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SOCIAL INCLUSION MARKETING

TRAINING NEEDS ASSESSMENT

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PROLOGUE

Social Inclusion marketing project "SIM project" is an educational proposal on "Cooperation for innovation and the exchange of good practices", developed under the key action of adult education of the ERASMUS+ programme. The strategic partnership of **"SIM project"** is formed by 4 partners from Switzerland (Università della Svizzera italiana); Bulgaria (National Association of Professionals Working With Disabled People - Narhu); Spain (Universitat de València) and Portugal (Associação De Paralisia Cerebral De Coimbra).

Specifically, SIM project tackles the challenge of improving the social inclusion of people with disabilities by adapting social marketing principles, tools and techniques to be used by disability professionals in their working routine.

The first intellectual output of this project as here presented consists of an assessment of the social marketing training needs of disability professionals. It was started and finished before the beginning of the project with the objective to be able for the partnership to design the project objectives and activities according to the real training needs of disability professionals. In addition, the theoretical content and conclusions of this study have been used during the project life as a reference to develop the other 3 project intellectual outputs: IO1) SIM workbook; IO2) SIM pedagogical strategy; and IO3) MOOC course.

This intellectual output explores, from an education and training perspective, the potential of social marketing to be better implemented in the disability field. Its contents might be divided into 3 different parts. The first part (Theoretical background) introduces the reader to the paradigm of social marketing, its most important characteristics, comparing social marketing with a few disability theoretical approaches. The second part explains the mixed method approach followed by the research to complete the training needs assessment and obtain the conclusions. Finally, the last part (discussion and conclusions) offers a prioritization of the social marketing training needs of disability professionals, explaining the synergies found between both fields and describing the potential of social marketing to be further implemented in the disability field. In addition, the reader will find at the end of the document the online questionnaire completed by disability professionals and the most relevant statistical analysis outputs.

ABSTRACT

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Purpose - This research explores, from an education and training perspective, the potential of midstream social marketing (SM) in the disability sector. It describes the most important features of SM, and assesses: a) which are the training needs of SM for disability professionals; and b) how to transfer SM techniques and strategies to disability sector organizations in order to improve the social inclusion and the quality of life of people with fewer opportunities.

Design/methodology/approach - This is a mixed method approach combining: a) a review of existing SM literature and other secondary sources; b) a web-based self-administered questionnaire in several European countries (N=137); c) and unstructured qualitative interviews pre and post questionnaire.

Findings - The SM concept, techniques and strategies are virtually unknown by the social service workforce. Qualitative data has shown that SM has the potential to be better implemented in the social sector. Quantitative data has identified that front-line professionals working directly with people with disabilities have higher SM training needs. These needs are mostly related to the clients´ behaviour and value co-creation. Their SM training priorities are: a) How to evaluate the factors influencing the clients' behaviours; b) How to design and carry out some of these actions together with the clients (value co-creation); and c) How to evaluate the impact of the interventions. In addition, action learning and case study were identified as the preferred pedagogical methodologies to learn SM.

Originality/value. This paper is the first to explore the untapped potential role of SM in the social sector using social actors as the principal delivery mechanism.

Key words: training needs assessment, midstream, value co-creation, behaviour, social marketing, social inclusion, disability.

Paper type: Report / survey research paper.

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CONTENTS

1. INTRODUCTION

Social marketing

Social marketing (SM) was born out of commercial marketing in the seventies, being developed and implemented largely by scholars and professionals from the marketing sector.

There are many definitions of SM in current literature (Dann, 2010; Smith, 2000; Gordon, 2013; iSMA, 2013; Kotler & Lee, 2008, Saunders et al., 2015...). It is proposed in this introduction a definition that is very closely connected with the scope and objectives of this research: "*Social marketing is the application of marketing principles to shape markets that are more effective, efficient, sustainable and just in advancing people´s wellbeing and social welfare*" (Phils et al., 2008).

Two of the most important characteristics of SM in its early stages were the use (or overuse) of marketing mix techniques (Lefbvre, 2012; Luca & Suggs, 2013; Tapp & Spotwood, 2013); and a downstream approach to address primarily the behavioural change of individuals (Dann, 2010; French and Russell-Bennet, 2015; Gordon, 2013; Truong, 2014; Wymer, 2011; Zainuddin et al., 2017). These two approaches might have arisen as a logical result of the initial SM dependence on commercial marketing.

As SM was evolving, new approaches and strategies were put into practice, leaving behind this initial limited individually focused marketing mix approach. Scholars and social marketers started to expand the boundaries of the discipline, embracing new and more complex social challenges that needed to be tackled by using a more holistic ecological approach (Andreasen, 2002; Brennan & Binney, 2008; Dibb, 2014; Domegan et al., 2013; Luca et al., 2016; Wood, 2016).

As a result of this, SM interventions started to be supported to a higher extent by psychological models and theories such as **"ecological model"**, "Social cognitive theory", "Theory of planned behaviour" and "Health belief model" (Truong, 2014).

SM programs started to focus not only on the downstream level (individual behaviour), but also on the **midstream level (professionals**, community associations, service providers...) and on the upstream level (strategic level, politicians, decision takers, etc.).

During the last years, "*SM has moved from its marketing management roots to a service mindset*" (Luca et al., 2016). Very close to this approach, there are two aligned concepts that are crucial to this research which have gained particular strength in the SM field: the **service-dominant logic and the value co-creation**.

The service-dominant logic plays a key role at midstream level, allowing organizations and their professionals to become key actors to co-create value (Luca et al., 2016a; Lusch and Vargo, 2006; Vargo, 2009; Russell-Bennett et al., 2013, Vargo and Lusch, 2008; Vargo and Lusch, 2016a; Vargo and Lusch, 2016b; Vargo et al., 2015).

Midstream actors (staff, services organizations, stakeholders, industries bodies, community associations, etc.) are key in the creation of value by shaping perceptions and improving the customer experience, facilitating the individual behavioural change (Wood, 2016).

This new whole holistic approach also allows SM to extend its range of action. SM has evolved with commercial marketing and with society's needs. SM started out by focusing exclusively on health issues such as nutrition, physical activity, diabetes, family planning, HIV/AIDS and smoking cessation/prevention (Luca & Suggs, 2013).

But SM has recently evolved extending its interventions to other social fields such us quality of life (Zainuddin et al., 2017), wellbeing, global warming, social welfare, working conditions, and social innovation (Lefebvre, 2012); and sustainability (Tapp & Spotswood, 2013).

Education and training of the social sector workforce.

The European Commission and The World Health Organization have produced many documents stating the importance of education and training in social services. This point of view is also shared by practitioners and stated in academic literature. In addition, the

ageing and increasing dependency of the European population will make it difficult to find the appropriate social services workforce.

Regarding to the implementation of SM in social services, professionals and organizations will need to be empowered. "*The introduction of social marketing programs can be a challenge...social staff will need to understand that the benefits of social marketing are more than promotion...*" (Russell-Bennett et al., 2013). Regarding the need to empower professionals, several authors suggest the benefits of improving staff competences on SM before starting any intervention (Luca et al., 2016a; Russell-Bennett et al., 2013; Wood, 2016).

The research on SM, social inclusion and disability.

Due to the commercial marketing origins of SM and the specific features of the discipline, SM has not tackled all social challenges existing in our society. Although some topics such as social inclusion, immigration or disability are high priorities for The European commission, ERASMUS+ initiative, and many National States, there is no evidence of any SM intervention addressing these priorities.

SM and social service have many things in common such as the use of psychological models, the costumer-focused and service-focused orientation; and even they share the "social" name and objectives. In spite of this, the truth is that SM is a "ghost" concept for the vast majority of professionals and decision-takers within social service organizations.

This might indicate that SM has not been recognized yet as a "social" tool by the social sector. Perhaps, this is because social services workforce is not confident in the SM discipline. It might be seen as a professional trespassing or encroachment of SM into the social sector. This leaves a huge space to explore looking into the reasons for this and how the potential of SM can be unlocked.

In addition, the few reviewed programs in which social organizations were carrying out what appeared to be SM actions did not fulfil the SM criteria (Andreasen, 2002; French & Russell-Bennett, 2015). Furthermore, these actions misunderstood the concept of SM. It was confused with other concepts such as social advertising, social media or corporate social responsibility.

This research focuses on this existing gap, trying to unlock the potential of SM to improve the social inclusion and quality of life of people with disabilities.

Because the social sector is a field too wide and complex to be covered, this research has chosen what is assumed to be an accurate representation of the social sector: the disability field. Likewise, not all the elements shaping the disability field are addressed in this research. It only focuses on what are currently the most important priorities and guiding framework models in the disability sector: a) the concept of quality of life (Schalock, 2004); and b) the individualized support model; and in one of its more important dimensions: social inclusion.

Social inclusion is a crucial concept for the European Union to achieve the key goal of "The Europe 2020 Strategy": "turning the European Union into a smart, sustainable and inclusive economy". Social inclusion is also a high priority by other European initiatives such ERASMUS+ and World-wide organizations such as World Health Organization.

With regard to the target groups, they have been divided into four professional categories: a) care-givers; b) front-line professionals; c) program designers/evaluators; and d) managers and decision takers. These categories have been considered by the research as **the key independent variable** to design and develop future training materials and to carry out learning and training activities.

Finally, and according to what we have exposed above, this research has four objectives:

- To explore the SM concept.
- To explore the relationship between SM and Social Services.
- To assess the training needs within SM that may impact on the social service workforce.
- To lay the foundations for future educational and training proposals to improve the competences on SM of social services workforce.

Taking into account these objectives, four research questions will shape this investigation:

RQ1- Do SM and Social Services share theoretical approaches?

RQ2- Could SM techniques and strategies benefit the social services workforce?

RQ3- If so, what are the SM training needs of these professionals?

RQ4- Could the results of this research be the basis to develop SM educational and training materials for the disability sector?

The first question will be discussed from a theoretical point of view, focusing on the relevant characteristics and models of both disciplines (Literature review). The two following questions will be addressed by completing a mixed method research (literature review, qualitative interviews with front-line professionals and managers of social services; and an online self-administered questionnaire).

The final question has the objective to find out if the topic (SM), target groups, and the identified training needs meet the criteria to design, develop and implement future educational and training tools and programs, giving to this research a **practical value**.

2. THEORETICAL BACKGROUND: SOCIAL SECTOR, DISABILITY AND SOCIAL MARKETING

2.1. INTRODUCTION

This research tackles the challenge of: "the training needs of **social services** professionals and decision-takers to learn methodologies and techniques from the **social marketing (SM)** field in order to improve the **social inclusion** and **quality of life** of disadvantaged groups".

Before starting to explain the methodology and discuss the results, it is crucial to define the theoretical structure supporting this research study.

Therefore, this section is devoted to explain three key concepts which lay the theoretical foundations of this research: a) The features of the social services and disability field in European Union; b) the concept of social inclusion; and c) the concept of SM.

In addition, the last part of this section is aimed at defining the most important shared approaches, similarities and differences between both fields. These concepts are crucial to try to assess the potential of SM in the disability sector.

2.2. THE SOCIAL SERVICES SECTOR

According to the Labour Force Survey (Eurostat, 2011), health and social services gives employment to 23.1 million workers in the European Union (10.4%), of which 78% are women. The number of workers in this sector has steadily risen in recent years, even during the crisis. Its weight in the economic output of the European Union is estimated to be higher than 7%.

The European Commission (COM(2006) 177 final) establishes, in addition to health services, two other categories of social services: a) statutory and complementary social security schemes; and b) other essential services provided directly to the person.

The statutory and complementary social security schemes are organised in various ways (occupational or mutual organisations), covering the main risks of life, such as those linked to disability, ageing, social housing, social assistance, health, unemployment services, training, elderly, and occupational accidents".

The other essential services provided directly to the person facilitate their social inclusion, offering customised support in areas such as drug addition, unemployment, social housing, care of the oldest or youngest, occupational training or integration of disabled people.

In accordance with the above classification stated by The European Commission (COM(2006) 177 final) , people with disabilities can be provided for by multiple services belonging to both categories.

For example, a typical individualized support plan for a person with intellectual disabilities will contain support to improve -or maintain- their transversal competences (educational field), to find a paid job (employment field), to improve their social network (social inclusion), to live in a sheltered home (social housing and daily life activities) and to keep their physical fitness (health field). In addition, our society is currently facing for the first time in history the challenge of this target group ageing, needing more specific services delivered to elderly people.

Summing up, the scope and responsibilities of the disability organizations and their professionals taking part in this training needs assessment can be considered as an excellent representative sample of all professionals working in social services.

The effectiveness and efficiency of social services and its workforce.

The European Commission states in several documents the relevance of measuring and improving the labour competences of the social services workforce. Papers such as "Literature review and identification of best practices on integrated social service delivery", "Health and social services from an employment and economic perspective" (2C); "Investing in the social services workforce" (3/2017) and "Integrated social services in Europe" states the need of: "...new competencies from front-line staff who need to be able to assess and respond to the needs of new groups of clients, liaise with new partners....". The relevance and need of further training of the professionals working in the social services is also stated in these documents. The document "Investing in the social services workforce" (3/2017) not only states the importance of training professionals of the social services, but also determines that the two most important needs assessed are closely related to the SM discipline: a) "Assessment of service users' needs (95%); and b) "Working in partnership with other professionals" (93%). In addition, this paper provides evidences of the key role that training can have to improve the necessary mutual understanding between social services and other services or fields such as the one being discussed in this research: social marketing.

In addition, the ageing and increase of dependency of the European population will make it difficult to find the appropriate social services workforce.

Evidence suggests there is a need to improve how the effectiveness in Social services is measured and how performance is reported (Goh et al., 2015). In this line of thought, the Global Service Alliance (2015) suggests that it is important to develop a framework to measure the efficiency of social services.

According to the document "EU employment and social situation (2014)", there will be a need to increase the workforce of the social sector due to the ageing of its workers, the consequences of the crisis (higher number of people demanding social services) and the demographic changes (ageing of the population).

As a result of this, the European Union states the need to improve the potential in the health and social services by, among other measures, developing more efficient learning and training schemes for the social professionals.

This needs study assessment aims directly at the core of this problem, providing information to contribute to improve efficiency of the social services sector.

2.3. SOCIAL INCLUSION

Although social inclusion lacks a formal definition and its concept seems to remain unclear (Bigby, 2012a, 2012b; Hall, 2009; Oxoby, 2009), several attempts to define social inclusion and its scope have been found in public documents supported by European Union and National States; and in existing academic literature.

From the academic point of view, social inclusion might be associated with the person´s degree of integration in the social, political and economic framework of a society (Oxoby, 2009). It can also be associated to the "abandonment of mainstream norms" (Lafree, 1998; Liebow, 1967) or "the generation of separate subcultures" (Hagan and Macarthy, 1998; Oxoby, 2004)

According to the Spanish National Action Plan on Social Inclusion 2013-2016, Social inclusion is "the process of a loss of integration or participation of the people in a society and in different social, economic and political fields". It is a complex and multi causal phenomenon that must be addressed from a holistic approach.

To do so, together with the priorities of smart and sustainable growth, the EU put forward a third priority directly linked with social inclusion. This priority is called "Inclusive growth". It aims at fostering a high-employment economy in which states must deliver better social and territorial cohesion. The target established by the European Union in the 2020 strategy related to poverty and social exclusion was: "At least 20 million fewer people in – or at risk of – poverty/social exclusion for the 2020 year".

According to the European Union, some statistical indicators might contribute to understand the risk of poverty and social inclusion of a person or a society: a) not having a paid job; b) living with severe material deprivation (lack of resources to own a car, telephone, washing machine, face unexpected expenses or heat their home); c) living on less than 60% of their country's average household income; d) to live in households where no one is employed.

In addition, there have been other risk factors identified by the existing literature such as living in a country in the European Union that has an insufficient welfare system; the person´s social network; health status; regional cohesion and the Gini coefficient; dropping out of the education system early; substance abuse, dependency and

addictions; the level of education and skills; and belonging to vulnerable groups such as the Roma population, female victims of domestic violence, immigrants, elderly people, and the project target group (disabled people).

The condition of being social excluded might be caused by only one of these factors, but usually the combination of several of these factors affecting a person is what triggers the state of social exclusion.

An excellent example would be the following: "not all poor people are in situation of social exclusion and vice versa" (Spanish National Action Plan on Social Inclusion 2013-2016).

The European Union and National States have a range of tools to help them achieve the objectives related to these three priorities. In the case of the priority named "inclusive growth", the most important tool is "The European platform against poverty and social exclusion". Erasmus+ and the "Agenda for new skills and jobs" might be considered two other important tools to fight against social exclusion. In addition, and according to the Spanish National Action Plan on Social Inclusion (2013-2016), The European Structural funds, and specifically, The European Social Fund are also key to reducing social exclusion.

The education and training activities developed under these programmes should contribute to implement "The European policy agenda for growth, jobs, equity and social inclusion".

According to ERASMUS+ principles, the investment in improving professionals competences (this is the case of one of the objectives of this research) will benefit not only these professionals but also the organizations they are working for and society as a whole.

Related to the concept of social inclusion in the field of intellectual disability, we have to note the relevance of the concept of "quality of life". The approach of quality of life "has increasingly being applied to people with intellectual disability over the past 20 years" (Schalock, 2004). In fact, it is used as a reference framework by all intellectual disability organizations taking part in this study. Disability organizations use this approach as a guide to their programmes and to measure the personal outcomes. "It has become the link between the general values reflected in social rights and the personal life of the individual" (Buntinx & Schalock, 2010).

According to this approach, QOL is a multidimensional phenomenon based on the ecological paradigm in which disability and human functioning are based and explained by the interactions between environmental and personal characteristics. "The ecological model understands disability as a individual limitation in a social context" (Brown et al., 2009). "It is based upon a system perspective in which several environments (macro, meso, micro...) are influencing the person´s wellbeing" (Verdugo et al., 2005).

Two of the most important strategies used by organizations to enhance the wellbeing of persons with intellectual disabilities are the "person centred-planning" and "individualized supports". Both responsive and flexible strategies are interlinked having the common goals to assess how a person wishes to live their own life (self-determination) and what individual and specific supports organizations and professionals have to deliver to them. It implies "involving clients in the decision making of their own lives and supports... through the knowledge of their rights, empowering them to be effective self-advocates" (Verdugo et al., 2012). The most important outcome of this process is the development and implementation of an individualized plan for each person. This plan "defines the types of supports needed to take part in specific settings; and the activities required to implement the plan" (Buntinx & Schalock, 2010)

Finally, and directly linked with social inclusion, the quality of life model is formed by 8 domains which "refers to the set of factors defining personal well-being" (Verdugo et al., 2005). Social inclusion is one of these domains, referring to a person´s community integration and participation; community roles and support; the access to public goods and services (public transportation, retirement clubs, evening classes, community associations and services...); and social network activities with people who are not staff, family members or other people with ID.

2.4. SOCIAL MARKETING FIELD (SM)

2.4.1. First stages of social marketing

As it was mentioned in the introduction, SM was first coined by Kotler and Zaltman (1971) to describe those practices, techniques, concepts, elements, logic, etc. that, belonging to commercial marketing, were being used to modify individual behaviours for the better. In the same article, the authors posited the first definition of SM: *"The design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution, and marketing research".*

In its first stage, the two most relevant characteristics of SM were: its **downstream approach,** and the overuse of **marketing mix**. Nowadays, these features are still considered important in SM but with lower relevance.

Firstly, at the beginning of SM, its interventions mostly targeted individuals´ health behaviours (downstream approach), leaving aside the midstream level (communities, NGOs, front-line social professionals, services providers, schools) and upstream level (decision-makers, politicians...).

This downstream approach is supported by several scholars analysed. For example, a systematic review of research on SM accomplished by Truong (2014) found that many researches (76%) were made at the downstream level. This research also found that 71.4% of the interventions were made in public health (smoking, alcohol, physical activity...). This author also found evidence that SM started within an advertising approach but it rapidly moved into social communication and promotion actions. Gordon (2013) concluded: "until the second part of the 90s, the focus of SM was on individual behaviour change, downstream". In addition, French and Bennet (2015) stated that: "The upstream approach in SM gained traction in the mid-2000´s when Andreasen (2002) noted that several levels of SM existed and formed a continuum". The supremacy of the downstream level over the upstream in SM is also stated by: Dann (2010); Wymer (2011); and Zainuddin et al. (2017).

The second of the features of SM during the twenty century was the overuse of marketing mix, mostly caused by its strong initial dependence of commercial marketing. It seems

logical to think that SM, as a result of having its roots in commercial marketing, had strong ties with commercial marketing and its techniques. These ties are still evident but to a lesser extent. In addition, SM has logically evolved over the years as commercial marketing has done.

In too many cases, SM has used only persuasive communication to achieve its goals (Lefebvre, 2011). It has found a tendency to use ‘‘promotion’’ as the most important element of SM (Luca & Suggs, 2013). Tapp & Spotswood (2013) also state the relevance of the 4Ps in SM, but questions its effectiveness. On one hand, Tapp points to the relevance of 4Ps, highlighting their usefulness to exchange propositions. On the other hand, the authors state that the marketing mix might be too close to commercial marketing and be too simple model to tackle complex social problems. Gordon (2013) states that: "the dominant four Ps marketing mix is no longer fit for purpose in contemporary SM". MacFadyen et al. (1999) stated that early SM actions focused on 4Ps to achieve social change. Another example is found in Peattie & Peattie (2003) where it is exposed that early social marketers seemed to refuse to tackle social problems that did not fit the marketing mix model.

Therefore, As Lefbvre (2011) and Luca & Suggs (2013) support, many of the social interventions in the first stage of SM focused mostly on persuasive communication and targeted only individuals (downstream level).

2.4.2. Evolution of social marketing

Not long after SM started, several key issues begun to attract attention of the SM community. Some examples are: a) the use of psychological theories, models and principles guiding or framing the interventions; b) the discussion around a proper definition of SM, meaning and scope; c) the use of tools, techniques, and practices (exchange propositions, interaction, value co-creation, service dominant approach, formative research...); d) the effectiveness of programs; e) the approach of academic research in the field; f) and the future and challenges of SM.

One of the most important issues discussed by SM scholars has been the attempt to define or update the concept of SM. Two recent examples can help us understand how much this is still an open debate. Dann (2010) offers an updated well-structured definition of SM: "*“the adaptation and adoption of commercial marketing activities, institutions and*

processes as a means to induce behavioural change in a targeted audience on a temporary or permanent basis to achieve a social goal". According to one of the most recent definitions found in the existing literature SM is (Saunders et al., 2015): "*the application of marketing principles to enable individuals and collective ideas and actions in the pursuit of effective, efficient, equitable, fair and sustained social transformation*". The former focuses exclusively on the behavioural change of a target audience. The latter broadens the scope of SM to tackle any kind of social transformation. In addition, and according to Saunders et al. (2015), social actors must play a key role in transforming and supporting sustainable and more fair societies. These authors see social marketers as a "social enablers". Following this line of thought, Peattie & Peattie (2003) debated the convenience to reduce SM dependence on commercial marketing, stating that the 4Ps should be abandoned.

The effectiveness of SM interventions has also been discussed by authors such as Stead et al., (2007) and Wymer (2011). Both articles conclude by stating that SM interventions they analysed were effective. At this point, it should be also stated (Stead et al., 2007; and Gordon, 2013) that is difficult to evaluate SM outcomes in comparison with commercial marketing outcomes.

Another element of SM that has attracted the attention of the SM community has been the usefulness of theories and models that support the SM interventions. The proposition that social interventions should be guided or framed by a theoretical framework is widely accepted by SM scholars and marketers. Grier and Bryant (2005) suggest that theoretical underpinnings might help SM to develop tools, understand influencing factors and to expand its vocabulary. The use of theories in SM will be a positive influence when designing the processes and evaluating the outcomes (Stead et al., 2007; and Luca & Suggs, 2013). According to these authors, and a systematic review of research (Truong, 2014), the most implemented theories in SM are: "Social cognitive theory", "Theory of planned behaviour" and "Health belief model". Later, we will discuss the progressive role that "System thinking and change" and the **"Ecological model"** are playing in SM when trying to tackle complex problems.

Other important elements of SM that have also been widely discussed during the SM life are: a) the use and role of models; b) the concept of exchange proposition; c) interaction and **value co-creation**; and d) the **service dominant approach** at midstream level. The

latter two concepts, as they have an utmost importance for this project, will be explained in detail later.

As society became aware not only on health issues, but also on other social issues such as quality of life (Zainuddin et al., 2017), wellbeing, global warming, social welfare, working conditions, and social innovation (Lefebvre, 2011); or sustainability (Tapp & Spotswookd, 2013), the initial downstream approach and the marketing mix actions started to be looked at as being too limited.

Finally, SM, at the same time that was acquiring knowledge and growing as a discipline, realized the demands on society had created a new market opportunity. Then, what was needed was to broaden its strategies beyond the initial individual behavioural change to become in which SM is today.

2.4.3. Social marketing today

The information referred in this section will help us to understand and assess what the current state of SM is. The research will show only those SM features which will help to develop the project framework and answer the questions to research. Specifically, the project devotes the following paragraphs to explain: a) the nature of the discipline; b) the ecological holistic approach; c) the service-dominant logic and value co-creation; and d) SM models, techniques and strategies.

a) The nature of SM

As it was noted before, SM started as a branch of commercial marketing mainly focused on behavioural change at individual level, but it has evolved over the last fifty years, without a clear agreement as to its nature, limits or interventions.

One of the most important problems that SM faces is the misunderstanding as to what is or is not. SM is still confused with other disciplines such as education, non-profit marketing or social media. Another example that shows a lack of agreement in this discipline is the number of definitions of SM found in the literature. Dann (2010) found more than forty-five definitions of SM. Finally, Peattie & Peattie (2003) states: *"SM should develop a distinctive theoretical base".*

For some authors, SM is nowadays a mature discipline using, to some extent, marketing principles (Andreasen, 2002), but others suggest there is still some work to do to become a distinctive discipline. French & Russell-Bennett (2015) highlight the lack of agreement about the focus and nature of SM. In this line of thought, Stead et al., (2007) state that SM is not a theory, it is only a framework. Lefebvre (2012) notes the difficulty for SM to develop a common perspective and to make progress in an unique way. From other points of view, scholars have spoken about the convenience of broadening the discipline and purpose (Saunders et al., 2015; Brennan and Parker, 2014; and Wood, 2016).

Therefore, it seemed that SM needed to evolve, specifically, if it wanted to tackle modern social problems. According to Lefebvre (2012), SM could play a key role protecting disadvantage groups from negative externalities of "market failures". If SM wanted to grow as a solid independent discipline, it should widen its scope to other fields outside of health behaviours.

b) The holistic ecological approach

To tackle the wicked problems that humanity is today facing such as social inequalities, sustainability and the lack of quality of life, SM needs to broaden its strategies and approaches.

There is an agreement that SM should develop programs targeting downstream, midstream and upstream groups; and to integrate new techniques in addition to the 4Ps.

Basically, it could be stated that there are two factors influencing the individual behavioural changes: a) internal factors; and b) external factors. The first one is linked to the downstream level; and the second is associated with midstream and upstream levels.

The internal factors are those belonging to the person and under their control (at least theoretically). For example, education level, skills, motivations...or other more specific to SM such as: general individual wellbeing (Zainuddin et al., 2017); underlying factors such as: beliefs, intentions, self-efficacy (Lefebvre, 2011); life experience and personality (Gordon, 2013); and self-efficacy or willingness to change (Grier et al., 2005).

External factors (midstream and upstream approaches) are those belonging to the individual´s environment. The alteration of these influencing factors are almost always out of reach of the target group whose behaviour SM wants to modify.

Upstream level refers to elements of the structural environment (policies, laws, social and economic conditions....) which might be a negative influence on behavioural change. An updated definition of upstream SM (Gordon, 2013) is: "*The adaptation and application of marketing alongside with other approaches to change the behaviour of decision makers and opinion formers which alters the structural environment and has a resultant positive influence on social issues".*

Midstream level refers to the influence that the nearest social environment might have on the target group. This environment depends on the person and is different for each specific challenge. It may be formed by a combination of different elements such as communities, and schools (Gordon, 2013); consumer associations (Wymer, 2009); fitness centres, and sports clubs (Zainuddin et al., 2017); personal networks, and peer groups (Luca, et al., 2016); or Service organisations and staff (Wood, 2016).

An example of these three levels is the case of obesity problem in children *(*Wymer, 2011) in which the children´s unhealthy practices are caused not only by their wrong choices, but also by external ones influencing these choices such as the food industry's marketing campaigns. According to the author, SM strategies on obesity, to be effective, need to focus on these three approaches: a) downstream: mass media campaigns (which have had only limited results), and actions to educate children; b) Midstream: activities targeting consumer associations and schools; and c) Upstream: strategies to make government change food industry regulation.

But the inclusion of new actions (in addition of the 4Ps) and the integration of the three levels in SM programs do not seem to be effective. In addition, and most importantly, if SM is going to add real value to our society, it will need to understand and acknowledge the complexity and dynamic nature of the systems where individuals live today. The systems, their components and people develop strong, intertwined and complex processes, forces, interactions, and relationships which have a huge capacity to influence the persons' behaviours. Social problems are multidimensional and caused by

a diversity of factors on different levels. The effective solutions to these problems will be found only by embracing a holistic ecological approach.

Therefore, theories such as "Systems thinking and change" (Andreasen, 2002; Brennan & Parker, 2014; and French et al., 2017); and "Ecological model" (Zainuddin et al., 2017; Truong, 2014; Wood, 2016; Brennan et al., 2016; and Luca et al., 2016;) have recently started to attract the attention of SM literature and are being used as theoretical frameworks in SM programs alone or combined with other theories such as "Health belief model", "social-cognitive theory", "theory of planned behaviour" and "Stage of change".

Systems thinking and change (Several authors, 1990)

It can be understood as a discipline -but also as a philosophy- by which systems are constantly changing, and behaving as a result of the existing relationships among their elements. It is a theory: "*for observing the wholes*". System thinking contributes to identifying the underlying causes of behaviours, pushing social actors to develop a mix of interventions within a strategic SM framework to tackle complex problems.

The social ecological model (Bronfenbrenner, 1977,1979)

According to this model, the human psychological functioning is influenced by four environmental systems: a) The microsystem is the closest level to the person (work colleagues, neighbours, family peer groups); b) The mesosystem is a system linking two or more Microsystems. It might be formed by social places and organizations; c) Exosystem refers to those factors indirectly affecting the person (parents' workplace, local government, social services, mass-media...); and d) Macrosystem are all these factors linked with culture and ideology (national economy, costumes, values, beliefs...)

From when a person is born, these four nested structures interact with them modelling their cognitive, moral and emotional development and influencing their behaviour. "*This model offers a good framework for understanding the various levels of action that may be required in social marketing programmes*" (French & Gordon, 2015).

c) The service-dominant logic (SDL) and value co-creation

Since the first articles of SDL were published (Vargo & Lusch, 2004 Vargo, 2009; Vargo & Lusch, 2004; Vargo & Lusch, 2006; Vargo, & Lusch, 2008; Vargo & Lusch, 2016a; Vargo & Lusch, 2016b; Vargo et al., 2015), this marketing logic has being attracting the attention of scholars and practitioners, being considered as an alternative to the traditional good-dominant logic (GDL).

While GDL focuses on goods and the exchange of these good to create value, SDL sees "the service as the foundation of the economic exchange, with all providers becoming service providers" (Edvardson et al., 2011). According to these authors, the concept of service focuses on how providers and customers create and use the resources, becoming both parts in resource integrators. The application of these resources in the specific social context of the customers makes full sense to the resources (value co-creation). Value is not considered a deliverable output (Zainnudin et al., 2017). Only the customers through their experiences and interactions can value the resources in context, giving a meaning to them. Therefore, the value of these resources is unique.

"SDL is based on the principle that value must be co-created with customers and assessed on the basis of value-in-context" (Edvardsson et al., 2010). Therefore, the beneficiaries become the co-creators of value. The relationship, dialogue and interaction between the beneficiaries and the service providers has maximum relevance. "The interaction and dialogue will be possible if organizations support the customer´s capacity for change (knowledge, skills, motivations...) across various touch points (Luca et al., 2016).

Therefore, the application of these resources and competences (knowledge and skills) are the basis of exchange, benefiting all the parts" (Vargo et al., 2008; and Edvardsson, et al., 2010).

Social organizations (NGOs, associations...) and customers (people with disability) become resource integrators. "The application of these resources associated with the competence (knowledge and skills for the benefit of an actor), are the bases of the economic exchange" (Vargo and Lusch, 2008).
According to SDL, stakeholders and clients are partners rather than intervention targets (Johansson et al., 2018). It requires an active participation of the stakeholders, interactively collaborating with social marketers. In this way, social actors, clients and

stakeholders together create value. The collaboration among services providers, stakeholders and customers is key to achieve interactive exchanges where the value is co-created (Johanson et al., 2018). Therefore, "organizations are key to co-create value, coordinating and facilitating these resources at network level" (Luca, et al., 2016). In addition, the experiences of interactions together with the search of a social role are the needed elements to create value. (Luca et al., 2016).

The relevance of SDL in this research is that "SDL can be usefully applied to complex social challenges that require change" (Luca et al., 2016); and the importance given to the use of social theories to obtain this positive change (Edvardsson et al., 2010).

Following the example of a car manufacturing firm (Vargo et al., 2008), and transforming it into a disability case, we would have that a disability organization applies its knowledge, skills and capabilities to offer a service to people with disabilities. The value creation occurs when the people with disabilities use this service and integrate it with other resources and make use of it in their context of their life. This is the value of the exchange. In this social context people with disability and social services organizations co-create value: disability organizations use their knowledge and skills to offer a service or improve the customers' competences; and people with disability apply their knowledge and skills in the use of the service in their daily life context.

d) SM models, techniques and strategies.

Nearly all the articles reviewed in this study spend several paragraphs discussing the role, convenience, or how to reformulate marketing mix within the SM framework. 4Ps and its techniques are considered by many authors the core of SM, at least for those interventions targeting behavioural change of individuals, which have dominated SM since its inception.

On the one hand, some authors have made an attempt to use the 4Ps in an effective way or adapt them to be used within the framework of social actions. To that, some advantages of using the marketing mix in SM have been found. SM, by using the 4Ps but not only communication and advertising, can contribute to create attractive packages and quality exchanges for the target audience (Andreasen, 2002). The marketing mix is

crucial to plan and implement marketing strategies in SM (Grier & Bryant, 2005). In addition, the marketing mix is a key factor of differentiation for SM (Luca & Suggs, 2013)

On the contrary, other authors highlight the importance of abandoning the marketing mix and using other techniques from commercial marketing and other disciplines or theories. This improvement will allow SM to broaden its scope and objectives. Marketing mix might be obsolete when trying to develop upstream actions such as public relations, advocacy or some stakeholder engagement (Gordon, 2013). Finally, there are authors who advocate to abandon the preconceived and limited 4Ps approach (Gordon, 2013; and Peattie & Peattie, 2003).

Although SM considers that marketing mix is at the core of SM, this technique will not be the focus of this research. As it was previously mentioned, marketing mix is playing an important role in SM, but there are other actions developed within the framework of SM and beyond the 4Ps and behavioural change. What will be crucial for this research is those other activities labelled as "SM techniques" outside the 4Ps. This is because: "*many social interventions are not managed by social marketing experts with large budgets"* (French & Russell-Bennett 2013).

For example, Social marketers might become "social enablers" to support the self-determination of individuals to freely choose their actions. (Saunders et al., 2015). When targeting the upstream level, other techniques outside marketing mix might be used, such as relationship building, stakeholders engagement, advocacy, public relations, and engaging in policy forums (Gordon, 2013). From the same author (Gordon, 2013), one attempt to re-tool the SM mix proposes actions such as: relational thinking, community engagement, and co-creation. The project START (Pentz et al., 1989) developed techniques such as school curriculum, community organization or activities targeting parents. Other scholars have found education to be an important technique of SM (Stead et al., 2007). Other techniques also developed within the SM framework are volunteer programs (Peattie & Peattie, 2003); or interpersonal interactions, training, financial and technical assistance, public relations, giveaways and fremiums...(Brennan et Parker., 2014). A point of view held by scholars and professionals close to charities is that SM actions might resemble those executed by "activists" more than marketers. This would allow SM stands out in social welfare and public health (Wymer, 2011).

It seems there is not a clear agreement of which techniques can be useful or should be included within the SM framework.

Finally, we would like to highlight four acknowledged efforts to add knowledge or to find alternatives to the 4Ps: a) reviewing the 4Ps (Gordon, 2012), b) the intervention matrix (French, 2011); c) a new vocabulary framework for SM (Peattie & Peattie, 2003); and d) a hierarchical model of social marketing (French & Russell-Bennet, 2015)

- **An alternative approach to the 4Ps (Gordon, 2012).**

The author states that the 4Ps are nowadays obsolete to be used within the framework of SM. The author argues for the need of SM to develop new independent interventions and techniques detached from those of marketing mix. According to the author, the short-term orientation of marketing mix (the lack of long-term commitments, co-creation value engagement, stakeholders' involvement) are limitations that SM must overcome. To tackle these limitations, the author has developed a new SM mix model. The key to this model is its consumer orientation (community-owned, co-creation of value, research driven...). In addition, the other 5 components of the model are: Process (relational thinking, holistic approach, long-term,...); Channels/strategies (Policy, advocacy, lobbying, PR/media, relations, information,...); Costs linked with modifications in the consumers behaviour; Organization and competition (relation between stakeholders, policy agenda...); and Circumstances (structural environment and upstream actions, social norms,...)

- **The intervention matrix (French, 2011).**

The article: "Why nudging is not enough" offers a review of the forms of exchange and the types of interventions used to bring about social good. The four forms of exchange described by the author are: Nudge, hug, smack, and shove. These four categories can be better represented in an exchange matrix. According to the author: "The matrix is formed by two axes: passive/active choosing; and positive and negative incentivizing or penalizing". The possible types of interventions are classified by the author into five categories: communicate/inform, engage/educate, service/support, context/design and regulate/control. Both domains combined (type of intervention and form of exchanges)

form the intervention matrix. According to the article, SM scope may combine different approaches, interventions, and forms of exchange such as education, include the action carried out by service providers, support to empower individuals...

- **A new vocabulary framework for SM (Peattie & Peattie, 2003).**

Focusing on three commercial marketing concepts (customer orientation, exchange and marketing mix) authors study the validity of these concepts when translated into a social context. According to the authors, SM has achieved a growth stage, therefore, it is needed to develop their own theoretical base, tools and vocabulary, and to leave behind the marketing 4Ps. According to the authors, the use of the following vocabulary would benefit SM: "Social proposition" rather than product; "cost of involvement" better than price; "accessibility" instead of place; "social communication" rather than promotion; "Interaction" better than exchange; and increased use of "ideas competition to attract acceptance and attention"). In addition, this need for SM to develop new vocabulary and tools, and the stated negative side-effects that marketing is having in social values might be very useful to justify my study.

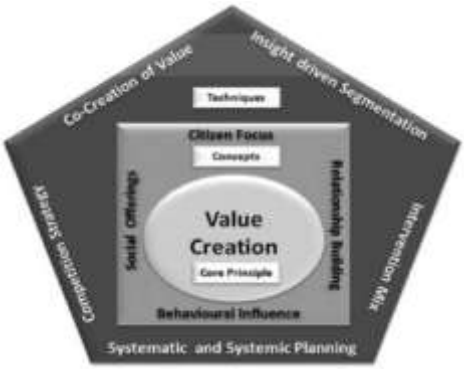
- **A hierarchical model of social marketing (French & Russell-Bennet, 2015)**

Based on the definition of social marketing stated by the International Social Marketing association (iSMA), The Australian Association of Social Marketing (AASM) and The European Association of Social Marketing, French & Russell-Bennet (2015) developed a new model in order to create a framework to describe and categorize social marketing, setting out the essential elements of SM: descriptors of actions, techniques and activities, together with some principles and concepts.

It is a theoretical work in which authors compare similarities and differences between marketing and SM by analysing previous literature, and improving the results from two previous models: Andreasen, (2002) and French and Blair-Stevens, (2005). These attempts to codify SM will allow the differentiation not only of commercial marketing from SM, but also the latter from other disciplines such as social media marketing, social advertising and social intervention.

According to the authors, their hierarchical model is formed by three categories of descriptive criteria: a) a SM principle; b) four marketing-derived elements; and c) five SM techniques.

Figure 1. Model of three categories of social marketing criteria.



Source: French & Russell-Bennet (2015)

The proposed core principle of SM is "*the creation of **social value** through the exchange of social offerings (products, ideas, experience, service, environment and systems*". The exchange can be positive (to pay for using a product that is less environmentally damaging) or negative (reducing speed when driving). The capacity to influence the behaviour and to measure the impact of any intervention are key elements of a SM practice. Citizen-centric planning and the construction of a robust relationship with citizens and stakeholders are also key features of SM.

A relevant feature of SM is its close relationship with the concept of "value creation" and the following four core marketing-derived elements:

a) Social behavioural influence: a range of upstream, midstream and downstream interventions are developed with the objective of changing specific behaviours by using behavioural theory, measurable objectives and indicators.
b) Citizen/customer/civic society-orientation focus: qualitative and quantitative behavioural analysis should be carried out to plan, implement and evaluate interventions around the target group´s attitudes, beliefs, wants and needs.
c) Social offerings; targeting markets (e.g. disabled people, their educators and decision takers) to offer products (assistive technology), services (health, education, housing, employment), ideas (self-determination, voting in elections), accessible environment (easy-to-read documents or signs) that provide value and advantage.

d) Relationship building. Wellbeing is achieved by a process of engagement and exchange. Stakeholders and citizens take part in the selection of priorities and in all stages of social interventions (design, implementation and evaluation)

These four concepts are the necessary supports to allow SM to create social value.

The presence of the five core SM techniques demonstrates the planning and analysis of an intervention has been correctly developed. This application will allow social actors to increase the effectiveness and efficiency of social interventions.

The five core SM techniques are the following:

a) Integrated intervention mix. Combination of different types of interventions (segmentation analysis, target market insight data, and competition analysis) to ensure the effectiveness and efficiency of a social program.
b) Competition analysis and action. Assessment of internal (genetic, internal psychological factors, risk taking, desires...) and external factors (environmental, social, cultural factors...) to reduce negative competition.
c) Systematic planning and evaluation. It refers to the use of proven models, theory and strategies to develop robust programs that will employ techniques such as "formative research, pre-test, situational research, monitoring evaluation and the development of learning strategies".
d) Insight-driven segmentation. To generate useful knowledge and hypothesis that can be used to help people. This data is obtained from the feelings and beliefs of the target market and their environmental circumstances. In addition, the segmentation to identify similarities and what influences target groups will lead to the production of tailor-made interventions based on the person´s values, needs and circumstances.
e) Co-creation through social markets. Key social actors are engaged in all the stages and elements of the social interventions in order to maximized their contribution.

Summing up, the development of social offerings, the value creation using exchanges, the relationship with stakeholders and the use of the described SM principles and

techniques are key to be able to influence the individual behaviours and obtain a positive social change.

2.5. SM AND DISABILITY SECTOR: SHARED THEORETICAL APPROACHES

This section will be devoted to explain the most important theoretical similarities and differences between SM and disability sector.

To start with, both fields have the common ultimate goal to support the **behavioural change** of a targeted audience to improve their personal well-being. In addition, and crucial for both fields is to start their social interventions with an assessment of the **clients´ needs** in order to plan the interventions.

But not only do they share the same goal and diagnosis of needs approach. They have also developed in parallel specific models and instruments based on similar principles and logic. This section will discuss the most relevant of them: a) the ecological model); b) the midstream level; and c) the SDL and the value co-creation.

The ecological model.

The ecological model was adopted by SM (Zainuddin et al., 2017; Truong, 2014; Wood, 2016; Brennan & Parker 2014; and Luca et al., 2016;) to understand the complexity and dynamic nature of the systems where individuals live today. The systems, their components and people develop strong, intertwined and complex processes, forces, interactions, and relationships which have a huge capacity to influence people's behaviour. Social problems are multidimensional and caused by a range of factors on different levels. The effective solutions to these problems will be found only by embracing a holistic ecological approach. This adoption allowed SM to extend its interventions from exclusively health interventions, to other social fields such us quality of life (Zainuddin et al., 2017), wellbeing, global warming, social welfare, working conditions, and social innovation (Lefebvre, 2012); and sustainability (Tapp & Spotswood, 2013). As a result of this evolution, a door has been opened to research the potential of SM in the social sector.

The ecological model is also a relevant theoretical framework for the disability sector and in the development of the construct of "quality of life" (Brown et al., 2009; Buntix & Schalock, 2010; Schalock, 2004; Schalock et al.,2008; and Verdugo et al., 2012). First and foremost, the ecological model is implicit in the very concept of disability: "*disability is the expression of limitations in individual functioning within a* ***social context***". Secondly, QoL is understood as "*a multidimensional construct influenced by individual*

and environmental factors... becoming the link between the general values reflected in the social rights and the personal life of the individual" (Buntix & Schalock, 2010).
Finally, "the individualized support model" is intended to provide not only guidance and personal training, but also other actions directly linked to improving the clients´ environment. Some examples are: a) the huge number of actions found to improve the clients´ social support; and b) the relevance of designing specific environments for the clients (accessibility, design for all...). Both actions aimed at improving the final goal of improving the client´s social inclusion (Schalock, 2004).

Midstream level.

Midstream level refers to the influence that the nearest social environment might have on the target group. It is formed by a combination of a range of elements such as communities, and schools (Gordon, 2013); consumer associations (Wymer, 2009); fitness centres, and sports clubs (Zainuddin et al., 2017); personal networks, and peer groups (Luca, et al., 2016); or Service organisations and staff (Wood, 2016). The last two elements mentioned (disability organizations and staff) are the two main target groups of this research. The relevance that service organizations and their staff have in midstream SM is highlighted by many relevant authors. Some examples are: "the staff play a critical role in co-creating value" (Russell-Bennett, 2013); "the close contact that staff generate with customers and families" (Luca et al., 2016); "the powerful role of staff-client relationships to co-create value" (Wood, 2016); "consumers working cooperatively with organizations and staff to co-produce" (French, et al., 2017); or "the critical staff capacity to create value" (Domegan et al., 2013).

On the social sector side, two key different roles of the disability sector at midstream level should be highlighted. On the one hand, disability organizations are themselves a key element of the environment in which people with disabilities and their families live. On the other hand, disability organizations are the resources that society has placed at the disposal of people with disabilities to make it possible for them improve their quality of life. In this way, they become resource integrators (SDL), facilitating the adjustment to the other elements of disabled people´s environment.

As it was stated in the preceding pages, QoL is the most relevant model for the disability organizations; and social inclusion is the crucial dimension of this model. Social inclusion addresses the midstream level, having the objective to achieve the person´s integration

into the community (Verdugo et al., 2005). As a result of this, social inclusion is embedded in the organizational culture and strategy of many disability organizations, being one of its most important strategic objectives. Therefore, many of the activities carried out by disability organizations are directly linked with social inclusion at the midstream level. Some examples of activities found in the existing literature are: volunteerism; access to community activities and services; work environment and relationships with people who are not staff, family members or other people with disabilities; "social support and home programs" (Schalock, 2000); and inclusive friendly environments, assistive technology and stable environments that promote well-being (Schalock et al., 2008).

Service dominant logic and value co-creation.

As it was posited in the previous section, "SDL is based on the principle that value must be co-created with customers and assessed on the basis of value-in-context" (Edvardsson et al., 2010).

According to SDL, Social organizations (NGOs, associations...) and customers (people with disabilities) become resource integrators. "The application of these resources associated with the competence (knowledge and skills for the benefit of an actor), are the bases of the economic exchange" (Vargo and Lusch, 2008).

Some of the SDL principles are also shared by the theoretical models of the disability sector. In this case, the QoL model has adopted proposals that share features with concepts embraced by SDL: a) the value creation in the client´s daily-life context (value in context); and b) a measurement strategy based on a stakeholders approach (co-creation).

The disability models reviewed in this research are completely aligned with the principle that the value of the interventions must be assessed in the client´s context. One of the most important challenges of disability organizations is to ensure that the competences acquired by people with disabilities become adaptive behaviours which will be used to match their wants and needs in their natural context. This concept is known in the disability sector as "transferability to the daily-life activities" and associated with two other domains of the QoL model: a) Personal development (personal skills and adaptive behaviour); and b) Self-determination (autonomy, personal goals,

decisions, choices....). Behaviours such as housekeeping, money management, self-care skills, meals...have to be expressed "in the daily life situation of the person" (Buntinx & Schalock, 2010).

In addition, QoL model encourages the involvement of staff, families and clients in the development of the evaluation methodology. The indicators to measure the individual performance behaviour are based on consumer satisfaction and personal outcomes (clients behaviours in their natural context). One of the key features of these indicators is that "they have to be built around what a person wants in their life and those factors that disability organizations have control over" (Schalock et al., 2008). The final objective is to assess "the degree to which clients have life experiences that they consider valuable" (Verdugo et al., 2005).

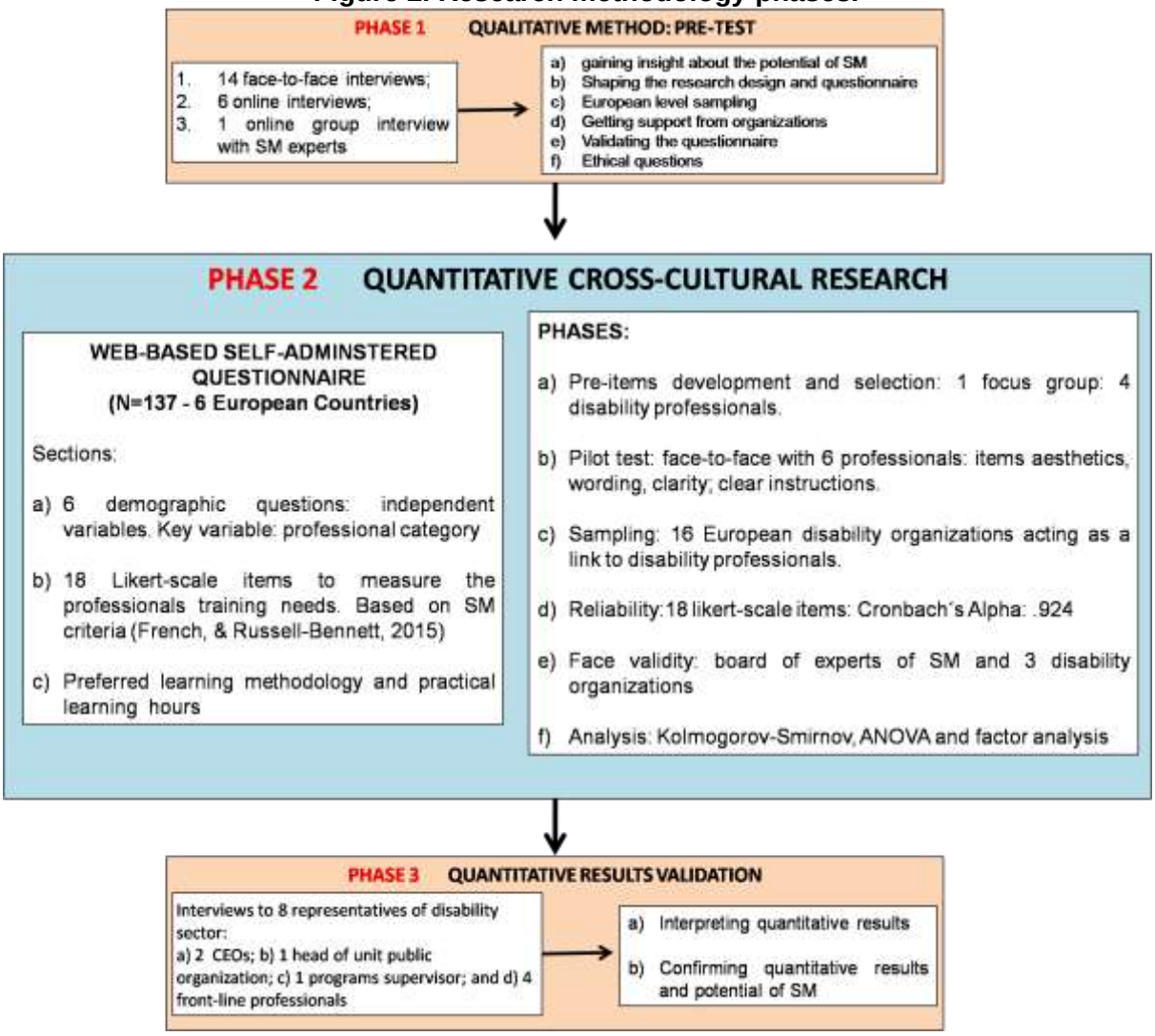
3. METHODOLOGY

As it can be seen in the figure 2, this exploratory research employs a mixed method approach combining qualitative and quantitative strategies.

3 Phases:

1. Pre-test phase. The research completed **20 unstructured interviews** and **1 online group interview**.
2. Quantitative cross-cultural research: **137** web-based self-administered questionnaires were completed in **6 European countries**.
3. Quantitative results validation. **8 unstructured interviews** were completed to validate the quantitative results.

Figure 2. Research methodology phases.



Source: own elaboration

3.1. Phase 1: pre-test

The information provided by the theoretical analysis completed in section two has been very valuable in getting an insight into the most important features of the two fields studied. In addition, several key and diverse new approaches for this research were also identified.

In order to organized all this information and pave the way to start the quantitative method (phase 2), a pre-test (phase 1) was completed. This would allow us to compare the theoretical information with the opinions of experts in SM and disability.

In this pre-test phase, the research completed **20 unstructured interviews** (14 face-to-face; 6 online) with professionals and politicians in social services sector from Australia, Spain, Belgium, Bulgaria, Italy, Portugal, Holland, Switzerland and UK, In addition, it was carried out an **1 online group interview** with experts in SM from UK, Spain and Switzerland.

The objectives of these interviews were: a) helping to shape the nature and process of the research design; b) gaining insight about the potential and barriers of implementing SM in the disability sector; c) finding information to shape the questionnaire and define the target groups; d) finding organizations to support the research; e) validating the questionnaire; f) discussing ethical questions; and f) helping to improve the sample at European level.

3.2. Phase 2: quantitative cross-cultural research.

Because one of the most important objectives of this research was: "to prioritize training needs using disability professionals as the principal delivery mechanism", a quantitative research method was included in the research design.

In addition, to be able to achieve the status of "European Research", there was a requirement to contact a set of disability organizations in selected European countries.

The best tool to collect quantitative information that matches these requirements is the web-based self-administered questionnaire. In addition, this method presents several advantages such as: a) no interviewer is needed; b) time and cost advantages; c) respondents privacy; d) no interviewer variability; and e) convenience for respondents which have influenced our decision.

Therefore, a web-based self-administered questionnaire was developed formed by three sections:

a) The 6 demographic questions (country of residence, age, years of working experience, type of organization, size of organization and professional category)
b) 2 questions about the preferred learning methodology. 1 question to find the preferred training methodology and 1 question to establish the number of theoretical/practical learning hours.
c) In addition, the respondents had the chance to leave their email address if they wanted to receive a summary of this research.

The demographic questions aimed at: a) gathering background information about the sample; but also, they have been used as independent variables to conduct the one-way ANOVA test.

In addition, the last demographic question "professional category" is considered a key independent variable in this research. The existing literature on SM (downstream, midstream and upstream levels; the service dominant logic; and the concept of value co-creation) and the qualitative interviews carried out suggested the relevance of focusing the research on this "professional category". This differentiation was understood to be crucial due to the different training needs that, "theoretically" these group have. Accordingly, 4 professional categories were defined:

- Care-givers: ongoing personal and physical care and support (transfers, dressing, toileting, grooming, eating...)
- Frontline professionals: direct contact intervention with the final beneficiaries. (For example: occupational therapists, educators, employment mediators, nurses, psychologists...)
- Program developers, coordinators or technician staff not working every day with the final beneficiaries. (For example: Professionals responsible for designing and evaluating interventions programs)
- Strategic level: Decision-takers, directors, politicians, managers. Management professionals, executive directors, lawmakers, responsible for approving policies and laws, and allocating budgets.

The core of the questionnaire is formed by **18 Likert-scale items designed to assess the specific training needs of disability professionals in SM.** A set of pre-items was written by the author of this research based on the SM criteria explained previously in this document (French & Russell-Bennet, 2015). **A focus group with 4 disability professionals** was carried out in order to select, re-write and edit the relevant items. An initial instrument was developed with 19 items.

A pilot test was completed with a sample of 6 professionals (face-to-face interviews) to measure whether the features of the items (aesthetics, wording, clarity, cultural issues and response time) were appropriate and if the instructions were clear. The word "stakeholders" was changed to the expression: "key social actors". It was suggested the concepts of "clients", "key social actors" and "manager" were explained. Two sentences were rephrased. Only one item was removed.

Data source

20 representatives of **European disability organizations** were contacted and invited to take part in the project. After explaining the goal of the research, an email with instructions and a specific link to the survey was sent. 4 of these organizations did not provide any answers. The distribution of the sample by country can be seen in the table 1. The questionnaire was translated into Spanish and Bulgarian. The participating organizations of the other countries circulated the English version.

Table 1. Country distribution of the sample.

Country	Number of organizations	Sample
Spain	7	94
Belgium	1	13
Italy	3	6
Bulgaria	3	11
Portugal	1	7
Holland	1	3
Other	-	3
TOTAL	**16**	**137**

Source: own elaboration.

Reliability and validity.

Reliability.

Cronbach´s Alpha test was run to check the internal reliability of the 18 Likert-scale items. The test showed a score of .924 which is considered excellent. Similar results were obtained when the test was run independently for each of the 4 professional categories: caregivers: .946; frontline professionals: .919; program designers: .909; and managers: .944.

Table 2. Cronbach´s Alpha using the 18 Likert-scale variables.

Estadísticas de fiabilidad

Alfa de Cronbach	Alfa de Cronbach basada en elementos estandarizados	N de elementos
,924	,924	18

Source: own elaboration from the sample data.

Face validity.

A board of experts of ESMA (European Social Marketing Association), a Bulgarian association that represents people with disabilities (NARHU), and a Portuguese organization of Cerebral Palsy (APPC) determined that the scale apparently reflects contents of SM that are appropriate for the research questions.

Analyses

Exploratory factor analysis was conducted to identify the underlying factor structure of the 18 items. KMO and Bartlett´s test indicates the suitability of the test. A minimum **eigenvalue of 1** was used to define the factors. Component analysis was conducted followed by Marimax rotation. Factor loading >.60 was used to include an item within a domain.

Table 3. SPSS´test of KMO and Bartlett.

Prueba de KMO y Bartlett

Medida Kaiser-Meyer-Olkin de adecuación de muestreo		,881
Prueba de esfericidad de Bartlett	Aprox. Chi-cuadrado	1308,733
	gl	153
	Sig.	,000

Source: own elaboration from sample data.

It has been decided to use the Likert-scale items as quasi-interval variables in spite of the existing controversy around this issue. This has allowed us to calculate the means, prioritize the items and run several tests.

Kolmogorov-Smirnov test showed that the 18 Likert-scale variables do not behave as normal data. But as ANOVA may tolerate some violations of the normality, the sample size is greater than 30 in many categories and there is no reasons to believe that the observations are not independent, it was decided to conduct this test. Therefore, the obtained results must be carefully interpreted.

One-way ANOVA was conducted to determine whether the means of the 18 Likert-scale items (dependent variables) differ by the categories included in the 6 demographic questions (independent variables).

In addition, two new variables were created. The first one, with the mean score of the 18 items. The second one grouped the four professional categories into two: a) caregivers and front-line professionals; and b) program designers and managers.

A p-value < 0.05 was considered in all the tests performed as an indicative of statistical significance.

3.3. Phase 3: Quantitative results validation

Once the quantitative phase was finished and the data analysed, **8 unstructured interviews** were completed with the objective to help the researcher confirm and interpret the results.

The sample was formed exclusively by the following representatives of the disability sector: a) 2 legal representatives of disability organizations; 1 head of unit of a Regional Ministry body; 1 programs supervisor; 2 front-line professionals; and 2 care-givers.

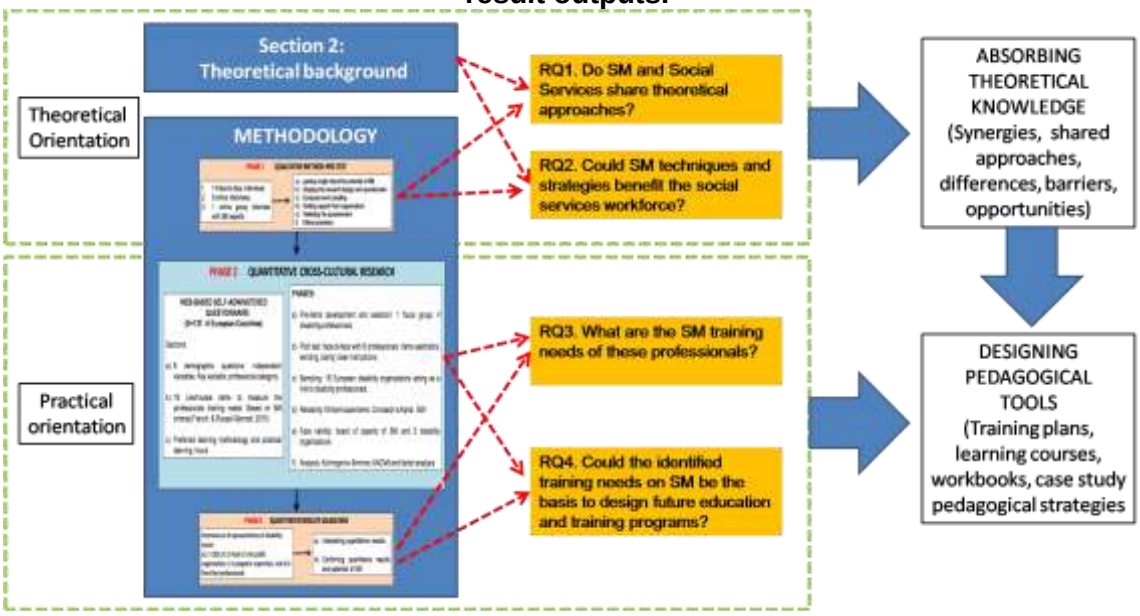
A brief report with the summary of the conclusions was sent to the participants before being interviewed. In addition, a Power-point presentation was prepared to explain the research results and discuss the following issues: a) training needs prioritization by professional category; b) specific training needs of care-givers; c) results of the factor analysis; and d) general thoughts of the participants regarding the development of pedagogical materials of SM for the disability sector.

4. DISCUSSION OF RESEARCH RESULTS

4.1 Introduction

This section will show how the methodology links to the research questions. As it can be seen in figure 3, the research questions and the methodologies can be divided into two blocks: a) the first two research questions have a theoretical orientation; and b) the other two have a more practical orientation.

Figure 3. Relationship between methodology, research questions and type of result outputs.



Source: own elaboration

In this sense, the two first phases "theoretical background" and "pre-test" are qualitative methods aimed at **theoretically** comparing the two fields and finding possible sources of synergies.

The phase "Quantitative cross-cultural research" was designed to provide practical information about the specific needs of disability professionals in SM. The fourth phase "quantitative results validation" contributes in confirming and interpreting the research results. The ultimate goal of this block is the design of specific SM pedagogical materials for the disability sector, **giving this research a practical utility**.

Although, each methodology was designed with the objective to focus only on answering the questions of one of the two blocks, in practice the information obtained from each methodology has contributed to some extent in answering the four research questions.

RQ1 - Do SM and Social Services share theoretical approaches?

Yes, they do.

The answer of the first research question requires the use of a qualitative methodology. The methodology chosen to answer it was the analysis of existing literature: section 2 of this research (Theoretical background).

To start with, both fields have the common ultimate goal to support the **behavioural change** of a targeted audience to improve their personal well-being. In addition, and crucial for both fields is to start their social interventions with an assessment of the **clients´ needs** in order to plan the interventions.

But not only do they share the same goal and diagnosis of needs approach. They have also developed in parallel specific models and instruments based on similar principles and logic. This section will discuss the most relevant of them: a) the ecological model; b) the midstream level; and c) the SDL and the value co-creation.

a) <u>The ecological model.</u>

The ecological model allowed SM to extend its interventions from exclusively health interventions, to other complex social challenges such those close related to the disability field such as wellbeing, social welfare, working conditions, and social innovation.

Related to the disability sector, the ecological model is implicit in the very concept of disability: "*disability is the expression of limitations in individual functioning within a **social context***". As a result of this, the social context has to be also relevant for all modern disability models such are the cases analysed in this research: a) the construct of "quality of life"; and b) the "individualized support model". According to these models, "several environments (macro, meso, micro...) are influencing the person´s wellbeing (Verdugo, et al., 2005)

b) <u>Midstream level.</u>

Midstream level refers to the influence that the nearest social environment might have on the target group. The relevance that service organizations and their staff have in midstream SM has been highlighted by many relevant authors analysed in this research.

On the social sector side, two key different roles of the disability sector at midstream level should be highlighted. On the one hand, disability organizations are themselves a key element of the environment in which people with disabilities and their families live. On the other hand, disability organizations are the "midstream" resources that society has placed at the disposal of people with disabilities to make it possible for them improve their quality of life and social inclusion.

c) Service dominant logic and value co-creation.

As it was posited in the previous section, "SDL is based on the principle that value must be co-created with customers and assessed on the basis of value-in-context" (Edvardsson et al., 2010).

Some of the principles of the disability models reviewed in this research are completely aligned with the SDL logic. Some examples are: a) the value creation in the client´s daily-life context (value in context); b) a measurement strategy based on a stakeholders approach (co-creation).

RQ2. Could SM techniques and strategies benefit the social services workforce?

Yes, they could.

SM techniques and strategies could benefit the social services workforce **(synergy creators)**. But also several barriers have been found which should be taken into account **(synergy destroyers)**.

The first interviews (Pre-test) completed by the research revealed a good overall acceptance of the research objectives among disability professionals and marketers. Although SM is a very unfamiliar field for the disability sector, once the concept was explained, Interviewees generally expressed the opinion that SM would benefit the social sector, and that it was worthwhile to take part in the research or future SM training activities. In addition, interviewees suggested that due to some similarities between both fields, synergies could be easily found and generated **(Synergy creators).**

The theoretical background analysis (section 2) found that SM is a mature discipline able to tackle many of today's complex social challenges (Luca et Al., 2016) such as those precisely affecting people with disabilities: quality of life (Zainuddin et al., 2017), wellbeing, social welfare, working conditions, and social innovation (Lefebvre, 2012); and sustainability (Tapp & Spotswood, 2013).

In addition, the exiting literature and the qualitative interviews have also confirmed the relevance of training the social service workforce if SM wants to be implemented in the disability sector ((Luca et al., 2016a; Russell-Bennett et al., 2013; Wood, 2016).

Interviewees (phase 3) also stated that the relationships developed in the disability sector between front-line professionals (specially care-givers) and customers are unique, genuine and long-lasting. No other professionals develop this strong relationship. Logically, **front-line professionals are very interested in all the issues focused on understanding their customer needs and behaviours**. This unique relationship and how the value is co-created between the professionals and clients could be a subject of interest for social marketers.

In addition, the development of SM training materials and courses specifically for disability staff, and awareness-raising activities were considered by interviewees as appropriate methodologies to implement SM in the Social Sector.

Finally, in spite of disability being a sensitive topic, interviewees did not find any ethical issue in the research.

Table 4. Mapping disability sector & SM.

SYNERGY CREATORS (Similarities between both fields)	
• Ultimate goal: behavioural change to improve the personal well-being • Interventions begin with a clients' needs assessment • Problems are complex and caused by a range of factors: ecological model • The midstream level (disability organizations) is key to achieve the objectives • The relevance of the client´s social context (value-in-context) • Value co-creation: involvement of stakeholders in the process	
SYNERGY DESTROYERS (Differences between both fields)	
Social Marketing	**Disability field**
Behaviours are determined by the mesosystem (public bodies)	Behaviour should be agreed with the client and their family.
Strategies: segmentation, marketing mix, raise-awareness, impact evaluation, competition analysis, education.	Strategies: development of an unique and genuine relationship, individualized support plans, person-centered planning.
Interventions focused on health behaviours to improve well-being.	Interventions focused on adaptive behaviour to improve self-determination, social inclusion, personal well-being.
Main barriers to implement social marketing in the social field	
• Disability sector is already successfully using several evidence-based practices. • Negative sector attitudes towards marketing (professional trespassing)	
Opportunities for social marketing	
• To help disability sector to improve the image of disability. • To help disability sector to launch efficient campaigns to prevent health problems. • The existing disability models (QoL, individualized support...) are not fully implemented in disability organizations. New and specific pedagogical materials are demanded by professionals. • To acquire the disability sector know-how.	

Source: own elaboration

SM barriers (Synergy destroyers)

The research has found three relevant barriers that should be taken into account when trying to implement SM techniques and strategies in the disability field.

The first and most important difference is associated with the concept of "behaviour" and based on: a) the subject who decides the behaviour that must be modified; and b) the behaviour goals set out and strategies used to achieve them.

Regarding to the first point, it has been found that a high number of SM interventions are determined by subjects unknown by the target group, and belonging to their mesosystem or exosystem (municipalities, health departments of Regional Ministries...). This is understood by the disability professionals interviewed (phase 3) as an "imposed" behaviour. On the other side of the coin, the intervention plans designed in the disability sector are expected to be the result of an agreement between the client and several components of their microsystem (family, community services, disability professionals and employers). Although professionals (phase 3) have also expressed that an important set of behaviours such as those related to clients' health are unilaterally decided by the service provider, therefore also "imposed" on the clients.

As a result of the client-professional agreement, disability intervention plans set up different objectives and deploy different working strategies which have been rarely found in SM by this research. The most relevant of them are: a) the individualized supports; b) the person-centered planning, c) self-determination; and d) adaptive behaviour.

Theoretically, "the concept of QoL is designed in terms of gains in adaptive behaviour skills" (Claes, et al., 2010). According to this, disability professionals modify their client´s behaviour to allow clients to manage their own life (Verdugo et al, 2012). Two domains of the model of QoL are understood to be specific to the disability sector and radically different from SM principles: Self-determination (autonomy, choices/decision, personal goals, personal control); b) and personal development (personal skills, adaptive behaviour...)

The objectives related to the development of these two domains are achieved by using two specific tools neither of which have been found in SM: a) the individualized supports; and b) the person-centered planning (Buntinx & Schalock, 2010; Schalock, 2000; Schalock et al., 2008; Schalock et al., 2018; and Verdugo et al., 2012).

The second relevant barrier found by the research is related to the professionals and families attitudes or beliefs. Two aspects of disability sector beliefs/attitudes have been discovered by the research that should be highlighted: a) the negative beliefs found in part of the society, disability professionals and families towards the full social inclusion of people with disabilities in the society; and b) the negative attitude of the disability sector towards marketing.

Finally, and regarding the three levels of marketing, participants in phase 1 suggested that it would be difficult to involve politicians (Upstream level) in this research or in later training activities related to SM.

RQ3. What are the SM training needs of disability professionals?

Those related to factors influencing and explaining client´s behaviours.

The two first research questions have been answered by using exclusively qualitative research methods. In contrast, the RQ3 will be answered mostly focusing on the quantitative information given by the disability professionals **(Phase 2: quantitative cross-cultural research).** The **Phase 3: Quantitative results validation** has been designed to help to confirm and interpret these quantitative result.

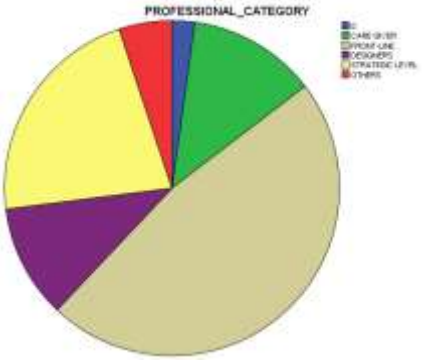
We will start this section by offering a general view of the sample demographic data (Further information can be seen in annex 2). It will follow a training needs prioritization and an ANOVA´s analysis of the 18 likert-scale and the independent variables, focusing on the "professional category" variable. Factor analysis will help us to group these training needs into four factors. Finally, the preferred training methodologies will be described.

Demographics

The questionnaire was completed by 137 disability professionals from 6 European countries. The sample is composed by professionals with high experience working in the social sector (89,8% have more than 3 years).

Related to their professional category, 47.4% of the respondents belong to the category of "Front-line professionals"; 21.9% to "strategic level"; 12.4% to "care-giver"; 10.9% to "program designers"; and 5.1% to "others" (Figure 4).

Figure 4. Sample distribution of professional categories.



Source: own elaboration from data sample.

Training needs prioritization: 18 Likert-scale items

The core of the questionnaire is formed by 18 Likert-scale items designed to do a quantitative assessment of the professional training needs in SM. The score of these items ranks from 1 to 5.

As it can be seen in table 5, the means of the 18 items vary from 3.61 to 4.46. This means that disability professionals have showed to have a high interest on the SM techniques appearing in the questionnaire.

Table 5. Means of the 18 Liker-scale variables and the transformed variable "mean 18 ITEMS".

ITEM	SCORE
4. I need to learn how to evaluate the factors that influence my clients behaviour.	4,46
12. I need to learn how to evaluate the impact (effect) of my interventions on the behaviour of my clients.	4,29
3. I need to learn how the interventions can be designed between clients and professionals both working together.	4,26
6. I need to learn how to design interventions with the capacity to modify my clients dysfunctional behaviours.	4,26
13. I need to learn how to implement good practices from other sectors.	4,22
15. I need to learn new techniques to evaluate the needs of my clients.	4,16
1. I need to learn how several organizations and companies (key social actors) could work together with the common objective to satisfy the needs of my clients (final beneficiary)	4,15
2. I need to learn how to build long-term relationships with key social actors and organizations (different services providers)	4,11
14. I need to improve my skills to communicate with my clients using different channels.	4,1
8. I need to learn how to use the objectives and indicators of the intervention programs	4,09
7. To learn how to design objectives and indicators to better measure my clients behaviour.	4,08
5. I need to learn how to evaluate the barriers (Architectural, lack of supports...) in the environment that prevent my clients from having a positive behavioural change.	4,06
9. I need to learn how to use the theories and models of behaviour that explain human actions (motivation theory, social cognitive theory, Health belief model, Theory of planned behaviour...)	3,96
10. I need to learn how to use qualitative and quantitative techniques of gathering information in order to design intervention programs.	3,91
17. I need to learn how to evaluate the expectations of our social key actors about the service we are offering to the clients.	3,82
11. I need to learn how to make subgroups with my clients according to their needs to provide more specific interventions.	3,77
18. I need to learn how to evaluate and modify the image that the stakeholders have of our	3,76
16. I need to learn how to classify my organization's stakeholders (key social actors).	3,61
Mean 18 ITEMS	**4,06**

Source: Own elaboration from data sample.

The items that have obtained a higher score are those related to the **factors detecting, explaining and influencing the clients' needs and behaviours**. It also can be highlighted the high scored obtained by the items related to the concept of value co-creation (12, 1 and 2).

According to the interviews completed in the phase 3, the modern disability paradigms (QoL and the individualized support models) are still being implemented in the disability sector. Disability organizations have had to adapt their strategies to implement these models. On many occasions, this has resulted in professionals´ having insufficient skills and becoming frustrated. Logically, new professional profiles and training needs have started to be relevant. This has been stated by interviewees (phase 3) as an opportunity for SM to benefit social services workforce.

ANOVA

Related to the independent variables, ANOVA test has not found significant differences between the Likert-scale items and the different categories of the independent variables.

But in the case of the variable "professional category", it has been found significant differences between the four professionals categories in 3 items (Table 6).

Table 6. Means of the 3 items with significant differences for the professional category.

ITEMS (TRAINING NEEDS)	Professional Category	Mean
5. I need to learn how to evaluate the barriers (Architectural, lack of supports...) in the environment that prevent my clients from having a positive behavioural change.	**Care-givers**	**4.47**
	Front-line professionals	**4.17**
	Program designers	3.47
	Managers/directors	3.83
14. I need to improve my skills to communicate with my clients using different channels.	**Care-givers**	**4.47**
	Front-line professionals	**4.25**
	Program designers	3.87
	Managers/directors	3.69
15. I need to learn new techniques to evaluate the needs of my clients.	**Care-givers**	**4.47**
	Front-line professionals	**4.32**
	Program designers	3.80
	Managers/directors	3.93

Source: own elaboration from sample data.

An initial approach suggests higher training needs in these three topics of the two first categories: a) care-givers; and b) Front-line professionals. It seems these two categories might behave similarly. The different training needs of the two professional groups was confirmed by the participants interviewed in the phase 3.

As a result of the differences observed in table 6 (similar behaviour of the categories of "Care-giver" and "Front-line professionals"), a new variable was created. The primary 4 professional categories were transformed into 2 categories. The first category was

formed by grouping the former categories of "care-giver" and "front-line professionals" and named "All front-line professionals". The second category was formed grouping the former categories of "program designers" and "managers", and was call "strategic level". (Figure 5)

Figure 5. Transformation of categories of the variable "Professional categories".

Source: own elaboration.

In this case, ANOVA test **did find significant differences** between the means of the two new professional categories and the dependent variable "mean 18 ITEMS" (P=.030).

Table 7. ANOVA test output of the new two professional categories and the variable "mean 18 ITEMS".

ANOVA

		Suma de cuadrados	gl	Media cuadrática	F	Sig.
MEAN_18_ITEMS	Entre grupos	1,768	1	1,768	4,817	,030
	Dentro de grupos	45,874	125	,367		
	Total	47,642	126			

Source: own elaboration from the sample data

There has been a general agreement among interviewers and participating organizations (phase 3) that the more a professional is directly working with a person with disabilities and is responsible to evaluate their needs or modify their conduct, the more they would benefit from social marketing techniques and strategies.

Factor analysis

Factor analysis does confirm what has already been stated in the above paragraphs. The test has revealed four underlying factors which can be easily associated with the two new professional categories and their specific training needs (table 8 and 9).

Table 8. SPSS´ factor extraction

Varianza total explicada

Componente	Autovalores iniciales			Sumas de extracción de cargas al cuadrado			Sumas de rotación de cargas al cuadrado		
	Total	% de varianza	% acumulado	Total	% de varianza	% acumulado	Total	% de varianza	% acumulado
1	7,948	44,158	44,158	7,948	44,158	44,158	4,128	22,934	22,934
2	1,862	10,344	54,502	1,862	10,344	54,502	3,089	17,162	40,095
3	1,177	6,541	61,043	1,177	6,541	61,043	2,893	16,070	56,166
4	1,100	6,110	67,153	1,100	6,110	67,153	1,978	10,987	67,153
5	,844	4,690	71,843						
6	,790	4,391	76,234						
7	,759	4,218	80,452						
8	,510	2,835	83,287						
9	,492	2,731	86,018						
10	,439	2,440	88,458						
11	,393	2,181	90,639						
12	,323	1,795	92,433						
13	,307	1,703	94,137						
14	,260	1,446	95,583						
15	,253	1,405	96,988						
16	,221	1,227	98,215						
17	,174	,969	99,184						
18	,147	,816	100,000						

Método de extracción: análisis de componentes principales.

Source: own elaboration from sample data

The items with a loading higher than .60 that cluster around the same factors suggest:

a) factor 1 represents "Understanding clients´ behaviours";
b) factor 2 represents "stakeholders mapping";
c) factor 3 represents "Clients' value co-creation";
d) factor 4 represents "Stakeholders' value co-creation".

Table 9. Underlying factors; items with loading higher than .60.

GROUP	ITEMS REPRESENTING THE FACTOR
Understanding clients' behaviours **FRONT-LINE PROFESSIONAL**	• I need to learn how to evaluate the factors that influence my clients behaviour. • I need to learn how to design interventions with the capacity to modify my clients dysfunctional behaviours. • I need to learn how to design objectives and indicators to better measure my clients behaviour. • I need to learn how to use the objectives and indicators of the intervention programs. • I need to learn how to make subgroups with my clients according to their needs to provide more specific interventions.
Stakeholders´ Mapping **STRATEGIC LEVEL**	• I need to learn how to classify my organization's stakeholders (key social actors). • I need to learn how to evaluate the expectations of our social key actors about the service we are offering to the clients. • I need to learn how to evaluate and modify the image that the stakeholders have of our organization.
Clients' value co-creation **FRONT-LINE PROFESSIONAL**	• I need to improve my skills to communicate with my clients using different channels. • I need to learn new techniques to evaluate the needs of my clients.
Stakeholders' value co-creation **STRATEGIC LEVEL**	• I need to learn how several organizations and companies (key social actors) could work together with the common objective to satisfy the needs of my clients (final beneficiary) • I need to learn how to build long-term relationships with key social actors and organizations (different services providers)

Source: own elaboration from sample data.

The first and third factor ("understanding clients´ behaviour" and "Clients´value co-creation") would show the training needs of **Front-line professionals**, and the second and fourth factor ("stakeholders mapping" and "stakeholders' value co-creation") would show the training needs of **"strategic" staff**.

"Understanding clients' behaviours" is considered the most important factor (44% of the variance). It is represented by 5 items reflecting the professionals needs related to understand, modify and evaluate clients´ behaviours. The third factor "clients' value co-creation" is also associated with this professional category, but having a slightly lower priority than the first factor.

According to the opinions stated by the participants in the phase 3, the factor **"understanding client´s behaviours should have the highest priority when starting to design specific training material or courses of SM for disability professionals**.

The other two factors have been named: "stakeholders' mapping" and "Stakeholders´ value co-creation". They address the needs of the second professional category "strategic level".

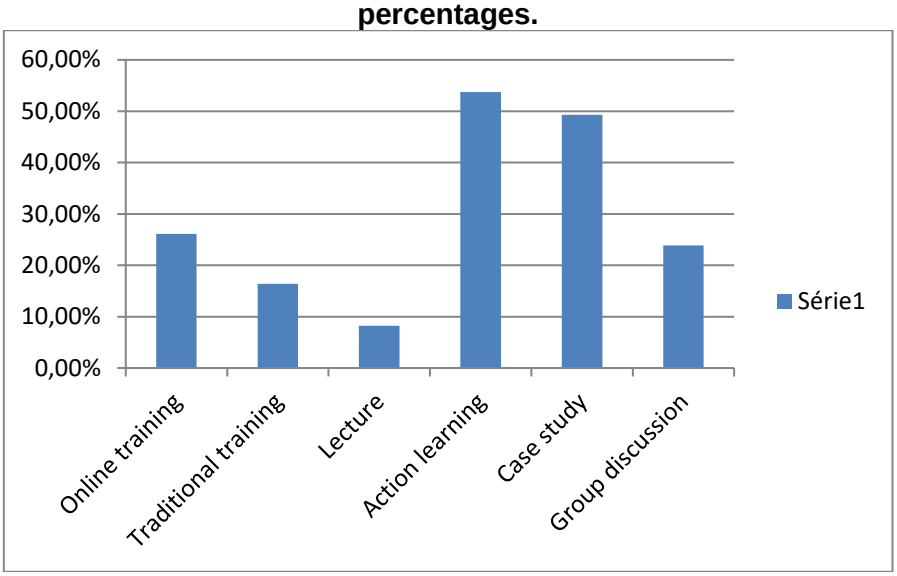
As strategic staff has showed lower training needs in SM, these two factors are not considered as relevant for the research as the two factors associated to the "All Front-line professionals" category. This statement was generally supported by the participants in the phase 3.

Training methodology

Finally, and related to the preferred pedagogical methodologies and percentage of practical learning hours, 53.7% of the respondents stated "action learning" as the preferred pedagogical methodology to take part in SM learning activities. This methodology was closely followed by the methodology "case study" (49.3%). The Case study methodology was also confirmed by interviewees in phase 3 to be the best methodology to adapt SM strategies in the disability sector.

In addition, the respondents have showed a preference for practical learning contents. The training and learning activities should have practical orientation, having at least 60% of practical learning hours.

Figure 6. General preferences on training methodology expressed in percentages.



Source: own elaboration

RQ4. Could the results of this research be the basis to develop SM educational and training materials for the disability sector?

Yes, they could.

As stated at the end of "introduction" section, one of the objectives of this research is to provide useful information to the community that can be used to develop innovative SM educational and training materials specific for the disability sector.

This paper has pointed out that since the research was explained to the SM and disability organizations (Pre-test phase), some of them decided to fully take part in all the project phases and in future actions stemming from this research.

The phase 2 (Quantitative cross-cultural research) identified a set of training priorities associated with SM, and the professionals interviewed in the phase 3 (Quantitative results validation) confirmed these training needs, helping to transform them **into two practical working proposals**.

The first proposal is already being used. Several European organizations (a Regional Ministry of Valencia Region, a UK expert organization in SM, three Colleges, and several European disability organizations) considered that the topic meets the eligibility ERASMUS+ criteria to apply for EU support (innovation, educational approach, social inclusion, target group, participating organizations active in the educational sector, European dimension to the problem and the proposal...)

As a result of this, a strategic partnership was formed and an ERASMUS+ proposal was designed and submitted.

The proposal aims at improving the SM competences of the disability workforce and is formed by three intellectual outputs:

1. **A social marketing handbook**. Educational contents to deliver a course of SM. It can be used both by trainers to give the lessons and by disability professional as a self-study book. It is divided into two sections: a) an introduction to social marketing; b) four real disability case study solved using SM techniques and strategies.
2. A social marketing case study **pedagogical strategy**. This is a systematic method for supporting the acquisition of SM learning outcomes through the use of the case-study methodology. The pedagogical strategy will be based on the

adaptation of social marketing techniques and strategies to be used as a case-study for disability professionals.

3. A social marketing MOOC COURSE. The most important SM training materials and methodologies will be adapted and uploaded to one of the Universities' platforms.

Finally, three participants in phase 3 suggested the idea of developing a "*kind of a SM resource centre*". As a result, there have been discussions among participating organizations about setting up in Valencia a SM non-profit organization aimed at: a) developing SM techniques for the disability sector; b) capturing European funds; c) to improve the image that society has about disability; and d) to launch social media campaigns to prevent health problems in the target group.

5. CONCLUSIONS

SM has evolved from a marketing-mix downstream approach to a mature discipline able to tackle many of today's complex social challenges (Luca et Al., 2016) such as those precisely affecting people with disabilities: quality of life (Zainuddin et al., 2017), wellbeing, social welfare, working conditions, and social innovation (Lefebvre, 2012); and sustainability (Tapp & Spotswood, 2013).

The SM concept, techniques and strategies are virtually unknown by the social service workforce. Nevertheless, the research has found enough evidence to determine that **Social marketing has the potential to be better implemented in the social sector**, improving its capacity to tackle specific challenges.

This statement is based on three specific findings: a) both fields have in common some social challenges and have similar ultimate goals which evolve around the concept of "behavioural change"; b) both fields share some theoretical background and principles; and c) the quantitative analysis indicates that disability professionals have specific training priorities closely associated to SM techniques and strategies. These three findings have been identified as **"synergy creators"** and explained below.

The first feature that might help to create synergies is the fact that both fields have the common ultimate goal to support the **behavioural change** of a targeted audience to improve their personal well-being. In addition, and crucial for both fields is to start their social interventions with an assessment of the **clients´ needs** in order to plan the interventions.

To achieve this goal, **Both fields also share similar principles and logic** from which they develop their social interventions. The most important similarities come from three elements: a) the ecological model; b) the midstream level; and c) the SDL and the value co-creation.

On the one hand**, SM embraced the ecological model** (Zainuddin et al., 2017; Truong, 2014; Wood, 2016; Brennan et al., 2016; and Luca et al., 2016;) to tackle the complex problems that humanity is facing today. On the other hand, **the disability sector also embraced the ecological model,** but in this case as a theoretical framework to support the development and implementation of three disability key concepts: a) the construct of "quality of life" (Brown et al., 2009; Buntix & Schalock, 2010; Schalock, 2004; Schalock

et al.,2008; and Verdugo et al., 2012); b) the generation of the modern concept of disability; and c) the implementation of the individualized support model.

The relevance of **the Midstream level in SM** to influence the clients´ behaviour has been discussed throughout the document, and is being supported by many authors (Brenan et al., 2016; French et al., 2017; Luca et al., 2016; Wood, 2016...). The relevance of midstream level in the disability sector comes from the fact that **disability organizations and their staff are one the most important elements of the client's midstream level**. It is believed that this justifies the disability professionals being the most important target of this research and the key vehicle to implement SM in the social sector. This statement is supported by many SM authors already mentioned in this research (Domegan et al., 2013; French, et al., 2017; Luca et al., 2016; Russell-Bennett, 2013; and Wood, 2016).

The third theoretical shared concept found by this research is the **SDL and the value co-creation**. In this case, two key similarities between both sectors have been found that both might also facilitate the implementation of SM in the social sector. Focusing on the disability sector, the QoL model encourages the involvement of staff, families and clients in the development of the interventions **(value co-creation)**. In addition, the competences taught to people with disabilities have always to be referred to "their daily life situation" (Buntinx & Schalock, 2010), which is understood as a parallel concept of **"value-in-context"** used by SDL.

The utmost importance to improve the competences of the social service workforce in the European Union has also been proved by this research. In relation to the specific training in the SM field, several authors suggest the benefits of improving staff competences on SM before starting any intervention (Luca et al., 2016a; Russell-Bennett et al., 2013; Wood, 2016).

The analysis of the quantitative data also confirms the conclusions obtained by the qualitative data. The questionnaire respondents have showed to have high professionals training needs associated to some SM techniques and strategies. In addition, two groups of professionals with different SM training needs have been found: "the front-line professionals" and "strategic staff".

Related to the professionals categories, the most important conclusion is that **the more a professional is directly working with a person with disabilities, the more they would benefit from SM techniques and strategies**.

Training actions in SM should be primary addressed to front-line professionals such as care-givers, occupational therapists, psychologists, social workers.... SM pedagogical materials and training courses should be specifically developed for these professionals and based on their real daily problems working with people with disability (case-study methodology).

The SM training priorities of the front-line professionals can be grouped into two categories (factors): a) "understanding client's behaviour"; and b) Clients value co-creation.

The first factor is named "Understanding client's behaviours" and expresses the following front-line professional training priorities: a) to understand and evaluate the factors influencing the client´s behaviours; b) to evaluate the impact of interventions in the clients´ behaviours; and c) to design interventions with the capacity to modify dysfunctional behaviours. The third factor is named "Clients' value co-creation" and refers to two training priorities: a) to evaluate the needs together with the client; and b) to improve skills which facilitate better communication with the clients.

The "strategic professionals" category has showed different and lower SM training priorities. In this case, SM might help these professionals to improve their competences linked with: a) the stakeholders mapping; b) to improve the image of the organization; and c) to co-create value with the organization´s stakeholders.

All professional categories showed the same preference for practical learning courses, with "action learning" and "case study" being the preferred pedagogical methodologies to learn SM.

In addition, disability experts believe that SM could play three key roles in helping the disability sector: a) to improve the image of the concept of disability: b) to launch campaigns to prevent health problems in the target group; and c) to change society and disability professionals' incorrect beliefs and attitudes towards the social inclusion of people with disabilities.

But the research has also found that the disability sector has specific and different methodologies and principles from SM. These differences might be considered as barriers **(synergy destroyers)** that could prevent SM from being implemented in the social sector. The two key differences are: a) the interventions in the disability sector aimed at **empowering** clients to manage their own lives according to the **self-**

determination principle; and b) professionals, client and family work together to agree an intervention plan. Therefore, the behaviours to be modified are not usually "imposed" by the macrosystem. In addition, negative disability sector attitudes towards marketing (professional trespassing) have been found by the research.

Finally, to make the implementation of SM easier within the disability sector, this discipline should take into account several techniques and evidence-based practices already successfully being used in the disability sector such as the QoL, person-centered planning or the individualized support model. In addition, the relationships developed in the disability sector between front-line professionals (specifically care-givers) and customers **are unique, genuine and long-lasting**. They might be considered as a source for "value co-creation".

Finally, some know-how and evidence-based practices from the disability sector might be also be adapted and used by SM practitioners to improve the SM field.

Research limitations

The most important research limitations come from the sampling method used and the web-based self-administered questionnaire.

This research has used a non-probability sampling method. This means that the organizations and professionals closer to the research team have been more likely to be selected. This is considered as a sampling bias.

In addition, although the disability sector is an accurate representation of the social sector, it is not the whole social sector. Future research should consider improving the sampling method, adding other social sectors and types of organizations to the sampling.

The use of web-based self-administered questionnaires have some limitations such as the impossibility to contact the respondents before sending the questionnaire; the difficulty for some professionals to access the questionnaire; the fact that the respondent can only view a part of the questionnaire on their PC or Smartphone; or the impossibility to know the non-response rate.

It should be also taken into account the social desirability and acquiescence response bias of the Likert-scale questionnaires.

Therefore, the findings of this research can not be generalized to the whole population of the social sector.

Future lines of action.

Three areas have emerged from this work that may have the potential for further research.

First, if the training initiative explained in RQ4 is eventually implemented, there will be a need for further research to evaluate the effectiveness of the proposal (short and long term). Research based on mixed methods using structured observation; focus groups; the development and use of validated tools are not common in SM, but might be considered as a way to evaluate this training proposal.

Second, The assessment of the needs of people with disabilities is considered to have huge potential for further research. The development of tools and methodologies to evaluate these specific needs; and the correlation that these needs have with the training needs of the professional taking care of them should be explored.

Third, the beliefs and attitudes of the social services sector towards marketing have been considered by this research to be a barrier to implement SM in the disability field. Further research about this issue and the development of validated tools to assess these beliefs might be appropriate.

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ANNEX 1. QUESTIONNAIRE: ENGLISH VERSION.

Training needs assessment for professionals of the social services

INSTRUCTIONS

This survey tries to identify the training needs of professionals of the social sector in some specific areas. The data will be only used for research purposes and to develop free-to-use training materials.

Please, fill it if you are a professional, director, manager, politician, civil servant, working in a public or private organization of the social services (disability, immigration, youth, volunteerism, international cooperation, elderly, unemployment, domestic violence o any other type of vulnerable group).

Your answers are anonymous. You can leave blank the questions that you do not have a clear opinion.

If you are interested in receiving a copy of the conclusions, write your email in the last question.

Thank you very much!

1. **0. Country of residence**
   Mark only one oval.
   - ◯ Belgium
   - ◯ Bulgary
   - ◯ Italy
   - ◯ Portugal
   - ◯ Spain
   - ◯ Other

2. **1. Age**
   Mark only one oval.
   - ◯ 18-30
   - ◯ 31-40
   - ◯ 41-50
   - ◯ 51-70

3. **2. Number of years of experience working as a professional in the field of social services**
   Mark only one oval.
   - ◯ Less than 1 year
   - ◯ Between 1 year and 3 years
   - ◯ More than 3 years

4. **3. Currently working in an organization**
   Mark only one oval.
   - ◯ Private
   - ◯ Public
   - ◯ Joint organization (private and public)
   - ◯ Self-employed professional

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5. **4. Size of the organization or company you are working for**
Mark only one oval.

- ◯ From 0 to 5 workers
- ◯ From 6 to 10 workers
- ◯ From 11 to 50 workers
- ◯ From 51 to 250
- ◯ More than 250

6. **5. Choose the option that best suits your professional category and duties**
Mark only one oval.

- ◯ Care-giver
- ◯ Frontline professionals: direct contact intervention with the final beneficiaries (clients). (For example: occupational therapists, educators, employment mediators, nurses, psychologists...)
- ◯ Program developers, coordinators or technician staff not working every day with the final beneficiaries. (For example: Professionals responsible for designing and evaluating interventions programs)
- ◯ Strategic level: Decision-takers, directors, politicians, managers. Management professionals, executive directors, lawmakers, responsible for approving policies and laws, and allocating budgets.
- ◯ Others

Training needs

PLEASE RATE THE FOLLOWING TOPICS ACCORDING TO THE IMPORTANCE TO RECEIVE

TRAINING IN YOUR CURRENT JOB POSITION.

KEY CONCEPTS

"CLIENT"
Final beneficiary or user of the service. For example: person with disability, immigrant person, unemployed person or any other kind of vulnerable group.

"KEY SOCIAL ACTOR"
Organizations providing final services to the user. For example: health departments, community-based services (leisure time, employment, sports, social services....) Vocational training centres, employment agencies, local NGO's, social enterprises...

7. **1. I need to learn how several organizations and companies (key social actors) could work together with the common objective to satisfy the needs of my clients (final beneficiary)**
Mark only one oval.

	1	2	3	4	5	
Not important	◯	◯	◯	◯	◯	Very important

8. **2. I need to learn how to build long-term relationships with key social actors and organizations (different services providers)**
Mark only one oval.

	1	2	3	4	5	
Not important	◯	◯	◯	◯	◯	Very important

9. **3. I need to learn how the interventions can be designed between clients and professionals both working together.**
Mark only one oval.

	1	2	3	4	5	
Not important	◯	◯	◯	◯	◯	Very important

10. **4. I need to learn how to evaluate the factors that influence my clients behaviour.**
Mark only one oval.

	1	2	3	4	5	
Not important	◯	◯	◯	◯	◯	Very important

11. **5. I need to learn how to evaluate the barriers (Architectural, lack of supports...) in the environment that prevent my clients from having a positive behavioural change.**
Mark only one oval.

	1	2	3	4	5	
Not important	◯	◯	◯	◯	◯	Very important

12. **6. I need to learn how to design interventions with the capacity to modify my clients dysfunctional behaviours.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

13. **7. To learn how to design objectives and indicators to better measure my clients behaviour.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

14. **8. I need to learn how to use the objectives and indicators of the intervention programs**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

15. **9. I need to learn how to use the theories and models of behaviour that explain human actions (motivation theory, social cognitive theory, Health belief model, Theory of planned behaviour...)**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

16. **10. I need to learn how to use qualitative and quantitative techniques of gathering information in order to design intervention programs.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

17. **11. I need to learn how to make subgroups with my clients according to their needs to provide more specific interventions.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

18. **12. I need to learn how to evaluate the impact (effect) of my interventions on the behaviour of my clients.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

19. **13. I need to learn how to implement good practices from other sectors.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

20. **14. I need to improve my skills to communicate with my clients using different channels.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

21. **15. I need to learn new techniques to evaluate the needs of my clients.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

22. **16. I need to learn how to classify my organization's stakeholders (key social actors).**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

23. **17. I need to learn how to evaluate the expectations of our social key actors about the service we are offering to the clients.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

24. **18. I need to learn how to evaluate and modify the image that the stakeholders have of our organization.**
Mark only one oval.

	1	2	3	4	5	
Nada importante	◯	◯	◯	◯	◯	Muy importante

25. **19. About the topics you have rated above, select one or two training methodologies you would prefer (Choose only 1 or 2 options)**
Tick all that apply.

- [ ] Online training
- [ ] Traditional classroom training: the teacher condenses the training contents and delivers them to the students in an organized way.
- [ ] Lectures: an expert explains the theoretical aspects of a social topic with a Powerpoint as a visual help. Students take notes or absorb the information.
- [ ] Action learning: working in small groups of around 6-8 people, meeting on regular bases, working through real social problems: reflexion followed by action to resolve the problem.
- [ ] Case studies: description of a challenging real social problem which its solution requires the application of theoretical concepts, an analysis and to take a decision.
- [ ] Group discussions: A trainer moderates an open conversation (exchange of ideas) on a social topic among the students.

26. **Please, select the percentage of theoretical & practical concepts you would prefer to receive:**
Mark only one oval.

- ◯ Only practical training
- ◯ Theoretical training 20% and practical training 80%
- ◯ Theoretical training 40% and practical training 60%
- ◯ Equal proportion 50%/50%
- ◯ Theoretical training 60% and practical training 40%
- ◯ Theoretical training 80% and practical training 20%
- ◯ Only theoretical training

27. **If you wish to receive a report with the conclusions of the assessment, write your email address or phone number**

_____

To finish, click on the "submit" button. Thank you very much!!

ANNEX 2. SPSS OUTPUTS

Descriptive stadistics of independent varaibles.

Estadísticos

		AGE	SECTOR_TENURE	TYPE_ORGANIZATION	SIZE_ORGANIZATION	PROFESSIONAL_CATEGORY
N	Válido	136	136	136	136	137
	Perdidos	1	1	1	1	0

AGE

		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Válido	18-30	16	11,7	11,8	11,8
	31-40	33	24,1	24,3	36,0
	41-50	43	31,4	31,6	67,6
	51-70	44	32,1	32,4	100,0
	Total	136	99,3	100,0	
Perdidos	Sistema	1	,7		
Total		137	100,0		

SECTOR_TENURE

		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Válido	Less_1_year	2	1,5	1,5	1,5
	1_to_3_years	11	8,0	8,1	9,6
	More_3_years	123	89,8	90,4	100,0
	Total	136	99,3	100,0	
Perdidos	Sistema	1	,7		
Total		137	100,0		

TYPE_ORGANIZATION

		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Válido	Private	42	30,7	30,9	30,9
	Public	73	53,3	53,7	84,6
	Mix	21	15,3	15,4	100,0
	Total	136	99,3	100,0	
Perdidos	Sistema	1	,7		
Total		137	100,0		

SIZE_ORGANIZATION

		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Válido	0-5	3	2,2	2,2	2,2
	6-10	13	9,5	9,6	11,8
	11-50	42	30,7	30,9	42,6
	51-250	13	9,5	9,6	52,2
	More250	65	47,4	47,8	100,0
	Total	136	99,3	100,0	
Perdidos	Sistema	1	,7		
Total		137	100,0		

PROFESSIONAL_CATEGORY

		Frecuencia	Porcentaje	Porcentaje válido	Porcentaje acumulado
Válido	0	3	2,2	2,2	2,2
	CARE GIVER	17	12,4	12,4	14,6
	FRONT-LINE	65	47,4	47,4	62,0
	DESIGNERS	15	10,9	10,9	73,0
	STRATEGIC LEVEL	30	21,9	21,9	94,9
	OTHERS	7	5,1	5,1	100,0
	Total	137	100,0	100,0	

Estadísticos descriptivos

	N	Mínimo	Máximo	Media	Desviación estándar
ITEM_1	137	2	5	4,15	,865
ITEM_2	136	1	5	4,11	,883
ITEM_3	137	2	5	4,26	,832
ITEM_4	137	1	5	4,46	,831
ITEM_5	135	1	5	4,06	,976
ITEM_6	136	1	5	4,26	,935
ITEM_7	135	1	5	4,08	,955
ITEM_8	134	1	5	4,09	,888
ITEM_9	134	1	5	3,96	,941
ITEM_10	135	1	5	3,91	,958
ITEM_11	133	1	5	3,77	1,079
ITEM_12	136	1	5	4,29	,910
ITEM_13	136	1	5	4,22	,832
ITEM_14	134	1	5	4,10	,933
ITEM_15	137	1	5	4,16	,925
ITEM_16	133	1	5	3,61	,952
ITEM_17	134	1	5	3,82	,964
ITEM_18	135	1	5	3,76	,988
MEAN_18_ITEMS	137	2,28	5,00	4,0624	,60998
N válido (por lista)	126				

ANOVA test. Likert-Scale items and 4 professional categories

ANOVA

		Suma de cuadrados	gl	Media cuadrática	F	Sig.
MEAN_18_ITEMS	Entre grupos	2,278	5	,456	1,235	,296
	Dentro de grupos	48,325	131	,369		
	Total	50,603	136			
ITEM_1	Entre grupos	2,136	5	,427	,562	,729
	Dentro de grupos	99,645	131	,761		
	Total	101,781	136			
ITEM_2	Entre grupos	2,680	5	,536	,679	,640
	Dentro de grupos	102,665	130	,790		
	Total	105,346	135			
ITEM_3	Entre grupos	2,567	5	,513	,735	,598
	Dentro de grupos	91,491	131	,698		
	Total	94,058	136			
ITEM_4	Entre grupos	4,193	5	,839	1,223	,302
	Dentro de grupos	89,836	131	,686		
	Total	94,029	136			
ITEM_5	Entre grupos	10,787	5	2,157	2,384	,042
	Dentro de grupos	116,738	129	,905		
	Total	127,526	134			
ITEM_6	Entre grupos	9,123	5	1,825	2,179	,060
	Dentro de grupos	108,870	130	,837		
	Total	117,993	135			
ITEM_7	Entre grupos	9,367	5	1,873	2,144	,064
	Dentro de grupos	112,736	129	,874		
	Total	122,104	134			
ITEM_8	Entre grupos	2,014	5	,403	,501	,775
	Dentro de grupos	102,911	128	,804		
	Total	104,925	133			
ITEM_9	Entre grupos	8,179	5	1,636	1,911	,097
	Dentro de grupos	109,552	128	,856		
	Total	117,731	133			
ITEM_10	Entre grupos	1,848	5	,370	,394	,852
	Dentro de grupos	121,085	129	,939		
	Total	122,933	134			
ITEM_11	Entre grupos	6,183	5	1,237	1,064	,383
	Dentro de grupos	147,591	127	1,162		
	Total	153,774	132			
ITEM_12	Entre grupos	1,821	5	,364	,430	,827
	Dentro de grupos	109,995	130	,846		
	Total	111,816	135			
ITEM_13	Entre grupos	2,437	5	,487	,697	,627
	Dentro de grupos	90,945	130	,700		
	Total	93,382	135			
ITEM_14	Entre grupos	10,103	5	2,021	2,448	,037
	Dentro de grupos	105,636	128	,825		
	Total	115,739	133			
ITEM_15	Entre grupos	9,369	5	1,874	2,292	,049
	Dentro de grupos	107,098	131	,818		
	Total	116,467	136			
ITEM_16	Entre grupos	2,826	5	,565	,614	,689
	Dentro de grupos	116,844	127	,920		
	Total	119,669	132			
ITEM_17	Entre grupos	2,341	5	,468	,494	,780
	Dentro de grupos	121,360	128	,948		
	Total	123,701	133			
ITEM_18	Entre grupos	3,842	5	,768	,780	,566
	Dentro de grupos	127,092	129	,985		
	Total	130,933	134			

ANOVA test. Likert-Scale items and two professional categories

ANOVA

		Suma de cuadrados	gl	Media cuadrática	F	Sig.
MEAN_18_ITEMS	Entre grupos	1,768	1	1,768	4,817	,030
	Dentro de grupos	45,874	125	,367		
	Total	47,642	126			
ITEM_1	Entre grupos	,159	1	,159	,219	,640
	Dentro de grupos	90,676	125	,725		
	Total	90,835	126			
ITEM_2	Entre grupos	,138	1	,138	,178	,674
	Dentro de grupos	96,306	124	,777		
	Total	96,444	125			
ITEM_3	Entre grupos	1,542	1	1,542	2,218	,139
	Dentro de grupos	86,883	125	,695		
	Total	88,425	126			
ITEM_4	Entre grupos	1,226	1	1,226	1,858	,175
	Dentro de grupos	82,506	125	,660		
	Total	83,732	126			
ITEM_5	Entre grupos	7,980	1	7,980	8,481	,004
	Dentro de grupos	115,732	123	,941		
	Total	123,712	124			
ITEM_6	Entre grupos	2,756	1	2,756	3,707	,056
	Dentro de grupos	92,173	124	,743		
	Total	94,929	125			
ITEM_7	Entre grupos	,312	1	,312	,383	,537
	Dentro de grupos	100,376	123	,816		
	Total	100,688	124			
ITEM_8	Entre grupos	,460	1	,460	,629	,429
	Dentro de grupos	89,177	122	,731		
	Total	89,637	123			
ITEM_9	Entre grupos	4,672	1	4,672	5,380	,022
	Dentro de grupos	105,933	122	,868		
	Total	110,605	123			
ITEM_10	Entre grupos	,130	1	,130	,138	,711
	Dentro de grupos	116,302	123	,946		
	Total	116,432	124			
ITEM_11	Entre grupos	2,129	1	2,129	1,932	,167
	Dentro de grupos	134,419	122	1,102		
	Total	136,548	123			
ITEM_12	Entre grupos	1,373	1	1,373	1,650	,201
	Dentro de grupos	103,167	124	,832		
	Total	104,540	125			
ITEM_13	Entre grupos	1,604	1	1,604	2,256	,136
	Dentro de grupos	88,174	124	,711		
	Total	89,778	125			
ITEM_14	Entre grupos	8,587	1	8,587	10,577	,001
	Dentro de grupos	99,050	122	,812		
	Total	107,637	123			
ITEM_15	Entre grupos	6,276	1	6,276	8,242	,005
	Dentro de grupos	95,188	125	,762		
	Total	101,465	126			
ITEM_16	Entre grupos	1,292	1	1,292	1,370	,244
	Dentro de grupos	114,187	121	,944		
	Total	115,480	122			
ITEM_17	Entre grupos	,000	1	,000	,000	,989
	Dentro de grupos	113,959	122	,934		
	Total	113,960	123			
ITEM_18	Entre grupos	1,800	1	1,800	1,861	,175
	Dentro de grupos	119,000	123	,967		
	Total	120,800	124			

Factor analysis for 18 likert-scale items

Varianza total explicada

Componente	Autovalores iniciales			Sumas de extracción de cargas al cuadrado			Sumas de rotación de cargas al cuadrado		
	Total	% de varianza	% acumulado	Total	% de varianza	% acumulado	Total	% de varianza	% acumulado
1	7,948	44,158	44,158	7,948	44,158	44,158	4,128	22,934	22,934
2	1,862	10,344	54,502	1,862	10,344	54,502	3,089	17,162	40,095
3	1,177	6,541	61,043	1,177	6,541	61,043	2,893	16,070	56,166
4	1,100	6,110	67,153	1,100	6,110	67,153	1,978	10,987	67,153
5	,844	4,690	71,843						
6	,790	4,391	76,234						
7	,759	4,218	80,452						
8	,510	2,835	83,287						
9	,492	2,731	86,018						
10	,439	2,440	88,458						
11	,393	2,181	90,639						
12	,323	1,795	92,433						
13	,307	1,703	94,137						
14	,260	1,446	95,583						
15	,253	1,405	96,988						
16	,221	1,227	98,215						
17	,174	,969	99,184						
18	,147	,816	100,000						

Método de extracción: análisis de componentes principales.

Matriz de componente rotado[a]

	Componente			
	1	2	3	4
ITEM_1				,839
ITEM_2				,840
ITEM_3				
ITEM_4	,709			
ITEM_5				
ITEM_6	,853			
ITEM_7	,839			
ITEM_8	,780			
ITEM_9				
ITEM_10				
ITEM_11	,651			
ITEM_12				
ITEM_13				
ITEM_14			,786	
ITEM_15			,649	
ITEM_16		,717		
ITEM_17		,761		
ITEM_18		,786		

Método de extracción: análisis de componentes principales.
Método de rotación: Varimax con normalización Kaiser.

a. La rotación ha convergido en 6 iteraciones.