

Community Capacity and Readiness Assessment Tasks

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Community Capacity

Community Readiness

Environmental Scan

Plan Review and Comment

Community-Based Organizational Activity

Community Capacity

Community assessment is a vital activity in Washington's development of a strategic plan for disparate populations/communities. While the assessment will seek out existing quantified data on any and all of the elements presented below, the expectation is that community assessment will produce a regularized qualitative view of community phenomena that is really a characterization, based on the opinion of informed community persons, of that community. The methods are the same (key informant interviews, report identification and review) and concurrent (the same investigators interviewing the same respondents).

Community assessment is composed of three integrated ways of seeing the community: community capacity, community readiness, and common environmental elements.

Capacity is defined as the overall ability and resources to counteract tobacco issues and does not refer to an *inherent* ability of a community.

According to Robinson, community capacity involves four components:

- ◆ Research (availability of researchers, recognition of researchers, availability of data, utilization of data, appropriate research methods, appropriate evaluation methods)
- ◆ Infrastructure (human resources, financial resources, communication resources, representative national coalitions, representative local coalitions, national tobacco control leaders, local tobacco control leaders, national elected officials, local elected officials, leadership in mainstream coalitions/organizations, staff in mainstream coalitions/ organizations)
- ◆ Programs (comprehensive school health, community programs, national programs), and
- ◆ Support for policy (advertising, excise taxes, youth access, and environmental tobacco smoke).

In terms of the community capacity inquiry, capacity elements can be added/substituted to the four components, but we need to keep each one of them concrete enough so that we can add them, eventually, to routine local health department procedures and datasets. This is part of the objective to create a culture shift inside of public health agencies, national-state-local, to incorporate local contexts into prevalence rates of health behaviors and health status.

So, the solutions we are looking for are individualized to and by specific communities and their contexts, but follow clearly articulated models and theories of action.

Community Readiness

As a response to the mismatch between community needs, perceptions, and attitudes and the need for prevention interventions, an approach labeled Community Readiness has been developed that focuses on community dynamics vis-a-vis the acceptance of these interventions. The underlying principle of this model is that communities are at different levels in their readiness and willingness to engage in prevention interventions; they may be in different stages of readiness to consider or take action or have the capacity to take action. If intervention is attempted before the community is ready, or if the intervention is too complex for the level of readiness, an implementation is likely to fail.

A critical aspect of the Community Readiness model is that it is prescriptive as well as descriptive. Descriptively, it can be used to objectively measure movement within the community. Prescriptively, a model can be used to foster community development. At each stage, there are interventions that can be undertaken to move the community along to the next stage.

The Community Readiness model is both qualitative and quantitative. Substantial amounts of interview data are collected in the process of specifying where a community is on the continuum. The end result, however, is a numerical rating that can be used in statistical analyses to determine whether or not a community has changed in their level of readiness as a result of a community development intervention.

Assessing Community Readiness

Researchers and practitioners alike have found that communities vary greatly in their interest and willingness to try new prevention strategies. While some communities may reject public recognition of a local problem, other communities show considerable interest in and identified problem, but have little knowledge about what to do about it.

A detailed sequenced community readiness scale that includes nine stages:

1. Community tolerance. The behavior, when occurring in a particular social context, is tolerated by community leadership -- "it's just the way things are." Community climate

may encourage the behavior; the behavior may be expected of one group and not another (e.g., tolerance varies according to gender, race, social class, age). The behavior is considered to be normative and accepted.

2. Denial. This stage involves the belief that the problem does not exist or that change is impossible. There is usually some awareness by community leadership that the behavior itself is or can be a problem, but there is little or no recognition that this might be a local problem. If there is some idea that it is a local problem, there is a feeling nothing needs to be done about it locally. "It's not our problem." Community climate tends to match the attitudes of leaders and may be passive, guarded, or apathetic.

3. Vague awareness. Vague awareness involves recognition of the problem, but no motivation for action to change it. There is a general feeling among community leaders that there is a local problem and that something not to be done about it, but there is no immediate motivation to do anything. There may be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotypical, vague, or both. No identifiable leadership exists, or leadership lacks the energy or motivation for dealing with this problem. Community climate is not sufficient to motivate leaders.

4. Preplanning. The preplanning stage indicates recognition of a problem and agreement that something needs to be done. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate may or may not support leadership efforts to deal with the problem.

5. Preparation. The preparation stage involves active planning and focuses on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but it may not be based on formally collected data. Leadership is active and energetic. There are decisions made about what will be done and who will do it. Resources (money, people, time, space, etc.) are actively sought or have been committed. Community climate may or may not support these efforts.

6. Initiation. Enough information is available to justify prevention activities, actions, or policies. An activity or action has been started and is underway, but is still viewed as a new effort. Staff is in training or has just been training. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Community climate may or may not support these efforts.

7. Institutionalization. This stage indicates that one or two programs are operating and are stable. They are supported by administrators or community decision makers area programs, activities, or policies are viewed as permanent. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness nor is there is sense that any recognized limitations suggest a need for change. There may or may not be some form of

routine tracking of prevalence. There may be some criticism, but community climate generally supports what is occurring.

8. Confirmation/expansion. This stage involves recognition of program limitations and attempts to improve existing programs. Original efforts have been evaluated and modified, and new efforts are being planned or tried in order to reach more people, those who are more at risk, or those of different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on the extent of local problems and efforts are made to assess risk factors and causes of the problem the community climate may challenge specific programs, but it is fundamentally supportive.

9. Professionalization. This stage is marked by sophistication, training, and effective evaluation. Detailed and sophisticated knowledge of problems, risk factors, and causes of the problem exists. Some efforts may be aimed at general populations, while others are targeted at specific risk factors, high-risk groups, or both. Highly trained staff are running programs or activities, authorities are supportive, and community involvement is high. Effective evaluation issues to test and modified programs, policies, or activities. The community climate could challenge specific programs, but it is fundamentally supportive.

Conducting a Capacity and Readiness Assessment

The most appropriate method found for assessing the community's level of capacity/readiness is some form of survey of key informants, since the planning, funding, and implementation of prevention programs often lies in the hands of community leaders, and because those people are the ones most likely to know what is happening in their community. The key informants' survey obtains factual information from community leaders or professionals who would logically be able to provide the data necessary to assess community readiness. The key informants should be selected from among community members who would know about the type of problem examined and existing prevention programs. They would be in touch with various segments of community leadership, and would themselves be leaders or professionals working in the community on a day-to-day basis. We believe that 10 interviews should be sufficient to gather the needed information. If inconsistencies are found in the interview data, more interviews should be conducted to clarify these issues.

Given the few number of informants, no useful quantification can be expected. In terms of our pursuit of community assets, community capacity, and community readiness, our approach will be to ask many more questions of fewer people, but those people are in a good position to reflect on the makeup of the community. If we turned to community forums, focus groups, or surveys, we would have more people addressing fewer questions and producing less knowledge.

The method here is to ask far more detailed questions of a few purposive informants to draw a *detailed* qualitative picture of the community in question. This picture will be

supplemented with published reports about and/or from within the community and statistics provided by public agencies and community-based service organizations. **Together, these data sources enable a concurrent assessment of community capacity, readiness, and environment.**

Possible Data Sources

Data collection in the community brings with it several challenges. A primary challenge is the recruitment of informants. Another challenge is convincing informants to talk about their tobacco control advocacy. To address this challenge, we intend to rely on trusted organizations to conduct the work within the community/population; these should have direct knowledge of and access to key informants and existing reports.

Those selected for key informants interviews include representatives of the following groups:

- local health officials
- local health care providers
- school officials (can include including alternative schools, public and parochial schools, adult education sites, community colleges, public libraries, resource centers, parks and recreation departments, YMCAs, YWCAs, and community centers)
- community agency representatives,
- law-enforcement representatives,
- older youth,
- community government officials,
- media representative
- civil rights groups,
- advocacy organizations,
- professional associations,
- local commissions,
- provider organizations,
- media, (can include daytime entertainment programming, TV curricula, public service announcements, docudramas, radio, magazines, newspapers, billboards, Internet sites, talk shows, disc jockeys, community theater, foreign language television and radio stations, foreign language magazines and newspapers, English language media that attract a sizable foreign language audience)
- political associations,
- Urban League,
- mutual assistance associations,
- youth leadership,
- community development persons,
- health commissions,
- formal political caucuses, .
- national organizations, especially those with local affiliates such as the NAACP

- businesses (can include point of purchase retail stores and worksites for youth
- community resources, (such as convenience stores, housing projects, social services offices, grocery stores, recreation centers, neighborhood groups, neighborhood associations)
- health-care sites (can include physicians offices, clinics, community health centers, local medical associations, continuing medical education, audiocassettes, teleconferences, videotapes, medical conferences, pharmaceutical newsletters, print media, and medical broadcast channels, such as lifetime medical television and physicians' radio network)
- parents (for younger children)
- peers (for children in intermediate and high schools)
- teachers, counselors, coaches, scout leaders, daycare personnel, after school personnel, school nurses, big brother/big sister staff and volunteers, 4-H club members
- valued athletes, celebrities, and other role models
- ministers and other spiritual leaders, church conventions, television and radio ministries, church newsletters, pulpit sermons
- political leaders and other community figures
- youth group and other community leaders, sororities and fraternities
- labor unions and organizing bodies.

The key informants are surveyed through semi-structured interview questions. Interviewers should be skilled, and, prior to beginning the interviews, should develop an in-depth understanding of the elements of community capacity, stages of community readiness for prevention, the meaning of community assets and networks, and community information. Interviews can be conducted in person or by telephone, but preferably in person.

Some minor modifications may be needed to the questions in order to align them to the issue under analysis; more extensive modifications may be needed for the policy related questions. The interviewer either tape-records or takes detailed written notes on each response.

When the interviewer believes the questions have all been answered as best as possible, the result should be a qualitative description of what is actually occurring in that community. Immediately after each interview, the interviewer or rater should write a brief statement summarizing the information related to each specific dimension.

The six dimensions to be explored through key informants interviews include:

- A. existing prevention efforts (programs, activities, policies, etc.)
- B. community knowledge about prevention
- C. leadership (includes appointed officials and influential community members)
- D. community climate
- E. knowledge about the problem
- F. resources for prevention efforts (people, money, time, etc.)

Tools

The elements of study (capacity, readiness, assets) are clear in the community assessment models. These will need to be incorporated into a single interview guide, blended into something like the one below. Each community and assessment agency will have to identify which of the questions can be addressed in their community and the correct wording.

1. Does the community see the tobacco cessation issue as a problem?
2. Are there efforts addressing the tobacco cessation issue in your community?
3. Are the people in the community aware of these efforts?
 - i. How long have these efforts been going on in your community?
4. What are the strengths and weaknesses of these efforts?
5. How are these efforts viewed by the community?
6. How much do the leaders, groups, or committees in your community know about these efforts?
7. Are there segments of the community in which these efforts do not apply?
8. Is there a need to expand these services? If no, why not?
9. Are there plans to expand or develop other efforts? If yes, what are the plans?
10. What types of policies and practices (rules and regulations) related to the tobacco cessation issue are in place in your community?
11. Are the people in your community aware of these policies?
12. Are there in formal practices, policies, or rules that are in place in your community?
13. How long have these policies been operating in your community?
14. Are there segments in the community to which these policies do not apply? Is there a need to expand these policies? If no, why not?
15. Is very needed to expand these policies? If no, why not?
16. Are there plans to expand the policies? If yes, what are the plans?
17. How I these policies viewed by the community?
18. Who, in your opinion, are the leaders, formal or in formal, in your community?
19. If informal, how did they become the "leaders"?
20. Does the leadership see the tobacco cessation issue as a problem?
21. Are the leaders in your community involved in prevention efforts? Please list.
22. Would the leadership support prevention efforts?
23. What is the general attitude about the tobacco cessation issue in your community?
24. Is there ever a time when, or circumstance in which, members of your community might think that tobacco use is tolerated?
25. Would the community support prevention efforts? If yes, how?

26. What are the primary obstacles to prevention efforts in your community?
27. Is there a sense of apathy or hopelessness among community members regarding the tobacco cessation issue?
28. Is there any information about how often the tobacco cessation issue occurs in your community? If yes, from whom?
29. How do people obtain information on your community?
30. What types of data are available on the tobacco cessation issue?
31. Who would a victim of tobacco use turn to first?
32. Who provides resources for these efforts and how long will they last?
33. What is the community's attitude about supporting prevention efforts with people, money, time, or space?
34. Do people in your community know what it takes to run these programs or activities?
35. Are you aware of any proposals or action plans that have been written to address tobacco use prevention?
36. What is the level of expertise and training among those working toward prevention of tobacco use?
37. Are you aware if there are any efforts been made to evaluate the prevention efforts or policies that are in place?
38. Are the evaluation results been used to make changes in programs, activities, or policies, or to start new ones?

Additional questions on demographics may be posed as relevant – age, ethnicity, position in the community, length of time in the community, willing to talk again on this tobacco cessation issue or review the strategic plan.

Once the interviews have been completed, providing a qualitative description about the stage of readiness within any one dimension should be possible, even if in fact there is some lack of consensus among the informants from this community.

The Environmental Scan

The environmental scan is part of the community capacity/readiness analysis; it should all be one action and a continuous part of the planning process. If the focus of the entire effort is on capacity building, community capacity, community assets, community readiness, research data, environmental scan, and SWOT become part of a single action and approach.

The purpose of the environmental scan is to assess and describe the “environment” which affects a population disparity that has been identified based on quantitative data, i.e. tobacco use prevalence, relapse rates, exposure to ETS, morbidity/mortality, etc.

The environmental scan relies on the compilation and/or gathering of qualitative data. This type of data typically summarizes a wide variety of ideas and opinions in a less precise manner than do quantitative methods. Qualitative methods provide insights into

issues related to the population group identified as having a tobacco-related disparity. If the information needed for the environmental scan is not readily available, the issue of how to collect the qualitative data may be addressed during the strategic planning process.

The factors which comprise the environmental scan address both the needs of the population group and the resources available for tobacco control and prevention. These resources include programs and activities available to the population group regardless of funding source.

Attributes of population groups with identified tobacco-related disparities

- What barriers exist in reaching this specific population group?
- What assets does the population group have that support tobacco prevention and control?
- What are the social norms, attitudes, and knowledge of the population group regarding tobacco use?
- What evidence exists that the tobacco industry is targeting this specific population group?
 - Tobacco industry advertising and promotional activity
 - Tobacco industry documents
 - Tobacco industry contributions, sponsorships, philanthropy, alliances, cultural events
- Is this population group considered a "community" (it has its own history, culture, context)?
 - What are the known means of access or influence?
- If this population group is not considered a "community," what are the known means of access or influence?

Comprehensive picture of programs, services, personnel, and funding

- Community/population based interventions which address the identified population disparity:
 - Type of intervention:
 - Goal area addressed:
 - Community:
 - Amount of Funding:
- Strategic use of media/counter-marketing
 - Does the State media plan address this disparity?
 - Media activities addressing the identified population disparity (includes media advocacy, media relations, counter advertising, reducing tobacco industry sponsorships and promotions, exposing tobacco industry tactics)
- Policy/Regulatory Activity
 - Policies in place addressing the identified population disparity
 - Clean indoor air
 - Excise tax

- Product regulation
 - Insurance coverage for treatment and cessation
 - MSA funding
 - Extent of the specific population group's involvement in policy/regulatory activities
- Surveillance and Evaluation
 - Are surveillance activities in place to monitor the identified population disparity?
 - What assessments are in place to evaluate the effectiveness of programmatic, policy, and media efforts?

Capacity/Infrastructure Assessment

- What is the level of inclusivity of representatives from the specific population group in program planning at the state level? Community level?
- What existing networks, organizations, coalitions, etc. exist which provide an infrastructure for this specific population group to address the identified disparity?
- What kinds of communication channels exist to link networks, organizations, coalitions, etc.?
- Types of training currently available:
 - Advocacy/policy training
 - Media advocacy training
 - Leadership development
 - Tobacco 101
 - Grant writing
 - Coalition building/community mobilization
 - Program planning/Evaluation

Plan Review

It is expected that the panel of informants will be formally presented with the draft strategic plan by the same interviewers and interviewed in detail about their suggestions for improvement. Their comments will be provided to the Cross Cultural Working Group in advance of the writing of the final version of the strategic plan.