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Integrating Social Marketing Into Fijian HIV/AIDS Prevention Programs: Lessons From Systematic Review

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ABSTRACT

Social marketing techniques have been tested and proven useful within the health sector worldwide. In Fiji, social marketing was introduced in the early 1990s, and more rapidly during the last decade to improve national response to an increasing incidence of sexually transmitted infections (STIs) such as human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). Given the limited amount of research in the area of program evaluation in Pacific Island Countries and Territories (PICTs), this study systematically analyzes five Fijian HIV/AIDS prevention programs through Andreasen's benchmark criteria, in order to identify gaps in program design that ultimately impact program effectiveness. Assessment results unveil some interesting trends regarding the focus and applications of past Fijian HIV/AIDS prevention programs in the past decade. This article discusses these findings and other valuable lessons for future HIV/AIDS prevention strategies in Fiji and elsewhere.

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Prevention of HIV/AIDS is a public health concern worldwide. In 2012, an estimated 35.3 (32.3–38.8) million people worldwide were living with HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2013). While global statistics indicate that new HIV infections decreased by 33%, from 3.4 (3.1–3.7) million in 2001 to 2.3 (1.9–2.7) million in 2012, some countries experienced an upward trend in HIV rates over the past decade. HIV incidence in Fiji, for instance, increased in recent years to an average of 60 new infections annually, which is a twofold increase compared to statistics between 2000 and 2008 (UNAIDS, 2012, 2013). As of 2013, Fiji recorded a cumulative total of 546 confirmed HIV cases that were predominantly spread through young adults, ages 20–29 years, and transmitted via heterosexual contact (Ministry of Health Fiji, 2014; World Health Organization [WHO], 2006). Probably a better reflection of the severity of the spread of sexually transmitted infections (STIs) among the Fijian population is the average annual number of gonorrhea cases, which was reportedly 1,348 between 1998 and 2004 (WHO, 2006). Other reports reveal that chlamydia cases in the Pacific, especially among pregnant women, are among the most numerous in the entire world (Hammar et al., 2011).

National efforts to prevent STIs/HIV/AIDS transmission in Fiji have been directed toward educational strategies, increasing treatment availability and accessibility, and improving health and counseling support services. Behavioral interventions, a recent phenomenon in Fiji, ensued after multiple health reports revealed that young adults continued to engage in risky sexual behavior despite knowing about HIV/AIDS (Bavinton et al., 2011; Fowler, O'Loughlin, & Tikinatabua, 2007; Hammar et al., 2011; Kaitani, 2003; UNAIDS, 2008). Studies have established that information alone—through leaflets, talks, mass media, or marketing campaigns—is insufficient to change behavior of at-risk individuals (Hughes, 1993). Therefore, some reviews have called urgently for intensive and sustained behavior change programs in Fiji (Fowler et al., 2007; UNAIDS, 2008).

Behavior change programs are an important component of HIV/AIDS prevention (Disease Control Priorities Project, 2009). Over the years, social marketing has been increasingly regarded as a useful method for developing effective behavior change programs as part of AIDS prevention strategies (Lombardo & Léger, 2007). In fact, more than 40 countries around the world utilize social marketing (Kotler & Lee, 2008). More specifically, social marketing has contributed to HIV/AIDS prevention efforts by increasing awareness, accessibility, and affordability of contraceptives, and influencing how people think about the risks of HIV/AIDS (Harvey, 2008; Nilimaa & Nixon, 2004).

Social marketing is described as "the systematic application of marketing concepts and techniques, to achieve specific behavioral goals to improve health and reduce health inequalities" (French & Blair-Stevens, 2006, p. 33). Social marketing directs its effort toward changing the behavior of the target audience. It seeks both to influence the real and perceived costs and benefits that may result from the behavior(s), and to modify people's perceptions of the likelihood that those costs and benefits will arise. The social marketers' essential task is to persuade the audience that there is more to gain than lose by adopting a health precautionary behavior (Lamptey & Price, 1998).

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Literature Review

Global Use of Social Marketing in HIV/AIDS Prevention

Reviewing the field in 1989, Novelli recorded that more than 30 social marketing projects in 27 countries had helped to improve contraceptive availability, increase sales of contraceptive products, and spread knowledge of and stimulate wider use of contraceptive methods. Similarly, a report by UNAIDS (2000) indicated that condom social marketing programs had helped to make condoms more accessible, affordable, and acceptable in many developing countries such as Haiti, Mozambique, India, Cameroon, Kenya, and Colombia. Bangladesh reportedly used social marketing to raise awareness and distribute such contraceptives as pills, condoms, and foaming spermicidal suppositories (Rosenfield & Binzen, 1987; Schellstede & Ciszewski, 1984). In Nepal, a celebrity campaign for HIV/AIDS, called "Black and White," turned out to be a huge success, receiving the Nepal Advertising Association Award in 2002 for Best Media Campaign (Honeyman, 2008). Similarly, a social marketing program called "Stop AIDS," developed by the Swiss AIDS Foundation in 1987, has been one of the longest running and most carefully evaluated social marketing programs in the world to have been developed for AIDS prevention (Honeyman, 2008).

Most parts of Africa have also successfully applied social marketing in their efforts to prevent the spread of the disease. For instance, a Zimbabwe campaign used social marketing to promote condoms for STI/HIV protection (Meekers, 2001); Tanzania utilized condom social marketing and observed the effects ranging from increased awareness to adoption of protective behaviors (Eloundou-Enyegue, Meekers, & Calves, 2005); and Cameroon reported a dramatic increase in condom use after implementing social marketing campaigns (Niebuhr, Gruber-Tapsoba, Degrando, & Gesing, 2004). Likewise, the U.S. Agency for International Development (USAID) implemented a mass-media campaign in Nigeria, the VISION project, to raise awareness and increase the consumption of services related to family planning, child survival, and HIV/AIDS. Keating, Meekers, and Adewuyi (2006) reported that the VISION project had reached a large number of Nigerian citizens and influenced their perceptions about HIV/AIDS.

Developed countries such as United States, New Zealand, Australia, and the United Kingdom have likewise felt the benefits of using social marketing (Reynolds & French, 2009).

Social Marketing Interventions in the South Pacific

The Pacific is one of the world's most diverse regions, but represents only 0.14% of the world's population (Commission on AIDS in the Pacific, 2009). Each of the 22 independent countries and territories within the Pacific region varies in terms of land size and population; lifestyle and living conditions; culture, traditions, and languages; economy; political system; and natural resources (United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP], 2010). HIV prevalence in the Pacific (excluding Papua New Guinea [PNG]) is generally low, but concerns have been raised regarding the escalating number of new HIV cases (Secretariat of the Pacific Community [SPC], 2005, 2010; United Nations Children's Fund [UNICEF], 2006). From 1984 to December 2012, a total of 1,737 HIV cases were reported across the 21 Pacific Island Countries and Territories (PICTs), (SPC, 2013). Apart from Papua New Guinea, which has already reached generalized epidemic rates (UNESCAP, 2010), 85% of all reported HIV cases in the Pacific emerged from Fiji, New Caledonia, French Polynesia, and Guam (Secretariat of the Pacific Community, 2013). In the absence of epidemiological HIV sero-surveys of the general population (UNAIDS, 2012), it is estimated that between 50,000 and 150,000 people could have HIV/AIDS region-wide (UNESCAP, 2010).

As part of regional prevention efforts in the 1990s, the South Pacific Alliance for Family Health (SPAFH) introduced social marketing campaigns to promote contraceptives in Fiji, Solomon Islands, Tonga, and Vanuatu (Duve & Samuel, 1995). The Fiji-based campaign proved to be successful in terms of increasing acceptability and visibility of contraceptives (Duve & Samuel, 1995), but there is little published information available on the effects of social marketing programs in other PICTs during this period.

In 2006, Marie Stopes International Pacific (MSIP) implemented condom social marketing (CSM) programs in eight PICTs: namely, Fiji, Tuvalu, Samoa, Solomon Islands, Vanuatu, Federated States of Micronesia, Palau, and the Marshall Islands (MSIP, 2007, 2010). MSIP's CSM programs were designed to increase awareness and promote safe sexual practices among young Pacific Islanders. Program evaluation reports by MSIP (2007, 2010) indicated that the Fiji-based CSM program had significantly improved awareness and sales of their branded condoms through social marketing.

Despite this reported success, researchers like Fowler and colleagues (2007) and Lui, Musson, Kishore, and Ram (2011) have criticized the developers of earlier Fijian HIV/AIDS prevention programs. Critiques include poor-quality programs that overlooked national frameworks and standards, lack of consulting with the experts from health care training institutions, and failing to conduct postprogram assessments. Indeed, most PICTs have failed to create well-designed and multisectorial responses to effectively combat the epidemic (Ahlburg, Larson, & Brown, 1998). In addition, there is general consensus regarding the underdeveloped status of qualitative behavioral and health services research in the Pacific (Cullen, 2000; Hammar et al., 2011; WHO, 2001). No epidemiological HIV sero-surveys to detect HIV/AIDS in the general population have yet been conducted in any PICTs (UNAIDS, 2012).

All HIV/AIDS prevention programs require thorough monitoring and assessment to determine how effective they are in influencing attitudes and behaviors of at-risk individuals (UNAIDS, 2012). In light of the shortfall in literature about the quality of prevention programs in the Pacific, the present study reviews HIV/AIDS programs implemented in the main island of Fiji (Viti-Levu) in the last decade. We conduct our analysis using Andreasen's benchmark criteria to determine whether Fijian HIV/AIDS programs meet international standards of social marketing and to identify gaps in program design that impact the effectiveness of the interventions.

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Table 1. Andreasen's Social Marketing Benchmark Criteria.

Element	Benchmark characteristic	Example
Behavioral objective	Intervention seeks to change behavior and has specific and measurable behavioral objectives.	Increase the rate of condom use and HIV testing, reduce the number of sexual partners, delay age of first sex, change drug-using behaviors, and increase medical male circumcision.
Consumer research	Formative research is conducted to identify consumer characteristics and needs. Interventions are pretested with target audience.	Find out what drives individuals to engage in risky sexual behavior and what is needed for them to change their behavior.
Segmentation and targeting	Different segmentation variables are used and a strategy tailored to the segments.	Possible target groups can include, but not limited to, youths, prisoners, seafarers, military and police officers, minority groups, pregnant women, religious leaders, injecting drug users, and school dropouts.
Marketing mix	Intervention uses all four Ps of the traditional marketing mix to distinguish it from advertising and communications. It creates attractive benefit packages (products), minimizes costs (price), makes exchange convenient and easy (place), and communicates powerful messages through media that is relevant and preferred by target audiences (promotion).	*Product*: Health-related messages, male and female condoms, IEC materials, VCCT services, HIV treatment/ vaccine, user-friendly STI clinics, and harm-reduction programs for drug users. *Price*: Diminished pleasure of condom use, embarrassment when purchasing condoms and taking HIV tests, low quality of condoms, and inaccessible condom distribution sites. *Place*: Increased accessibility to VCCT services, availability of condoms in traditional and non-traditional outlets, and increased promotion of sites which distribute condoms and provide HIV tests. *Promotions*: Can include multiple strategies such as mass media, social media, personal selling, outdoor and indoor advertising, celebrities, and social events. *Policy*: Mandatory sexual education curriculum for primary and secondary schools, and workplace policy that prevents discrimination against people living with HIV/AIDS (PLWHIV).
Exchange	Intervention considers what will motivate target audience to engage voluntarily with the intervention and offers them something beneficial in return, whether it is tangible or intangible.	*Benefits*: Better understanding of HIV/AIDS, peace of mind after receiving HIV test, and avoidance of unplanned pregnancy and STIs when using condoms.
Competition	Intervention identifies factors that prevent behavior change (or compete for the time and attention of target audiences) and uses strategies to decrease competition.	*Social factors*: Sex work (prostitution), forced sex, peer pressure to have sex, unsafe tattooing practices, substance abuse, and discrimination against PLWHIV. *Cultural factors*: Cultural taboo that prevents open discussions about sexual-related issues, and religious beliefs against condom use. *Structural factors*: Gender inequality, unemployment, and lack of access to health services. *Behavoral factors*: Limited knowledge about HIV/AIDS, temptation to have multiple sexual partners, and dislike for condoms.

Note. Sources: Andreasen (2002), Carins and Rundle-Thiele (2013), Christopoulos and Reynolds (2009), French (2006), Gordon et al. (2006), Stead et al. (2007), and (UNAIDS, 2008).

Andreasen's Social Marketing Benchmark Criteria

Alan Andreasen created six essential benchmarks in 2002 to give social marketing a clear structure, to distinguish social marketing from other approaches (such as health education, advertising and communications), and to help practitioners review different types of interventions more systematically and effectively (Andreasen, 2002; Carins & Rundle-Thiele, 2013; French, 2006; Grizzell, 2008). Andreasen's benchmark criteria require practitioners to (a) focus on influencing and changing people's behavior, not just informing and educating them, (b) use formative research to gain deep understanding of customers' characteristics, (c) cater to the needs of selected target audiences, (d) use all marketing mix elements, not just advertising or communications, to provide holistic solutions to customers' problems, (e) offer incentives to induce both trial and repeat behavior, and (f) identify and address factors that interfere (or compete) with behavior change.

Andreasen's benchmark criteria have been previously used to assess the effectiveness of social marketing interventions. For instance, Stead, Gordon, Angus, and McDermott (2007) reviewed 54 social marketing interventions targeted at nutrition, physical activity, and substance abuse using the benchmark criteria and concluded that social marketing can effectively promote healthy behavior among various target groups and in different settings. In a separate study, Carins and Rundle-Thiele (2013) examined social marketing interventions targeted at healthy eating behavior and reported that interventions need to fully adopt the benchmark criteria in order to be effective. In a similar manner, the present study uses Andreasen's benchmark criteria to review the design and effectiveness of Fijian HIV/AIDS prevention programs.

Methods

Search Strategy and Selection Criteria

Organizations that were actively involved in HIV/AIDS prevention work in Fiji were identified through two approaches: (a)

Table 2. Program Assessment Results Overview.

Campaign title	Organization responsible	Type of program	Program objective	Social marketing components present	Components missing
Condoms & Clubs (CC)	Ministry of Health (MoH)	Awareness	Increase provision of user-friendly services and develop skills that support behavior modification in development of healthy sex life (MoH Fiji, 2009).	Behavioral objective Formative research Segmentation Exchange Competition	Marketing mix
Stepping Stones (SS)	Secretariat of the Pacific Community (SPC)	Behavior-change communication	Achieve positive behavior change especially with regard to sexual and reproductive health (including HIV, STIs, and unplanned pregnancy), domestic violence, drugs and alcohol through participatory learning techniques and local-level decision making (SPC, 2009, 2010).	Behavioral objective Formative research Exchange Competition	Segmentation Marketing mix
Condom Social Marketing (CSM)	Marie Stopes International Pacific (MSIP)	Social marketing	Reduce spread and incidence of HIV/AIDS and other STIs among men and women of reproductive age (16–29 years) by promoting subsidized condoms and adoption of attitudinal and behavioral change through commercial marketing techniques (Marie Stopes International Pacific [MSIP], 2007, 2010).	Behavioral objective Formative research Segmentation Marketing mix Exchange Competition	None
STOP HIV	Oceania National Olympic Committees (ONOC)	Sports-based	Use the power of sports to deliver education and awareness to prevent further transmission of HIV/STIs among male and female youth in the Pacific (ONOC, 2008).	Formative research Segmentation Marketing mix Exchange Competition	Behavioral objective
Together We Can (TWC)	Fiji Red Cross Society (FRCS)	Awareness	Provide accessible and appropriate STIs/HIV/AIDS knowledge, skills, and resources to young people in order to enable them to take control of their health and reduce their vulnerability to STDs (Fiji Red Cross Society, 2008, 2009).	Formative research Marketing mix Exchange Competition	Behavioral objective Segmentation

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online search using various search engines, and (b) the snowball sampling technique, in which organizations initially interviewed were asked to give further referrals. Once information about active organizations was collated, we (the authors) contacted the organizations via e-mail and/or phone and briefed them about the research objectives. On the basis of their feedback and willingness to participate in the research, appointments were arranged with program developers or coordinators. Interviews, conducted by both of us, served two purposes: to (a) discuss the health campaign in detail in terms of its design and implementation and (b) obtain copies of program reports, such as mid-terms reviews, annual reports, and other program-related documents. We also searched corporate websites for additional information about the organizations.

Health interventions were selected only if they met all of the following five criteria: the program (a) targeted HIV/AIDS prevention; (b) was implemented post 2000; (c) had been completed and assessment reports were available, or was ongoing but preassessment reports were available; (d) could provide information about program design and implementation process; and (e) had a program organizing committee representative willing to answer queries.

Sample

This study selected five programs that met all the program inclusion criteria. The first HIV/AIDS prevention program was the Condom Social Marketing (CSM) program that was implemented by Marie Stopes International Pacific (MSIP) from 2006 to 2010. The second was a behavior-change-communication program called Stepping Stones (SS) initiated by the Secretariat of the Pacific Community in 2006 and still running at the time of the study. The third was the Together We Can (TWC) program implemented by the Fiji Red Cross Society (FRCS) between 2007 and 2009. Another program of interest was STOP HIV, a program implemented by the Oceania National Olympic Committees (ONOC) in 2008 and ongoing since then. Finally, this study evaluated the brief Condoms and Clubs (CC) program implemented by the Ministry of Health, Fiji, between December 2, 2008, and December 5, 2008.

It is noteworthy that the programs reviewed in this study varied in duration (as highlighted in the preceding) as well as in their nature. Only CSM could be identified as a social marketing exercise; otherwise, the programs were self-proclaimed as awareness campaigns (TWC and CC), a behavior-change-communication campaign (SS), and a sports-based campaign (STOP HIV). Because the number of explicitly labeled social marketing programs was so limited, all five programs were selected for systematic review.

Procedures and Measures

Five Fijian HIV/AIDS prevention programs (already stated) were reviewed against Andreasen's benchmark criteria to ascertain their resemblance to social marketing and determine their effectiveness. The benchmark criteria served as a checklist of essential social marketing characteristics. Table 1 outlines Andreasen's (2002) criteria with examples of each benchmark criterion retrieved from past studies on HIV/AIDS prevention programs.

We used a coding system to record social marketing constructs found in program reports and other relevant documents. First, we searched for "problem" behavior and the type of "desired" behavior that the organization achieved through its intervention. For the second and third social marketing elements, we scanned program reports to identify in-depth discussions about the target audience and the method used by

the organization to collect this data, and whether pretesting of program materials had been conducted with target audiences. For traditional marketing mix, the fourth social marketing element, careful scrutiny of the program reports produced evidence related to health products or services, pricing, place, and promotions. For the fifth social marketing element, we evaluated program reports to assess whether programs had offered something beneficial in return for audience participation. Finally, we assessed whether programs had identified and addressed internal and external forces that competed with behavior change. Results were finalized once there was consensus between the two authors.

Results

Program Assessment: Design and Implementation

All five programs assessed in this study were aimed at HIV/AIDS and STI prevention, with the overarching aim of developing healthy and safe sexual and reproductive health among Fijians, especially young people aged 16–29 years. Table 2 provides an overview of the results of our assessment of Fijian HIV/AIDS programs.

Behavior Change Objective

The central tenet of social marketing interventions is to influence behavior, rather than educate, inform, or raise awareness about public health issues. Two programs from our review did not meet this criterion. One can argue that awareness and education are prerequisites of behavior change. Even if this were true, the problem with awareness programs is that they seek to inform the target audience about a particular health behavior, probably within a short, intensive time frame, without actually attempting long-term behavior changes (Grizzell, 2008; Suarez-Almazor, 2011). In other words, the education approach may produce cognitive changes or alter an individual's beliefs and risk perception, but hardly generates behavioral outcomes (Martinsen, 2003; Rothschild, 1999). Surely awareness programs are required in societies where knowledge rates about HIV/AIDS/STIs are low; however, this should be followed up by intensive behavior change programs if HIV/AIDS is to be averted.

In our study, programs that were behavior oriented had very broad (at times, vague) goals and were multifaceted (targeting multiple behaviors). The condom social marketing program, for instance, focused on "promoting subsidized condoms" (notice that this statement is more provider centered; an alternative statement could be "increase condom use," but perhaps this was the underlying assumption by the providers) and "promoting adoption of attitudinal and behavioral change" (a vague statement). Similarly, the Condoms and Clubs program focused on "increasing provision of user-friendly services" (provider-centered statement) and "developing skills that support behavior modification in development of healthy sex life" (unclear statement that doesn't specify the desired skills). According to the benchmark criteria, behavioral objectives must be specific and measurable, but these characteristics were hardly visible in any of the programs that we reviewed.

The shift toward a multifaceted behavioral approach by the Stepping Stones program, which targeted safe sexual behavior in conjunction with behaviors such as domestic violence and drug and alcohol abuse, signifies the complexity of human behavior and calls for a more integrative approach to achieving behavior change. Sutton, Balch, and Lefebvre (1995) stress that behavior change is an incremental process, one that involves a chain of steps that lead to the ultimate target behavior. For instance, programs with the overarching goal of increasing condom use and HIV/AIDS testing need to first ensure that people know about condom-distribution and HIV/AIDS-testing sites, and then convince them to use these products and services for their own benefit. Effective HIV/AIDS prevention requires a more holistic approach that not only integrates multiple behaviors, but also seeks to create social, structural, biomedical, and environmental changes to support behavior change (Keating et al., 2006).

Consumer Research

A characteristic common to all programs was consumer research, although the nature and intensity of research varied across programs. Research is typically conducted to understand consumer characteristics and needs. In the context of HIV/AIDS, it is crucial to know what drives high-risk individuals to engage in risky behavior and what is needed for them to change their behavior. In our program review, we noted that formative research was carried out by organizations to help select target audiences and design program strategies. It was, however, difficult to ascertain whether program designers had conducted in-depth investigations to fully understand needs and characteristics of target audiences.

Varied methods were used by organizations. The Ministry of Health (responsible for CC) and the Secretariat of the Pacific Community (responsible for SS) have in-house research departments, while other organizations like the Fiji Red Cross Society (responsible for TWC) and Oceania National Olympic Committees (responsible for STOP HIV) used research teams (comprising program coordinators and assistants) to collect research data for their programs. Marie Stopes International Pacific (responsible for CSM), on the other hand, hired a research company (Tebbutt Research) to examine market penetration and usage of its products prior to program launch (Marie Stopes International Pacific [MSIP], 2007).

The level of pretesting of programs with the target audience was generally poor. Only two programs, namely, CSM and SS, were designed in consultation with members of their target audiences. We noted that developers of the CSM program collaborated with the youth to design posters, brochures, and labels for condom packets. These materials were further pretested on a sample of youth before they were produced and distributed on a large scale. Programs like TWC, STOP HIV, and CC can improve by engaging in the pretesting process.

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Audience Segmentation and Targeting

The highest incidence of HIV/AIDS and STIs in Fiji has been reported among young people who engage in risky sexual behavior (Ministry of Health Fiji, 2014). Three programs reviewed in this study were directed most appropriately at young adults aged 16–29 years. The other programs, Stepping and Together We Can, targeted a very broad audience (general public, but within rural settings). The high-risk group, comprising of youth, was further segmented by means of specific settings like nightclubs in the central business district (by Condoms and Clubs) and major sports events like hockey, netball, football and rugby around Fiji (by STOP HIV and Condom Social Marketing). These target audiences were approached by peer educators, who advocated HIV/AIDS/STI prevention and distributed condoms and information leaflets. The problem with such strategies is that there is hardly any follow-up or repeat sessions at that target location and with that particular target audience.

Carins and Rundle-Thiele (2013) suggest that a narrow target group gives a specific reference point for intervention design (p. 7). Programs can divide people who are most at risk of contracting HIV/AIDS into distinct segments based on current behavior, future intentions, readiness to change, product loyalty, and/or psychographics such as lifestyle, values, or personality characteristics (Grier & Bryant, 2005). Indeed, proper audience segmentation helps develop customized interventions that meet the health needs of target audiences and aid program-impact evaluation within specific settings. Future programs may consider using a randomized control trial (RCT) design to determine the program's impact and effectiveness (Christopoulos & Reynolds, 2009).

Marketing Mix (Product, Price, Place, and Promotion)

Product

All five programs offered some form of product and/or service to the target audiences. The most common product offerings included health messages about safe sexual behavior, HIV/AIDS transmission and prevention, and more broadly about sexual and reproductive health by peer educators, community facilitators, and/or Peace Corps volunteers.

With the exception of SS, all programs also provided free condoms and information leaflets during community awareness sessions and social events. CSM and STOP HIV additionally provided specialized services, such as HIV/AIDS testing and free health checks, through their mobile outreach programs. Furthermore, CC and TWC provided free lessons about proper condom use (by means of demonstrations) during community awareness programs.

Price

Barriers, or the price that one pays to adopt a health behavior, either actual or perceived, deter people from adopting and maintaining healthy habits. In the case of HIV/AIDS prevention, multiple barriers prevented Fijians from practicing safe sexual behavior, as highlighted by all the programs that we reviewed. Common barriers included cultural and social taboos regarding open discussions about sexual and reproductive health, negative attitudes toward condom use, stigma attached to HIV/AIDS, religious barriers against condom use, people's reluctance to openly accept condom packages in public, and gender inequalities related to condom-use negotiations.

Place

All programs conducted community-awareness sessions at convenient and easily accessible settings, such as schools, community halls, workplaces, tertiary schools, and schools. In terms of geographical coverage, programs targeted rural and/or urban communities; however, there was a slightly greater concentration of programs within the capital city, Suva. For instance, Condoms and Clubs, true to its name, targeted nightclubs and service stations in Suva, while STOP HIV and CSM targeted national sports events around Suva. Programs that targeted both rural and urban communities included CSM and TWC, while SS focused mainly on rural communities.

Promotion

The use of promotional tools varied significantly among the five programs. CSM used a myriad of advertising tools such as billboards, magazine advertisements, sports celebrities, radio talkback shows, and participation in street marches and national events to advertise its products and services, advocate about safe sex practices, and communicate with the target audiences. Similarly, STOP HIV organized entertainment activities like quizzes and prizes during sports events, allowed sports captains and people living with HIV/AIDS to give speeches before the matches, and used television advertisements that featured local sports celebrities. The remaining four programs did not utilize advertising tools exclusively but some degree of promotion was achieved through dissemination of contraceptives and information leaflets. In the case of the Condoms and Clubs program, despite facing financial constraints that limited the use of advertising tools, the program's representatives creatively promoted their health campaign by wearing color-coordinated t-shirts and distributing custom-made contraceptive packages to their target audiences. A characteristic common to all programs was the use of persuasive communication by peer educators and community facilitators to educate people about safe sexual behavior and encourage contraceptive use.

Exchange

Incentives, in the form of health products and services, were offered by all five programs to attract their target audiences and persuade them to attend educational workshops. Some useful items offered by programs to their target audiences included condoms at a subsidized price and sometimes free of charge, information leaflets, voluntary confidential counseling and testing (VCCT) services, and health checks during community education workshops and at other promotional sites. Furthermore, as an incentive for participation, TWC provided morning and afternoon tea if awareness sessions were conducted for 1–3 full days (FRCS, 2008, 2009).

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Competition

The programs highlighted two types of competition: (a) forces that prevented target audiences from utilizing their services (user-end competition), and (b) forces that prevented organizations from implementing the program successfully and achieving their program objectives (provider-end competition). CSM reportedly faced competition from other nongovernmental organizations (NGOs) and health clinics that freely distributed condoms, and from private companies that sold high-quality, branded condoms. We view this as healthy inter-competition that eventually leads to greater program efficacy. User-end competitive factors that were reported by programs included work commitments of target audiences that prevented them from participating in awareness workshops, religious beliefs regarding condom use, gender inequality affecting condom negotiations by women, perceived stigma and discrimination attached to activities associated with HIV/AIDS and toward people living with HIV/AIDS, reluctance and shyness in receiving contraceptive packs in public places, and inaccessibility of proper health services (such as HIV/AIDS testing), contraceptives, and information resources due to remoteness of certain villages from town areas.

Some programs tried to overcome these challenges. For instance, peer educators from TWC and SS facilitated open discussions among young people, STOP HIV used sports celebrities to promote safe-sex messages and minimize stigma associated with the topic of HIV/AIDS, and both CC and CSM distributed free contraceptives and ensured that condoms were available at nontraditional outlets. Nevertheless, we could not fully ascertain whether the programs had actually managed to address (or minimize) all these competitive factors to facilitate future behavior change projects.

Discussion

In the context of HIV/AIDS prevention, social marketing allows for distribution of both behavior change messages (such as abstinence, fidelity, safe sex, HIV/AIDS testing) and barrier methods (such as condoms, prophylactic treatment) to prevent disease transmission (Meadley, Pollard, & Wheeler, 2003). The success of social marketing programs is largely determined by their ability to generate consumer response, use, and satisfaction (Lefebvre, 2011). In other words, actual behavioral outcomes define success for social marketing programs, not sales figures, visits, products distributed, reach, exposure, and other measures of process (Lefebvre, 2011, p. 61).

In our assessment of Fijian HIV/AIDS prevention programs, we found that social marketing characteristics were present in a majority of the programs regardless of the nature or type of program. Such results imply that programs that are not exclusively labeled as marketing still adopt marketing principles. A nonmarketing program, such as Stepping Stones, addressed all marketing mix elements except promotion. Similarly, other programs addressed many benchmarks of the social marketing criteria; however, the degree of coverage of each benchmark varied across the programs. MSIP's CSM was the only intervention to closely address all benchmarks.

Major deficiencies in previous Fijian HIV/AIDS prevention programs, as indicated by our program reviews, have been lack of behavior-change orientation, lack of specific and measurable behavioral goals, lack of consumer-centric approaches that offer customized solutions to the needs of specific target audiences, and lack of randomized control trials to determine the program's impact and effectiveness. To some extent, this study concurs with findings from previous research, such as that of Drysdale (2004) and Fowler et al. (2007), that most prevention efforts in Pacific Island countries erroneously target awareness raising (through education and information workshops) instead of implementing specific behavior-change programs. Indeed, social marketing programs in developing countries have focused mainly on raising awareness about HIV/AIDS, educating people about safe sexual behavior, and promoting the use of contraceptives (Fox, 1988; Rosenfield & Binzen, 1987; Schellstede & Ciszewski, 1984; Vernon, Ojeda, & Townsend, 1988). Future Pacific HIV/AIDS response will benefit more by focusing on unprotected sex and other high-risk behaviors (Commission on AIDS in the Pacific, 2009). In Fiji, an immediate shift toward intensive behavior change programs is required, and Drysdale (2004) and Fowler et al. (2007) further state that the duration of prevention strategies needs to be increased in order to initiate and sustain safe behavioral practices among high-risk groups. We concur once again, since the programs we reviewed in this study greatly varied in span and scope. For instance, Condoms and Clubs operated for only a short duration (4 days) and was confined to the capital city, whereas the remaining programs were implemented in both urban and rural settings and lasted for 2 to 5 years, but lacked proper monitoring and evaluation systems.

Meaningful and long-lasting behavioral impact is only possible when programs are consumer-centric, realistic, and relevant to target audiences. We reported earlier that it was difficult to ascertain whether program designers had sought to fully understand the needs and characteristics of target audiences. Another disturbing finding was that some programs had provider-centered objectives such as "promoting subsidized condoms" and "increasing provision of user-friendly services," as if these were the indicators of program success. The creation of consumer-centric programs is possible only when providers conduct necessary needs analysis to identify the exact demands and deterrents to behavior change of target audiences. This will require frequent interaction with representatives from target groups (pretesting and inclusive approach to program design) and close partnership with key stakeholders (such as policymakers, nonprofit organizations, health care providers and workers, and suppliers).

Research Limitations and Future Directions

Our study was primarily constrained by the low response rate from organizations involved with HIV/AIDS prevention work in Fiji, which restricted our systematic review to only five programs that had been implemented between 2006 and 2010. In order to perform a more extensive review, future

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research could examine and compare an array of HIV/AIDS prevention programs in the wider South Pacific region to identify factors that contribute towards the programs' success or failure. Although many of the PICTs are small in terms of land mass and population, it would be interesting to study how the Pacific region's diverse cultures and traditions, apart from social and economic factors, affect the design, implementation, and evaluation of social marketing and behavior-change programs.

The second limitation of this research is the use of an earlier version of the social marketing benchmark criteria, which lacks elements such as behavioral theory and insight, to review Fijian health campaigns. Our decision to use Andreasen's (2002) six-point benchmark criteria was based on the fact that social marketing is still in its infancy in Fiji and results from our literature search showed that published data on social marketing and behavior-change programs, especially between 2000 and 2010, were sparse. Hence, it seemed inappropriate and beyond the scope of this study to perform extensive reviews using advanced features of social marketing. Nonetheless, an extension to this research would be to apply frameworks, such as the Social Marketing Consistency Criteria that were modified in 2012 by French, to review and evaluate different types of social marketing interventions across the Pacific region.

Conclusion

This study has systematically assessed five HIV/AIDS prevention programs in Fiji using Andreasen's (2002) benchmark criteria to determine which social marketing elements were integrated within the programs. Consequently, this allowed us to identify gaps in program design that significantly impact program effectiveness. Results indicate that although very few programs were explicitly labeled as "social marketing" programs, they still managed to address the criteria to some degree. Social marketing elements that were poorly addressed by some programs included behavior-centric approach, specific and measurable behavioral objectives, in-depth understanding of the needs and characteristics of high-risk groups, and targeting of specific audiences with customized solutions. Furthermore, findings from this study indicate that HIV/AIDS prevention programs need to be designed more systematically and assessed using control groups in order to determine program impact and efficacy. While commendable steps have been taken to prevent the spread of HIV/AIDS in Fiji and elsewhere, prevention strategies need to be further strengthened to produce a greater impact.

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