

Involving Diverse Community Organizations in Tobacco Control Activities

Kitty K. Corbett, Linda Nettekoven, Linda C. Churchill, Lesa T. Dalton, Carolyn L. Johnson, Lysha Dickinson, Glorian Sorensen, and Beti Thompson

THE RATIONALE FOR INVOLVING COMMUNITY ORGANIZATIONS

In the Community Intervention Trial for Smoking Cessation (COMMIT), the active participation of multiple sectors of the community was a fundamental vehicle for comprehensive changes in the “tobacco control environment” in communities.

In addition to focusing on the workplaces, clinical settings, and school-based organizations so necessary to health promotion, the COMMIT project from the outset recognized that community and civic organizations were important targets of and channels for pursuit of health promotion objectives (Sorensen et al., 1990; Lasater et al., 1986). Some organizations representing employees and employers, medical care practitioners and clinical settings, and schools were considered so necessary to COMMIT’s goals that from the outset they warranted separate, dedicated channels (and are discussed in separate chapters in this monograph). Miscellaneous remaining community organizations were handled within the separate and more amorphous channel of “other organizations.” This chapter summarizes the experiences of the 11 COMMIT intervention communities in working with diverse civic and community organizations to accomplish tobacco control objectives. The rationale for such involvement is compelling. However, the process of engaging such organizations in tobacco control was highly challenging for participants.

All community-based health promotion efforts use community organizations in many ways (Cuoto, 1990; Hatch et al., 1993; Nickens, 1990; Shea, 1992). Organizations are points of access to targeted individuals for planned interventions. Many organizations are involved in publicity, magnet events, assistance with logistics for activities, and provision of expertise for health promotion efforts. When hospitals, other clinical settings, educational institutions, and worksites are enlisted in multifaceted community projects, staff members are recruited from organizations with a health promotion or social service focus. Representatives of organizations that have implemented smoking bans have been involved in conferences and other educational forums throughout the country. Voluntary agencies (e.g., American Lung Association [ALA], Canadian Cancer Society [CCS]) and health departments have sponsored many health promotion activities. Community organizations also have been useful in efforts to secure funding of health promotion efforts, for example, through written endorsements of and involvement in specific projects.

Community organizations offer opportunities for identifying smokers and others at risk from tobacco, and they also are sources of persons and resources

for fostering change and its maintenance (Roncarati et al., 1989; DePue et al., 1987; Eng et al., 1985; Carlaw et al., 1984). Community organizations are important local institutions through which to implement policy changes, publicize project activities, offer programs, provide education, and otherwise create an environment supportive of health. Organizational policies and opinions of leaders may have considerable influence on members' attitudes and behaviors. Networks of organizations in the form of coalitions may wield considerable influence in a community, and their activities and policies are often well covered by local media. Some types of community organizations have a long history of community service, outreach, and participation in



health promotion and education. Many such groups already regard health-related social service as part of their mission. Organizational facilities, many of which are in neighborhoods, are centers for their members and often for other people and functions. They allow dissemination of information to people outside usual health promotion settings (i.e.,

educational and medical care settings). Some community organizations (e.g., church groups, community centers) also deal with families, which is another important sector infrequently addressed as a unit elsewhere and which may not be readily reached via other channels. Programs such as a Salvation Army mission, those dealing with employment and training, and the Women, Infant, and Children's program (WIC) also can be seen as organizations providing important access to diverse special populations.

Religious organizations appear to have enormous potential as a channel for smoking control messages and activities. They are central social and cultural institutions in American and Canadian communities. Membership in a religious organization in 1990 was reported by 69 percent of American adults in a Gallup Poll, and 40 percent said they had attended a church or synagogue in the past 7 days (Princeton Religious Research Center, 1993). Many religious organizations already take part in health-related activities, such as education, treatment, and screening programs dealing with subjects such as diet and nutrition, fitness, alcohol and substance abuse, mental health, stress management, AIDS (acquired immunodeficiency syndrome), heart disease prevention, and CPR (cardiopulmonary resuscitation), to name a few (Corbett et al., 1991; Elder et al., 1989). Many religious organizations also are interested in prevention programs, have restrictive smoking policies, and have become involved in a variety of programs for their members (Emory University, Carter Center and Park Ridge Center, 1990; Foege, 1990; Hatch and Lovelace, 1980; Hatch and Johnson, 1981; Lasater et al., 1986; Levin, 1984; Saunders and Knog, 1983; Smith, 1983; Wiist and Flack, 1990; Stillman et al., 1993). It is reasonable to assume that clerics, who have seen members die of smoking-related diseases and counseled them and their grieving families, would be receptive to tobacco control. In addition, many members of religious organizations may live with a smoker, have a child who smokes, work with smokers, or have friends who smoke; nonsmokers who become

informed and involved through a religious (or other) organization may be useful channels of tobacco control messages and information to smokers they encounter in their daily lives. Even in those religious organizations with few members who are smokers, nonsmokers could endorse community-wide nonsmoking norms and communicate information about tobacco control and cessation resources to their family members, friends, associates, and acquaintances who are smokers.

The developers of the COMMIT protocol recognized that success required having enduring, influential community organizations endorse the project's goals, steer interventions over the period of Federal funding, enhance their own smoking control policies, participate in tobacco control activities, and provide access to targeted smokers (Lichtenstein et al., 1990-91; Thompson et al., 1990-91). Community organizations beyond health care, worksite, and educational institutions needed to be incorporated into COMMIT's plan, but which ones, and how?

OTHER ORGANIZATIONS IN COMMIT

In COMMIT's protocol, organizational entities dealing with health care, public education, and cessation resources were targeted through channels handled separately from other organizations.

Worksites were structurally linked with other organizations into a single channel but also were dealt with separately in the delineation of activities and process objectives. Other organizations, by virtue of the nebulous character of the channel as well as their diversity, became in effect the stepchild of the worksites and organizations channel.

Community organizations are diverse and complex, with no standard configuration across communities. They vary in type, mission, values, structure, leadership, demographic representation, sheer numbers, charter, rules, and relationships with members. A nonexhaustive list of types of community organizations would include religious organizations, service and fraternal organizations, coalitions (e.g., for health promotion, drug use prevention, community beautification), ethnic organizations, voluntary agencies, business

groups, unions, veterans' organizations, social service locales (e.g., WIC program offices, employment development offices), self-help and support groups, and other local groups such as recreational, neighborhood, and social clubs. Membership or affiliation in community organizations is voluntary, and in many, leadership is short term or rotating. Organizational rules often are derived from tradition and consensus and are adhered to or enforced



internally and informally, without support from formal legal sanctions. In most organizations, participation is occasional, optional, or sporadic. The manner of implementation of activities must be responsive to the special and diverse characteristics of organizations. In addition, specific organizations vary in their potential for assisting with the achievement of COMMIT's objectives. Some organizations were clearly less appropriate for COMMIT activities than others.

The 11 COMMIT intervention communities had diverse constellations of organizations that appeared appropriate for tobacco control activities. The visibility, influence, and penetration of specific organizations were different in various sites. Organizations varied greatly in size in a community. An initial tally of other organizations in the 11 sites (from a review of telephone book classified listings [e.g., "Yellow Pages"] and chamber of commerce lists and modified by other sources, including staff members' knowledge of the community) was more than 1,500 groups, of which about 56 percent were religious organizations and 24 percent were civic and fraternal organizations (Table 1). The number of religious organizations serving the communities totaled more than 800.

All communities contained a wide range of organizations, such as those listed above. In addition, various communities mobilized less traditional organizations such as Drug Abuse Resistance Education (DARE), WIC agency offices, the Puerto Rican Day Committee, and summer youth programs to implement successful intervention activities. In one site, Medford/Ashland, OR, there was no local health voluntary association presence at all, whereas in another, there was a small operation dedicated to preserving its existing mandate and tasks rather than expanding its role. In the Vallejo, CA, and Raleigh, NC, sites, health voluntary associations were the most powerful,

Table 1
Initial tally^a of other organizations in the COMMIT intervention sites, by type of organization

Type	Number	Percent
Religious Organizations	843	55.7
Business/Professional Groups	101	6.7
Fraternal/Sorority Groups	80	5.3
Civic Groups	281	18.6
Trade/Labor/Union Groups	105	6.9
Groups With Health Mandate ^b	80	5.3
Miscellaneous Groups	23	1.5
Total	1,513	100.0

^a These numbers reflect the specific organizations generated by staff in each site in the preliminary community analysis from review of telephone book classified listings, chamber of commerce lists, and other local sources prior to final trialwide adjustment of operational criteria for interventional and promotional organizations.

^b This category includes organizations beyond those that would be targeted through the health care providers or worksites channels.

best funded, and most visionary tobacco control advocates. Both well-known, longstanding groups (e.g., health voluntaries, the Rotary Club) and local, shorter term, grassroots coalitions (e.g., Minority Coalition for Cancer Prevention, Coalition for Health and Responsible Public Policy, Healthy Mothers/Healthy Babies, Community Partnership for Substance Abuse, neighborhood coalitions) played central roles in COMMIT's attempts to meet its objectives.

A typology of community organizations was developed in response to cross-community diversity and COMMIT's varied needs. The activities mandated by the COMMIT protocol for organizations were designed on the premise that community organizations tend to play one or both of two basic roles in tobacco control efforts: (1) acting as institutions through which smokers can be contacted directly or (2) serving as a source of volunteers and other resources that can be engaged in tobacco control efforts directed broadly at the community. In the first case, the organizations were expected to provide a locale where smokers periodically gathered or through which smokers might be reached with mailings, organizational policies, activities, special events, and cessation programs. Organizations so identified were designated as "interventional" organizations. Particular organizations such as large churches and business-related groups such as chambers of commerce, unions, and service organizations were designated interventional organizations when they met the following criteria:

- Active membership of at least 50 adults as evidenced by:
 - size of attendance at meetings;
 - size of attendance at organization-sponsored events; and
 - number of dues-paying members (persons committed enough to send in dues are likely to be accessible through an organization's mailouts).
- Meet at least six times a year.
- Have a regular meeting place.
- Have a number of members who smoke, as determined by available information (e.g., key informant, informal conversations with one or more members).
- At least 30 percent of membership are estimated to be community residents.

In addition to those criteria, limits were placed on the size of religious organizations targeted for intervention activities. Given the many religious organizations in some COMMIT sites, limited resources did not permit that interventions be directed at all of them. Reasoning that religious organizations with 250 or more members would be likely to reach more smokers than those with fewer than 250 members, the size of the religious organization became an additional eligibility criterion.

Other targeted organizations were designated as “promotional” organizations, although some fit in both promotional and interventional categories. Promotional activities were those that were held to contribute to community smoking control efforts in one or more of the following ways:

- generating community recognition of, interest in, and sanction for the COMMIT project;
- providing greater access to the socioeconomically disadvantaged and other nonmainstream groups likely to include heavy smokers;
- increasing the amount of information available in the community regarding smoking cessation/control efforts and resources;
- generating volunteer support for COMMIT activities;
- providing material resources (e.g., money, supplies, equipment, meeting space);
- enhancing media coverage, publicity, and other public relations activities related to smoking control;
- contributing to community mobilization for smoking control through the creation or enhancement of local networks; and
- helping to increase the number of quit attempts made by community residents.

This approach was designed for organizations that did not necessarily include a substantial number of smokers within their membership yet might be willing because of their mission or role in the community to involve volunteers or other resources to the tobacco control cause.

Once revised operational criteria were employed, the number of organizations designated for assessment of progress toward process objectives totaled 726 interventional and 702 promotional organizations across the 11 sites (Table 2). Beyond the challenge posed by the sheer numbers involved, the numbers by community illustrate the diversity existing among the sites: The number of interventional organizations ranged from a low of 46 to a high of 138, and promotional organizations ranged from a low of 21 to a high of 256. Site ratios of the number of organizations targeted for intervention activities to the total population ranged approximately from .0005 to .001, with only slight agreement between size of community and number of organizations identified for intervention.



Table 2

Numbers of interventional and promotional organizations for assessing annual achievement of process objectives, by site, for the initial 3 years of intervention^a

Sites	Interventional	Promotional	Both
Site A	50	77	127
Site B	57	78	135
Site C	47	27	74
Site D	103	53	156
Site E	138	256	394
Site F	54	69	123
Site G	46	21	67
Site H	67	105	172
Site I	86	34	120
Site J	85	24	109
Site K	50	36	86
Total	726	702	1,428

^a Adjusted totals for the final intervention year summed only a few more: 727 and 713 for interventional and promotional organizations, respectively. Sites are listed in random order.

The emphasis in the channel of other organizations shifted early in the COMMIT project. In the planning phase, a wide variety of organizations were featured as potentially equivalent, with the relative importance of their diverse types to be determined locally. However, as the evaluation requirements of the overall project were articulated into mandated activities and concrete process objectives, religious organizations emerged as the sole type of organization in the channel that could be formally evaluated in standardized fashion (Mattson et al., 1990-91; Corbett et al., 1990-91). In light of the considerable diversity of organizations in communities and the difficulty of generating comparable sampling frames of organizations across communities, a decision was made to use a survey of religious organizations as a kind of proxy for assessing the penetration and



efficacy of COMMIT activities in diverse organizations. The articulation of this in the mandates expressed in the COMMIT protocol (i.e., required activities and process objectives) and the recognition of the survey of religious organizations as a critical evaluation tool resulted in a shift in local understandings of priorities in the channel. In most sites there was also a corresponding shift in activities implemented in the channel. Religious organizations came to preeminence in this channel at a trialwide level and in most communities. Requirements for evaluation data drove the intervention to a degree unforeseen by COMMIT's designers.

The mandated activities of this channel are given in Table 3 and reflect the difference between interventional and promotional organizations.

Presentations on Smoking Issues To increase awareness of the tobacco problem, COMMIT staff members and volunteers made short presentations of at least 15 minutes to organizations targeted for intervention during the groups' regular meetings. Presentations included information on smoking cessation, the health implications of tobacco use and secondhand smoke, policy and program resources, and national as well as local trends in tobacco control. If appropriate, COMMIT speakers also provided information on legal issues and publicized upcoming smoking policy and cessation seminars and workshops. Organizations likely to include a high proportion of smokers on their membership rolls, such as labor unions or veterans' groups, were emphasized. Promotional organizations also were contacted in an effort to strengthen local tobacco control networks.

Table 3
Activities and process objectives for organizations

Activities for Each Community	Cumulative Objectives (1988-1992)	Number Completed	Process Objectives Achieved ^a (%)
Short Presentations to Organizations Targeted for Intervention	30%		83
Comprehensive Seminars to Organizations Targeted for Intervention	44 seminars 30%	40 seminars	91 77
Promotional Activities in Organizations Targeted for Intervention	50%		152
Distribution of Self-Help Materials in Organizations Targeted for Intervention	50%		160
Distribution of Promotional Materials to Organizations Targeted for Intervention	50%		172
Annually Involve Organizations Targeted for Promotion in Magnet Events	440 organizations	497 organizations	113

^a Average for combined communities.

- Seminars on Smoking Issues** Seminars or policy presentations of at least 1 hour in length were offered to representatives of organizations targeted for intervention. The longer format allowed presenters to cover tobacco control topics in more detail. Workshop content included the health implications of tobacco and secondhand smoke, cessation resources and strategies, national and local trends, legal issues, and policy and program options. Examples of nonsmoking policies and cessation efforts from local organizations were highlighted. In some communities separate seminars were held, for example, for religious groups or labor organizations. In other cases, tobacco control issues were covered as part of a larger workshop agenda on a related topic, such as substance abuse, that was designed to reach larger numbers of participants.
- Activities Promoting Magnet Events** To foster member participation in communitywide cessation events, COMMIT staff members and volunteers conducted promotional activities in organizations targeted for interventional and promotional activities. In conjunction with “magnet events” such as “Quit and Win” contests, The Great American Smokeout (GASO), and Non-Dependence Day, COMMIT staff members distributed event materials, solicited signups, displayed information, and conducted other activities such as carbon monoxide testing.
- Promotion of Self-Help Materials and Cessation Services** Although activities and materials teaching the skills needed to quit smoking were already available in most communities, the COMMIT project sought to enhance the effectiveness and penetration of these cessation resources by directly targeting interventional organizations. Posters, flyers, brochures, pamphlets, and other information were delivered directly to organizations for distribution to their members who smoke. In addition, materials encouraged smokers to join the Smokers’ Network. The network, created by COMMIT, was a voluntary list of smokers in each community who were interested in receiving mailings designed to provide information on how to quit smoking and remain smoke-free (see Chapter 8 [Lichtenstein and colleagues]).
- SUCCESSFUL EFFORTS WITH COMMUNITY ORGANIZATIONS** Community groups already existed in most sectors of the community and, consequently, provided useful structures for enlisting smokers on the network, reaching diverse populations, and bringing about restrictive tobacco control policies and bans. To recruit smokers to COMMIT’s Smokers’ Network, communities enlisted the support of groups as diverse as the Girl Scouts of U.S.A., WIC providers, ethnic organizations, sports groups, and the American Red Cross. Activities ranged from health fairs, materials dissemination, and a “Butt-out Party,” including a display of the domino effect of 720 cigarette packages. Diverse populations were reached through DARE in Bellingham, WA, the Puerto Rican Day Parade in Paterson, NJ, and food distribution at neighborhood health centers. Community grants also were given to various organizations to reach diverse populations in creative ways, thereby promoting cessation and maintenance. The Vallejo site provided a positive, high-energy experience in tobacco prevention and cessation through its



“African-Americans Celebrate Life” event. In sites that achieved restrictive tobacco control policies and bans (e.g., local ordinances banning vending machines), success resulted from the collaboration of tobacco control advocates with other coalitions, such as substance abuse prevention groups, community organizations such as the Boy Scouts of America, and police and health departments. Communities used sports and recreational events; for example, Utica, NY, disseminated a tobacco-free message to 1,500 fans of the Champion Boomerang Team in a “Throw Tobacco Out of Sports Campaign.” Medford/Ashland and Bellingham each held a

“Smoke-Free Night” with local baseball teams, and Yonkers, NY, promoted a “Nix to Nicotine” basketball game. Paterson held a rally against cigarette billboards in collaboration with the National Coalition of Negro Women.

Organizations involved in promotional activities included groups with a health orientation (e.g., American Red Cross, American Dietetic Association, American Chiropractic Society, community hospital auxiliaries), service and civic organizations (Big Brothers/Big Sisters, Hispanic Community Progress Foundation, Rotary Club, Soroptimists), and business and professional organizations (e.g., chambers of commerce, downtown merchants’ associations, personnel directors’ associations). Examples of their “promotional” involvements with COMMIT included assisting with the development of local tobacco control events; staffing the GASO and Tobacco Free Young America activities; generating publicity for smoking control efforts and specific events through meeting announcements, networking, newsletters, and bulletin boards; providing volunteers, local staff, and Board members for smoking control efforts; and providing other resources, advice, and expertise for the implementation staff.

In all sites, representatives of community organizations were integrally involved in local COMMIT planning, program design, and decisionmaking. Health-related organizations such as local health departments and health voluntary agencies, such as the American Cancer Society (ACS), ALA, and American Heart Association (AHA), played key roles in many communities. Members of civic and service clubs were mobilized to assume promotional roles as the project’s leaders sought broader participation and outreach by citizens. From the outset COMMIT sought existing coalitions for health promotion or substance abuse prevention and joined with them or encouraged them to participate in COMMIT’s efforts. In many communities, civic task forces and community coalitions that addressed drug-related issues were encouraged to add smoking control and educational efforts. In Brantford, Ontario, Canada, town forums were called to foster grassroots ideas and involvement in the initial stage of the project; these events also generated some volunteers for the project. In a few communities, COMMIT formally subcontracted with local organizations to carry out mandated

activities, thereby capitalizing on a local agency's experience and creativity with, for instance, smoking cessation resources or media advocacy. In Utica, the Summer Youth Employment Program trained and employed young people from low-income families to counsel smokers to quit while those smokers were attending community centers (e.g., health clinics or WIC clinics) or community sponsored programs (e.g., blood pressure screening programs).

Cooperating with existing groups in public events was a creative way to foster partnership with the community as well as gain publicity. A youth theater group in Vallejo, eager for an opportunity to be involved, produced skits that humorously illustrated the fact that smoking is not at all glamorous or sophisticated. In Bellingham, COMMIT participants paraded publicly in a turkey costume, to promote "quitting cold turkey," and in cigarette costumes in an annual parade. Vallejo and Medford/Ashland used a Statue of Liberty and "Statue of Liberation from Tobacco" theme, one site for Halloween and the other for a Fourth of July parade. In Cedar Rapids/Marion, IA, Girl Scouts marched in a parade along with a COMMIT float, and the entry won second prize. Publicity through such activities may well have assisted in establishing the legitimacy of COMMIT efforts in the community as well as furthering smoking control goals.



COMMIT communities' successes included an "Adopt-A-Tavern" campaign, as in Bellingham and Fitchburg/Leominster, MA, in which volunteers became responsible for keeping taverns, bars, bowling alleys, and other facilities where smoking is prevalent supplied with materials about tobacco control and cessation. Paterson found it beneficial to work through youth groups in religious organizations to get information about tobacco control to the entire membership.

The primary emphasis in COMMIT's other organizations arena was on large religious organizations. Although this was found by all communities to be a difficult channel, several experienced successes using a variety of innovative approaches. In Cedar Rapids/Marion, a coalition of representatives from the U.S. Attorney's Office, Substance Abuse Free Environment (SAFE) coalition, Iowa Substance Abuse Information Center, and COMMIT Cedar Rapids sponsored "Congregations for a Substance-Free Environment: A Conference for Clergy and Lay Leaders." The conference was



attended by 150 people representing a broad spectrum of religious and ethnic groups. As one of the financial sponsors for this conference, COMMIT was able to contact difficult-to-reach organizations and encourage religious organizations and social service organizations to think of tobacco use as an addiction. Specifically, the conference asked attendees to consider the following issues: (1) tobacco as a drug along with alcohol and drugs, (2) the dangers of passive smoking, (3) the need for education and cessation interventions, (4) the establishment of smoke-free policies at places of worship as well as worksites, and (5) the continuing efforts of tobacco companies to thwart these efforts through extensive advertising. This event led to a half-day strategic planning conference to discuss possible interventions and a workshop to train ministers and lay leaders in intervention skills.

To involve churches in more than just the provision of self-help materials and information about local cessation resources, Paterson implemented a proactive “adopt-a-smoker” campaign aimed at nonsmoking church members who were asked to do the “morally right thing,” that is, help someone in need: a smoker. Working through the Paterson Pastor’s Workshop, an organization composed of about 32 area ministers, a “Smokeless Sabbath” program was initiated. It was a day of religious observance that would be declared by the congregation as a day during which smoking issues would be the focus of the sermon, educational materials would be disseminated, and available community resources would be identified.

COMMIT in Vallejo reported some success in this channel. An ecumenical focus group of local ministers was convened to develop strategies for effectively involving religious organizations in tobacco control. The focus group generated one consensus issue that they believed would be of universal concern to religious organizations: They did not want young people to start smoking. Based on shared information from recent research about tobacco use and youth, the clergy members recommended moving away from the “tired and worn” health education approach to tobacco prevention and suggested highlighting instead the youth-oriented marketing efforts of the tobacco industry (Fischer et al., 1991; DiFranza et al., 1991; Pierce et al., 1991). COMMIT staff members reported that once they understood churches’ perceived role in promoting ethical standards among their congregations (and especially with youth), staff members were able to engage them in advocating against the tobacco industry marketing strategies. Staff members designed a biblically based curriculum using discussion and visual aids to encourage youth to discuss how to assess claims to truth made in tobacco advertising, how such marketing affects youth, the health effects of smoking, and potential advocacy opportunities to combat the efforts of the tobacco industry. The foundation for the 1-hour curriculum was the story of King Solomon’s gift of wisdom that enabled him to discern right from wrong. The “Mission Possible: Target YOUTH” curriculum was reviewed and approved by a panel of teachers, ministers, and health educators and is still being used in some Sunday school programs.

**CHALLENGES
ENCOUNTERED
WITH COMMUNITY
ORGANIZATIONS**

The key process objective for this channel, making presentations to at least 30 percent of organizations targeted for intervention activities, was not achieved on a trialwide basis. The average across sites was 25 percent, and only four sites met the goal of 30 percent. Although one community succeeded in reaching 52 percent of rostered organizations, two sites reached only 10 percent of the organizations. Problems were experienced by all the communities in using other organizations.

A few problems were linked to the protocol's definitions and specifications. For the initial 2 years of COMMIT's intervention phase, staff members across the 11 sites struggled with the protocol's nebulous distinction between interventional and promotional organizations. Definitional ambiguities across the trial were not resolved until late 1990. Gathering the necessary information for categorizing specific religious organizations was a burdensome task. Once designated as promotional, an organization may not have been targeted for attention until late in the intervention. Although it may have been logical to present an informational talk to a promotional organization before requesting cooperation or resources, staff members reported that such a step was often neglected because, by the protocol's mandates, only presentations to interventional organizations "counted" toward process objectives (see Table 3). Many communities expressed greater success, or greater optimism, only in the final year or two of the intervention period.

COMMIT's designers underestimated the difficulty COMMIT staff members and volunteers would experience in establishing contact with and gaining access to interventional organizations that were assumed to have smoking members. Although some activities were as simple as the delivery of cessation information and materials, many fraternal, service, and labor-related organizations such as the Elks, Lions, Masons, Veterans of Foreign Wars groups, and unions had no one onsite during business hours. In many organizations, access to meetings was restricted to members only. Often, it was only after repeated return visits that contact was established with a member or staff person. In at least one site, gatekeepers were then found to be protective of members who smoked and resistant to smoke-free policies or dissemination of cessation information. Many groups met only for social gatherings and business meetings and had no forum for outside speakers to present programs.

There were also multiple challenges in dealing with promotional organizations such as parent-teacher associations (PTAs), substance abuse prevention programs, and service clubs (e.g., Rotary, Lions, Soroptimists). These organizations were diverse, each with its own established mission and full agenda. Many did not perceive community tobacco control activities as a priority. Staff members typically found that getting to know organizations well was labor intensive, and they questioned the efficacy of the time spent making these contacts. Likewise, in many communities the ideas of reciprocity, linking with organizations' existing agendas, or

expanding beyond a single-issue approach were not developed until late in the project. Finding a “hook” with which to involve organizations with COMMIT required knowledge of their missions and structures. One potential hook was to highlight concerns about youth (everyone wanted to help young people), but with COMMIT’s focus on adult smokers, staff members and volunteers were reluctant to use children’s issues as “bait.”

COMMIT’s most logical ally among community organizations was thought to be the health voluntaries (ACS, CCS, AHA, ALA), but experiences with them varied across sites. In six sites (Bellingham, Medford/Ashland, Fitchburg/Leominster, Santa Fe, NM, Paterson, and Yonkers), the local voluntaries were found to be struggling for volunteers and funds. In these sites COMMIT became responsible for the smoking problem and the local health voluntaries focused their resources on programs targeting other risk factors or diseases, such as breast cancer, high cholesterol, asthma, and tuberculosis. In a few communities where the voluntaries were strong, COMMIT Boards and staff members had to deal with competition, conflict-of-interest, and turf issues. Recruitment of volunteers for COMMIT through other organizations was sometimes viewed as competition in a shrinking community pool of potential volunteers. Four communities (Utica, Vallejo, Cedar Rapids/Marion, and Raleigh) contracted with or gave grants to the voluntaries to carry out some required activities. Developing requests for proposals and reviewing them, plus monitoring progress toward achieving process objectives, took a great deal of COMMIT staff time.

As the intervention progressed, several sites added community organizers to the staff to concentrate their efforts to achieve process objectives. Sites began to recognize that combining worksites and organizations under one task force was not effective because outreach to organizations tended to become a low priority on an already crowded task force agenda. The sheer numbers of organizations in some communities was daunting (see Table 2); for many staff members and volunteers, there seemed to be barely enough time to say hello as flyers and informational materials were delivered to organizations. Paterson set up a separate community task force to target this channel.

In the last 2 years of intervention, most COMMIT sites designed new strategies to reach heavy smokers. Although the protocol did not specifically target low-income, minority, or high-risk populations, there was a growing awareness of their importance as targets and messengers for tobacco control. Staff members and volunteers focused on agency settings such as employment offices, job training programs, WIC food voucher distribution clinics, American Red Cross blood drives, gospel mission shelters, and community centers serving minority populations. Special events were targeted at places smokers frequent, including outdoor sports stadiums, bowling alleys, bingo halls, and bars/taverns. At the same time communities used umbrella organizations such as human services coalitions, minority coalitions, and community action agencies to promote intervention activities.

Although some COMMIT communities experienced successes in working with their community's religious organizations, many reported facing a multitude of problems in forming partnerships with this sector. Pursuing clerics as intermediaries in smoking control seemed to be a natural course because bonds often are formed between congregations and clerics who are, in general, respected members of the community. However, many clergy were not receptive to COMMIT's attempts. For some, resistance was passive; clergy did not respond to verbal or written attempts to enlist their support. Others explained that tobacco control was not a priority issue. The Brantford site had an involved and helpful minister on the community Board, but as its final report stated, "even with his help" they were unable to "crack" religious organizations. Smoking was not common among parishioners, and it was not a priority issue.

The failure of some clerics to view smoking as an important issue had several explanations. In some sites clerics immersed in the issue of substance abuse and other social problems did not acknowledge the connection between smoking and other drug use. Others felt that churchgoers were not involved in drug use. Often, staff members heard that smoking is not an issue because "no one smokes in church." Some who did acknowledge the problem of smoking and nicotine addiction resisted outside intervention efforts, relying on the religious organization to provide answers. Some clerics, especially smokers, expressed skepticism as to their ability to help people quit. Other reasons for resistance included the clergy's already taxing workload and an unwillingness to take on another burden or join one more community organization. Some congregations were concerned that implementing smoking policies would conflict with income-producing church functions such as wedding receptions and bingo games. One church was reluctant to implement a smoking policy for fear of alienating a church board member who smoked.

Resistance also was fostered by the diversity of religious denominations. In some communities religious organizations or clergy were responsive to umbrella organizations that often had different agendas. For example, in Yonkers, two of the four umbrella groups were involved in the city's struggle to introduce desegregated housing. In Cedar Rapids/Marion, plans for a clergy conference were complicated by competing events, including the actions of an ecumenical clergy group (spanning Christian denominations) that sought to exclude non-Christian faiths from participating in the planning committee and refused to change its name to an interfaith council.

Work with religious organizations relative to other efforts within COMMIT was often so labor intensive that staff members wondered whether results were worth the level of effort and resources invested. Because most



churches had few or no paid staff members, many attempts were made to reach the cleric before receiving a response. In Medford/Ashland, staff members reported that it took an average of six attempts before contact was made. Staff members became frustrated with unreturned telephone calls and having to leave messages on machines. When a staff person was reached, he or she was frequently unwilling to act as a representative for the church. At least two communities reported that some church staff members refused to accept materials while the pastor was out.

Despite difficulties, communities continued to develop strategies to include religious organizations in smoking control activities. In some cases, task forces developed activities specifically to elicit clergy support and address their issues. Based on feedback from a presentation to the clergy, Yonkers COMMIT developed a seminar on addiction to educate clergy on the problems of nicotine and other drug addiction and to give them specific tools for identifying and addressing this problem. A planning committee was established, and outreach efforts were extensive; however, only two clerics participated in planning the event. The clergy's lack of response prompted the committee to broaden the seminar's focus to include other community intermediaries as well as the general public. In Raleigh, a seminar incorporating nicotine with substance abuse was designed for clergy. Staff members felt challenged to keep peace within planning meetings and were disappointed by the limited clergy turnout. Other issues arose regarding the view by some major religious denominations that alcohol and drug use is a sin; thus, an individual smoker's need for the church's help would be viewed as an admission of sinning. Although a similar conference in Cedar Rapids was mostly successful, staff members faced challenges in maintaining the issue of tobacco use on the program because the conference planners and audience had more interest in alcohol and drugs. Staff members had to repeatedly remind the planning committee to include tobacco in each part of the event.



Making presentations to church groups also proved to be challenging. In Fitchburg/Leominster, three staff members repeatedly contacted religious organizations to schedule presentations, with little response. In Medford/Ashland, the community involvement coordinator focused much of her energy on reaching clergy through presentations but had little return on her time and effort. Similarly, in Yonkers, staff members devoted many hours to reaching targeted churches but made minimal progress. Although

presentations were made at two meetings of the community's largest umbrella group, attendance was poor, and staff members felt that participants were merely being polite. At the second meeting, clergy admitted that smoking was not a priority issue; housing, desegregation, and substance abuse were their primary concerns. When offered suggestions for prohealth activities that would involve the congregation, attendees stated that they could only post informational and cessation materials. However, when following up on the attendees' willingness to display cessation information, staff members found that, in reality, few were willing to help.

Overall, COMMIT communities had to overcome many obstacles to accomplish objectives with religious organizations. Staff members and task forces often redefined objectives to make progress in enlisting support and involvement. Eventually, communities were gratified by even minimal successes, and project reports packaged these achievements in a positive light, perhaps to help maintain morale. Regardless of the individual experiences, staff members learned a valuable lesson in attempting to work with religious organizations on the issue of smoking control: Be prepared for a challenge.

EXPERIENCES WITH OTHER ORGANIZATIONS ACROSS THE COMMUNITIES

Overall, the community organizations channel was reported to be the most problematic, difficult, and frustrating of the intervention channels. In most instances even high levels of staff and

volunteer effort did not produce much return on their investment. Communities were concerned that they did less well than they would have liked in reaching blue-collar workers, ethnic minority groups, and low-income smokers.

The development of relationships with existing organizations was a critical task at each site. Involving existing community organizations in the local definition, refinements, and governance of the project was a basic strategy for community mobilization in COMMIT, and community groups were a prime source of grassroots support, volunteers, and staff. Community groups provided an extensive network of local

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persons from multiple backgrounds and with a great variety of affiliations. Working with or joining existing organizations and coalitions was valued over creating new, competitive, or exclusive structures or replacing activities that were within another group's domain. However, gaining entree into much of the other organizations channel was inordinately time consuming for representatives of all the COMMIT communities. As several sites' final reports explicitly stated, community organizations may have been a more useful target for the dissemination of information than for direct involvement in activities. "The payoff isn't worth it," said Raleigh's report, "unless it's already part of their agenda. Otherwise the most impact you get is to become 'speaker of the week'" (Community Intervention Trial for Smoking Cessation, 1993a, p. 8). Medford/Ashland staff members summarized their experiences, "No real successes here" (Community Intervention Trial for Smoking Cessation, 1993b, p. 10), and Bellingham COMMIT said it was "never able to convince organizations to be concerned about this issue" (Community Intervention Trial for Smoking Cessation, 1993c, p. 2).

Why were so many organizations, across all the communities, difficult to penetrate? Some staff members speculate that they may have been besieged already with requests from nonprofit organizations and community causes. Organizational "gatekeepers" may have been protecting the organization from outsiders' requests. Some organizations were inaccessible by telephone or in person; presumably, some were without a paid staff, street address, regular office location, or telephone-answering machine. The meetings of some organizations included no forum open to outside speakers or issues. Most key organizations already had full agendas, and tobacco may not have been a logical add-on. COMMIT recognized also that smoking and health issues were often seen as unrelated to the group's purpose. The charter of organizations with regard to such issues varied widely, and whereas one group (e.g., the high school PTA) might have been eager to emphasize smoking control and prevention, another seemed to regard it as counter-productive interference with their principal objectives. Yet another organization might have seen smoking as irrelevant to their activities. Finally, and importantly, COMMIT brought a single-issue, time-limited mission into intervention communities that had many existing, longstanding organizations, and COMMIT was a new, "outsider" organization with no local history, name recognition, or promise of longevity.

Productive relationships required knowledge of organizations individually as well as existing coalitions, networks, and other umbrella organizations. To be successful, COMMIT intervention activities had to be congruent with the contexts and cultures of each community (Bracht and Gleason, 1990). Community analyses developed in the first months of the project (see Chapter 5 [Thompson and colleagues]) were essential sources of information for later programs (Bracht, 1988). They were based on review of media, secondary sources, and interviews with informants from the communities and described community organizations, leaders, and historical considerations that acted as potential facilitators of or barriers to COMMIT efforts. The trial also required that a local Community Planning Group be formed to nominate and recruit

COMMIT Board members. The planning group was to recruit members who were representative of the various key local organizations as well as to modify the community analysis so that good decisions about involving various groups could be made. However, the planning did not predict the amount of time and ongoing interpersonal interaction with organizations that most sites believed would have been essential to success in this channel.

The COMMIT protocol called for a Worksites and Organizations Task Force. The task force was a means of involving organizations in tailoring and implementing the specifics of intervention activities in the communities. The task force, under the direction and guidance of the COMMIT Board, prepared an annual action plan to specify how activities would be implemented in its community. In some communities, other groups were used or formed to target organizations more effectively. For instance, Vallejo drew on the community's minority coalition, and Paterson established a separate community task force.

Activities mandated by health promotion projects needed to be flexible, creative, and sensitive enough to reflect varied needs of diverse situations. Significant time and resources were needed to identify sites, develop creative ideas, and maintain individuals' involvement throughout the project with an issue whose relative priority was low to begin with or was threatened by other issues. Communities noted that being put on organizations' agendas was often difficult and labor intensive and staying on the agendas and producing results required ongoing "nurturing." Many organizations had no forum available for presentations on tobacco issues. Decisions had to be made about the level of participation to be solicited from different groups, taking into account the level of effort necessary for recruitment, training, and coordinating activities. In some situations, despite COMMIT staff members' allegiance to principles of cooperation and the enhancement of local resources, COMMIT was perceived by persons in other organizations as a competitor for local resources, such as volunteers or funding.

All communities found it useful to localize and tailor their approaches with community organizations based on the staff members' and task forces'

knowledge of the group's goals, needs, structure, and general mode of operation. The level of participation solicited varied along a continuum of involvement from little to extensive and intensive. Between those poles were activities such as one-time involvement on a specific activity (e.g., posting flyers about the GASO on a bulletin board, speaking out at a city council meeting), to regular



information dissemination (e.g., publishing notices each month about smoking cessation classes in the organization's bulletin), to central involvement in an event (e.g., designing and riding on a theme float in a parade), to an ongoing role on a task force.

Many organizations had little interest in participating in assessing needs, designing elements of the project, setting smoking control agendas, or otherwise taking on leadership roles. Their representatives may have had little experience with, understanding of, or interest in several optional activities around tobacco control or were not interested in adding another item to an already full agenda. However, many appeared to be comfortable with small roles in specific activities. A typical mode for addressing social issues that fell outside the organization was to respond to specific requests from other groups or people for concrete, time-limited help. Consequently, it was a sound, appropriate strategy for COMMIT task force members and their staffs to decide how they could best use the services of selected organizations and to make specific, direct requests of them.

Given the different nature, size, and history of communities and their associations, a major focus on a particular type of organization (e.g., religious organization) was deemed wise in some communities but not in others. For instance, in the COMMIT sites situated in metropolitan areas, the membership of some organizations contained many nonresidents, so targeting them for interventions was not thought to be as useful as emphasizing other organizations or even other intervention channels. For example, a community where a ministerial association already included innovators in church-based health promotion warranted a different approach and expectations than a community where major religious institutions were only marginally involved in communitywide social concerns or where competing agendas overwhelmed the attention of the leaders.

With only a few exceptions, the COMMIT communities questioned whether pursuing religious organizations as a means to reach smokers was a productive use of staff time and resources. A Cedar Rapids/Marion informant described churches as "the most difficult of the difficult" groups to reach, and a staff member from Raleigh said, "Forget them; they might not have been worth the effort." Field staff members in Brantford rated their religious organizations' involvement and use of resources as low and the difficulty of working with them as high. Although in these sites the field staffs attempted to maintain a minimum level of contact with these target groups, they often redirected energies to other channels where the anticipated effect was greater. For those communities able to overcome some obstacles, progress was made through hours of staff time and one-on-one contacts. The key to Vallejo's moderate success was reported to have been a staff person's being a practicing Christian. As that site reported, "Once religious organization leaders learned this, doors started to open." But just as having the right person among the staff members or volunteers was critical, so was finding the right counterpart in the religious organization.

Overall, few religious organizations were perceived by staff members to have participated in COMMIT's motivational, educational, or cessation activities. Attendance by representatives of religious organizations at workshops or seminars on smoking issues was reported to be low. A few religious organizations already prohibited smoking by members (e.g., Seventh-Day Adventists, Mormons), and some seemed to regard a smoking control focus as unnecessary, unless like some Seventh-Day Adventist congregations they regard tobacco control and education as part of their mission.

Special skills were needed by the COMMIT staff members charged with conducting mandated activities in the diverse organizations found in the sites. Knowledge was needed of current and past activities of local organizations in health and smoking issues and of organizations' histories of working with other groups. Staff members needed special skills for encounters and meetings with people of different education, class, and ethnic backgrounds, including chief executive officers, union representatives, blue-collar workers, grassroots activists, and representatives of ethnic groups. They needed to understand the benefits and problems of working with volunteers and to be able to work effectively with them. Staff members also needed to recognize that some citizens and organizations (e.g., unions, blue-collar smokers) objected to smoking control activities and had to be prepared to address these objections with clarity and sensitivity. They needed to attend to media coverage as well as promotional activities of local organizations. Staff members' efforts required creativity in tailoring or designing activities for local organizations and in enlisting support for promotional activities. They also needed to be committed to recruiting diverse persons and organizations, especially underserved groups and those with a high prevalence of heavy smokers.

**RETHINKING HOW
TO WORK WITH
COMMUNITY
ORGANIZATIONS**

With the benefit of hindsight, what should or could have been done differently with community organizations? To meet its objectives, COMMIT needed to generate community recognition of, interest in, sanction for, and practical support of the project and its goals among all sectors. COMMIT required more time to nurture relationships with organizations, to address smoking appropriately within local and parent organizations, and to tailor activities to them. Community groups and organizations presented unique opportunities and stages for information dissemination and enhancement of project visibility in the community. Nevertheless, the consensus was that this was a time-consuming and often thankless channel where few "victories" occurred.

If the protocol were rewritten with the benefit of hindsight, the mandates for handling other organizations would need to define better which constellation of organizations and which specific organizations in the communities should have highest priority. Perhaps an innovative way to map and visualize community organizations and the sectors they serve could be developed, and the Program Records onsite data management system could be expanded to allow for better cross-referencing and tracking of organizations. That other organizations were linked with worksites in

the Worksites and Organizations Task Force probably contributed to most communities' lesser emphasis on organizations through much of the trial. It may have been productive to tie organizations more explicitly to the Cessation Resources Task Force, or a task force dedicated only to organizations might be considered. Finally, the protocol's nature may have inhibited pursuit of some needed but neglected onsite activities. Concrete numbers specified in process objectives became targets, and the concern for evaluation data outcomes may have unwittingly driven decisions in the field. Although communities were encouraged to tailor the protocol to the local context, as one staff member said, "Instead, we let it creep in and color our thinking about the smoking problem. The protocol encouraged us to think like managers (civil servants) counting off numbers of organizations contacted instead of thinking like entrepreneurs, being creative about how to work effectively with those that might be most important to our success."

Experiences affirmed the need for fitting COMMIT's agenda and plans into those of targeted community organizations. To implement activities for COMMIT's other organizations channel, special skills, information, creativity, and access to expertise were needed. This included information about the structure, goals, formal and informal modes of operation, means of economic support, management practices, governing bodies, and decisionmaking mechanisms of diverse individual organizations. Activities may be more effectively and efficiently implemented when there is a period of ongoing involvement during which trust can be built, when there is regular attendance at community events, and when collaboration among participants and of agendas occurs between organizations.

COMMIT staff members and volunteers found that having a person supportive of COMMIT's goals working inside a community organization was useful. The personal ties of task force, Board, and staff members with leaders in other organizations opened many doors. Where these bonds did not already exist, entrée often required a high personal investment of time and energy, commodities that were sometimes in short supply.

In working with religious organizations, communities usually proceeded from the assumption that the largest, most prominent religious organizations in communities should be the primary targets for COMMIT because they had the greatest potential for affecting the most people. In hindsight, a better strategy would have been to initially target the religious organization with which a staff or task force member had a personal affiliation or which had a clergy member known in the community for social activism involvement in health promotion. Where it is determined that religious organizations should be brought into smoking cessation and control activities, emphasis should be placed on strategies for reaching and engaging them.

Discussions late in the project with Christian clerics in COMMIT-related focus groups generated suggestions for approaching religious organizations with tobacco control messages. Two key variables emerged: (1) moral codes regarding smoking and (2) the size of the organization. First, churches with

strong moral codes (i.e., smoking regarded as a “sin” and unlikely to be discussed openly by smokers) should be approached with an outreach ministerial program to offer to other family members, friends, or coworkers. The basic assumption is that although the church members may not smoke, they may live next to, work with, or know people who do. The program can focus on how individuals can help others quit smoking. In churches without clear moral codes around smoking and where smoking is often allowed during social gatherings, the approach of having a smoke-free activity and offering an educational program around passive or secondhand smoke can be used. In such a setting it would then be possible to offer self-help materials and possibly a smoking cessation class. Given that a program taking place in a religious organization already has a certain moral tone, care should be taken to ensure that any smoke-free message be as positive and nonblaming as possible. In developing a program for any size church (moral code or not), a packaged approach would be best. If the message is directed toward youth, prevention education programs can be offered to both types of churches during Sunday School or youth education classes.

Second, church size and type should inform program implementation. For the purposes of developing intervention strategies, knowledge of the relationship between the size and characteristics of religious organizations would be useful. Local church leaders readily supply ideas of categories and critical features of different organizations, as in Vallejo where a focus group generated a set of types, including family churches, pastoral churches, program churches, and corporate churches. A shortage of research in this area precludes firm recommendations, but it is important that approaches to churches be carefully tailored to general and local considerations.

Seminars and workshops designed to attract representatives of diverse organizations should address topics relevant to them, based on careful needs assessment and groundwork. If tobacco is not immediately recognized as an important issue, it may be more productive to add it to whatever agenda is already a central theme in the organization, whether family life, substance abuse, or social outreach.

Was specifically targeting community and civic organizations, clubs, churches, and other local associations for interventional activities worth the substantial effort involved? Significant problems were reported in every community. Given the limited resources and the competing priorities of other trial activities, it remains unclear whether the energy needed to mobilize these diverse groups was well spent.

In sum, the other community organizations channel was more nebulous and equivocal in COMMIT than the more conventional channels relating to health care, worksites, cessation resources, and the media. It may have considerable potential for targeting smokers, reinforcing smoking control messages and policies in the wider community, and disseminating smoking cessation information, but strategies for efficient and effective cooperation still need work.

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AUTHORS

Kitty K. Corbett, Ph.D., M.P.H.
Adjunct Investigator
Division of Research
Kaiser Permanente Medical Care Program
3505 Broadway
Oakland, CA 94611
and
Assistant Professor
Health and Behavioral Sciences, CB-103
Department of Anthropology
University of Colorado at Denver
P.O. Box 173364
Denver, CO 80217

Linda Nettekoven, M.A.
Project Coordinator
Oregon Research Institute
1715 Franklin Boulevard
Eugene, OR 97403

Linda C. Churchill, M.S.
Project Director
Department of Preventive and Behavioral
Medicine
University of Massachusetts Medical
School
Room S-7, 746
55 Lake Avenue North
Worcester, MA 01655

Lesla T. Dalton
Project Director
Division of Health Promotion Research
American Health Foundation
Fifth Floor
800 Second Avenue
New York, NY 10017

Carolyn L. Johnson, R.N.
Program Manager
Healthy Start Program
Jackson County Department of Health and
Human Services
Building A
1005 East Main Street
Medford, OR 97504

Lysha Dickinson
Research Associate/Project Coordinator
Division of Research
Kaiser Permanente Medical Care Program
3505 Broadway
Oakland, CA 94611

Glorian Sorensen, Ph.D., M.P.H.
Associate Professor
Department of Epidemiology and Cancer
Control
Dana Farber Cancer Institute
Harvard School of Public Health
44 Biney Street
Boston, MA 02115

Beti Thompson, Ph.D.
Associate Professor
University of Washington School of Public
Health and Community Medicine
Associate Member
Fred Hutchinson Cancer Research Center,
MP-702
1124 Columbia Street
Seattle, WA 98104