# A systematic review of sports sponsorship for public health and social marketing

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## Abstract

**Purpose** – This paper aims to provide a systematic review of evaluations of public health and social marketing campaigns reporting the use of sports sponsorship. Sports sponsorship is a key health promotion strategy, yet academic literature on the use of sponsorship in social marketing and public health is surprisingly limited.

**Design/methodology/approach** – Seventeen studies were identified following systematic literature review procedures.

**Findings** – Coupling of social marketing and public health sponsorship with changes in policies in sporting clubs and associations offers an effective means to achieve desired outcomes, e.g. behaviour change.

**Research limitations/implications** – The analysis presented in this review included information that was reported in the identified studies, which might be an incomplete representation of work undertaken but not reported. All of the studies identified in this review were conducted in English-speaking countries. Considerable opportunity for future research is apparent, and areas for future research are outlined.

**Practical implications** – Limited evidence was available, and additional research examining the effectiveness of sponsorship in attaining behavioural change is urgently needed. Future studies should assess the role, scope of involvement in, aims and benefits of non-government sponsors of public health and social marketing campaigns; use methods that do not rely on self-reporting, such as observations; and explore the influence of health sponsorship on attitudes, social norms and behaviours.

**Originality/value** – This is the first study to provide a systematic review of the use of sports sponsorship in public health and social marketing.

**Keywords** Public health, Social marketing, Sports sponsorship, Systematic review

**Paper type** Literature review

## Background

Sports sponsorship has been a key health promotion strategy that has been used over the past 30 years, yet academic literature on the value of sponsorship for social marketing and public health is limited. An assessment of the value of sponsorship assists to establish the factors that should be considered by social marketers and public health practitioners when implementing sponsorship. Drawing from commercial marketing literature sponsorship has been described by authors such as Meenaghan (1983, p. 9) as "the provision of assistance

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either financial or in-kind to an activity by a commercial organisation for the purpose of achieving commercial objectives". However, in social marketing and public health, where sponsorship is frequently used to achieve social rather than commercial objectives, studies (Madill and O'Reilly, 2010; Madill *et al.*, 2014; O'Reilly and Madill, 2007) have relied on Rifon *et al.*'s (2004, p. 30) definition which adopts a wider stance, indicating the purpose of sponsorship as an exchange process in which a "corporation [or other investor, for example a health promotion foundation] creates a link with an outside issue or event, hoping to influence the audience by the connection" which, in turn, may assist to deliver sustained social programs. Taken together, definitions indicate that sponsorship in public health and social marketing may involve the provision of assistance either financial or in-kind and/or the formation of a partnership and a resulting exchange that mutually benefits both parties. Sponsorship arrangements involve two parties: a sponsor and a sponsee. The sponsor is responsible for providing cash and/or an in-kind contribution (e.g. products such as athletic apparel or services) to a sponsee in exchange for promotional opportunities to create links with an event, cause or organisation (Madill and O'Reilly, 2010; O'Reilly and Madill, 2007). In social marketing and public health, sponsors are usually private companies (Rodgers and Bae, 2007), and sponsees are frequently sporting and arts non-for-profit and government organisations, teams, programmes, persons and events. Sponsees rely on achieving their goals via resources provided by sponsors (Rosenberg and Ferguson, 2014). Partnering with a commercial organisation can assist behaviour change practitioners, who typically have limited budgets, to reach a larger audience. Further, private partnerships can help behaviour change practitioners to deliver more value to the target audience. For example, private partnerships can deliver discount offers that attract attention or repeat engagement with a campaign which, in turn, reinforces the campaign aims for the target audience and increases likelihood of delivering the desired change.

Sport is an important context for public health organisations, as it offers potential to deliver public health messages to large populations (Corti *et al.*, 1997b). Further, according to a National Health and Medical Research Council review (NHMRC, 1996), strategically targeted sponsorship not only offers a potential for public health and social marketing campaigns to reach priority groups, but also facilitates structural (i.e. environmental) changes in sporting venues (Crisp and Swerissen, 2003). Some of the first examples of health sponsorship of sports emerged in the 1980s in the UK (Hastings *et al.*, 1988), followed by the USA (Olsen, 1999). In the 1990s, health sponsorship became commonly used in Australia (Giles-Corti *et al.*, 2001). More recently, Australian health promotion foundations have been considered as leaders in using sponsorship as a health promotion strategy (Corti *et al.*, 1997b). The rise of health sponsorship in Australia can be attributed by and large to the creation of health promotion foundations, aiming initially to compete with tobacco sponsorship (Jalleh *et al.*, 2002). Health sponsorship was first used to financially support sports and arts organisations that had historically relied on tobacco industry sponsorship for their survival. Health sponsorship has been identified by some authors as a uniquely Australian phenomenon, where health promotion foundations act as sponsors (Madill and O'Reilly, 2010) providing, for example, funds to sports and arts organisations in exchange for health promotion, behavioural change outcomes or assets that include (but are not limited to) naming rights for sporting and cultural events, wearing promotional clothing, and programme advertisements and signage (Crisp and Swerissen, 2003). In other countries, for example, in Canada and the USA, where statutory frameworks do not offer the same opportunities to public health bodies, private companies, with their commercial rather than public health objectives, dominate the sports sponsorship landscape in public health (Madill and O'Reilly, 2010). The understanding of health sponsorship as a uniquely Australian

public health strategy explains limited availability of relevant literature internationally, and where it does exist it is often not empirically evaluated (Madill and O'Reilly, 2010). Therefore, this article responds to this gap and aims to provide a systematic review of evaluations of public health and social marketing campaigns reporting the use of sports sponsorship.

## Methods

Following the systematic literature review procedures outlined in Carins and Rundle-Thiele (2014), two searches were conducted to identify public health and social marketing studies reporting the use of sports sponsorship published in peer-reviewed journals. Seven databases (see Table I) were searched using the following terms: sponsorship* or partnership* AND "social marketing" (Search 1); and sponsorship* AND "public health" AND sport* (Search 2). The use of * allows for singular or plural word forms to be identified. Database names and the number of records retrieved from each database are shown in Table I. The variation in the number of records retrieved from the different databases is explained by the size and the subject specialisation of each database. ProQuest, for example, is made up of 20 databases representing a much larger database than most.

The search processes can be found in Figure 1. The initial results were limited to peer-reviewed academic journal articles published up to December 2015 (Search 1) and February 2016 (Search 2). All records retrieved from the seven databases were downloaded to EndNote, the results were collated and duplicate records identified via different databases were removed. The combined total of records downloaded from all databases was 877 in Search 1 and 190 in Search 2. From the initial records collected, 299 (Search 1) and 61 (Search 2) duplicate records were removed, leaving 578 unique sources in Search 1 and 129 unique sources in Search 2. The remaining sources were then screened based upon their title and abstract. To ensure that records were an accurate representation of the use of sports sponsorship for social marketing and public health, the following exclusion criteria were applied to exclude records that did not report evaluations of public health and social marketing campaigns using sports sponsorship: records not including sports sponsorship (e.g. when other forms of sponsorship, e.g. arts sponsorship, were the main focus), records that did not state the use of social marketing (Search 1), records not including public health campaigns (Search 2), reviews or conceptual papers, records detailing formative research with no sponsorship executed, records containing only references to dissertations, abstracts, conference papers and book chapters, and records not in English (see Figure 1).

A large number of records (510 in Search 1 and 118 in Search 2) were removed once the exclusion criteria were applied, leaving 68 and 11 unique studies, respectively. Backward searching was completed by examining the reference lists of all 79 journal articles for

| Database | No. of sources retrieved in Search 1 | No. of sources retrieved in Search 2 |
|---|---|---|
| EBSCO all databases | 91 | 13 |
| Emerald | 10 | 4 |
| Ovid (all databases) | 157 | 26 |
| ProQuest (all databases) | 108 | 89 |
| ScienceDirect | 93 | 6 |
| Taylor & Francis | 240 | 4 |
| Web of Science | 178 | 48 |

**Table I.**
Databases and sources retrieved in the initial search

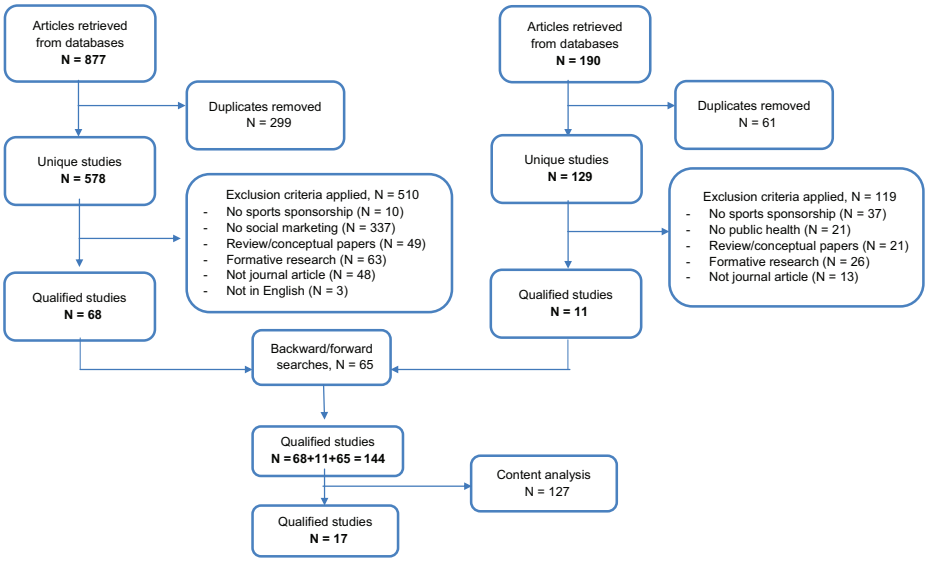


**Figure 1.**
Systematic literature review flowchart



further sources that may give additional information regarding sports sponsorship that may fit the search criteria. The identified sources were located and examined in the same way as the original records, through title and abstract analysis. Forward searching was conducted using author and campaign names to search within Google Scholar and the University library databases to locate additional academic papers related to specific campaigns as well as additional campaigns undertaken by the authors.

The backward and forward searching yielded 65 additional academic papers, giving 144 studies. Full texts of all studies were downloaded to EndNote and content analysed to identify relevance to sports sponsorship and the review aims. The overwhelming majority of studies included only very brief references to sports sponsorship, for example, a sentence stating the use of sports sponsorship as part of a wider social marketing campaign without providing any details of the sponsorship or its evaluation. Following the analysis of all studies, 17 studies including evaluations of sports sponsorship were included in the final review.

## Results

In total, 17 studies were identified. Drawing on key elements identified in Kubacki *et al.* (2015) study elements are presented in Table II. Original names for identified campaigns are shown in italics. The following discussion focuses on budgets, locations, target audiences, aims, evaluation methods and outcomes for each sponsorship programme, i.e. both VicHealth sponsorship programmes and Healthway, and the remaining individual studies. Four of the studies were reviewed as individual sponsorship campaigns (Corti *et al.*, 1997a; Dobbinson *et al.*, 1999; Jalleh *et al.*, 2001; Jalleh *et al.*, 2002) – although they were associated with Healthway and VicHealth sponsorship programmes, the evaluations reported in those studies focused on specific campaigns rather than evaluations of the Healthway and VicHealth sponsorship programmes (see Table II).

**Table II.**
Study summary

| Study name | Study | Years | Budget | Location | Target Audience(s) | Aim(s) | Evaluation method | Outcomes |
|---|---|---|---|---|---|---|---|---|
| Scottish Health Education Group | Hastings *et al.* (1988) | 1984-1986 | Approx. £250,000 per year | Scotland | Males (10-44 years old) with interest in football and their immediate female relatives | Attitudes | Survey, multiple collection points | Awareness (3-yr) –[a]<br>Attitudes to campaign (3-yr) +/– |
| *Tobacco Free Challenge Racing* | Weinreich *et al.* (1999) | 1991-1998 | n/a | Northern California, USA | Blue-collar workers, minority groups, low-income youth | Social norms | Survey, interviews, multiple collection points | Awareness +<br>Attitudes +<br>Policy + |
| *Tobacco Action Project* | Ivers *et al.* (2006) | 1999-2000 | n/a | Northern Territory, Australia | Aboriginal Australians in remote NT communities | Behaviour | Survey, sales data, multiple collection points | Behaviour +/–<br>Knowledge +<br>Intentions + |
| *SunSmart* (VicHealth) | Dobbinson *et al.* (1999) | 1987-1997 | n/a | Victoria, Australia | Lifesavers | Knowledge<br>Policy | Survey | Awareness +[b]<br>Policy +<br>Behaviour + |
| VicHealth sponsorship programme 1 | Crisp and Swerissen (2003) | 1999 | $10,000 to $60,000 per year/per organisation | Victoria, Australia | Participants and visitors of sporting organisations | Policy | Interviews | Policy +/– |
| VicHealth sponsorship programme 2 | Dobbinson *et al.* (2006) | 2001 | $25.8 million in the first 4 years, $5.4 million in 2001 | Victoria, Australia | Sporting and other organisations promoting healthy environments in the community | Behaviour<br>Policy | Survey | Policy +/– |
| *Smoking? No Way!* (Healthway) | Corti *et al.* (1997a) | 1993 | n/a | Western Australia | Children (8-14 years old) enrolled in holiday football clinics | Awareness (promotion) | Survey, multiple collection points | Awareness + |
| *The Western Australian Mouthguard Promotion Campaign* (Healthway) | Jalleh *et al.* (2001) | 1997-1998 | n/a | Western Australia | Junior basketball and rugby union players, parents and coaches | Awareness<br>Behaviour | Observations | Behaviour + |

(*continued*)

**Table II.**

| Study name | Study | Years | Budget | Location | Target Audience(s) | Aim(s) | Evaluation method | Outcomes |
|---|---|---|---|---|---|---|---|---|
| *Respect Yourself* and *Quit* (Healthway) | Jalleh *et al.* (2002) | 2002 | n/a | Western Australia | *Respect Yourself* - males 18-30 years old; *Quit* – smokers aged 18+ | *Respect Yourself* – awareness (promotion); *Quit* - attitudes and behaviour | Survey, multiple collection points | Awareness (both) +<br>Attitude (*Respect Yourself*) + |
| Healthway sponsorship programme | Corti *et al.* (1995) | 1991-1992 | $5.16 million (1990-1991) | Western Australia | Sport, arts or racing organisations; | Awareness (promotion) | Survey (organisational) | Policy + |
| | Oddy *et al.* (1995) | 1992 | n/a | | Spectators at sport, arts or racing events | Policy | Survey (participants) | Participation + |
| | Corti *et al.* (1997a) | 1994 | n/a | | | | GPE<br>Surveys (organisational and community) | Policy + |
| | Holman *et al.* (1996), Donovan *et al.* (1997) | 1992-1994 | n/a | | | | GPE (survey) | Participation +<br>Promotion +<br>Policy +<br>Awareness +<br>Message acceptance + |
| | Holman *et al.* (1997) | 1995 | $2.5 million (1990-1994) | | | | GPE (survey) | Participation +<br>Policy +<br>Awareness + |
| | Giles-Corti *et al.* (2001) | 1992-1998 | n/a | | | | Surveys (organisational and spectators)<br>Observations | Awareness +<br>Policy + |
| | Rosenberg and Ferguson (2014) | 2008-2013 | $60 million (2008-2012) | | | | Survey | Awareness +<br>Message acceptance +<br>Intentions + |

**Notes:** [a] – negative change;[b] + positive change

*Locations and budgets*

All studies included in this review were found to be in developed and English-speaking countries; 15 studies were conducted in Australia. The majority of studies focused on evaluations of two significant health sponsorship programmes run by two state health promotion agencies – Western Australia's Healthway (eight studies) and Victoria's VicHealth (two studies). Four studies reported specific campaigns associated with the VicHealth sponsorship programme (Dobbinson *et al.*, 1999) and Healthway (Corti *et al.*, 1997a; Jalleh *et al.*, 2001; Jalleh *et al.*, 2002). The remaining study in Australia was conducted in the Northern Territory (Ivers *et al.*, 2006). One study was conducted in Scotland (Hastings *et al.*, 1988) and one in the USA (Weinreich *et al.*, 1999).

Financial details were not reported in all studies, and when they were it is difficult to make direct comparisons as the years of funding reported spread over nearly 30 years, from 1984 (Hastings *et al.*, 1988) to 2013 (Rosenberg and Ferguson, 2014). This precludes drawing conclusions from this review on the costs of running an effective sponsorship programme. All studies reported state departments of health and their agencies (e.g. The Western Australian Health Promotion Foundation (Healthway) and VicHealth) as sponsors.

*Target audiences*

Target audiences are the group(s) at which the public health and social marketing campaigns are aimed. All studies included in this review fell into one of two broad categories of target audience.

The first group of sponsorships primarily targeted organisations. It included eight Healthway sponsorship programme evaluation studies focused on sport, arts and racing organisations (Corti *et al.*, 1995; Corti *et al.*, 1997b; Donovan *et al.*, 1997; Holman *et al.*, 1996; Holman *et al.*, 1997; Giles-Corti *et al.*, 2001; Oddy *et al.*, 1995; Rosenberg and Ferguson, 2014) and two VicHealth sponsorship programme evaluation studies (Crisp and Swerissen, 2003; Dobbinson *et al.*, 2006). In contrast, the primary foci of VicHealth's sponsorship were sporting and other organisations promoting healthy environments in the community. Both organisations' sponsorship programmes broadly aimed to reach spectators, participants, visitors and members associated with sponsees.

The second group includes the seven studies describing campaigns with a diverse range of specific target audiences. For example, groups targeted for change included 10- to 44-year-old males with an interest in football (primary audience) and their immediate female relatives (secondary audience) (Hastings *et al.*, 1988); blue-collar workers; minority groups and low-income youth (Weinreich *et al.*, 1999); 8- to 14-year-old children enrolled in holiday football clinics (Corti *et al.*, 1997a); lifesavers (Dobbinson *et al.*, 1999); Aboriginal Australians in remote communities (Ivers *et al.*, 2006); junior basketball and rugby union players, parents and coaches (Jalleh *et al.*, 2001); and 18- to 30-year-old males and 18+ smokers (Jalleh *et al.*, 2002). Previous studies contend that sponsorship may be effective at reaching hard-to-reach and hard-to-impact target audiences in the community (Corti *et al.*, 1995). One may, therefore, argue that those seven studies reported sponsorship of activities that enabled access to those specific audiences, for example, via football games (Hastings *et al.*, 1988), racing events (Weinreich *et al.*, 1999), holiday football clinics (Corti *et al.*, 1997a) and programmes in Aboriginal communities (Ivers *et al.*, 2006).

*Sponsorship aims*

The aims that were reported reflected the multifaceted nature of health sponsorship. Five different types of aims were reported in the studies:

(1) aims to change policies;
(2) aims to change awareness (including knowledge);
(3) behavioural aims;
(4) aims to change attitudes; and
(5) aims to change social norms.

All of the studies analysed in this review stated a specific aim for their sponsorship programme ensuring a focus and goal, and several studies reported more than one aim. Apart from the eight studies evaluating the Healthway sponsorship programme, four other studies identified a combination of two different objectives – awareness and policy (Dobbinson *et al.*, 1999), behaviour and policy (Dobbinson *et al.*, 2006), attitudes and awareness (Jalleh *et al.*, 2002), and awareness and behaviour (Jalleh *et al.*, 2001).

Policy was the main aim in two large sponsorship programmes provided by Healthway and VicHealth. Eight studies evaluating the Healthway sponsorship programme (Corti *et al.*, 1995; Corti *et al.*, 1997b; Donovan *et al.*, 1997; Holman *et al.*, 1996; Holman *et al.*, 1997; Giles-Corti *et al.*, 2001; Oddy *et al.*, 1995; Rosenberg and Ferguson, 2014) and two studies evaluating different elements of the VicHealth sponsorship programme (Crisp and Swerissen, 2003; Dobbinson *et al.*, 2006) reported policy aims. The main purpose of Healthway's sponsorship programme was to create a healthy environment through structural changes at events, such as introduction of smoke-free policies and provisioning of healthy food choices (Holman *et al.*, 1993). VicHealth's sponsorship programme aimed to implement structural change in sporting settings.

Awareness was identified as an aim in 12 studies. For example, *SunSmart* (Dobbinson *et al.*, 1999) aimed to educate lifesavers about the need for better sun protection practices to raise awareness of the campaign's message; *Smoking? No Way!* (Corti *et al.*, 1997a) aimed to promote a no smoking message to children, and *The Western Australian Mouthguard Promotion Campaign* (Jalleh *et al.*, 2001) aimed to increase awareness of the protective benefits of custom-built mouthguards. All eight studies of Healthway sponsorships aimed to fund activities that promote good health (see Table II).

Four studies reported behavioural aims. For example, *Tobacco Action Project* aimed to reduce the damaging effects of tobacco for Aboriginal people, consumed as tailor-made cigarettes or "rollies" of loose tobacco, occasionally smoked in a pipe (commercial, crab-claw or Macassan [Indonesian] pipe) or chewed with eucalyptus ash ("mubbudge") (Ivers *et al.*, 2006), and *the Western Australian Mouthguard Promotion Campaign* aimed to increase the use of mouthguards among junior players for competition and training (Jalleh *et al.*, 2001).

Three studies reported attitudinal and social norms aims. Attitude is a tendency to evaluate or appraise a behaviour favourably or unfavourably. The sponsorship offered by the Scottish Health Education Group aimed to improve the image of health through the sponsorship link with football, health being defined as fitness, non-smoking and moderation in alcohol consumption (Hastings *et al.*, 1988). Jalleh *et al.* (2002) aimed to assess the awareness and attitude effects of sponsorships using two campaigns: *Respect Yourself* and *Quit*. Social norms were reported as an aim in one study: *Tobacco Free Challenge Racing* (Weinreich *et al.*, 1999) aimed to change social norms abound tobacco among racetrack audiences.

*Evaluation methods*

A frequent criticism of social marketing and public health campaigns is the lack of systematic and methodologically sound evaluations (Babor *et al.*, 2010). Best practice

campaigns include an evaluation component to monitor their effectiveness in the achievement of aims and for identifying areas for increasing the effectiveness of the campaign (Grier and Bryant, 2005).

The overwhelming majority of studies identified in this review (15 of 17) reported using quantitative surveys as the evaluation method used to research individuals or organisations. For example, in Giles-Corti *et al.* (2001), 613 randomly selected spectators attending eight Western Australian football league clubs were surveyed to ascertain their support for the introduction of smoke-free policies, and 185 spectators were surveyed following the introduction of a policy banning smoking to determine awareness of, agreement with and support for the smoke-free venue policies. In addition, the study reported organisational surveys of all sport, arts and racing organisations that had commenced Healthway-funded projects during the previous 12 months.

Two studies reported using qualitative interviews. In *Tobacco Free Challenge Racing* (Weinreich *et al.*, 1999), two series of interviews were conducted with fans and drivers in 1997 and 1998. In Crisp and Swerissen's (2003) study of VicHealth sponsorship programme, 33 interviews were conducted with the representatives of 13 sponsored organisations who were responsible for managing the sponsorship within their organisation and relevant staff members from VicHealth and other health agencies.

Two other evaluation methods were reported in the identified studies: sales data (Ivers *et al.*, 2006) and observations (Giles-Corti *et al.*, 2001; Jalleh *et al.*, 2001). In the *Tobacco Action Project* (Ivers *et al.*, 2006) information on monthly orders for each type of cigarette and tobacco was collected from either the store manager or from the store's wholesaler for each of the communities in the study. Consumption was then calculated using the number of cigarettes or "cigarette-equivalents" of loose tobacco ordered through stores for each month; this was then divided by the number of community members aged 12 years or older, as estimated from the 1996 Australian Bureau of Statistics Census. One of the Healthway evaluation studies (Giles-Corti *et al.*, 2001) reported using observational studies at sporting venues to assess the extent to which smoke-free policies at sporting events were implemented and adhered to. Some 8,212 people were observed adhering to smoke-free policies.

A frequent criticism of research is the lack of matched control groups and the lack of multiple data collection points across time (Babor *et al.*, 2010; Cuijpers, 2002). Five studies reported using both pre- and post-tests allowing for comparative data analysis. *Tobacco Free Racing Challenge* (Weinreich *et al.*, 1999) involved pre- (n = 339) and post-test (n = 347) surveys of racing event attendees. In *Smoking? No Way!* (Corti *et al.*, 1997a), the pre-test questionnaires were administered to children at the beginning of football clinics and prior to the promotional packages being put in place. The post-test questionnaires were administered at the end of the third day of the clinics. All promotional materials used at the clinics were removed before the post-test. Overall, 828 children participated in the pre-test survey and 754 in the post-test. The evaluation of *the Western Australian Mouthguard Promotion Campaign* employed a quasi-experimental field design with pre- and post-campaign observations (Jalleh *et al.*, 2001). *Tobacco Action Project* (Ivers *et al.*, 2006) involved pre- and post-evaluation in the intervention communities, at baseline – in the month prior to the planned campaign – and at a follow-up visit, a year later. The evaluation included community-wide surveys to identify any changes in smoking behaviour, attitudes (readiness to quit) and knowledge following the community tobacco campaigns. In *Respect Yourself* and *Quit* study (Jalleh *et al.*, 2002) two independent samples were taken pre- and post-test at two events to allow assessment of both awareness and attitude effects without prior questions contaminating later measures. In addition to those studies, two other studies

reported multiple data collection points. The Scottish Health Education Group sponsorship (Hastings *et al.*, 1988) of the Scottish FA Cup was monitored in three stages covering the 1984, 1985 and 1986 competitions. Each year, just under 700 men were interviewed face-to-face using a highly structured questionnaire. Finally, Giles-Corti *et al.* (2001) reported conducting organisational surveys in mid-1992 (n = 269), 1994 (n = 511) and 1997 (n = 536).

Best practice evaluation of social marketing and public health campaigns should also involve the inclusion a control group, to effectively evaluate change towards the desired outcome, e.g. behaviour. The use of a control group permits confounding factors to be examined ensuring that a comprehensive understanding of why the change occurs is gained. A control group was established in only two studies. In *SunSmart* (Dobbinson *et al.*, 1999), New South Wales was selected as the control community based on its proximity to Victoria, sufficient beaches frequented by metropolitan beach goers, and limited and relatively recent involvement of lifesavers in sun protective initiatives. In *the Western Australian Mouthguard Promotion Campaign*, Australian Rules Football players were used as a control group (Jalleh *et al.*, 2001).

*Outcomes*

As noted earlier, social marketing and public health campaigns have a variety of aims including to change behaviours, attitudes, intentions and policy, and to raise awareness. Outcome(s) evaluation should ideally be linked to the study aim(s). For example, a study aiming to raise awareness should be evaluating awareness to understand campaign effectiveness. All studies reported some positive outcomes.

*Policy.* Policy change outcomes were reported by ten studies. Six of those studies reported positive policy changes associated with the evaluation of Healthway's sponsorship programme. For example, Corti *et al.* (1995) reported a substantial increase in the level of reform in five of Healthway's priority structural reform areas:

(1) provision of smoke-free areas;
(2) access for disadvantaged groups;
(3) safe alcohol practices;
(4) healthy food choices; and
(5) sun protection measures.

Two studies also reported policy outcomes associated with VicHealth's sponsorship programme. Crisp and Swerissen (2003) reported that sponsored sporting organisations varied extensively with respect to the extent to which they reported implementing structural changes – while smoke-free venues and sun protection measures were widespread, responsible serving of alcohol and in particular healthy catering options were more difficult to achieve in the sporting context. Dobbinson *et al.* (2006) reported that the establishment of written policies on the key health areas by sports clubs varied widely by affiliated sport and health area; for example, 70 per cent of all clubs with bar facilities had written policies on responsible serving of alcohol, but only approximately one-third of sports clubs had a smoke-free policy.

*Awareness.* Ten studies showed significant change in awareness. Again, five of them were associated with the evaluation of Healthway's sponsorship programme. For example, Holman *et al.* (1996) and Donovan *et al.* (1997) reported that 67 per cent of respondents within the primary target groups were aware of the promoted health message and 60 per cent could recall the message unprompted. More recently, Rosenberg and Ferguson (2014) reported that awareness of the sponsored health message was 58 per cent across all

sponsored events. In *SunSmart* (Dobbinson *et al.*, 1999), 29 per cent of Victoria beach goers were aware of health messages at the beach, and of these, 36 per cent noticed *SunSmart*. In *Tobacco Free Racing Challenge* (Weinreich *et al.*, 1999), the results showed continuing increase in awareness, and Hastings *et al.* (1988) observed that between a quarter and a third of respondents showed prompted awareness of SHEG's involvement with the Scottish Cup, but awareness of both the sponsorship and the advertising fell slightly over the three years.

*Attitudes.* A consumer's attitude toward a specific behaviour is a function of how he or she believes the action will lead to a specific outcome (either favourable or unfavourable). Based on this, it may be assumed that attitude change is one of many precursors to behavioural change. However, only three studies reported attitudinal outcomes. Jalleh *et al.* (2002) reported that the *Respect Yourself* campaign showed a significant positive change in attitude toward the issue (alcohol moderation). *Tobacco Free Racing Challenge* (Weinreich *et al.*, 1999) noted a general increase among all respondents in dislike of tobacco sponsorship of racing (34.4 vs 40.1 per cent) and "hating" to sit next to smokers (41.8 vs 53.4 per cent). In the final study, Hastings *et al.* (1988) reported that attitudes towards the sponsorship campaign were largely positive and remained stable over time, with only one negative item – "No one notices sponsorship at football matches" – increasing from 29 to 40 per cent.

*Behaviours.* Behavioural outcomes were reported in only three studies, indicating that the evidence that sponsorship can have a direct effect on behaviour remains scarce (Jalleh *et al.*, 2002). A quasi-experimental field design in *The Western Australian Mouthguard Promotion Campaign* (Jalleh *et al.*, 2001) showed that mouthguard usage increased at competition events among both rugby and basketball players, and at training for basketball players. The *SunSmart* campaign (Dobbinson *et al.*, 1999) delivered positive behavioural change, with marked improvements in Victorian lifesavers' hat, sunscreen and shade use over the nine years of the campaign. Mixed behavioural outcomes were reported in *Tobacco Action Project* (Ivers *et al.*, 2006): 10 per cent of people who claimed to be smokers at the baseline visit had quit at the follow-up survey; however, some ex-smokers and some who reported that they had never smoked took up smoking during the campaign year.

*Participation.* Participation in sponsored events was an important measure reported in four Healthway sponsorship programme studies. In Oddy *et al.* (1995), participation was used as a measure of whether sponsorships were being allocated to reach appropriate target audiences, with the study reporting that the average Western Australian attended a Healthway-sponsored event on approximately four occasions in 1992. Participation was higher in those who smoked, drank alcohol unsafely, reported sunburn and reported low consumption of fruit and vegetables, providing evidence indicating that target audiences had been reached. However, participation had declined in people who were sedentary. Holman *et al.* (1996) and Donovan *et al.* (1997) reported that on average, each Healthway-sponsored project was attended by 94 organisers, elite sports players and arts performers, 1,433 active participants and 5,923 spectators. Finally, Holman *et al.* (1997) reported that 25 Healthway-sponsored projects reached 1.3 million people, with an average attendance of 50,847 per project.

*Other outcomes.* Other outcomes were reported in three of the identified studies. Holman *et al.* (1996) and Donovan *et al.* (1997) reported high levels of message acceptance. Of respondents who were aware of the health message, 82 per cent comprehended the message and 88 per cent of these accepted the message. The studies also reported that promotional and educational measures were recorded on 217 projects and one or more promotional benefits were realised in 86 per cent of projects. Message acceptance was also reported by Rosenberg and Ferguson (2014), stating that acceptance of the sponsored health message was high (91.9 per cent), with females and respondents over 40 years of age significantly

more likely to accept the sponsorship health message compared with males and participants younger than 40 years of age. The authors also reported positive behavioural intentions among 40.6 per cent of respondents across all sponsorships, with those over the age of 40 years, 1.7 times more likely to form a relevant behavioural intention compared with people under 40 years of age.

## Discussion

The aim of this study was to provide a systematic review of evaluations of public health and social marketing campaigns reporting the use of sports sponsorship. This review indicated that in line with an argument made nearly a quarter of a century ago by Holman *et al.* (1993), academic literature on sports sponsorship practice in public health and social marketing still remains limited. Although much has been written about sponsorship theory (see e.g. Donovan and Henley, 2010; Madill and O'Reilly, 2010), our review identified only 17 peer-reviewed studies reporting evaluations of sports sponsorship in social marketing and public health. Further, as the majority of the identified studies were published in the 1990s (largely focusing on the Healthway sponsorship programme), and no studies were published between 2006 and 2014, with only one study published in the past ten years (Rosenberg and Ferguson, 2014), it is difficult to draw definite conclusions from available evidence. It is clear that there is currently little interest in sports sponsorship in the academic literature, despite the significant volume and value of sports sponsorship worldwide. This, therefore, constitutes an important gap in the literature, i.e. studies evaluating the use of sports sponsorship in social marketing and public health are urgently needed. While it is important to acknowledge that in practice sponsorship is often one of several elements of the marketing mix, there are studies identifying sponsorship as one of the strategies used in public health and social marketing campaigns, and any identified and reported behavioural impacts are an outcome of the total marketing mix. Yet there is a conspicuous lack of more detailed description and evaluations of sponsorship effectiveness, and future studies should compare impacts where sponsorship is the primary or only tool versus campaigns where sponsorship is part of a comprehensive marketing mix to examine the role that sponsorship plays in overall programme effectiveness.

Previous studies indicated that health sponsorship is an Australian phenomenon where health promotion foundations act as sponsors (Crisp and Swerissen, 2003; Madill and O'Reilly, 2010). Our systematic review provides further evidence to support this claim, as 15 of 17 studies were about Australian sponsorships. Ten of these focused on evaluations of two large health sponsorship programmes run by two state health promotion agencies – Western Australia's Healthway and Victoria's VicHealth. Four additional studies focused on specific campaigns associated with VicHealth and Healthway's sponsorship programmes. We can, therefore, conclude that the majority of available evidence has come from Healthway and VicHealth. In consequence, as all studies reported on programmes sponsored by state departments of health and their agencies, the health sponsorship landscape appears to be dominated by government funding. There is, therefore, a second significant gap in the literature – future studies are needed assessing the role, scope of involvement, aims and benefits of non-government sponsorship of public health and social marketing campaigns.

Sponsorship is typically one element of a much broader marketing mix. Therefore, evaluations of sponsorship need to be able to isolate the unique effect that one component (e.g. sponsorship) delivers within the wider mix. The overwhelming majority of studies identified in this review reported using surveys as the main evaluation method, which may limit understanding given known biases resulting from exclusive reliance on self-report

data (Adamsen *et al.*, 2013). Only three studies reported the use of methods that do not rely on self-report: sales data and observations. There is, therefore, a third significant gap in the literature – future studies using methods that extend beyond self-reporting, such as observations, are needed to gain a more accurate understanding of the effectiveness of health sponsorship on behavioural change. Additionally, methods exist permitting effects to be tested in isolation. For example, use of eye-tracking enables a team to assess whether messages placed in a venue attract target audience attention, which can provide a more direct assessment ensuring that any awareness and image reported is not reflecting the wider campaign.

Communication and structural change aims have been previously identified as the main aims of health sponsorship (Jalleh *et al.*, 2002). However, Jalleh *et al.* (2002) emphasised that it is unrealistic to expect that health sponsorship on its own and in a short period of time can have a direct effect on behaviour. In our systematic review, policy aim (structural change) was the main aim in the two large sponsorship programmes run by Healthway and VicHealth. Only four studies reported behavioural aims. As expected, policy change outcomes were reported by ten studies, and ten studies also showed significant change in awareness. However, behavioural outcomes were reported in only three studies. Our results, therefore, confirm that health sponsorship can be effective in raising awareness and achieving policy aims; however, there is very limited (albeit positive) evidence that health sponsorship can lead to change in attitudes, social norms and behaviours. However, in 1994, Andreasen stated that "the bottom line of social marketing is behaviour change" (p. 111). Behaviour change can be found in all social marketing benchmark criteria classifications (Andreasen, 2002; French and Blair-Stevens, 2006; Walsh *et al.*, 1993), as behaviour change is fundamental to evaluating campaign success. Social marketing scholars, French and Blair-Stevens (2006, p. 1) stated that social marketing must have "a clear focus on behaviour, based on a strong behavioural analysis, with specific behaviour goals". There is, therefore, the fourth gap in the literature – future studies are needed to explore the influence of sports sponsorship on attitudes, social norms and behaviours.

## Practical implications

All practical implications identified in this review must be viewed in light of the limited evidence currently available. (Limited) evidence exists, indicating that smaller sponsorship values may be more effective in delivering changes than sponsorships of a larger value. For example, the evidence drawn from Holman *et al.* (1996) indicates that small sponsorship projects were more cost-effective than larger sponsorship projects. Outcomes reported in the review suggest that practical leverage can be gained by providing smaller grants to more organisations to enhance outcomes.

Sponsorships requiring structural change delivered enhanced outcomes in comparison to sponsorships-seeking communication and/or policy only change. The introduction of practices in Surf Lifesaving Victoria Association for lifesavers delivered long-term outcomes and sustained change at a national level over time (Dobbinson *et al.*, 1999). To best leverage sponsorship, it is recommended that sponsorship agreements seek practice change as the key deliverable rather than communication or policy aims.

## Conclusions, limitations and future research directions

This paper provided a systematic review of evaluations of public health and social marketing campaigns reporting the use of sports sponsorship. Although 17 peer-reviewed studies reporting evaluations of sports sponsorship programmes and campaigns in social marketing and public health were identified, only one study has been published in the past

10 years, confirming that sponsorship literature is largely conceptual in nature (Madill *et al.*, 2014). This research contributes to our knowledge of the actual and potential impact of sports sponsorship in social marketing and health promotion in two main areas. First, the systematic literature review reported in this paper provides an overview of the current state of play by systematically reviewing and synthetising a large amount of information included in identified studies to provide insights into some key aspects of sponsorship campaigns, including locations, target audiences, aims, evaluation methods and outcomes. The results indicate that sport sponsorship can be very effective in influencing policy and raising awareness. However, there is only limited positive evidence that sport sponsorship can be used to facilitate positive behaviour change. Second, the results of the literature review were used to identify four gaps in the literature and recommend future research areas in sports sponsorship in social marketing in public health. The areas for future research are the empirical evaluation of the use of sponsorship in social marketing and public health campaigns; the assessment of the role, scope of involvement in, aims and benefits of non-government sponsors of public health and social marketing campaigns; and the measurement of the impact of sports sponsorship on attitudes, social norms and behaviours. From a methodological viewpoint, the contribution to knowledge of future studies could be augmented by data collection methods that do not rely on self-reporting alone.

This review has important limitations. First, analysis presented in this review included information that was reported in the identified studies, which might be an incomplete representation of work undertaken but not reported. Many of the excluded studies did not report details of their sponsorship programmes or evaluations of those programmes. Social marketing and public health studies tend to report campaign outcomes rather than the process through which such outcomes are achieved. It is, therefore, important for researchers when presenting the outcomes of their campaign to describe the campaigns and report their results in a comprehensive manner to enable future systematic reviews of evidence. Second, all of the studies identified in this review were conducted in English-speaking countries. Future reviews should be conducted in other languages to review studies and campaigns which might have not been published in English.



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