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A Process Evaluation of an Intervention to Promote Home Smoking Bans among Low Income Households

Cam Escoffery, PhD, MPH, CHES¹, Lujca Bundy¹, Regine Haardoerfer, PhD¹, Carla J. Berg, PhD¹, Lara S. Savas, PhD², Rebecca S. Williams, PhD³, and Michelle C. Kegler, DrPH¹

Cam Escoffery: cescoff@emory.edu; Lujca Bundy: lbundy@emory.edu; Regine Haardoerfer: regine.haardoerfer@emory.edu; Carla J. Berg: cjberg@emory.edu; Lara S. Savas: lara.staub@uth.tmc.edu; Rebecca S. Williams: rebeccawilliams@unc.edu; Michelle C. Kegler: mkegler@emory.edu

¹Rollins School of Public Health, Emory University, 1518 Clifton Rd, Atlanta, GA 30322

²University of Texas School of Public Health, 7000 Fannin St., Suite 2668, Houston, TX. 77030

³University of North Carolina at Chapel Hill, 200 N. Greensboro Street, Suite D-13, Carrboro, NC 27510

Abstract

Exposure to secondhand smoke occurs primarily in the home due to passage of smoke-free legislation. Creation of a total household smoking ban can reduce associated health conditions such as asthma, lung cancer, heart disease and stroke. This paper describes the results of a randomized control trial of a minimal intervention to create smoke-free homes. 2-1-1 callers were invited to participate in the trial and were randomized to an intervention (mailings and a coaching call) or a control group (no intervention). We assessed reach, dose, fidelity, and receptivity to the intervention through program records and a 3-month follow-up survey with intervention participants. For the intervention materials, materials were mailed to 244 participants (99.2%) and 227 participants (92.3%) received the coaching call intervention. 92.3% received all intervention components. Participants who had full household bans at 3 months were more likely to conduct behaviors leading to a smoke-free home (i.e., making a list of reasons, having a family talk, posting a pledge) than were those with no/partial ban. The intervention materials also were rated higher in relevance and usefulness by non-smokers than smokers. Results demonstrate that this minimal intervention had high fidelity to the delivery of components and relatively high receptivity.

Keywords

process evaluation; smoking restrictions; smoke-free home

Conflict of interest statement

The authors declare that they have no conflict of interest.

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1. Introduction

Process evaluation is a critical component of a comprehensive program evaluation plan to monitor and assess program coverage, delivery and fidelity of implementation. This paper reports findings from the process evaluation of a smoke free home (SFH) intervention, which was conducted to monitor the program, inform results and guide potential program modifications for future dissemination. SFH interventions focus on reducing secondhand smoke (SHS) in private households, without focusing on cessation as a primary goal. Children and nonsmoking adults who live with a person who smokes experience significant exposure to SHS in the home (CDC, 2008 and Pirkle et al., 2006). Chronic exposure to SHS in children increases risk of lower respiratory infections, middle ear infections, severity of asthma symptoms, sudden infant death syndrome, and lung cancer later in life (USEPA 1992, Gehrman & Hovell, 2003, and Anderson & Cook, 1997). For adults, SHS exposure can lead to heart disease and stroke mortality and increases the risk for stroke and heart attacks (USDHHS, 2006a). The prevalence of a total home smoking bans increased from 58.1% to 83.8% from 1995–2007; households with low income, one or two current smokers, parents with less than a college education, or single parents were less likely to report a total home ban (Zhang et al., 2012). Smoke-free homes have been shown to reduce exposure to SHS for both nonsmokers and children (Gehrman and Hovell, 2003, Biener et al., 1997, Wakefield et al., 2000, and Pizacani et al., 2003). Because there is no safe level of exposure to secondhand smoke (USDHHS, 2014), interventions to promote total home smoking bans should be developed and evaluated. Our SFH intervention is the first to promote household smoking policy to reduce SHS exposure, without a focus on cessation.

Process evaluation measures the implementation of a health promotion intervention and the extent to which it reaches the target population (Linman & Steckler, 2002 and Saunders, Evans, & Hoshi, 2005). Process evaluation data provide a unique opportunity to explore the feasibility of the delivery of intervention components and differential impacts of the various intervention components among different subgroups of participants. Different process indicators include: recruitment, reach, dose delivered (offered by implementers) and received (uptake/use by participants), fidelity, implementation, and context (Linnan & Steckler, 2002). In this study, we specifically will explore if there are differences in dose received (e.g., reading materials, engagement) between non-smokers and smokers receiving the intervention. This knowledge can assist in determining who appropriate change agents in the home are.

The purpose of this study was to report on the reach, program delivery/fidelity in terms of dose delivered and received, and reactions to the Smoke-free Homes program. We further explored differences in the intervention among participants who were smokers or non-smokers to assess variability in intervention impact. We examined differences in reactions and participation in intervention behaviors between households with different smoking and ban status. Specifically, we answer the following questions: 1) What was the reach and dose received of the intervention? 2) Was success in creating a full ban associated with greater engagement with the intervention? and 3) Did intervention engagement and reactions vary by household ban status (partial vs. no ban) or by participant smoking status (smoker vs. nonsmoker)?

2. Methods

2.1. Smoke-Free Homes Intervention

We conducted a randomized controlled efficacy trial of the Smoke-Free Homes program with 3- and 6-month follow-up surveys after the intervention, the outcomes of which are detailed elsewhere (Author et al., 2015). Callers (n=498) to the United Way of Greater Atlanta 2-1-1 social services referral hotline were recruited to participate in the research study. The 2-1-1 information and referral system covers over 240 state and local call centers operating in all 50 states (Daily, 2012). Callers to 2-1-1 request assistance with basic human needs such as finding or paying for shelter, heat, electricity and food (Kreuter, 2012). Half of study participants received four smoke-free homes intervention components at two-week intervals (the remainder, in the control group, received no intervention components). Intervention components included three mailings and one coaching call to help participants create a smoke-free home. Reading levels for the materials ranged from 4th to 7th grade. The first mailing included a Five-Step Guide to a Smoke-free Homes, information on secondhand smoke, reasons for going smoking free, and a smoke-free homes pledge. The one-time, 20-minute phone-based brief coaching call employed motivational interviewing and was delivered by an English-speaking research staff. The second mailing contained a photo story of a family going smoke-free and a challenges and solutions booklet. The third and last mailing included a newsletter, a thirdhand smoke factsheet, stickers and a window cling to promote and remind about the household's smoke-free home policy. The content of the print materials and the coaching call were based on Social Cognitive Theory (Bandura, 1986) and the Transtheoretical Model's stages of change (Prochaska, DiClemente, & Norcross, 1992). Behavioral change strategies included persuasion, role modeling, goal setting, environmental cues to action, and reinforcement. A full detailed description of each of the intervention components was previously published.¹⁸

2.2. Procedures

2-1-1 information and referral specialists (call agents) recruited participants from United Way 2-1-1 of Greater Atlanta program. The 2-1-1 referral service program connects people to the assistance and information they need to address every day challenges of living, primarily related to health and human services (e.g. rent and utility assistance, health, employment and financial assistance programs). Callers who reached any one of 5 line agents trained in study procedures were invited to participate in the study. The 2-1-1 Informational & Referral Specialists recruited 2-1-1 callers from the United Way of Metropolitan Atlanta (UWMA) program from date to date. To be eligible, participants had to: be at least 18 years of age or older, have a combination of at least one smoker and one non-smoker in the home (including children), allow at least some smoking in the home, and speak English. Callers who were clearly in crisis (very distressed about a problem they were calling about, such as facing homelessness) were not invited to participate. Callers deemed eligible to participate were invited to participate, read a consent form, and took a brief baseline survey, after which they were randomized into the brief intervention or control (measures-only) arm.

2.3. Measures

Enrolled participants completed a baseline survey by telephone which lasted approximately 5–10 minutes. The baseline survey included questions related to smoking history, secondhand smoke exposure, cigarette consumption, cessation attempts, household composition and smoking status, and demographics. For home smoking ban status, participants were asked, “Which statement best describes the rules about smoking regular cigarettes inside your home?”²¹ Response options were: “Smoking is not allowed anywhere inside your home; smoking is allowed in some places or at some times; there are no rules about smoking inside the home or smoking is allowed anywhere inside the home.”

All components of the intervention were delivered prior to the 3-month follow-up interview. An online application system tracked the delivery of each intervention component. Study staff members were trained on the system and survey data collection. For the coaching call, the intervention research team made up to 12 attempts on different days and times. We conducted 3 and 6 months follow-up surveys to assess outcomes but only the 3 month is reported here since it includes the process data. For the surveys, we also had a non-response protocol with up to 12 attempts. Process measures were collected at the 3-month follow-up to assess the proportion of materials mailed, received and reviewed, and the usefulness, relevance, and satisfaction of the materials and coaching calls (responses 1= *not at all* to 5= *very*). Participants also reported on conduct of behavioral targets: posting smoke-free home signs, signing and/or posting the pledge, coming up with a list of reasons for making the home smoke-free, having a family talk, or calling a smoking cessation services. They were also asked what materials they liked the most and least. Participants were compensated with a \$25 gift card for completing each survey. The study protocol was approved by the Emory University Institutional Review Board.

2.4 Analyses

At 3-month follow up, 192 intervention participants were asked process evaluation questions about the receipt of mailed materials, the proportion of materials read, the usefulness and relevance of materials, satisfaction with the coaching call, and utilization of intervention materials. For the purpose of our analyses, we will report on the 180 participants who reported receipt all intervention mailed materials at follow-up (227 received all of the components). We ran descriptive statistics on all process measures. We also conducted chi-square tests to assess differences in the review, understanding, relevance, and usefulness of the materials and similar characteristics of the coaching call by smoking status (i.e., smoker vs. non-smoker). Additionally, chi-square tests were run to examine differences in use of the materials by home smoking ban status. A significance level of 0.05 was used for all analyses.

3. Results

3.1. Participant characteristics and dose

A total of 246 participants were randomized into the intervention group. Intervention materials were mailed to 244 participants (99.2%) and 227 participants (92.3%) received the coaching call intervention. Participants (n=19) who missed the coaching call were

unreachable (n=17) or dropped out of the study. Of the 192 participants surveyed at the 3-month follow-up interview, 92.3% received all intervention components. Ninety-four percent (N=180) participants reported receiving the mailed intervention materials and 82% (N=148) reported receiving the coaching call. On average, the coaching call lasted for 18.2 (SD=5.4) minutes. The participants were mostly female (84.4%), African American (89.4%), high school educated or less (61.2%), single (53.3%) and not employed (81.7%) (Table 1). While eligibility criteria required at least one smoker to live in the home, 48% of participants lived with two or more smokers in the home. Many were smokers (76.7%) and had a partial ban at baseline (63.3%).

3.2. Conduct of Intervention Behaviors by Ban Status

Table 2 shows participant's conduct of key recommended intervention behaviors by household ban status (no ban/partial ban or full ban). Regardless of ban status, most participants reported coming up with a list of reasons for making their home smoke-free (76.7%), having a talk with their household about making the home smoke-free (92.8%), signing a pledge (56.7%), putting up signs (60.6%), and using the stickers (65.6%). There were significant differences among household ban status and putting up smoke free home signs. More participant households with full bans (75.0%, $p=0.026$) reported putting up signs than participant households with partial bans or without a ban (54.0%).

3.3 Participants' Reaction by Ban Status

Table 3 shows the participants' ratings of relevance, usefulness, and satisfaction of the mailed intervention materials and the coaching call by ban status of the participant. There were no significant differences between ban status and receptivity of the materials overall; however, two ratings approached significant differences. More participants with full bans (39.3%) read the materials more often than those with partial or no ban (20.2%). Similarly, participants with full bans were more likely to find the materials very relevant to them (80.4) than those with partial or no ban (65.3%). The majority of participants (82.8%, N=149) reported that the materials were very useful.

3.4 Participants' Reaction by Smoking Status

Table 4 shows the participants' ratings of relevance, usefulness, and satisfaction of the mailed intervention materials and coaching call by smoking status of the participant. About half of the participants (46.1%, N=83) reported reviewing the mailed materials sometimes, and 25.6% of participants (N=46) reported reviewing the materials often. Most participants (86.7%, N=156) reported that the materials were very easy to understand, and (70.0%, N=126) were very relevant to them personally. Significantly more nonsmokers ($p=0.002$) found the materials very relevant to them personally compared to smokers. The majority of participants (82.8%, N=149) reported that the materials were also very useful.

Of the 148 who reported receiving the coaching call, 68.2% (N=101) reported that the coaching call was very relevant to them personally. More nonsmokers (92.7%, $p=0.03$) reported that the coaching call was somewhat/very relevant to them personally than smokers (79.5%). Most participants (77%) reported that the information provided in the coaching call was very useful and 82% were very satisfied with it. However, significantly more smokers

(95.5%, $p=0.01$) reported that the coaching call was somewhat/very useful than nonsmokers (82.0%). For the print materials, sub-analyses found no difference between demographic variables and ratings of understanding, relevance, and usefulness as well as relevancy, usefulness, and satisfaction.

For the coaching call, 2 significant differences were found. Households with 2 or more smokers indicated higher satisfaction with the coaching call ($M = 3.86$, $SD = 0.40$) compared to those households with only one smoker ($M = 3.67$, $SD = 0.68$), $p = .049$. Households without children indicated higher satisfaction with the coaching call ($M = 3.93$, $SD = 0.27$) than those with children ($M = 3.72$, $SD = 0.60$), $p = .01$ (data not reported in tables).

3.4 Other Intervention Feedback

Participants were asked to indicate specific components in the intervention materials they liked the best and the least. Participants reported that they liked the steps to making a home smoke-free (28.9%), information about secondhand smoke and children (20.5%), learning the truths about secondhand smoke (16.8%) and information on the health risks associated with secondhand smoke (16.8%).

4. Discussion

The Atlanta Smoke-Free Homes process evaluation found that this minimal intervention has high receipt (dose) and acceptability among those enrolled and impacted rates of total home smoking bans and reduced exposure to SHS (Author et al., 2015). These results highlight the feasibility of delivering the intervention and reaching low-income smokers and non-smokers living in homes with SHS exposure. The minimal intervention requires little expertise and low burden to deliver. Participants reported high rates of acceptability and satisfaction across intervention components, as well as acceptability of telephone- and mail-based formats of intervention delivery. These results are similar to our findings from our pilot testing of the intervention in the satisfaction, conduct of behaviors related to making homes smoke-free, and engagement of smokers in the materials and coaching call; however, more participants in this trial called for cessation services (19.4% vs 14.0%) (Author et al., 2012). With 92% of participants receiving the full intervention, this finding indicates an efficient and practical approach to reaching low income groups with exposure to SHS in the home. Findings from previous clinic-based interventions for home smoking restrictions reflect mixed results and more intensive home-based interventions have had greater success (Gehrman & Hovell, 2003). In contrast to the intensive intervention, we found that this minimal intervention has high receipt (dose) and acceptability among those enrolled and impacted rates of total home smoking bans and reduced exposure to SHS (Author et al., 2015).

Use of multiple strategies offering different opportunities for engagement in the intervention appeared salient in the success of creating smoke-free homes. Three separate mailings included materials that offered visual tools to communicate SFH messages. Most participants did not review the written materials often (39% of participants who achieved full bans and 20% of participants who achieved partial or no bans reviewed the materials

often). However, most reported implementing the simple strategies, including posting the visual tools to help make their homes smoke-free (e.g., signs, stickers). Three-months post intervention, participants who reported full smoking bans, compared to those with no bans or partial bans, were more engaged in posting signs (75% vs. 54%), creating a list of reasons to make their homes smoke-free (84% vs. 73%), putting up stickers (73% vs. 62%), and having a family talk (98% vs. 90%). Interestingly, those reporting higher rates of signing a pledge to make their home smoke free were less successful implementing a full ban compared partial or no bans (39% vs. 62%). However, participants who actually posted their pledge reported higher success in achieving full smoking bans compared to the no ban/partial ban group (57% vs. 48%); therefore, the posting could reinforce their commitment and shows higher collective intentions to change their house smoking rules. However, we found no significant differences in reactions to the intervention materials by ban status at 3 months follow-up. The majority liked the intervention materials overall and open-ended comments supported this as well.

We found that non-smokers generally were more receptive to the smoke-free homes materials. This is not surprising since households with no smokers are more likely to have a smoke free home rule than those with at least one smoker (Gilpin, White, Farkas & Pierce, 1999, and CDC, 2014). The non-smokers read the intervention materials more often, and rated the materials higher in usefulness and relevance than did smokers. Interventions aimed at household smoking restrictions could target non-smokers as change agents for creating smoke-free homes. Interestingly, the smokers reported greater relevance and utility of the coaching call than non-smokers. It may be that they are seeking ways to quit or reduce smoking and this call provides a unique opportunity to discuss these changes. We found a larger reduction in number of cigarettes smoked daily by smokers at the end of the trial in the intervention group ($M=9.8$, $SD=6.3$) versus the control group ($M=13.0$, $SD=8.5$) (Author et al., 2015). However, there was no statistical significant difference in number of smokers between the 2 groups.

Process evaluation was helpful in describing high receipt of intervention components and slight differences between reactions among different sub-groups of participants. This process evaluation has several limitations. The sample was mostly female, African-American, unemployed with a high school education or higher. It may not be representative of other households with no total home smoking restrictions. The conduct of the recommended behavioral strategies was all based on self-report of the participants. Finally, there may have been socially desirable responses; however, we found a variance across ratings of the intervention components.

A strength of the SFH intervention is its efficient reach to low-income non-Hispanic whites and African Americans affected by SHS exposure in the home over time with staged intervention materials. The findings show feasibility of outreach and very high receipt of components, as 2-1-1 callers opted into the program. Reasons for the high implementation fidelity possibly are the training of the 2-1-1 and university staff for recruitment and delivery of the mailings/coaching call, intervention tracking system, and packaged intervention components. Research has demonstrated that skill proficiency of the provider/implementer, training and formulation of tasks are elements of successful program

implementation (Durlak & DuPre, 2008). Participants rated intervention materials highly relevant and useful regardless of ban or smoking status, and the intervention approaches have been linked to effectiveness in prior studies (Author et al., 2012 and Author et al., 2015). Those with full bans at 3 months did tend to perform more of the behaviors related to preparing for a smoke-free home although it was not significant when compared with households with partial or no bans. These findings demonstrate the importance of process measures and proximal behavior changes toward a smoke-free home in impacting future total smoking restrictions for some households.

Future steps for the translation of this minimal SFH intervention are the conduct of effectiveness trials in North Carolina and Texas and then dissemination of the intervention through a grants mechanism to other 2-1-1 information and referral systems around the country. This model allows for the study of intervention *and* implementation effectiveness in real world setting, and exploration of elements of successful delivery and moderating effects such as congruence of the intervention to different cultures and perceptions of the program implementers (Marchand et al., 2011). More research is needed to understand program acceptability, relevance and satisfaction in other groups (e.g., Hispanics) and across settings for future dissemination of the SFH intervention. Effectiveness research requires evaluation of an intervention with different settings and populations to increase the external validity of the program (Glasgow et al., 2006, and Glasgow, Lichtenstein, & Marcus, 2003). Multi-site trials can increase variability of participant and setting characteristics to learn more about implementation effectiveness as planned with our future studies (Glasgow et al., 2006). Because this was an efficacy study, process evaluation research can continue to focus on implementation issues as delivered by 2-1-1 specialists in 'real world' conditions and provide more information on implementation issues and facilitators, fidelity to the original intervention, and its acceptability among different participants with future effectiveness and dissemination trials with 2-1-1 referral systems. Moreover, long-term follow-up is needed to understand sustained impact of the SFH intervention on reducing home smoking exposure.

5. Conclusion

Results from the Smoke-Free homes program found that a minimal household intervention was delivered with high fidelity and participants were receptive to the materials and coaching call regardless of ban status. However, nonsmokers generally had more positive ratings of relevance and utility of the materials than did smokers. In addition, the participant that had full bans were more likely to perform recommended behaviors to create a smoke-free home than those who had no or partial bans indicating that these strategies may have led to intervention impacts.

6. Lessons Learned

Process evaluation can be crucial in providing data about program receptivity and implementation, especially for health promotion programs that are being disseminated. It is valuable to conduct a process evaluation in addition to testing outcomes of interventions to understand the reach, dose received by participants, participant receptivity and satisfaction,

and barriers and facilitators to implementation. These data could inform decisions for program refinement or future program replication.

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Highlights

- The home is a primary source for secondhand smoke for low income households
- This study presents a process evaluation of an intervention to create smoke-free homes
- The program had high fidelity with 92% receiving all components
- Non-smokers rated the materials higher in relevance and usefulness than did smokers
- Participants with a total ban performed more the recommended program behaviors

Table 1

Demographics of Process Evaluation Participants at Baseline (n= 180)

	n (%)
Participant Characteristic	
Gender	
Female	152 (84.4%)
Age, Mean (SD)	41.2 (11.2)
Race	
White	12 (6.7%)
African American	161 (89.4%)
Other	7 (3.9%)
Relationship Status	
Not married, living with partner	51 (28.3%)
Married	33 (18.3%)
Single	96 (53.4%)
Income	
Less than \$10,000	100 (55.6%)
\$10,000–\$35,000	73 (40.7%)
\$35,000–\$50,000	3 (1.7%)
Work status	
Employed, full-time or part-time	33 (18.4%)
Not working	147 (81.6%)
Education	
Less than high school	42 (23.4%)
High school/GED	68 (37.8%)
More than high school	70 (38.8%)
Current smoker	138 (76.7%)
Cigarette smoked per day, Mean (SD)	12.2 (7.2)
Household Characteristic	
No. of Children under 18, Mean (SD)	1.76 (1.5)
Smoking Ban Status	
Partial ban	114 (63.3%)
No ban	66 (36.7%)

Table 2

Recommended Intervention Behaviors by Household Ban Status 3 Months Post Intervention (n=180)

Question	% Yes	Full ban	Partial ban/No ban	p-value
		%Yes	% Yes	
Did you come up with a list of reasons for SFH?	76.1	83.9	72.6	.09
Did you have a family talk?	92.8	98.2	90.3	.28
Did you sign pledge?	50.6	38.5	61.5	.09
Did you post pledge?	51.1	57.1	48.4	.28
Did you put up signs?	60.6	75.0	54.0	.03*
Did you use stickers?	65.6	73.2	62.1	.26
Did you call smoking cessation services?	19.4	23.2	17.7	.39

Table 3

Receptivity to the SFH 3-months Post Intervention by Ban Status

		Household Ban status						p-value
		Total		Full		Partial/No		
		N	%	N	%	N	%	
SFH Intervention Materials (n=180)								
Review of materials								
Never	13	7.2	4	7.1	9	7.3		
Rarely	37	20.6	9	16.1	28	22.6		.06
Sometimes	83	46.1	21	37.5	62	50.0		
Often	47	26.1	22	39.3	25	20.2		
Understanding ¹								
Not at all	0	0.0	0	0.0	0	0.0		.25
A little	6	3.3	1	1.8	5	4.0		
Somewhat	16	8.9	3	5.4	13	10.5		
Very	157	87.2	51	91.1	106	85.5		
Relevance								
Not at all	0	0.0	0	0.0	0	0.0		.09
A little	18	10.0	5	8.9	13	10.5		
Somewhat	36	20.0	6	10.7	30	24.2		
Very	126	70.0	45	80.4	81	65.3		
Usefulness								
Not at all	0	0.0	0	0.0	0	0.0		.43
A little	6	3.3	2	3.6	4	3.2		
Somewhat	25	13.9	5	8.9	20	16.1		
Very	149	82.8	49	87.5	100	80.6		
Coaching Call (n=139)								
Relevance								
Not at all	1	0.7	0	0.0	1	1.1		.40
A little	14	10.1	6	12.5	8	8.8		

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	Household Ban status					p-value	
	Total		Full		Partial/No		
	N	%	N	%	N		%
Somewhat	30	21.6	7	14.6	30	21.6	
Very	94	67.6	35	72.9	59	64.8	
Usefulness							.68
Not at all	0	0.0	0	0.0	0	0.0	
A little	11	7.9	5	10.4	6	6.6	
Somewhat	20	14.4	6	12.5	14	15.4	
Very	108	77.7	37	77.1	71	78.0	
Satisfaction							.19
Not at all	1	0.7	0	0.0	1	1.1	
A little	6	4.3	1	2.1	5	5.5	
Somewhat	18	12.9	3	6.3	15	16.5	
Very	139	82.0	44	91.7	70	76.9	

Relevance, Usefulness and Satisfaction with SFH Intervention Components by Smoking Status (n=180)

Table 4

		Smoking status						p-value
		Total		Non-smoker		Smoker		
		N	%	N	%	N	%	
SFH Intervention Materials (N=180)								
Review of materials								
Never		13	7.2	3	6.0	10	7.7	0.68
Rarely		38	21.1	12	24.0	26	20.0	
Sometimes		83	46.1	20	40.0	63	48.5	
Often		46	25.6	15	30.0	31	23.9	
Understanding ¹								
Not at all		0	0.0	0	0.0	0	0.0	0.24
A little		6	3.3	3	6.0	3	2.3	
Somewhat		17	9.4	4	8.0	13	10.0	
Very		156	86.7	42	84.0	114	87.7	
Relevance								0.002***
Not at all		0	0.0	0	0.0	0	0.0	
A little		18	10.0	8	16.0	10	7.7	
Somewhat		36	20.0	2	4.0	34	26.2	
Very		126	70.0	40	80.0	86	66.2	
Usefulness								
Not at all		0	0.0	0	0.0	0	0.0	0.07
A little		6	3.3	3	6.0	3	2.3	
Somewhat		25	13.9	3	6.0	22	16.9	
Very		149	82.8	44	88.0	105	80.8	
Coaching Call (N=148)								
Relevance								
Not at all		1	0.7	1	2.6	0	0.0	0.03*
A little		15	10.1	7	18.0	8	7.3	

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	Total		Smoking status				p-value
			Non-smoker		Smoker		
	N	%	N	%	N	%	
Somewhat	31	21.0	4	10.3	27	24.8	0.01**
Very	101	68.2	27	69.2	74	67.9	
Usefulness							
Not at all	0	0.0	0	0.0	0	0.0	
A little	12	8.1	7	18.0	5	4.6	0.01**
Somewhat	22	14.9	2	5.1	20	18.4	
Very	114	77.0	30	76.9	84	77.1	
Satisfaction							
Not at all	1	0.7	0	0.0	1	0.9	0.50
A little	6	4.1	3	7.7	3	2.8	
Somewhat	19	12.8	4	10.3	15	13.8	
Very	122	82.4	32	82.1	90	82.6	