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Isaac Prilleltensky / Eliseo Martell / Eunice Valenzuela / Pablo Hernández
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A Value-based Approach to Smoking Prevention with Immigrants from Latin America: Philosophy and Program Description

Un Enfoque Valórico a la Prevención del Tabaquismo en Inmigrantes de Latino América: Filosofía y Descripción de Programas

*Isaac Prilleltensky, Eliseo Martell,
**Eunice Valenzuela, and Pablo Hernandez

Abstract

The article describes a value-based approach to smoking prevention. This approach was implemented in a program with immigrants from Latin America in Canada. The approach is based on the values of *participatory community planning and sensitivity to cultural diversity, and on a comprehensive philosophy of health*. The program had six specific objectives: (a) to expand knowledge on the effects of smoking, (b) to help teens resist the pressure to smoke, (c) to increase family communication and parental input regarding smoking, (d) to engage children and parents in community activism to prevent the use of tobacco, (e) to reduce intentions to smoke, **and** (f) to disseminate the program to other ethno-cultural communities. The article shows how the main values inform the various phases of the program. The implications of this approach for smoking prevention and for value-based planning are discussed.

Resumen

El artículo describe un enfoque valórico a la prevención de tabaquismo. Este enfoque fue implementado en inmigrantes latino americanos a Canadá. Está basado en los valores de una comunidad participante de planificación, y de sensibilidad a la diversidad cultural, y a una filosofía comprensiva a la salud. El programa tenía sus objetivos específicos: (a) expandir el conocimiento de los efectos del tabaco (b) aumentar la comunicación familiar e input parental relacionado con fumar, (c) ayudar a los adolescentes a resistir las presiones a fumar, (d) incorporar a padres y niños de la comunidad activa (o del activismo comunitario) a prevenir el uso del tabaco., (e) a reducir las intenciones de fumar y, (f) a difundir el programa en otras comunidades etno-culturales. El artículo muestra como los principales valores informan las varias fases del programa. Se discute la implicación de este enfoque en la prevención de la conducta de fumar y para el planeamiento basado en valores.

* Victoria University, Community Health Departmet, Region of Waterloo.

** Latin American Educational Group, Kitchener, Ontario.

Introduction

«Cigarette smoking is the single most preventable factor contributing to illness, disability, and death» (Miller & Slap, 1989, p. 129). The devastating effects of cigarette smoking, the tremendous potential for prevention, and the need to promote the health of minority groups were compelling arguments for a group of immigrants to launch a tobacco prevention project. The impetus for the program was strengthened when the group realized that there were no local programs addressing the consumption of tobacco among children and youth of Latin American origin (North York Public Health Unit, 1994). These considerations led the Latin American Educational Group (LAEG) of Kitchener, Ontario, to mount a smoking prevention program for the community's children and youth. As a founding member of the group, the first author was involved in the creation, planning, implementation, evaluation, and dissemination of the program.

The purpose of this article is to describe a value-based program for smoking prevention with immigrants. The program was based on a high level of stakeholder participation during the planning, implementation, and evaluation phases. In our view, the program contributed to knowledge in the areas of value-based (Prilleltensky, Peirson, Gould, & Nelson, 1997; Prilleltensky, Peirson, & Nelson, 1997) and participatory approaches (Papineau & Kiely, 1996) to planning and evaluation. Our program was based on three explicit values: (a) participatory community planning and evaluation, (b) sensitivity to cultural diversity, and (c) a comprehensive philosophy of health. The project adopted a participatory approach based on the popular education model of the late Brazilian educator Paulo Freire (Bruss & Macedo, 1985; Freire, 1971, 1975, 1985; Macedo, 1994). In

this approach, everyone has something to contribute to the group and to the learning process. Participants rely on their life experience to enlighten themselves and others about issues affecting their lives. This approach focuses on the collective solution of common problems. This model of education strives to educate participants about specific issues and to build community at the same time. Freire criticized the banking approach to education, according to which the teacher "deposits" knowledge in the student. Instead, Freire proposed a model that relies not so much on accumulated knowledge but rather on a critical perspective that emphasizes the emancipatory potential of education. This framework helps students to explore the social and moral dimensions of the subject matter. Many Latin Americans are well acquainted with this method of learning and feel comfortable with it. The LAEG also strived to give voice and self-determination to prospective users of the program. The values of collaboration and self-determination, central to community development (Prilleltensky & Nelson, 1997), featured prominently in the program.

Like several authors in the literature (Biglan et al., 1996; Cummings & Coogan, 1992; Goodman & Wandersman, 1994; Harachi, Ayers, Hawkins, Catalano, & Cushing, 1996; Hernandez & Lucero, 1996; Johnson et al., 1990; Kaftarian & Hansen, 1994; Lichtenstein, Lopez, Glasgow, Gilbert-McRae, & Hall, 1996; Papineau & Kiely, 1996; Sowers, Garcia, & Seitz, 1996; St. Pierre, Kaltreider, Mark, & Saikin, 1992; Vicary, Doeblner, Bridger, Gurgevich, & Deike, 1996), we believed that community-based approaches were the most promising ones in addressing the issue of tobacco use among children and youth. We were sensitive to the importance of mobilizing community resources in fostering a prevention mentality regarding the use of tobacco. We understood

the need to involve parents, schools, media, civic institutions, and local businesses in efforts to address prevention effectively (Biglan et al., 1996; Desjardins, Kishchuk & Lamoureux, 1994; Goodman & Wandersman, 1994; Hawkins et al., 1992; Kaftarian & Hansen, 1994; Lichtenstein et al., 1996; Oei & Fea, 1987; St. Pierre et al., 1992; Wallack, 1985).

Sensitivity to cultural diversity was the second explicit value endorsed by the group. Being immigrants themselves, members of the LAEG were acutely aware of the need to tailor the program to their unique histories, cultures, and life circumstances. The literature suggests that prevention programs should address the specific circumstances of each ethno-cultural group (Botvin, Dusenbury, Baker, James-Ortiz, & Kerner, 1989; Botvin et al., 1992; Schinke, Moncher, Holden, Botvin, & Orlandi, 1989). Hernandez and Lucero (1996) claimed that it «seems imperative that prevention curricula be culturally adaptable to the target populations it services...Clients are more willing to fully participate when the program is designed and structured to incorporate their values, beliefs, and traditions» (p. 270).

The third principle guiding the intervention was a comprehensive philosophy of health. The group adopted an ecological orientation to health that recognized the importance of risk and protective factors at the individual, family, community, social, economic, and political levels. An individual's wellness depends not only on personal attitudes and beliefs, but also on the health of the environment. A youth's ability to resist pressure to smoke is contingent upon exposure to tobacco advertisement, peer and parental modelling, cultural practices, cognitive expectancies, social norms, critical consciousness about the tobacco industry, and other factors (Hine, Summers, Tilliczek, & Lewko, 1997). A

community's norms influence a person's decision to smoke or not to smoke. Smoking behavior is determined by a complex interaction between social and personal factors.

Following the definition of the World Health Organization (1986), health is more than the absence of illness; it is a resource for personal and collective wellness. Health comprises individual, cultural, political, and ecological factors that enable persons and communities to prosper. These principles are embodied, for instance, in the United Nation's Convention on the Right of the Child (Prilleltensky, 1994), in the United States Advisory Board on Child Abuse and Neglect (Melton & Barry, 1994), and in Canada's Population Health Promotion models (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994, 1996; Hamilton & Bhatti, 1996). Given the multiple determinants of health, our group decided to address not only children and youth, but also parents and the community at large. Our comprehensive understanding of health led us to promote community activism as an important vehicle for the prevention of smoking. If smoking is to be prevented, the group reasoned, community leaders ought to help young people by legislating appropriate policies and by promoting healthy practices (Canadian Public Health Association, 1996; Barry, 1994; Lichtenstein et al., 1996; Perreault et al., 1996).

Qualitative and quantitative outcome and process evaluations were conducted to assess the effectiveness of the program and are described in detail elsewhere (Prilleltensky, Nelson, & Sanchez Valdes, 1997). When compared to a control group in a pre-post intervention design, program children of ages 8 to 14 improved their knowledge about some aspects of tobacco use and effects, engaged in more community activism, and

showed a decrease in intentions to smoke. Whereas the improvement in knowledge only approximated statistical significance, the gains in community activism and intention to smoke were statistically significant. No statistical differences were noted between comparison and intervention groups in the areas of social skills and family communication. The qualitative evaluation indicated that parents, children, and staff were highly satisfied with the contents of the program as well as with the processes employed to deliver it. Although statistical differences were found only on some measures, the qualitative evaluation showed that the program was regarded as highly successful by the primary stakeholders involved in the project. Given the somewhat encouraging results of these evaluations, we think others may find the program useful and adaptable to their own communities. We believe that the value-based and participatory nature of our program are quite unique and demonstrate the feasibility of enacting humanistic values in community programs (Prilleltensky & Nelson, 1997; Prilleltensky, Peirson, Gould, & Nelson, 1997). While the importance of anchoring psychological interventions on explicit values has been recently recognized, the literature is still short on examples of how this might be done (Prilleltensky, 1996; 1997).

The literature is also short on demonstrations of integrative approaches to smoking prevention. While authors recognize the need to intervene at the individual, family, social, and community levels, very few are the programs that manage to integrate these dimensions into their efforts (Johnson et al., 1990; Schinke et al., 1989; Van Houten, Vicary, & Sowers, 1996). In light of the need for demonstration projects that follow explicit moral values and that integrate various channels of prevention, we present our project as an example for review

and critique. We describe next the social context of the program as well as its goals, objectives, and activities. We conclude with a discussion of the program's challenges and contributions to value-based planning and smoking prevention.

Social Context of Smoking Prevention Program

It is estimated that there are about 8,000 people from Latin-America residing in the region of Waterloo, Ontario. The community where the project took place has a concentration of families from El Salvador, Nicaragua, Guatemala, Mexico, and Cuba. Many families arrived as refugees, fleeing unstable political situations.

The LAEG, a community-based mutual help group, was created in 1991 for the purpose of promoting integration and adaptation of Latin American families into Canadian society. The main goals of our organization at the community level are to facilitate the successful integration of Latin American families into Canadian society and to foster a sense of community and social support. With regards to minority children and youth, our objectives are to enhance educational success, promote healthy development, and prevent psychosocial problems. The group has been successful in obtaining funding from a variety of sources and has relied on many dedicated volunteers. The group employs a part-time coordinator. Most activities are carried out by approximately 10 volunteers.

Some of the major activities undertaken by our group include a community needs and resources assessment (Prilleltensky, 1993), a volunteer-run Spanish school for about 50 children, parenting groups, community celebrations, publication of

newsletters in Spanish, women's groups, employment workshops, English study club, and educational presentations at numerous local organizations.

The program was directed at children, youth, and families. Through its Spanish school and parenting courses, the LAEG had weekly contact with approximately 50 children and 20 families in the local community in Kitchener. We discussed with the teachers and a group of parents the possibility of conducting the program as part of the school, and everyone was in agreement that it would be an ideal situation. Students participated in the tobacco program through the Spanish school.

Program Goals and Objectives

For the purpose of managing the tobacco demonstration project, the organization hired a coordinator, assistant coordinator, and facilitators. The tobacco demonstration project had an advisory group and paid staff. The staff consisted of the coordinator, assistant coordinator, facilitators, and volunteers. The advisory group appointed a planning and evaluation committee to oversee the operation of the tobacco demonstration project.

Given our comprehensive philosophy of health, and our principles of participatory community planning and sensitivity to cultural diversity, we believe that the best way to attract youth and parents to a project is by asking them what they need and what type of program they would like to have. We think that the people from a particular setting hold the most valuable knowledge about themselves (Toulmin & Gustavsen, 1996). We have been employing this grounded theory approach quite successfully for some time with the community. In the past, we have

been successful in obtaining children's input for a variety of activities, such as summer camp, celebrations, and Spanish school activities. We have held a number of focus groups with children, adolescents, and parents (Prilleltensky, 1993).

In seeking community consultation for this project, we attracted several families to a planning meeting held in 1995. During the consultation session we asked parents what they thought would be important issues to address in this project. Their input was incorporated into our activities. Community participation in the actual execution of the program was facilitated by hiring local people to serve as facilitators and baby-sitters. To actualize the participatory philosophy, we invited other members of the community to attend training sessions and to contribute in various ways to the program. To ensure the ongoing participation of children and families in the program we utilized a few incentives. Children and parents were given gift certificates for local stores and restaurants.

Many of the prevention programs available deal exclusively with tobacco consumption behaviour and start during adolescence. These are serious limitations in that efforts to prevent tobacco use should take into account other variables such as parental, peer, and sibling patterns of smoking, peer pressure, social skills, family environment, isolation, general well-being, and social climate (National Clearinghouse on Tobacco and Health, 1993; see also Hawkins et al., 1992; Hernandez & Lucero, 1996; Miller & Slap, 1989; Oei & Fea, 1987). In addition, interventions should start when children are young (Glynn, 1993; Oei & Baldwin, 1992). These factors have been shown to correlate with tobacco consumption in many studies, including local ones (Region of Waterloo Community Health Department,

1994). Consequently, our intervention was based on a holistic understanding of health that included an appreciation for the influence of multiple social factors and the importance of starting the job of prevention early in life (Prilleltensky & Laurendeau, 1994; World Health Organization, 1986). The early and multiple foci of intervention were two unique features of our project.

The product we envisioned was a program designed to prevent the use of tobacco among children and youth. Within this overarching goal, we had six objectives in the areas of knowledge, social skills, family communication, community activism, intention to smoke, and dissemination. Specifically, our main six objectives were:

- (a) to expand *knowledge* on the effects of smoking,
- (b) to improve *social skills* and help children and youth resist the pressure to smoke,
- (c) to increase *family communication* and parental input regarding smoking,
- (d) to engage children and parents in *community activism* to prevent the use of tobacco,
- (e) to *reduce intentions to smoke*, and
- (f) to *disseminate* the program to other ethno-cultural communities.

The first two objectives derive from research that demonstrates the effectiveness of increased knowledge and improved resistance and social skills in handling peer pressure (Botvin, Dusenbury, Baker, James-Ortiz, & Kerner, 1989; Botvin et al., 1992; Johnson et al., 1990; Morgan et al., 1986; Oei & Baldwin, 1992; St. Pierre et al., 1992). The third objective is included because of the

heavy influence of parents on the smoking behaviour of their children (Bailey, Ennett, & Ringwalt, 1993; Hernandez & Lucero, 1996; Miller & Slap, 1989; Oei & Fea, 1987; Oei & Baldwin, 1992), a finding that seems to be particularly relevant in Hispanic populations (Marin, Marin, Perez-Stable, Otero-Sabogal, & Sabogal, 1990). While the first three objectives are standard in the literature, we believe the fourth one is innovative in that previous programs have not made use of youth's readiness for social activism (Pancer & Pratt, in press; Ungar, 1995; Watts & Abdul-Adil, in press). Adolescents look for an identity that will help them feel good about themselves. The same energies that are expended on smoking, and thus belonging in a «smoking» group, can be redirected to help them create identities around positive health, social justice, and the elimination of commercial exploitation. Based on previous studies (Pancer & Pratt, in press; Ungar, 1995; Watts & Abdul-Adil, in press), we believe that consciousness raising can be a useful tool for mobilizing teens against smoking. This Latin American community is familiar with the work of the late Paulo Freire, who advocated for a popular education approach to raise levels of consciousness about political and commercial exploitation.

The fourth objective is also innovative in that we worked together with parents and youth to foster community activism. By engaging entire families in the process of social action, we planned not only to serve the community but also to strengthen the families and give them an opportunity to work collaboratively on a tobacco prevention project. This, in turn, was meant to reinforce the third objective of increasing parental input in decisions related to tobacco use. The fifth objective of reducing intentions to smoke derives from the expected combined effect of the previous four objectives.

The last objective concerns the dissemination of the program to other ethno-cultural communities. It is important that demonstration projects and innovative programs reach a large audience. Otherwise, the efforts invested in creating these programs go to waste. Without dissemination of existing programs, other communities are bound to «re-invent the wheel» and commit avoidable mistakes.

Program Description

The prevention program can be divided into four main phases: community consultation, program planning, program activities, and dissemination. Table 1 illustrates how the three guiding values informed the different phases of the program.

Phase I

Community Consultation

Upon receipt of a call for proposals from Health Canada, the LAEG congregated to consider an application. The LAEG decided to organize a community forum to study the community's interest in such a project. Parents and children attended the forum and the overwhelming response was positive. The LAEG made an effort to advertise the event widely in order to attract a good number of people. About 15 adults and 20 children attended the event. The participants were divided into small groups to discuss the various aspects of the proposal and to offer suggestions. The forum helped in providing input and in creating an early sense of community ownership over the program. We considered it important that people identify with the objectives of the program from the outset. Community participation was

deemed essential in the eventual success of the program.

The community forum was informative in many ways. While most parents endorsed the idea of becoming involved themselves in the program, a few others showed reluctance to commit themselves. They explained that in their countries of origin, under a particular regime, they were pressured to attend community events and that in Canada they were looking forward to a break from community functions. We also perceived resistance on the part of some parents who were smokers themselves. They showed hesitancy and a measure of defensiveness. They admitted the program would be valuable for their children, but were afraid to feel pressured to quit if they would attend the program. In retrospect, we should have reassured these parents that it was not our intention to pressure them to quit but rather to help their children resist the pressure to smoke.

Phase II

Program Planning

Planning and Evaluation Committee

The LAEG appointed a planning and evaluation committee to oversee the execution of the program and its evaluation. This group was entrusted with the responsibility to oversee all aspects of the program. The committee held weekly or bi-weekly meetings for the duration of the program. As soon as the committee was appointed it began developing plans for program activities, staff hiring and training, materials, budget management, evaluation, and project dissemination. The committee was composed in its entirety of members of the Latin American community and it included professionals from the fields of psychology, public health, education, and

business administration. The four members of the committee were respected by the local community due to their previous involvement in other initiatives.

Training of Facilitators

The planning and evaluation committee hired facilitators for the program and planned two training workshops (one three day workshop and one three hour follow up session). Most of the facilitators were women who were teachers in their countries of origin. A pre-requisite for working for the program was knowledge of Spanish, as this was the primary language of the program. The objective of the workshops was to familiarize facilitators with the project and to train them in the methodology of popular education. Among other activities, facilitators reflected on personal experiences associated with smoking, role played peer pressure and conflictive family situations, and discussed the economic factors related to the widespread consumption of tobacco.

The training sessions were open to other members of the community who were interested in learning about tobacco use and about popular education. A few community members took advantage of the offer and participated in the training as well. Feedback for the workshops was very positive. Facilitators and guests alike found the experience illuminating and fun. The workshop helped create a sense of cohesion and competence among facilitators, as documented in a separate article (Prilleltensky, Nelson, & Sanchez Valdes, 1997).

Preparation of Sessions and Materials

Given that it was a challenge to obtain materials in Spanish, the facilitators had to write considerable portions of them. Some materials were translated from English and

some others were obtained from the US directly in Spanish. The actual preparation of materials was a team effort. Facilitators met on a weekly basis to develop materials and to review previous sessions. They helped each other and created a cohesive team. The mutual support played a key role in maintaining a positive and enthusiastic atmosphere towards the program.

Project Management Team

Once facilitators were hired and trained, they were invited to join the planning and evaluation committee in bi-weekly or monthly meetings to discuss progress on the project. These meetings were scheduled to coincide with meetings of the board of directors of the LAEG. The board of directors, the facilitators, and the planning and evaluation committee formed the project management team. Including facilitators and the LAEG in all major decisions fostered a sense of communal control over the program. A high level of involvement of this broad constituency was seen as consonant with the value of community participation.

During these meetings the various parties exchanged communication and were able to problem solve as a team. The exchange of information was crucial in that some people had access to information that others were not aware of. Members of the LAEG alerted the rest of the group that some parents who smoked were reluctant to come lest they feel judged. On another instance facilitators shared with the planning and evaluation committee that some discipline problems were developing in the program. The entire group problem solved around these issues and benefited from everyone's input. This mode of management shares the responsibility and ownership of the program among various stakeholders, thus increasing the sense of control everyone experienced over the program.

Finances

The entire project had a budget of \$ 67,000.00 (Canadian) for two years. The assistant coordinator was in charge of overseeing the expenses and preparing budgets and quarterly reports to the Ministry of Health. The participatory approach of the project enacted an informal policy of trying to hire people from the local community. This was viewed as an investment in the local community. This would not only provide part-time employment, but also foster a sense of ownership over the project. We trained local people in the various aspects of planning and conducting a project; skills they could apply in other settings and other jobs in the future. Overall, we employed a coordinator, an assistant coordinator, eight facilitators, four baby-sitters, three research-assistants, and three volunteers from the local community. They helped with planning, administration, evaluation and dissemination.

We tried to enact a democratic process for allocating of resources. Although daily decisions concerning financial transactions were made by the assistant coordinator in charge of the budget, all major decisions were made in consultation with the planning and evaluation committee and with the management team. We made an effort to keep everyone informed of how the money was being managed.

Phase III:

Program Activities

The program consisted of psychoeducational sessions for children and parents. In order to meet the program's objectives, we conducted twelve sessions with children and youth and eight sessions with parents. The sessions covered issues such as

smoking prevalence, effects of smoking, life and social skills, and communication skills. Children had eight sessions by themselves and four together with their parents. Parents had four sessions by themselves and four together with their children. About fifty children of ages 4-14 and seven parents participated regularly in the program.

Sessions with Children and Youth

Children and youth were divided into four groups. One group was for children 4 - 7 years old. The other three groups for children 8 - 14 years old were divided according to their level of Spanish. The groups run from March to June 1996 and each session lasted approximately 90 minutes. The weekly sessions were in the evening and were part of the Spanish school that the LAEG had been running for four years.

In order to expand knowledge on the effects of smoking (objective #1), two sessions were devoted to learning factual information about smoking and its effects. The topics covered included prevalence of smoking in Canada, reasons for smoking or not smoking, the process of becoming a smoker, second hand smoking, effects of smoking, and addiction.

In order to improve social skills and help children and youth resist the pressure to smoke (objective #2), four sessions were devoted to the topics of assertiveness, decision making, stress and anxiety, and self-esteem. Some materials from Botvin's Life Skills Training — Level I (1990) were employed in these sessions. Additional materials were developed by facilitators to meet the particular cultural dimensions of the group. Role play and drama were methods the children enjoyed a great deal. The children showed no hesitation in participating in little drama productions. These were filled with humor and laughter.

In order to enhance communication skills in general and family communication in particular (objective #3), two sessions were devoted to this topic. Children learned about different types of communication and about the value of asking questions. These sessions provided information on how to communicate effectively and how to improve communication with their parents.

In order to enhance community activism (objective #4), four sessions were devoted to learning about the different aspects of social action. In one session children learned about leadership, team building, and group cohesion. A second session was used to produce pamphlets and posters the children would distribute during the third session in shopping centres. During the third session a group of children went to a shopping mall to post their art work and distribute pamphlets. A second group of children went to city hall to deliver to Kitchener's mayor and city council a petition against smoking in public places. The fourth session dealing with community activism was a celebration that children and parents attended at the end of the program. During the celebration children presented their work and put together a short drama presentation.

Sessions with Parents

Four sessions were exclusively for parents. Another four sessions were spent working with children on objective 4: community activism, as detailed above. About seven parents attended sessions regularly. About 20 parents attended the final celebration session.

In order to enhance parents' knowledge of tobacco effects (objective #1), one session was devoted to addictive behaviours and tobacco's harmful effects. Parents learned statistical information about morbidity and smoking prevalence rates in Canada in the different age groups.

In order to enhance family communication (objective #3), three sessions dealt with communication and parenting skills. Listening skills, conflict resolution, and building children's self-esteem were the key topics covered.

In order to enhance community activism (objective #4), during two sessions parents helped children design pamphlets and art work about the harmful effects of tobacco. In another session they accompanied children to a shopping mall to distribute the pamphlets and exhibit their work. The last session devoted to community action was the celebration at the end of the project. Parents listened to the children talk about the harmful effects of tobacco and were treated to a drama presentation by their youngsters.

Phase IV

Dissemination

The final phase of the program entailed writing a manual, distributing it to various community and health organizations across Canada, and consulting with selected ethno-cultural communities on the feasibility of adapting our program to meet their groups' needs. The values of participatory community planning, sensitivity to cultural diversity, and holistic health were very much present in this phase of the project. The manual was written by a team of writers and was based on wide consultations with program staff. Several revisions were made to incorporate input from various quarters. Although there were serious disagreements at times about the contents and format of the manual, consensus was achieved in the end through the use of an open and democratic consultative process.

The question of cultural diversity came up many times during the dissemination phase.

The group wanted to document in an authentic fashion what had happened in our program, but it was also aware that other ethnic communities may not find some of our Latin American traditions appropriate to their culture. We struggled with representing accurately what we did in our program on one hand, and thinking about the needs of prospective users of the manual on the other. In the end, we tried to reach a balance between depicting clearly what we did and offering prospective users alternatives they may adopt for their own initiatives.

We tried to write a document that would be useful not only to Latin American communities but to other ethno-cultural groups as well. In that spirit, we formulated recommendations in such a way that potential users would be able to adapt the program to their unique backgrounds and expectations. In order to enhance the transferability of our program to other groups, we interviewed key informants from minority associations about the usefulness of our manual in the context of their conceptions of smoking and health. The feedback we received from these key informants helped us in our ongoing efforts at dissemination.

Discussion

The main goal of the program was to help prevent the use of tobacco among children and youth in a Latin American community. The encouraging results of outcome and process evaluations of the program motivated us to share some of its unique features (Prilleltensky, Nelson, & Sanchez Valdes, 1997). In our view, the program differs from existing ones in two respects. First, it integrates various modes of intervention into one program; and second,

it is explicitly driven by a set of values. Following a discussion of these two distinctive features we draw attention to program limitations and directions for future research and action.

There are many calls in the literature for comprehensive community-based prevention programs that address individual, family, social, cultural and policy factors (Johnson et al., 1990; Schinke et al., 1989; St Pierre, 1992; Van Houten, Vicary, & Sowers, 1996), but very few projects achieve this integrative standard. The Kansas City project, described by Johnson and colleagues (1990), is a rare exception that combines interventions with parents, school, mass media, and community organizations. Their study showed that «a comprehensive community program-based approach can prevent the onset of substance abuse and that the benefits are experienced equally by youth at high and low risk» (1990, p. 447). But their intervention is not the norm. Most substance abuse prevention programs directed at youth focus primarily on social competence and social resistance skills (Botvin, et al., 1989; Botvin et al., 1992), while others concentrate on policy enforcement and reduction of sales to minors (Biglan et al., 1996; Feighery, Altman, & Shaffer; 1991; Jason, Ji, Anes, & Birkhead, 1991; Skretny, Cummings, Sciandra, & Marshall, 1990). The relative success of these interventions notwithstanding, in most cases the researchers themselves admit that multiple channels of prevention are needed to achieve stronger effects.

Although our program was very modest in scope and reached only about 50 children directly, it did integrate multiple channels of prevention. At the individual level, our program offered children and youth sessions on social competence, social pressure, self-esteem and tobacco knowledge. At the family

level, we offered sessions dealing with parenting, communication with children, and smoking awareness. At the community level, we engaged participants in social actions such as submitting a petition to city council and posting anti-tobacco art work in shopping malls. In addition, our program reached children as young as four years old, a somewhat neglected population in the substance abuse prevention field (Oei & Fea, 1987). It is the combination of these varied features, regarded in the literature as essential preventive tools, that makes our program interesting and somewhat unique. We believe that our pilot intervention is worthy of further development and replication at a larger scale.

In addition to its integrative quality, we regard our program as distinct in its emphasis on explicit values. Other health and social programs are also, no doubt, driven by values of health and self-determination, but they fall short of articulating their value-base (Prilleltensky, Peirson, Gould, & Nelson, 1997; Prilleltensky, Peirson, & Nelson, 1997). The importance of value-explicitness cannot be crucial because people interpret values in different ways, and because their implementation is far from self-apparent. Whereas some practitioners may interpret the value of health in individualistic terms, others may ascribe to health a holistic and ecological meaning. Similarly, while everyone may concur with the abstract idea of self-determination, in practice this notion may look very different to different people. Some may regard self-determination as a superordinate goal, whereas others may be willing to compromise it for the benefit of the community as a whole. In addition, values occasionally conflict with each other and a resolution is needed as to which one should take precedence in a specific context (Prilleltensky, 1996, 1997; Prilleltensky & Nelson, 1997). These considerations require

that writers explicate their values and mode of implementation. Our reading of the literature points to a gap in this regard. In this article we have tried to contribute to the literature by elucidating the main values guiding our intervention.

The project was based on the principles of participatory community planning, sensitivity to cultural diversity, and holistic health. We strived to implement these values as best we can, but the process was not without challenges. Some of the benefits and tribulations of this process are worth recounting.

The development of this particular program was a logical outgrowth of a previous needs and resources assessment conducted by the first author (Prilleltensky, 1993). Thus, there was an integrated cycle of assessment, planning, and evaluation, which fits with a participatory action research approach (Kroeker, 1996). This participatory action approach is not only congruent with fundamental values such as control and empowerment, but it is also efficient (Toulmin & Gustavsen, 1996). This approach enhanced ownership of the program by participants (Whitmore, 1991). The program and the evaluation were truly done «with» not «on» the community stakeholders. From the program evaluation we learned that we were quite successful in fostering community participation. This gratifying finding notwithstanding, we could not disprove the fact that parental participation in the program was less than expected. In that sense, we fell short of reaching optimal level of community participation. We were somewhat naive in thinking that all the parents who attended the community forum would also attend the program. Mothers and fathers at the forum politely acquiesced to our request for participation in the program, but, when the time came to follow through, the majority

did not come. This was particularly true of fathers, who came in numbers to the forum but whose absence at the program was resounding. Casas (1992) has commented on the Hispanic concept of *simpatía*, a «central cultural value and social script that mandates politeness and respect» (p. 105), even though people may disagree with the message. It is likely that some parents at the forum wished to appear agreeable but they had reservations about attending the program.

The second value we tried to enact was cultural sensitivity. The fact that the entire team planning, running, and evaluating the program was from Latin America helped to achieve this goal. An effort was made to plan activities congruent with the mentality of the local population. Examples include the use of a popular education methodology, flexibility in the agenda to accommodate parents' desire for informal exchanges, and festivities with Spanish themes. The community as a whole felt pride in launching a prevention program from a Latin American perspective. People's identities were respected and enhanced. These were definite benefits derived from our sensitivity to the ethno-cultural background of our participants. But the enactment of this value was not entirely smooth. When the time came to write a report and a manual that would be of use to other communities, some tension developed. Some of us had been in Canada for longer periods of time and «thought that knew» what shape the final report and manual should have. A couple of us in particular had definite ideas as to what the manual should look like.

An interesting conflict evolved between the «veterans,» who also happened to be the more academic-based people in the group, and a few others. The former group thought that the manual should try to bridge between our community and others, even if this meant

writing the report from a more general, as opposed to a more Latin American perspective. This group reasoned that for others to benefit from our experience we should write more general recommendations and perhaps omit some specific references to our activities. The objective was to produce a report that other ethno-cultural communities could use, an objective that could be impeded by too many references to activities that fit exclusively the Spanish culture. Other people maintained that we should report exactly what we did. Otherwise, the report would lose authenticity. Whereas the «veteran» group wanted to emphasize the «bridging» function of the report so that it would help other communities, the other group preferred to emphasize the cultural authenticity of the document. This conflict, which was amicably resolved in a compromise, shows that even within minority groups there are cultural disagreements, something anyone who works with communities, homogeneous or heterogeneous, knows. In our case, this manifested itself in the writing of the final report. The resolution required that we dialogue, argue, and compromise.

Our aspiration to disseminate the program to other ethno-cultural communities led us to share the report with leaders of other minority groups. We interviewed some of them and asked them to give us feedback on the feasibility of applying some of our materials and lessons to their communities. We are learning in this process that while some features apply, others don't. Navigating the ethno-cultural terrain is difficult and requires an attitude of openness on our part and on our partners' part. We believe the challenge is worth pursuing. Whether we will meet the challenge remains to be seen.

The value of holistic health also informed our program, and like the previous two values, it delivered some gains at the same

time that it made us aware of our own limitations. We embraced a comprehensive philosophy of health which was translated into interventions at the individual, interpersonal, family, community, and political levels. We taught social skills, parenting skills, and family communication. We wrote and delivered petitions, made presentations in schools, talked to the media, and posted anti-tobacco art work in shopping malls. We educated children about the ill effects of tobacco and role played peer pressure situations. All these activities evolved from our broad-based definition of health promotion. The LAEG felt proud of fostering such a vision of health. But the enthusiasm has to be tempered by the rather small magnitude of our impact. The program reached about 50 children and 20 families. A petition to city council was delivered, but we don't know what real impact it had on tobacco legislation. Although we espoused a comprehensive vision of health, the extent of our reach is quite modest.

We conclude this article with an optimistic but temperate message. The project, based on the values of community participation, sensitivity to cultural diversity, and holistic health, has the potential of stimulating other integrative and value-based initiatives. While the impact of our program is admittedly modest, it shows how small ethno-cultural communities, with little financial support, can begin to take control of their health.

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Table 1
Expression of Main Values in Various Phases of the Program

Values	Program Phases			
	Phase I Community	Phase II Program	Phase III Planning Activities	Phase IV Program Dissemination
	Consultation			
Community Participation	Community forum was used to seek input and create a sense of ownership from the outset	Local residents were involved in planning and were hired as program facilitators and evaluators	Use of participatory popular education methods with children and adults	Involvement of local residents and staff in composing final report and in dissemination efforts
Cultural Sensitivity	Forum, conducted in Spanish, sought to learn about community's unique perceptions on smoking.	Creation and adaptation of program materials to reflect the Latin American culture	Sessions with parents and children were conducted in Spanish and tailored to unique background of community	Interviews with key informants from other ethno-cultural communities to study feasibility of adapting our program to their culture
Comprehensive Vision of Health	Forum participants were consulted on various ecological factors affecting smoking behavior	Through the use of popular education methods facilitators learn about role of social and political factors in smoking	Activities related to individual, familial, social communal, political and economic determinants of health	Dissemination study inquires about perceptions of smoking and health in the context of each ethno-cultural community

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Correspondence concerning this article may be sent to Isaac Prilleltensky, Department of Psychology, Victoria University, POBox, 14428, Melbourne City, MC, Victoria 8001, Australia. Electronic mail may be sent via Internet to Isaac.Prilleltensky@vu.edu.au