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Community-Based Prevention Marketing: Organizing a Community for Health Behavior Intervention

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This article describes the application and refinement of community-based prevention marketing (CBPM), an example of community-based participatory research that blends social marketing theories and techniques and community organization principles to guide voluntary health behavior change. The Florida Prevention Research Center has worked with a community coalition in Sarasota County, Florida to define locally important health problems and issues and to develop responsive health-promotion interventions. The CBPM framework has evolved as academic and community-based researchers have gained experience applying it. Community boards can use marketing principles to design evidence-based strategies for addressing local public health concerns. Based on 6 years of experience with the "Believe in All Your Possibilities" program, lessons learned that have led to revision and improvement of the CBPM framework are described.

Keywords: *social marketing; community organization; adolescent health; smoking prevention; alcohol use prevention*

Social marketing has been used in public health for about two decades (Grier & Bryant, 2005). It has been used to promote breastfeeding (Lindenberger & Bryant, 2000), condom use (Cohen,

Farley & Bedimo-Etame, 1999), nonuse of illicit drugs (Worden & Slater, 2004), HIV prevention (Kennedy, 2000), and recently, youth physical activity through the VERB™ campaign (Wong et al., 2004). Social marketing also has been used to encourage breast cancer screening (McCormack Brown et al., 2000), to increase WIC program participation (Lindenberger & Bryant, 2000), and to encourage school board members to adopt pro-nutrition policies (McCormack Brown et al., 2004). Recognizing the importance and influence that a community-based effort has on behavior and social change, the Florida Prevention Research Center (FPRC) at the University of South Florida is developing, implementing, and evaluating an approach to health-behavior change called community-based prevention marketing.

Community-based prevention marketing (CBPM) is a community-directed social change process that applies marketing theories and techniques to the design, implementation, and evaluation of health-promotion and disease-prevention programs. CBPM integrates community capacity-building principles and practices, behavioral theories, and marketing concepts and methodologies into a synergistic framework for directing positive change among selected audience segments. (Bryant, Forthofer, McCormack Brown, & McDermott, 1999, p. 61)

Unlike other community-based approaches, CBPM specifically applies social marketing concepts and principles with community members as partners to increase the likelihood that interventions are appropriately

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tailored and responsive to community needs. Using social marketing,

- a conceptual framework guides intervention development consistent with exchange theory and a concern with consumers' perceptions of the 4 Ps: *product* benefits, the *price* or costs associated with the desired behavior, the *place* the behavior is practiced and where information about it is distributed, and *promotional* activities (Kotler, Roberto, & Lee, 2003);
- formative research seeks input from the priority population and is applied for understanding people's aspirations, values, fears, and perceptions of the intervention's (i.e., the product's) perceived benefits versus perceived costs (Parsons & McCormack Brown, 2004);
- analytical techniques segment the community into distinct audiences (i.e., markets) that are more likely to receive and respond to an intervention (Forthofer & Bryant, 2000);

- audience research creates a marketing plan that guides program implementation;
- pretesting of messages, materials, and strategies ensures their effectiveness in reaching priority audiences (Salazar, 2004; Salazar, Bryant, & Kent, 1997); and
- program monitoring identifies ineffective activities that require modification as well as effective ones worthy of sustaining (Bryant et al., 1999).

CBPM recognizes the need for integrated interventions at the individual and environmental levels (Green & Raeburn, 1990). Through its participation, a community can develop competence in making evidence-based marketing decisions, enhance its sense of power, and enable favorable health outcomes (Minkler & Wallerstein, 1997; Syme, 1990). Community ownership of problems and solutions can foster development of culturally acceptable and politically feasible interventions (Gerstein & Green, 1993). Participation in research and demonstration activities also can facilitate development of interventions that become integrated with existing structures, making them more sustainable after outside funding ceases (Bracht, 1999; Israel, Schulz, Parker, & Becker, 1998).

Many community-participatory approaches rely on data to assess needs and assets and to increase understanding of factors that impact conditions that the program seeks to change (Israel et al., 2003). In addition, when community-based participatory research (CBPR) methods are employed, community members are actively involved in research activities as well as other aspects of program planning and implementation. For instance, participatory intervention and research in communities, such as the Kahnawake Schools Diabetes Prevention Project in Canada, employed several principles that are incorporated into CBPM and other CBPR frameworks, as follows:

- (1) the integration of community people and researchers as equal partners in every phase of the project,
- (2) the structural and functional integration of the intervention and evaluation research components,
- (3) having a flexible agenda responsive to demands from the broader environment, and
- (4) the creation of a project that represents a learning opportunity for all involved. (Potvin, Cargo, McComber, Delormier, & Macaulay, 2003, p. 1295)

However, the value added by CBPM is community members' use of a marketing mindset to define problems and set research objectives, design research methods and tools, collect and interpret data, and use results to

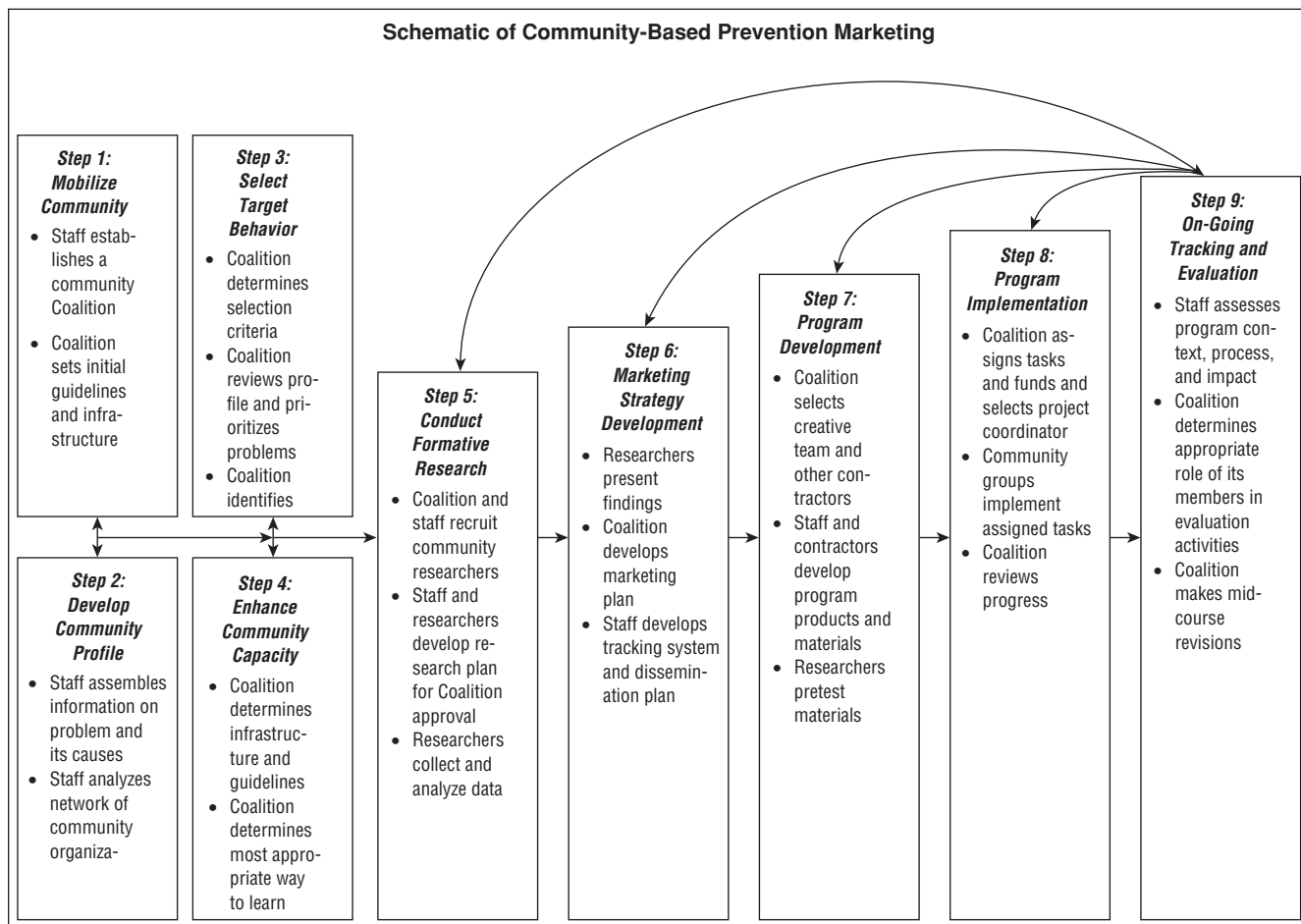


FIGURE 1 General Schematic of Community-Based Prevention Marketing Framework

guide program planning and evaluation. Such involvement can empower the community and democratize planning and evaluation by placing community members in control of the issues investigated (Coombe, 1997; Israel et al., 1998; Israel et al., 2003).

This article describes the FPRC's initial deployment of CBPM in the field (Sarasota County, Florida), summarizes lessons learned, and discusses revisions to the framework for future applications (see Figure 1). Rather than comparing CBPM to other models or reporting intervention results, the article focuses on the steps and procedures for using CBPM to organize a community for health problem identification and prioritization, to conduct research, and to develop a behavior-change intervention that employs a marketing mindset.

► COMMUNITY-BASED PREVENTION MARKETING DEMONSTRATION PROJECTS

Since 1998, the FPRC has collaborated with the Sarasota County Health Department and a community board (also identified herein as the *coalition*) comprised of representatives from more than 35 organizations, as well as with citizens-at-large, to design, implement, and evaluate a program to prevent and control smoking and alcohol consumption among middle-school students. In collaboration with the FPRC, this group conducted formative research with youth and parents and used results to develop a comprehensive social (prevention) marketing plan to reduce prevalence of these products. The multifaceted plan became

the blueprint for the “Believe in All Your Possibilities” social marketing campaign directed at middle-school students as a primary market segment and parents, middle-school teachers, administrators, and youth-oriented community organizations as secondary market segments. “Believe in All Your Possibilities” includes six intervention strategies: (a) tobacco and alcohol citations carried out by law enforcement officials, (b) special tobacco education for youth who receive tobacco citations, (c) 100% smoke-free schools, (d) a parent-oriented video addressing parents’ self-efficacy for communication and control of children’s tobacco and alcohol use, (e) use of the Florida Comprehensive Assessment Test (FCAT) module on tobacco and alcohol for teachers, and (f) a teen theater production to illustrate refusal skills and enhance youth competency for putting them into action (FPRC, 2002).

▶ LESSONS LEARNED AND PLANNED FRAMEWORK REVISIONS

This section describes the steps of the CBPM framework and offers lessons that are guiding researchers and communities engaged in other CBPM projects.

Step 1: Mobilize the Community

The first step in CBPM creates a community structure to guide the CBPM process. Either the local health department or another community organization serves as a lead agency. A person from that agency coordinates local activities. This local coordinator, along with academic researchers and members of other relevant agencies, defines community boundaries and organizes a community board (i.e., coalition). Ideally, the local coordinator or another coalition member emerges as a “program champion” (Steckler & Goodman, 1989) and acts as catalyst for this mobilization.

In the CBPM framework, *community* refers to aggregates of people who share a sense of identity, belonging, and connectedness, as manifested in common values, goals, and institutions (Bryant et al. 1999). Therefore, a community may be based on geographical boundaries, ethnicity, sexual orientation, occupation, or other shared interests (Israel, Checkoway, Schulz, & Zimmerman, 1994). In this demonstration project, the community was based on locality and defined by the geographical boundaries of Sarasota County. The health department was invited to be lead agency because of its experience in coordinating a long-standing Planned Approach to Community Health (PATCH) coalition (Alfonso, Lopez, Bryant, & Bumpus, 2001). The health department designated a staff member as the local coordinator to be the

liaison between the FPRC and other community organizations and to support coalition activities.

Lessons learned. The a priori selection of an organization to assume the lead role in community mobilization, providing staff support for the coalition, and coordinating project activities has both drawbacks and important benefits. Major advantages include the knowledge that a local organization brings to selecting and recruiting board members, the credibility and trust that an agency has with community members, and the convenience of having an indigenous agency (rather than an external group comprised of university-based researchers) organize coalition meetings and other activities. The distribution of funds to an agency early in the project also initiates a partnership involving the university, the health department, and the coalition and reinforces the desire to have community organizations ultimately direct the health-behavior-change intervention.

However, selecting a lead agency prior to convening the coalition can be problematic. Some board members may resent being excluded from the decisions of choosing a fiscal agency and the local coordinator. When these issues surfaced, some members felt that their respective organizations or others were better equipped to assume responsibility. Moreover, the selection of a lead agency to manage community funds, hire project staff, and act unilaterally may undermine the board’s authority to direct the project by placing the funds and power in the hands of a single agency.

Refinements to CBPM framework. The revised framework urges that a community agency be selected as a planning entity to assist with the initial mobilization efforts. However, once a board is established, it determines the organizational structure for the project and selects the agency and necessary personnel. Agencies may be more willing to join and support a coalition if they help to determine its structure and select the organization and people to spearhead its efforts. Academic researchers assess organizational strengths of community agencies interested in serving as the planning agency before one is selected to convene the board. In the revised framework, university researchers measure the organizational capacity and strengths of those interested in being the planning agency and share results with the board. Criteria used to select a planning agency include (a) density of network ties with potential board members and other program partners, (b) quality of relationships with other community organizations, (c) commitment to work under the board’s direction and ability to play a neutral role in project affairs, (d) willingness and ability to support and sustain project activities

(e.g., train other organizations and serve as an example for applying the CBPM framework, contribute staff, space, and supplemental funds), (e) extent to which the agency's composition represents the community of interest and reflects its dimensions, and (f) ability to build a cohesive board and project team. Experience suggests that the project coordinator should be selected by the board rather than by the lead agency. The board should determine the duties and qualifications of this position and establish procedure for selecting this individual.

Step 2: Develop a Community Profile

In the original framework, we recommended that a community profile be developed using demographic, mortality, morbidity, and behavioral data and that the community's assets be assessed (McKnight & Kretzmann, 1992). The Sarasota County School Board had recently developed a detailed profile of the needs of local youth. Using this information, a subcommittee of the PATCH coalition, working with the Sarasota County School Board, identified smoking as a priority problem based on local Youth Risk Behavior Surveillance System (YRBSS) data. Whereas some community board members had participated in assembling the community profile, others joined the community board without this knowledge. To familiarize them with the data and develop a sense of procedural ownership, it was imperative to review the smoking prevalence data for Grades 5 through 12.

Lessons learned. It is valuable to build on the community's previous efforts to study and prioritize local problems rather than devote additional time and resources. However, if the board includes members that did not assist in developing the community profile, review of data improves understanding of the rationale for the next step—selection of the priority problem.

Refinements to CBPM framework. The activities that comprise this step vary depending on the availability of existing data and the community's expertise in understanding its problems. In communities that have assembled a profile, it is important to familiarize board members with data so they are prepared to select a population and a problem. In communities with no such profile, time and resources must be devoted to organizing relevant secondary data and/or collecting primary data.

Step 3: Select the Risk/Protective Behavior to Be Promoted

With CBPM, a board uses the community profile to identify, prioritize, and select a population and a health

problem. In projects funded by categorical grants (i.e., funds earmarked for a designated public health problem, such as obesity), the board may select the protective behaviors (e.g., physical activity) and audience segments (e.g., sixth and seventh graders) on which interventions are to be focused.

Sarasota County had completed part of Step 3 before the pilot project began (youth as a priority population and smoking as one of this age group's most important health problems). This fact was a major reason for selecting this particular venue for the project. However, some board members recommended that the project focus on underage drinking instead of, or in addition to, youth smoking. Underage drinking in Sarasota County was prevalent and dramatically visible. When the group could not reach consensus about the project's focus, the Sarasota County School Board provided resources to conduct formative research on alcohol use among youth, and the FPRC agreed to devote personnel and monetary resources to develop a drinking-prevention marketing plan. In exchange, the board agreed to generate new resources from local sources for plan implementation.

Lessons learned. Problem selection is a critical phase in the CBPM process and one requiring time and negotiation to allow community members to prioritize problems and select an appropriate focus. Board members must agree on the criteria and system for prioritizing before they are comfortable selecting the problem. Balancing the needs and priorities of board members and avoiding health problems that alienate some members are especially important tasks. Although use of a "democratic" definition of need (Stufflebeam, McCormick, Brinkerhoff, & Nelson, 1985) may not always get at a community's most urgent need, its use may foster trust among community partners and create a bond that promotes joint initiatives in the future.

Refinements to CBPM framework. The revised framework reinforces the importance of the criteria and processes for selecting the project focus. It calls for the university partners to assist the board in developing decision-making criteria and techniques for selecting a project focus.

Step 4: Develop a Project-Specific Advisory Committee

Originally, the CBPM framework recommended that the community board develop written bylaws and select a steering committee to carry out activities between meetings.

For the “Believe in All Your Possibilities” project, FPRC staff and community board members participated in a 2-day retreat to become acquainted, build mutual respect, learn the CBPM framework, develop a vision for interventions, and discuss principles to guide project work. A subcommittee prepared written guidelines that captured these principles, defined the roles and duties of officers, and developed operating procedures. Although the board adopted these guidelines, it has neither critiqued nor revised them and only occasionally refers to them (FPRC, 2000).

Lessons learned. Discussions of the principles that guide the project encourage the board to reflect on its values for developing ownership (Minkler & Wallerstein, 1997). However, community members are in a key position to determine the board’s infrastructure (e.g., how to manage project funds and personnel) and may not find it necessary to adopt formal bylaws.

Refinements to CBPM framework. The board decides whether or when to form a steering committee, determines the relationship between the board and its member organizations, and develops the principles and guidelines for working together. The FPRC provides the board with sample guidelines. The board is not expected to develop a fixed set of bylaws but is encouraged to view guiding principles as dynamic and subject to regular review and revision as new situations are encountered. These revisions are consistent with expert recommendations (Minkler & Wallerstein, 1997) that each board adopt its own set of principles and recognize that internalization and ownership of guiding principles occur only as the board implements them in the course of an actual project. At the beginning of each board meeting, the steps of CBPM are reviewed, noting accomplishments and what lies ahead. Board members also learn by participating in data collection, strategy formation, concept testing, and other project activities. To reflect these changes in the framework, this step has been renamed “building community capacity.”

Step 5: Formative Research

As originally conceptualized, community members participate in all research initiatives. Community researchers’ expertise and level of involvement is expected to increase as the research progresses. For the “Believe in All Your Possibilities” project, high school students were trained to interview other youth (Landis et al., 1999; McCormack Brown et al., 2001; McCormack Brown, McDermott, Bryant, & Forthofer, 2003). Youth researchers’ review and discussion of the results enriched university researchers’ interpretation.

Coalition members also participated in the research, although they decided that academic researchers should assume primary responsibility for survey design, implementation, and analysis. They reviewed the overall research design, including the sampling plan and survey instruments. Some board members were trained to conduct focus groups with parents. Formative research spanned almost 2 years. Although most board members had a sense of the project’s continuous momentum through their input, others questioned the practicality of a framework requiring so much time for developing an intervention.

Lessons learned. Experience shows that participatory research is effective in identifying consumer perceptions of the community’s health problems and their determinants. Youth can be effective researchers but require close supervision. We also learned that the roles of both community and academic staff members fluctuate from one phase of a project to another, rather than shifting steadily toward greater community involvement. Many community members lack interest in specific types of data collection or analysis and prefer to leave some research-related tasks to academicians. It is still important for results to be shared with community members so they can interject new insights and assist in interpreting their meaning in ways that will help to tailor interventions.

Finally, we have recognized the need to accelerate the timeline required to develop and launch interventions. Some community organizations and members grow impatient with a protracted timeline, especially when activities are delayed by the demands of participatory research. Therefore, whenever possible, it is important to use existing research results as well as primary data collected from the local community to guide marketing plans and to adapt existing evidence-based prevention strategies.

Refinements to CBPM framework. Because the CBPM framework integrates the principles of CBPR, community researchers continue to be active in the revised framework. The board reviews all proposed research methods and activities. Specific responsibilities of community researchers depend on their interest, skills, experience, and availability. Moreover, an academic researcher may become “indigenous” to the community during the formative research phase. To accelerate the schedule, greater use is made of existing literature to identify findings not requiring replication as well as similar projects that demonstrate effective materials and tactics that can be pilot-tested concurrently as formative research is conducted.

Step 6: Marketing Strategy Development

In the original CBPM framework, the community board uses formative research to develop a marketing plan. FPRC personnel facilitate strategy development sessions, review research results, and pose marketing questions that the board answers using the evidence base.

Creation of the “Believe in All Your Possibilities” campaign required several meetings to develop a comprehensive marketing strategy. Board members and other stakeholders devoted time to making key marketing decisions for decreasing youth tobacco and alcohol use. Meetings with middle-school students and, later, with parent groups and teachers occurred. In each meeting, FRPC personnel highlighted research findings and facilitated discussion to identify (a) segments of the youth population to receive highest priority, (b) behavioral objectives for each audience (i.e., market segment), (c) product benefits that best distinguish the recommended behavior from its competition (e.g., popularity), (d) tactics to lower perceived and real costs (i.e., price) associated with not smoking or drinking, (e) tactics for intervening at places where tobacco or alcohol are obtained and used, and (f) other tactics related to promotion of achieving the behavioral outcomes. At subsequent board meetings, members prioritized recommendations and selected six intervention activities. Later, a marketing plan was prepared and distributed to community organizations and citizens-at-large.

Lessons learned. The inclusion of people who were not members of the board in strategy development sessions offered advantages and drawbacks. Their participation sparked interest in the project, fostered ownership of the marketing plan, and occasionally motivated them to join the board or become valuable program partners. However, inclusion of persons peripheral to previous initiatives who were unfamiliar with the CBPM framework and evidence-based decision making also made the focus on marketing decisions hard for them to understand.

Refinements to CBPM framework. Although board members are trained in marketing’s conceptual framework—exchange theory, audience segmentation, the 4 Ps, and the use of consumer research to develop a marketing plan (Kotler et al., 2003), greater emphasis is placed on using the marketing mindset as they progress through the phases. For example, they apply marketing principles throughout the initial planning phase by reviewing and applying existing data to priority audiences and behaviors for the project, and during formative research, only ask questions that assist

them in identifying product, price, place, and promotion. These exercises prepare them to “think like marketers” when adapting the formative research to create the marketing plan. Only board members who understand what is needed to complete the task are invited to the initial marketing-strategy-development session. Based on this initial session, a “draft” marketing plan is developed. Other stakeholders unfamiliar with marketing principles may provide input during separate sessions by reviewing research results, giving feedback about the plan, and offering other insights. After the core marketing strategy evolves, the board develops both a marketing plan and an implementation plan. An evaluation plan also emerges for assessing the intervention’s impact on the priority behavior.

Step 7: Program Development

In the original CBPM framework, all intervention materials and tactics are developed and pilot-tested. The board helps to mobilize resources for the intervention and reinforces the institutional foundation on which the intervention must be sustained.

In this project, the board developed and disseminated a request for qualifications (RFQ) for vendors who could produce a program name, logo, print materials, videotape for parents, teen theater scripts, and ancillary materials based on recommendations of the prevention marketing plan. When no agency responded, a second call with specific invitations to agencies believed to have the requisite skills was successful in recruiting a social marketing organization. The selected organization began concept development and testing. However, circumstances necessitated contracting instead with a local governmental agency that worked regularly with the health department. Unfortunately, this agency was unfamiliar with social marketing in designing and producing materials. As a result, their materials required extensive revisions before meshing with the marketing strategy, and program implementation was delayed.

High school students pilot-tested materials with middle-school youth and their parents. Board members did likewise with parents and other stakeholders. University personnel provided the summary and interpretation of findings. Recommendations were made to the creative team and materials underwent revision. Four concepts emerged: *trust*, *stand*, *truth*, and *believe*. High school students and board members further tested these concepts with audiences and two (*truth* and *stand*) were eliminated. The others (*trust* and *believe*) were modified in font appearance, background colors, and tag line. The “Believe” concept was changed to

avoid any unintended religious connotation. After further testing, “Believe in All Your Possibilities” emerged as the concept of preference.

Lessons learned. One cannot anticipate the types of materials needed for a CBPM project; thus, the selection of vendors to produce them must be scheduled after a marketing plan has been developed. It benefits the project to identify and involve local organizations such as social marketing firms, advertising and public relations agencies, video producers, instructional designers, and graphic artists that are qualified producers of program materials as early as possible. Youth and adults can be trained to pilot-test campaign materials. It is important to ensure that their data offer clear direction for revision of materials.

Refinements to CBPM framework. The revised framework gives the board greater control and flexibility in structuring its relationship with member organizations and managing its resources. Representatives from organizations that may produce program materials are invited to serve on the board, enabling their commitment to the project and fostering understanding of CBPM’s databased health-message-design philosophy before they are called on to help and/or recruit other local resources. If local resources are unavailable, negotiations are begun early enough with an external social marketing firm or related organization to minimize possible contractual constraints. Participatory research is used to pilot-test program materials and tactics. Academic and community researchers work together to ensure that data are responsive to the needs of persons charged with revising these materials and strategies.

Step 8: Program Implementation

Originally, CBPM relied on the community coordinator to orchestrate the program’s implementation, working with the board to ensure proper sequencing of legislative advocacy, organizational policy and procedural changes, professional training, materials distribution, public relations, and public information. When the “Believe in All Your Possibilities” campaign was implemented, having a board representing diverse interests of the community allowed the project to access numerous organizations and other resources to enable implementation of the prevention marketing plan. For example, the board and other groups motivated law enforcement officials (e.g., Sarasota County Sheriff’s Office) to enforce laws regarding underage drinking and smoking more consistently. Also, a school board representative introduced new school procedures,

and several substance abuse organizations helped promote a videotape and educational workshop for parents.

Lessons learned. The coalition plays a critical role at this juncture, providing access to both expertise and resources. To ensure smooth integration of program components and to carry out board functions between meetings, the human resources of a coordinator and other community organizations are needed. The coordinator must be savvy enough to mediate any philosophical gaps among board members, academic researchers, and persons representing the lead agency.

Refinements to CBPM framework. In the revised framework, the coalition continues to direct program implementation. Furthermore, it determines how and with whom the strategies and materials developed can be used, the appropriate structure and personnel needed to coordinate project activities and build the foundation for sustaining the program rather than relying exclusively on a lead agency (or university-based partners).

Step 9: Tracking and Evaluation

Having specialized evaluators is key to the success of community-based prevention marketing (McDermott, 2004). Academic and community researchers assess program context, process, and impact in a comprehensive evaluation. The board uses tracking information to identify mid-course revisions. Tracking the “Believe in All Your Possibilities” campaign included monitoring citations for smoking or drinking, identifying factors contributing to the magnitude of intervention “dose,” charting exposure and frequency of public service announcements, and measuring other program elements. The FPRC’s approach to evaluation is characterized by triangulated methods to gather data from multiple perspectives and using data not merely for assessing intervention implementation or impact but also for refinement of the CBPM framework’s application.

Lessons learned. The FPRC’s use of a mixed-methods evaluation helps overcome one of the potential barriers to evidence-based public health practice—the lack of available evidence regarding intervention effect (Hausman, 2002)—by providing communities with support in discerning the expected contributions of various intervention strategies. Although a mixed-methods design has obvious strengths, rigor has to be balanced against what may be perceived in the community as unnecessary complexity. Board members became frustrated with what they perceived to be the slow pace of evaluation. There was a “disconnect” between the expectations of

academic researchers and board members, with the latter group seeking more rapid results and feedback. University researchers concentrated on relatively labor-intensive measures and a “clinical trials” mindset requiring protracted time frames for data collection and analysis (e.g., multiple instruments to measure board members’ experience, the detailed monitoring of local print media, and attempts to evaluate numerous activities launched as part of the overall marketing plan). Although board members were impressed with these sophisticated designs, they preferred more easy-to-understand, straightforward, and practical measures that could demonstrate “movement of the needle” and facilitate their ability to obtain funds to sustain the effort through local foundations and philanthropic organizations.

Costs and benefits of participation are tracked throughout the phases of the project. Understanding participation costs and benefits enhances academic researchers’ capacity to engage community partners in evaluation. This type of collaboration, however unfamiliar, is invaluable for mediating and easing “insider-outsider” and “impact/outcome versus process” tensions. Community members bring a new lens to evaluation through which to view project outcomes, thereby diminishing the boundaries that separate insiders from outsiders and products from processes.

Refinements to CBPM framework. Collaboration in evaluation has provided new insights for optimizing the role of community partners. Because evaluation often is unfamiliar to a coalition, and because of the need to balance attention on process and product, community members are offered options for evaluative measures, estimated costs, and relative advantages and disadvantages. The board is invited to participate in selecting the measures and methods of assessment for their community. Experience suggests that community members must have the freedom to determine the extent of their input and participation without pressure from academic researchers or other persons. Ultimately, we anticipate that this communication between academic researchers and community partners will generate new ideas for expanding the scope of evaluation in nontraditional directions as well as enhance community ownership and understanding of the measurement and evaluation processes. Experience with the “Believe in All Your Possibilities” campaign draws us to the conclusion that future evaluation designs will be simplified, with behavioral outcomes given the highest priority. Finally, we understand that establishing realistic expectations concerning the likely impact of interventions must go hand-in-hand with offering communities choices in evaluation activities.

► SUMMARY

CBPM is a community-based participatory research approach to social change that is distinguished from other community-based approaches by community members’ use of a marketing mindset to define, solve, and evaluate local public health problems. The CBPM framework can help direct health behavior and social change by blending marketing theories and techniques, community organization principles, and behavioral theories in designing, implementing, and evaluating evidence-based health promotion programs. This project demonstrates that a community board can use evidence and employ marketing principles to design strategies and tactics for addressing local health concerns. Experience with CBPM has led to revision of the original framework to give the community greater flexibility and authority for key decisions. CBPM will improve as academic and community-based researchers gain more experience in applying it. Refining and sustaining CBPM includes discussion, deliberation, compromise, and reflection. The addition of new communities and health issues will test its flexibility, adaptability, and appropriateness for adoption on a larger scale.

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