Bringing social marketing closer to the disability field

Jose Manuel Gil Guzman
Department of European projects, Valencian Institute of Social – Health Care, Valencia, Spain

Asuncion Hernandez-Fernandez and Pedro Canales-Ronda
Department of Marketing, Faculty of Economics, University of Valencia, Valencia, Spain

Received 23 June 2020
Revised 21 October 2020
4 January 2021
8 March 2021
Accepted 8 March 2021

Abstract

Purpose – This paper aims to show the advantages that social marketing training programs for disability professionals can play in improving the approach to the problems faced by people with disabilities, offering a necessary mutual understanding between both sectors. So, describing what are the training needs in social marketing expressed by disability professionals and providing an initial shared theoretical framework of both fields that could contribute to implementing social marketing strategies in the field of disability as an inducer of quality of life.

Design/methodology/approach – This is a mixed-method approach combining: a quantitative analysis with a web-based self-administered questionnaire completed in six European countries and a qualitative analysis: interviews to experts pre and post questionnaire.

Findings – Quantitative data has identified that: front-line professionals working directly with people with disabilities have high social marketing training needs; these needs are mostly related to the assessment and modification of clients' behavior and the development of interventions according to the concept of value co-creation. Qualitative data has shown that: both fields share some similar theoretical frameworks. Therefore, it is stated that social marketing has the potential to be better implemented in the disability field.

Research limitations/implications – Considering public policy; stigma and discrimination; regulations; other models and improving the sampling method.

Originality/value – Sharing theoretical framework of both fields, social marketing strategies into the disability field as an inductor for quality of life. No research has analyzed the needs of disability professionals when they have to face a problem and find a solution that social marketing strategies could offer into the disability field.

Keywords Health promotion, Social marketing, Disability field, Training needs assessment, Quality of life model, Service dominant logic, Value co-relation

Paper type Research paper

Introduction

According to the World Health Organization (WHO, 2019, 2015), a person with a disability is anyone who has a problem in the function or structure of the body, which limits or hinders their activity with participation restriction. Following this definition, more than 15% of the people on our planet experience some type of disability. Similar figures are found in EU statistics. The European Health and Social Integration Survey

This work was supported by the Erasmus+ Programme of the European Union. "Social Inclusion Marketing Project" (Referenced 2019–1-PT-01-KA204-060716).

2042-6763
DOI 10.1108/JSOCM-06-2020-0105

(EHSIS) (2019) establishes that there are 70.0 million people with disabilities 15 years of age or more in the EU-27, which is equivalent to 17.6% of the population. Almost 37% of them reported some degree of need for assistance such as personal care activities, home care activities, needs for accessibility to products or services (Bigby, 2019) or assistance at work.

Given these figures, in recent years, the involvement of States and Organizations in the regulation of public policies in the field of disability has been extensive. The EU Directive on accessibility (Directive 2019/882) promotes their equitable, full and effective participation, by improving access to the main products and services that, either through their initial conception or through their subsequent adaptation, are aimed at the special needs of people with disabilities. In turn, both the WHO (2015) and UNESCO (2020) confirm social concern about the persistence of global discrimination, the intensity of social exclusion and the increase in inequalities.

Besides the above, the concept and scope of social inclusion seem to remain unclear (Bigby, 2012a, 2012b; Hall, 2009; Oxoby, 2009). 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 society (Oxoby, 2009). It can also be associated with the abandonment of mainstream norms (Lafree, 1998) or the generation of separate subcultures (Oxoby, 2004). The condition of being discriminated or socially excluded is understood as a combination of several factors affecting a person. It is a complex and multi-causal phenomenon that must be addressed at the highest levels (European Commission, 2020; WHO, 2019) and by a holistic approach.

However, addressing all these approaches would be extremely extensive work outside the scope of this academic article.

Nevertheless, how could it be less, we do have taken into account the real situation of these relevant public policies in the daily life of professionals in the disability sector. On one hand, following Koehler *et al.* (2020), the principle of inclusion implies that people have the right to access information and participate in the making, implementation and evaluation of decisions that directly affect their life and well-being. Therefore, professionals must know how to apply at all stages of development, implementation and evaluation, social marketing interventions (Szablewska and Kubacki, 2019).

On the other hand, for stopping the stigmatization process and mitigate the harmful consequences of health-related stigma (leprosy, epilepsy, mental health, cancer, HIV and obesity/overweight) the objective of the organizations that have participated in our research, is essential to have an appropriate intervention policy for each situation. According to Stangl *et al.*, 2019, different research paths can be followed when attempting an approach from the field of disability and the field of social marketing. As we said in the previous paragraphs, multiple theoretical perspectives could be addressed in a topic as broad as this, however, our point of view is different. Many authors have looked through the eyes of people with disabilities and they have analyzed the changes in attitude that citizens need (Koehler *et al.*, 2020; Vize *et al.*, 2015); the changes in the communications of provided facilities and accessibility conditions of urban policies (Casais and Castro, 2020) or the needs of these people with disabilities that social marketing can change (Russell-Bennett *et al.*, 2019).

But nobody has looked through the needs of disability professionals when they have to face a problem and find a solution that social marketing can offer to improve the quality of life of the people under their care and this has been the point of view addressed in this paper.

The quality of life of people with disabilities is lower than the rest of the population showing clear gaps between these two groups such as access to the labor market, inclusive education and the risk of poverty and social exclusion (European Commission, 2017). In this sense, the European Commission (2020, 2017) states in several documents the relevance of the labor competencies of the social services workforce for helping these people, but for achieving that goal this social services workforce needs to measure and improving their training. Baltruks *et al.* (2017) state the need for new competencies from front-line staff who need to be able to assess and respond to the needs of new groups of clients. Baltruks *et al.* (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 social marketing discipline: assessment of service users' needs and working in partnership with other professionals.

Social marketing nowadays has become a complex field, holding great hope for promoting well-being (Bakan, 2016) and quality of life (Zainuddin *et al.*, 2017) to society. However, social marketing, to extend its scope to other different areas, has had to overcome many barriers. This article addresses primarily two of these barriers. First, the implementation of social marketing in the disability field will give rise to ethical and moral problems (professional trespassing feeling) (Russell-Bennett *et al.*, 2013). Second, disability professionals, before starting any social marketing intervention, will need to be trained to find out which disability problems might be tackled by social marketing and master the skills needed to use its techniques and strategies.

Therefore, the main contribution of this article to social marketing is to offer a new fresh approach to its potential in the disability field by using the views expressed by disability professionals as the principal delivery mechanism. Besides, the article will provide a critical analysis of the possible interrelation between two relevant frameworks of each field. On the side of social marketing, it will be analyzed the service-dominant logic (SDL) (Johansson *et al.*, 2018; Lefebvre, 2012; Luca *et al.*, 2016; and Russell-Bennett *et al.*, 2013). This logic will be compared, looking for synergies, with one of the most common frameworks used in the disability field: The quality of life model (QoL) (Schalock, 2004; Schalock and Verdugo, 2007; Verdugo *et al.*, 2012)

In short, this paper shows the key role that social marketing training programs for disability professionals can play in improving the approach to the problems faced by people with disabilities, offering a necessary mutual understanding between the disability sector such as important part of social services and social marketing. To that end, first, it is presented a review of the basic concepts of one of the most important models in the disability field, the QoL, looking for shared theoretical approaches with the SDL and social marketing. Second, it is explained the objectives and the process of the research. Finally, it states the specific training needs of disability professionals on social marketing, revealing important conclusions.

Quality of life model

The QoL model is the link between the general values reflected in social rights and personal life (Buntix and Schalock, 2010). This conceptual model and its measurement framework have been developed and cross-culturally validated by the authors over the past 20 years (Verdugo *et al.*, 2012; Schalock, 2004) being used as a guide for their programs and to measure personal results.

It is understood as a concept identified with a movement of a step forward, innovation and change in the practices and services of professionals that allows promoting actions at the personal, organizational and social system level (Schalock and Verdugo, 2007). QoL is

based on the ecological paradigm in which disability and human functioning are explained by the interactions between environmental and personal characteristics. The ecological model understands disability as an individual limitation in a social context (Brown *et al.*, 2009). It is based on a system perspective in which various environments (macro, meso, micro) are influencing the well-being of the person (Verdugo *et al.*, 2005).

Thus, the quality of life is a desired situation of well-being, both when the needs of a person are satisfied and the person has the opportunity to pursue the enrichment of life in environments of important life activities (Verdugo *et al.*, 2012). Therefore, is the result of a good match between people's wants and needs and their satisfaction (Schalock, 2000).

The model highlights the participation of the person in the planning of activities and programs by the professional team and produces a new methodology to establish the objectives of the person, named the personal support plan. In addition, the model supports the participation of people with disabilities and their families in intervention programs (Verdugo *et al.*, 2005).

The QoL model identifies three factors (independence, social participation and well-being) and eight domains unevenly distributed in these three factors. The domains of personal development and self-determination form the factor of independence; Interpersonal relationships, social inclusion and rights form the factor of social participation; and emotional well-being, physical well-being and material well-being form the well-being factor. Also, the indicators to measure QoL are oriented to the situation of the person's daily life and their valued personal experiences and circumstances (Schalock *et al.*, 2010). The assessment of the quality of life should be based on these factors and domains (Verdugo *et al.*, 2005).

Two of the most important strategies aligned with the QoL model and used by disability organizations are the person centered-planning (Taylor and Taylor, 2013; Verdugo *et al.*, 2012) and individualized supports (Herps *et al.*, 2016; Van Heumen and Schippers, 2016; Bigby *et al.*, 2014; Buntinx and Schalock, 2010).

Both responsive and flexible strategies are interlinked, having the common goal 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 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 and Schalock, 2010).

The service-dominant logic and value co-creation

As the first articles of SDL were published (Vargo, 2009; Vargo and Lusch, 2004, 2006; 2008; 2016a, 2016b; Vargo *et al.*, 2015) this concept has been attracting the attention of scholars and practitioners, being considered as an alternate to the traditional good-dominant logic (GDL) it means, from product-centricity to customer focus (Wolfson *et al.*, 2019).

According to these authors, the concept of service focuses on how providers and customers create and use the resources, becoming both parts of resource integrators. The application of these resources in the specific social context of the customers makes full sense to value co-creation. Value is not considered a deliverable output (Zainuddin *et al.*, 2017), only the customers through their experiences and interactions can value the resources in context, giving meaning to them. Therefore, the value of these resources is unique.

Thus, SDL is based on the principle that value must be designed with customers and assessed based on value-in-context (Edvardsson *et al.*, 2011). Therefore, the beneficiaries become the co-creators of value.

The relationship, dialogue and interaction between the beneficiaries and the service providers have maximum relevance and it will be possible if organizations support the customer's capacity for change (knowledge, skills, motivations, etc) across various touchpoints (Luca *et al.*, 2016). The application of these resources and competencies is the basis of exchange, benefiting all the parts (Edvardsson *et al.*, 2011). In sum, social organizations (NGOs, associations [. . .]) and customers (people with disabilities) become resource integrators.

Moreover, and according to SDL, stakeholders and clients are partners rather than intervention targets (Johansson *et al.*, 2018), requiring active participation of the stakeholders, interactively collaborating with social marketers. In this way, social actors, clients and stakeholders together create value. The collaboration among service providers, stakeholders and customers is key to achieve interactive exchanges where the value is co-created (Johansson *et al.*, 2018). In this point, disability organizations are basic to co-create value, coordinating and providing these resources at the network level (Luca *et al.*, 2016), unifying experiences of interactions together with the search for a social role (Luca *et al.*, 2016). The relevance of SDL in this research is that can be usefully applied to complex social challenges that require positive changes

Social marketing

On the other hand, the social exclusion of people with disabilities is a social problem that can be addressed through social marketing (Kubacki *et al.*, 2017). Social marketing is a discipline that addresses several social problems. According to French and Russell-Bennett (2015), its objective is to provide social value through the reciprocal exchange of resources or assets at the individual, community, social or global level. It begins by understanding the root causes and changing causes of the factors that lead to social problems and then developing policies, strategies, products, services and/or social experiences that will help the target achieve social benefits individually or collectively (French and Russell-Bennett, 2015). Therefore, in this paper, we propose that, due to its multidisciplinary in solving social problems, social marketing can be adapted to the field of disability, addressing the issue of social inclusion of the disadvantaged groups (Bardus *et al.*, 2019) as we understand that the defining characteristic of social marketing is that it focuses on changing behaviors that perpetuate or cause social problems; this includes the field of disability and its problems.

In this sense, social marketing is considered an effective approach for people with disabilities, as it offers a useful framework for effective social planning (Hastings, 2003) as different authors have expressed (Andreasen, 2002; Brennan and Binney, 2008; Domegan *et al.*, 2013; Dibb, 2014; Luca *et al.*, 2016; Wood, 2016) using traditional marketing concepts such as the dominant logic of service and the joint creation of value (Luca *et al.*, 2016; French *et al.*, 2017)

Thus, social marketing could play a key role in protecting disadvantaged groups from the negative externalities of market failures (Lefebvre, 2012). In line with this claim, the definition of social marketing as the application of marketing principles to shape markets that are more effective, efficient, sustainable and fair in advancing people's well-being and social well-being (Phils *et al.*2008; Lefebvre, 2012; Zainuddin *et al.*, 2017) is closely related to the objectives pursued by the European disability strategy 2010–2020 and has been applied to specific disability challenges. Some examples found in marketing and health journals are: improving early identification and treatment of autism (Daniel *et al.*, 2009); the development

of communication strategies and social reforms to transform the disability sector (Small *et al.*, 2020); the use of marketing to assess the factors that influence whether training and employment services for people with disabilities are considered satisfactory (Peltier and Scovotti, 2004; and Scovotti and Peltier, 2005); and a corporate social marketing intervention that successfully changed employee attitudes and increased donations to a disability cause (Bennett and Vijaygopal, 2019).

Could social marketing be closer to the disability field through disability professionals?

Despite all the actions mentioned above, it must be stated that social marketing interventions completed so far in the disability field have been designed from a social marketing perspective and implemented exclusively by social marketing professionals. Unfortunately, there is still little evidence of the development of social marketing programs by organizations or professionals belonging to the disability sector. Among others, highlight the experiences of Public Health England (2017). Nor is there any evidence of an adaptation or systematic use of any social marketing tool by disability professionals. As a result of this, these tools have not yet been added to any vocational training program or professional profile in the disability sector. This has made it impossible to integrate social marketing strategies as a part of the disability professional working routine. Having stated this, it must be highlighted that the adaptation and subsequent integration of the social marketing strategies in the disability sector are the ultimate aims for this research and for the educational innovation initiative in which it is included (ERASMUS+).

This indicates that social marketing has not yet been recognized as a social tool by the disability sector. Several reasons might be behind this fact. One could be that the disability professionals do not come to understand which problems could be addressed by using social marketing tools and the benefits. Another reason might be linked with a possible lack of knowledge and expertise in the use of these tools. Therefore, the disability professionals might need to be empowered and trained to be able to use social marketing tools. In this line of action, several authors have suggested the benefits of improving staff competencies on social marketing before starting any intervention (Russell-Bennett *et al.*, 2013; Luca *et al.*, 2016; Wood, 2016).

As it was mentioned in the introduction, 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. The social marketing strategies and interventions might contribute to improving these training schemes, therefore, the efficiency of the social services.

Although social marketing and the disability field have evolved independently, their theoretical background, objectives and intervention methodology might have more elements in common than expected. By studying and comparing the most important model of the disability field (QoL) with one relevant model and one concept from social marketing (SDL and the value co-creation), this research focuses on trying to find the differences (synergy destroyers) and similarities (synergy creators) between these two fields. Besides, the research will analyze the specific social marketing training needs of the disability workforce. Both complementary methods are aimed at trying to unlock the real potential of social marketing to improve the QoL of people with disabilities.

Taking into account these premises, three research questions will shape this investigation:

RQ1. Do social marketing and the disability field share theoretical approaches?

RQ2. Could social marketing techniques and strategies benefit the disability field?

RQ3. What are the social marketing training needs of disability professionals?

Methodology

This research uses a mixed-method approach combining qualitative and quantitative strategies. It is divided into three phases: pre-test phase, quantitative training needs assessment and the validation of the results.

Phase 1: Pre-test

In this pre-test phase, the research completed 20 unstructured interviews (with open questions and free opinions), 14 face-to-face; 6 online with professionals and politicians in the social services sector from Spain, Belgium, Bulgaria, Italy, Portugal, Holland, Switzerland and UK. Also, it was carried out 1 online group interview with experts in social marketing from UK, Spain and Switzerland. This phase provided us with the essential information for the final design of the entire process of collecting and analyzing the information we required to achieve the objectives.

Phase 2: Training needs assessment on social marketing: quantitative research

To quantitative assess the disability professional training needs, it was decided to develop a web-based self-administered questionnaire. The core of the questionnaire is formed by 18 Likert-scale items designed to assess the specific training needs on social marketing of disability professionals. The items were obtained by transforming social marketing criteria elements (French and Russell-Bennett, 2015) into meaningful items within the disability field. In addition, the questionnaire was formed by 6 demographic questions (country, age, years of working experience, type of organization, size of the organization and professional category):

The demographic questions are 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.

It must be highlighted that the professional category is considered a key independent variable in this research. This variable was divided into four categories to be able to find the specific training needs of each professional group:

- 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.

Phase 3: Quantitative results validation

Once the quantitative phase was completed and the data analyzed, 8 unstructured interviews, from Portugal, Spain and Bulgaria, were carried out to help the researcher to confirm and interpret the results.

The experts were formed exclusively by the following representatives of the disability field: 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 preliminary conclusions was sent to the participants before being interviewed. Also, a power-point presentation was prepared to explain the research results and discuss the following issues:

- training needs prioritization by professional category;
- specific training needs of caregivers; and
- results of the factor analysis.

Participants

Representatives from European disability organizations were contacted and invited to take part in the project. After explaining the research objectives, an email with instructions and a specific link to the survey was sent to the organizations. In total, four of these organizations did not provide any answers. The questionnaire was translated into Spanish and Bulgarian. The participating organizations of the other countries circulated the English version.

The questionnaire was completed by 137 disability professionals from 6 European countries. The sample is composed of professionals with high experience working in the social sector (89,3% have more than 3 years) and belonging almost half of them to public organizations (47,4%). The distribution of the sample can be seen in Table 1.

Qualitative analysis

The interviews (pre-test) completed as part of the research revealed that, although social marketing is a very unfamiliar concept for the disability sector, once it was explained to the interviewees, they expressed the opinion that social marketing might benefit the disability field, showing, at the same time, a lack of knowledge about:

- which specific disability problems might be tackled by social marketing; and
- which specific social marketing techniques or strategies might be adapted to be used by the disability professionals.

Despite this, participants managed to provide some examples of how social marketing could be used in the disability field:

- The development of a social marketing campaign to reduce obesity of people with intellectual disabilities. At the downstream level, social marketing might be of help to the disability professionals to identify the psychological barriers of people with disabilities that impede them from having healthier habits. Social marketing techniques could also be used to design posters, brochures, logos, drawings and rewards in a way that attracts the attention of people with disabilities[. . .] At the midstream level, social marketing could be used to better target families, consumer associations, schools and mass media to carry out fund-raising activities, educational actions and radio spots. At the upstream level, social marketing might

Age	• Age: 63.5% of respondents are over 40 years old
Employee tenure	• 89.3% of the respondents have more than 3 years of working experience in the field of disability
Type of organization	• 30.7% of the respondents work in a private organization • 53.3% work in a public organization • 15.3% of the respondents are working in a mixed organization
Size of the organization	• 47.4% of the respondents are working in an organization larger than 250 workers • The second-highest category is "between 11 and 50 workers" with 30.7%
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 7.3% to "others" (Figure . . .)
Country	• Spain (7 organizations, 94 samples) • Belgium (1 organization, 13 samples) • Italy (3 organizations, 6 samples) • Bulgaria (3 organizations, 11 samples) • Portugal (1 organization, 7 samples) • Holland (1 organization, 3 samples) • Other (3 samples)

Table 1.
Sample characteristics

techniques might be used to influence decision-makers to modify or create new food regulation specific for people with disabilities.

- The design of a marketing mix program to improve the image of disability in society and reduce barriers. Social marketing techniques might be used to improve the use of politically correct language; find ambassadors; create impacting messages and images; design follow-up indicators; and implement a methodology for evaluating effectiveness.
- The development of an employment plan with the key stakeholders (trade unions, employer associations, disability organizations, families, policymakers, vocational training centers[. . .]). This plan would focus on the environmental factors that impede people with disabilities from being included in the labor market. The combined efforts of stakeholders could create the added value in the context which is one of the bases of the economic exchange and, therefore, of the SDL (Vargo and Lusch, 2008).

Quantitative analyzes

Phase two of this research is based on the quantitative analysis of a questionnaire formed by 6 demographic questions and 18 Likert-scale items aiming at assessing the specific training needs on social marketing of disability professionals.

ANOVA test was run with two objectives:

- to obtain the mean of the 18 dependent variables to prioritize the needs; and
- to find significant differences between the mean of the Likert-scale items and the different categories of the independent variables.

Also, exploratory factor analysis was conducted to identify the underlying factor structure of the 18 items. The results of both tests were compared and preliminary conclusions were obtained. They were presented to participants of phase 3 to get the conclusions.

Reliability and validity

Cronbach's Alpha test was run to check the internal reliability of the 18 Likert-scale items. The test showed a score of 0.924 which is considered excellent. A board of experts of three organizations taking part in the ERASMUS+ "Social Inclusion Marketing Project" determined that the scale reflects contents of social marketing that are appropriate for the research questions.

An exploratory factor analysis (EFA) was conducted to identify the underlying factor structure of the 18 items (Table 2), during this process, some items were eliminated (see Table 3) that did not meet the required conditions (loading < 0.60). This method was selected because the potential of social marketing in the disability field has not previously

Table 2. Exploratory factor analysis extraction

Social marketing needs	Loading	Variance explained	α-Cronbach
Factor 1: Understanding clients behavior		*44.158*	*0.889*
1. I need to learn how to evaluate the factors that influence my clients' behavior	0.709		
2. I need to learn how to design interventions with the capacity to modify my clients' dysfunctional behaviors	0.853		
3. I need to learn how to design objectives and indicators to better measure my clients' behavior	0.839		
4. I need to learn how to use the objectives and indicators of the intervention programs	0.780		
5. I need to learn how to make subgroups with my clients according to their needs to provide more specific interventions	0.651		
Factor 2: Stakeholders mapping		*10.344*	*0.799*
1. I need to learn how to classify my organization's stakeholders (key social actors)	0.717		
2. I need to learn how to evaluate the expectations of our social key actors about the service we are offering to the clients	0.761		
3. I need to learn how to evaluate and modify the image that the stakeholder has of our	0.786		
Factor 3: Communication with clients		*6.541*	*0.721*
1. I need to improve my skills to communicate with my clients using different channels	0.786		
2. I need to learn new techniques to evaluate the needs of my clients	0.649		
Factor 4: Stakeholders value co-creation		*6.110*	*0.768*
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)	0.839		
2. I need to learn how to build long-term relationships with key social actors and organizations (different services providers)	0.840		

ITEM	Mean	Factor
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	
*3. I need to learn how the interventions can be designed between clients and professionals both working together**	4.26	
4. I need to learn how to evaluate the factors that influence my clients' behavior	4.46	Understanding clients behavior
*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 behavioral change**	4.06	Stakeholders value co-creation
6. I need to learn how to design interventions with the capacity to modify my clients' dysfunctional behaviors	4.26	Stakeholders value co-creation.
7. To learn how to design objectives and indicators to better measure my clients' behavior	4.08	–
8. I need to learn how to use the objectives and indicators of the intervention programs	4.09	Understanding clients behavior
*9. I need to learn how to use the theories and models of behavior that explain human actions (motivation theory, social cognitive theory, health belief model, the theory of planned behavior. . .)**	3.96	–
*10. I need to learn how to use qualitative and quantitative techniques of gathering information to design intervention programs**	3.91	–
11. I need to learn how to make subgroups with my clients according to their needs to provide more specific interventions	3.77	Understanding clients behavior
*12. I need to learn how to evaluate the impact (effect) of my interventions on the behavior of my clients**	4.29	–
*13. I need to learn how to implement good practices from other sectors**	4.22	–
14. I need to improve my skills to communicate with my clients using different channels	4.10	Communication with clients
15. I need to learn new techniques to evaluate the needs of my clients	4.16	Communication with clients
16. I need to learn how to classify my organization's stakeholders (key social actors)	3.61	Stakeholders mapping
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	Stakeholders mapping
18. I need to learn how to evaluate and modify the image that the stakeholder has of our	3.76	Stakeholders mapping

Note: *In italics, deleted items

Table 3.
Means of the 18 liker-scale variables and factor analysis results

been tested or validated, making an exploratory approach most appropriate. KMO and Bartlett's test indicates the suitability of the test. A minimum eigenvalue of 1 was used to define the factors. The component analysis was conducted followed by Varimax rotation (Zeller, 2005). Factor loading >0.60 was used to include an item within a domain.

Results and discussion

Do social marketing and the disability field share theoretical approaches?

The research has found (RQ1) that both fields have the common ultimate goal to support the behavioral change of a targeted audience to improve their well-being. In addition, and crucial for both fields is to start their social interventions with an assessment of the clients' needs to plan the interventions.

SDL is based on the principle that value must be co-created with customers and assessed based on value-in-context (Edvardsson *et al.*, 2011). Two principles of the QoL model are completely aligned with the SDL logic:

(1) the value creation in the client's daily-life context (value in context); and

(2) a measurement strategy based on a stakeholder's approach (co-creation).

Besides, the importance of the ecological model is crucial for both fields. It is implicit in the very concept of disability as the expression of limitations in individual functioning within a social context. As a result of this, this social context is a relevant part of the model of the QoL and the individualized support model. According to these models, several environments (macro, meso and micro) are influencing the person's wellbeing (Verdugo *et al.*, 2005).

The relevance of the midstream level in social marketing to influence the clients' behavior has been discussed throughout the document and is being supported by many authors (Luca *et al.*, 2016; Wood, 2016; French *et al.*, 2017). In the disability field, two of the most important elements of this midstream level are the disability organizations and their professionals. They are the most valuable resource for people with disabilities and the target group of this research.

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. Value creation occurs when people with disabilities use this service and integrate it with other resources and make use of it in their life context. 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' competencies and people with a disability apply their knowledge and skills in the use of the service in their daily life context.

Could social marketing tools and strategies benefit the disability field?

The first interviews (Pre-test) revealed a good overall acceptance of the social marketing objectives and strategies among disability professionals and marketers (RQ2). Although social marketing is a very unfamiliar field for the disability sector, once the concept was explained, interviewees generally expressed the opinion that social marketing would benefit the disability field. It was suggested that synergies could be easily found and generated between the two fields (Synergy creators). It should be highlighted that front-line professionals showed very interested in all the issues from social marketing related to the understanding of the customer needs and behaviors or in the concept of value co-creation.

The literature states that social marketing is nowadays 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 and Spotswood, 2013).

Besides, and according to the interviews completed in phase 3, the modern disability paradigms (QoL and the individualized support models) are still being implemented in disability organizations. It implies organizational changes and new professionals' tasks for which disability professionals might not have the proper skills. In this context, new methodologies and strategies, therefore, new training needs might arise such as those coming from other disciplines such as social marketing. This process of re-adaptation has been stated by interviewees (phase 3) as an opportunity for social marketing to be implemented in the disability field.

The research has also found two relevant barriers that should be taken into account when trying to implement social marketing tools and strategies in the disability field.

The first and most important difference between the two fields is associated with the concept of behavior and based on:

(1) the subject who decides the behavior that must be modified; and

(2) the behavior goals set out and strategies used to achieve them.

Regarding the first point, it has been found that a high number of social marketing 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 behavior. 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 behaviors 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 to set up different objectives and deploy different working strategies which have been rarely found in social marketing by this research. The most relevant of them is the individualized supports; the person-centered planning; self-determination; and adaptive behavior.

The concept of QoL is designed in terms of gains in adaptive behavior skills (Claes *et al.*, 2010). According to this, disability professionals modify their client's behavior 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 social marketing principles: Self-determination (autonomy, choices/decision, personal goals, personal control); b) and personal development (personal skills, adaptive behavior[. . .]). The objectives related to the development of these two domains are achieved by using two specific tools:

(1) individualized supports; and

(2) person-centered planning (Buntinx and Schalock, 2010; Schalock, 2000; and Verdugo *et al.*, 2012).

The use of these two tools has not been found in social marketing.

The second relevant barrier found by the research is related to the negative attitude of many professionals of the disability field toward marketing who link this concept mostly with the promotion and advertising.

Finally, to make the implementation of social marketing 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. Also, the relationships developed in the disability sector between front-line professionals (specifical care-givers) and customers are unique, genuine and long-lasting. They might be considered as a source for value co-creation. In addition, some know-how and evidence-based practices from the disability sector might be also be adapted and used by social marketing practitioners to improve the social marketing field.

What are the social marketing training needs of disability professionals?

To answer this question (RQ3), 137 disability professionals responded to a quantitative questionnaire formed by 6 demographic questions and 18 liker-scale items designed to assess the specific training needs on social marketing of the target group.

As can be seen in Table 3, the mean scores of these 18 items vary from 3.61 to 4.46 (rank from 1 to 5), being the mean of the 18 items 4.06.

The items that have obtained a higher score are those related to the factors detecting, explaining and influencing the clients' needs and behaviors: "I need to learn how to evaluate the factors that influence my clients' behavior" (4.46); "I need to learn how to evaluate the impact of my interventions on the behavior of my clients" (4.29); "I need to learn how to design interventions with the capacity to modify my clients' dysfunctional behavior" (4.26) and "I need to learn new techniques to evaluate the needs of my clients" (4.16).

It also should be highlighted the high score obtained by the items related to the concept of value co-creation: "I need to learn how the interventions can be designed between clients and professionals both working together" (4.29); "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) and "I need to learn how to build long-term relationships with key social actors and organizations (different service providers)" (4.11).

On the contrary, social marketing techniques such as those related to stakeholders mapping, corporate image evaluation and segmentation appear to have less interest for disability professionals.

Related to the independent variables, the ANOVA test has not found significant differences between the means of Likert-scale items and five out of six independent variables: country of residence; age; years of working experience; the size of the organization and type of organization.

But in the case of the variable "professional category," it has been found significant differences among the four professionals' categories (care-givers, front-line professionals, program designers and managers). The mean scores obtained by the categories of "Care-givers" and Front-line professionals were slightly higher than the other two categories (Table 4). Also, ANOVA found statistical differences in the mean scores of these two sub-groups in 3 items: 5, 14 and 15.

An initial approach suggests the professional categories of care-givers and front-line professionals might behave similarly, sharing the same social marketing training needs.

As a result of this, a new variable was created. The primary four professional categories were transformed into two categories. The first category was formed by grouping the former categories of "caregiver" 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 called "strategic level" (Figure 1).

Besides, factor analysis (Table 2) revealed four underlying factors that might be associated with the two new professional categories and their specific training needs.

The first and third factors would show the training needs of Frontline professionals. "Understanding clients' behaviors" is considered the most important factor (44% of the

Table 4.
Mean scores of initial and transformed professional categories

Professional category	Mean score 18 items	Two transformed professional categories	Mean score 18 items
Care-givers	4.14	All front-line professionals	4.16
Front-line professionals	4.16		
Program designers	3.83	Strategic level	3.91
Managers	3.9		

Note: Seven respondents included in the professional category "Other" were excluded

variance). It is represented by five items reflecting the professionals' needs related to understand, modify and evaluate clients' behaviors. The third-factor "communication with clients" is also associated with this professional category, but having a slightly lower priority than the first factor.

The second and fourth factors ("stakeholders mapping" and "stakeholders' value co-creation") would show the training needs of "strategic" staff. As strategic staff has shown lower training needs in social marketing, these two factors might not be considered as relevant as the two factors associated with the "All Front-line professionals" category.

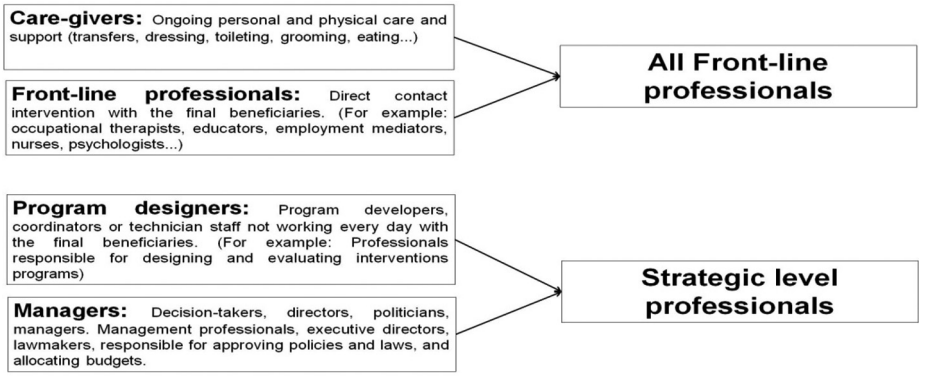
Conclusions, contributions and implications

The research found that the social marketing and disability field show more parallels than expected. These so-called synergies might facilitate the further implementation of social marketing techniques and strategies in the disability field. The comparative analysis of a relevant model used in social marketing (SDL) and another one from the disability field (the QoL) brought to light that both fields share the use of the ecological paradigm, the midstream level and the value co-creation to guide their interventions.

Data from the quantitative analysis confirmed the prior results, identifying, also, the existence of some social marketing training needs of disability front-line professionals in their working routine, particularly in those social marketing techniques used to understand and modify the client's behavior or to co-create value (Szablewska and Kubacki, 2019).

However, research has also found that the disability sector has specific and different methodologies and principles from social marketing. These differences can be considered as barriers (destroyers of synergies) that could prevent social marketing from being implemented in the social sector (Table 5).

Given previous statements, several implications emerge. The point of departure of this research is the assumption that some social marketing techniques and strategies might be started to be used by disability professionals in their working routine. As the research found pieces of evidence of it, disability organizations and training providers might start to adopt some social marketing techniques and introduce them in the vocational training programs of the disability field. As a result of this, new approaches to solve disability problems and to improve the quality of life of people with disabilities may arise.



Source: Own elaboration

Figure 1. Transformation of categories of the variable "professional categories"

Synergy creators (similarities between both fields)

- Ultimate goal: behavioral change to improve the personal well-being
- Interventions begin with a clients' needs assessment
- Problems are considered as complex and caused by a range of factors: an 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 social interventions: families, clients, local public services, professionals . . .

Synergy destroyers (differences between both fields)

Social Marketing	**Disability field**
Behaviors are determined by the mesosystem (public bodies)	Behavior to modify should be agreed upon with the client and their family
Strategies: segmentation, marketing mix, raise-awareness, impact evaluation, competition analysis and education.	Strategies: development of a unique and genuine relationship, individualized support plans and person-centered planning
Interventions focused on health behaviors to improve well-being	Interventions focused on adaptive behavior to improve self-determination, social inclusion and personal well-being

Main barriers to implementing social marketing in the social field

- Disability sector is already successfully using several evidence-based practices
- Negative sector attitudes toward marketing (professional trespassing)

Opportunities for social marketing

- To help the disability sector to improve the image of disability
- To help the 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

Table 5.
Mapping disability sector and social marketing

Finally, this paper might contribute not only to improve the disability field efficacy by offering new solutions but also to improve the theoretical and practical applications of social marketing, extending its scope of action and becoming more widely accepted

Limitations and future research

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. The sampling distribution per country is not balanced, having Spain higher participation than the rest of the countries. Therefore, as exploratory work, the findings of this research cannot be generalized to the whole population of the disability field. We have to continue working on it.

Both, disability field and social marketing field, include many theoretical approaches, policies, sectors and professionals' categories. Not all have been considered in this research. Future research should: considering the public policy field of inclusion, facing stigma and

discrimination and also the regulations under this field, considering other models different from the QoL which addresses mostly people with intellectual disability and improving the sampling method, adding more types of organizations and new professional categories 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.

Finally, two main areas have emerged from this work that may have the potential for further research. First, 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. Second, the beliefs and attitudes of the disability field toward marketing have been considered by this research to be a barrier to implement social marketing in the disability field. Further research about this issue and the development of validated tools to assess these beliefs might be appropriate.

References

Andreasen, A.R. (2002), "Marketing social marketing in the social change marketplace", *Journal of Public Policy and Marketing*, Vol. 21 No. 1, pp. 3-13.

Bakan, J. (2016), "Social marketing: thoughts from an empathetic outsider", *Journal of Marketing Management*, Vol. 32 Nos 11/12, pp. 1183-1189.

Baltruks, D., Hussein, S. and Montero, A. (2017), *Investing in the Social Services Workforce*, European Social Network, Brighton.

Bardus, M., Domegan, C.T., Suggs, L.S. and Mikkelsen, B.E. (2019), "Engaging students and communities through service learning and community-academia partnerships: lessons from social marketing education", Pinheiro, I. M. M., Estima, A. and Marques, S. (Eds), *Evaluating the Gaps and Intersections between Marketing Education and the Marketing Profession*, IGI global, pp. 84-116.

Bennett, R. and Vijaygopal, R. (2019), "What if the company's 'charity of the year' deals with severe to moderate mental disability? A case study of fundraising problems and possibilities", *Journal of Social Marketing*, Vol. 9No No. 2, pp. 161-179.

Bigby, C. (2012a), "Social inclusion and people with intellectual disability and challenging behavior: a systematic review", *Journal of Intellectual and Developmental Disability*, Vol. 37 No. 4, pp. 360-374.

Bigby, C. (2012b), "A model of processes that underpin positive relationships for adults with severe intellectual disability", *Journal of Intellectual and Developmental Disability*, Vol. 37No No. 4, pp. 324-336.

Bigby, G. (2019), "Web accessibility policy design. Appoint of reference", *Accessibility Testing UOC*, pp. 1-19.

Bigby, C., Knox, M., Beadle-Brown, J. and Bould, E. (2014), "Identifying good group homes: qualitative indicators using a quality of life framework", *Intellectual and Developmental Disabilities*, Vol. 52No No. 5, pp. 348-366.

Brennan, L. and Binney, W. (2008), "Concepts in conflict: Social marketing and sustainability", *Journal of Nonprofit and Public Sector Marketing*, Vol. 20 No. 2, pp. 261-281.

Brown, R., Schalock, R. and Brown, I. (2009), "Quality of life: Its application to persons with intellectual disabilities and their families – introduction and overview", *Journal of Policy and Practice in Intellectual Disabilities*, Vol. 6 No. 1, pp. 2 -6.

Buntinx, W. and Schalock, R. (2010), "Models of disability, quality of life, and individualized supports implications for professional practice in intellectual disability", *Journal of Policy and Practice in Intellectual Disabilities*, Vol. 7 No. 4, pp. 283 -294.

Casais, B. and Castro, C. (2020), "Online communication of accessibility conditions in touristic spots: the design-communication gap in Porto destination", *Journal of Hospitality and Tourism Technology*, doi: 10.1108/JHTT-07-2019-0096.

Claes, C., Van Hove, G., Loon, J., Vandevelde, S. and Schalock, R. (2010), "Quality of life measurement in the field of intellectual disabilities: eight principles for assessing quality of life-related personal outcomes", *Social Indicators Research*, Vol. 98 No. 1, pp. 61-72.

Daniel, K., Prue, Ch, Taylor, M., Thomas, J. and Scales, M. (2009), "Learn the signs. Act early': a campaign to help every child reach his or her full potential", *Public Health*, Vol. 123 No. 1, pp. e11-16.

Dibb, S. (2014), "Up, up and away: social marketing breaks free", *Journal of Marketing Management*, Vol. 30 Nos 11/12, pp. 1159-1185.

Domegan, C., Collins, K., Stead, M., McHugh, P. and Hughes, T. (2013), "Value co-creation in social marketing: functional or fanciful?", *Journal of Social Marketing*, Vol. 3 No. 3, pp. 239-256.

Edvardsson, B., Tronvoll, B. and Gruber, T. (2011), "Expanding understanding of service exchange and value co-creation: a social construction approach", *Journal of the Academy of Marketing Science*, Vol. 39 No. 2, pp. 327-339.

European Commission (2017), "Progress report on the implementation of the European disability strategy (2010 – 2020)", available at: https://op.europa.eu/ (accessed 4 March 2020).

European Commission (2020), "Communication from the commission to the European parliament, the council, the European economic, and social committee, and the committee of the regions", *Action plan on Integration and Inclusion 2021-2027 (SWD (2020) 290 final)*.

European Health and Social Integration Survey (2019), "Report about disability", available at: https://ec.europa.eu/ (accessed 4 March 2020).

French, J. and Russell-Bennett, R. (2015), "A hierarchical model of social marketing", *Journal of Social Marketing*, Vol. 5 No. 2, pp. 139-159.

French, J., Russell-Bennett, R. and Mulcahy, R. (2017), "Travelling alone or traveling far? Meso-level value co-creation by social marketing and for-profit organizations", *Journal of Social Marketing*, Vol. 7 No. 3, pp. 280-296.

Hall, S.A. (2009), "The social inclusion of people with disabilities: a qualitative meta-analysis", *Journal of Ethnographic and Qualitative Research*, Vol. 3, pp. 162-173.

Hastings, G. (2003), "Relational paradigms in social marketing", *Journal of Macromarketing*, Vol. 23 No. 1, pp. 6-15.

Herps, M., Buntinx, W. and Curfs, L. (2016), "Individual support planning with people with ID in The Netherlands: official requirements and stakeholders' expectations", *ALTER – Alter*, Vol. 10 No. 4, pp. 281-288.

Johansson, C., Bedggood, R., Farquharson, K. and Perenyi, A. (2018), "Shared leadership as a vehicle to healthy service eco-systems: practical or fanciful?", *Journal of Social Marketing*, Vol. 8 No. 2, pp. 159-181.

Koehler, G., Cimadamore, A.D., Kiwan, F. and Monreal, P.M. (Eds) (2020), *The Politics of Social Inclusion: Bridging Knowledge and Policies towards Social Change*, Published in 2020 by the United Nations Educational, Scientific and Cultural.

Kubacki, K., Ronto, R., Lahtinen, V., Pang, B., Rundle-Thiele, S., Pang, B., Kubacki, K., Ronto, R., Rundle-Thiele, S. and Lahtinen, V. (2017), "Social marketing interventions aiming to increase physical activity among adults: a systematic review", *Health Education*, Vol. 117 No. 1, pp. 69-89.

Lafree, G. (1998), *Losing Legitimacy*, Westview, Boulder, CO.

Lefebvre, R.C. (2012), "Transformative social marketing: co-creating the social marketing discipline and brand", *Journal of Social Marketing*, Vol. 2 No. 2, pp. 118-129.

Luca, N., Hibbert, S. and McDonald, R. (2016), "Midstream value creation in social marketing", *Journal of Marketing Management*, Vol. 32 Nos 11/12, pp. 1145-1173.

Oxoby, R. (2009), "Understanding social inclusion, social cohesion, and social capital", *International Journal of Social Economics*, Vol. 36No No. 12, pp. 1133-1152.

Oxoby, R.J. (2004), "Cognitive dissonance, status, and growth of the underclass", *The Economic Journal*, Vol. 114 No. 498, pp. 729-749.

Peltier, J.W. and Scovotti, C. (2004), "Relationship marketing and disadvantaged health care segments: using internal marketing to improve the vocational rehabilitation process", *Health Marketing Quarterly*, Vol. 22 No. 2, pp. 69-90.

Phils, J.A., Deiglmeier, K. and Miller, D.T. (2008), "Rediscovering social innovation", *Stanford Social Innovation Review*, pp. 34-43.

Public Health England (2017), "Public health England. Social marketing strategy 2017 to 2020", available at: https://assets.publishing.service.gov.uk/ (accessed 28 February 2021).

Russell-Bennett, R., Wood, M., Previte, J. (2013), "Fresh ideas: services thinking for social marketing", *Journal of Social Marketing*, Vol. 3 No. 3, pp. 223-238.

Russell-Bennett, R., Fisk, R.P., Rosenbaum, M.S., Zainuddin, N., (2019), "Commentary: transformative service research and social marketing – converging pathways to social change", *Journal of Services Marketing*, Vol. 33 No. 6, pp. 633-642.

Schalock, R.L. (2000), "Three decades of quality of life", *Focus on Autism and Other Developmental Disabilities*, Vol. 15 No. 2, pp. 116-127.

Schalock, R.L. (2004), "The concept of quality of life: what we know and do not know", *Journal of Intellectual Disability Research*, Vol. 48 No. 3, pp. 203-216.

Schalock, R.L., Keith, K.D., Verdugo, M.A. and Gomez, L.E. (2010), "Quality of life model development and use in the field of intellectual disability", in Kober, R. (Ed.), *Quality of Life: Theory and Implementation*, Sage, New York, NY, pp. 17-32.

Schalock, R.L., Verdugo, M.A. (2007), "The concept of quality of life in the services and supports for people with intellectual disability", *Siglo Cero. Revista Española Sobre Discapacidad Intelectual*, Vol. 38 No. 4, pp. 21-26.

Scovotti, C. and Peltier, J. (2005), "Participant satisfaction with the vocational rehabilitation process: a micro perspective of relationship dimensions", *Health Marketing Quarterly*, Vol. 22No No. 4, pp. 3-26.

Small, F., Mehmet, M. and Kleinschafer, J. (2020), "The circle of vulnerability and the myth of choice", *Journal of Social Marketing*, Vol. 10 No. 4, doi: 10.1108/JSOCM-09-2019-0149.

Stangl, A., Earnshaw, V., Logie, C.H., Brakel, W., Simbayi, L., Barré, I. and Dovidio, J. (2019), "The health stigma and discrimination framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas", *BMC Medicine*, Vol. 17 No. 1, pp. 17-31.

Szablewska, N. and Kubacki, K.A. (2019), "Human rights-based approach to the social good in social marketing", *Journal of Business Ethics*, Vol. 155 No. 3, pp. 871-888.

Tapp, A. and Spotswood, F. (2013), "From the 4Ps to COM-SM: reconfiguring the social marketing mix", *Journal of Social Marketing*, Vol. 3No No. 3, pp. 206 -222.

Taylor, J. and Taylor, J. (2013), "Person-Centered planning: evidence-based practice, challenges, and potential for the 21st century", *Journal of Social Work in Disability and Rehabilitation*, Vol. 12 No. 3, pp. 213-235.

UNESCO (2020), "Report about inclusion and education: all means all", available at: https://en.unesco.org/gem-report/allreports (accessed 6 March 2021).

Van Heumen, L. and Schippers, A. (2016), "Quality of life for young adults with intellectual disability following individualized support: individual and family responses", *Journal of Intellectual and Developmental Disability*, Vol. 41 No. 4, pp. 299-310.

Vargo, S. (2009), "Toward a transcending conceptualization of relationship: a service-dominant logic perspective", *Journal of Business and Industrial Marketing*, Vol. 24 No. 5/6, pp. 373-379.

Vargo, S. and Lusch, R. (2008), "Service-dominant logic: continuing the evolution", *Journal of the Academy of Marketing Science*, Vol. 36 No. 1, pp. 1-10.

Vargo, S. and Lusch, R. (2016a), "Institutions and axioms: an extension and update of service-dominant logic", *Journal of the Academy of Marketing Science*, Vol. 44 No. 1, pp. 5-23.

Vargo, S. and Lusch, R. (2016b), "Service-dominant logic 2025", *International Journal of Research in Marketing*, Vol. 34 No. 1, pp. 46-67.

Vargo, S.L. and Lusch, R.F. (2004), "Evolving to a new dominant logic for marketing", *Journal of Marketing*, Vol. 68 No. 1, pp. 1-17.

Vargo, S.L. and Lusch, R.F. (2006), "Service-Dominant logic: what it is, what it is not, what it might be", In Lusch, R.F. and Vargo, S.L. (Eds), *The Service-Dominant Logic of Marketing: Dialog, Debate, and Directions*, M. E. Sharpe, New York, NY.

Vargo, S., Maglio, P. and Akaka, M. (2008), "On value and value co-creation: a service systems and service logic perspective", *European Management Journal*, Vol. 26 No. 3, pp. 145-152.

Vargo, S., Wieland, H. and Akaka, M. (2015), "Innovation through institutionalization: a service ecosystems perspective", *Industrial Marketing Management*, Vol. 44, pp. 63-72.

Verdugo, M., Navas, P., Gómez, L. and Schalock, R. (2012), "The concept of quality of life and its role in enhancing human rights in the field of intellectual disability", *Journal of Intellectual Disability Research*, Vol. 56 No. 11, pp. 1036-1043.

Verdugo, M., Schalock, R., Keith, K. and Stancliffe, R. (2005), "Quality of life and its measurement: important principles and guidelines", *Journal of Intellectual Disability Research*, Vol. 49 No. 10, pp. 707-717.

Vize, S., Goossens, E., MacLachlan, M. and Yanhong, Z. (2015), "Policies and processes for social inclusion", *Exploring Possibilities in Northern ASEAN Countries*, Vol. 2, UNESCO.

Wolfson, A., Dominguez-Ramos, A. and Irabien, A. (2019), "From goods to services: the life cycle assessment perspective", *Journal of Service Science Research*, Vol. 11 No. 1, pp. 17-45.

Wood, M. (2016), "Social marketing for social change", *Social Marketing Quarterly*, Vol. 22 No. 2, pp. 107-118.

World Health Organization (2015), "WHO global disability action plan 2014-2021", *Better Health for All People with Disabilities*, available at: www.who.int (accessed 10 March 2020).

World Health Organization (2019), "World report on disability", available at: www.who.int (accessed 3 January 2021).

Zainuddin, N., Dent, K. and Tam, L. (2017), "Seek or destroy? Examining value creation and destruction in behavior maintenance in social marketing", *Journal of Marketing Management*, Vol. 33, pp. 1-27.

Zeller, R.A. (2005), "Measurement error, issues, and solutions", In: Kempf-Leonard, K. (Ed.) *Encyclopedia of Social Measurement*, Vol. 2, Elsevier Academic Press: Amsterdam pp. 665-676.

Further reading

Brown, I., Keith, K.D. and y Schalock, R.L. (2004), "Quality of life conceptualization, measurement, and application: validation of the SIRG-QOL consensual principles", *Journal of Intellectual Disabilities Research*, Vol. 48, Nos 4/5, pp. 451.

Casais, B. and Castro, C. (2020), "Online communication of accessibility conditions in touristic spots: the design-communication gap in Porto destination", *Journal of Hospitality and Tourism Technology*, doi: 10.1108/JHTT-07-2019-0096

Dann, S. (2010) Redefining social marketing with contemporary commercial marketing definitions", *Journal of Business Research*, Vol. 63, No. 2, pp. 147-153.

European Commission (2010), "The European disability strategy 2010-2020", available at: https://eurlex.europa.eu/ (accessed 9 March 2020)

European Commission. Budapest Institute (2015), "Literature review and identification of best practices on integrated social service delivery", available at: https://op.europa.eu/ (accessed 12 February 2020)

Gordon, R. (2013), "Unlocking the potential of upstream social marketing", *European Journal of Marketing*, Vol. 47, No. 9, pp. 1525-1547.

Keith, K.D. and Schalock, R.I. (1994), "The measurement of quality of life in adolescents: the quality of students life questionnaire", *American Journal of Family Therapy*, Vol. 22, No. 1, pp. 83-87.

Lefebvre, R.C. (2011), "An integrative model for social marketing", *Journal of Social Marketing*, Vol. 1, No. 1, pp. 54-72.

Liebow, E. (1967), *Tally's Corner: A Study in Negro Streetcorner Men*, Little Brown, Boston, MA.

Luca, N. Suggs. L.S. (2013), "Theory and model use in social marketing health interventions", *Journal of Health Communication*, Vol. 18, No. 1, pp. 20-40.

Public Health England (2017), "Public Health England. Social Marketing Strategy 2017 to 2020", available at: https://assets.publishing.service.gov.uk/ (accessed 28 February 2021)

Schalock, R. L., Gardner, J.F. and Bradley, V. J. (2007), *Quality of life for persons with intellectual and other developmental disabilities: Applications across individuals, organizations, communities, and systems*, American Association on Intellectual and Developmental Disabilities, Washington, DC.

Truong V.D. (2014), "Social marketing: a systematic review of research 1998–2012", *Social Marketing Quarterly*, Vol 20, No. 1, pp. 15-34.

Wymer, W. (2011), "Developing more effective social marketing strategies", *Journal of Social Marketing*, Vol. 1, No, 1, pp. 17-31.

Corresponding author
Pedro Canales-Ronda can be contacted at: pedro.canales@uv.es