

Pilot Test of an Assessment Instrument for Latina Community Health Advisors Conducting an ETS Intervention

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Community health advisors (CHAs), also known as *promotores*, are lay individuals in the community that others tend to look toward for advice and support. Studies incorporating CHAs are relatively rare, and CHAs have not been used in previous intervention studies to reduce environmental tobacco smoke (ETS) exposure. The present study pilot tested a CHA assessment instrument and examined the effects of *promotora* training on CHAs' knowledge, attitudes, and beliefs concerning ETS reduction. Participants were 11 women recruited from the local community. CHA training produced changes on several psychosocial constructs. Anticipated outcomes regarding ETS reduction and emotional reactions related to volunteering in the community were more positive after training. Self-esteem and self-efficacy showed increases after training. Future research will investigate the relationship between the psychosocial characteristics measured in the assessment instrument and subsequent success implementing the ETS reduction intervention.

KEY WORDS: community health workers; *promotores*; health education; health care accessibility; environmental tobacco smoke.

Environmental tobacco smoke (ETS) can have a detrimental impact on children's health. Children exposed to ETS have an increased risk for a variety of medical disorders, including a higher incidence of allergic complications and pulmonary function problems (1). Additionally, they have an increased risk of lower respiratory tract infections like pneumonia and bronchitis (1, 2). Exposure to at least 10 cigarettes a day may increase the likelihood that a child will develop asthma (3), and have more severe symptoms and episodes. Furthermore, a cross-sectional study of families who participated in the 1991 National Health Interview Survey showed that children who were exposed to ETS had more days of restricted activity, bed confinement, and more days of school absence (4).

Many children in the United States may be susceptible to these adverse health effects, as a recent national survey indicated that 43% of children between the ages of 2 and 11 years live in homes with at least one smoker (5). Such statistics indicate that ETS poses a major health risk for children that needs to be addressed.

Less educated and lower income groups are likely to be at greater risk for smoking and ETS exposure (6). According to the Smoking and Health National Status Report (1990), smoking prevalence falls from 28.9% for those who have a household income of \$10,000 or less to 21.8% for those with a household income of more than \$40,000 (6). Minority groups are more likely to be less educated and have lower incomes. For example, in the border community of San Diego County, Latinos, may be at particularly high risk, as 23% of this population live below the poverty line (7). Thus, interventions geared toward reducing ETS among Latino children could have a significant impact on public health in communities such as the San Diego area.

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Past studies typically have used professionals to deliver ETS reduction interventions. For instance, a study by Hovell *et al.* used experienced, paid counselors to successfully decrease ETS exposure among asthmatic children (8). Another study by Greenberg *et al.* used nurses to conduct home visits to help families reduce infant exposure to tobacco smoke (9). A possible drawback to these studies is that many minorities (e.g., low-aculturated Latinos as well as other minority groups) tend to rely on informal sources for health information. Many get advice from others in their community whom they trust and with whom they can easily communicate (10). The importance of these informal sources of information is made greater by the fact that many minority groups, such as low-income Latinos, have relatively less access to formal health care systems and health professionals (11).

“Natural” caregivers, sometimes referred to as community health advisors (CHAs) or *promotores*, are lay people that others naturally turn to for advice, emotional support, and tangible aid. They provide informal, spontaneous assistance, which is so much a part of everyday life that its value is often not recognized (12). CHAs create awareness of health issues among their targeted group by having health information available and offering support for behavior change (10). CHAs can often provide much needed health care information to minority subgroups who otherwise would have very limited access to such information from formal professional sources (13).

Studies have shown that CHAs can be effective in the Latino community. A study by Navarro has shown that CHAs were effective in helping Latinas increase their use of cancer screening tests (14). The use of CHAs is relatively new yet growing in the United States, and is seen as an effective and relatively untapped way to get health information to those who do not have ready access to health care services (15). Because of previous CHA’s successes in the Latino community, a large study was funded to use CHAs to deliver an ETS intervention in Latino households with young children.

The present study pilot tested a CHA assessment instrument designed to measure psychosocial constructs theorized to be characteristic of successful *promotores*. The primary aim of this study was to examine the effects of participation in an ETS training program on these psychosocial constructs, including *promotoras*’ knowledge, attitudes, beliefs, and skills regarding community volunteerism and ETS reduction. The theoretical framework and development of the assessment instrument are also discussed.

METHODS

Participants

Eleven Latina CHAs were recruited from the same communities as the families who were going to be recruited to participate in the intervention. The CHAs were bicultural and bilingual, with Spanish as their preferred language. They were initially interviewed either because they were recommended by our community contacts or because they were known to have prior volunteer experience. Our community outreach coordinator prescreened potential CHAs on characteristics such as (a) reasons for wanting to work as a CHA, (b) leadership potential, and (c) confidence in one’s ability to affect community change. For this study, only female CHAs were chosen because we expected that the CHAs would be providing the intervention mostly to women (e.g., mothers of identified children) in each household. We wanted to avoid any potential problems with husbands being concerned about male CHAs coming into their homes to work with their wives.

Procedures

Promotoras participated in a training designed to prepare them to visit Latino households and work with a family member (primarily the mother) using behavioral problem-solving techniques to lower children’s exposure to ETS in the home. CHAs participated in a total of 20 h of training over eight sessions during a 1-month period. The training sessions focused on ETS reduction using educational and behavioral-rehearsal procedures that incorporated both the content and delivery of the intervention. All CHAs participated in role-playing that was used to practice delivery of the intervention, problem-solving techniques, and recruitment of families. The specific content of the training sessions is described in Appendix B.

CHA Survey Development

The research team had several bilingual/bicultural members, and a concerted effort was made in the initial phases of this research project to find or develop measures that were valid for Spanish speakers with the educational levels typical of the CHAs and participants. Any materials originally developed in English were translated into Spanish, then back-translated into English as a cross-check. The

bilingual/bicultural project staff that developed the curriculum for the intervention took much care to ensure that materials and procedures were culturally and linguistically appropriate. Materials were also pilot tested with local Latinas before using them in this project.

CHA Assessment Survey

A self-administered survey was developed by project staff to measure various CHA characteristics and their knowledge, attitudes, and skills related to community volunteerism and ETS reduction. CHAs completed the survey both before and after 20 h of training that took place over a 1-month period. Survey items were categorized into two broad subsets. One set consisted of general items relating to community volunteerism. Another set consisted of specific items on the ETS reduction intervention material (for specific survey items, see the Appendix A. A Spanish version is available from the authors). The items in these two broad categories were also designed to measure a variety of behavior theory constructs believed to be associated with successful CHAs. These constructs were drawn from several major theories on attitude change that include Social-Cognitive Learning Theory, Health Belief Model, Theory of Reasoned Action, Self-Regulation/Self-Control, and Subjective Culture/Interpersonal Relations. The specific behavior theory constructs measured in our CHA survey were taken from a workshop monograph (16) and are described below.

Intentions. Measures a person's subjective probability or subjective likelihood that they will perform the behavior in question. The stronger a person's intention, the more likely the person will carry out the behavior. Each intention score was computed as the mean score of two items either related to ETS reduction or regarding volunteering in the community. Items were measured on a scale ranging from 1 to 5, with higher scores indicating stronger intentions.

Environmental Constraints. A set of circumstances that may allow or prevent the performance of the behavior in question. These circumstances can be either internal or external to the individual. An environmental constraint score was computed as the mean score of three items on constraints related to community volunteerism and single item score for the constraint relating to ETS reduction. Items were measured on a scale ranging from 1 to 5, with higher scores indicating fewer environmental constraints.

Anticipated Outcomes. Expectancies or attitudes that a person holds about performing the behavior in question. The behavior will not be performed unless the person believes that the advantages outweigh the disadvantages. An anticipated outcome score was computed as the mean score of two ETS reduction-related items and three items on expectancies about volunteering in the community. Items were measured on a scale ranging from 1 to 5, with higher scores indicating better anticipated outcomes.

Perceived Normative Pressure. People are potential sources of social influence who may be putting pressure on the individual either to perform or not to perform a given behavior. CHAs may be more successful if those around them think what they are doing is important. Scores were computed as the mean of each of two items for perceived normative pressures related to ETS reduction and for community volunteerism. Items were measured on a scale ranging from 1 to 5, with higher scores indicating more positive perceived normative pressure.

Self-Standards. A person determines whether performance of a given behavior is consistent or inconsistent with one's self-image. Self-standards scores were computed as a single score for the item regarding ETS reduction and as the mean score of four items for questions related to community volunteerism. Items were measured on a scale ranging from 1 to 5, with higher scores indicating that being a CHA in an ETS reduction intervention or a community volunteer is highly consistent with one's self-image.

Self-Efficacy. An individual's perceived capabilities of performing a given behavior. The stronger a person's self-efficacy, the stronger the likelihood a person will perform that behavior. Self-efficacy scores were computed as the mean score of two items each for questions related to ETS reduction and community volunteerism. Items were measured on a scale ranging from 1 to 5, with higher scores indicating higher self-efficacy for implementing an ETS reduction intervention or being a community volunteer.

Emotional Reaction. One may experience strong emotional reactions when thinking about performing a particular behavior. These emotions may influence a person's decision about whether to perform this behavior. An emotional reaction score was computed as the mean score of five items for questions regarding ETS reduction and community volunteerism. Items were measured on a scale range from 1 to 5, with higher scores indicating a more positive emotional reaction regarding working as an ETS CHA or community volunteer.

Skills/Ability. A behavior will only be performed if one has the skills necessary to perform it. Ability scores were computed as the mean score of two items each for questions related to ETS reduction and community volunteerism. Open-ended questions relating to situations a CHA may encounter on an intervention visit were coded to reflect "quality" and "quantity" of skills. Two trainers who conducted the ETS reduction training sessions completed the coding. During scoring, each CHA's identity and time of survey completion was concealed (i.e., whether pre- or posttraining). To determine quality, each CHA's overall response was rated on a scale of 1 to 4, with higher scores indicating better problem-solving skills. Quality scores were then computed as a mean of two items each for questions regarding ETS reduction and community volunteerism. The number of original problem-solving strategies used in each response determined quantity scores. Quantity scores were also computed as a mean of two items each for general and ETS questions.

In addition to these constructs, this survey also collected information on CHAs' knowledge about being a community health advisor (5 items; e.g., "It is okay to tell my family and friends personal information that participants tell me."), and ETS knowledge (10 items; e.g., "Children's bodies are naturally protected from tobacco smoke."), with correct answers scored 1 and incorrect answers scored 0, then summed for the scale measure. General self-esteem (17, 18) and general self-efficacy (19, 20) scales were also included in the survey, based on Spanish versions used in previous research (18, 20). The Rosenberg self-esteem scale is comprised of 10 items and is scored using a 4-point scale (*strongly agree, agree, disagree, and strongly disagree*) that results in a scale range of 10–40 with higher scores representing higher self-esteem. The general self-efficacy scale is composed of 10 items and is scored using a 4-point scale (*not at all true, barely true, moderately true, and exactly true*) and results in a scale range of 10–40 with higher scores representing higher self-efficacy. Selected demographic information was also collected in the survey completed prior to training.

RESULTS

CHA Characteristics

As shown in Table I, the average age was 45 years. All CHAs were of Mexican origin, and all were married. Ten participants were living with their spouses

Table I. Sociodemographic Characteristics of Community Health Advisors

Variable	Mean (SD)	Median
Age	45.27 (11.36)	47
Household Size	4.00 (1.18)	4
		<hr/> % (n)
Country of origin		
United States		
Mexico		100.0 (11)
Other		0.0 (0)
Marital status		
Married, living with spouse		90.9 (10)
Married, not living with spouse		9.1 (1)
Divorced		0.0 (0)
Separated		0.0 (0)
Never been married		0.0 (0)
A member of an unmarried couple		0.0 (0)
Education		
No school or kindergarten only		0.0 (0)
Grammar school (grades 1–6)		27.3 (3)
Secondary school (grades 7–9)		18.2 (2)
Preparatory school (grades 10–12)		18.2 (2)
Vocational/trade school		18.2 (2)
Some college/college graduate		18.2 (2)
Monthly gross household income		
\$700 or less a month		9.1 (1)
\$700–\$1,099 a month		36.4 (4)
\$1100–\$1,499 a month		0.0 (0)
\$1500 – 1,899 a month		18.2 (2)
\$1900–\$2,199 a month		18.2 (2)
\$2200–\$2,599 a month		9.1 (1)
\$2600 or greater a month		9.1 (1)
Employment status ^a		
Employed for wages		18.2 (2)
Self-employed		0.0 (0)
Out of work for less than 1 year		9.1 (1)
Out of work for more than 1 year		18.2 (2)
Homemaker		81.8 (9)
Volunteer		72.7 (8)
Student		27.3 (3)
Retired		9.1 (1)
Disabled/unable to work		0.0 (0)

^aRespondents could mark all that apply.

and one was not living with her spouse. All but 2 CHAs were educated in Mexico, and 6 of 11 had the equivalent of a high school education or higher. For most CHAs, the monthly household income was modest by U.S. standards. Five of the 11 reported household incomes of less than \$1100 a month. Eighty-two percent ($n = 9$) of the CHAs categorized themselves as homemakers.

Behavior Theory Constructs

Table II presents pre- to posttraining changes in the behavior theory constructs. A paired sample *t*-test

Table II. Mean Changes Pre- to Posttraining on Psychosocial Constructs Oriented Toward Community Volunteerism and ETS Reduction^a

Constructs	Mean (SD)		<i>t</i>	<i>p</i> level
	Pretest	Posttest		
Anticipated outcomes				
Community volunteerism	4.70 (0.48)	4.64 (0.46)	0.80	.441
ETS reduction	4.18 (0.72)	5.00 (0.00)	-3.77	.004
Emotional reaction				
Community volunteerism	4.44 (0.47)	4.84 (0.28)	-3.71	.004
ETS reduction	4.82 (0.41)	4.78 (0.53)	0.17	.872
Intentions				
Community volunteerism	4.82 (0.34)	4.82 (0.34)	-0.54	1.00
ETS reduction	4.73 (0.65)	4.86 (0.45)	0.00	.602
Environmental constraints^b				
Community volunteerism	3.79 (0.50)	4.00 (0.52)	-1.75	.111
ETS reduction	3.27 (1.90)	3.55 (1.44)	-0.58	.574
Perceived normative pressure				
Community volunteerism	4.55 (0.52)	4.68 (0.46)	-1.00	.341
ETS reduction	4.55 (0.69)	4.59 (0.80)	-0.18	.858
Self-standards				
Community volunteerism	4.86 (0.26)	4.95 (0.15)	-1.79	.104
ETS reduction	4.73 (0.65)	4.73 (0.47)	0.00	1.00
Self-efficacy				
Community volunteerism	4.82 (0.46)	4.91 (0.20)	-0.80	.441
ETS reduction	4.73 (0.65)	5.00 (0.00)	-1.40	.192
Skills/ability (quality)				
Community volunteerism	2.91 (0.80)	2.59 (0.77)	1.25	.240
ETS reduction	2.27 (0.72)	2.68 (0.56)	-2.04	.068
Skills/ability (quantity)				
Community volunteerism	1.77 (0.75)	1.86 (0.60)	-0.41	.690
ETS reduction	1.55 (0.47)	1.73 (0.65)	-0.63	.542

^aSee Appendix A for the actual items used in constructing the community volunteerism and ETS reduction scales specific to each of the nine psychosocial constructs.

^bThese scales were reverse-scored so that higher scores reflected lower perceived constraints, and increases over time indicated "improvement" (i.e., reduction) in perceived constraints.

showed that ETS-related anticipated outcome scores posttraining were significantly higher than at pretraining, indicating that after training CHAs were more likely to expect their intervention efforts to have positive results. A separate paired *t*-test showed that posttraining emotional reaction scores regarding community volunteerism were significantly more positive than at pretraining. Lastly, there were trends for pre-post training changes indicating increases in ETS-related skills/ability "quality" scores, increases in positive self standards for community volunteerism, and increases in perceived environmental constraints regarding community volunteerism. There were no significant changes in scores related to ETS-reduction intentions, environmental constraints, perceived normative pressure, self-standards, self-efficacy, emotional reaction, or skills/ability "quantity" scores.

Additionally, there were no significant differences in scores regarding community volunteerism-related anticipated outcomes, intentions, perceived normative pressure, self-efficacy, or skills/ability scores.

Generalized Trait Scales and Knowledge Scores

Table III shows the means, standard deviations, *t* values and *p* levels for pre- and posttraining generalized trait measures and knowledge scores. Paired sample *t*-tests showed that general self-esteem scores at posttraining were significantly higher than at pretraining. A separate paired sample *t*-test showed that posttraining general self-efficacy scores were significantly higher than at pretraining. There were no significant changes in knowledge regarding ETS reduction or

Table III. Mean Changes Pre- to Posttraining on Trait and Knowledge Scales

	Mean (SD)		<i>t</i>	<i>p</i> level
	Pretraining	Posttraining		
Trait scales				
Self-efficacy	32.73 (5.29)	36.36 (4.01)	-2.92	.015
Self-esteem	31.55 (5.94)	36.18 (4.71)	-4.80	.001
Knowledge scales				
Community volunteerism	2.45 (0.93)	2.36 (1.03)	0.21	.839
ETS reduction	8.82 (1.40)	8.73 (1.56)	0.25	.810

volunteering in the community from pretraining to posttraining.

DISCUSSION

The CHAs examined in the present study were relatively homogeneous on demographic characteristics. When examining changes in the theoretical constructs measured before and after training, significant changes were found in ETS-related anticipated outcomes and emotional reactions related to community volunteerism. Also, trends were found for increases in the quality of ETS-related skills/abilities, increases in positive self-standards for community volunteerism, and improvements in perceived environmental constraints related to volunteering in one's community. Additionally, there were improvements in the CHAs' general self-efficacy and self-esteem from pre- to posttraining. No differences were found in CHAs' knowledge regarding community volunteerism or ETS reduction from pre- to posttraining.

Although there were several positive pre-post changes that occurred as a result of the training, results as a whole indicated that the CHAs came into the program with already high levels of the positive characteristics that were measured in the constructs. This may have been due to good selection before entering training. These women were chosen because they were identified in their community as potential leaders, and this may have accounted for the high initial scores.

The similarities of the CHAs on social-cultural factors (e.g., Spanish speaking, primarily of Mexican origin, relatively low income) was also considered ideal, as other research has suggested that the effectiveness of an intervention may be enhanced by virtue of CHAs having demographics similar to the Latino families participating in the intervention. Studies have

shown that similarity of educators to their target population can influence the acceptance of health messages. Feldman (21) examined nutrition attitudes and behavior of high school students and found that the greater the perceived similarity of the communicator, the greater the influence the communicator had on the students.

Results on the theoretical constructs showed that a ceiling effect might have accounted for the lack of change in some constructs. Ten of the 12 construct means were already above 4.5 on a 5-point scale at pretraining, so there was little room for improvement. Although environmental constraint means were not above 4.5 at pretraining, this construct was external to the training content and was not expected to improve as a result of training. The marginal change in the ability-quality construct and the lack of change in the other ability constructs could be due to the way the constructs were measured. The definition of what was considered excellent, good, OK, or poor quality was somewhat subjective and may not have been highly reliable.

The lack of change of knowledge scores regarding ETS reduction and community volunteerism was puzzling at first; however, upon reviewing the exact curriculum covered by the trainers, it was found that some of the knowledge facts might not have been adequately covered. Furthermore, the items that were covered during training were only done so verbally. Since many of these questions were very specific (e.g., over 1,000,000 children in California are exposed to tobacco smoke in the home), there may have been a change in knowledge scores if these facts had been incorporated in written form into the CHA training curriculum. Furthermore, another possible reason that ETS knowledge did not increase from pre- to posttraining could be that ETS exposure is not an issue that is frequently presented to the public, whereas smoking is. The media often present stories about the harmful effects of smoking on the smoker, but much less common are media spots about the problem of tobacco smoke on those around the smoker. ETS is a relatively new issue, thus it may be harder for some individuals to fully comprehend related facts in a short period of time.

Increases in general self-efficacy and self-esteem after the training show that the CHAs felt better about themselves generally as a result of their training. The observed short-term improvements were unexpected since these scales are thought to measure relatively stable qualities. However, this finding is consistent with anecdotal reports of increases in perceived

self-worth among CHAs as a result of working in their community. Additionally, the majority of the CHAs were homemakers and it is possible that the training was a new and empowering experience for them.

Most of the measures assessed in the CHA survey represent characteristics thought either to change as a result of training or to predict better CHA performance. Several of these constructs did change over the course of training. Follow-up research is planned to examine whether the CHA characteristics assessed in this study predict different intervention outcomes. For example, fairly subjective criteria were used to select CHAs in the present study. However, if certain CHA characteristics are found to be associated with better or poorer intervention implementation or intervention results, this would provide highly useful information. To the extent that some CHAs had characteristics that are subsequently shown to be associated with poorer intervention implementation or intervention results, this would be an important consideration for understanding the overall results in the current study. Further, such information would be very useful for future studies to help develop more objective selection criteria shown to be predictive of better intervention/health outcomes. Information that helps define the characteristics most highly associated with success in sharing health information and motivating health behavior change would be very useful for refining CHA selection criteria to help maximize community health intervention success.

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APPENDIX A: COMMUNITY HEALTH ADVISOR SURVEY ITEMS FOR THE BEHAVIOR THEORY CONSTRUCTS

Intentions

Community volunteerism

- I intend to promote healthful behaviors in my community.
- I intend to be a leader in my community.

ETS reduction

- I intend to get people to find sources of tobacco smoke in the home.

- I intend to help people learn how to keep tobacco smoke away from their children in the home.

Environmental constraints

Community volunteerism

- My family and friends support my helping others in my community be healthier.
- I find it difficult to fit the things I need to do into my schedule. (*Reverse coded*)
- I am comfortable going out in my community at night.

ETS reduction

- At times, it is impossible to protect children from tobacco smoke in the home. (*Reverse coded*)

Anticipated outcomes

Community volunteerism

- My work as a *promotor* will help me get jobs in the future.
- My efforts on the project will help people in my community become healthier.
- My work as a *promotor* will make me feel good about myself.

ETS reduction

- My visits with people will reduce children's exposure to tobacco smoke in the home.
- My visits with people may reduce ear infections in children.

Perceived normative pressure

Community volunteerism

- Most people who are important to me think I should spend time helping in my community.
- People I respect and admire volunteer to help out in their community.

ETS reduction

- Most people who are important to me think I should help reduce children's contact with tobacco smoke.
- I think children's contact with tobacco smoke is an important health issue.

Self-standards

Community volunteerism

- I am the kind of person who listens well.
- I am the kind of person who seeks out information about health.
- I am the kind of person who helps others out any way I can.

- I am the kind of person who likes to meet new people.

ETS reduction

- I am the kind of person who feels comfortable asking people not to smoke around children.

Self-efficacy

Community volunteerism

- I am confident that I can help people in my community become healthier.
- I am confident that I can handle difficult situations that arise in my work as a *promotor*.

ETS reduction

- I am confident that I can help people keep smoke away from their children.
- I am confident that I can help people meet their goals to reduce children's contact with tobacco smoke in the home.

Ability/skills

Community volunteerism

- As a *promotor*, you find the person you're working with easily gets distracted. What do you do?
- You are scheduled to meet a participant and your car breaks down or the bus doesn't show. What do you do?

ETS reduction

- A smoker tells you he/she doesn't want to smoke on the patio because the child would be left alone. What do you do?
- A mother tells you her husband is getting mad at her attempts to get him to smoke outside. What do you do?

Emotional Reaction

Community volunteerism

- When I think about working as a *promotor*, in my community I feel . . .

ETS reduction

- When I think about getting people not to smoke near children, I feel . . .

APPENDIX B TRAINING SESSIONS

Session 1. CHAs signed a consent form and completed the pretraining survey.

Session 2. CHAs learned about the larger project and what their role would be as a CHA delivering the intervention. They discussed benefits of participating

as well as what they expected to contribute to the project.

Session 3. There was a discussion on what characteristics contribute to success as a CHA. They also learned about some dangers of smoking, secondhand smoke, and benefits of quitting.

Session 4. CHAs learned about their responsibilities on the project and how Head Start families would be recruited to the study.

Session 5. CHAs were taught how to make phone calls to recruit families. They were also taught how to fill out eligibility screening forms for families, how to explain the family assessment schedule, and how to administer consent forms.

Session 6. CHAs were expected to be able to describe the content of the intervention and explain the schedule for intervention visits. They were also taught about reflective listening and motivational interviewing techniques.

Session 7. CHAs were expected to demonstrate the principals of motivational interviewing through continued role-playing.

Session 8. CHAs participated in role-plays to practice intervention phone calls to families. They were taught how to establish steps to assist families reach the goal of reducing ETS. They were also expected to know alternative strategies to help families reduce ETS in their homes.

Session 9. The final home visits to families were practiced through role-plays. CHAs were taught strategies to encourage families to continue to participate in assessments. They were also informed about support that would be available during the time that they were CHAs. The posttraining survey was completed.

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