



Ethical evaluation of audience segmentation in social marketing

Audience
segmentation

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Received 28 September 2011
Revised 18 March 2012
Accepted 9 July 2012

Abstract

Purpose – The ethicality of using audience segmentation in social marketing contexts has typically been framed within either a consequentialist or non-consequentialist perspective, leading to a hitherto intractable debate. This paper seeks to shed new light on this debate using two alternative ethical frameworks: the theory of just health care (TJHC) and integrative social contracts theory (ISCT).

Design/methodology/approach – The paper uses cross-sectional survey data from a Kenyan social marketing campaign that aimed to increase awareness and support for the use of anti-retroviral therapy (ART), a class of drugs that inhibit the development of HIV.

Findings – Application of the TJHC and ISCT to the Kenyan social marketing campaign revealed the use of audience segmentation to be ethically justified. Moreover, the TJHC provided a useful framework for guiding decisions about the selection of target audience(s) in health-related contexts.

Practical implications – In situations where there are known asymmetries in exposure to mass media channels, adopting a non-segmented mass-media approach may unintentionally entrench pre-existing disparities in health knowledge.

Originality/value – The application of the TJHC and ISCT to health-related social marketing contexts offers a means of resolving the longstanding debate about the ethicality of audience segmentation. The ethical principles underpinning the TJHC also provide a decision-making framework to guide discussions about whether audience segmentation should be based on cost-effectiveness (consequentialism) or need (non-consequentialism). This is particularly relevant in social marketing settings, where the resources available for conducting campaigns are often limited and segmentation decisions about the groups that are targeted or excluded can have important health-related implications.

Keywords Social marketing, Ethics, Segmentation, Kenya, HIV/AIDS

Paper type Research paper

Introduction

Social marketing explicitly draws from commercial marketing. Kotler and Zaltman's (1971) landmark article that heralded the emergence of social marketing, for instance, was motivated by Wiebe's (1951) question of "why can't you sell brotherhood and rational thinking like you sell soap?" (p. 679). Similarly, one of the most commonly cited definitions of social marketing describes the practice as "the adaptation of commercial marketing technologies to programs designed to influence the voluntary behaviour of target audiences to improve their personal welfare and that of the society of which they are a part" (Andreassen, 1994, p. 110).



Social marketing has arguably benefited from the transfer of knowledge from commercial marketing. Indeed, a systematic review of the social marketing literature concluded that the commercial marketing techniques underpinning social marketing can be an effective means for motivating behaviour change in contexts as varied as increasing physical activity levels and preventing smoking and illicit drug use (Stead *et al.*, 2007). Nevertheless, there are some fundamental differences between commercial and social marketing that render the wholesale transfer of techniques from one field to another potentially problematic. Accordingly, this study examines whether audience segmentation, a commercial marketing technique that has attracted particular debate within the social marketing literature, can be ethically applied in social marketing contexts.

This paper is outlined as follows. First, the debate between consequentialists and non-consequentialists regarding the ethics of using segmentation in social marketing campaigns is reviewed. Next, two alternative ethical frameworks, Integrative Social Contracts Theory (ISCT; Donaldson and Dunfee, 1994, 1995, 1999) and the Theory of Just Health Care (TJHC; Daniels, 1985, 2001), are introduced and examined in the context of segmentation. These frameworks are then used to evaluate the ethics of using segmentation in a health-related social marketing campaign conducted in Kenya. Finally, implications concerning the ethics of using segmentation in social marketing campaigns are discussed.

Segmentation and social marketing

Each consumer is unique, yet similarities in consumer needs and desires may nevertheless exist across social, psychological, or demographic groupings (Plummer, 1974; Wedel and Kamakura, 2000). Developing campaigns that appeal to specific groups of consumers can therefore increase the efficiency and effectiveness of those campaigns (Kotler and Lee, 2008). A corollary of segmentation, however, is that while some groups of consumers may be targeted to receive the marketing campaign, others may not. As a result, some groups who may well benefit from being exposed to a social marketing campaign may ultimately be excluded from receiving that campaign. Consider, for example, newly single older women. This cohort tends not to be targeted in safer sex campaigns because their risk of contracting sexually transmitted infections (STI) has generally been considered low (Idso, 2009). In recent years, however, a growing number of newly single older Australian women have begun to find new sexual partners via online dating sites (Bateson *et al.*, 2011). Lacking the STI knowledge typically communicated in safer sex campaigns, new singly older Australian women are more willing to have unprotected sex than their younger counterparts, contributing to the recent surge in STI rates that has been observed among this cohort (Bateson *et al.*, 2011).

As this Australian case highlights, there are two central issues surrounding the use of segmentation in social marketing contexts: can the use of segmentation be ethically justified; and if segmentation can be justified, what approach should be used to select the groups that are included or excluded from the target audience. In the social marketing literature, these issues are typically evaluated using non-consequentialist or consequentialist frameworks.

Non-consequentialists contend that some actions are inherently good, irrespective of the outcomes that may arise from those actions. This ethical framework has given rise

to two perspectives on segmentation. Adherents of the first perspective argue that social marketing campaigns should be egalitarian and non-discriminatory to ensure that some groups are not systematically favoured at the expense of others (Bloom and Novelli, 1981). These individuals therefore advocate non-segmented, population-wide campaigns that target each individual equally (Bloom and Novelli, 1981). Adherents of the second perspective give partial support to segmentation, arguing that it can be ethically justified if it is used to direct the benefits of social marketing to the most vulnerable or needy members of the population (Donovan and Henley, 2003). An implicit example of this perspective can be seen in a document released by UNAIDS (1998), where, in the context of reducing rates of HIV/AIDS, social marketing was described as making “condoms accessible, affordable and acceptable to low-income populations and high-risk groups” (p. 3). In sum, therefore, non-consequentialists seek either to proscribe segmentation or to use it selectively to improve the wellbeing of those deemed to be in greatest need of a specified intervention.

Unlike their non-consequentialist counterparts, consequentialists determine the ethics of an action on the basis of the outcomes arising from that action. For instance, proponents of utilitarianism, a variant of consequentialism, argue that an action is ethical if it achieves the greatest good for the greatest number of people. From a utilitarian perspective, a campaign that results in substantial improvements for one group (but not another) would be considered preferable to a second campaign that results in mediocre improvements for all groups (Rothschild, 2000). Thus, consequentialists favour a form of segmentation that directs limited resources towards those segments where the greatest good can be achieved, even if this means that more needy segments of the population may ultimately miss out on the campaign (Donovan and Henley, 2003).

Given that consequentialism and non-consequentialism provide contradictory views on segmentation, the ethicality of using this technique in social marketing campaigns is currently uncertain. Indeed, as numerous authors have noted (Andreasen, 1995; Andreasen, 2006; Bloom and Novelli, 1981; Brenkert, 2002; Dholakia, 1984), social marketing campaigns that utilise segmentation are commonly criticised for discriminating against specific groups or populations, particularly by the government agencies that fund these campaigns. There is consequently a very real risk that an efficacious method for enhancing the effectiveness of social marketing campaigns may not be utilised to the fullest extent possible.

Unfortunately, the controversy surrounding segmentation is difficult to resolve, not least because the ethical views of social marketers tend to vary as a function of their disciplinary background. Social marketers from a commercial marketing background, for instance, typically hold consequentialist views, whereas those from a public health background generally maintain a non-consequentialist perspective (Basil, 2001; Donovan and Henley, 2003). This disciplinary divergence is perhaps unsurprising. Most ethical issues in commercial marketing settings arise from the predatory or deceitful practices of marketers (Beauchamp *et al.*, 2009), so the fact that segmentation may prevent some groups from being exposed to these practices raises few ethical issues. Indeed, in commercial contexts, the ethics of segmentation is typically only considered when vulnerable consumers (i.e. those who are less able to protect their own interests; Smith and Cooper-Martin, 1997) are preferentially targeted with potentially harmful product offerings, such as cigarettes or credit cards (e.g. Brenkert, 1998;

Nwachukwu *et al.*, 1997; Rittenburg and Parthasarathy, 1997; Smith and Cooper-Martin, 1997). Public health professionals, in contrast, operate in an environment where the product being made available (i.e. medical knowledge or treatment) is, by definition, capable of maintaining or improving health. Making decisions about who will access the public health product on the basis of group membership can therefore give rise to serious group-based inequalities in health, fostering a mindset that favours the fair distribution of public health interventions (Kass, 2001). Thus, appeals for the supremacy of consequentialist over non-consequentialist thinking (e.g. Truss and White, 2010) are unlikely to resolve the ethical debate surrounding segmentation because they do not sufficiently address why social marketers from public health backgrounds hold non-consequentialist views.

One way of addressing this impasse and moving the debate forward would be to apply complementary ethical frameworks to evaluate the use of segmentation in social marketing campaigns. Two alternative ethical frameworks, Integrative Social Contracts Theory ([ISCT], Donaldson and Dunfee, 1994, 1995, 1999) and the Theory of Just Health Care ([TJHC], Daniels, 1985, 2001), may be particularly useful in this regard. ISCT was developed to evaluate ethical issues in business contexts and has been applied in a range of commercial marketing settings, while the TJHC emerged from the public health literature. Identifying areas of consensus between the two frameworks could therefore give rise to a view of segmentation that is equally acceptable to those from both commercial marketing and public health backgrounds. Thus, the purpose of this study was to evaluate the use of segmentation in social marketing campaigns using ISCT and the TJHC. Two particular issues were examined during the course of this evaluation. First, is the use of segmentation ethically justified in social marketing contexts? Second, if the use of segmentation is justified, how should decisions about which group is targeted by the social marketing campaign be made?

Integrative social contracts theory

The underlying premise of ISCT is that the ethicality of behaviour is determined by macrosocial and microsial contracts (Donaldson and Dunfee, 1994, 1995, 1999). Macrosocial contracts encapsulate universal principles that specify what individuals ought to do, while microsial contracts refer to informal agreements about ethical behaviour that organically develop within self-defined communities of individuals. The relationship between macrosocial and microsial contracts is governed by two processes: authenticity and legitimacy. Microsocial contracts are said to be legitimate when they are consistent with macrosocial contracts. Microsocial contracts also gain authenticity when the vast majority of the community supports and acts in accordance with that contract. In this way, macrosocial contracts provide boundaries for acceptable behaviour, and within these boundaries communities can develop their own understandings of ethical behaviour.

ISCT has prompted a diverse body of research within the marketing discipline. Dunfee *et al.* (1999), for instance, used ISCT to evaluate the use of bribes in marketing settings, noting in the process the theory's applicability for examining the complex, boundary-spanning issues that are common to the marketing discipline. Maignan and Ferrell (2004), in contrast, used ISCT to understand how social contracts influence corporate social responsibility practices. ISCT has also been used by Hunt and Vitell

(2006) to inform the revision of their descriptive theory of marketing ethics, and by Laczniaik and Kennedy (2011) to conceptually ground their search for macrosocial contracts relevant to international marketing. As such, ISCT may also be germane to examining the ethical issues surrounding the use of segmentation in social marketing campaigns (Smith, 2001).

Application of ISCT to segmentation requires an evaluation of extant macrosocial and microsocal contracts. Microsocial contracts regarding the use of segmentation may vary across communities, necessitating further empirical research to identify the nature and content of these contracts within specific communities. Macrosocial contracts, in contrast, can be identified *a priori* in that they are consistent with major philosophies and religious precepts, supported by relevant professional bodies in the international community, and enshrined in law across numerous countries (Donaldson and Dunfee, 1999).

While there is no macrosocial norm regarding the use of segmentation *per se*, a macrosocial norm concerning a right to health may provide a basis for supporting some form of segmentation in health-related social marketing contexts. Article 25 of the Universal Declaration of Human Rights, for instance, states that “everyone has a right to a standard of living adequate for the health of himself and of his family” (United Nations, 2011). The preamble to the World Health Organisation’s constitution is even more explicit, stating that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (World Health Organization, 2006, p. 1). A right to health has also been recognised in the constitutions of more than 100 nation states and supported through numerous successful court decisions around the world (Hogerzeil *et al.*, 2006). Thus, these sources suggest that each individual has a right to achieve the highest possible standard of health, irrespective of their sociocultural background. Given that health status frequently varies along sociocultural lines (Adler *et al.*, 1994; Blane, 1995; Poulton *et al.*, 2002; Starfield *et al.*, 2002; Wilkinson, 1994), the use of segmentation in social marketing campaigns may therefore be required to ensure that those groups who have experienced, or are at risk of experiencing, health declines are able to receive remediative assistance. Indeed, signatories to the Ottawa Charter for Health Promotion pledged to “respond to the health gaps within and between societies” (World Health Organization, 1986, p. 4), providing support for the use of segmentation in health-related settings. As such, from an ISCT perspective, the use of segmentation is supported in principle by a macrosocial contract regarding the right to health.

Although ISCT finds support for the ethicality of segmentation, the framework provides little guidance on how to decide which population segments should be preferentially targeted. Indeed, as has been argued elsewhere (Daniels, 2001), there are no commonly agreed-on principles of distributive justice, making the search for macrosocial contracts on which to justify preferential targeting futile. However, other frameworks, such as Daniels’ (1985) TJHC, may be better able to address this issue.

Theory of just health care

The TJHC is an extension of Rawls’ (1972) theory of justice as fairness. The basic premise of Rawls’ theory is that individuals under a hypothetical “veil of ignorance” that precludes knowledge of their personal circumstances will select outcomes that

maximise benefits for those who are worst off in society. According to Rawls, this premise gives rise to three principles. The first principle, “a right to basic liberties”, requires all individuals to have a basic set of rights, such as freedom of expression and freedom of personal property. The second principle, “fair equality of opportunity”, necessitates the absence of impediments for progressing to better social positions. Put another way, this principle holds that traits irrelevant to the performance of ability-based positions should not be used to make decisions about who will be appointed to those positions. The third principle, referred to as the “difference principle”, states that instances where inequalities exist should be dealt with in a way that maximises benefits to those who are worst off in society. These principles are hierarchically ordered, with the basic liberties principle having precedence over the fair equality of opportunity principle, and the fair equality of opportunity principle having precedence over the difference principle.

Rawls’ (1972) theory of justice as fairness has been recognised by numerous authors as having particular relevance to marketing ethics (Laczniak and Murphy, 2006; Robin and Reidenbach, 1987; Schlegelmilch and Öberseder, 2010; Tsalikis and Fritzsche, 1989). Laczniak (1983) laid the groundwork for this attention, arguing that Rawls’ theory could be usefully applied to marketing issues because it provides sophisticated, multidimensional guidelines for ethical behaviour and represents a legitimate and contextually relevant alternative to utilitarian theories. Rawlsian perspectives on equality and fairness have also guided the development of marketing-specific ethical frameworks, including Klein’s (2008) benefit-cost approach, Laczniak and Murphy’s (2006) principles for enlightened marketing, and Ferrell and Ferrell’s (2008) macromarketing ethics framework. Thus, Daniels’ (1985) TJHC, which adapts Rawls’ theory to address the ethical issues associated with healthcare, may also be appropriate for examining the unique issues that arise in health-related social marketing contexts.

The TJHC (Daniels, 1985) uses the fair equality of opportunity principle from Rawls’ (1972) theory as a conceptual starting point for developing a just health system. According to Daniels, an individual whose normal level of functioning has been reduced through disease or disability has fewer opportunities available to him- or herself than if they had no disease or disability. It is important to note, however, that Daniels’ conceptualisation of opportunity expands on that advanced by Rawls. Where Rawls was interested in ensuring equal career opportunities, Daniels’ focus was on protecting access to the normal opportunity range. Thus, in Daniels’ words, individuals should have “a fair chance to enjoy the normal opportunity range of their society [. . .] allowing an individual to enjoy that portion of the normal range to which his skills and talents would normally give him access” (p. 103).

From a TJHC perspective, the fundamental purpose of health-related social marketing campaigns is to protect individuals’ access to the normal opportunity range. Justification for segmentation can therefore be found through the TJHC if some group is experiencing, or is at risk of experiencing, declines in their normal opportunity range and if the segmented social marketing campaign is targeted towards this at-risk group. In this regard, the TJHC is consistent with ISCT in that both provide conditional support for the use of segmentation. Unlike ISCT, however, the TJHC also addresses the issue of how to determine which groups should receive preferential attention. Daniels (1993) termed this issue the “priorities problem” to reflect the fact that with only limited resources available, attempts to improve the health of the population may

result in winners and losers. The problem therefore becomes one of equitably distributing finite resources among competing groups. Because there are no commonly agreed-on principles of distributive justice, Daniels (2001) advanced four conditions aimed at ensuring that the priorities problem can be resolved in a manner that is consistent with a just health system. These conditions may therefore also help social marketing practitioners to ensure that the segmentation decisions they make are fair.

The first condition advanced by Daniels (2001) is that all decisions restricting health care access to certain segments of the population should be publicly disseminated, along with the arguments underpinning those decisions. This condition is designed to improve the transparency and public scrutiny of health care decisions while simultaneously educating the general public about the need to balance competing health interests. The second condition is that the criteria used to determine which groups receive access to a specific form of health care should be deemed relevant by all groups (Daniels, 2001). For example, while consequentialists may have concerns about selecting target segments on the basis of need alone, most consequentialists and non-consequentialists will acknowledge that need plays a role in target selection (see, for example, the segmentation strategies advanced by Andreasen, 1995; Donovan *et al.*, 1999; Kotler and Lee, 2008). The purpose of this condition is to assure groups ultimately excluded from receiving access to a particular type of health care that the criteria used to make this decision were reasonable, even if members of these groups do not agree with the decision itself.

The third condition advocated by Daniels (2001) is that an appeals process should be instituted such that earlier decisions can be revised if new evidence supporting alternative decisions is found. This, in turn, would allow social marketing campaigns to be reflexive to changing community needs. For instance, an appeals process could mean that future Australian STI campaigns address the increased STI risk profile of newly single older women. Finally, the fourth condition advanced by Daniels is that the preceding three conditions should be regulated through voluntary agreements or legislation. Thus, Daniels' four conditions are aimed at fostering a public deliberative process that extends beyond the decisions made by individual organisations or governmental agencies.

Empirical evaluation

The four conditions advanced by Daniels (2001) for resolving the priorities problems can be defended or opposed on the basis of ethical arguments alone. The preconditions advanced in ISCT and the TJHC regarding the ethicality of segmentation, in contrast, have both an ethical and an empirical dimension. That is, ethical justification for the use of segmentation in social marketing contexts requires not only agreement with the premises underlying ISCT and the TJHC but also evidence that the preconditions associated with these theories have been met. To this end, pre-campaign survey data from a social marketing campaign conducted in Kenya was used to determine whether: specific population segments were at risk of experiencing reduced health (ISCT and TJHC); and a microsocial norm supporting a right to health existed (ISCT).

The purpose of the campaign was to increase the general Kenyan community's awareness and support for the use of antiretroviral therapy (ART), a class of drugs that inhibit the development of HIV cells and which consequently form an essential element of HIV treatment programs (Carpenter *et al.*, 2000). Given the difficulties associated

with measuring socioeconomic status in developing nations (Howe *et al.*, 2008; Onwujekwe *et al.*, 2006), the primary segmentation variable used in this analysis was highest level of attained education. Education is an important segmentation variable in its own right, having both direct and indirect effects on health (Guralnik *et al.*, 1993; Ross and Wu, 1995; Steenland *et al.*, 2002). The highly educated, for instance, tend to have better social, financial, and psychological resources for maintaining or improving their health than those with lower levels of education (Ross and Wu, 1995). In commercial marketing contexts, low levels of education have also been linked with greater consumer vulnerability to unscrupulous segmentation strategies (Smith and Cooper-Martin, 1997).

Method

Participants and procedure

Given the diversity of languages spoken in Kenya, the study survey was translated from English into three main regional languages (Kiswahili, Dohluo, and Kikuyu) and then back-translated into English to ensure that linguistic and conceptual equivalence had been maintained (Behling and Law, 2000). A fieldwork firm with experience conducting research in Kenya was then contracted to recruit participants and collect the survey data. Fieldworkers from the market research firm were trained to administer the survey in English as well as in Kiswahili, Dohluo, and Kikuyu.

Institutional ethics approval for the study was granted prior to the commencement of recruitment. Recruitment took place through six hospital and medical clinics that had been selected to provide a cross-section of populations from urban, peri-urban, and slum settings across Kenya. Recruiting clinical populations through medical facilities is common in Africa, for alternative means of cost-effectively reaching these populations, such as through consumer panels, are frequently unavailable (Mascolini and Zuniga, 2008). A systematic sampling procedure was employed (Black, 2006), with every seventh person entering the outpatient reception area of the selected hospital/clinic sites being asked to participate in the study. Inclusion criteria for participation were being aged 15 years or older and attending the hospital/clinic for the purpose of receiving medical treatment.

Individuals who agreed to participate in the study were administered the survey face-to-face prior to seeing a clinician. Face-to-face data collection was used because: approximately 38.5 per cent of the adult Kenyan population is illiterate (Kebathi, 2008); and it increases survey response rates (Hox and de Leeuw, 1994) and reduces social desirability response bias (Holbrook *et al.*, 2003) relative to alternative one-on-one methods of obtaining survey data. To maintain confidentiality and reduce distractions, interviews were conducted in a separate office or a quiet section of the reception area. At the beginning of the interview, fieldworkers asked participants their preferred language so that they could be administered with the appropriate language variant of the questionnaire. Each interview took approximately 25-30 minutes to complete.

In total, 1,624 participants were recruited from the selected hospital/clinic sites over a three-week period during December 2004. This sample of participants comprised 703 (43.3 per cent) males and 921 (56.7 per cent) females. Additional information pertaining to the demographic profile of the study sample can be found in Table I.

The survey instrument was comprised of four sections. In the first section, participants completed items assessing their language preference, reasons for

Demographic variable	<i>n</i>	(%)	Audience segmentation
<i>Gender</i>			
Male	703	43.3	
Female	921	56.7	
<i>Age</i>			
15-24	467	28.8	1429
25-34	638	39.3	
35-44	373	23.0	
45 +	146	9.0	
<i>Education</i>			
No formal education	118	7.3	
Primary	731	45.0	
Secondary	531	32.7	
College	244	15.0	
<i>Recruitment location</i>			
Nairobi (Nairobi Province)	272	16.7	
Mombasa (Coast Province)	278	17.1	
Kiambu (Central Province)	259	15.9	
Thika (Central Province)	269	16.6	
Kisumu (Nyanza Province)	273	16.8	
Homa Bay (Nyanza Province)	273	16.8	

Table I.
Socio-demographic characteristics of the participant sample

attending the medical clinic, the media channels to which they had access, the radio stations and newspapers that they had listened to or read in the past seven days, and their unprompted recall of any health-related campaigns that they had seen or heard in the past six weeks. Participants were then asked whether they were aware of ART. Those who were aware of ART proceeded to complete the second section of the survey, where they were asked to select the sources through which they had heard about ART in the past month, their unprompted recall of ART campaigns, and their knowledge and beliefs about ART. All participants were then asked whether they had received an HIV test and, if they answered in the affirmative, whether their test results indicated that they were HIV positive. Those participants who were HIV positive and ART aware then completed the third section of the survey. In this section, issues surrounding ART use and non-use were examined. The fourth section, which captured sociodemographic information, was completed by all participants.

Measures

Following Fishbein and Ajzen (1975), a qualitative pilot study of 23 individuals involved in the provision of ART and 49 individuals receiving ART was conducted to elicit the ART beliefs held by the target population. These beliefs were then incorporated into the survey (Fishbein and Ajzen, 1975). As such, the survey assessed both correct and incorrect beliefs about ART.

One of the elicited ART beliefs assessed in the second section of the survey was “people with HIV should start using ART medications as soon as possible”. While this belief is technically incorrect insofar as ART should only be used among HIV patients with CD4 cell counts below 350 cells/mm³ (World Health Organization, 2009), it

nevertheless assesses support for individuals with HIV to use, and therefore have access to, ART. This belief therefore provides an indirect measure of participants' support of the right to health. Support for this belief item was assessed on a five-point Likert scale that ranged from 1 (disagree) to 5 (agree). "Smiley face" scale prompts were used to aid in the interpretation of the scale as such prompts have proved useful in research conducted among populations with low rates of literacy (Spark, 1999).

Given the importance of stigma about HIV on willingness to seek ART (Murray *et al.*, 2009), participants who were HIV positive were also asked whether it was acceptable to take ART. Specifically, they were asked to indicate whether they would: "only go for ART if a close friend/relative was also"; or "go for ART even if I didn't know anyone who is on ART".

Results

Microsocial contract for a right to health

Support for a right to health in the context of providing access to ART was assessed among the general community who were aware of ART and among individuals diagnosed with HIV. At the community level, agreement with the notion that "people with HIV should start using ART medicines as soon as possible" was examined across educational segments as an indirect measure of a right to health. An independent measures ANOVA revealed significant differences in support ($F(3,436) = 3.91, p < 0.01$), with Tukey's *post hoc* analyses indicating that college graduates ($M = 4.40, SD = 1.07$) more strongly endorsed this belief than primary school ($M = 3.98, SD = 1.29$) or secondary school ($M = 3.94, SD = 1.33$) graduates. Nevertheless, comparison of mean scores suggests that support for this belief was high across all groups.

Indirect support for a right to health was also found among individuals diagnosed with HIV. Specifically, 96.7 per cent ($n = 88$) of participants who were HIV positive and ART aware indicated that they would "go for ART, even if I do not know anyone who is on ART". This subsample was therefore highly supportive of going for, and receiving, ART.

Risk of experiencing reduced health

Ultimately, individuals with HIV must take ART to safeguard their access to the normal opportunity range, for failure to do so will lead to premature death (Farmer *et al.*, 2001; Walensky *et al.*, 2006). ART awareness and HIV status were therefore examined by educational status to ascertain whether individuals in at least one segment were at risk of experiencing reduced health. Individuals in all educational segments were found to be at some risk of experiencing reduced health should they become HIV positive, for ART awareness was incomplete across each segment (see Table II). Nevertheless, some segments were at potentially greater risk than others. Specifically, primary school graduates and those with no formal education were significantly less likely to be aware of ART than college and secondary school graduates (see Table II). Moreover, primary school graduates were more likely to have been diagnosed with HIV than college graduates (see Table II). As such, compared with their more educated counterparts, those with lower levels of education were at greater risk of experiencing reduced health should they become diagnosed with HIV due to their lower levels of ART awareness.

Variable	None		Primary		Secondary		College		χ^2
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	
<i>ART</i>									
Not aware	106	89.8 ^d	577	78.9 ^d	359	67.6 ^c	114	46.7 ^c	115.89 ^{***}
Aware	12	10.2 ^c	154	21.1 ^c	172	32.4 ^d	130	53.3 ^d	
<i>HIV status</i> ^a									
Positive	6	28.6	80	33.3 ^d	44	22.2	9	7.5 ^c	29.95 ^{***}
Negative	15	71.4	160	66.7 ^c	154	77.8	111	92.5 ^d	
<i>ART and HIV status</i> ^b									
HIV positive and ART aware	1	16.7	30	37.5	13	29.5	2	22.2	—
HIV positive and ART unaware	5	83.3	50	62.5	31	70.5	7	77.8	

Notes: ^a $p < 0.05$; ^b $p < 0.01$; ^c $p < 0.001$; ^drefers to the $n = 579$ participants who had been tested for HIV and received their test results; ^b χ^2 not computed as expected cell count < 5 for 20.0 per cent or more of cells (Agresti, 2002); ^cpercentages indicate adjusted standardised residual ≤ 1.96 ; ^dpercentages indicate adjusted standardised residual ≥ 1.96

Table II.
Educational background
by ART awareness and
HIV status

Given these segment-based disparities, follow-up analyses were conducted to determine whether a non-segmented, mass media campaign would reach each educational segment equally. Chi-square tests of independence revealed that primary school graduates or those with no formal education were less likely than college or secondary school graduates to report exposure to TV, radio, newspapers, magazines, and video (see Table III). Those with no formal education were also less likely to report exposure to cinemas than those with a college education (see Table III).

Finally, a one-way ANOVA was used to determine whether the total number of media channels to which participants were exposed varied as a function of their educational status. A significant difference was observed, $F(3, 1620) = 181.66$, $p < 0.001$, with Tukey's *post hoc* analyses revealing that all groups significantly differed from each other. Specifically, college graduates had the greatest exposure to different media channels ($M = 3.65$, $SD = 1.29$), followed by high school graduates ($M = 2.75$, $SD = 1.44$), primary school graduates ($M = 1.80$, $SD = 1.31$), and those with no formal education ($M = 0.97$, $SD = 0.81$).

Discussion

The purpose of this study was to evaluate: the ethicality of using segmentation in social marketing campaigns; and which segments should be preferentially targeted.

The ethics of segmentation

Analysis of the ART pre-campaign data revealed that the preconditions associated with ISCT and the TJHC were met, supporting the use of segmentation in the context of this campaign. ISCT yielded support on the grounds that: a social contract regarding a right to health existed at both the microsocial (i.e. within Kenya) and macrosocial levels; and population groups in Kenya were at risk of experiencing reduced health because of low levels of ART awareness. A more parsimonious defence of segmentation was provided by the TJHC. Specifically, segmentation could be justified through the TJHC on the grounds that groups within Kenya were at risk of

Media	None		Primary		Secondary		College		χ^2
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	
<i>TV</i>									
No exposure	98	83.1 ^b	400	54.7 ^b	168	31.6 ^a	29	11.9 ^a	242.79 ^{***}
Exposure	20	16.9 ^a	331	45.3 ^a	363	68.4 ^b	215	88.1 ^b	
<i>Radio</i>									
No exposure	36	30.5 ^b	126	17.2 ^b	52	9.8 ^a	12	4.9 ^a	57.87 ^{***}
Exposure	82	69.5 ^a	605	82.8 ^a	479	90.2 ^b	232	95.1 ^b	
<i>Newspaper</i>									
No exposure	108	91.5 ^b	550	75.2 ^b	212	39.9 ^a	54	22.1 ^a	340.61 ^{***}
Exposure	10	8.5 ^a	181	24.8 ^a	319	60.1 ^b	190	77.9 ^b	
<i>Magazine</i>									
No exposure	118	100.0 ^b	662	90.6 ^b	389	73.3 ^a	114	46.7 ^a	254.07 ^{***}
Exposure	0	0.0 ^a	69	9.4 ^a	142	26.7 ^b	130	53.3 ^b	
<i>Video</i>									
No exposure	116	98.3 ^b	626	85.6 ^b	392	73.8 ^a	133	54.5 ^a	137.14 ^{***}
Exposure	2	1.7 ^a	105	14.4 ^a	139	26.2 ^b	111	45.5 ^b	
<i>Cinema or mobile cinema</i>									
No exposure	118	100.0 ^b	711	97.3	513	96.6	231	94.7 ^a	8.17 [*]
Exposure	0	0.0 ^a	20	2.7	18	3.4	13	5.3 ^b	

Table III.Educational background
by media exposure**Notes:** ^{*}*p* < 0.05; ^{**}*p* < 0.01; ^{***}*p* < 0.001; ^apercentages indicate adjusted standardised residual ≤ 1.96; ^bpercentages indicate adjusted standardised residual ≥ 1.96

experiencing declines in their normal opportunity range. Both theories therefore yielded positions that were in opposition to the variant of non-consequentialist thought that views segmentation as inherently unethical.

The pre-campaign findings provide further insight into the non-consequentialist perspective that favours treating all individuals equally. Specifically, participants with arguably the greatest need for information about ART (i.e. those with limited education) also reported having the lowest level of mass media exposure. As such, a non-segmented mass media campaign, the typical recourse of non-consequentialists wishing to ensure that all individuals receive the same treatment (Bloom and Novelli, 1981), may have had the unintended consequence of entrenching pre-existing asymmetries in health knowledge.

This scenario presents an interesting counterpoint to traditional ethical perspectives of segmentation in that it is generally the use, as opposed to the non-use, of segmentation that has generated concern. In commercial settings, for instance, segmentation is censured when it is used to preferentially target harmful products to vulnerable consumers who are less able to protect their own interests (Brenkert, 1998; Smith and Cooper-Martin, 1997). Similarly, in social marketing circles, segmentation is often criticised for withholding interventions that can maintain or improve the wellbeing of needy groups (Bloom and Novelli, 1981). The scenario emerging from the pre-campaign data therefore broadens the discourse surrounding the ethics of segmentation by demonstrating that the non-use of this technique may also have ethical implications.

At this point, it should be noted that knowledge inequalities may also arise as a result of segmentation strategies. Nevertheless, campaign managers would at least be cognisant of the potential for such differences to arise and could therefore seek to redress these differences in subsequent campaigns. Indeed, as Kotler and Lee (2008) argued, social marketers should “present, or at least mention, a long-range plan that will eventually address groups you are not addressing in this phase” (p. 131) of the campaign. The current findings therefore provide a cautionary note regarding the use of non-segmented campaigns for the purpose of ensuring equal access to social marketing campaigns. This cautionary note is particularly pertinent in developing world contexts, where lower literacy rates and greater levels of poverty may interact to restrict media access to specific segments of the community.

Selecting population segments ethically

A more complex picture emerged regarding the second major ethical controversy surrounding segmentation, which centres on determining which segments should receive preferential targeting. Consequentialists, for instance, contend that segments should be targeted on the basis of cost-effectiveness, while non-consequentialists supporting the use of segmentation argue that such decisions should be based on need. Unfortunately, in the absence of widely held principles of distributive justice, absolutist arguments in favour of consequentialist or non-consequentialist methods for selecting population segments are unlikely to be appropriate in every context. Indeed, as Deutsch (1975) noted, the values that individuals use to make decisions about distributive justice tend to vary from one situation to another. It is within this context that the four conditions advanced by Daniels (2001) have particular appeal. These conditions do not assume that one framework for selecting population segments is superior to any other framework. Rather, these conditions democratise the rationing of limited health funds by opening the “black box” surrounding health care rationing decisions to public scrutiny, empowering consumers to take part in the broader social discourse about how health care rationing takes place. In this way, both non-consequentialist and consequentialist approaches to selecting population segments can be accommodated within the same framework.

Although Daniels’ (2001) four conditions have not previously been discussed in a marketing context, application of some elements associated with these conditions would not be without precedence. Kumcu and Vann (1991; Vann and Kumcu, 1995), for example, emphasised the need for open discourse in macromarketing programs aimed at promoting socioeconomic development in settings where diverse interest groups have conflicting economic needs. Specifically, these authors argued that actors should be empowered to formally or informally participate in the design of macromarketing programs, providing actors with opportunities to develop a broader consensus as to how outcomes should be distributed.

Procedures approximating some of Daniels’ (2001) conditions have also appeared within the social marketing literature. Daniels’ public disclosure condition, for instance, is consistent with Kotler and Lee’s (2008) argument that social marketers should “be prepared to present your rational criteria and evaluation that led to decisions to focus resources on the target market you have selected” (p. 131). A similar call was made by Brenkert (2002), who argued that “transparency should be the prime directive for social marketers” (p. 23). Brenkert also advocated allowing communities

to participate in the design and formulation of social marketing campaigns. These prescriptions therefore accord with the intent of Daniels' four conditions in that they seek to foster a public deliberative process surrounding campaign decision-making.

Limitations and conclusion

One limitation of this study was that the survey instrument was not specifically designed to conduct an ISCT or TJHC-based evaluation. As a result, only indirect support could be found for the existence of a right to health microsocial norm. Nevertheless, the findings suggest that ISCT and the TJHC are useful frameworks for exploring the ethics of segmentation in health-related social marketing campaigns. Future research could therefore use these frameworks to conduct a more detailed ethical evaluation of the use of segmentation within health-related settings.

In conclusion, both ISCT and the TJHC support the ethics of segmentation in health-related social marketing contexts. The TJHC also provides a framework that can accommodate consequentialist and non-consequentialist arguments regarding the priorities that should be attached to segmentation decisions. Indeed, from a TJHC perspective, segmenting on the basis of cost-effectiveness (consequentialism) or need (non-consequentialism) is ethically justifiable so long as the reasoning underpinning the selected segmentation strategy is publicised and there is a feedback or review mechanism for altering segmentation decisions. Using the TJHC to justify the use of segmentation therefore affords a means of addressing the divisive debate concerning whether segmentation should proceed along consequentialist or non-consequentialist lines (see Bloom and Novelli, 1981; Donovan and Henley, 2003). This, in turn, may help to overcome the controversy surrounding the use of segmentation in government-funded social marketing campaigns (see Andreasen, 1995; Andreasen, 2006; Bloom and Novelli, 1981).

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