participants from whom data was collected was included in this thesis in order that readers may assess the applicability of findings to other settings.

3.8.3 Dependability

The dependability of a study refers to the extent to which the research process is clearly defined, and open to scrutiny (Stringer & Genat, 2004). In an effort to increase the dependability of this study, included in this thesis are: a thorough literature review, research problem, research processes, and findings. This thesis was reviewed by a thesis committee and outside reviewer, and findings of the study were disseminated to all participants.

3.8.4 Confirmability

Confirmability refers to the extent which the findings of the study are demonstrably drawn from the data (Stringer & Genat, 2004). As a means of increasing confirmability, all steps of the research process were clearly documented. The resulting

audit trail will be held for a period not less than five years at the University of Saskatchewan, College of Nursing.

3.9 Ethical Considerations

Ethical approval for this study was obtained from the University of Saskatchewan Behavior Research Ethics Board as well as the Ethical Review Boards of both health regions in which the research was completed. This study is in accordance with the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (Medical Research Council, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2003), and the University of Saskatchewan Research Guidelines (University of Saskatchewan Behavioral Research Ethics Board, 2003).

This study was deemed unlikely to result in harm, discomfort, or perceived harm to participants. No form of deception or coercion was used, and participants were not compensated for their participation.

An informed consent sheet was provided to each potential participant prior to their involvement in the study (see Appendix F). All participants were over the age of eighteen years and thus able to consent their own participation. The informed consent sheet clearly stated that participation was completely voluntary, and would in no way affect their current or future employment. Consent to participate was indicated through a signature on the consent form, and participants retained a copy of the form. Participants were made aware of their right to withdraw from the study at any time, without reason given for their choice. None of the 11 participants chose to withdraw from the study, however they were all informed that if they chose to withdraw, their contributions could

not be withdrawn since the researcher had no means by which to identify specific contributions made in the focus group recordings. No additional consent for the release of transcripts were collected. Findings of the demographic questionnaire were reported in aggregate form, and findings from the focus groups in generalizations and unattributed quotations, in order to ensure that individual participants were not identifiable through the reporting of data. Given the focus group nature of the study, complete anonymity of participants could not be guaranteed.

Contact information for the researcher as well as the Behavioral Research Ethics Board was provided to participants, and they were encouraged to call with any questions prior to their participation or at any time thereafter.

During the course of the study, all study material was secured by the researcher. To further ensure confidentiality, all email contact between the researcher and participants was done using an email address only the researcher has password access to. As per the University of Saskatchewan guidelines, upon the completion of the study, all study material was secured by Dr. Lynnette Leeseberg Stamler and will be held at the College of Nursing, University of Saskatchewan for a period not less than five years.

CHAPTER FOUR – FINDINGS

4.1 Sample Group Characteristics

There were only two inclusion criteria for participation in this study. First, participants must have been a manager in public health at the time of data collection. For the purposes of this study, a public health manager was described as anyone responsible for the direct or indirect supervision of public health nurses in Saskatchewan. Despite the inclusion of all levels of management, only managers who directly supervise PHNs volunteered to participate in this study. Second, individuals must have been a public health manager in one of two health regions chosen for this study. Within the two health regions, every public health manager was invited to participate. The total population group comprised of 19 public health managers. Of these, 12 directly managed, and 7 indirectly managed public health nurses. The total number of study participants was 11 of 12 direct managers, representing representing 92% of this population. No upper-level managers chose to participate.

Although no limitation was placed on the sex of participants, ultimately it was only women who volunteered to participate in this study. A background questionnaire was administered to each participant in an effort to gather contextual information to aid in

the analysis of qualitative data (see Appendix A). The following was derived from their responses.

4.1.1 Years Experience in Public Health

In Site A, five of six participants reported having in excess of ten years experience in public health, and only one reported having between eight and ten years experience. In Site B, four of five participants reported having more than ten years experience in public health, and only one reported having between five and seven years experience.

With respect to their number of years as a public health manager, in Site A, one participant reported having one year or less, two reported having between two and four years, two reported having between five and seven years, and one reported having in excess of ten years. In Site B, the level of experience was much less diverse. Two participants reported having between two and four years, and three reported having between five and seven years.

4.1.2 Level of Education

With respect to the highest level of education received in nursing, in Site A, five participants reported having a baccalaureate degree in nursing, and one reported having a master's degree in nursing. In Site B, one participant reported having a diploma in nursing, and four reported having a baccalaureate degree in nursing.

When asked to report the highest level of education achieved in any discipline, responses from the two sites differed. In Site A, all but one participant had received their highest level of education in nursing. Five had baccalaureate degrees and one had a master's degree in nursing. However in Site B, only two participants received their

highest level of education in nursing, one at a diploma level and one at a baccalaureate level. All three participants in Site B with master's level preparation received their degree in a discipline other than nursing.

4.1.3 Geographic Location

Participants were asked to report the types of geographical regions in which they directly or indirectly supervise PHNs. Three choices were given 1) Rural Area 2) Small Urban Area (less than 30,000) and 3) Large Urban Area (greater than 30,000). Some participants reported supervising PHNs in more than one geographic region. In Site A, only one participant reported supervising public health nurses in a rural area, while six reported supervising PHNs in a large urban area. However, in Site B, three participants reported supervising PHNs in a rural area, one in a small urban area, and two in a large urban area. Thus within the total sample, there existed a balanced representation from both rural and large urban areas, with only one participant reporting the supervision of PHNs in a small urban area.

4.1.4 Knowledge of Social Marketing

Participants were also asked to rate their own understanding of social marketing prior to their participation in this study as one of the following: poor, fair, good, or excellent. Five participants in Site A evaluated their knowledge level as fair and one as good. Results were similar in Site B, where three evaluated their knowledge level as fair and two as good.

Participants were also asked to report the level of formal training or education they had received in social marketing. In Site A, three reported having none, and three reported having a small amount. In Site B, one reported having none, and four reported

having a small amount. No participants reported having either a moderate or substantial amount of training in social marketing. Thus, many participants had developed their level of knowledge regarding social marketing through informal means.

4.1.5 Use of Social Marketing

When asked to report how often they believe the nurses they supervise use the complete social marketing process, responses varied between sites. In Site A, one participant reported the PHNs she supervised as never using the complete social marketing process, four reported PHNs rarely using it, and one reported PHNs sometimes using it. However in Site B, all participants reported the PHNs they supervise as rarely using the entire social marketing process.

In contrast, when asked how often they believe the PHNs they supervise use portions of the social marketing process, results were very similar throughout. In Site A, two participants reported PHNs rarely using it, three reported sometimes using it, and one reported often using it. In Site B, two reported PHNs rarely using it, and three reported sometimes using it.

Though managers across both sites reported a low level of use with respect to social marketing, there was a higher level of reported use of selected portions of the social marketing process than there was of the process as a whole.

4.2 Group Interaction Data

According to Duggleby (2005), an analysis of focus group findings is incomplete without the inclusion of group interaction data. "Group interaction data reflect the interactive patterns within focus groups" (Duggleby, p. 832). It encompasses rich data potentially lost during the transcription process, and provides context for participants'

verbal contributions. This context is integral to analysis because "contributions of members of the group are not independent of one another. Individuals' stories of their experiences will be responded to and influenced by others in the group" (Stevens, 1996, p.172). For the purpose of this analysis, a set of pertinent analytic questions proposed by Stevens were examined (see Appendix G). The resulting findings are discussed below.

The focus group sessions employed in this study were conducted in non-descript meeting rooms within each of the respective public health offices. It was at the request of participants that the focus group sessions be held on-site for ease of attendance. In both sites, the meeting room was well lit, containing long board-room tables surrounded by comfortable chairs. Tables and chairs were arranged in a closed square to allow for the highest level of participant comfort possible, as well as to accommodate for audio recording devices.

In each of the sites, participants were well acquainted prior to their participation in this study. In most cases, they had worked together for years, meeting regularly, and collaborating on various projects. According to Stevens (1996), this prior relationship can result in hesitancy on the part of participants to contribute individual opinions. This phenomenon was not observed in this study. The overall atmosphere of the focus groups were very friendly and supportive. As participants arrived, pleasant conversation was initiated related to both professional and personal issues. All participants were welcomed, and included equally in this discussion. In both sites, participants also made an effort to include the researcher in off-topic discussions during breaks by relating background information or explaining the context of stories.

Throughout the focus group discussion, participants were highly responsive to one another, making both gestures and comments of support. When individuals were in disagreement with a specific contribution of another member, each was gracious, allowing for the opinions of everyone to be heard. No significant points of conflict arose from the discussion. Though certain individuals responded in more depth to certain questions, on the whole, participation was distributed relatively equally among all members. This may have been in part due to the fact that all participants held a similar position within public health services, with relative equality in responsibility. No difference was noted in participation relative to participants' educational preparation.

The majority of participants' responses adhered to the questions posed, however, at times discussion deviated slightly based on the response of one participant. In site A, this occurred when the issue of budget and time were raised. Participants became visibly frustrated and recounted examples of their lack of financial and material resources in other program areas. In site B, this occurred when the issue of educational preparation was raised. For a short time, participants discussed the history of diploma and baccalaureate education. In both instances, participants were easily brought back on topic with very little effort required on the part of the facilitator.

According to Carey (1995), data collected using focus group methods is consistently more negative in nature than when collected using surveys or individual-interview techniques. Carey asserts that "social desirability in responding in an interview or survey may inhibit negative but not positive responses, whereas negative responses may be supported or even encouraged in a group setting" (p. 490). This was not the case in this study. In fact, participants made extraordinary efforts to present even the strongest

of barriers with a positive tone. For example, when describing a significant lack of financial resources, one participant qualified her point by adding that the PHNs she supervises do an incredible job of using the minimal resources available most effectively. Another participant stated that despite the hindrance of their efforts by inadequate financial resources, she was grateful that her budget had not been cut any more drastically than it was.

4.3 Enablers to the Use of Social Marketing

One of the research questions posed was related to the identification of current enablers to the use of social marketing, however, nearly all managers reported PHNs rarely to never use social marketing. Therefore, the identified enablers are more accurately described as potential enablers to the future use of social marketing among PHNs in Saskatchewan.

4.3.1 Site A - Complete List of Enablers

The complete list of enablers was derived using the nominal group process (see Appendix C). Each participant was asked to independently list, from their perspective, the enablers to the use of social marketing among PHNs in their health region. The researcher gathered those lists, and amalgamated them into the complete list of enablers seen below. By using this process, the anonymity of each participant's responses was maintained.

Complete List of Enablers

- PHNs are working in the community
- PHNs are dedicated to changing social issues
- PHNs are creative
- Public health looks at the whole, not just part
- Public health nursing is client centered, not nurse directed and so is social marketing

- PHNs are familiar with health promotion strategies
- PHNs are open to the concept of social marketing
- PHNs believe in the strategy
- PHNs knowledge of health promotion techniques
- PHNs general knowledge of change theory
- PHNs willingness to learn about social marketing
- Public Health Services believes in the use of a multiple strategy approach
- PHNs are degree trained (and social marketing is included in that training)
- PHNs are familiar with community development
- Existing material resources
- Creativity of PHNs
- Many of the target audiences receive media messages well
- Demographics of Saskatchewan are not as diverse as other areas of Canada (therefore its easier to target more of the population with one campaign)
- Nurses in general are creative
- Cost of advertising time (radio/TV/billboard) is less expensive in SK than in other provinces
- Support of supervisors, nursing consultant, and medical health officer for the use of new strategies
- Public belief in the knowledge of nursing
- Budget (small amount of finances for new health promotion efforts)
- Networks with community groups
- Assignment system of PHNs (either to a program or community)
- Existing website
- Existing information sheets

4.3.2 Site A - Group List of Enablers

As a group, the participants reduced the complete list of enablers, removing redundancies, and adding missing content, to formulate the group list of enablers. This final list compiled by the group was then ranked independently by each participant. The resulting rankings are displayed in the table below.

Group List of Enablers

A → Creativity of PHNs
B →Some money in budget for population health initiatives
C → Market value of advertising in SK is higher than other provinces
D → PHNs are working in communities with clients and partners
E → PHNs practice with client centered approaches (similar to social marketing)
F → Public health is dedicated to changing social issues

G → Existing BSN knowledge (computer skills, communication skills, community development, change theory, health promotion, social marketing)
H → PHNs, medical health officer, Supervisors and Nursing Consultant are open and supportive of new techniques
I → Existing material resources (print)
J → Population is less diverse in SK (thus able to target greater number of individuals with the same campaign)
K → Consumer confidence in public health services and PHNs
L → Job assignments of PHNs (either assigned to a community or a program)

Group Ranking of Enablers from 1-5 (1being low, 5 being high influence)

	A	B	C	D	E	F	G	H	I	J	K	L
	4	2	3	5	4	5	4	5	2	3	4	4
	5	3	2	3	4	5	4	4	4	2	3	4
	4	4	2	4	4	4	5	5	4	2	4	4
	3	4	3	4	4	3	3	3	2	3	2	3
	3	2	1	5	5	5	5	5	4	3	4	5
	4	1	2	5	5	4	3	4	2	3	2	3
Sum	23	16	13	26	26	26	24	26	18	16	19	23
Range	2	3	2	2	1	2	2	2	2	1	2	2
Mode	4	2,4	2	5	4	5	3,4,5	5	2,4	3	4	4
Median	4	2.5	2	4.5	4	4.5	4	4.5	3	3	3.5	4

Group List of Enablers ranked highest influence to lowest influence (using sum scores)

26 D, E, F, H
24 G
23 A, L
19 K
18 I
16 B, J
13 C

4.3.3 Site B - Complete List of Enablers

An identical process was used to compile the complete list of enablers in Site B, as was used in Site A.

Complete List of Enablers

- PHNs strive to be up to date
- SRNA Professional competencies support ongoing learning
- SK Health provides leadership and expectations to use health promotion
- Strategies
- Many health-related illnesses are a result of chosen behavior
- PHNs have exposure to communities and individuals to facilitate social marketing interventions
- Program review guides the adoption of new strategies
- The population looks to public health for leadership
- There is a commitment of the health region recognizing the value of social marketing
- The health region supports skill building of PHNs with existing forum for in-service learning
- The health region already has strong networks built with other sectors (ex education)
- Public health nursing is population focused
- PHNs use evidence based practice
- PHNs already advocate for healthy public policy using other strategies
- SK health's current focus on health promotion and population health will influence the inclusion of social marketing
- Access to existing reliable population health statistics & research
- The health region supports the creation of "catchy" campaign material
- Existing community partners
- Existing material resources
- PHNs already have established a relationship in the communities they work with
- PHNs practice in a variety of settings
- PHNs have credibility and respect within the communities
- BSN curriculum includes social marketing
- Social marketing is a strategy valued by public health management

4.3.4 Site B - Group List of Enablers

The exact process was used to compile the group list of enablers in Site B, as was used in Site A.

Group List of Enablers

A → Public health nursing is evidence based and independent
B → Existing community and other sector partnerships
C → Sask Health, the health region, and public health services management all support population health and primary heath care strategies that use social marketing
D → BSN entry to practice
E → PHNs work within multidisciplinary teams
F → Public health services is a respected agency
G → PHNs are already connected and seen as leaders with the communities in Saskatoon
H → Public Health Services and the SRNA both have established processes for ongoing learning
I → CHNAC PHN standards recognize the role of social marketer
J → PHNs are population focused
K → Existing material resources
L → Social marketing has the potential to influence behavior and many illnesses targeted by public health are a result of health behavior

Group Ranking of Enablers from 1-5 (1being low, 5 being high influence)

	A	B	C	D	E	F	G	H	I	J	K	L
	3	5	5	3	5	2	2	4	5	5	4	5
	5	5	4	4	5	5	5	3	3	4	4	4
	4	4	2	5	3	5	5	4	2	5	2	3
	4	4	5	5	4	4	3	3	3	3	3	5
	4	4	3	3	5	5	5	4	3	5	1	2
Sum	21	22	24	20	22	21	20	18	16	22	14	19
Range	2	1	3	2	2	3	3	1	3	2	3	3
Mode	4,5	4	5	5	5	5	5	4	3	5	4	5
Median	3	4	4	4	5	5	5	4	3	5	3	4

Group List of Enablers ranked highest influence to lowest influence (using sum scores)

24 C
22 BEJ
21 AF
20 DG
19 L
18 H
16 I
14 K

4.3.5 Abridged List of Enablers

Following the analysis of the group list of enablers from both sites, an abridged list of enablers was derived. It is intended that the abridged list of enablers encompasses the overall sentiments of both groups. This list will be examined in further detail below. In addition, the abridged list of enablers will be further used to examine identified strategies for strengthening enablers to the use of social marketing among public health nurses in Saskatchewan.

4.3.5.1 BSN Preparation

Participants felt strongly that a baccalaureate degree in nursing was sufficient preparation for PHNs current and future roles. No published literature exists outlining the extent to which social marketing is incorporated into baccalaureate nursing education throughout Canada. However, participants articulated their support for BSN programs, including the Nursing Education Program of Saskatchewan, where social marketing is incorporated into the core curriculum. Entering into public health nursing practice with this educational background was seen as a valuable asset for PHNs in their potential role as social marketer. Participants commented on the proficiency of new graduates in strategies integral to social marketing, such as leading focus groups, running computer software, and accessing up to date research.

> *"When we graduated, most of us had a degree in nursing. It was a great nursing education for that time, but now nurses need to graduate with skills that never used to be part of nursing. Yes, acute care is getting more and more*

technologically advanced, but so it public health. I mean, graduates learn computer skills, public speaking, even the internet. These are all things we are still struggling to learn on the job years later."

4.3.5.2 Client Centered and Evidence-Based Practice

The client centered and evidence-based perspectives from which PHNs currently practice were paralleled by participants to the process of social marketing. Public health managers articulated their belief that PHNs value many of the same philosophies inherent in social marketing. They made a link between target audience segmentation and client-centered care, and market research and evidence-based practice. It was felt that PHNs made excellent candidates as social marketers because they already practice with many of the ideals integral to social marketing.

"I think we use (social marketing), but we don't call it that. I think that it's incorporated into a number of the things that we do, but maybe we haven't used the whole process."

4.3.5.3 Established Community Relationships

The trusting relationships established by PHNs with community members and community organizations were seen as a strong enabler to PHNs' use of social marketing. Over the course of the focus group sessions, the PHNs' *"specialty knowledge"* about the community in which they practice was articulated repeatedly. Participants highlighted the

significance of the relationships PHNs had developed with community members. Managers felt that this level of trust would enable PHNs to more easily assess the needs of the target audience in the context of a social marketing campaign. In addition to their relationship with individual community members, managers reported that PHNs also had strong established links with other community based organizations, and other sectors (such as education) concerned with health issues. These existing partnerships were seen as potential allies in the development of a social marketing campaign.

> *"They (PHNs) become very skilled and knowledgeable about what's going to work for this community or this group of clients. That expertise does exist, it's just a matter of how you harness it into something more."*

4.3.5.4 Nature of Health Challenges Addressed by Public Health

Many of the health challenges routinely addressed by public health, such as sexual health, obesity and heart disease are, at least in part, a result of health related behavior. Public health managers felt that this direct link to behavior makes these health challenges ideal targets for a social marketing campaign since the mandate of the strategy is behavior change.

4.3.5.5 Support of Nursing Organizations

Support by nursing organizations for PHNs' role in social marketing was noted as an enabler among managers in public health. A specific example given by participants

was the Community Health Nurses Association of Canada (CHNAC) standards, which explicitly recognize PHNs in the role of social marketer.

> *"In a way, support for public health nurses to do social marketing from organizations like CHNAC gives us a kind of permission to incorporate it into our role. Its not that we're wanting to do something extra or unnecessary, it is part of our mandated role as public health nurses."*

Public health managers also perceived organizational support for ongoing learning as an enabler to social marketing use. The expectation of career-long learning by the Saskatchewan Registered Nurses Association (SRNA) is exemplified in their mandatory continuing competence program. In this program, registered nurses licensed in the province of Saskatchewan are required to develop an annual learning plan, and independently seek out opportunities for professional learning and growth (SRNA, 2004). In addition, Public Health Services also has established processes for ongoing learning in the form of in-service sessions. Though neither directly emphasizes social marketing specifically, public health managers felt that these two established strategies for ongoing learning could be potential vehicles by which social marketing could be incorporated into the learning plan of practicing PHNs, and thus constituted an enabler to its use.

4.4 Strategies for Strengthening Enablers

Following the use of nominal group process, group discussion was facilitated by the researcher. A list of guiding questions was used to facilitate discussion regarding

possible strategies to strengthen enablers (see Appendix D). Though participants clearly articulated their belief in the importance of all identified enablers, BSN preparation was the only enabler for which public heath managers identified a strategy.

4.4.1 BSN Preparation

Public health managers, as a collective, were highly supportive of the inclusion of social marketing content in baccalaureate nursing education. However, they did comment that there was room for improvement in this area. One strategy suggested by participants was to include social marketing as a health science elective. Participants felt this would serve three distinct purposes. First, it would offer nursing students interested in a career in public health the opportunity to develop more in depth skills in social marketing. Public health managers felt that a three credit course, with emphasis on practical application, would serve this purpose. Second, if the class were open to all health science students, an opportunity for interdisciplinary collaboration would be fostered. Given that nurses in practice would inevitably rely on professionals from other disciplines in both the development and delivery of successful social marketing campaigns, participants felt that it would be appropriate to learn the strategy in this collaborative context. Finally, participants felt that as the number of practicing PHNs knowledgeable in social marketing increased, the likelihood of social marketing becoming an integral strategy in public health would also increase. Participants were conflicted about which needed to come first, the health region's commitment to the strategy of social marketing or the education of public health professionals in its use.

"I would like to see social marketing introduced as a health science elective. That can be the first step because the individuals choosing to take it, chances are they're already leaning towards (the) community/public health sector . . ."

"By offering it as a health science elective, you may draw on physicians, pharmacists, nurses as a multidisciplinary approach which is what social marketing is all about. The people that tend to talk, that are open to looking at it from a multidisciplinary perspective are the ones we want."

"By the time we get it (social marketing) incorporated into the organization's strategic plan, we're going to want the people there with the training."

4.5 Barriers to the Use of Social Marketing

4.5.1 Site A - Complete List of Barriers

The complete list of barriers was derived using the nominal group process. Each participant was asked to independently list, from their perspective, the barriers to the use of social marketing among public health nurses in their health region. The researcher gathered those lists, and amalgamated them into the complete list of barriers seen below. By using this process, the anonymity of each participant's responses was maintained.

Complete List of Barriers

- Lack of time
- Lack of resources
- Lack of someone to champion the cause
- Time and effort to increase skills of PHNs
- Reluctance to add "one more thing" to public health nursing
- Lack of financial resources
- Staff size
- Limited time
- The health region lacks knowledge of the role of PHNs
- Lack of support from upper levels of management r/t social marketing
- Small budget for population health initiatives
- Lack of time in PHNs daily schedule
- Budget is cumbersome to re-allocate
- Human resources are limited (nursing and support staff)
- PHNs already have more work than they do time to complete it
- Bureaucracy is cumbersome in requesting funds to do something new
- Too many other tasks
- Not enough staff or monetary resources
- Reluctance of the health region to try something new
- Too many messages already sent to the public – we won't be heard
- The public wants a quick fix
- Not a present focus
- Upper management unsupportive of change
- Computer limitations
- Funding not available to complete the process (eg. money for focus groups)
- Lack of knowledge regarding social marketing
- Workloads are already unreasonable
- Saskatchewan weather limits activity in the winter
- Lack of district and provincial support

4.5.2 Site A - Group List of Barriers

As a group, the participants reduced the complete list of barriers, removing redundancies, and adding missing content, to formulate the group list of barriers. This final list compiled by the group was then ranked independently by each participant. The resulting rankings are displayed in the table below.

Group List of Barriers

A→ Existing program workloads already exceed capacity of PHNs
B → Budget is currently allocated for existing programming and difficult to change
C → Lack of material resources
D → Lack of human resources (nursing and support staff)
E → Need for a social marketing consultant (internal position for the entire region)
F → The health region and SK Health don't fully understand the role of public health services
G → Process of change (to add social marketing strategy) is too cumbersome
H → Public wants money spent on acute care "quick fix" not upstream health promotion
I → Social marketing competitors (proponents of poor health behavior choices)
J → Lack of in-service training related to social marketing
K → Winter a difficult time to engage the community

Group Ranking of Barriers from 1-5 (1being low, 5 being high influence)

	A	B	C	D	E	F	G	H	I	J	K
	5	5	5	5	4	5	4	4	4	5	4
	5	4	5	5	5	5	5	5	5	5	3
	2	5	3	5	5	2	5	5	4	4	3
	5	4	3	4	4	4	4	4	3	3	3
	5	5	4	5	3	5	4	4	3	4	3
	5	5	4	2	5	4	2	5	3	2	2
Sum	30	29	23	26	26	27	23	25	20	24	18
Range	0	1	3	3	2	1	3	2	2	3	2
Mode	5	5	4,5	5	5	4,5	4	4	3	5	3
Median	5	5	4	5	4.5	4.5	4	4	3	4.5	3

Group List of Barriers ranked highest influence to lowest influence (using sum scores)

30 A
29 B
27 F
26 D, E
25 H
24 J
23 C, G
20 I
18 K

4.5.3 Site B - Group List of Barriers

As previously stated, after identifying enablers using the nominal group process, the participants in Site B requested that they be allowed to generate the list of barriers as a collective, and the researcher complied. However, the group list of barriers was still ranked independently by each participant. The resulting rankings are displayed in the table below.

Group List of Barriers

A → Public and/or political pressure may direct what PHNs focus on
B → Concepts/ Principles of social marketing are not formally known (or used) in public health
C → Lack of formal education on social marketing in the BSN program
D → Lack of ongoing in-service training in public health related to social marketing
E → Lack of time to dedicate to the process of social marketing – many other commitments
F → Lack of role clarity of PHNs as social marketer
G → Lack of PHNs
H → Health region's organizational process too cumbersome
I → The health region communities are quite conservative thus limiting social marketing messages
J → Lack of monetary resources allocated to health promotion (thus social marketing)
K → Difficult to quantify results of social marketing campaigns
L → Inability of PHNs to identify with many target audiences
M → Pressure from the health region to target "all"
N → Lack of focus on evaluation and planning
O → No formal processes to maintain momentum or sustain resources

Group Ranking of Barriers from 1-5 (1 being low, 5 being high influence)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
	4	5	5	5	5	5	5	4	4	5	4	3	4	4	4
	4	5	5	5	5	4	3	3	3	5	3	5	4	5	5
	4	5	5	4	5	5	5	4	5	5	4	3	4	4	5
	5	4	4	4	5	4	5	5	5	3	2	3	5	5	4
	4	4	3	3	4	4	3	3	3	5	2	3	4	3	4
Sum	21	23	22	21	24	22	21	19	20	23	15	17	21	21	22
Range	1	1	2	2	1	1	2	1	2	2	2	2	1	2	1
Mode	4	5	5	5,4	5	4	5	4	5	5	4	3	4	4	4
Median	4	5	5	4	5	4	5	4	4	5	3	3	4	4	4

Group List of Barriers ranked highest influence to lowest influence (using sum scores)

24 E
23 B, J
22 C, F, O
21 A, D, G, M, N
20 I
19 H
17 L
15 K

4.5.4 Abridged List of Barriers

Following the analysis of the group list of barriers from both sites, an abridged list of barriers was derived. It is intended that the abridged list of barriers encompasses the overall sentiments of both groups. This list will be examined in further detail below. In addition, the abridged list of barriers will be further used to examine identified strategies for overcoming barriers to the use of social marketing among public health nurses in Saskatchewan.

4.5.4.1. Human Resources

Participants unanimously identified a shortage of PHNs as a huge contributor to the hesitancy towards implementing new programs and strategies including social

marketing. Comments such as "*existing workloads already exceed capacity*" and "*our nurses feel like they can't even come up for air*" were made repeatedly throughout the focus group sessions. With this shortage of human resources, managers felt that nurses were only given enough time to concentrate on the priority programs such as immunization clinics. Managers were clear that it was not the PHNs themselves who did not want to participate more fully in community development and population health interventions, but rather time acted as a barrier.

> *"In most of the public health programs social marketing techniques would be very important . . . every one of us has a certain message, or certain ideas they want to change within the community. That relevancy is there. We have already set it up, we have a vehicle to get social marketing going. Our barrier is the time."*

> *"You only have so much time, and so much effort, and so much energy, so you concentrate on the priorities 'cause that's really all you get is the priorities, if that."*

As a result of this shortage of time on the part of both managers and PHNs, participants also identified a lack of focus on long term planning and evaluation. It was noted that the nurses may, out of necessity, shortcut on the planning phases of strategies

such as social marketing, or avoid these strategies all together under the assumption that there isn't the time to complete the process properly.

> *"Its hard to justify spending a bunch of time on evaluating a past program when we barely have time to run the ones we're doing now, let alone plan for increasing programming in the future."*

Finally, participants also identified a lack of clarity regarding the role of PHNs. It was felt that upper levels of management within the health regions and Sask Health did not fully understand the capacity of PHNs. Comments such as "*Immunization is all they think we do*" and *"They don't understand the potential PHNs have*" were articulated. Public health managers felt that this lack of role clarity was, in part, responsible for the clinical emphasis placed on public health. Participants felt that if social marketing was embraced as a PHN role by managerial decision makers, the likelihood of additional human resources being allocated would increase.

> *"If they see our role as limited to immunizations and well baby clinics, then why would we expect them to give us the human resources we need to fulfill other roles like social marketing?"*

> *"I think it comes back down to a matter of what people recognize is value from the work that you do. Clinic is*

important, you won't find a public health nurse that would disagree with that. It's the easiest thing to identify as 'we did this'. There is solid evidence that immunization works and so you know that what you are doing, you know it makes a difference . . . A lot of the other things we do are harder to quantify, so you did this, and what difference did it make? I think that those are the parts that make it harder for someone to use it (social marketing.)"

4.5.4.2 Financial Resources

The public health managers in this study, on the whole, were very animated when discussing the financial constraints public health units face. This may be, at least in part, because budgeting falls under the responsibility of the public health managers themselves. At times, there was a tone of exasperation in the discussion. One participant joked "*I guess I could not buy pens this year; that would free up some money*". It was clearly articulated that managers felt as if their current budgets simply didn't leave room for additional programs like social marketing. They realized that the process required time and financial commitment, and they hesitated to start a process they were not sure they could financially support through to fruition.

"Our budgets are bare bones. It barely meets the things like immunization clinics, the things we just can't cut."

Managers also felt powerless as a *"small program in a much bigger health region"*. There was a sentiment of feeling in constant competition within the larger health region for financial and material resources. Participants felt that PHNs struggled to plan for health promotion programs in a health care system with an acute care focus.

> *"We're in competition with the whole health region. It's hard because it depends on the powers that be, on what they determine is the priority. And right now, acute care is the priority."*

> *"It gets to the point where you don't even want to present anything more because you know nobody is going to be interested because it's preventative and not a matter of life and death . . . that is what we are told."*

Without adequate financial resources, public health managers felt they were unable to provide PHNs with the material resources needed to develop effective social marketing programs. Social marketing is highly concerned with competing messages received by the target audience (Kotler et al., 2002). In the case of public health, the competing messages for unhealthy behavior choices are in large part derived from the commercial sector, which has significantly more resources. Several managers cited examples of material resources PHNs routinely complained were lacking. In some public health offices, up to twenty PHNs share one desktop computer equipped with only word

processing software. They are limited to an hour or two per week for checking email, and creating educational material for use in their community. Participants felt that in this highly technological era, their presentations often lacked professionalism when hand-written on flipchart paper.

> *"Even our audience is what I'm getting at. I mean we go out and deliver messages to audiences that . . . spend a great deal of time with TV, movies and that type of thing, so they are expecting the quick change, the brilliant pictures, and the music, the catchy extra techniques. And we take out or flipcharts and occasional overhead, when we can get it. We just can't compete."*

Public health managers also shared that both they and PHNs felt pressure *"to target all"* of the population with the limited resources available. The expectation to create a health promotion campaign that targets the entire population does not fit with the principle of target audience segmentation in social marketing (Kotler et al., 2002). It was articulated that the investment of time, energy, and money into a campaign to target only a small portion of the community, may be perceived as unrealistic within the context of health region expectations.

4.5.4.3 Familiarity with the Strategy

As stated earlier, public health managers felt that PHNs already practice with many of the ideals inherent in social marketing. However, participants articulated that

PHNs on the whole, did not fully understand the principles of social marketing. Though new graduates receive some social marketing content in their baccalaureate program, more experienced nurses are unfamiliar with the strategy, and a very limited number of PHNs would be considered proficient in its use. Public health managers also reported the ongoing education of practicing PHNs in the area of social marketing was not currently occurring in public health services. This was identified as a significant barrier to its use.

4.5.4.4 Formal Process to Maintain Momentum

Participants were adamant that if social marketing were to become a commonly used strategy in public health, a formal process to maintain the momentum would be required. It was felt that in past, there had been many great ideas and new strategies proposed in public health that fell short as a direct result of a combination of logistical constraints such as high workloads, a nursing shortage, and pressure from the health region to provide evidence of success.

> *"Without a champion for the cause, sometimes even the best intentions are set aside. When you're feeling overloaded and overworked you cut where you can."*

4.6 Strategies for Overcoming Barriers

Following the use of nominal group process, group discussion was facilitated by the researcher. A list of guiding questions was used to facilitate discussion regarding possible strategies to overcome barriers (see Appendix D). Participant responses will be discussed below as they apply to each of the barriers.

4.6.1 Human Resources

Public health managers identified two main strategies to alleviate the shortage of PHNs available to undertake social marketing. First, and most obvious, was to increase staffing. This suggestion was made with an obvious air of skepticism that it would ever be realized. Many of the managers who participated in this study had, for years, been trying to have funds made available for the hiring of additional PHNs. However, a second suggestion was also made to hire additional support staff, thus freeing up time for PHNs to concentrate on social marketing. One manager cited an example of PHNs spending an hour of their day cleaning up meeting rooms and arranging furniture since janitorial services were not available in their facility every day. Another manager cited a significant amount of PHNs' time spent on filing and calling clients because clerical staff were unavailable.

4.6.2 Financial Resources

A lack of financial resources was echoed among both sites in this study. The strategy identified to overcome this barrier is best described as a philosophical shift on the part of financial decision makers. Participants felt that it wasn't enough to obtain one-time funding for a specific social marketing program. They required long term commitment of adequate resources. This commitment of core funding is currently in place for other programs within public health, and participants felt that social marketing should be among them. Public health managers felt that dedicated funding would send the message to PHNs that efforts in social marketing are valued and would be supported, even if positive health behavior change was not immediate.

"I think that money is important. I mean the resources (needs) are huge. Adequate funding to do a good job, thoroughly and effectively, a recognition of that. We need commitment that it takes time. There is no quick fix."

4.6.3 Familiarity with the Strategy

Participants felt strongly that if PHNs are to be expected to use the social marketing process, they should have the opportunity to first participate in in-service training to develop the necessary skills. Public health managers also felt that this training should include a significant practical component.

"Whenever you are going to develop a new skill, you need the background to be able to do it. You need some knowledge and some understanding, and then the chance to practice. So if we are expecting PHNs to use these skills (social marketing), we have to give them a way to find or create the development of it."

"The less familiar it (social marketing) is to you, the less likely you are going to be to find ways to incorporate it into your existing workload."

"I think we have to use social marketing more as a lingo, and start using it more and say it more and then maybe it will gain more weight along the way."

4.6.4 Formal Process to Maintain Momentum

Though participants felt that PHNs should receive in-service training with regards to social marketing, they identified that it was unreasonable to expect every PHN to become an expert in the strategy. Rather, they saw a need for *"someone to champion the cause"*. Participants felt that a consultant, trained at the masters level, who worked directly for the region or the province, would provide the continued momentum necessary. They saw this individual's role as a consultant who would work with individual public health offices in all stages of the social marketing process. Participants felt that since this strategy is new to most PHNs, the likelihood of them incorporating it into their practice would increase significantly if they had access to an expert in the field. Participants were also clear that the role of the consultant was just that, a consultant. They felt that the PHNs' familiarity with the community, established relationships, and BSN preparation made them more suited to implement a social marketing campaign than an outside expert.

"We need an actual position, somebody that for them this is more of a prime responsibility of their work. They can support change, they can support teams who are wanting to do this sort of process, on-site program support."

"Public health practice is too broad a field for anyone to be an expert in everything. We rely on experts all the time to consult with, or for training. Why not for social marketing? This is a new strategy for us. If we are going to really incorporate it and make it a part of public health practice, then we are going to need more than a manual to follow."

4.7 The Key to Success

Most of the barriers to the use of social marketing among PHNs in Saskatchewan were identified as being at the system and regional levels. As a result, it is imperative that managers at those levels understand the principles of social marketing more fully. Participants in both sites articulated their belief that decision makers in their health regions were generally open to new approaches and supported health promotion strategies compatible with social marketing. However, it was viewed as unrealistic to expect upper-level managers to commit financial, human and material resources to the implementation of a strategy they know little about. Participants clearly articulated their belief that if any of the barriers are to be overcome using the identified strategies, it is ultimately necessary that managers within the public health system and health region gain a more in-depth understanding of social marketing.

"This is something that has to become organizational in commitment and that means having individuals from a lot of

different departments knowledgeable about social marketing and the impact it has on the public's health."

"I think it needs to be incorporated into the strategic plan for the health region . . . If we don't strategically plan to use it, it will be kind of hit and miss."

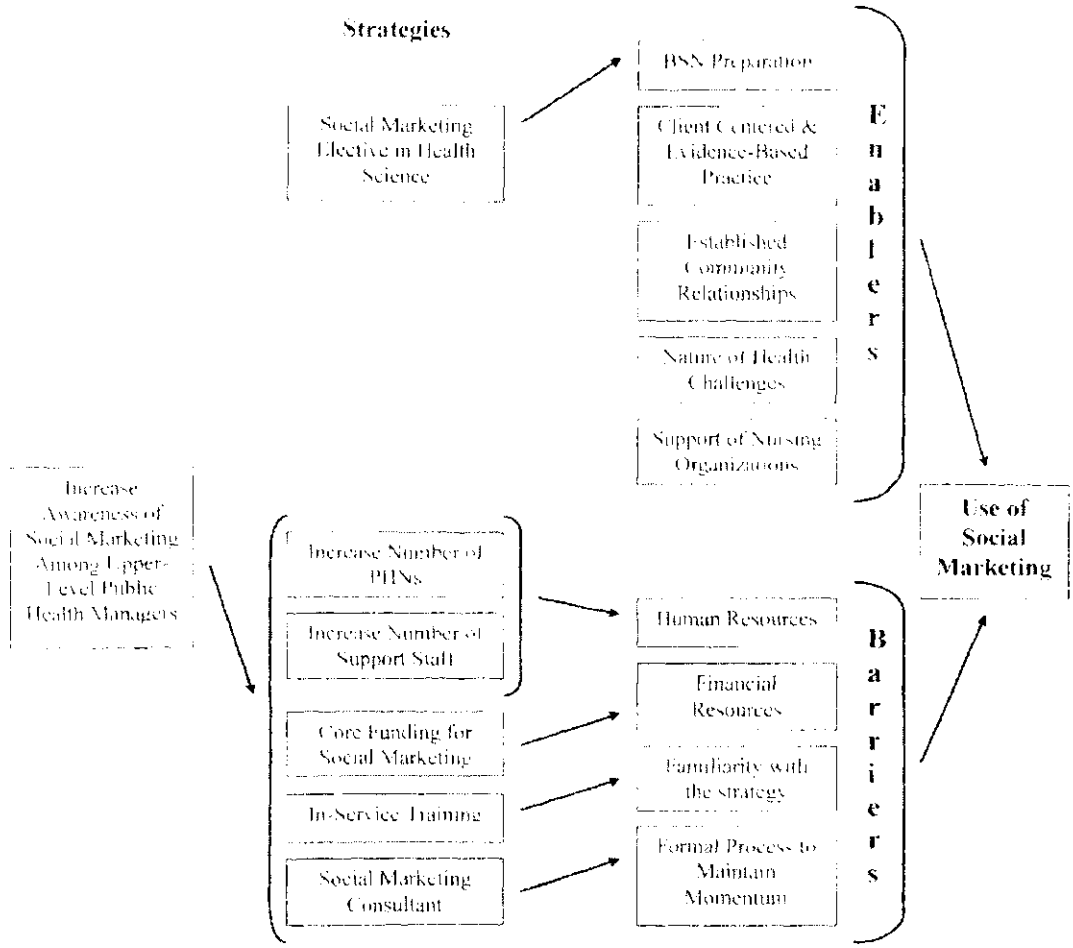
"Another huge strategy would be getting to managers and changing the culture of our organization to give them (PHNs) permission, to say that it's ok to get into social marketing. It's ok to spend the time on this strategy."

4.8 Diagram of Social Marketing Use

Nine separate factors were identified as directly influencing the use of social marketing among PHNs in Saskatchewan. Five of these factors were identified as enablers including: BSN preparation, client-centered and evidence-based practice, established community relationships, nature of health challenges, and support of nursing organizations. In contrast, four factors were identified as barriers including: human resources, financial resources, familiarity with the strategy, and formal process to maintain momentum. One strategy, a social marketing elective in health science, was proposed to strengthen the enabler of BSN preparation, while five separate strategies were proposed to overcome identified barriers. They included an increase in the number of PHNs and support staff, core funding for social marketing, in-service training, and the addition of a social marketing consultant. Participants also clearly articulated the direct

link between awareness of social marketing on the part of upper-level public health managers, and the likelihood of strategies being embraced and implemented. The following schematic depicts the interaction of precursors to social marketing use as described above.

Diagram of Social Marketing Use



4.9 Serendipitous Findings

Serendipitous findings are those results that do not relate to the research questions posed. They are findings the researcher did not set out to discover, but none the less were revealed. In this study, the frequency and strength of two particular themes warranted discussion. Throughout focus group sessions, in both sites, managers displayed a high level of support for the PHNs they supervise. It was noted that managers frequently

assumed an advocacy role when referring to PHNs. Participants made frequent comments regarding the positive attitude, work ethic, and capabilities of PHNs. It was clear that the managers in this study highly valued the PHNs.

> *"I know my nurses are capable of using social marketing. They are an amazing group of nurses. It's not that they aren't capable or that they don't want to take on more responsibility. In fact, they tend to take on more than I even ask them to. In this case, it is a failure of the system to support them in this role."*

> *"My nurses are incredibly creative and eager. They work incredibly hard. If they were given the chance to do more of this (social marketing) I have no doubt they would"*

The second serendipitous finding related to the education session public health managers participated in prior to focus group sessions. It was intended that the educational session would increase the likelihood that participants had a common understanding of social marketing when discussing the strategy in focus group sessions. However, the education sessions in both sites also had the unintended benefit of stimulating managers' willingness to employ social

marketing strategies. The majority of participants made comments regarding their intent to incorporate the strategy, either in part or in full, when they returned to their public health office.

> *"Before today I valued social marketing in theory, but it had fallen onto my back burner. I'm excited to go back to my (public health) office and look at places I can incorporate it."*

> *"Sometimes we need a day like this to get re-focused. With all the day to day stuff, sometimes even the best of intentions to try new things get forgotten. Days like today remind me that there are other methods out there. Just because we aren't using it, doesn't mean we shouldn't be. Sometimes we need to push ourselves to see if there is a better way to do what we are doing. It's easy to get stuck in a rut."*

CHAPTER FIVE – DISCUSSION

The purpose of this study was to utilize a qualitative, community based action research design to examine social marketing use. More specifically, the intent was to identify and explore the enablers and barriers to the use of social marketing among public health nurses in Saskatchewan. A review of research and academic literature prior to this study revealed a very limited number of publications on the subject. In addition, previous findings pointed to a misunderstanding and under-use of the strategy (McDermott, 2000; Quinn et al., 2005; Schoenfeld & MacDonald, 2002). As a result, in this study, the author expressly chose to explore the factors associated with social marketing use. In order to ensure that all participant contributions were made with a similar understanding of social marketing, all of the managers in this study attended an educational session on social marketing prior to focus group sessions. It is difficult to compare the results of this study to past research since no previous study expressly examined factors associated with the use of social marketing among health care practitioners, however attempts will be made where possible.

The majority of enablers identified by the public health managers who participated in this study related to the PHNs' aptitude and practice. These included:

PHNs' baccalaureate preparation, PHNs' client centered and evidence-based practice philosophy, and the existing relationships with both individual community members and community organizations PHNs have forged. In addition to these, managers also identified the nature of the health challenges addressed by the PHNs as highly amenable to the behavior change focus of social marketing. Finally, the support of nursing organizations for ongoing education and PHNs' role as social marketer were noted. None of the enablers identified related directly to the public health system or health region.

In contrast, the majority of barriers identified were system level factors within either the health region or public health services. These included: human resource deficits, financial resource deficits, and a lack of formal processes for the maintenance of social marketing momentum. PHNs' lack of familiarity with social marketing was highlighted as a barrier, however public health managers felt the onus should be placed on the health region to provide in-service training for practicing PHNs.

In addition to the provision of in-service training, other strategies identified included: the addition of social marketing as a health science elective, an increase in the number of PHNs and support staff, and the addition of a social marketing consultant within the health regions. Every strategy identified by public health managers for overcoming the identified barriers to social marketing use were at the level of upper management within public health services and the health region as a whole. It was noted by participants that individuals at elevated levels of management were likely to be largely unaware of social marketing, and as a result, efforts were required to increase their level of knowledge and understanding if a commitment to the use of this strategy was to be expected.

These enablers, barriers, and strategies will be further examined throughout this chapter in relation to a selected conceptual framework.

5.1 Conceptual Framework

A review of relevant literature revealed no existing research that examined the use of a conceptual framework to explain and/or predict the use of social marketing as a health promotion strategy. Since social marketing draws on two distinct fields of study, both marketing and health, one model from each discipline was chosen for analysis.

The potential applicability of the Health Promotion Model and the Diffusion of Innovation Model in addressing the enablers and barriers to the use of social marketing will be examined throughout this chapter. To assist in the comparison of these two models, the following table was derived from the abridged lists of enablers and barriers (as presented on pages 61 and 71 of this document).

	Health Promotion Model	**Diffusion of Innovations Model**
What are the potential enablers?	- prior related behavior (practice philosophy of PHNs) - personal factors (BSN preparation) - interpersonal influences (established community relationships) - situational influences (nature of health challenges)	- innovation attributes (nature of health challenges, practice philosophy of PHNs, established relationships) - communication channels (BSN preparation of PHNs)
What are the barriers?		- adopter categories (lack of awareness in upper levels of management) - communication channels (familiarity with the strategy, mechanism to maintain momentum) - social system (human and financial resources)
How can enablers be reinforced?	- personal factors (social marketing elective)	- innovation attributes (social marketing consultant)

		- communication channels (social marketing elective)
How can barriers be overcome?		- communication channel (in-service training, social marketing consultant) - social system (increase # of PHNs and support staff, establish core funding)
What is the adaptability of the model to public health nursing?	- explains the behavior choices of individuals related to the use of social marketing - accounts for only individual level barriers	- explains the diffusion of social marketing as a strategy in the public health system - accounts for both system level and individual barriers

5.1.1 Health Promotion Model

Following the development of the above table, exploration of the Health Promotion Model as a framework through which to examine social marketing use was completed. The Health promotion model examines the influence of eleven interrelated factors on an individual's health behavior (Pender et al., 2006). In this study, most of the enablers identified were attributed to PHNs' aptitude and practice. However, all of the barriers and strategies identified by participants were at the system level. Participants clearly articulated that the present under-use of social marketing was not a result of unwillingness or inability on the part of PHNs to implement the strategy. They felt that the limited use of social marketing within public health in Saskatchewan was more directly related to barriers including deficits in financial and human resources, training, and availability of consultative services. Participants articulated that even if PHNs were willing and individually able to incorporate social marketing approaches into their nursing practice, barriers over which they have little or no control would impede that process. In effect, it is not a matter of individual nurses choosing to use social marketing.

Public health managers felt the strategy must be embraced at the regional level, and diffused throughout public health services. For these reasons it was determined that the Health Promotion Model was not the optimal choice to explain and/or predict social marketing use among PHNs in Saskatchewan.

5.1.2 Diffusion of Innovation Model

Following the development of the above table, exploration of the Diffusion of Innovation Model as a framework through which to examine social marketing use was completed. In contrast, to the Health Promotion Model, the Diffusion of Innovation Model explains and predicts individuals' and societies' adoption of a new idea or product (Rogers, 1995). The inclusion of both individual and system level factors made this model a more appropriate choice for the explanation and possible prediction of social marketing use. The Diffusion of Innovation Model proposes five interrelated factors contribute to an innovation's rate of adoption. These include: innovation attributes, communication channels, social system, innovation process, and adopter categories (Rogers). These factors will be further explored below as they related to the data collected in this study.

5.1.2.1 Innovation Attributes

According to participants, social marketing has a high **relative advantage** over the traditional health education strategies used in public health because of its unilateral focus on behavior change. **Relative advantage** of an innovation over the status quo is a significant predictor of innovation diffusion (Rogers, 1995). Managers noted that the majority of health challenges addressed by PHNs, such as sexual health, nutrition, and

immunization, are a direct result of behavior choice, making them ideal targets for a social marketing campaign.

According to Rogers (1995), in order for any innovation to become widely accepted, it must be **compatible** with current practice philosophies. Social marketing places a strong emphasis on the research and data collection phases of campaign development (Kotler et al., 2002). According to participants, this emphasis is highly congruent with the client centered, evidence based practice philosophy with which PHNs practice. Managers also identified the established relationships PHNs have with both community members and community organizations as ideal partnership opportunities within the social marketing process.

A lack of familiarity on the part of PHNs with regards to social marketing was identified by participants as contributing to the perceived **complexity** of the strategy. Within the Diffusion of Innovation Model, the perceived **complexity** of an innovation can act as a barrier to its diffusion (Rogers, 1995). Participants articulated the need for in-service training on social marketing for practicing PHNs. Managers felt that an increased knowledge and skill level with respect to social marketing would inevitably reduce PHNs' hesitation with its use, by demystifying the strategy and increasing PHNs' confidence in the role as social marketer.

In addition, participants identified the availability of a social marketing consultant as an influence on PHNs' comfort with the strategy. Managers felt that access to a social marketing consultant would lessen the hesitation of PHNs to initiate long term campaigns. According to participants, this ongoing support would not only increase the

likelihood of social marketing use, but also the act as a mechanism to maintain momentum.

Participants acknowledged that since social marketing is largely underused in Saskatchewan, there are few local campaigns from which nurses can learn. However, it was noted that as increasing numbers of public health units begin to employ social marketing strategies, the **observability** of the strategy would increase. The opportunity to observe an innovation's implementation prior to committing to its use increases the rate of adoption (Rogers, 1995). As well, both **observability** and **triability** would be enabled through in-services training. Participants felt strongly that in-service training on social marketing should include a significant practical component allowing PHNs the opportunity to solidify their new skills. According to Rogers, the ability to initially implement a new strategy on a limited basis significantly increases the likelihood of adoption.

5.1.2.2 Communication Channels

There are several communication channels through which social marketing could be disseminated throughout public health system, and among PHNs. All PHNs entering into practice do so with baccalaureate preparation. Many baccalaureate programs in nursing, including the Nursing Education Program of Saskatchewan (NEPS), include social marketing in their curriculum (NEPS, 2005). In addition to the current content, participants suggested the incorporation of a social marketing elective, which nursing students would have the opportunity to take alongside other health science students. Managers felt this would enable the diffusion of social marketing by increasing the number of new nursing graduates well versed in the use of this health promotion strategy.

The potential opportunities for interdisciplinary collaboration this course would provide were also viewed as essential by participants. According to Kotler et al. (2002), collaborative opportunities are also integral to the success of social marketing campaigns.

Participants acknowledged that there are also a significant number of practicing PHNs for whom social marketing was not included in their basic nursing education. Managers felt that for the most part, these nurses would be largely unfamiliar with the strategy. In-service training was suggested as a communication channel through which ongoing opportunities for learning and discussion regarding social marketing could be provided, thus facilitating diffusion of the strategy.

Another possible communication channel identified by participants was the recommended social marketing consultant. For participants, this position represented an ideal means for continued dialogue between front line PHNs and a social marketing expert. Managers also related the potential communication channel this consultant may establish with upper-level management, acting as an advocate for PHNs regarding their use of social marketing.

5.1.2.3 Social System

The context within which an innovation is diffused is highly influential on its rate of diffusion (Rogers, 1995). In the case of this study, the social system is described as the public health sector and health region within which PHNs practice. Participants identified that the diffusion of social marketing may be hampered by a deficit in human and financial resources within this system. Managers felt that an increase in the number of PHNs and support staff would enhance PHNs' availability to incorporate new strategies such as social marketing into their practice. Since the commitment to a social marketing

campaign is often long term, participants insisted that core funding be established for the express purpose of integrating social marketing strategies. It was clearly articulated by participants that core funding would perpetuate the diffusion of social marketing into public health by ensuring PHNs are able to maintain programs through to fruition.

5.1.2.4 Innovation Process

The innovation decision period, that is, the time required for the diffusion of an innovation, may differ among various structural levels within an organization (Rogers, 1995). According to participants, PHNs are, by nature, creative and adaptable, making them more likely to be **innovators** or **early adopters**. While direct public health managers may place value on social marketing, they are also responsible for a variety of public health programs, and as such, may be slightly more hesitant to commit to the process. As a result, public health managers may be better described as being in the **early majority**. Finally, participants felt that given upper-level managers' relative unfamiliarity with social marketing, and their responsibility to divide waning resources among a variety of health programs across the health region, they may be slow to commit the necessary resources. Their hesitancy to commit to a new strategy until it is proven to result in positive health behavior change (and thus cost effective), makes them more likely to be in the **late majority** or **laggard** categories. Participants did note however, that individual propencity towards change may vary significantly individual to individual, and that it was direct and upper-level managers' professional responsibilities that were likely to slow their adoption of a new innovation such as social marketing.

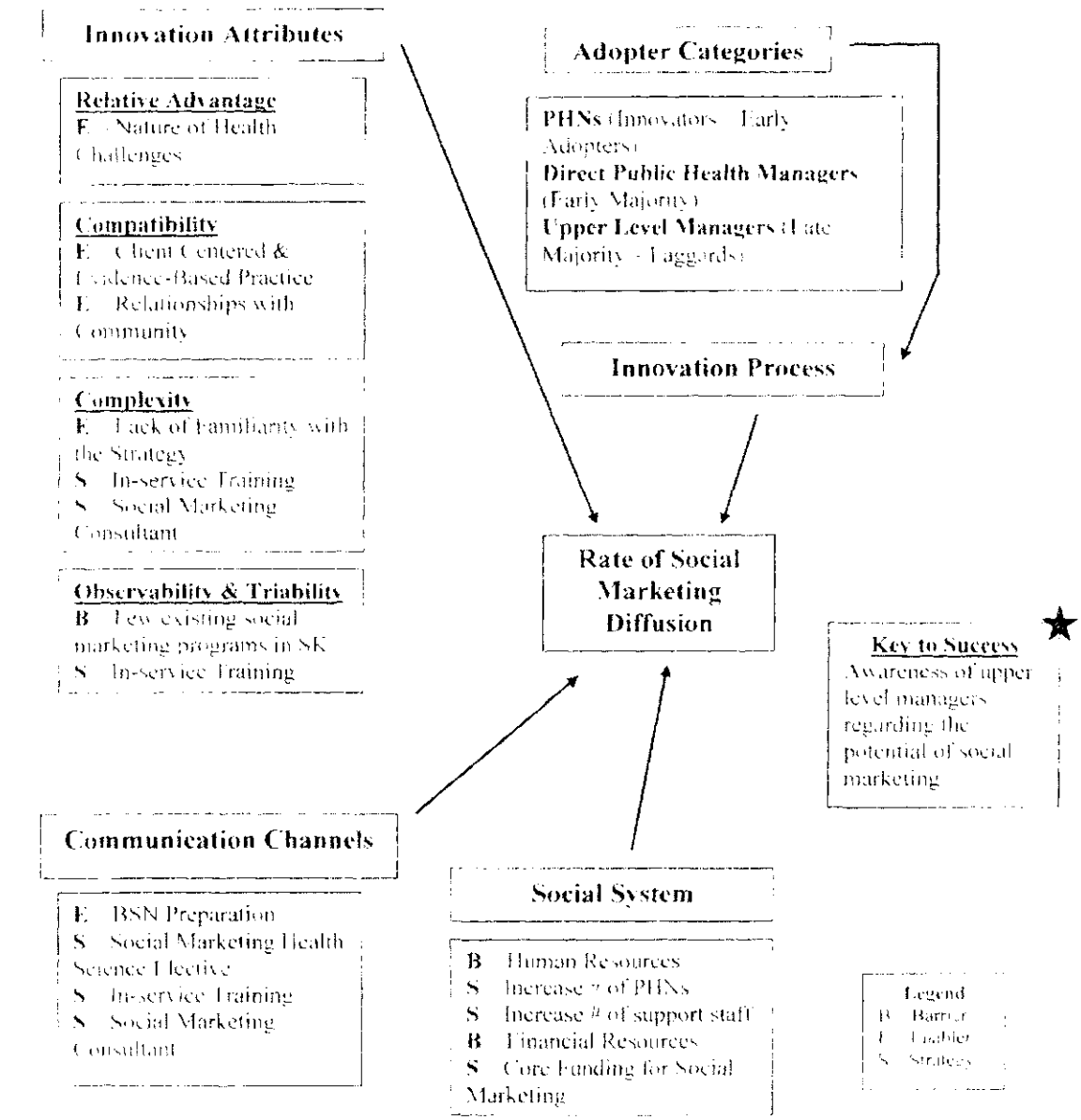
5.1.2.5 The key to success

Without exception, participants identified the key to successful diffusion of the social marketing innovation as an increased awareness of the strategy among upper-level managers. The majority of barriers to social marketing and strategies for overcoming those barriers identified by managers were at the level of upper management. As a result, participants felt it was imperative that these upper-level managers become aware of the potential health promotion value of social marketing if any of the proposed strategies were to be embraced. This is consistent with the findings of Quinn et al. (2005) who stated that although front-line participants of a social marketing training program gained considerable knowledge and appreciation for the strategy, the major barrier surrounded upper-level management.

5.1.2.6 Diagram of the Integration of Social Marketing Into the Diffusion of Innovation Model

The following schematic depicts the integration of social marketing into the Diffusion of Innovation Model described above.

Diagram of the Integration of Social Marketing Into the Diffusion of Innovation Model



Adapted from Rogers (1995)

5.1.2.7 Relevance of the Diffusion of Innovation Model to Social Marketing Use

As a marketing strategy, social marketing views the target audience as potential consumers. Akin to commercial consumers, it is acknowledged that the consumers of health promotion messages have the choice to accept or reject the "product" or message (Kotler et al., 2002). In the same manner, individual PHNs and the public health system as a whole, have the choice to accept or reject social marketing. There are many health promotion strategies that have, over the years, fallen in and out of favor. For social marketing to be embraced and incorporated into public health long term, it must be "marketed" appropriately. The Diffusion of Innovation Model is an suitable choice for explaining and/or predicting the use of social marketing because within the model, the strategy is recognized as an innovation with the potential to be diffused, or not.

Implementation of the Diffusion of Innovation Model to explain social marketing use may facilitate a big picture focus. Participants in this study overwhelmingly identified the barriers and related strategies as being at the system level. The Diffusion of Innovation Model is congruent with this focus. The model allows for the inclusion of both individual and system level factors. The findings of this study indicate that a variety of interrelated factors contribute to PHNs use of social marketing. This model may aid in strategic planning for the incorporation of social marketing by providing a system level framework through which to examine these factors.

5.2 Communication of Findings

The findings of this study are communicated through this thesis manuscript available at the University of Saskatchewan, College of Nursing. Findings may also be

communicated to interested nursing organizations such as the Canadian Association of Schools of Nursing, the Community Health Nurses Association of Canada, and the newly developed Office of Public Health, Public Health and Human Resources Strategies Division of the Public Health Agency of Canada. In addition, findings may be communicated to educational institutions such as the University of Saskatchewan and Saskatchewan Institute of Applied Science and Technology. As well, results may be published in appropriate academic journals such as Social Marketing Quarterly or Public Health Nursing, and presented at relevant conferences such as those organized by the Canadian Public Health Association or Social Marketing Institute for large scale dissemination. Each participant will receive a copy of study findings unless they requested otherwise. Participating health regions will also be offered the opportunity to have results presented to any public health managers and public health nurses, at the expense of the health region. Finally, results may be used to guide further research in this field.

5.3 Study Limitations

During the recruitment of study participants, all managers who either directly or indirectly supervise PHNs within the two selected health regions were invited to participate. Despite the inclusion of managers at both levels of administration, only direct managers of PHNs chose to participate in this study. It is worthy to note however, that of the 19 individuals invited to participate in this study, 17 contacted the researcher either to accept or decline participation. All of the participants who contacted the researcher to decline participation, stated that their decision was not related to a lack of interest or unwillingness on their part, but instead, reflected scheduling difficulties and time

constraints. The lack of representation from upper-level management in this study may have limited the depth of data collected. It is possible that upper-level managers may have revealed additional perspectives to those captured.

Given that public health managers were questioned regarding the practice of the nurses they supervise, it is also possible that the perspectives of the public health managers may not accurately reflect the practice realities of all PHNs.

Finally, due to the time constraints of public health managers, it was unreasonable to expect participants to attend more than one focus group session. Had additional time been available, a second focus group session may have provided the opportunity for participants to express perspectives gained following their reflection on the first session. Though participant input was solicited in an individual follow up phone call or email, these methods limited group interaction effects.

5.4 Implications of the Research Study

While the qualitative nature of this study limits the transferability of findings, implications of this research are numerous. These implications will be examined as they relate to future research, public health management, public health nurses, and baccalaureate nursing education programs.

5.4.1 Future Research

From the results of this research, there are three distinct areas recommended for future study. First, the replication of this study with an expanded population group, second, study of the Diffusion of Innovation Model as a framework for the incorporation of social marketing into public health, and third, the evaluation of existing social marketing education programs.

As stated above, the participant group in this study consisted solely of direct managers of PHNs. Given that the identified barriers and strategies were largely related to upper-level management, it is pertinent that the perspective of these individuals be explored in future research. Although upper-level managers were invited to participate in this study, none accepted. It may be necessary to further explore the barriers to their participation in an effort to capture their perspectives in future studies of a similar nature. Participants in this study felt that upper-level managers were largely unfamiliar with social marketing strategies, which is consistent with the results of previous studies (Quinn et al., 2005). As a result, it is recommended that an education session be included in future research, as was employed in this study.

It would also be highly advantageous to solicit the perspectives of practicing PHNs. It is possible that the perspectives of managers may not, in all cases, accurately describe the practice realities of PHNs. It is also acknowledged that for strategies to be most effectively implemented, they must be embraced by the PHNs themselves.

In this study, the Diffusion of Innovation Model was proposed as a framework to explain and or predict the use of social marketing. However, further research examining its applicability as a strategic planning model for the diffusion of social marketing among PHNs is warranted.

Finally, there exist several basic social marketing education programs that show promise for use in public health in-service sessions. However, Quinn et al. (2005) were the only authors to examine the implications of a specific training program. As well, their study examined only one program, making comparison difficult. If in-service training for PHNs regarding social marketing is to be successfully implemented, further research

addressing the most effective methods in which to provide the training is required. One of the serendipitous findings of this study was that education sessions in both sites also had the unintended benefit of stimulating managers' enthusiasm to employ social marketing strategies. Though this was not formally measured, it was noted that many managers left the education session articulating a renewed eagerness to incorporate social marketing into their practice. The potential of education sessions as a means to transfer knowledge is obvious; however the implications they may have to aid in the diffusion of the strategy in other ways warrants exploration.

5.4.2 Public Health Management

Public health managers were chosen as the population group for this study in part because of the link they represent between PHNs and the larger health care system. For this same reason, the results of this study may allow public health managers to advocate for the resources PHNs require to incorporate social marketing. An understanding of potential barriers and enablers to social marketing use may allow public health managers to more effectively plan for the success of social marketing diffusion among PHNs within their own public health units. The results of this study may guide strategies at this level including the incorporation of in-service training, and creative scheduling to allow PHNs the time necessary for program planning and evaluation.

5.4.3 Public Health Nurses

There are two distinct implications of this study for practicing PHNs. First, one serendipitous finding revealed an intense level of admiration and support on the part of public health managers for the PHNs they supervise. Overwhelmingly, managers in this study advocated for PHNs ability in the role of social marketer. An awareness of the

appreciation and esteem with which they are viewed by their managers may contribute to PHNs willingness to incorporate this new strategy into their practice.

Second, an understanding of the nature of barriers to social marketing use may enable PHNs to more effectively articulate their resource needs when advocating to their direct or indirect managers.

5.4.4 Baccalaureate Nursing Education Programs

As curricula evolve, it is critical that nursing educators are aware of the practice realities of PHNs. It is imperative that new nursing graduates are well prepared for increasingly complicated practice environments. The results of this study have the potential to influence community health nursing curricula by clarifying the educational requirements of PHNs in the area of social marketing. In addition, the identified need for interdisciplinary learning opportunities in social marketing education is important as health science programs move toward an increasingly collaborative learning environment.

5.5 Conclusions

Despite the significant potential social marketing has for health promotion in Saskatchewan, it has not yet diffused into public health nursing practice. There are a number of interrelated factors that contribute to PHNs use of social marketing. Identified enablers include: BSN preparation, client-centered and evidence based practice, established community relationships, nature of health challenges, and support of nursing organizations. The only strategy suggested for strengthening enablers was the development of a social marketing elective for all health science colleges. Identified barriers include: financial resources, human resources, familiarity with the strategy, and

formal process to maintain momentum. Strategies suggested for overcoming these barriers include: increased number of PHNS, increased number of support staff, core funding for social marketing, in-service training, and a social marketing consultant. The majority of enablers to the use of social marketing relate to the PHNs' aptitude and practice, while barriers are, for the most part, the product of system level factors. As a result, the key to overcoming those barriers is an increase in the knowledge and appreciation of social marketing within upper-level management. This could be achieved through formal training on social marketing for all levels of management within public health services. This training could be further supported with continued encouragement for the incorporation of social marketing into the PHN's role from organizations such as the Community Health Nurses Association of Canada, and the Canadian Public Health Association. This increased knowledge and subsequent commitment on the part of those responsible for budgetary planning is critical. By nature, behavior change takes time, therefore, the sustainability of social marketing is vital. The Diffusion of Innovation Model has been proposed in this study as a framework through which to explore the barriers, enablers, and strategies associated with social marketing use. It is the hope of the researcher that an understanding of the factors associated with social marketing use among PHNs may facilitate its diffusion throughout public health in Saskatchewan. The resulting increase in social marketing campaigns could have significant potential for the promotion of health in this province.

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APPENDIX A

Participant Questionnaire

1. Which of the following best describes your number of years experience in public/community health?

1 year or less 2-4 years 5-7 years 8-10 years More than 10 years

2. Which of the following best describes your number of years managerial experience in public/community health?

1 year or less 2-4 years 5-7 years 8-10 years More than 10 years

3. What is the highest level of education you have achieved?

Diploma Baccalaureate Degree Masters Degree Doctoral Degree

4. What is the highest level of education you have achieved in nursing?

None Diploma Baccalaureate Degree Masters Degree
Doctorate

5. Which of the following best describes the geographical region in which you directly or indirectly supervise public health nurses? Please check all that apply.

Rural Area (agricultural/small town)
Small Urban Area (small city) Large Urban Area (large city)

6. Prior to your participation in this study, how would you rate your understanding of social marketing?

Poor Fair Good Excellent

7. Prior to your participation in this study, how much formal training/education did you have in the area of social marketing?

None Small Amount Moderate Amount Substantial Amount

8. How often to you believe the public health nurses you directly or indirectly supervise use social marketing?

Never Rarely Sometimes Often

APPENDIX B

Letter of Permission for use of Educational Material

Kristin Holland

From: "Kristin Holland" <kristinholland@sasktel.net>
To: <turnpt@u.washington.edu>
Sent: Friday, June 17, 2005 5:04 PM
Subject: Request for document use

Hello,

My name is Kristin Holland and I am a Masters Student in Nursing at the University of Saskatchewan, Canada. I have begun work on my masters thesis in the area of social marketing. It will be a qualitative study with a subject group of public health managers at various levels of management. My intent is to identify the enablers and barriers to the use of social marketing in the Saskatchewan public health care system. I will be gathering data though individual interviews as well as focus groups. However, one of the assumptions of my study is that there are misconceptions within the system as to exactly what social marketing is to begin with. As a result, prior to the interviews, I intend to have participants engage in a short session on social marketing. The intent is to have everyone on the same page about what social marketing is, prior to the collection of data regarding its use. I will not be delivering an in-depth training sessions by any means, simply an overview of the main concepts. This brings me to the reason for my email. I have read the various social marketing educational documents on your website and was very impressed. I would like permission to distribute these documents to my participants (approximately 10) as part of my study. Your organization would, of course, be acknowledged as the author, and I would not adapt the document in any way. The presentation would involve highlighting the main concepts and the distribution of your documents for participants to take home.

I welcome any questions you may have, and look forward to your response.

I thank you in advance for your consideration of my request.

Kristin Holland BScN, RN, MN student

39 - 102 Pawlychenko Lane
Saskatoon, Saskatchewan
Canada S7V 1G9

(306)668-0455
kristinholland@sasktel.net

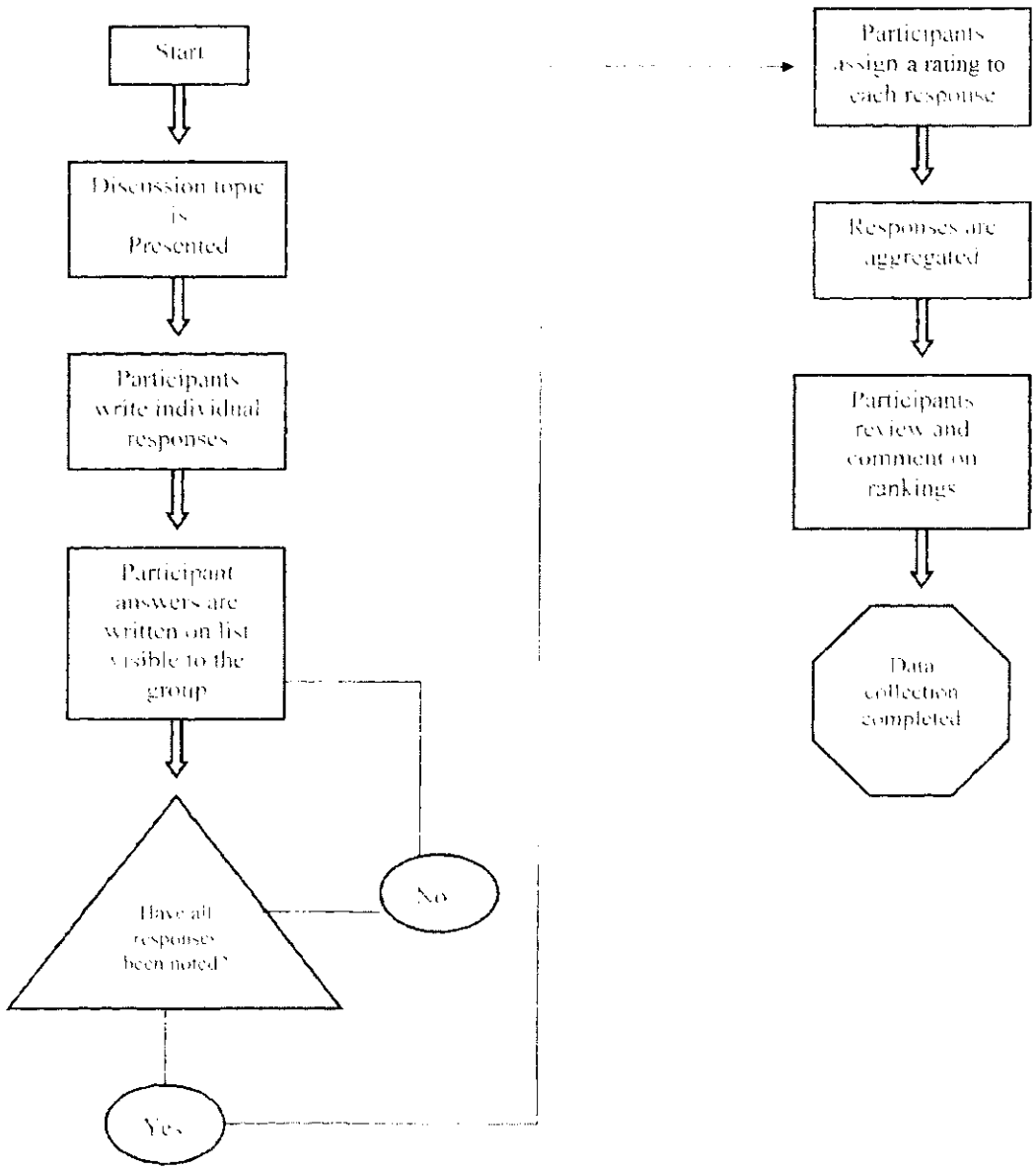
From: "Marleyse Borchard" <borchard@u.washington.edu>
To: <kristinholland@sasktel.net>
Sent: Thursday, June 23, 2005 10:58 AM
Attach: with. As a result, prior to the interviews, I intend to have.dat
Subject: Fw: Fw: Request for document use

Hi Kristin.
We got your message. We are happy to have you use the documents, as long as you provide attribution. Best wishes in your work.
-Marleyse Borchard
----- Original Message -----
From: "Sylvia J. Pirani" <sjp03@health.state.ny.us>
To: "Marleyse Borchard" <borchard@u.washington.edu>
Cc: <bobbich@u.washington.edu>; "Thomas H. Reizes" <thr02@health.state.ny.us>
Sent: Thursday, June 23, 2005 9:43 AM
Subject: Re: Fw: Request for document use

6/23/2005

APPENDIX C

Nominal Group Process



Adapted from Dunham (1998)

APPENDIX D

Focus Group Guiding Questions

1. What strategies do you think could be employed to strengthen the enablers to the use of social marketing the group identified?
2. What strategies do you think could be employed to overcome the barriers to the use of social marketing the group identified?
3. If you could adapt your current workplace to make it conducive to accomplishing population health using social marketing, what changes would you make?

APPENDIX E

Participant Invitation Letter

You Are Invited to Participate in a Research Study on Social Marketing

As a manager in public health, responsible for the direct or indirect supervision of public health nurses, you have been identified as a potential participant in a research project entitled

Pubic Health Manager's Perspectives on the Use of Social Marketing Among Public Health Nurses in Saskatchewan

The purpose of this study is to explore enablers and barriers associated with the use of social marketing. It is hoped that once enablers and barriers to social marketing are identified, the means by which enablers can be strengthened and barriers overcome can be explored. In addition, the researcher hopes to determine the potential applicability of the health promotion model or diffusion of innovation model in explaining and/or predicting the use of social marketing among public health nurses in Saskatchewan.

If you choose to participate, you will be requested to complete a short questionnaire, attend one educational session on social marketing (approx 2 hours), and attend one focus group related to social marketing (approx 2 hours). In addition, the researcher will contact you once by phone or email, at your convenience following data analysis to elicit your opinions on preliminary findings. There is no cost associated with your participation and participation is completely voluntary. Your choice to participate will in no way affect your current or future employment.

This study was approved by the University of Saskatchewan Behavioral Sciences Research Ethics Board on Month, 00, 2005. Questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services (966-2084). Out of town participants may call collect.

If you are interested in learning more about this study or would like to participate, please contact Kristin Knibbs, and more details will be provided.

Sincerely,

Kristin Knibbs BScN, RN
Masters of Nursing Student
College of Graduate Studies and Research
University of Saskatchewan
kristin.knibbs@usask.ca (306)668-4455

APPENDIX F

Participant Informed Consent

Informed Consent

You are invited to participate in a Masters Thesis Study entitled **Pubic Health Managers' Perspective on the Use of Social Marketing Among Public Health Nurses in Saskatchewan.** Please read this form carefully and feel free to ask questions you might have.

Researcher
Kristin Knubbs BScN, RN
Masters of Nursing Student, College of Graduate Studies and Research
University of Saskatchewan
kristin.knubbs@sasktel.net

Research Supervisor
Lynnette Leeseberg Stamler PhD, RN
Associate Professor, College of Nursing
University of Saskatchewan
Phone 966-1477

Purpose and Procedure: The purpose of this study is to explore enablers and barriers associated with the use of social marketing. It is hoped that once enablers and barriers to social marketing are identified, the means by which enablers can be strengthened and barriers overcome can be explored. As well, the researcher hopes to determine the potential applicability of the health promotion model or diffusion of innovation model in explaining and or predicting the use of social marketing among public health nurses in Saskatchewan.

The information gathered in this study will be used for thesis work by Kristin Knubbs, and may be disseminated in conferences or to nursing organizations or journals. If you choose to participate, you will be requested to complete a short questionnaire, attend one educational session on social marketing (approximately 2 hours), and attend one focus group related to social marketing (approximately 2 hours). In addition, the researcher will contact you once by phone or email, at your convenience following data analysis to elicit your opinions on preliminary findings. There is no cost associated with your participation and participation is completely voluntary. Your choice to participate will in no way affect your current or future employment.

Potential Risks: There are no foreseeable risks associated with your participation in this study.

Potential Benefits: Potential benefits of participation include increased understanding of the use of social marketing in public health practice, and the knowledge that your participation has contributed to research that

Will enable evidence based practice in this area of public health nursing. No benefits associated with your participation in this study are guaranteed.

Storage of Data: During the course of this study, all study material will be securely stored by the researcher. Following the completion of the study, all study information will be secured by Lynnette Leeseberg Stamler at the College of Nursing, University of Saskatchewan for a period not less than five years.

Confidentiality: All group discussions will be recorded and transcribed verbatim. Data will be reported in aggregates and unattributed quotations in order to ensure confidentiality of participants. Moreover, consent forms will be stored separately from other study material, so it will not be possible to associate a name with any given responses. In signing this, you are consenting to the use of group transcriptions for the identified purpose. All email contact between the researcher and participants will also be kept confidential. Only the researcher will have password access to the email address provided.

The researcher will do the utmost possible to safeguard the confidentiality of discussion, but cannot guarantee that other members of the study group will do so. Please respect the confidentiality of the other participants by not disclosing the contents of discussions outside the group.

Right to Withdraw: Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, your contributions will not be withdrawn since the researcher has no means by which to identify individual contributions in the focus group recordings.

Questions: If you have questions concerning this study, please feel free to ask at any point; you are also free to contact the researcher at the number provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioral Sciences Research Ethics Board on Month, 00, 2005. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.

Each participant will receive a summary of research findings by mail following the completion of the study. If you do not wish to receive this, please advise Kristin Knibbs. As well, your workplace will have the option to have findings presented by the researcher in the form of a seminar following the completion of the study.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw at any time. I also consent to the use of focus group transcripts, to which I have contributed, to be used for the purposes identified above. A copy of this form has been given to me for my records.

Thank you for your Participation!

Participant Signature _____ *Researcher Signature* _____

Date _____

APPENDIX G

Procedural Guidelines for Managing Focus Group Discussions

Before Leaving for the Site

Review notes. Include notes from focus group discussions conducted earlier for this study, including team debriefings if they were done.

Review study protocol and topic guide.

Gather materials.

Prepare tape recorder, extra tape recorder, sufficient cassettes, extra batteries, notepads, pens, labels, name tags, topic guides, gifts, snacks or travel reimbursements for participants, other materials.

Test tape recorder.

At the Site Before Discussion Begins

Set up the room. Refreshments should be available before focus group discussion begins. Ensure that participants help themselves or are served. Arrange mats or chairs in a circle. A table may or may not be present, depending on cultural norms of conversation.

Test the tape recorder.

Label the cassette with the date and group identification code; load and test it.

Greet the participants.

Collect sociodemographic data informally.

Make labels with numbers corresponding to data sheets if you are using them to identify individual speakers during recording and note taking.