Mobilizing the COMMIT Communities for Smoking Control

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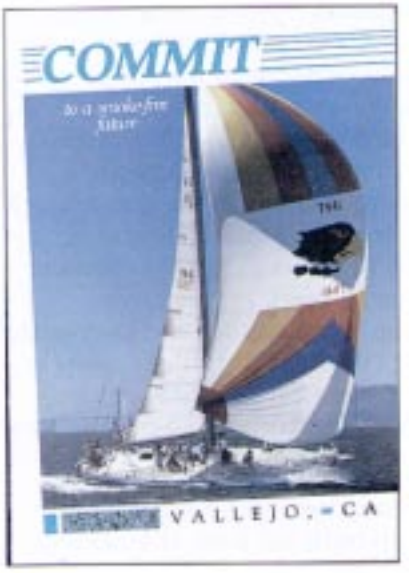
INTRODUCTION Twenty years of community intervention studies have taught us much about the need to engage communities in health behavior change and about the processes required to involve communities (Abrams et al., 1986; Carlaw et al., 1984; Elder et al., 1986; Farquhar et al., 1985; Puska et al., 1985). Widespread agreement about the benefits of using community organizations as primary delivery systems in large-scale health behavior change programs (Green and Raeburn, 1990; McAlister et al., 1982; Tarlov et al., 1987) has been supported by theoretical arguments that durable changes in lifestyles of whole populations require changes in the community environment to support the behavior changes by individuals (Egger et al., 1983; Fortmann et al., 1990; Puska et al., 1983; Tarlov et al., 1987). Several community studies have been conducted in recent years, primarily on cardiovascular risk reduction; initial results from those studies and large-scale smoking cessation trials indicate that behavior change is possible (Carlaw et al., 1984; Egger et al., 1983; Elder et al., 1986; Puska et al., 1985; Fortmann et al., 1990). Most such studies have been carried out with some collaboration by investigators and the communities.

Collaboration between community and researchers, although seen as essential to the research project, varies widely in both the form it takes and the way it is developed. Collaboration can vary from little community involvement, such as community permission to target a particular place for intervention activities by an external agent, to total community control, such as giving a community funds to develop its own solutions to a specific problem. However, for the majority of external funding agencies, a more moderate approach is followed in which the community becomes a partner in the change activity. Increasingly, a strategy called "community organization" is being used, whereby community members become active participants in addressing a problem that affects the entire community (Thompson et al., 1990-91). Theoretically, there are three assumptions that underlie the need to involve local citizenry in a change effort. The first is that behavior occurs in a social context rather than in a vacuum or on an individual basis; the second is that large-scale behavior change requires that the social context be changed; and the third is that change is more likely when the people affected by a problem are involved in defining and solving it (Abrams et al., 1986; Kuriji et al., 1988; Florin and Wandersman, 1990; Thompson and Kinne, 1990). Funding agents and studies that now are attempting to reduce chronic disease risk factors at the community level almost uniformly foster relationships with the community receiving interventions so that local

citizens participate in the projects (Chavis et al., 1983; Crosby et al., 1986; Englund, 1986; Millar and Naegle, 1987).

Gaining citizen participation in communities generally requires mobilization of at least some portions of the community. Community, in this context, is a group of people sharing a locality, being interdependent, having interpersonal relationships, and having a sense of belonging to the larger entity (Thompson and Kinne, 1990; Warren, 1958).

Mobilization is the process whereby the community or some of its parts become aware of a condition that has negative implications for the community, identify the condition as a priority for community action, and institute steps to change the condition (Thompson and Pertschuk, 1992). Mobilization is a complex process often idiosyncratic to a community and a project. Partially as a result, few data have been systematically gathered or published about mobilization activities in diverse community studies; rather, an occasional description of the mobilization process may be included in a progress report on research development. A few researchers have examined the process more concretely (Burghardt, 1982; Hunkeler et al., 1990; Stunkard et al., 1985; Thompson et al., 1993), thereby yielding some information on the processes of initially interesting and involving communities in health behavior change.



Although any kind of external funding agency is likely to constrain community efforts to address a problem, research in communitywide projects addressing health promotion poses special problems for involving communities. In a "pure" community approach, community members take the initiative by defining a problem; however, in externally funded projects, the original impetus for the community to accept the existence of a problem comes from external sources that have their own plans for defining and addressing the problem. In addition, the need for integrity of the research and the constraints of funding by government agencies generally put strict limits on the extent to which individual communities can be part of the decisionmaking processes in health promotion projects. Although community members may have their own ideas for addressing a problem, there is likely to be little researcher support for innovation or deviation from a research plan. For example, the Community Intervention Trial for Smoking Cessation (COMMIT) project required communities that were to receive funds to define smoking as a major public health problem. In addition, it utilized a standardized protocol that required the community to implement certain activities before turning to activities that came up from the community.

In spite of the departure from a pure community organization model, the COMMIT project attempted to build a partnership with the

11 intervention communities; it followed a standardized mobilization protocol to build community infrastructures that could address the smoking problems. In this chapter, the mobilization experiences of the 11 communities that participated in COMMIT are described. Because the communities followed a standardized mobilization protocol to organize themselves to address tobacco control, this experience offered a unique opportunity to examine several questions about mobilization and the use of a common strategy for mobilizing communities.

Specific questions of interest included the following: What are the important factors in developing a common mobilization process? Can a single mobilization protocol be implemented across 11 communities? Can mobilization protocol objectives and timelines be met consistently in the various communities? Are the experiences of these communities generalizable to other community health initiatives? What happened in the field as the communities followed the protocol? The lessons learned from the initial mobilization process in the 11 COMMIT intervention communities are presented in this chapter.

ADAPTATIONS FOR RESEARCH PURPOSES

COMMIT builds on a community organization perspective (Blackburn, 1983; Green, 1986; Farquhar, 1978; Kelly, 1979; Labonte, 1989). The partnership arrangement initially planned was one that would reflect "community ownership," important both in theory and in practice. Essentially, the outside experts—the researchers—would be facilitators to guide change, not to control and define it. The general principles of partnership and community ownership were adopted by COMMIT investigators; however, early in the trial, investigators recognized that the design features of COMMIT introduced many potential problems for establishing partnerships with the communities.

After much debate about the shape of the trial (see Chapters 3 and 4), the research direction adopted for COMMIT treated the project as a single study with the equivalence of 22 "subjects": 11 intervention and 11 control communities. With the community as the unit of randomization, it became necessary to define a basic intervention to be tested, with a decision to provide basic commonality in the intervention to permit comparisons across communities (see Chapters 3 and 4). Investigators decided that total local ownership of the project might result in significantly different organizational structures and foci of interventions; indeed, there was a concern that the project might produce 11 different

demonstrations rather than a single trial. Researchers also were aware of the danger of too much mandated structure and the threat it might present to local involvement and participation. A compromise approach was developed to maintain trial integrity and provide enough flexibility to accommodate local variations.

Trial integrity was achieved through a protocol that defined a general mobilization process for organizing the intervention communities, establishing a basic structure for organizing local projects, implementing a set of required intervention activities consistent with community customs, and carefully documenting the process (Thompson et al., 1990-91). The general mobilization process and the requirements for establishing the organizational structure are described in this chapter.

The approach used for COMMIT does not meet all the criteria for an equal partnership with the community: As in other community research projects (Chavis et al., 1983; Goodman and Steckler, 1989), scientific goals are a higher priority than the community development goals (Rothman, 1979). Although COMMIT sought to promote partnership whenever possible, it was an unequal process, and the community had less power than either the funding agency (National Cancer Institute [NCI]) or the research institutions receiving funds to administer local projects.

STEPS IN MOBILIZING COMMUNITIES

Significant effort was devoted to defining both the community mobilization process and the resulting structure. The "leadership board" model served as the basic organizational structure. In this structure, a community Board of influential and informed people, often leaders representing key organizations in the community, was formed. The process required an understanding of the community through an examination of secondary sources, conversations with key informants, and involvement of local people with influence in their community to identify and nominate members to serve on a community Board. The approach encourages the inclusion of other community members, especially through task forces, but the focus is on identification and recruitment of known community leaders who have access to, or control over, resources and policy decisions. The model emphasizes participation by members of key community sectors (Thompson and Kinne, 1990) so that the majority of the community is represented.

The COMMIT research team established 12 activities (Table 1) that each site was expected to do in support of its mobilization efforts. Most were undertaken during the initial planning phase of the trial before implementation of the intervention. Both the activities and the percent of communities completing each activity are given below:

COMMUNITY ANALYSIS

An old Chinese proverb advises: "Go in search of people. Begin with what they know. Build on what they have." This is the challenge facing health promotion advocates as they attempt to design and implement community interventions. The first step in meeting this challenge is to systematically gather information about the strengths, resources, opportunities, and needs in a community. This process has been labeled variously as community diagnosis, community needs assessment, health education planning, and community mapping (Haglund et al., 1990). Ideally, health promotion advocates undertake such a process *with* rather than *to* the community and create opportunities to increase awareness and ownership of any health interventions that result.

The community analysis is designed to provide an indepth, comprehensive look at the community. For lasting change to occur, attention must be paid to the underlying factors that influence behavior, including the factors that might facilitate or inhibit a proposed change within a community as well as the factors that are likely to make a given approach a "good fit" with its host environment. Drawing on the experiences of other community-based health programs, the COMMIT project undertook a series of information-gathering steps in the 11 pairs of communities targeted for study.

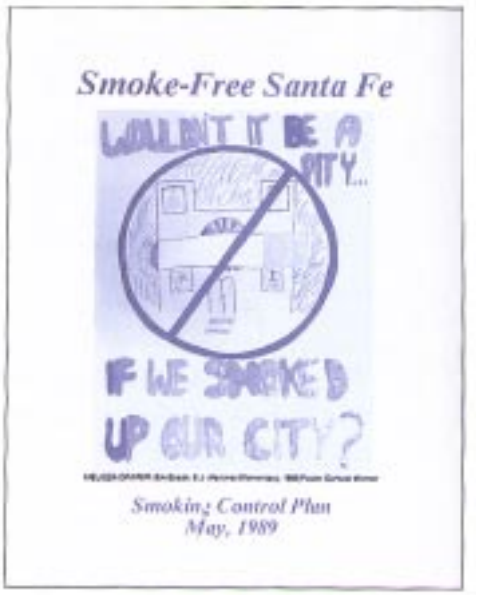
Table 1
Mobilization activities and process objectives

Activities To Be Conducted by Each Community	Communities Completing Activities (%)
Establishment of Community Planning Group	100
Planning for Program Office and Staff	100
First Community Board Meeting	100
Creation of Task Force Member List and Recruitment	100
Writing of By-Laws	100
Field Site Management Plan	91
Smoking Control Plan	100
First Annual Action Plan	100
Second Annual Action Plan	100
Third Annual Action Plan	100
Fourth Annual Action Plan	100
Transition Plan	100

Prerandomization In the first step, researchers prepared a community profile for each of the 22 communities in the trial. Each document blended quantitative information, such as demographic indicators and lists of programs and services, with qualitative information on the community's history and image of itself. The analysis required the collection of extensive information about the communities, including identification of media outlets, health care providers and settings, worksites and business groups, local organizations, available smoking cessation services, and schools and other youth-serving agencies. The analysis also contained a crude assessment of potential intervention channels and resources.

To avoid activation of any of the communities prior to randomization, the report drew primarily on secondary and archival sources (e.g., census data, chamber of commerce publications, local business and trade lists, local media). In addition, a few key informants (people who are knowledgeable about the community) were identified. Discussions with these individuals provided additional information about community structures, key players, influence networks, and previous examples of collaborative effort that focused on public issues.

Postrandomization For each of the 11 randomly selected intervention communities, a more detailed community analysis was conducted. The postrandomization community analysis assessed the major factors likely to facilitate or inhibit the accomplishment of project goals and the tobacco control activities required for each intervention area. The analysis identified additional key players and stakeholders, provided an assessment of community programs and resources that might be relevant to future tobacco control efforts, and more closely examined the intervention channels. Methods the COMMIT project could use to build on established community organizations were closely explored because a key tenet of the project was to avoid competing with, duplicating, or replacing existing program services. Information gained from the analysis helped staff members work with local organizations.



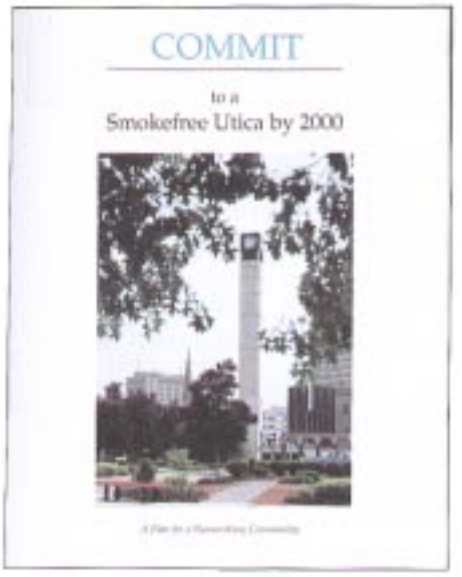
As part of the postrandomization analysis, investigators developed a description of the community sectors whose participation was considered essential for the project to succeed. Building on the prerandomization analysis, a Community Planning group, consisting of community members representing a variety of sectors and agencies, was convened. The planning group had several responsibilities,

including providing input to and refinement of the community analysis. The analysis ended with a community-specific blueprint for forming the community Board, including the sectors to be represented and a list of candidate Board members.

The community analysis is the cornerstone of any community intervention. Across communities, it appears the community analysis is an important tool for both researchers and field staffs as they engage in the initial activation of the community to address tobacco control. In most cases, the community analysis process identified community leaders and other influentials, and it informed participants which groups had been involved in prior health promotion efforts or had a current stake in the tobacco control issue. It laid out a plan for establishing a Board and task forces with a list of possible participants from all fundamental sectors of the community. Community representatives consistently commented that all groups and agencies that became involved in COMMIT were appropriate participants. Yet even after 4 years of effort, all communities could point to one or more groups that did not participate in the project.

What the analysis did not provide in some instances was sufficient insight about the priorities and concerns of key groups that had not been involved previously in tobacco control. This information had to be gathered as the intervention progressed, and many communities were less successful than expected at involving groups that might have provided access to the heavy smoker target group, whether they were unions, blue-collar worksites, racial or ethnic minority organizations, low-income residents, or less educated people. Somehow the analysis failed to provide some communities with the necessary "hooks and handles" to reach into those heavy-smoker enclaves.

Even when such information was available, staff members sometimes did not produce the expected results. In Utica, NY, for example, representatives of the minority community were invited to participate in project planning and management via the COMMIT Board and task forces. Later meetings focused on finding ways to tailor COMMIT activities to fit the needs and culture of minority residents. However, despite repeated contacts with appropriate community leaders, other problems, such as drug abuse, crime, and unemployment, continued to receive a higher priority than tobacco use.



Having members of key target groups as volunteers or project employees did pay off in some cases. In Bellingham, WA, the initial Board included both minorities and representatives from blue-collar worksites, and this was seen as important in helping oil refineries become smoke-free. The Vallejo, CA, site attributes much of its success in reaching out to religious organizations to the fact that the staff

person doing the outreach was active in the religious community prior to the beginning of the project.

The community analysis was a useful tool for the initial phases of mobilization. Its utility during subsequent years of the trial is more difficult to assess. About half the communities continued to find it useful; however, others complained that it was not user-friendly, seemed redundant, and required the reader to "jump around" the document to find information. Because the community analysis was almost completed before the field staff members and volunteers were deeply involved in the project, many felt little ownership of the document. As a result, some communites reviewed and ratified the community analysis, as required by the protocol, and set it aside and did not consult it again.

Community Activation

Community activation is the process of familiarizing community members with the issue under investigation—in this case, smoking—and involving them in activities to address the problem. The community analysis provided the basic plan for activating the community. The information gathered in that analysis gave the Community Planning Group the basis for nominating and recruiting Board members and for selling the project to other community members. The short timeframe led many communities to involve research institution staff members in the recruitment process. The haste needed for the initial Board formation reflects yet again the contradiction between the community needs and the research constraints.

The planning group also had the responsibility for hiring a local field director to run the project. The limited period, the hiring regulations of the research institutions, and the position of the field director vis-a-vis the community Board and the research institution made this task difficult for some communities. The short time allotted to recruiting a field director sometimes made it a process conducted largely by the research institution because the planning group was busy recruiting Board members. Research institutions had their own regulations concerning employees (field directors were the institutions' employees), and this sometimes interfered with the process.

The mobilization protocol acknowledged that the field director would be required to serve two masters: the research institution and the community. For many communities, this duality became an immediate issue in the hiring decision. In some communities, the selection of the field director

became a researcher decision, with little or no input by the community Board. In Cedar Rapids/Marion, IA, the Board complained about the research institution's choice but was overruled. (Fortunately, the person hired soon won over the Board members.) In another community (Bellingham), the research institution's first choice of candidates was different from those of the planning group, but the planning group's choice was accepted when members argued that it was their community and they knew best who would be a good fit. (Fortunately, the person selected soon won over the research institution staff.)

The hiring of the field director and the formation of the community Board occurred simultaneously. The basic organizational structure for the communities is shown in Figure 1. The community Board was to be broad based. It would identify and nominate members to serve on four task forces corresponding to the four channels of intervention (public education, health care, worksites and organizations, and cessation resources). Flexibility was allowed in the basic structure: Some Boards added executive committees to make decisions for the Board; two groups added broader community coalitions to meet annually and review project progress; and some Boards added task forces to focus on specific activities.

The process of forming the Board and hiring the field director meant that most communities were prepared to begin in terms of other organizational requirements (e.g., establishing bylaws, recruiting task force members, producing a smoking control plan), and this had implications for the local project. The examples of three communities may be illustrative.

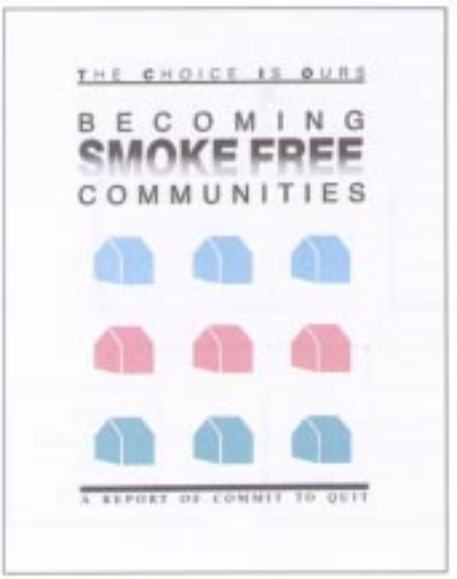
The Board recruitment experience in Brantford, Ontario, Canada, was typical of many communities. The research institution checked the "pulse" of the community through the community analysis and identified influential and interested people in Brantford to participate in the project. The Medical Officer of Health identified individuals who would best represent the

Figure 1
Standardized organizational structure

community. The principal investigator of the research institution then contacted those people and requested their involvement. The group that joined (the Community Planning Group) was responsible for planning the Board formation. They also were invited to become Board members; only a few refused. The initial Board had some conspicuous gaps, most notably representatives of local voluntary agencies. However, once the field director was hired, the executive committee of the community Board and the field director developed think-tank sessions to identify people from various sectors to become involved in the project. This approach seemed to work well, and the Board that emerged stayed strong and committed throughout the project.

In Raleigh, NC, the planning group expedited the hiring of a field director so she could assist with the formation of the community Board. Once the field director was on staff, the planning group met with her, identified community sectors that were critical for involvement, and suggested individuals who were good choices to serve on the Board. The planning group members contacted the nominees first; if nominees were willing to serve, the field director followed up. The next step was a letter outlining the project and the expectations held for the volunteers. The personal contact was emphasized as the key to recruiting Board members. This approach was followed throughout the mobilization process in this community. Task forces and replacement members to the Board also were recruited this way as the project continued. Another fruitful recruitment method was inviting the prospective member to serve on an ad hoc committee with a time-limited commitment for a specific event or campaign. Regular meetings of the ad hoc committee with the field director allowed the necessary facilitation without taking the process and product away from the subcommittee.

The research institution in Bellingham selected the small Community Planning Group of seven people. The group worked closely with research institution staff members to identify the important community sectors and potential community Board members from those sectors. They also agreed to recruit specific individuals for the local project. Through their efforts, a Board of 18 members was nominated and recruited within a week after the field director assumed her position. Although the entire group knew a little about the project, the normal complexities of setting up new projects were evident. In an early meeting, the Board members heard a presentation about the project along with a description of their roles and responsibilities. Nevertheless, there were many unanswered questions, including questions about budget and the paperwork required to set up an office. Researchers were honest in their responses; they did not know all the answers at that stage. Group members kept their good humor by telling themselves that the protocol was their "friend"



and following it would help them in the organization and implementation process.

The field director's first priorities were orienting the new Board members to the project, explaining their relationship with the research institution, and familiarizing them with the "joys and sorrows" of the protocol. This orientation led to some initial cohesion among the group, which took seriously the task of writing bylaws and recruiting task force members. During the process, some issues emerged that further helped the group come together. Early conflicts among Board members actually facilitated and expedited unity. The issues involved conflicts of interest of Board members who wished to take personal advantage of the project's resources. When the issues came to light, the research institution offered to deal with the problem, but the response from the Board was unanimous: "This is our community; we are responsible for the project; and we will take care of this problem."

Community Buy-In A major hope in the COMMIT project was that communities would become partners with the research institutions. Because the agenda imposed on the community was artificial—tobacco control was the problem to be addressed, regardless of other problems in the community—effort was needed to promote partnership and ownership. After establishment of the Board and task forces, their first activity was the creation of a comprehensive smoking control plan that would be the framework for intervention activities for the entire project. The plan document was to be produced locally and tied to local facts, figures, and plans. Some communities found the process of producing the plan an important part of the partnership-building process. Other activities, described below, were reported by the field directors as important parts of the buy-in process. There is little doubt that the time required to build feelings of partnership varied among communities; however, representatives from all communities reported that they felt a strong partnership by about the middle of the trial. A few examples follow.

For Brantford, buy-in occurred in small steps. The production of bylaws and the smoking control plan joined people together in understanding the project. The big step occurred with the purchase of office furniture. The frustration of not getting furniture in the field office when it was needed led to a confrontation between the Board members and the staff from the research institution. The research institution responded by changing the process so the community Board could be more active.

For Brantford, as for most communities, a large boost for ownership came when the community Board chairpersons for all the

intervention communities were invited to a national COMMIT meeting to see how different groups operated. Other communities also were energized by this meeting. Many Board chairpersons or representatives renewed their energy and gained a common understanding of what it was possible to ask from research institutions.

Some communities relied on specific activities to foster buy-in. For Raleigh, several specific activities pulled the Board and task forces closer together. A COMMIT To Quit contest required much planning that involved many sectors of the community. Board and task force members distributed brochures in health care provider offices, worksites, churches, grocery stores, and malls. They also recruited people and organizations from the larger community to get involvement; that is, they solicited prizes, time, or energy from local radio disk jockeys, a basketball coach, and a drugstore chain. The final tally of more than 1,000 smokers who joined the contest astounded the Board members and made them proud.

A less successful example of buy-in in the same community involved protesting the Philip Morris-sponsored Bill of Rights tour. Despite preparations of Board and task force members to protest the tour under the sponsorship of another tobacco control agency, the research institution stepped in at the last minute to cancel the protest.

Several key activities marked the early buy-in of the project in Bellingham. The initial activity was a daylong retreat of the Board members and task force chairpersons to produce the smoking control plan for the community. After examining the protocol requirements, the group decided to transform the plan into something useful and applicable to their own community. Their plan focused on health, used local people as models and local data, and used a logo created by graphics students at the local college. The group's pride in the way they adapted a protocol requirement to a unique plan for their community contributed quietly to a strong sense of ownership. Other activities also led to ownership in this community. Early formation of a finance committee ensured that the Board knew as much as the research institution about the financial status of the trial. From the beginning, the Board members and task force chairpersons had a friendly relationship with the protocol, viewing it as a roadmap rather than a roadblock. The group also donated space, reduced-cost products, prizes for contests, in-kind resources, and countless volunteer hours, which led to strong feelings of ownership.

Maintaining Community Involvement

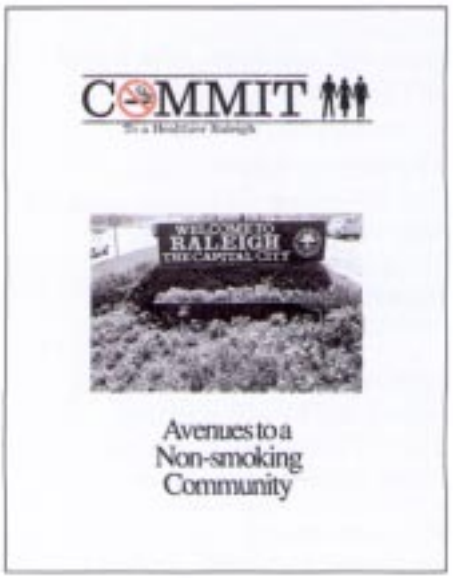
Mobilization does not end when the organizational structure is formed. It is an ongoing process that requires attention to volunteers, adaptations of the initial structure, careful attention to allocation of tasks, and rewards, such as information about the outcome of the interventions. Any organization that relies on volunteers may expect attrition as individuals' lives change, their interest wanes, and other activities compete. Recognizing the likelihood of such attrition means that project staff members need to establish processes to bring on new members. As the COMMIT project continued, it was often obvious that the existing organization had

to adapt to make the work flow more smoothly. Some groups added a finance committee, a transition committee to begin thinking about what would happen after the project ended, and ad hoc committees focused on specific events and activities. These activities allowed a more directed approach to some of the issues and problems facing the Board. Another common problem that faced some Boards was that apathy developed among their members as the task forces and field staff members did most of the work. This apathy among their members was probably perpetuated by the trial rules about data disclosure; aside from process data, no data were available, to either the communities or the research institutions, about whether the intervention was leading to smoking cessation.

Communities dealt with those ongoing mobilization problems in different ways. Brantford volunteers for the Board were asked for a 4-year commitment up front; this kept their attrition low. The Board continued to be active, especially in the face of controversy. When a proposed task force activity was rejected by officials in the community, the Board responded, "Let's go for it . . . ."

The Brantford group dealt with the above-mentioned data problem by requesting a monthly status report from the research institution that summarized activities and groups reached (e.g., health care providers, worksites). Although the report could not discuss success in outcome, it did reassure the Board that progress was being made in the intervention.

The Raleigh Board recognized that attrition was likely and, 2 years into the project, conducted another recruitment of Board and task force members. As previously mentioned, the Board used ad hoc committees for specific events. Because the bursts of intensive and dedicated activity necessary to a big event are almost impossible to sustain with the same people over a long period, the ad hoc committee approach was ideal for maintaining enthusiasm and interest. A side benefit was that it brought into the COMMIT project other organizations and individuals who continued their interest in tobacco control. The field staff members in this community also divided groups into subgroups for discussion and brought them back together for decisionmaking. This process, requiring that everyone be involved at some level, prevented the tedium of sitting through countless meetings merely listening to reports. The field director also emphasized that lively, timely, and productive meetings were essential to maintaining interest.



The Raleigh community used the process-objective information as a way to document progress. The members were cognizant of the process objectives and took pride in meeting or exceeding them. The baseline data were used by the director of the health department

in Raleigh in initiating a policy, and later an ordinance, that restricted smoking in public buildings. Board members saw that event as evidence that things were working.

More than one community (e.g., Bellingham, Cedar Rapids/Marion) suffered from a case of the "middles": The Board was active initially and toward the end of the project but became apathetic in the middle period as work and activities were distributed to task forces and field staff. Some Board members left during this time; however, their leaving provided opportunities to recruit new members who had enthusiasm and different views about tobacco control. In Bellingham the Board became energized when it discovered that it would have a small amount of discretionary funding to give to individuals or groups that proposed ideas for tobacco control. The projects proposed had to be consistent with the overall goals of the protocol but were considered optional activities. This action led to funding activities directed to low-income pregnant women through the county health department. Another activity funded was through the D.A.R.E. (Drug Abuse Resistance Education) program; tobacco control was incorporated as part of the D.A.R.E. curriculum and activities. The Board took pride in reviewing the proposals and deciding about the use of discretionary funds.

From the beginning, Bellingham used the process data to assess achievements and progress. Quarterly reports of process objectives attained were supplemented with large wall charts that showed the timeline for activities for a year, by task force, with lines colored in as activities were completed. The charts provided an immediate overview of accomplishments.

MOBILIZATION EXPERIENCES ACROSS COMMUNITIES

Although the protocol provided a general mobilization process, there were different experiences among the 11 intervention communities. Both field staff and Board members across the 11 communities cited factors that they found critical in the mobilization process.

One positive feature of the trial was that it provided funds for the communities. This was seen as a great asset by many community members because it meant they could focus on the intervention and not on fundraising activities. Another positive factor mentioned was the

approach taken by the trial; it focused on helping smokers to quit rather than portraying them in a negative light.

Many obstacles to mobilization also were seen by project staff and Board members. The short time allocated for initial mobilization was cited by many respondents as a barrier to effective mobilization. As the Bellingham field director noted, "We had to move so quickly, learn what was required of us, and produce accurate and complete plans, that at times we literally felt we were singing in a foreign language." Community Boards and staff members were further frustrated by the time it took to obtain space and set up offices, because such processes had to be approved by NCI (the sponsoring agency) and often by the research institution as well.

Another constraint on mobilization was the approach taken by research institution. Research institutions had different levels of experience with community work, and this led to differing degrees of control. Similarly, research institutions had different types of connections with the intervention communities; where they were not well connected, it was more difficult to mobilize the community. Proximity of the research institutions and intervention communities also had an effect; more distance between the two made it more difficult for research institution staff members to assist with mobilization. The reputation of the research institution within the community was also important. It was easier to approach a community if the research institution working with COMMIT had high credibility and visibility than if the community was unfamiliar with the research institution or had negative experiences with it.

Three intervention communities were dual communities (Cedar Rapids, IA, Fitchburg/Leominster, MA, Medford/Ashland, OR); these resulted from the inclusion of two cities as the target for intervention. In two cases, two communities were combined to make populations sufficiently large to meet research guidelines. In the third case, geographic proximity led to the decision to include both communities. The process of mobilizing them was slowed by the need to contact two sets of city officials, civic organizations, school districts, and so forth. This also complicated hiring, meeting arrangements, and the logistics of some intervention activities. In addition, it was difficult to determine which community should house the field office so that both communities could participate easily in the project.

There was substantial initial confusion over ownership and partnership. In some instances, Board members became frustrated or demoralized when they realized some of the limitations of the protocol because they had developed expectations about the level of control they would have over the intervention. However, other Board members commented that the protocol was a great help to them in both mobilization and implementation because it allowed them to get to work immediately without needlessly repeating earlier efforts. Others commented that it was a broad blueprint that allowed the community to determine strategic details.

In general, the organizational structure required by the protocol was seen as good, and few staff members found it unduly cumbersome. A problem that emerged was the composition of the Board and task forces. The protocol suggested that community leaders be recruited for the Board because of their ability to open doors and lend credibility to the project. Although many communities opted for this approach, some established a Board of people who had reputations for getting things done. There were problems with both approaches. The Boards comprising community leaders soon found it convenient to delegate all the tasks to either field staff or task force members, which somewhat removed the Board from the project. The other approach suffered from a lack of credibility, which slowed down some activities. Many communities combined the two approaches by having a leadership Board with task force members who were more likely to do the work required. However, there was almost unanimous agreement that all Boards and task forces delegated more work to the field staff than had been expected.

As the mobilization process continued, the relationship between research institutions and field staff members became increasingly important. In communities where both understood and accepted the constraints of the protocol and were able to develop a relationship based on trust and mutual respect, mobilization seemed to proceed more smoothly. This tone was passed on to Board members and enhanced the process. In communities where the lines of authority were unclear or information was withheld (e.g., about the budget), the process was delayed. However, it also was noted that in some cases Board cohesion increased when the funding agent or the research institution was seen by the Board as the "common enemy."

A related issue was the transition of activities from the research institution staff to the community and subsequent role clarification. As the field director was hired and began taking responsibility for project activities, the project director at the research institution had to step back gracefully and play a behind-the-scenes role. As the Board became more familiar with the protocol and wanted to take charge of certain activities, the field director had to give way to task force members, other field staff members, and volunteers. In communities where adaptation to changing roles was poor, conflict often was the result.

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

In the interest of providing information for other groups and projects contemplating a community intervention in the future, the field staff and Board members were asked to comment on what could be done differently to make the mobilization process run more smoothly. Some responses apply not only to a randomized trial but to any community project.

The most common response was that a more realistic, longer timeframe must be allowed for the initial mobilization. Ideally, field staff members should be hired and Board and task force members thoroughly familiar with the project, their roles, and any constraints before intervention activities begin. Staff members need time to get to know people, to find common ground, and to develop reciprocity. More time would allow the entire group

to know whether it had found the appropriate people for the Board and task forces. This is especially important when the agenda is an artificial one to which the community has not given a high priority; momentum must build slowly as people are educated about the problem.

Individuals involved in the COMMIT project also were frustrated by the shortness of the intervention period. Mobilizing an entire community requires much time. Volunteers noted that the project had just begun to develop good community recognition when the project ended.

Field directors recommended beginning community projects with small tasks so that immediate success can be seen. For achieving this, a suggestion was made to capitalize more effectively on the development of the smoking control plan as an early mobilization activity. In communities where developing the plan was identified as an objective, a sense of partnership emerged sooner than in those where the community Board had little input into the plan.

Almost all the communities acknowledged that they did not have enough representation from minorities and heavy smokers on their Boards and task forces. Again, more time to explore these populations and engage them in the project was seen as potentially having a large payoff. One person recognized that attention to the protocol shifted priorities away from organizing hard-to-reach groups such as blue-collar and ethnic minority groups. Involving such groups would have enhanced the likelihood of reaching heavy smokers. Putting minority recruitment directly into the protocol would have accomplished the inclusion of hard-to-reach groups and thereby reached heavy smokers more easily.

Many respondents noted that training should have been more specifically focused; for example, training should be more culturally relevant, deal with conflicts, and use the project materials more.

The early products of the trial, such as the prerandomization and postrandomization analyses, were not seen as user-friendly by many communities. This seemed to be partly because the communities' involvement in producing the documents was limited; most groups ratified the documents but never used them as resources for ongoing mobilization activities. It was suggested that the Community Planning Group prepare the analysis so that the community would have some ownership of the report.

CONCLUSIONS The COMMIT mobilization protocol attempted to integrate the best known principles of community organization into an approach that required standardization. Several key principles of community organization were reinforced. Several community studies have noted the need for good community analysis prior to intervening with a community (Bracht, 1988; Haglund et al., 1990). This chapter recognizes that need and suggests that such an analysis include community input as well as comment because understanding the community is a critical step in successful mobilization. Analysis identifies key leaders and actors whose participation is required.

Unfortunately, the trial completely locked communities out of early involvement in trial design and planning. Also, contrary to the basic premises of community organization, it limited their involvement in the community analysis that is the groundwork for later intervention. As a result, there was substantial early confusion over roles and responsibilities.

Community ownership, control, and maintenance are concepts based on the traditions of local autonomy and general community development. In practice, the realization of the overall ownership goal was slow, was not always well understood, and required continuing clarification. Some factors helped: sharing as much information as possible, recognizing the need for joint decisionmaking, and acknowledging that conflict and tension are inevitable in work with large, diverse groups.

Would the COMMIT mobilization status have been different if a standardized protocol had not been used? Would the communities have come to the same place in the same time? Would they have felt more ownership of the project or less? The lessons from the field may not answer these questions, but they do provide insights and suggestions for other groups contemplating community organization strategies for research projects.

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