PARTNERSHIPS FOR SOCIAL MARKETING PROGRAMS: AN EXAMPLE FROM THE NATIONAL BONE HEALTH CAMPAIGN

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ABSTRACT

Partnership development for national social marketing campaigns is a much copied, but poorly researched, area of practice. As part of the development of Phase II of the Centers for Disease Control's National Bone Health Campaign, several needs-assessment and market analysis activities were conducted to develop partnership strategies that were responsive to the needs of both potential campaign priority audiences and those of possible partner organizations. We discuss how the findings present strategic options for partnership recruitment and some of the key marketing issues that need to be considered in crafting an effective partnership model at the local, state and national level.

INTRODUCTION

The strategy of developing partnerships for national public health education programs goes back at least to the establishment of the National High Blood Pressure Education Program (NHBPEP) in 1972. As described by Ward (1984), the NHBPEP developed as a coalition of federal, state, voluntary and professional organizations; state and local public health departments; insurance, pharmaceutical and other private sector industries; and numerous community agencies. Three early areas of focus for NHBPEP and its partners were marketing problems: building awareness of high blood pressure as a public health and personal health issue (promotion), creating a distribution system (place) to deliver blood pressure education materials to health care professionals and their patients, and working with communities to make access to information and services more convenient (price).

The activities of the NHBPEP over the past 30+ years offer a template for the use of partnerships in national education programs. Some of the roles for NHBPEP partners have included serving on a Coordinating Committee; engaging in consensus-building processes to identify major issues of concern and to develop program activities; defining national priorities for the NHBPEP; examining critical issues in the science and practice of high blood pressure control; exploring future opportunities for program development and expansion; sponsoring national activities; and promoting collaboration among the many organizations involved in the prevention, detection, treatment, and control of high blood pressure. The success of the NHBPEP model is evident by its duplication in other countries, and the use of this model for other disease states and risk factors, including the National Asthma Prevention and Education Program, the National Cholesterol Education Program, the National Heart Attack Alert Program, the National Diabetes Education Program, and the National Kidney Diseases Education Program (Nicola & Hatcher, 2000).

Aside from case histories and program descriptions, the study of the development and implementation of partnerships at the national level has been relatively ignored. However, at the state and community level, there is a large body of evidence that addresses successful and unsuccessful strategies and tactics to develop, manage and sustain coalitions (Goodman, Steckler and Kegler, 1997; Wolff, 2001).

In the field of social marketing, there have been several well described efforts at incorporating community approaches into social marketing programs (Bryant, Forthofer, Brown, & McDermott, 1999; Kelly, Plested, Edwards, Thurman, Comello, & Slater, 2003; Lefebvre, 1990; and McKee, 1992). Kelly et al. (2003) describe a formative research process to categorize a community at one of nine levels of readiness in order to tailor interventions to that stage. At the heart of the model is a series of four to five semi-structured interviews with key informants in a community. Six dimensions of community readiness to engage in health promotion activities are addressed in these interviews: existing efforts (programs, activities, policies, etc.); community knowledge of efforts; leadership (includes appointed leaders and influential community members); community climate (prevailing attitudes in community about the issue); knowledge about the issue; and resources relating to the issue.

This article describes a needs-assessment process, or market analysis, undertaken by the National Bone Health Campaign (NBHC), a national campaign to prevent osteoporosis among girls, to inform partnership development. The purpose of this analysis was to hear from many different stakeholders in various contexts, as well as from potential target audiences of the campaign. The operating principle was that the convergence of opinions on various aspects of partnership roles and responsibilities, as well as unique perspectives that might be offered by certain groups, would give campaign planners a nuanced picture of how to create and sustain partnerships. The discussion will focus on how the results might be applied in the NBHC and their implications for social marketing programs involving partnership development at the local, state and national levels.

OSTEOPOROSIS AND BONE HEALTH: OVERVIEW OF THE PROBLEM

Osteoporosis is a bone disease characterized by low bone mass and deterioration of bone structure, which

causes bone fragility and increases the risk of fracture. According to the Surgeon General's Report, osteoporosis is a silent disease that affects millions of Americans. The report estimates that 1.5 million individuals suffer a bone disease-related fracture annually (U.S. Dept. of Health and Human Services (HHS), 2004). The Surgeon General's Report notes that, "if we do not take immediate action, by 2020, half of all Americans over age 50 will have weak bones from osteoporosis and low bone mass." (HHS, 2004).

There are a number of behavioral and environmental risk factors that contribute to the increased incidence of the disease. These risk factors include:

- A diet low in calcium and Vitamin D – a lifetime diet low in calcium and Vitamin D increases a person's risk for bone loss.
- Physical inactivity – lack of weight-bearing physical activity and an overall inactive lifestyle tends to weaken bones.
- Household hazards – risk factors in the home can increase the chance of falling and breaking bones.
- Reactions of medicines – medicines taken to treat other health conditions can weaken bones.
- Unhealthy body weight – being underweight raises the risk of bone loss and fracture.
- Smoking – smoking can reduce bone mass.
- Alcohol use – heavy alcohol consumption reduces bone mass.

While there are multiple contributors to the risk of the development of osteoporosis, including genetic and biological factors, the current body of knowledge suggests preventive measures, such as behavioral interventions to increase calcium consumption and weight-bearing physical activity, may help reduce the risk of osteoporosis later in life. As a person's bone density reaches its maximum by the early 20s, it seems particularly important to urge children and teens, their families, caregivers, schools, communities and health care professionals to create the awareness, and expand behavioral change opportunities, to increase consumption of foods high in calcium and vitamin D and the amount of time children engage in weight-bearing physical activity as a key population-based intervention strategy.

However, relatively few individuals, especially children age 8 and older, follow the recommendations related to the amounts of weight-bearing physical activity, calcium and Vitamin D that are needed to maintain optimal bone health. Studies indicate between 75 to 90% of girls age 8 and older, and boys ages 9 to 13, do not meet the requirements for adequate calcium intake (International Food Information Council, 2002). In fact, teens and "tweens" have very little knowledge of the risk factors of osteoporosis, and do not place any importance on calcium consumption or weight-bearing physical activity as it relates to bone health (Auld et al., 2003; Martin et al., 2004).

A number of social and environmental factors can be hypothesized as contributing to this issue – from the ever-increasing promotion of unhealthy eating habits and inactive lifestyles, to busy and hurried parents who perceive little time to provide or encourage a healthy lifestyle for their children, to the disappearance of health education and physical activity programs in many of the nation's school systems. According to the Surgeon General's Report, a key need is for more population-based interventions at the individual and community level to address the general lack of concern regarding osteoporosis and bone health (HHS, 2004).

THE NATIONAL BONE HEALTH CAMPAIGN

In 1998, the U.S Congress funded HHS' Office on Women's Health (OWH) to develop and implement a public education campaign on osteoporosis and bone health for girls 9–18. OWH partnered with the Centers for Disease Control and Prevention (CDC) and the National Osteoporosis Foundation (NOF) to research, develop, and implement the National Bone Health Campaign (NBHC). This multi-faceted campaign is designed to promote optimal bone development and health in girls. The NBHC believes that girls who consume sufficient calcium and Vitamin D and regularly participate in weight-bearing physical activity can develop stronger, denser bones, thus reducing their risk of osteoporosis later in life.

In Phase I (1998–2004), the NBHC targeted young girls ages 9–12 and their parents. The goals of the campaign were to promote girls' adoption of bone-healthy behaviors as life-long habits and to encourage parental behavior supporting and enabling these behaviors. The NBHC's objectives in Phase I were to expose girls to campaign messages through a multitude of media and community channels, to elevate the importance of calcium consumption and regular physical activity for bone health, and to increase knowledge of easy ways to increase calcium intake and physical activity levels. Secondary objectives of the campaign were to elevate parents' understanding of the importance of bone health as part of their daughter's overall health and that of girls in general, to raise the importance of calcium consumption and regular weight-bearing physical activity for bone health, and to convince parents and influencers that they can help girls meet their calcium and weight-bearing physical activity requirements.

During this first phase of the campaign, collateral materials were drafted for girls, featuring a spokestoon, "Carla," as a prominent figure, including journals, calendars, pens, and water bottles, to be used during promotional activities. Other campaign materials included print ads, a 30-second radio spot, and a girls' focused Web site. The NBHC also participated in the 2001 Radio Disney Live Tour. Materials developed for parents included a website, double-sided placemats and clipboards. In addition, a toolkit for public health professionals was created and distributed, and there was ongoing media outreach through media releases and advisories. In response to requests from state and other partners, a packet of campaign materials was developed and distributed to them and other interested groups. This packet included a website user's guide, a slide presentation on the campaign, a fact sheet for girls, a summary of lessons learned about communicating effectively with girls, a compendium of research findings, a selection of campaign graphics, and a flyer and poster file.

To ensure the NBHC's effectiveness in reaching and impacting key target audiences, the campaign is shifting into Phase II – a five-year social marketing initiative. CDC's goal for Phase II is for NBHC to go beyond raising awareness through communications and begin changing behavior through social marketing strategies.

In September 2004, a 10-month planning process was implemented to explore strategies the campaign could execute in Phase II to change current bone health behaviors. Several activities were used to prepare a social marketing approach for Phase II of the campaign, including the development of a recruitment plan for partners. The overall approach was based on an understanding and consideration of the audience perspective blended with the

scientific and theoretical understanding of osteoporosis and behavior change to:

- Set behavioral objectives that are relevant and achievable by the audience.
- Address the costs and benefits for changing (or not changing) their current behaviors.
- Increase the opportunities (and access) for the audience to engage in the desired behaviors.
- Promote these behaviors, their benefits and opportunities to the audience at times and places when they are most likely to attend and act upon them.

The specific assessment and market analysis efforts that were conducted to inform this planning process included:

- An evaluation of the campaign and input for Phase II from Phase I partners.
- An extensive environmental scan that reviewed recent research studies and media coverage of selected national public health campaigns.
- Interviews with selected key opinion leaders involved in youth, bone health and social marketing programs.
- Exploratory needs-assessment and concept testing with core and intermediary audiences.
- Two strategic planning meetings with key stakeholder groups.

In this article, our focus is on the results we obtained from these projects that helped to craft our approach to a partnership program for the second phase of the NHBC. Indeed, the involvement of partners and stakeholders in all aspects of the planning, implementation and evaluation activities of the NBHC is a priority for the campaign.

METHODOLOGY

During Phase I, 27 partner organizations were involved in various NBHC activities (all were drawn from the public and nonprofit sectors). Representatives from many of these partners were interviewed individually at the end of Phase I on how to improve the campaign and especially its partnership opportunities in Phase II.

The NBHC conducted an environmental scan to begin building the foundation for the campaign's strategic planning process. The scan included an analysis of studies on bone health in adolescent girls published or presented at scientific meetings between October 2001 and October 2004 (roughly corresponding to the end of the literature review contained in the Surgeon General's Report). The environmental scan also analyzed nearly 20 public education campaigns focused on bone health, general health, nutrition and physical activity.

NBHC also reached out to organizations and individuals that were identified as opinion leaders and/or stakeholders in youth lifestyles, health, physical activity and nutrition. Twenty-four organizational representatives agreed to participate in structured individual telephone interviews to discuss their insights and lessons learned for targeting girls with health and marketing campaigns.

With the input from the environmental scan, individual interviews and the first strategic planning committee (see Results section), needs-assessment and concept testing groups were held with nine groups of girls segmented by grade level (3rd–5th, 6th–8th, 9th–12th: $n = 76$), two groups of boys ($n = 16$), six groups of parents (three each of mothers and fathers only, $n = 50$), and three groups of influencer audiences (one each of school-based, health care professionals and youth-serving organization leaders, $n = 27$). Topics varied among the groups, and in some groups, questions were posed

to elicit responses as to the perceived credibility and relevance of partnerships in general, as well as specific organizations and corporations.

Two strategic planning meetings were convened in February and July of 2005 to gain further insight into planning Phase II of the Campaign. Participants included representatives from many aspects of girls' lives, including the osteoporosis community, other youth-related social marketing campaigns, youth groups, health professional associations and youth-oriented media. These meetings consisted of plenary sessions, moderated discussions and breakout discussion groups that allowed stakeholders to offer their personal experiences and professional expertise to the planning of Phase II. One day of the agenda of the second meeting specifically focused on partnership questions and issues for the NBHC. Only those comments and insights relevant to the planning of the partnership aspect of the next phase of the NBHC are presented.

RESULTS

PHASE I STAKEHOLDERS

The interviews with key stakeholders about Phase I noted that the NBHC should (1) increase the number of partners and stakeholders in order to expand its distribution channels, (2) provide partner organizations with marketing assistance, and (3) conduct strategy checks to ensure that the partners' activities are consistent with NBHC's brand. These stakeholders also offered that the campaign's partnership component could be improved by defining each organization's role more clearly, developing a process for communication among partners, and resolving the incongruence between the levels and amount of staff support from various partners so that partners share equally in the work and responsibilities.

ENVIRONMENTAL SCAN

The environmental scan, particularly of other campaigns and their media coverage, offered several valuable insights. First, obviously, was the high profile of several campaigns that might be leveraged to enhance the visibility of the NBHC. Chief among these campaigns was the National Dairy Council's *3-A-Day of Dairy* campaign, the CDC *VERB* campaign and several state osteoporosis initiatives. Other tactical considerations that emerged from this scan included:

- Spokespeople provided by credible partners seemed to enhance media coverage of an issue.
- Release of data from participating organizations about the campaign's progress also generated better coverage.
- Media were more likely to quote adolescents who were willing to speak about their own experiences than their parents.
- Various government campaigns on related or overlapping subject areas, audiences and behaviors needed to be aligned so that all campaigns could benefit from one another's efforts.

OPINION LEADER INTERVIEWS

While many of the questions asked of them were posed to gain insights into the NBHC target audiences, several points of view converged on issues related to partnership development strategy.

- Adults – parents and other influencers – need to know what to say to girls about bone health, nutrition and physical activity. These adults need guidelines for curriculum, instructional practice and ways of assessing whether girls have acquired these standards.
- Girls want (need) their MTV, iPod and mobile phone(s) – teen and tween

girls spend exorbitant amounts of time communicating electronically with each other. Girls respond more readily to online resources than in-person communication – the anonymity is appealing to them.

- Interviewees from state bone health programs noted the challenges in penetrating the school curriculum and school food service system with bone health messages and programs, noting that it is hard to get overburdened administrators and teachers to agree to add more to their plates.
- They also noted that educating physicians will be a challenge for the campaign as the Surgeon General's Report mentioned that one of the biggest problems relating to bone health is that physicians are not identifying cases of osteoporosis early on or performing appropriate screenings.

FOCUS GROUPS

Again, most questions posed to any of these groups focused more on audience needs, realities and receptivity to NBHC objectives than partnership issues. However, on several occasions questions were posed that opened up discussion of partnerships or sponsorships. Among the findings from these groups that were of particular interest are discussed below.

Calcium is almost singularly associated with milk and dairy products among both parents and children. When asked what words, phrases or images came to mind when they heard the word "calcium," the vast majority across all grade levels volunteered "milk," "dairy" or "dairy products." One 3rd–5th grade girl stated, "I think of white because milk is white and it has calcium." Few participants in any of the girls' groups were able to name other foods and beverages with calcium, though some suggested "orange juice."

Text messaging is the number one way for girls in grades 6–12 to stay in touch with their friends. Instant messaging and cell phones round out the top-three ways of talking to friends. Young girls in grades 3–5 also report "IMing" while online, but it doesn't appear to be a social necessity as of yet.

Video gaming is the most popular recreational activity for boys across grade levels. Boys, like girls, are busy with homework, chores and many activities in their free time. A majority of 3rd–5th grade boys report playing videogames last weekend and volunteer a seemingly endless list of names of their favorite games. Boys in the 6th–8th grade also report playing videogames or visiting online gaming sites in their free time. They also mention spending a considerable amount of time reading gaming magazines.

Boys and girls are divided over incentives that will motivate them to consume more calcium-rich foods and do more physical activity. Boys in grades 6–8 are most favorable about promotions that offer opportunities to win game systems, such as XBox and Playstation. Other popular options with this audience are tickets to sporting events and giveaways for videogames, books or magazines. Girls in the same grade level somewhat like the idea of coming up with a new yogurt flavor, essay contests, the chance to win an iPod, and a discount or free pass to a gym that accepts children. Girls in grades 9–12 did not find any of the potential incentives particularly appealing.

Teen magazines rule as popular ways to reach tween and teenage girls. *Seventeen* and *Teen People* reign as the most popular magazines among girls in both the 6th–8th and 9th grade and higher groups. Girls in the 9th grade and higher group offered blackplanet.com (suggested by African-American girls) and Myspace.com (suggested by girls from various ethnic

backgrounds) as their favorite places to visit online.

Parents are open to making changes to promote their children's long-term bone health; however, they point to a need for specific and clear messages and direction. "Put the information where we see it when we think about food and/or make food choices (such as supermarkets or milk cartons)."

Fathers see themselves as primarily responsible for providing their children with opportunities to be physically active. As one father noted, "it's my job to make sure they are exposed to a range of activities so that they can pick something they like."

When it comes to healthy choices in general, and bone health issues specifically, mothers do not regard themselves as key influencers, placing a great deal of responsibility on other people in their daughters' lives, such as doctors, teachers, and coaches.

All participants – girls, boys, parents, health care providers and other influencers – point to school cafeterias and the easy accessibility to fast foods, as a major negative influence on what girls eat everyday. The girls often reported eating only one meal at home each day – dinner; they often skipped breakfast.

Like healthcare providers, educators feel strongly that parents should be responsible for educating their children about nutrition and physical activity and establishing good habits early. In their opinion, parents bear the ultimate responsibility for educating their children about these issues and they should teach their children good habits while they are young.

Teachers, coaches, and food service personnel all have their own, sometimes competing, agendas that prevent them from working together on these issues. "The cafeteria has to be profitable; the athletic department gets a large percentage of the profit from vending machines; teachers are spread thin with professional commitments and limited resources," said one educator who was in a supervising position and also coaches boys sports. Changes in nutrition and physical education at schools can only be instituted from the top-down.

Healthcare providers made a point of speaking to their patients (as well as their patients' parents) about healthy diets; however, the subject of bone health rarely comes up in these discussions. The majority say they do not have much time with each of their patients and although discussing eating habits is a priority ("It's on my check list"), speaking specifically about osteoporosis is not. However, as one participant reasoned, "We already talk to them about cholesterol, why can't we mention bone health?"

CDC enjoyed strong credibility among all audiences. Most would trust an unbiased scientific organization to advocate on behalf of the bone health issue. A majority of respondents across the board were suspicious of any partners with vested commercial or perceived political interests ("What are they trying to sell me?").

STRATEGIC (PARTNERSHIP) PLANNING MEETINGS

Several suggestions relevant to partnership formation and development came out of the first planning meeting, including:

- With collaborations it is necessary to review/address branding issues as they relate to the campaign.
- Link popular websites for girls to NBHC (i.e., Nick, *Seventeen*, etc.)
- Link popular websites for parents to NBHC (i.e., WebMD).
- Review survey data and literature from other stakeholders in bone health.

- Develop relationships with nontraditional media vendors.
- Create a synergy versus a competition with other organizations and programs working on the childhood obesity issue.

At the second meeting partnership development was a major focus of the agenda. We asked the participants for their input on several key issues:

What qualities do you look for from potential partners and partnerships?

- Trust
- Their credibility with the audience.
- Capability to raise awareness of target audience about the target behavior and/or campaign.
- Ability to commit to partnerships.
- Potential contribution toward sustainability.
- Similar missions.
- Mutually beneficial partnerships/opportunities.
- Aspire to one larger goal.
- To fill a gap that exists within their own organization or program.
- Ability to bring resources to the table.
- Honest, open communication on goals and responsibilities.
- Access to decision-makers within the organization.
- Cultural competence.
- Clear boundaries.
- Flexibility.
- Need to be meet everyone's return on investment.
- Capabilities to disseminate information to target audience(s).
- Collaborate on the development of messages and materials.

Then the participants discussed what partners would want from the NBHC and the CDC in particular:

- To raise awareness of their group or product within the CDC.
- Their participation would be responded to favorably by the community and government.
- Develop trust with the audience, building on CDC's high-level of credibility.
- Logo/brand the campaign so it's instantly recognizable.
- Develop deep/long-term partnerships beyond just the specific program or project.
- Something unique.
- Exclusivity (a few participants identified that this may be a problem with potential corporate partners).
- Open communication.
- Honest and upfront about goals and objectives.
- Access to other partners.
- Customizable materials for partners to make their own and add their logo.
- The ability to link NBHC grass-roots networks with a partner's existing grass-roots network.

The group then offered their opinions about what the campaign and the various partners need:

What would create a "win-win" situation?

- Honest and upfront about goals and objectives.
- Credibility.
- Commitment.
- Alignment of audience, desired behavior and collaborators.
- Consistency.
- Clear about expectations.
- See a return on investment (in some cases, not necessarily monetary).
- Feedback on results and whether the campaign accomplished its goals.

The discussion then centered on what the value-added would be, from the

audience point-of-view, to have partners on board:

- Increased visibility of the campaign.
- Saturation of the market.
- Make the campaign more credible.
- Have more tools for the audience to use and achieve behavior change.

Next, NBHC wanted the participants' input on what NBHC could ask for from potential partners in terms of money, in-kind contributions, etc. Suggestions included:

- Co-create materials and ideas for the Campaign (collaborative brainstorming).
- Be upfront about what you have to offer; create clear expectations.
- Shared or individual research projects.
- Share lessons learned through partners' experience.
- Create a synergy in messaging of the organization and the messaging of the campaign.
- Face-to-face meetings were useful for partners to be informed and involved.

Some of the measurements of success the participants offered were:

- Partners can keep diaries of activities and evaluation.
- Surveys to evaluate partnership expectations and successfulness.
- Numbers of materials distributed.
- Product sales.
- Talk to other Federal programs to see how they measure success with their partners.

The following tools were identified as ones that were needed to attract partners and enhance the effectiveness of the partnerships when implementing the strategic plan and meeting NBHC objectives:

- CDC needs to disseminate more ideas for partners to react to and make decisions.
- Provide opportunities to have meetings with key government officials (i.e., chronic disease directors).
- Develop capacity to work with existing programs.
- Have a clear description of partnerships and a call to action.
- CDC should be aware of the various cultures of other organizations.
- Demonstrate the success of Phase I.
- Tools must be easy to use (i.e., toolkit for partners).
- CDC needs to illustrate cause and affect (i.e., what will program do/accomplish).
- Be open to the food industry and other corporate partners.
- Develop creative ways to change behavior.

The group continued the discussion to examine the downside of partnerships:

- Loss of control.
- "You are the company you keep" – This statement can work against you when partners get bad PR.
- It's labor intensive to build a brand.
- Partnerships depend on personal relationships; staff turnover can work against partnership development.
- You cannot guarantee a long-term partnership with employee and board turnover of some groups.
- Organizational priorities may shift over time – especially with staff turnover at various levels of participating organizations.
- It's important to meet expectations on both sides of the partnership, otherwise it could end.
- There is a learning curve to figure out how each partner works.
- Some organizations may not have infrastructure in place for a successful partnership.
- Partners need to recognize that they are part of a "fleet" each representing

partnership, stewardship, leadership, sponsorship, etc.
- Identifying the "win-win" is hard because some partners may have hidden agendas.
- Often times it's difficult and time consuming to identify the right contact.
- The "languages" of the organizations may be different – government vs. non-profit vs. corporate – and they need to be addressed.

DISCUSSION

Partnership, coalition and/or community development and participation can be approached from any number of perspectives. From a marketing point-of-view, the formation of national partnerships should consider all four elements of the marketing mix. As noted earlier, often times potential partners are identified to meet recognized needs for distribution of materials or promotional support. However, these tactical concerns should not outweigh bringing partners earlier into the planning process, as they can often be more insightful and creative about distribution and promotion (after all, those are their strengths) than the plans that have been laid out for them to implement. Creating a sense of ownership and common purpose is one of the first important steps that need to occur for the development of a successful partnership effort. However, it is also important when creating partnerships to keep in mind not just the "win-win" between partners, but also the "win" that is captured from the audience perspective (what one participant termed the "win-win-win" scenario). We consider this latter point first.

What is often overlooked in partnership recruitment is what potential partners can contribute to the behavioral (product) attributes and benefits. For example, participants in our focus groups consistently linked sources of calcium with dairy products. From a strategic perspective, this gives the program planners at least two stark choices: reinforce this association by recruiting partners from the dairy products industry, or look to expand the behavioral choices available to priority audiences by soliciting partners from other sectors of the food industry whose products are also rich sources of calcium (i.e., produce, calcium fortified products such as orange juice). Another option would be to stress weight-bearing physical activity as bone-building behaviors, and recruit partners that can reinforce and create opportunities to engage in these types of behavior.

Another aspect of behavior change that has implications for partner recruitment, concerns the relative passivity or perceived lack of influence that parents have over their childrens' bone health behaviors - especially their food choices. In the focus groups, we found parents placing responsibility for nutrition and physical activity education on the schools and healthcare providers. If these behaviors, or lack of, and audience were to be a target for the campaign, it would have huge implications for partner recruitment. From a pricing perspective (that is, costs and benefits of engaging in bone healthy behaviors), some of the insights from our research that might affect partnership development activities included the rather pessimistic assessment that not much could be done regarding changes or additions to school curricula. This suggests that far less effort be placed on partnership recruitment to implement these types of tactics. Far more important were the incentives that boys and girls identified as important to them. From a marketing perspective, efforts directed towards involving partners who could provide these types of incentives might be more effective than ones aimed at

addressing traditional barriers found in schools.

Distribution activities are historically a primary reason for developing partnerships. From the audience perspective, whomever they receive materials, incentives, campaign messages and other products and services is important. What we found was that the CDC was perceived as a credible source of information about bone health by adults, but that they were somewhat mistrustful of information that might come from private sector sources they perceived as having ulterior motives. Among tweens and teens, we found some support for the same position, but also tested a variety of manufacturuers and retailers who market to these audiences to gain a sense of "who's in and who's out." The area of promotional channels found the usual print, electronic and new media being mentioned by various audiences. Perhaps the two more interesting observations from our interviews and focus groups were: (1) the convergence of all groups on school cafeterias, fast food establishments and other sources of "junk foods" as the major culprits for the obesity problem; and (2) the virtual neglect of any conversations about barriers or incentives to increasing physical activity, suggesting that these behaviors are not top-of-mind concerns of teens, their parents or their adult influencers when it comes to bone health. From a strictly "promotional" or health communications point-of-view, these two areas might receive considerable review and further exploration as the campaign's research agenda is developed.

The input we received from current, past and potential partners suggests that the marketing of partnerships rests on six key principles:

- Partners need to visualize how their participation makes a unique contribution to the overall campaign and the success of their organization.
- There needs to be both an initial commitment and a periodic reassessment of that commitment to participation and action by both key decision makers and staff to the vision and the strategy of the NBHC.
- Demonstrate flexibility to adapt campaign needs and expectations to a partner organization's capacities and resources.
- Create opportunities that allow for organizations to interact with each other outside of the partnership relationship.
- Devote time and effort towards developing tools and technical assistance support (marketing was explicitly mentioned) for partners to more fully engage in the campaign's activities.
- Demonstrate and publicize successes to partners, other stakeholders and the priority audiences.

There are obviously many other process variables that are involved in developing and sustaining effective partnerships and coalitions. Wolff (2001) for instance, notes the importance of coalition members' readiness to engage in an inter-organizational approach versus going it alone; the shared intentions of potential partners towards achieving mutual objectives; the structure and organizational capacity of the partnership; the ability of partners to take on orchestrated actions; the nature of the membership itself; the leadership; the dollars and resources available to the partnership relative to its objectives; the nature of the relationships among partners; and the availability of technical assistance, consultation, training and support for the staff, boards, committees and members of the partnership.

Nicola and Hatcher (2000) note that among the factors that influence why people participate in partnerships and coalitions include the sociopolitical environment, community needs, community attitudes and beliefs, and the existing leadership and organization in the community. They also summarize the research literature on the subject to state that people participate in coalitions when they feel a sense of community, see their involvement and the issues as relevant and worth their time, believe that the benefits of participation outweigh the costs, and view the process and organizational climate of participation as open and supportive of their right to have a voice in the process. It is our view that all of these issues can be addressed by a marketing approach that uses needs-assessment and market analysis to craft a program that responds to the realities of the priority audiences, meets the needs of potential partners, and lays the foundation for a program that addresses behavioral choices, incentives and barriers to change, opportunities to try and practice new behaviors, and promotes these choices, incentives and opportunities in ways that touch an audience where and when they are open to the possibilities.

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