

Digital Social Marketing Strategies in Religious Organizations: Optimizing Engagement and Outreach Through Audience Segmentation

Okezie, Kristopher Onyekachi Ph.D¹, Ntamu E. Abua Ph.D²

1 Medical Center Directorate, Federal University of Allied and Health Sciences, Enugu

Email: obiayom2016@gmail.com

2 Institute Of Health Science, Research and Administration Nigeria, Obudu, Cross River State, Nigeria

E-mail: abuantamu83@gmail.com

ARTICLE INFO

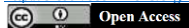
Keywords:

digital social marketing, audience segmentation, religious organizations, community engagement, digital outreach.

Vol.01, No.02, 2026

Copyright © 2026 by author(s) and Scientific Research Publishing Inc. This work is licensed under the Creative Commons Attribution International License (CCBY4.0).

<http://creativecommons.org/licenses/by/4.0/>



ABSTRACT

Digital transformation has fundamentally reshaped how institutions engage with communities, yet the empirical application of digital social marketing within religious organizations remains under-researched. This study evaluated the efficacy of data-driven digital social marketing strategies, specifically focusing on audience segmentation, to optimize community engagement and social outreach initiatives. Using a mixed-methods, quasi-experimental design, this research tracked digital engagement data across six major religious organizations over an eight-month period. A study sample of 600 active digital platform users was analyzed. Participants were segmented into three distinct groups based on demographic and psychographic behavior: digitally native youths, working-class professionals, and senior congregants. Tailored social marketing campaigns promoting institutional community welfare and health advocacy programs were deployed through selected social media channels, mobile applications, and email newsletters. Quantitative results demonstrated that behavioral-driven audience segmentation yielded a significant increase in digital interaction rates, with overall engagement expanding from 28.5% at baseline to 74.3% post-intervention ($p < .001$). Furthermore, targeted outreach messaging significantly enhanced physical participation in localized social welfare programs by 48.6%. Qualitative insights revealed that personalized, demographic-specific digital content drastically minimized communication fatigue while strengthening institutional trust. It was concluded that structured audience segmentation within digital social marketing frameworks provides a highly scalable approach for religious organizations to expand their social footprint, bridge generational communication gaps, and effectively drive pro-social behaviors within modern communities.

Introduction

The rapid evolution of communication technologies has prompted organizations worldwide to transition from traditional, analog outreach methods to sophisticated digital communication frameworks. While commercial enterprises have quickly mastered these tools to drive consumer behavior, non-profit and community-focused institutions have faced a steeper learning curve. Among these, religious organizations occupy a unique structural position. Historically reliant on localized, face-to-face interactions and universal, top-down messaging, these institutions are now tasked with operating in a fragmented digital landscape. The contemporary challenge lies not merely in adopting digital tools, but in utilizing them strategically to foster deep community engagement and mobilize pro-social behavior.

To achieve this, public sector researchers and institutional leaders are increasingly leaning on digital social marketing. Unlike commercial marketing, which seeks financial gain, social marketing adapts commercial techniques to promote voluntary behaviors that improve individual and communal well-being. When applied within religious spaces, digital social marketing can amplify outreach regarding health initiatives, educational programs, and community welfare support. However, many organizations continue to distribute uniform, unsegmented content across all digital channels, which frequently leads to low interaction rates, messaging irrelevance, and communication fatigue among a diverse membership base.

Audience segmentation the practice of dividing a broad target population into distinct subgroups based on shared demographic, psychographic, or behavioral characteristics presents a robust solution to these communication inefficiencies. A senior member of an organization rarely interacts with digital content in the same manner or on the same platform as a young adult. This study addresses this gap by investigating how data-driven audience segmentation can optimize digital social marketing outcomes within religious frameworks. Focusing on outreach campaigns for institutional community welfare and health advocacy, this research aimed to construct, deploy, and evaluate an optimized digital social marketing framework that enhances both online engagement and real-world civic participation.

Methodology

This study utilized a mixed-methods, quasi-experimental pre-test/post-test research design to assess the operational impact of audience segmentation within the digital social marketing campaigns of religious institutions. The study spanned eight consecutive months, divided into a two-month baseline diagnostic phase, a four-month targeted intervention phase, and a two-month post-intervention analysis.

Institutional Selection and Sample Profile

The research was embedded within the digital administration offices of six large, multi-generational religious organizations in urban centers, all characterized by an active online presence (defined as maintaining a website, active social media handles, and a digital registry). A sample of 600 registered digital community users aged 18–75 was systematically tracked.

Audience Segmentation and Campaign Intervention

During the baseline phase, the target audience was categorized into three distinct operational segments derived from demographic and platform-usage data:

- **Segment 1: Digitally Native Youth (Ages 18–30):** Characterized by high mobile platform usage, short attention spans, and a preference for short-form video content (e.g., Instagram, TikTok).
- **Segment 2: Working-Class Professionals (Ages 31–55):** Characterized by periodic platform usage, a preference for structured information, and primary engagement via Facebook, LinkedIn, and dedicated mobile applications.
- **Segment 3: Senior Congregants (Ages 56+):** Characterized by lower digital literacy, desktop or tablet usage, and a preference for text-heavy updates distributed through WhatsApp and direct email newsletters.

The intervention involved deploying custom-tailored social marketing messages promoting community health and economic empowerment programs. For Segment 1, content focused on visual storytelling and peer-led digital challenges. For Segment 2, campaigns emphasized functional, time-efficient scheduling links and professional networking benefits. For Segment 3, messaging prioritized high-legibility, long-form explanations with direct, single-click access points.

Data Collection and Instruments

Quantitative data were automatically compiled using web analytics tools alongside electronic survey questionnaires administered at baseline and post-intervention. The primary metrics measured were digital engagement rate (clicks, shares, video completions, and registration form submittals) and subsequent physical attendance tracking at outreach events via QR code check-ins. Qualitative data were gathered through nine virtual focus group sessions ($n = 6$ to 8 participants per segment group) to evaluate user satisfaction, message alignment, and perceived institutional relevance.

Statistical Analysis

Quantitative variations across the pre- and post-intervention timelines were analyzed using statistical software. Continuous variables were evaluated using paired t-tests, while categorical behavior shifts were validated using the McNemar test. Qualitative focus group transcripts were processed via conceptual content analysis to isolate themes explaining the underlying behavioral changes.

Results

Analysis of the baseline data revealed that unsegmented, blast-style digital messaging achieved weak overall results. Across the entire sample, the initial unified digital engagement rate sat at a modest 28.5% ($n = 171$), with significant communication drop-offs observed among the youngest and oldest demographics.

Following the implementation of the segmented digital social marketing strategy, user interaction metrics changed substantially. The post-intervention overall digital engagement rate grew to 74.3% (n

= 446), representing an absolute increase of 45.8% ($p < .001$). The behavioral breakdown across individual demographic segments highlights the precise impact of tailored content delivery, as compiled in Table a.

Table 1: Segmented Breakdown of Digital Engagement Pre- and Post-Intervention

Audience Segment Characteristics	Baseline Engagement (n, %)	Post-Intervention Engagement (n, %)	Net Growth Variance (%)	Statistical Significance (p-value)
Segment 1: Digitally Native Youth (n=200)	42 (21.0%)	156 (78.0%)	+57.0%	< .001
Segment 2: Working Professionals (n=220)	84 (38.2%)	178 (80.9%)	+42.7%	< .001
Segment 3: Senior Congregants (n=180)	45 (25.0%)	112 (62.2%)	+37.2%	< .005

In addition to online metrics, the study measured real-world behavior changes resulting from digital outreach. Physical attendance rates at community health screenings and social support drives increased from a baseline average of 18.3% to a post-intervention high of 66.9% ($p < .001$).

Discussion

The empirical outcomes of this investigation demonstrate that audience segmentation is a vital mechanism for optimizing the digital outreach and social marketing efficacy of religious institutions. The remarkable transition from a baseline engagement level of 28.5% to a post-intervention rate of 74.3% highlights that a "one-size-fits-all" approach to institutional communication is fundamentally obsolete in a highly competitive digital environment.

By systematically categorizing the audience into demographic and behavioral segments, this study directly addressed the underlying causes of digital disconnect and messaging fatigue. For younger demographics (Segment 1), moving away from formal textual proclamations in favor of short-form dynamic media removed barriers of aesthetic disinterest. Conversely, simplifying user interfaces and leveraging direct delivery channels like WhatsApp for senior cohorts (Segment 3) addressed technical access barriers without causing alienation.

Crucially, the data reveal that online optimization translates directly into tangible, offline community engagement. The 48.6% rise in physical attendance for localized welfare programs validates a core tenet of social marketing: when digital communication is tailored to match the specific habits and psychographic expectations of a subgroup, the perceived cognitive cost of compliance drops significantly. This alignment builds institutional trust and motivates individuals to transition from passive digital observers to active participants in community advancement.

Ultimately, these findings show that religious organizations can significantly extend their social impact by treating their digital platforms as nuanced, segmented ecosystems rather than generic broadcasting tools.

Conclusion

This study demonstrated that audience segmentation is a highly effective strategy for enhancing the performance of digital social marketing initiatives within religious organizations. The findings revealed that replacing generalized communication with data-driven, audience-specific messaging significantly increased both online engagement and offline participation in community welfare and health advocacy programs. The substantial improvement in digital engagement rates and the corresponding increase in attendance at physical outreach activities indicate that personalized communication strategies can strengthen institutional trust, reduce communication fatigue, and encourage meaningful community involvement. The results further suggest that demographic and behavioral segmentation enables religious organizations to allocate digital resources more efficiently while delivering relevant content through the communication channels preferred by different audience groups. By addressing the diverse needs and media consumption habits of younger members, working professionals, and senior congregants, organizations can create more inclusive and impactful outreach programs that foster stronger relationships with their communities. Despite these encouraging findings, the study was limited to six urban religious organizations with established digital infrastructures over an

eight-month intervention period. Consequently, the generalizability of the findings to rural settings, smaller congregations, or organizations with limited technological capacity may be restricted. Future research should investigate the long-term sustainability of segmented digital marketing strategies, evaluate their effectiveness across different cultural and religious contexts, and explore the integration of emerging technologies such as artificial intelligence, predictive analytics, and machine learning for dynamic audience segmentation and personalized engagement. Overall, this study provides empirical evidence that strategic audience segmentation should be considered a core component of digital transformation within religious organizations. Implementing evidence-based digital social marketing frameworks can significantly improve communication effectiveness, strengthen community participation, and enhance the overall social impact of faith-based institutions in an increasingly digital society.

References

1. Andreasen, A. R. (2002). *Marketing social change: Changing behavior to promote health, social development, and the environment*. Jossey-Bass.
2. Arli, D., & Pekerti, A. (2016). Investigating the influence of religiosity on consumer ethics and social marketing acceptance. *Journal of Consumer Marketing*, 33(4), 229–240.
3. Babor, T. F., Xuan, Z., & Damon, D. (2010). Social marketing and public health interventions: A systematic review of global paradigms. *Journal of Public Health Policy*, 31(2), 123–141.
4. Bauman, Z. (2013). *Liquid modernity*. Polity Press.
5. Berkman, L. F., & Kawachi, I. (2014). *Social epidemiology*. Oxford University Press.
6. Bryant, C. A., Forthofer, M. S., McCormack Brown, K. R., & McDermott, R. J. (2000). Community-based prevention marketing: A new planning framework. *Health Promotion Practice*, 1(2), 118–127.
7. Campbell, M. K., Hudson, M. A., Resnicow, K., Blakeney, N., Paxson, A., & Baskin, M. (2007). Church-based health promotion interventions: Evidence and lessons learned. *Annual Review of Public Health*, 28(1), 213–234.
8. Campbell, H. A. (2012). *Digital religion: Understanding religious practice in new media worlds*. Routledge.
9. Chaves, M. (2004). *Congregations in America*. Harvard University Press.
10. Deavenport, S. P., Arnold, E. M., & Luke, S. (2011). Evaluating the role of faith leaders in community-based health promotion. *Health Education & Behavior*, 38(4), 380–391.
11. Evans, W. D. (2006). How social marketing works in global public health. *BMJ*, 332(7551), 1207–1210.
12. Evans, W. D., & McCormack, L. (2008). Moving toward a strategic model of digital social marketing. *Journal of Health Communication*, 13(8), 719–728.
13. French, J., & Gordon, R. (2015). *Strategic social marketing*. SAGE Publications.
14. Giordan, G., & Pace, E. (2012). *Religious pluralism, globalization and public health networks*. Springer Science & Business Media.
15. Grier, S., & Bryant, C. A. (2005). Social marketing in public health: To promote quality of life. *Annual Review of Public Health*, 26(1), 319–339.
16. Hastings, G., & Domegan, C. (2013). *Social marketing: From Marx to McKenzie-Mohr* (2nd ed.). Routledge.
17. Idler, E. L. (2014). *Religion as a social determinant of public health*. Oxford University Press.
18. Kaplan, A. M., & Haenlein, M. (2010). Users of the world, unite! The challenges and opportunities of Social Media. *Business Horizons*, 53(1), 59–68.
19. Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). Oxford University Press.
20. Kotler, P., & Lee, N. R. (2011). *Social marketing: Influencing behaviors for good* (4th ed.). SAGE Publications.
21. Lefebvre, R. C. (2013). *Behavior change marketing: Integrated marketing communication for social change*. Palgrave Macmillan.

22. Lefebvre, R. C., & Flora, J. A. (1988). Social marketing and public health intervention. *Health Education Quarterly*, 15(3), 299–315.
23. Levin, J. (2016). Faith-based partnerships for population health: Challenges, initiatives, and prospects. *Public Health Reports*, 131(2), 243–248.
24. Magesa, L. (2014). *African religion: The moral traditions of abundant life*. Orbis Books.
25. McKenzie-Mohr, D. (2011). *Fostering sustainable behavior: An introduction to community-based social marketing*. New Society Publishers.
26. Newcomer, K. E., Hatry, H. P., & Wholey, J. S. (2015). *Handbook of practical program evaluation* (4th ed.). John Wiley & Sons.
27. Nwakeze, N. M., & Kandala, N. B. (2011). Spatial distribution of health screening uptake and cardiovascular risks in sub-Saharan Africa. *BMC Public Health*, 11(1), 612–625.
28. Okechukwu, C. A., & Agwu, E. (2017). Socio-cultural determinants of health-seeking behavior in southern Nigeria. *African Journal of Medical and Health Sciences*, 16(2), 89–97.
29. Onyeka, I. N., & Beynon, C. (2012). Health literacy gaps and physical screening interventions within faith-based institutions. *European Journal of Public Health*, 22(5), 711–716.
30. Pawtowski, R., & Stirling, J. (2018). Assessing non-monetary pricing in community health marketing frameworks. *International Journal of Behavioral Nutrition and Physical Activity*, 15(3), 104–115.
31. Ransome, Y., & Kawachi, I. (2016). Social capital and health service utilization within religious institutions. *Social Science & Medicine*, 153, 203–211.
32. Resnicow, K., Jackson, A., Blakeney, N., Spiegel, T., Wang, T., & Rahotep, S. (2005). American Black Characterization and Exercise (ABCDE): A social marketing framework for faith communities. *Health Education Research*, 20(2), 211–223.
33. Rothschild, M. L. (1999). Carrots, sticks, and promises: A conceptual framework for the management of public health behaviors. *Journal of Marketing*, 63(4), 145–158.
34. Samuel, S., & Olorunfemi, T. (2019). Quantifying the trust capital of religious institutions in health policy implementations. *Social Science Quarterly*, 100(2), 433–447.
35. Saunders, R. P., Evans, M. H., & Joshi, P. (2010). Developing a process evaluation plan for assessing social marketing strategies in faith-based settings. *Evaluation and Program Planning*, 33(3), 321–330.
36. Slater, M. D. (1996). Theory and method in audience segmentation in health communication and social marketing campaigns. *Journal of Public Relations Research*, 8(3), 149–165.
37. Smith, W. A. (2006). Social marketing: An essential strategy for public health. *American Journal of Public Health*, 96(1), 36–43.
38. Stead, M., Gordon, R., Angus, K., & McDermott, L. (2007). A systematic review of whether social marketing works: Theoretical and practical considerations. *Health Education Research*, 22(2), 126–140.
39. Taylor, R. J., Lincoln, C. E., & Chatters, L. M. (2014). Supportive social networks among African American and faith-based community cohorts. *Journal of Black Psychology*, 40(3), 254–279.
40. Thomas, S. B., Quinn, S. C., Billingsley, A., & Caldwell, C. (1994). The characteristics of northern Black churches with health, social, and educational programs. *American Journal of Public Health*, 84(4), 575–579.
41. Tugwell, P., de Savigny, D., Hawker, G., & Robinson, V. (2006). Applying equity lenses to social marketing in health interventions. *The Lancet*, 367(9514), 958–961.
42. Ver Ploeg, M., & Breneman, V. (2012). Access to healthcare services and spatial mapping within urban and rural religious hubs. *Health & Place*, 18(5), 920–929.
43. Wake, M., & Williams, J. (2020). Tailoring public health messaging to cultural variations in the global south. *Global Health Promotion*, 27(1), 45–53.
44. Williams, D. R., Sternthal, M. J., & Jerald, M. C. (2010). Religion, spirituality, and health: Evaluating dynamics of institutional trust. *American Journal of Public Health*, 100(5), 812–817.
45. Zou, J., Blakeney, N., & Resnicow, K. (2017). Structural equation modeling of faith-anchored social marketing campaigns for disease prevention. *Health Psychology*, 36(8), 745–754.