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AN ASSESSMENT OF COMMUNITY CAPACITY TO IMPLEMENT AND SUSTAIN TOBACCO PROGRAMS IN EAST TEXAS: 2002

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EXECUTIVE SUMMARY

Introduction

This study was conducted to provide a "capacity analysis" for community-based tobacco prevention and control (TPC) programs in Public Health Regions (PHR) that are within the boundaries of the *Texas Tobacco Prevention Initiative.* Initial community funding for this initiative was begun by the Texas Department of Health (TDH) in the Spring, 2000. The study presented in this report is one component of a multi-level framework for capacity analysis. It focuses on community capacity to accept, implement, and sustain comprehensive efforts to achieve the goals of tobacco prevention and control. A second report in this series provides capacity analysis at the level of individual agencies that provide or implement tobacco prevention, cessation, media, or enforcement programs in the local communities. The current analysis is directly in support of those elements of the *Texas Tobacco Prevention Initiative* that include outreach to involve community leaders and citizens in developing, owning, implementing and sustaining tobacco prevention and control programs at the grass-roots level.

Approach

Objectives of this community capacity analysis were to: (a) examine the status of community-wide capacity for implementing and sustaining TPC programs in 2002 compared with baseline in 2000, (b) obtain feedback about perceived impact of TPC efforts in communities, and (c) ascertain community-level key informants' views of assets, barriers and levers that may influence start-up, implementation and sustainability of future tobacco control initiatives statewide. A written questionnaire was distributed in September 2002 to project directors or other key informants within local agencies that in 2001 or 2002 had contracts or subcontracts to use funds administered through TDH to implement and/or coordinate TPC programs and activities in PHR 4, 5, 6. Questionnaire items indicative of the set of conditions influencing implementation and sustainability were drawn from the research literature. Responses were received from 47 key informants representing 17 communities. Complete data with which to compare community capacity in 2002 with the baseline year of 2000 were supplied for 15 of the 17 communities.

Key Findings

Community-wide capacity was reported to be stronger and more widespread in 2002 than it was in 2000 in the following areas:

- More communities with TPC initiatives were reported to have the following assets:
  - Broad based citizen participation;
  - Leadership through coalition or task force;
  - Inclusive decision-making that draws on local leadership and experience;
  - Communication and information network that includes media links; and
  - Outreach mechanisms and feedback.

- The number of communities in which a high priority is placed on goals of the *Texas Tobacco Prevention Initiative* has increased. Goals most often reported as a high priority in 2002 were:
  - Preventing youth from starting to use tobacco; and
  - Motivating cessation.

- Positive impacts on prevention of youth from starting to use tobacco and on motivation of youth and/or adults to cease tobacco use was reported for TPC initiatives in nearly all communities represented in this assessment. Main assets for supporting effective implementation of TPC initiatives were:
    - Funding
    - Training, and
    - Media support.

Although progress is notable, some elements of community capacity for effective TPC still need to be strengthened.

- Only a few communities were reported to have all of the key indicators of community-wide capacity to implement and sustain comprehensive efforts to achieve the State tobacco-related goals. The single indicator most often reported absent was availability of resource support—e.g., community financial support through in-kind and matching funds, and adequate numbers of skilled volunteers.

- Barriers to effective implementation noted most often in narrative feedback from the local key informants were:
    - lack of funding;
    - politics—e.g., officials may be reluctant to restrict use of tobacco when they perceive that substantial numbers of persons in their constituency are tobacco users or have businesses that profit from tobacco use;
    - competing priorities—e.g., teachers may be reluctant to dedicate class time to tobacco prevention curricula and activities when district and state priorities are focused on immediate outcomes of academic skills testing; and
    - the presence of persons who smoke—e.g., when parents smoke they not only expose their children to secondhand smoke but also serve as negative role models influencing their children to resist or even oppose tobacco use prevention messages and programs.

- Opposition to tobacco prevention and control was reported in approximately half of the communities represented in this assessment. In 2002, health-related tobacco problems apparently are not seen to be a major concern in more than one-fourth of the communities represented in this assessment.

- Although increases were reported since 2000 in the number of communities placing a high priority on the goals of reducing tobacco use in special and diverse populations and protecting the public from environmental tobacco smoke, these two goals still were not top priorities at the community level by more than two-thirds of communities.

Recommendations

Options for building on identified strengths and continuing to increase community capacity for tobacco prevention and control include:

- Sharing results of this report with participating communities. This would provide opportunities for special recognition to local leaders for the substantial progress made since the baseline year of 2000 and assist communities with future planning;

- Inviting leaders in communities that are having greater success in recruiting broad-based citizen participation and inclusive decision-making to serve as consultants or mentors to leaders of communities that are in earlier phases of program development and implementation;

- Ensuring that local leaders are informed about training available to support capacity building, with an emphasis on identified community needs such as skill building, volunteer involvement and strategies for acquiring in-kind and external funding.

- Providing technical assistance and guidance to support development of local long-range plans that build on successes in prevention and cessation and also work toward the integration of additional goals for tobacco control including protecting the public from exposure to Secondhand Smoke (SHS) and reducing tobacco use in diverse and special populations.

INTRODUCTION

Capacity—to implement, to coordinate, to sustain—is a term often used in health promotion work (1-4). Capacity building is an important first step in models of systems change and community intervention (5) and is a recommended "best practice" for comprehensive tobacco control programs (6).

This report provides a capacity analysis for community-based tobacco prevention and control (TPC) programs in Public Health Regions (PHR) that are within the boundaries of the Texas Tobacco Prevention Initiative in East Texas. Community-level funding for the initiative was started by Texas Department of Health (TDH) in Spring 2000. The four goals of the Initiative are: (a) preventing youth from starting tobacco; (b) motivating youth and/or adults to cease tobacco use; (c) protecting the public from involuntary exposure to second hand smoke tobacco smoke; and (d) eliminating disparities in local populations (7).

Community capacity to implement and sustain comprehensive effort to achieve TPC goals is the focus of this report. A second report in this series provides capacity analysis at the level of individual agencies/organizations that provide or implement tobacco prevention, cessation, media, or enforcement programs within communities in PRH 4, 5 and 6 in East Texas (8).

Community is defined by Webster's New College Dictionary (1999) as "people with common interests living in a particular area" (7). The baseline report published by TDH which describes the Initiative during start-up identified seven municipalities (Tyler, Lufkin, Texarkana, Longview, Beaumont, Port Arthur, Houston) and eight counties (Brazoria, Fort Bend, Galveston, Harris, Liberty/Chambers, and Montgomery/Waller) within PHR 4, 5 and 6 as "community sites" for the Initiative (7). These communities were the targets for the current capacity analysis.

A definition of capacity at the community level is "the set of assets or strengths [and other resources] that residents, individually and collectively, bring to the cause of improving local quality of life" (1). The current analysis is built on the concept, drawn from the research literature (1-6, 11-19), that community capacity for achieving health goals is indicated when there is: (a) broad-based citizen involvement; (b) infrastructure and processes for facilitation of community-level planning and coordination; (c) community-based resources and support; (d) an inclusive decision making process that draws on local leadership and expertise; (e) communication/information networks, including media links; (f) outreach, evaluation and feedback mechanisms; and (g) community concern and priority placed on goal attainment.

Community capacity analysis is directly in support of those elements of the Texas Tobacco Prevention Initiative that include outreach to involve community leaders and citizens in developing, owning, implementing and sustaining TPC programs at the grass-roots level. Objectives of this analysis are to: (a) examine the status of community-wide capacity for implementing and sustaining TPC programs in 2002 compared with baseline in 2000, (b) obtain feedback about perceived impact of TPC in the communities, and (c) ascertain community-level key informants' views of assets, barriers and levers which may influence start-up, implementation and sustainability of future tobacco control initiatives statewide. A written questionnaire was distributed in September 2002 to project directors or other key informants within local agencies that in 2001 or 2002 had contracts or subcontracts to use funds administered through TDH to implement and/or coordinate TPC programs and activities in PHR 4, 5, 6.

METHODS

Sampling Plan

The sample of communities was selected to be inclusive of the East Texas "community sites" identified for the *Texas Tobacco Prevention Initiative* by soliciting the participation of project directors or their designees within local agencies that in 2001 or 2002 had contracts or subcontracts to use funds administered through TDH to implement and/or coordinate TPC programs and activities in PHR 4, 5, 6. These individuals were especially well positioned to serve as *key informants* regarding local community-wide capacity for tobacco prevention and control. According to the research literature, a *key informant* is a person who is likely to know about the problem or issue of concern – not necessarily a leader or decision-maker, but the "people who are involved in community affairs and know what is going on" (8). Three or four is the number of key informants recommended to generate confidence in assessments for any given community.

Invitations to serve as key informants were extended to a total of 107 persons at agency/organization addresses in the following municipalities and counties:

- Region 4: Texarkana (n=5) in Bowie County; Marshall (n=3), Longview (n=2), and Mt Pleasant (n=1) in Harrison County – Total of 11 persons.
- Region 5: Beaumont (n=16), Port Arthur (n=13), Groves (n=2), Nederland (n=1) in Jefferson County; Lufkin (n=2) in Angelina County; Vidor (n=1) in Orange County; and Nacogdoches (n=1) in Nacogdoches County – Total of 36 persons; and
- Region 6: Clute (2) in Brazoria County; La Marque (n=6) in Galveston County; Richmond (n=2), Stafford (n=2), and Sugar Land (n=3) in Fort Bend County; Bellaire (n=1), Houston (n=41); and Humble (n=2) in Harris County; and Huntsville (n=1) in Walker County – Total of 60 persons.

The largest concentration of agencies were located in Houston in Harris County (n=41), Beaumont (n=16) and Port Arthur in Jefferson County (n=13), and Texarkana (n=5) in Bowie County. This distribution reflects the largest population-areas for the prevention initiative in 2001 and 2002.

A total of 15 communities responded to questions in the Figures – which compare perceptions of community status in 2000 and 2002. A total of 16 communities responded to questions in the Tables, which compare perceptions across public health regions in 2002.

Data Collection

A written questionnaire was distributed in September, 2002. Completed questionnaires were returned through December, 2002.

Questionnaire items solicited key informants' assessments of the breadth and diversity of citizen involvement as well as resources and other strengths brought to the cause of improving local quality of life through tobacco prevention and control. Three of the indicators are about inclusiveness: citizen involvement, leadership, and inclusive decision-making. Another three indicators are about factors that facilitate success: resources, communication networks, and outreach and feedback mechanisms. A final indicator is the priority placed on TPC. Multiple questions were asked to obtain data about the specific attributes that make up the given indicator.

These attributes were derived from the source materials for the indicators described earlier. Questions were asked in retrospective-pretest format to obtain key informants' observations about community capacity in 2000 and in 2002 (9).

The questionnaire also sought feedback about perceptions of effectiveness or impact of tobacco prevention and control activities in the community. The questionnaire concluded with invitations for the respondents to provide narrative recommendations of ways to strengthen Texas TPC.

The questionnaire was pilot-tested on six graduate students with expertise in community health promotion. Their scores for directions, vocabulary, clarity and content comprehensiveness averaged in the "good" range. Modifications were made based upon recommendations of pilot test participants and expert reviewers.

To minimize paperwork burden for respondents, questions about community capacity were integrated with questions assessing agency capacity in the written questionnaire. A copy of the Community Capacity Questionnaire may be found in Appendix A.

Data Coding

Each respondent was asked to identify and assess the one county or municipality with which they were most familiar in terms of tobacco initiatives. Items to assess indicators of community capacity were presented as Likert-type scales on which respondents marked the degree to which he or she agrees that a specific attribute or aspect of community capacity is present in the community. Because community is the unit of analysis for this study, responses were averaged across persons whose assessments were for the same community.

Data Analysis

Except for qualitative analysis of responses to narrative questions about barriers and levers to effective TPC efforts, all analyses were descriptive and criterion referenced.

To produce a status measure for indicators of community capacity, key informants' responses to the individual questions or location measures for the set of attributes that make up any given indicator were aggregated by calculating the average score. This straight forward multi-attribute approach (10) for evaluating the presence or absence of indicators of community capacity was possible because the location or attribute measures for all indicators had the same response scales. Key informants were asked to indicate the extent to which the attribute was present in the community (4=strongly agree to 1=strongly disagree). When the average score across attributes was greater than 2.5, it was taken to mean that local key informants "agree" the community has that indicator of community capacity. Attribute measures were aggregated as follows: broad-based citizen participation= average of items 1.4, 1.5, 1.11; leadership=item 1.6; resources including in-kind and matching funds=average of items 1.9, 1.10, 1.12; inclusive decision-making that draws on local leadership and expertise=average of items 1.7, 1.8; communication and information networks, including media links=average of items 1.13, 1.14, 1.15; outreach mechanisms and feedback=average of items 1.16, 1.17.

To produce the status measure for community-wide concern and priority placed on the goals, separate analyses were reported for items 1.18 through 1.21. For items 1.20, 1.19, and 1.18, a score greater than 2.5 signaled presence of concern about tobacco-related health problems, presence of a great deal of support for TPC, and lack of opposition to TPC, respectively. Item

1.21 asked the key informants to provide a numerical rating of the priority placed on each one of the four TPC goals. The criterion value for these ratings (ranging from 1 to 10 where 10 represents high priority) placed on the four goals was set at 7—i.e., values 7 through 10 indicates the community has placed high priority on that goal.

Questionnaire item 1.22 was a self-anchored scale analyzed separately to provide feedback about the extent to which TPC activities are seen to have positive impact in the local communities (4=very positive impact to 1=negative impact).

Questionnaire items 3.1, 3.2, and 3.3 were open-ended questions inviting narrative responses, which were post-coded to document key informants' recommendations regarding ways to strengthen tobacco prevention and control statewide.

Counts were made of the numbers of communities with indicators of community capacity for implementing and sustaining efforts to achieve TPC goals and of numbers of communities in which TPC program impact has been positive or very positive. Results representing the baseline period (January-December 2000) were compared with those representing the current period (January-December 2002) to evaluate progress in community capacity development. Results also were inspected to identify similarities and differences across PHR 4, 5 and 6.

RESULTS

Communities represented in the current study

Completed questionnaires were returned by 47 persons who provided assessments for 17 communities (see Table 1). Assessments for four of the 17 communities are based on responses from the recommended number of at least three or four key informants: Harris County (n=18), Jefferson County (n=6), Beaumont (n=4), and Port Arthur (n=3). Two counties each had two key informants: Bowie County and Fort Bend County. The remaining 11 communities represented had feedback from one key informant each: Angleton, Houston, SE Harris County, Lufkin, Marshall, South Jefferson, Nederland, Galveston, Gregg, Montgomery, and Harrison. Because of the small number of key informants per community, caution is warranted in generalizing from this sample. Not all 17 communities are represented in all of the analyses presented in the current report. Several informants did not answer that part of the questionnaire requesting retrospective assessment of the indicators for their community in the baseline year of 2000 and/or other items that were used as predictor or pivot variables in analysis of community capacity.

Table 1. Municipalities and counties selected by key informants as the community on which they based their answers to questions about capacity for TPC

PHR	Municipalities	Counties
4	Marshall (n=1)	Bowie (n=2), Harrison (n=1), Gregg (n=1)
5	Beaumont (n=4), Lufkin (n=1), Port Arthur (n=3), Nederland (n=1)	Jefferson (n=6), South Jefferson (n=1)
6	Houston (n=1), Angleton (n=1)	Fort Bend (n=2), Galveston (n=2), Harris (n=18), SE Harris (n=1), Montgomery (n=1)

Community capacity to implement and sustain TPC goals

Although some information was provided by key informants in 17 communities, complete information to compare indicators of community capacity in 2000 and in 2002 was supplied for 15 communities. In 2002, the majority of these 15 communities had the following indicators of community capacity to accept and sustain comprehensive TPC efforts:

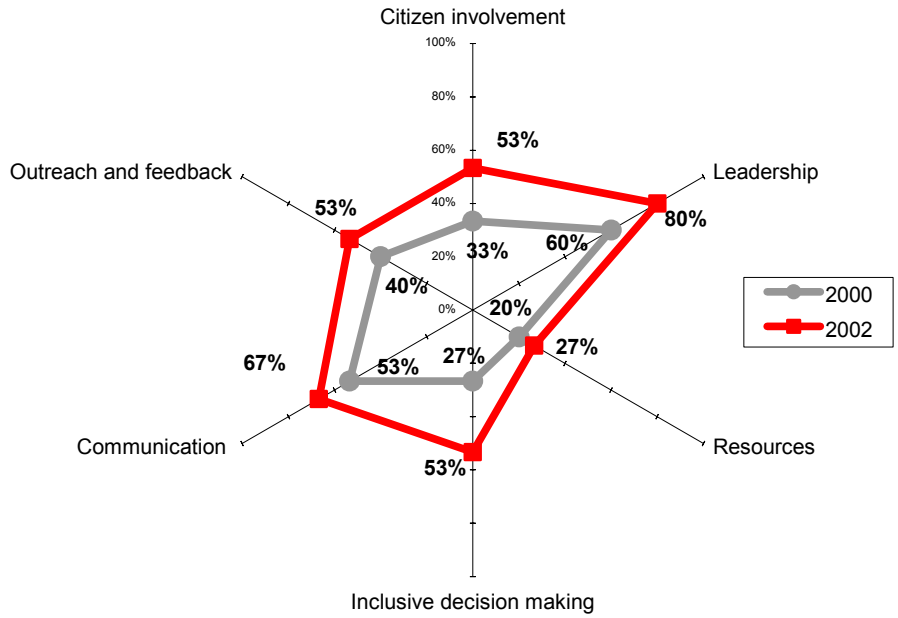
- An inclusive decision-making structure that draws on local leadership and expertise to support tobacco prevention and control efforts community-wide;
- A communication and information network that includes media links;
- Mechanisms for outreach and feedback;
- Broad based citizen participation; and
- A coalition or task force to support planning and coordination.

Availability of resources—i.e., local support that includes skills, volunteers, and in-kind and matching funds—was the only indicator of community capacity that was missing in 2002 in more than half of communities.

Key informants more often reported that these indicators of community capacity were present in 2002 than was the case in 2000 (see Figure 1). Development of inclusive decision-making and increase in the base of citizen participation were areas where change from year 2000 to 2002 was most frequently reported. Attributes that showed most improvement were:

- The amount of citizen involvement,
- Skills for planning and implementing TPC initiatives, and
- Two-way communications between local programs and regional, state, and/or national efforts.

Figure 1. Percentage of communities with indicators of capacity for TPC in 2002 compared with 2000 shown by indicator* (n=15 communities)



**Each community was counted as having a given capacity indicator if the average score was greater than 2.5 (on a scale where 4=strongly agree and 1=strongly disagree) across attributes for that indicator and across key informants for that community.*

Although these data indicate progress in the development of community-wide capacity to support effective TPC programs, as many as half or more of the communities were reported to be lacking one or more of the indicators of community capacity. Only six of the 15 communities met criterion on all six of these capacity indicators in 2002. Specific attributes that were reported absent in half or more of the communities were resources involving adequate amounts of time, money and skills available for local tobacco programs.

Leadership through a local coalition, task force and/or a communication network that includes media links were strengths across communities in 2002 (see Table 2). Key informants from 16 of the 17 communities supplied information about indicators of community capacity for the year 2002. Broad based citizen participation, inclusive decision-making, and outreach to involve the community in TPC initiatives was relatively wide spread across communities in Region 5, but rare in Region 4.

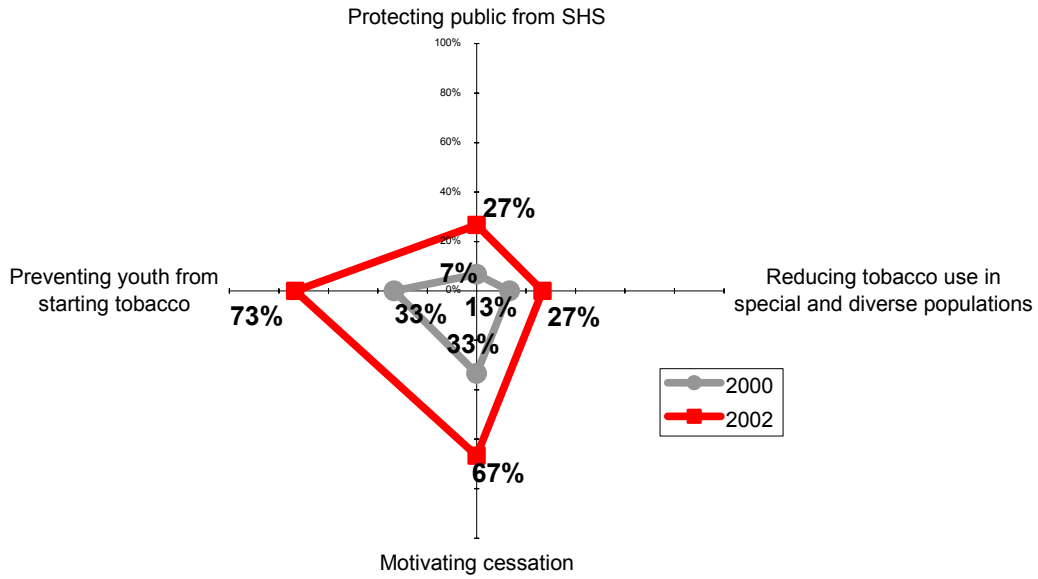
Table 2. Numbers of communities with indicators of capacity for TPC in 2002 shown by PHR and by indicator*

Indicators of Community Capacity • Attributes	**Region 4 (n=4)**	**Region 5 (n=6)**	**Region 6 (n=6)**
Broad based citizen participation			
• Citizen involvement is broad based	0	5	3
• Involves citizens from all community sectors	1	5	3
• Adequate numbers of staff & volunteers	1	1	2
Local leadership	3	6	4
Community resources			
• Donations, matching funds, in-kind contributions	1	3	2
• Adequate skills for planning & implementing	2	6	6
• Adequate amounts of time, money, & skills	1	4	1
Inclusive decision making			
• Local leadership guides decision making	1	5	5
• Includes youth & persons of diverse backgrounds	1	3	2
Communication network with media links			
• Communication links across groups and agencies	1	4	3
• Direct communication with key local leaders	1	6	2
• Two-way communications with state and national	2	5	4
Outreach and feedback mechanisms			
• Outreach to diverse & special populations	2	4	4
• Local evaluation and feedback	1	2	5

* *A community was counted as having a given attribute when the average score across key informants for that community was greater than 2.5.*

A substantial increase was reported from 2000 to 2002 in the numbers of communities placing a high priority on each of the four state tobacco goals (see Figure 2). Preventing youth from starting to use tobacco and motivating cessation among tobacco users were goals most often rated as a high priority in over two-thirds of the 15 reporting communities. In 2000 and again in 2002, less than one-third of the communities were reported to place high priority on the reduction of tobacco use in special and diverse populations to eliminate disparities in tobacco-related disease. Similarly small numbers were reported to place high priority on the goal of protecting the public from involuntary exposure to secondhand tobacco smoke.

Figure 2. Percentage of communities placing high priority on TPC goals in 2002 compared with 2000 shown by goal area. (n=15 communities)



The pattern of reported priorities—i.e., high priority placed on preventing youth from starting to use tobacco and motivating cessation among tobacco users—was similar across communities in different regions (see Table 3).

Table 3. Numbers of communities placing high priority on TPC goals in 2002 shown by PHR and by goal area*

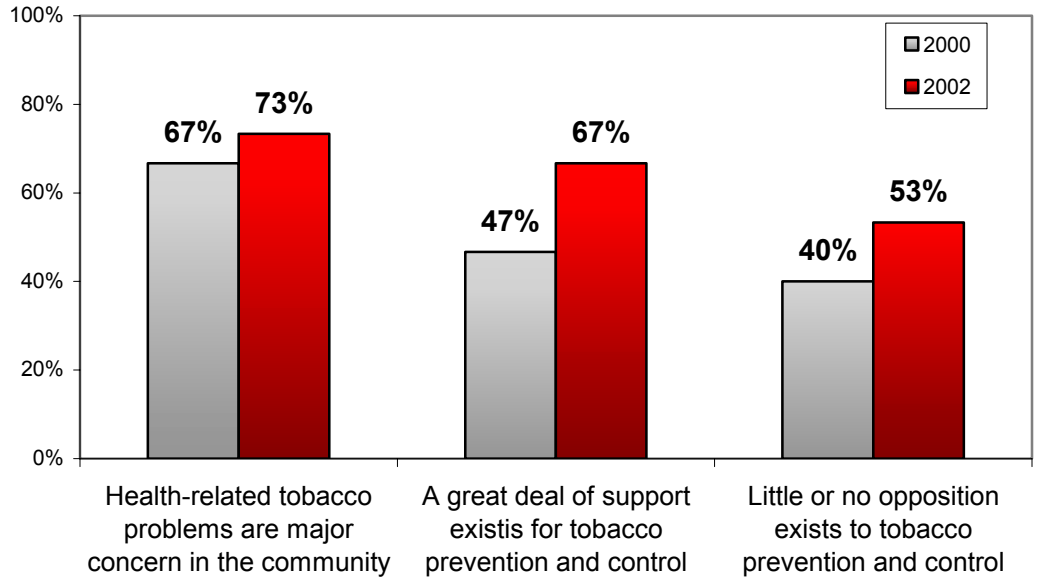
Tobacco Prevention and Control Goals	Region 4 (n=4)	Region 5 (n=6)	Region 6 (n=6)
Preventing youth from starting to use tobacco	3	4	4
Motivating cessation	2	4	4
Protecting the public from second hand smoke	0	3	1
Reducing tobacco use in special populations	1	1	2

**A community was counted as placing high priority on the given goal when the average score (on a scale where 10 = high priority and 1=not a priority) was 7 or higher across key informants for the given community. Each key informant assigned priority ratings independently for each goal.*

Other indicators of community wide concern and priority for TPC goals were measured by asking key informants to indicate the extent to which concern, support, and opposition exist in their community. Key informants indicated an increase from 2000 to 2002 in the amount of attention and support available in the local community for TPC (see Figure 3). In 2002, more than half of

the 15 communities were reported to have a high level of concern about health-related tobacco problems, a great deal of support, and little or no opposition to TPC initiatives. It is important to note, however, that opposition to tobacco control was also reported in as many as half of the communities. Furthermore, results suggested that health-related tobacco problems still are not a major concern in as many as one-fourth to one-third of communities represented in this assessment. (see Figure 3).

Figure 3. Percentage of communities with indicators of concern about and support for TPC in 2002 compared with 2000 shown by indicator. (n=15)



Interest in and support for tobacco prevention and control initiatives was relatively more wide spread across communities in Regions 5 and 6 than in Region 4 (see Table 4).

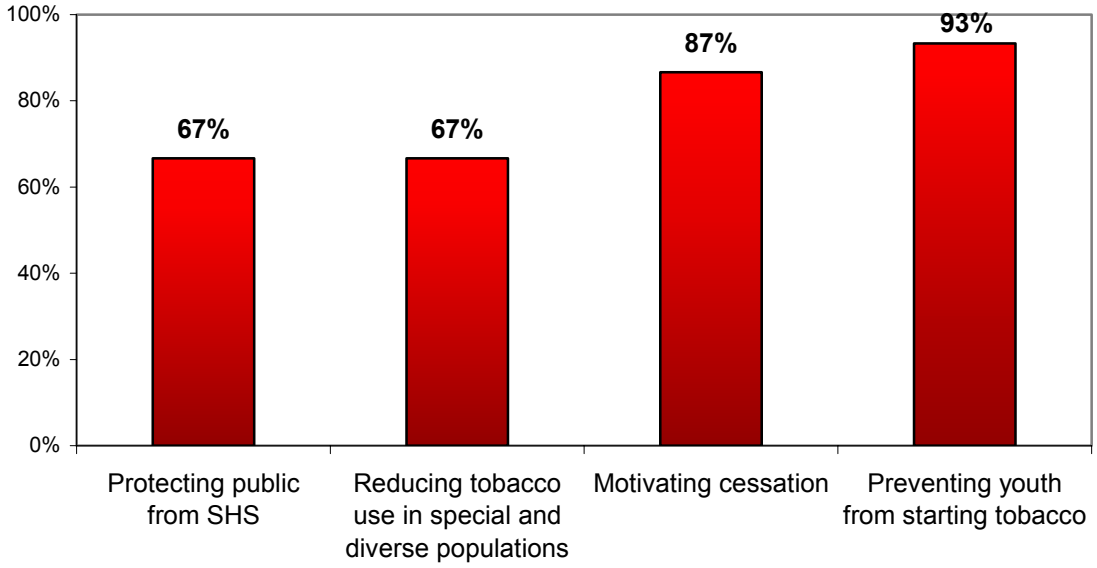
Table 4. Numbers of communities with indicators of concern about and support for TPC in 2002 shown by PHR and by indicator.

Community perspectives of local interest and support	Region 4 (n=4)	Region 5 (n=6)	Region 6 (n=6)
Health-related tobacco problems are a major concern in the community	1	5	5
A great deal of support exists for TPC	1	5	4
Little or no opposition to TPC in community	2	3	3

Perceived impact of tobacco prevention and control activities

The positive impact of local programs to prevent youth from starting to use tobacco and to motivate youth and/or adults to cease tobacco use was reported for TPC initiatives in nearly all communities represented in this assessment (see Figure 4). A positive impact in at least one goal area was reported for all 15 communities for which data were supplied, and nearly half (seven of 15) were reported to have experienced a positive impact in all four goal areas. Youth prevention was the goal area in which most communities (n=7) experienced a very positive impact.

Figure 4. Percentage of communities in which a very/moderately positive impact was reported for TPC goals in 2002 shown by goal areas (n=15)



Similar patterns of positive impact was reported across all three regions (see Table 5).

Table 5. Numbers of communities in which a very/moderately positive impact was reported for TPC goals in 2002 shown by PHR and by goal area*

Goals of Texas Tobacco Prevention Initiative	Region 4 (n=4)	Region 5 (n=6)	Region 6 (n=6)
Preventing youth from starting to use tobacco	4	6	4
Motivating cessation	2	6	5
Protecting the public from secondhand smoke	1	5	4
Reducing tobacco use in special populations	2	4	4

Differences in perceptions of a positive impact in the different goal areas perhaps are explained by differences in relative community priorities placed on the different goal areas. As noted earlier in this report, in 2000 and again in 2002, youth prevention and youth/adult cessation were more often reported as *high priority*. Only a few communities were reported to place high priority on protecting the public from secondhand smoke or reducing tobacco use in special and

diverse populations. The numbers of communities whose TPC initiatives were reported to have had at least moderately positive impact in these latter two goal areas were notably fewer than the numbers for which positive impact was reported for prevention and cessation.

Factors influencing implementation and sustainability of future TPC statewide tobacco-related initiatives

The final section of the questionnaire invited respondents to:

- describe the main asset that can be used to support effective implementation of tobacco prevention and control initiatives statewide;
- describe the main barrier that may hinder or delay implementation of effective TPC initiatives statewide; and
- identify what is needed to support effective implementation of TPC initiatives statewide.

Reference to "funding" was by far the most frequent response to all three of these questions. Thirty-one of the 47 respondents (66%) referred to aspects of funding in at least one of the three questions. "Continue to provide funding," "additional funding," and "need adequate funding" were typical responses to the question about the main asset that can be used to support effective statewide TPC initiatives. "Not enough funds," "limited resources-money," and "lack of funding" were viewed as typical barriers to effective statewide implementation. "Release more settlement money," "find more funding sources," and "more funding" were typical views of levers or gateways to effective implementation of TPC initiatives statewide. Table 6 lists assets in addition to funding that were cited by more than one key informant. The list includes training (e.g., "new law enforcement officer training") and media support (e.g., "high impact media contacts").

Table 6. Factors identified by key informants as assets, barriers, and levers for effective tobacco prevention and control

Assets	Barriers	Levers
• Funding • Training • Media support	• Lack of funding • Politics • Competing priorities • Negative role models by smokers	• More funding • Legislative support • More training, enforcement, education, outreach • Strong coalitions

Barriers other than lack of funding cited by more than one respondents were politics (e.g., "political officials and business are afraid to step forward"), competing priorities (e.g., "teachers pressured with TAKS preparation"{state academic achievement examination} and "other law enforcement obligations"), and smokers (e.g., "if children see their parents/adults smoke, they assume it is acceptable to smoke").

Levers or gateways, in addition to increased funding, cited by more than on key informant were legislative support (e.g., "must be mandatory and not optional" and "stricter laws" and "support from government officials"); more programming (e.g., "enforcing current tobacco regulations," "training community leaders" and "more education on tobacco prevention"); strong coalitions (e.g., "collaborations/partnerships that bring more resources" and "collaboration with more statewide agencies."

CONCLUSIONS

Community-wide capacity was reported to be stronger and more widespread in 2002 than it was in 2000 in the following areas:

- More communities with TPC initiatives were reported to have the following assets:
  - Broad based citizen participation;
  - Leadership through coalition or task force;
  - Inclusive decision-making that draws on local leadership and experience;
  - Communication and information network that includes media links; and
  - Outreach mechanisms and feedback.

- The number of communities in which a high priority is placed on goals of the *Texas Tobacco Prevention Initiative* has increased. Goals most often reported as a high priority in 2002 were:
  - Preventing youth from starting to use tobacco; and
  - Motivating cessation.

- Positive impacts on prevention of youth from starting to use tobacco and on motivation of youth and/or adults to cease tobacco use was reported for TPC initiatives in nearly all communities represented in this assessment. Main assets for supporting effective implementation of TPC initiatives were:
  - Funding
  - Training, and
  - Media support.

Although progress is notable, some elements of community capacity for effective TPC still need to be strengthened.

- Only a few communities were reported to have all of the key indicators of community-wide capacity to implement and sustain comprehensive efforts to achieve the State tobacco-related goals. The single indicator most often reported absent was availability of resource support—e.g., community financial support through in-kind and matching funds, and adequate numbers of skilled volunteers.

- Barriers to effective implementation noted most often in narrative feedback from the local key informants were:
  - lack of funding;
  - politics—e.g., officials may be reluctant to restrict use of tobacco when they perceive that substantial numbers of persons in their constituency are tobacco users or have businesses that profit from tobacco use;
  - competing priorities—e.g., teachers may be reluctant to dedicate class time to tobacco prevention curricula and activities when district and state priorities are focused on immediate outcomes of academic skills testing; and
  - the presence of persons who smoke—e.g., when parents smoke they not only expose their children to secondhand smoke but also serve as negative role models influencing their children to resist or even oppose tobacco use prevention messages and programs.

- Opposition to tobacco prevention and control was reported in as many as half of the communities represented in this assessment. In 2002, health-related tobacco problems apparently are not seen to be a major concern in more than one-fourth of the communities represented in this assessment.

- Although increases were reported since 2000 in the number of communities placing a high priority on the goals of reducing tobacco use in special and diverse populations and protecting the public from environmental tobacco smoke, these two goals still were not top priorities at the community level by more than two-thirds of communities.

RECOMMENDATIONS

Options for building on identified strengths and continuing to increase community capacity for tobacco prevention and control include:

- Sharing results of this report with participating communities. This would provide opportunities for special recognition to local leaders for the substantial progress made since the baseline year of 2000 and assist communities with future planning;

- Inviting leaders in communities that are having greater success in recruiting broad-based citizen participation and inclusive decision-making to serve as consultants or mentors to leaders of communities that are in earlier phases of program development and implementation;

- Ensuring that local leaders are informed about training available to support capacity building, with an emphasis on identified community needs such as skill building, volunteer involvement and strategies for acquiring in-kind and external funding. Examples of available materials include modules on *Developing Community Capacity* available through the W. K. Kellogg Foundation in partnership with the Healthcare Forum (5), and guides and training materials on capacity building through the Colorado Trust (11).

- Providing technical assistance and guidance to support development of local long-range plans that build on successes in prevention and cessation and also work toward the integration of additional goals for tobacco control including protecting the public from exposure to second hand smoke and reducing tobacco use in diverse and special populations.

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APPENDIX A

Texas Public Health Regions