

Bracht, N. & Rice, R. E. (2012).
Community partnership strategies in health campaigns.
In R. E. Rice & C. K. Atkin (Eds.),
Public communication campaigns
(4th ed., Chapter 20, pp. 289-304).
Thousand Oaks, CA: Sage.

Community Partnership Strategies in Health Campaigns

Neil Bracht and Ronald E. Rice

This chapter reviews lessons learned from numerous community studies and experiences that have employed a community involvement orientation. Commitment of campaign planners and professionals to community empowerment and capacity building not only adds to the material and human resources needed for any given campaign but also increases the likelihood that campaign results endure beyond the campaign or project period (Thompson & Winner, 1999). The chapter discusses four major themes: 1) community collaboration, 2) community change theory, 3) a five-stage model of basic strategies in planning and organizing at the community level, and 4) a summary of lessons learned and future research implications.

COMMUNITY COLLABORATION: PERSPECTIVES ON PARTNERSHIP APPROACHES

Looked at broadly, the concept of *citizen participation* is a fundamental aspect of civic life and democratic tradition. Numerous examples of community improvement are initiated through civic action and volunteer effort (sometimes with and sometimes without professional input). Some health problems clearly require a community orientation and involvement, such as for disaster preparedness and management (International Federation of Red Cross and Red Crescent Societies, n.d.). When disparate community resources and talents are mobilized for a specific campaign goal, the larger community can be energized for action, utilizing all institutional sectors (e.g., media, schools, work sites, government, business, civic groups, etc.). This intersecting integration allows for the incorporation of campaign goals throughout several sectors of daily community life.

This paradigm shift to community-wide or population-based models of intervention has fostered hundreds of community health promotion and research projects. Chapters in Bracht (1999) provide international examples, while Mittelmark (1999) reviewed many diverse projects. In keeping with the goal of community empowerment and capacity

building, many community-based projects use lay volunteers and leaders to deliver campaign interventions. Nearly 50% of Americans volunteer annually (Review and outlook, 1999). This citizen pool is an enormous resource of talent and energy and has been used to achieve many of the goals of the health promotion movement (Breslow, 1999), such as church group involvement in heart health campaigns (Lasater, Abrams, Artz, Beaudin, Cabrera, Elder et al., 1984) or local citizens advocating enforcement of alcohol sale ordinances for minors (Veblen-Mortenson, Rissel, Perry, Forster, Wolfson, & Finnegan, 1999). Basing a campaign within a local community context also generates opportunities for members to observe other members engaging in the promoted behaviors, leading to greater compliance with (here, televised and workplace) media messages, as in the case of a community-based, physical activity campaign in Yuma County, Arizona (Renger, Steinfeldt, & Sydney, 2002).

The use of community-based organizations and associations to assist in broad public health work is, of course, not a new phenomenon (see Paisley & Atkin, Chapter 2). Starting in the late 1800s, block committees of local mothers were organized in support of early maternal and child health clinic goals (e.g., Hull House in Chicago). Also in Chicago, in the 1890s, two community organizations (one founded by women) worked for citywide reform of garbage collection (Knight, 2007). The National Citizens' Committee on Prevention of Tuberculosis worked closely with public health professionals to combat infectious diseases in the early 1900s. The National Mental Hygiene movement of the 1930s was a citizen-based group that was instrumental in achieving important reforms in the treatment of the mentally ill. Today, hundreds of voluntary health and social reform groups (e.g., The American Cancer Society, Mothers Against Drunk Drivers) bring outstanding volunteer resources to community improvement programs.

A very extensive and influential example of community-oriented campaigns was the Stanford Five City Project (1978 to 1992) to reduce cardiovascular disease. Underlying premises were that 1) attempts to change behavior must go beyond individuals and include the family, social, and cultural contexts, 2) affecting the interactions between personal and environmental factors requires intervention strategies in multiple community domains, and 3) all community members could benefit (Flora, 2001; Fortmann, Flora, Winkelby, Schooler, Taylor, & Farquhar, 1995; Schooler, Farquhar, Fortmann, & Flora, 1997).

In addition to standard campaign goals of 1) knowledge and attitude change, 2) behavior change (e.g., diet, activity, smoking cessation, and weight reduction), and 3) risk reduction (e.g., cholesterol level), it also included an educational program and extensive community mobilization. The community mobilization orientation applied principles of consensus development with community constituencies (e.g., to institutionalize education programs), social actions to mobilize community members (e.g., advocacy to create smoke-free environments), and social planning through use of community-collected objective data to guide system-wide change. The project's formative evaluation included an organizational needs analysis based on interviews with leaders, gatekeepers, and workplace personnel to identify community resources and readiness for change. Community organizations were then brought into project advisory groups, helped develop institutional programs, and promoted the project. Community organizations played a supplemental role as metachannels of health information via mechanisms of instrumental material support and affinity-oriented social support (Stephens, Rimal, & Flora, 2004).

Intervention components (each evaluated) included: 1) media (TV programs and PSAs, radio series, doctors' columns in newspapers, mass mailings, information booklets, and self-help kits), 2) more than 800 sessions of formal and informal, face-to-face education (delivered by community teachers and health educators), 3) workplace programs (distributing print materials, providing workshops, sponsoring contests, and measuring environmental risks), 4) educational programs involving schools, school administrators, teachers, students, and families, 5) implementation of health food programs and menu labeling in restaurants, cafeterias, and grocery stores, 6) health professionals who participated in training programs, received and distributed materials, and applied risk reduction programs in their practices, 7) contests in both work sites and the general community with incentives to change smoking, exercise, nutrition, and weight control behaviors, and 8) sustainability of program components through cooperative learning methods to community health educators.

In an application of this model in two South Carolina communities, Croft, Temple, Lankenau, Heath, Macera, and Eaker (1994) described how a comprehensive, community-based nutrition intervention to reduce risk of cardiovascular disease included classes, grocery store tours, a supermarket point-of-purchase program, a restaurant labeling program, speakers' bureaus, home study courses, work site nutrition programs, and mass media coverage (such as local radio and TV PSAs, talk shows, and newspaper articles).

Internationally, NGOs play similar roles in providing citizen input and leadership. One of the pioneering community-based studies to reduce heart disease, the North Karelia Project in Finland (Puska, Nissinen, Tuomilehto, Salonen, Koskela, McAlister, et al., 1985), utilized the local voluntary heart association as a major partner in conducting the campaign to inform the citizens of very high rates of heart-related mortality in the region. Other groups in agriculture and food processing were also involved. The Global Transport Knowledge Partnership (<http://www.gtkp.com/theme.php?themepgid=93>) also reinforces the notion that community partnership in campaigns (here, road safety) avoids the limited effects and lack of engagement in traditional top-down public health campaigns, illustrated through case examples ranging from Bangladesh to Thailand and South Africa.

COMMUNITY CHANGE THEORY: MULTIPLE APPROACHES

Community Change Theory

Thompson and Kinne (1999) reviewed and integrated various change theories (e.g., behavioral, organizational, environmental, etc.), including both community and wider environmental and societal factors. A unifying construct in the application of social change theory to population health is the view of the community as a dynamic system in which change or alteration in one segment or institutional sector will have influence on one or more other sector(s) (a systems perspective; see also Rice and Foote, Chapter 5). The health promotion movement generally targets multiple sectors (churches, work sites, schools, etc.) of the entire community system in order to maximize intervention dissemination throughout the broader population. Community collaboration also helps to integrate the program in

existing social and administrative structures (Bryant, McCormack Brown, McDermott, Forthofer, Bumpus, Calkins, et al., 2007). Of course, enhanced marketing or organizing strategies can simultaneously occur in selected sectors (e.g., special outreach efforts or involvement of Hispanic churches in the religious sectors of a city).

Behavioral and Advocacy Approaches

Many of the earlier health promotion projects focused on behavioral change outcomes only (e.g., smoking cessation, improved diet and exercise). The overall results have been mixed (see Fortmann et al., 1995; Kottke, 1995; Mittelmark, 1999; Seedhouse, 1997; Shea & Basch, 1990; Snyder & LaCroix, Chapter 8).

Recent social advocacy approaches (e.g., stronger enforcement of penalties in proven illegal tobacco or alcohol sales to minors) have offered alternative strategies (see Dorfman & Wallack, Chapter 23). For example, a community alliance in a small city in Western Australia developed a public health advocacy campaign to deal with increased road traffic (Gomm, Lincoln, Pikora, & Giles-Corti, 2006). It was successful in pressuring key stakeholders (via attracting public attention, reframing media messages, and providing alternative policies) to alter road policies. Increasingly, both behavioral and social advocacy approaches are being combined in community campaigns.

Social Marketing Approaches

Another trend is to combine social marketing with community campaigns (Grier & Bryant, 2005; Middlestadt, Schechter, Peyton, & Tjugum, 1997). The social marketing perspective highlights the audience's balance between barriers and benefits and the components of commitment, prompts, norms, effective messages, incentives, design, and evaluation (McKenzie-Mohr, 2010). This perspective involves five primary domains (Andreason, 2005; Kotler & Lee, 2007). The first is a philosophy of *exchange*, where consumers (or at-risk populations, campaign audiences, etc.) enter into a fair arrangement with providers and campaign sponsors so that both meet their needs. This means that campaign designers must understand those needs and construct messages and interventions that provide exchange value rather than imposing their values or presuming what constitutes a satisfying exchange. The second is an ongoing, *iterative research* strategy as needs, subgroups, and external conditions change over time. The third is the *marketing mix*, or the appropriate emphasis upon the combination of the 4 Ps: *product benefits* (perceptions, uses, attributes), *price* (including all individual, social, and institutional barriers to change), *place* (the infrastructure and social system enabling or preventing one from engaging the service, product, or behavior, including training, sales, advice, etc.), and *promotion* (including not just the traditional campaign message but also user education, interpersonal support, public relations, conferences, etc., provided through appropriate channels and media). Finally, social marketing emphasizes the importance of *positioning* the message, product, or service within the context of competing messages, products, services, attitudes, fears, expectations, and norms (such as from friends or advertisements advocating cigarette smoking) and oriented toward relevant and changing audience segments.

The combined principles from community-based campaigns and social marketing are being applied to community-based prevention marketing (CBPM) projects such as the University of Florida's Prevention Research Center's program to prevent initiation of smoking and alcohol consumption among middle-school students in one county, with parents, school staff, and youth-oriented community organizations as secondary audiences (Bryant, Forthofer, Brown, Landis, & McDermott, 2000; Bryant et al., 2007; Bryant, McCormack Brown, McDermott, Debate, Alfonso, Baldwin, et al., 2009). This project team essentially helps bring together and train community partners and coalitions in social marketing concepts and practices, but the community's advisory committee leads the stages. Another project extended the national media campaign promoting physical activity (the VERB™ campaign during 2002 through 2006) by developing a Summer Scorecard (<http://www.cdc.gov/youthcampaign/partners/scorecard/scorecard.htm>) as one way to reduce childhood obesity. The program provided tweens a card with 24 physical activity squares, upon which an authorized adult could confirm each activity. Upon completion, they could turn in their card for prizes (also related to physical activity). The program also aimed to increase awareness of activity possibilities and provide a handy way for parents to remind their children to exercise. From 2002 to 2007, surveys involving from 2,600 to 4,000 respondents showed that awareness of the Summer Scorecard rose from 35% to 79%, and the number of scorecards submitted went from 355 to 1,720, although completion of the scorecard rose only from 25% to 30%.

Community-Based Social Marketing (<http://cbsm.com>) is an online guide describing how to use community-based social marketing to design and evaluate programs to foster sustainable behavior in the areas of agriculture and conservation, energy, transportation, waste and pollution, and water (see also McKenzie-Mohr, 2010).

BASIC STRATEGIES IN ORGANIZING COMMUNITY CAMPAIGNS: A FIVE-STAGE MODEL

We now consider the stages and key tasks of community mobilization and campaign implementation using a five-stage model, summarizing Bracht, Kingsbury, and Rissel's (1999) detailed description and the many activities associated with each stage. It should be noted that these stages are overlapping, and some tasks may need to be repeated in later stages. For example, planning tasks for durability of effort should begin in the analysis phase, but progress and finalization of plans need to be assessed in the maintenance and dissemination stages as well.

Stage One: Conduct a Community Analysis

Commitment to community participation in campaigns requires above all else a knowledge of the assets, capacity, and history of a local community. While all communities share certain definable functions (e.g., social participation, social control, etc.), a careful mapping of the community brings forth the unique qualities, norms, and modes of organization in each community (McKnight, 1988), allowing realistic matching of goals with

citizen readiness, expectations, and resources. The product of community analysis is a dynamic profile that blends health and illness statistics with demographic, political, and sociocultural factors.

Key Task 1: Define the Community

Community is a term that has different meanings and interpretations. Hillery (1955) studied 94 definitions of community and found that 73% of the definitions agreed that social interaction, area, and common ties were frequently found features. Rissel and Bracht (1999) discuss the implications of using differing conceptual approaches to the study of a community. Clarity about target audience or geographical boundaries, and so on, must be achieved early and in consultation with local representatives. If more than one community in a region is to be involved, patterns of cooperation, commerce, jurisdictions, and regulations among and across the communities may need special analysis.

Key Task 2: Initiate Data Collection

Community analysis requires the collection and analysis of a wide range of data in order to achieve a comprehensive profile of the campaign area or target group. Rissel and Bracht (1999) summarize these various data needs—generalized community characteristics, structure and history; health-wellness outcomes assessment; health risk profile (behavioral, social, and environmental risks); community health promotion survey; and specialized studies (gatekeepers, influentials)—and the likely sources of such information. In a community approach, citizens and local organizations are directly involved in this study process. Some of the information required may have already been compiled locally or is available from past community projects in the area.

Key Task 3: Assess Community Capacity and Readiness for Change

A primary assessment focus in community-wide health promotion programs is the study of social institutions or organizational sectors (education, health, recreation business and labor, etc.) and the possibilities for coordinating community-wide programs of health action. Leadership persons are often the source of this information, and their willingness to cooperate is another indicator of community support or readiness for program initiation. Rissel and Bracht (1999) discuss techniques and approaches used to study leadership patterns. Community readiness for change can be measured by a combination of factors, such as past history of cooperative community action, degree of support and enthusiasm among community influentials for the current project, willingness to commit organizational resources, local skill level (e.g., quit smoking counseling) of lay citizens and professionals available for use in the campaign, and the presence of motivated advocates or visionaries supporting the project.

Stage Two: Design and Initiation of a Campaign

A core planning group of citizens and professionals will usually begin the process of establishing a more permanent organizational structure (e.g., coalition) to elicit and coordinate

broader citizen support and involvement. This group's responsibilities may also include calling public attention to the data analysis and identified community needs, writing a mission statement, and selecting a community-based project coordinator. Some preliminary decisions will likely have to be made about campaign objectives and initial intervention design(s). Later, these decisions will be approved by the permanent citizen organization.

Key Task 1: Develop an Organizational Structure for Collaboration

There are several alternative structures for organizing community involvement and participation, including an advisory board, coalition, lead agency, informal network, and so on, each with pros and cons (Thompson & Winner, 1999). Sometimes, existing agencies or coalitions can be used as collaboration structures for campaigns, thus avoiding the start-up time required for new organizations. The type of structure chosen should be based on community factors such as culture and history of change efforts, past decision-making styles, and any competing events or programs. Final choice of organizational structure usually rests with the community and its representatives. However, some funding agencies often prescribe in advance the community structure most preferred or recommended (e.g., coalition). This can be risky because one model seldom fits all communities, and citizen-based structures are dynamic, with organizational patterns often evolving into new or modified arrangements.

Coalitions involving multiple community groups and health organizations have become increasingly popular structures for implementing community health promotion efforts. *Coalition* has been defined as an organization of individuals representing diverse organizations, factions, or constituencies who agree to work together in order to achieve a goal, often in response to a specific issue or legislative goal. The major advantage of the coalition is that it involves a breadth and diversity of membership that may make, at times, for strange bedfellows but can cut across ideologies and constituencies in order to achieve results not attainable by more narrowly focused groups. Bracht and colleagues (1999) reviewed the literature on coalition effectiveness and found the following functions important to overall coalition productivity: leadership, management, communication, conflict resolution, perception of fairness, shared decision making, and perceived benefits versus costs (see also Dluhy & Kravitz, 1990). The Florida Kidcare campaign (Ray, White, Cannon, Powen, & O'Rourke, 2006) created coalitions involving child advocacy groups, community partners, and government agencies to inform families about a very short time frame in 2005 for enrolling their children in a state health insurance program. It succeeded in enrolling almost five times the average for any prior enrollment period.

Key Task 2: Increase Community Participation and Membership in the Organization

The core planning group contacts individuals to assess interest in serving on task forces or the executive committee of the new organization. Such collaboration may raise issues of both visible and invisible power relations, which emerged during a process evaluation of a community public health media campaign on HIV prevention for women (Champeau & Shaw, 2002). Thus, such issues should be raised and discussed very early on.

The experience and skill of a paid coordinator or community organizer is frequently used in health promotion programs. The person employed for this purpose must understand how change occurs in communities and must be knowledgeable about local history and values. Past experience in facilitating organizational collaboration, including good management skills, and in deploying volunteers is critical.

Key Task 3: Develop Early Intervention Design and Plans

During this phase of work, collaboration between community groups and outside professionals usually begins on intervention goals and design. A review of data collected from the analysis stage is a good beginning point for such deliberations. A heart disease prevention intervention(s) will require a close look at prevalence and incidence data to answer questions such as what the focus of intervention work should be (e.g., nutrition education, exercise, smoking cessation, rapid treatment). A task force of citizens and professionals can usually develop a preliminary plan within two to three months. The plan should include a preliminary evaluation and monitoring strategy as well. Pirie (1999) (and the evaluation chapters in this volume) provides a helpful guide to evaluation strategies in community-based health promotion. Later, the intervention goals and objectives will need the approval and support of the wider community group as mentioned above.

Stage Three: Campaign Implementation

Implementation turns theory and ideas into action, translating design into effectively operating programs. Organizations and citizens are mobilized and involved in the planning of a sequential set of activities that will accomplish campaign objectives. For example, a project in Haiti included community members in the design and implementation of disaster preparedness information campaigns through 22 local civil protection committees, each receiving technical and funding support during 2003 and 2004 (<http://www.comminet.com/node/277293>). Overall, these campaigns developed both public awareness as well as capacity building and contributed to developing a culture of safety.

Written intervention action plans with specific timelines have been shown to be critical forerunners of successful change efforts (Fawcett, Paine-Andrews, Francisco, Schultz, Richter, Lewis et al., 1995). Intervention cost estimates should be included in the plan, along with monitoring and feedback strategies. The key element in this stage is determining priority intervention activities and focusing efforts for maximum impact. Based on experience from other community projects, it has been learned that some community members may want to rush the intervention implementation process. There is a tendency to want to jump in with both feet and get the project going. Organizers need to channel enthusiasm, helping task forces and work groups to select, evaluate, and plan for best practices in implementation. While such "delays" can dampen the enthusiasm of more action-oriented volunteers, it is probably better to have to deal with this motivational issue than to see interest and commitment to the project dampened by early reports of negative results of interventions caused by poorly operationalized and delivered campaign strategies.

Key Task 1: Clarify Roles and Responsibilities of All Partners

Complex community campaigns require the coordinated effort of many people and resources. Role clarification at the outset is essential if the project is to unfold smoothly and systematically. For example, in a community stop-smoking campaign, how will the role of the local Heart Association be coordinated with the ongoing antismoking activities of the American Lung Association? A written understanding of intervention roles is often helpful, especially in large, coalition-led programs. A formal process called *responsibility charting* (explained in detail in Bracht, 1999, p. 99) helps participants to review some 30 tasks associated with campaign implementation—such as determine goals and priorities, community and public relations, staff hiring, design evaluation strategies, plan for durability, and so on—and decide on which person or group will be accountable for completion of required activities.

Key Task 2: Provide Orientation and Training

Effective citizen and volunteer involvement usually requires some level of additional training and skill development. For example, special classes in smoking cessation techniques for community professionals may be in order. Such training adds to community capacity building and also enhances the likelihood of the durability of ongoing campaign and community objectives.

Key Task 3: Refine Intervention Plan to Local Situation

No matter how good an intervention looks on paper or reported in the literature, when it is implemented in a community, it must speak that community's language (Vincent, Clearle, Johnson, & Sharpe, 1988). The approaches and messages must be acceptable to the community. For example, Ramirez (1997) and colleagues have developed a most useful training manual on mass media messages and community outreach for minority groups. Their work shows how to better integrate community values into the programs, materials, and messages of the campaign.

Key Task 4: Generate Broad Citizen Participation

Throughout the implementation process, continuing efforts to reach out to people and encourage their participation is required. Special attention to ways of involving minority communities may be needed if there is a history of noninclusion or lack of participation in health projects. Interviews with key community minority participants will help in this process and shed light on current or past difficulties with trust and collaboration (Kone & Sullivan, 1998).

Stage Four: Program Maintenance and Consolidation

During this stage, the citizen organization should be developing a solid foundation and acceptance in the community. Problems in implementation (e.g., media misses coverage of certain key events) will obviously have been encountered, but an indicator of community capacity building will be the ability to overcome and improve future intervention

activities. Campaign program elements should be more fully incorporated into the established structures of the community (e.g., exercise programs become a regular part of work site culture). Task forces of the local citizen organization need to reassess past efforts and determine any new tasks or directions of the program.

Key Task 1: Maintain High Levels of Volunteer Effort

Turnover of volunteers and even of paid staff is to be expected in multiyear projects. To counteract this, one needs to establish a plan to identify, recruit, and involve new people in the project on an ongoing basis. New sources of energy and commitment can be helpful to volunteers who may be experiencing some burnout characteristics. Typically, a small percentage of individuals provides much of a project's volunteer needs, and such projects may experience tensions between their needs and those volunteers' expectations, especially when there are racial differences (Boyle & Sawyer, 2010). Florin and Wandersman (1990) found that participation was more prevalent in people who were concerned about their neighborhood, had more experience in community leadership, and felt that other competent colleagues could be engaged in order to reach project goals. Peer support and morale are critical factors in group cohesion and continued participation. Appreciation letters to volunteers, celebratory luncheons, and training retreats are ways of enhancing volunteer morale and commitment to the project.

Key Task 2: Continue to Integrate Intervention Activities Into Community Networks

Integration of intervention activities into established community structures creates a broad context for the acceptance and adoption of health-promoting behaviors and norms. In one Midwest heart disease prevention project, local churches initiated a monthly exercise Sunday project into their routine service schedule. The project encouraged families to leave the car at home and walk, bike, or jog to church. Key influentials and stakeholders often assist in this kind of organizational adoption and integration of programs. For more discussion of this process, see Rissel, Finnegan, and Bracht (1995).

Stage Five: Dissemination and Durability

Communities and citizens need to receive clear, succinct messages describing what has been accomplished and what continuing effort may be required. Such messages are reinforcing when community influentials and decision makers, as opposed to professional experts, are involved in their presentation. How this dissemination process occurs is a basic element of a durability plan along with a vision for future programming.

Key Task 1: Reassess Campaign Activities and Outcomes

Final results of campaigns may not always be available in time for citizens and communities to act on future directions. Processes or formative evaluations that have been done during the campaign (for example, participation rates in health-risk screening programs, etc.) can help assist the project group in reassessing interventions that have worked and

those that have experienced difficulty. Steps in implementation can be retraced and analyzed. A report to the community should be drafted and submitted to the overall citizen group for review and comment. When complete, this report on campaign results becomes the foundation of a durability plan.

The CBPM project team discussed earlier evaluated the CBPM approach (Bryant et al., 2000, 2007) through process and impact evaluation. The process evaluation assessed the feasibility of the elements, community perceptions of the value of the elements, and the extent to which the project was managed in accord with community-based research and action. The impact evaluation assessed changes in community competence, durability, and sustainability; control and social capital; the use of social and prevention marketing in other community problems; and the extent to which the smoking prevention objectives were met. They also explained lessons learned, involving constituting the lead agency and coalition board, awareness of community profile information by board members, tensions and decision processes in selecting the risk and preventive behavior, increasing flexibility in applying policies, varying expertise and commitment by members, developing a valid marketing strategy, finding an appropriate company or agency to develop the materials, assuring sufficient board diversity, and requirements for sufficiently rigorous mixed-methods evaluation that did not exceed community members' patience and understanding (Bryant et al., 2007). Based upon these CBPM projects, Bryant and colleagues (2007) developed a revised nine-stage campaign process: Mobilize the community, develop a community profile, select the target behavior, enhance community capacity, conduct formative evaluation, develop a marketing strategy, develop the program, implement the program, track and evaluate, and provide feedback and adjust the stages (Fig. 1, p. 156).

Key Task 2: Refine the Durability Plan

The citizen group needs to address several important questions: What has been accomplished to date, and what do citizens desire to continue? What is the vision of the project for the future? What human resources would be required to continue interventions or modifications of same? Are any new skills required for the future, and what kinds of trainings might be required to finalize community capacity for maintaining such efforts? Finally, what kind of citizen structure will work for the future? The process of answering these questions may take several weeks or months, so it should be started as soon as possible.

Key Task 3: Update the Community Analysis

Part of durability planning may require updating the community analysis and profile. This involves looking for changes that have occurred in leadership, resources, and organizational relationships in the community. Key community members, opinion leaders, and organizations in a community will change over time. Reviewing these changes may point to a need for new collaborators and for efforts to recruit new board and task force members. Based on this new review of resources, programs are modified, expanded, or abandoned. Thompson and Winner (1999) developed a strategic planning model to be used by communities that wish to develop a detailed plan for durability of project effort.

Conclusion

The participatory community approach to campaigns in health promotion seeks to stimulate and fuse citizen energies, interests, and resources into a collective response for change. Often, this is done in collaboration with professional or research groups, but the decision-making role of community groups should remain paramount. The theories and principles of community organization and empowerment (Minkler & Wallerstein, 1997) are central to this approach.

Community-based campaigns are taking good advantage of the Internet to provide online tools and resources. For example, The Community Guide (<http://www.thecommunityguide.org/index.html>) of the CDC provides systematic evaluations, recommendations, evidence, and materials (including slides and promotional materials) based on more than 200 public health interventions in 18 topic areas. The Community Tool Box from the University of Kansas (<http://ctb.ku.edu/en/default.aspx>) offers extensive materials on all aspects of community campaigns, with 46 chapters and 300 sections including models for promoting community health and development, community assessment and agenda setting, promoting interest and participation, developing a strategic plan and organizational structure, leadership and management, designing or adapting community interventions, implementing community interventions, community building, effective advocacy, evaluating community programs, maintaining quality, generating and sustaining financial resources, social marketing, program sustainability, and research design and data collection. The Community Initiative (<http://www.comminit.com/en/about-global.html>) is an example of an online metacampaign community, which provides a wide array of resources for people and organizations applying communication for economic and social development change.

The Benton Foundation (<http://www.benton.org/node/6173>) applies its focus on community media and telecommunication to its New Routes to Community Health program, which uses local media to improve new immigrants' health. The Obesity Prevention Program of the CDC, University of North Carolina (<http://www.center-trt.org/index.cfm?fa=opstrategies.pa&page=community>) supports community-wide campaigns that engage mass media, social support programs, individual education, health fairs, physical activity events, and environmental changes to increase physical activity. Earthworks (<http://www.earthworksaction.org/communitysupport.cfm>) collaborates with local campaigns and community-based organizations concerned with implications and risks of proposed or existing mines. The Centers for Disease Control and Prevention (2009) provides very detailed guidelines and resources (what they call procedural guidance) for a range of community-based campaigns and interventions related to HIV/AIDS.

The key factors that seem to contribute most to successful citizen mobilization and community collaboration in campaigns, based on a wide range of national and international studies and experiences (e.g., see Bracht, 1999; Hopkins, Briss, Ricard, Husten, Carande-Kulis, Fielding et al., 2001; Norris, Nichols, Caspersen, Glasgow, Engelgau, Jack, Jr., et al., 2002; Shults, Elder, Sleet, Nichols, Alao, Carande-Kulis et al., 2001; Thompson, Corbet, Bracht, & Pehacek, 1993; Zaza, Sleet, Thompson, Sosin, Bolen, & Task Force on Community Preventive Services, 2001), include:

1. Early commitment of project leaders to partnership and community development approaches should be established.
2. Decision-making authority of citizen groups should be clearly defined. Resources to carry out designated roles and functions must be available and adequate and include skill development training opportunities.
3. A strong volunteer management and training program must be in place at the start of a campaign. This includes things such as regularly scheduled performance assessments, clearly stated time commitments, and planned recognition and celebratory events.
4. Timely use of conflict resolution strategies should be implemented when disagreements arise over project goals, research objectives, or implementation issues.

References

- Andreason, A. R. (2005). *Social marketing in the 21st century*. Thousand Oaks, CA: Sage.
- Boyle, M. P., & Sawyer, J. K. (2010). Defining volunteering for community campaigns: An exploration of race, self perceptions, and campaign practices. *Journal of Community Practice, 18*(1), 40–57.
- Bracht, N. (Ed.). (1999). *Health promotion at the community level: New advances* (2nd ed.). Thousand Oaks, CA: Sage.
- Bracht, N., Kingsbury, L., & Rissel, C. (1999). A five-stage community organization model for health promotion: Empowerment and partnership strategies. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 83–104). Thousand Oaks, CA: Sage.
- Breslow, L. (1999). Foreword. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. ix–xii). Thousand Oaks, CA: Sage.
- Bryant, C. A., McCormack Brown, K., McDermott, R. J., Debate, R. D., Alfonso, M. A., Baldwin, J. L., et al. (2009). Community-based prevention marketing: A new framework for health promotion interventions. In R. DiClemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research: Strategies for improving public health* (2nd ed., pp. 331–356). San Francisco: Jossey-Bass.
- Bryant, C. A., McCormack Brown, K., McDermott, R. J., Forthofer, M. S., Bumpus, E. C., Calkins, S., et al. (2007). Community-based prevention marketing: Organizing a community for health behavior intervention. *Health Promotion Practice, 8*, 154–163.
- Bryant, C., Forthofer, M., Brown, K. Mc., Landis, D., & McDermott, R. (2000). Community-based prevention marketing: The next steps in disseminating behavior change. *American Journal of Health Behavior, 24*(1), 61–68.
- Centers for Disease Control and Prevention. (2009). *Provisional procedural guidance for community-based organizations*. Retrieved July 15, 2011, from http://www.cdc.gov/hiv/topics/prev_prog/ahpl/resources/guidelines/pro_guidance/index.htm
- Champeau, D. A., & Shaw, S. M. (2002). Power, empowerment, and critical consciousness in community collaboration: Lessons from an advisory panel for an HIV awareness media campaign for women. *Women and Health, 36*(3), 31–50.
- Croft, J. B., Temple, S. P., Lankenau, B., Heath, G. W., Macera, C. A., Eaker, E. D., et al. (1994). Community intervention and trends in dietary fat consumption among black and white adults. *Journal of the American Dietetic Association, 94*(11), 1284–1290.

- Dluhy, M., & Kravitz, S. (1990). *Building coalitions in the human services*. Newbury Park, CA: Sage.
- Fawcett, S. B., Paine-Andrews, A., Francisco, V. T., Schultz, J. A., Richter, K. P., Lewis, R. K., et al. (1995). Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology, 23*, 677-697.
- Flora, J. (2001). The Stanford Community studies: Campaigns to reduce cardiovascular disease. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns* (3rd ed., pp. 193-213). Thousand Oaks, CA: Sage.
- Florin, P., & Wandersman, A. (1990). An introduction to citizen participation, voluntary organizations, and community development: Insights for empowerment through research. *American Journal of Community Psychology, 18*(1), 41-53.
- Fortmann, S., Flora, J., Winkleby, M., Schooler, C., Taylor, C., & Farquhar, J. (1995). Community intervention trials: Reflections on the Stanford five-city experience. *American Journal of Epidemiology, 142*, 576-586.
- Gomm, M., Lincoln, P., Pikora, T., & Giles-Corti, B. (2006). Planning and implementing a community-based public health advocacy campaign: A transport case study from Australia. *Health Promotion International, 21*(4), 284-292.
- Grier, S., & Bryant, C. A. (2005). Social marketing in public health. *Annual Review Public Health, 26*, 319-339.
- Hillery, G. A. (1955). Definitions of community: Areas of agreement. *Rural Sociology, 20*(2), 118-127.
- Hopkins, D. P., Briss, P. A., Ricard, C. J., Husten, C. G., Carande-Kulis, V. G., Fielding, J. E., et al. (2001). Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine, 20*(2S), 16-66.
- International Federation of Red Cross and Red Crescent Societies. (n.d.). Retrieved July 15, 2011, from <http://www.ifrc.org/en/what-we-do/disaster-management/>
- Knight, L. W. (2007). Garbage and democracy: The Chicago community organizing campaign of the 1890s. *Journal of Community Practice, 14*(3), 7-27.
- Kone, A., & Sullivan, M. (1998). *The community interview project: Promoting collaboration between communities and researchers*. Seattle, WA: King County Department of Public Health.
- Kotler, P., & Lee, N. (2007). *Social marketing: Influence behaviors for good* (3rd ed.). Thousand Oaks, CA: Sage.
- Kottke, T. (1995). Community-based heart disease prevention: The American experience. In P. Puska, J. Tuomilehto, A. Nissinen, & E. Vartiainen (Eds.), *The North Karelia Project: 20-year results and experiences* (pp. 331-343). Helsinki, Sweden: National Public Health Institute.
- Lasater, T., Abrams, D., Artz, L., Beaudin, P., Cabrera, L., Elder, J., et al. (1984). Lay volunteer delivery of a community-based cardiovascular risk factor change program: The Pawtucket experiment. In J. D. Matarazzo, S. H. Weiss, J. A. Herd, N. E. Miller, & S. W. Weiss (Eds.), *Behavioral health: A handbook of health enhancement and disease prevention* (pp. 1166-1170). New York: Wiley.
- McKenzie-Mohr, D. (2010). *Fostering sustainable behavior: An introduction to community-based social marketing* (4th ed.). Gabriola Island, British Columbia: New Society Publishers.
- McKnight, J. (1988). *Mapping community capacity*. Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University.
- Middlestadt, S., Schechter, C., Peyton, J., & Tjugum, B. (1997). Community involvement in health planning: Lessons learned from practicing social marketing in a context of community control, participation, and ownership. In M. Goldberg, M. Fishbein, & S. Middlestadt (Eds.), *Social marketing: Theoretical and practical perspectives* (pp. 291-312). Mahwah, NJ: Lawrence Erlbaum.
- Minkler, M., & Wallerstein, N. (1997). Improving health through community organization and community building. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), *Health behaviour and health education: Theory, research and practice* (2nd ed.). San Francisco: Jossey-Bass.

- Mittelmark, M. (1999). Health promotion at the community-wide level: Lessons from diverse perspectives. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 3-28). Thousand Oaks, CA: Sage.
- Norris, S. L., Nichols, P. J., Caspersen, C. J., Glasgow, R. E., Engelgau, M. M., Jack, Jr., L., et al. (2002). Increasing diabetes self-management education in community settings: A systematic review. *American Journal of Preventive Medicine*, 22(4S), 39-66.
- Pirie, P. (1999). Evaluating community health promotion programs: Basic questions and approaches. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 127-134). Thousand Oaks, CA: Sage.
- Puska, P., Nissinen, A., Tuomilehto, J., Salonen, J. T., Koskela, K., McAlister, A., et al. (1985). The community-based strategy to prevent coronary heart disease: Conclusions from the ten years of the North Karelia Project. *Annual Review of Public Health*, 6, 147-193.
- Ramirez, A. (1997). *En accion training manual*. (NIH Pub. No 97-4260). Bethesda, MD: National Cancer Institute.
- Ray, J., White, M., Cannon, P., Bowen, C., & O'Rourke, K. (2006). Implementing the Florida Kidcare open enrollment communications campaign: A framework for mobilizing community partners to reduce the number of uninsured children. *International Quarterly of Community Health Education*, 26(4), 365-377.
- Renger, R., Steinfeld, V., & Sydney, L. (2002). Assessing the effectiveness of a community-based media campaign targeting physical inactivity. *Family & Community Health: The Journal of Health Promotion & Maintenance*, 25(3), 18-30.
- Review and outlook. (1999). *Wall Street Journal*, December 17, p. 17.
- Rissel, C., & Bracht, N. (1999). Assessing community needs, resources and readiness: Building on strengths. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 59-71). Thousand Oaks, CA: Sage.
- Rissel, C., Finnegan Jr., J., & Bracht, N. (1995). Evaluating quality and sustainability: Issues and insights from the Minnesota Heart Health Program. *Health Promotion International*, 10(3), 199-207.
- Schooler, C., Farquhar, J. W., Fortmann, S. P., & Flora, J. A. (1997). Synthesis of findings and issues from community prevention trials. *Annals of Epidemiology*, 7(S7), 54-68.
- Seedhouse, D. (1997). *Health promotion: Philosophy, prejudice and practice*. Chichester, England: Wiley.
- Shea, S., & Basch, C. (1990). A review of five major community-based cardiovascular disease prevention programs. Part I: Rationale, design, and theoretical framework. *American Journal of Health Promotion*, 4, 202-213.
- Shults, R. A., Elder, R. W., Sleet, D. A., Nichols, J. I., Alao, M. O., Carande-Kulis, V. G., et al. (2001). Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *American Journal of Preventive Medicine*, 21(4S), 66-88.
- Stephens, K. K., Rimal, R. N., & Flora, J. (2004). Expanding the reach of health campaigns: Community organizations as meta-channels for the dissemination of health information. *Journal of Health Communication*, 9, 97-111.
- Thompson, B., Corbett, K., Bracht, N., & Pehacek, T. (1993). Lessons learned from the mobilization of communities in the Community Intervention Trial for Smoking Cessation (COMMIT). *Health Promotion International*, 8, 69-83.
- Thompson, B., & Kinne, S. (1999). Social change theory: Applications to community health. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 29-46). Thousand Oaks, CA: Sage.
- Thompson, B., & Winner, C. (1999). Durability of community intervention programs: Definitions, empirical studies and strategic planning. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 137-154). Thousand Oaks, CA: Sage.

- Veblen-Mortenson, S., Rissel, C., Perry, C., Forster, J., Wolfson, M., & Finnegan, Jr., J. (1999). Lessons learned from project Northland: Community organization in rural communities. In N. Bracht (Ed.), *Health promotion at the community level: New advances* (2nd ed., pp. 105-117). Thousand Oaks, CA: Sage.
- Vincent, M., Clearle, A., Johnson, C., & Sharpe, P. (1988). *Reducing unintended adolescent pregnancy through school-community educational interventions: A South Carolina case study*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control.
- Zaza, S., Sleet, D. A., Thompson, R. S., Sosin, D. M., Bolen, J. C., & Task Force on Community Preventive Services. (2001). Reviews of evidence regarding interventions to increase use of child safety seats. *American Journal of Preventive Medicine*, 21(4S), 31-47.