Published in final edited form as:

Fam Community Health. 2012 ; 35(2): 139–146. doi:10.1097/FCH.0b013e3182465153.

The Latino Migrant Worker HIV Prevention Program:

Building a Community Partnership Through a Community Health Worker Training Program

Jesús Sánchez, PhD,

Department of Sociobehavioral and Administrative Pharmacy, College of Pharmacy, Nova Southeastern University, Fort Lauderdale, Florida

Georgina Silva-Suarez, MPH,

Department of Health Promotion and Disease Prevention, Robert Stempel College of Public Health and Social Work, Florida International University, Miami

Claudia A. Serna, MPH, and

Department of Health Promotion and Disease Prevention, Robert Stempel College of Public Health and Social Work, Florida International University, Miami

Mario De La Rosa, PhD

School of Social Work, Robert Stempel College of Public Health and Social Work, Florida International University, Miami

Abstract

There is limited information on the impact of the HIV/AIDS epidemic on Latino migrant workers (LMWs), although available data indicate that this community is being disproportionately affected. The need for prevention programs that address the specific needs of LMWs is becoming well recognized. HIV prevention interventions that train and employ community health workers are a culturally appropriate way to address the issues of community trust and capacity building in this community. This article describes the Latino Migrant Worker HIV Prevention Program and its efforts to train and engage community health workers in the prevention of HIV among LMWs in South Florida.

Keywords

community-based participatory research; HIV/AIDS; HIV prevention programs; Latino migrant workers

THE Latino community living in the United States has been disproportionately impacted by the HIV/AIDS epidemic.¹ Furthermore, the development, implementation, and evaluation of HIV prevention interventions designed to reduce the risk of infection among Latinos lag behind prevention efforts targeting other communities.² This public health gap is even more evident when considering the sparse attention received by Latino migrant workers (LMWs)

Correspondence: Jesús Sánchez, PhD, Department of Sociobehavioral and Administrative Pharmacy, College of Pharmacy, Nova Southeastern University, 3200 S University Dr, Fort Lauderdale, FL 33328 (js2769@nova.edu).

The authors declare no conflicts of interest.

in the United States despite their high risk for HIV infection. Research has specifically linked migration to increased HIV incidence and vulnerability in a variety of contexts and places. First, migrant workers are a large and growing population with an estimated 125 million people living and often working outside their country of citizenship, whereas between 2 million and 4 million migrate permanently each year. Second, migrant populations have a greater risk for poor health in general and HIV infection in particular due to circumstances, including their economic transitions, decreased accessibility of health services, and the complication of the host country health systems to address the needs of migrants. Third, the uniqueness of migrants often fosters a kind of ethnic/racial intolerance and hostility by the host community, which is likely to be even more severe with HIV-positive migrants, particularly regarding stigmatization and discrimination. Thus, migrants may further hide their HIV status as long as possible, thus making support services unavailable for them. Fourth, even if health providers were prepared to assist migrant populations, they would likely encounter great difficulties to reach out to them. Many migrants live in constant fear of deportation, having no stay or work permit for the host country. Therefore, any contact with official government agencies increases that fear and is often accompanied by suspicion. Finally, workers in the southeastern United States are more likely to live away from their families while doing farm and nursery work than migrant worker populations in other areas of the United States.^{3,4}

The few available studies on HIV transmission and prevention specifically conducted among LMWs highlight the role played by risk factors such as inadequate or incorrect HIV transmission knowledge, limited access to HIV risk reduction information, unprotected sexual practices, alcohol and other drug use, cultural and gender roles, and immediate survival problems (ie, housing and employment).^{5–9} While these studies have made a critical contribution to advance our understanding of the Latino migrant population in the United States and highlight numerous potential differences between this and other populations, their HIV prevention interventions have demonstrated only limited effectiveness^{10–14} and documented a critical need for tailoring effective HIV prevention interventions for the Latino migrant population. These adaptations, however, cannot be limited to the cultural translation of existing interventions to be responsive to the cultural uniqueness of Latino migrant populations. The development of new interventions to address HIV prevention in Latino migrant communities needs to take into account their specific circumstances as well as their traditional mistrust of conventional research, which they view as paternalistic and irrelevant to their needs. Consequently, culturally adapted interventions must prompt community engagement and participation at every phase of the program if they do not want to remain culturally blind. It is now widely accepted that conventional, *single-shot* interventions are likely to fail to adequately help LMWs to adopt and maintain HIV risk reduction behaviors in a constantly shifting personal and social environment.^{9,15,16} As a result, it seems critical to provide the LMW community with the capacity and infrastructure to prolong community-based HIV prevention activities over time. Latino migrant workers are most likely to benefit from HIV prevention efforts when these efforts are supported at the community level and sustained over time and other needs in the community are also addressed.^{17,18}

Community-based participatory research (CBPR) has emerged as a research paradigm that addresses the limitations of conventional research models and offers a “collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. The ultimate goal is to promote social change to improve community health and reduce health disparities.”^{19(p6)} Advantages of CBPR include that it is a participatory and cooperative approach, requires equitable power and mutual ownership, is framed in a co-learning experience, and seeks the balance between research and action. Furthermore, it is an empowering process that involves capacity building among all partners involved. Being a collaborative approach, it is understood that the researcher and community members should work as partners during the entire research process and that trust and mutual respect are aspects that must be present all the time and should guide the relationship among researchers, community members, and all the partners involved in the process.¹⁹

Although the call for more CBPR-oriented research has increased significantly over the last 15 years, the difficulties in applying such an approach to health promotion and disease prevention are significant and constitute a great challenge to researchers and community members. In this article, we describe (a) Project Salud, a growing CBPR partnership between the Latino migrant community in South Florida and researchers at the Nova Southeastern University and the Florida International University, and (b) a community health worker (CHW) training program—the Latino Migrant Worker HIV Prevention Program (LMW-HIVP)—conducted under Project Salud.

METHODS

Project Salud—officially titled “HIV Risk Reduction Among High Risk Latino Migrant Workers in South Florida”—was a 4-year major study funded by the National Institute on Minority Health and Health Disparities as part of C-Salud, a P20 Exploratory Center of Excellence at the Florida International University. The main objective of Project Salud was to assess the differential effectiveness of an Adapted Stage-Enhanced Motivational Interviewing (A-SEMI) process compared with a Health Promotion Comparison condition for producing long-term reductions in HIV risk and increased health behaviors among LMWs. The design of the A-SEMI intervention is considered to be an enhancement over existing cognitive behavioral risk reduction approaches because A-SEMI integrates key contextual components from effective HIV prevention interventions (ie, peer counseling) linked to maintenance of risk reduction effects.

Project Salud was originally conceived as a CBPR project with the goal of engaging the LMW community in Homestead in the implementation of an HIV prevention intervention. By framing Project Salud within the CBPR approach, this study responded to the National Institutes of Health priority on establishing equitable partnerships between community members and researchers with the final goal of increasing community participation in the research process, improving community health, and reducing HIV-related health disparities.

A network-based sample of 278 LMWs was recruited from November 2008 to December 2010 from migrant communities in the Homestead area in Miami-Dade County, Florida.

Homestead is part of a predominantly rural area in the south of Miami-Dade County, Florida. Official census data indicate that most of the population in Homestead (51.8%) is Hispanic/Latino, more than one-third (36%) is foreign-born, and a majority (57.3%) speaks a language other than English at home.²⁰ Agriculture and nursery constitute an important business in the Homestead area, allowing for access to seasonal farm work. Homestead's LMW population is composed primarily of recently arrived, young, single, or married men who are in the United States alone. They live in small, crowded apartments with family or friends. Most are Mexican and Central American arriving in this area with little or no English language skills and very limited resources.

After screening for eligibility, participants were administered a structured baseline questionnaire using A-CASI that included basic sociodemographic information, alcohol and other drug use history, sexual behaviors, acculturation, and behavioral intentionality. An Oral Health questionnaire was also administered at the 9-month follow-up. This study was approved by the institutional review board of the Florida International University.

Barriers to CBPR

Although building trust to involve community members can be a challenge to any CBPR project,^{21–23} this issue became extremely relevant within the Latino migrant community in South Florida because of the legal status of members of this community. Many community members, including community leaders, were undocumented and extremely hesitant to participate in a process that they did not trust or understand. Consequently, a considerable amount of effort went into the process of developing a relationship of trust with the community. As this relationship developed, it became clear that the remaining reticence on the part of the community emanated from a deep lack of understanding of the research process, in general, and CBPR, in particular. For our partnership with the Latino migrant community to be a successful one, we understood that this knowledge gap had to be addressed. In commenting on their own experience developing a partnership in the community, Andrews and colleagues²⁴ pointed out how participants in their study who had formal training in CBPR (ie, coursework, seminars, mentored experiences) had a better appreciation for the CBPR principles and were more likely to sustain partnerships over time. Since none of our partners in the Latino migrant community had any exposure to CBPR, we decided to provide them with that opportunity by creating a training program modeled after existing CHW initiatives within a CBPR framework.^{19,25–27}

The Latino Migrant Worker HIV Prevention Program

At the early stages of Project Salud, we planned to address the issue of reinforcing trust in the community while creating community capacity as a key building block in the development of our partnership with the Latino migrant community. We initiated a dialogue with key community partners and community members with the goal of identifying what type of knowledge and skills would be necessary to address the issue of HIV prevention among LMWs. The ultimate goal of this dialogue was to juxtapose the views of both the community and the researchers. On the basis of this exchange of ideas and using other researchers' experiences as a learning framework,^{19,25–27} we have created the LMW-HIVP, which is a CBPR-based CHW education program designed to build the knowledge and skills

needed at the community level to develop and sustain an effective CBPR partnership to support HIV/AIDS research and prevention in the Latino migrant community.

LMW-HIVP objectives

The LMW-HIVP had 3 main objectives. The first objective was to develop the LMW-HIVP training curriculum and create a training manual and Web site based on it. The second objective was to implement the training curriculum to educate community members as CHWs and incorporate them into Project Salud's HIV prevention efforts. The training curriculum included various fundamental aspects of HIV research and prevention including community outreach and education, data collection, and findings dissemination. The third and final objective was to provide the community with a permanent research facility.

Creating the curriculum

Our first priority was to create a training curriculum that would provide the Latino migrant community with the knowledge and skills to address the issue of HIV research and prevention in their community from a CBPR standpoint. Qualitative methods were used to gain an understanding of the sociocultural values, beliefs, and practices in the area of HIV/AIDS of LMWs working and residing in Homestead. Ethnographic methods used during the curriculum development phase included participant observations, focus groups, and one-on-one, in-depth, semistructured interviews. Project Salud staff spent 14 months in the field attending numerous meetings and community events during which the curriculum was developed.

The curriculum includes 6 units: CBPR Principles, Research Ethics, HIV/AIDS and its impact on the Latino community in the United States, Oral Health, Quantitative Methodology, and Qualitative Methodology. Each unit contains learning objectives, in-depth content information about the topic(s) being presented, examples and interactive exercises that are designed to trigger discussion and to help better understand the concepts being presented, and suggested references and resources. The curriculum was built upon a combination of approaches to teaching and learning and customized to the specific needs of the community. It was also developed to build on and reflect existing community strengths and assets.*

Implementation of training curriculum

Before implementing the training curriculum, we hired 2 members from the community to be trained on the training curriculum, assist with the development of the training manual, and support training efforts at the community level.

An empowerment model of education was used for the delivery of the training program. This model, based on the works of Paulo Freire,²⁸ uses a learning cycle of listening-dialogue-action. The *listening* phase involves systematic listening of community concerns. The *dialogue* phase involves a problem-posing method to enable participants in the analysis

*Extensive information on the curriculum—in both its Spanish and English versions—is available at the following Web site: <https://sites.google.com/a/fiu.edu/hispanic-migrant-workers-training-curriculum/>

of their problems including underlying causes. Finally, during the *action* phase, the facilitator uses structured dialogue within a participatory interactive model for education to help participants identify and reflect on the actions needed to address identified problems individually and socially within the community.^{29–31}

The implementation of the training curriculum consisted of a workshop that included seven 1-day training sessions. The entire workshop took place over the course of 2 weeks, and training participants received \$442 at the end of session 7. The first 6 sessions of the training workshop were devoted to each of the 6 units on the curriculum, whereas session 7 was a wrap-up session. Although community participants were welcome to offer their feedback throughout the entire 7-day workshop, we conducted a formal evaluation at the end of session 7. We used participants' comments and the formal evaluation to update and improve the training manual so that each new cohort of community participants would benefit from these improvements. Forty-six community members—26 women and 20 men—were trained in cohorts of 4 to 6 participants.

The success of a CHW program depends in part on recruiting and training individuals with broad social networks who have the time and desire to pass on their knowledge and skills to other members of the community. Our CHW program presented additional challenges since HIV and related risk behaviors—particularly, sex behaviors—are not typically discussed in the Latino culture.³² We selected training participants on the basis of the following eligibility criteria: (1) Latino migrant worker; (2) literate; (3) aged 18 and older; (4) open-minded about discussing HIV and related risk behaviors; and (5) living and residing in the Homestead area for, at least, 4 months of the year.

Project Salud staff viewed retention in the LMW-HIVP as not merely completion of the program but as active participation in all parts of the program. Therefore, the program addressed issues of access on multiple levels including (1) a relevant and accessible curriculum; (2) teaching methods that fit with cultural norms; (3) making transportation and childcare available to training participants; and (4) providing meals, snacks, and beverages at different points during the training sessions.

Creation of a permanent research facility

The third objective of the LMW-HIVP was to provide the community with a permanent research facility that would support the community efforts to promote health and prevent HIV infection over time. In a combined effort between Project Salud and one of its main community partners, the Farmworker Association of Florida (FWAF), we created a permanent research environment through the creation of a research facility at the offices of the FWAF in Homestead. This office has been furnished with new computer equipment, printers, software, office supplies, and, in general, everything necessary for the day-to-day operation of a research facility, including technical assistance by Project Salud staff. This new research facility currently houses the ongoing LMW-HIVP training workshops and serves as a hub for the array of activities being conducted under Project Salud. For instance, as we are preparing a new grant proposal to extend and expand Project Salud's HIV prevention efforts in the community, we are using this research facility for CAB meetings, focus groups, and other activities.

DISCUSSION

Challenges to conducting CBPR are well documented and may discourage researchers and community members from engaging in this type of research.^{33–35} Project Salud engaged the Latino migrant community in South Florida with the goal of establishing a partnership based on CBPR principles to address HIV prevention. One of the most critical challenges we faced was a lack of understanding on the part of the community regarding research, in general, and CBPR, in particular. We realized that it was not viable to establish and sustain a true collaborative, equitable research partnership with the Latino migrant community unless we could generate co-learning and capacity-building opportunities that could provide them with the necessary knowledge and skills as well as maintain HIV prevention efforts in the community.

In response to this assessment, Project Salud has been genuinely invested in building community capacity by developing and implementing a CHW education training program—LMW-HIVP—and creating a permanent research environment in the community. The training program gave community members an opportunity to acquire knowledge and skills on how to conduct research that were very scarce in the community. The training program also increased community awareness and understanding of the effect of HIV epidemic on Latinos in the United States and the importance of community efforts to prevent HIV infection in the community. Finally, as they finished their training, CHWs were integrated into Project Salud's HIV research and prevention activities such as recruitment of study participants, delivery of survey and intervention instruments, and dissemination of information. Following a long-standing tradition of training community members in underserved communities and employing them as CHWs,^{36–38} LMW-HIVP trainees play a key role in disseminating the knowledge and skills they received as part of their training to promote health, prevent HIV infection, and reduce health disparities in the Latino migrant community. As members of the community, training participants possess an intimate understanding of community social networks, communicate in a similar language, and recognize and incorporate cultural elements to promote health and health outcomes within their community.

However, research and prevention strategies require not only knowledge and skills but also the material means to apply them. Project Salud, in partnership with the FWAF, has created a permanent research facility in the association's offices in Homestead that houses many of the activities related to this project and plans for future ones.

CONCLUSIONS

Although a summative evaluation of the LMW-HIVP is in the process of being conducted, we have received feedback from the community that supports the implementation of a CBPR approach to HIV prevention in the community as well as the utilization of CHWs as a key component of this approach. Community members participating in the training have demonstrated a substantial growth in their competency, knowledge, and skills required to optimize their contribution to HIV prevention in their community. We have also observed an increase in community awareness and in the number of members of the LMW community

who have approached Project Salud staff or any of our community partners asking about testing, resources, and referrals as a result of coming in contact with a CHW. Finally, we have been approached by different migrant worker organizations and clinics about the possibility of partnering in different HIV prevention projects, which will sustain the ongoing efforts.

As evidence of the added benefit of their contribution to health promotion and disease prevention continues to mount, CHWs can and should become key players toward the implementation of any CBPR-based project in the Latino migrant population of South Florida.

Acknowledgments

The authors thank the Latino migrant worker community in Homestead, South Florida. This study could not have been conducted without their generous support and collaboration. This research was funded by the National Institute on Minority Health and Health Disparities (award no. P20MD002288).

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute on Minority Health and Health Disparities or the National Institutes of Health.

References

- Centers for Disease Control and Prevention. HIV Among Hispanic/Latino. Atlanta, GA: Center for Disease Control and Prevention; 2010. <http://www.cdc.gov/hiv/hispanics/index.htm>. Accessed November 4, 2011
- Centers for Disease Control and Prevention. HIV Behavioral Interventions for Hispanics/Latinos in the US: A Meta-Analytic Review. Atlanta, GA: Center for Disease Control and Prevention; http://www.cdcnpi.org/scripts/HispanicLatino/files/herbst_latinoconsult.pdf. Accessed November 4, 2011
- Soskolne V, Shtarkshall RA. Migration and HIV prevention programmes: linking structural factors, culture, and individual behaviour—an Israeli experience. *Soc Sci Med*. 2002; 55(8):1297–1307. [PubMed: 12231010]
- Shtarkshall, R., Soskolne, V. UNESCO UNAIDS. Paris, France/Geneva, Switzerland: 2000. Migrant populations and HIV/AIDS: the development and implementation of programmes: theory, methodology and practice.
- Organista PB, Organista KC, Soloff PR. Exploring AIDS-related knowledge, attitudes, and behaviors of female Mexican migrant workers. *Health Soc Work*. 1998; 23(2):96–103. [PubMed: 9598392]
- Aranda-Naranjo B, Gaskins S. HIV/AIDS in migrant and seasonal farm workers. *J Assoc Nurses AIDS Care*. 1998; 9(5):80–83.
- Fernandez MI, Collazo JB, Hernandez N, et al. Predictors of HIV risk among Hispanic farm workers in South Florida: women are at higher risk than men. *AIDS Behav*. 2004; 8(2):165–174. [PubMed: 15187478]
- Hernandez MT, Lemp GF, Castañeda X, et al. HIV/AIDS among Mexican migrants and recent immigrants in California and Mexico. *J Acquir Immune Defic Syndr*. 2004; 37(4):s203.
- Sanchez MA, Lemp GF, Rodriguez-Magis C, Bravo-Garcia W, Carter S, Ruiz JD. The epidemiology of HIV among Mexican migrants and recent immigrants in California and Mexico. *J Acquir Immune Defic Syndr*. 2004; 37(4):s204–s214. [PubMed: 15722863]
- Mishra, SI., Conner, RF. Evaluation of an HIV prevention program among Latino farmworkers. In: Mishra, SI., Conner, RF., Magaña, JR., editors. *AIDS Crossing Borders: The Spread Among Migrant Latino*. Boulder, CO: Westview Press; 1996. p. 157-182.
- Weatherby NL, McCoy HV, Bletzer KV, et al. Sexual activity and HIV among drug users: migrant workers and their sexual partners in southern Florida. *Fla J Public Health*. 1995; 7(1):22–26.

12. McCoy HV, McCoy CB, Lai S. Effectiveness of HIV interventions among women drug users. *Women Health*. 1998; 27(1/2):49–69. [PubMed: 9640634]
13. McCoy HV, McCoy CB, Lai S, et al. Behavior changes among crack-using rural and urban women. *Subst Use Misuse*. 1999; 34(4/5):667–684. [PubMed: 10210099]
14. Weatherby NL, McCoy HV, Bletzer KV, et al. Immigration and HIV among migrant workers in rural southern Florida. *J Drug Issues*. 1997; 27(1):155–172.
15. Rao P, Hancy K, Velez M, et al. HIV/AIDS and farmworkers in the US. *Farmworker Justice (White Paper)*. 2008:1–12.
16. Vega WA, Rodriguez MA, Gruskin E. Health disparities in the Latino population. *Epidemiol Rev*. 2009; 31:99–112. [PubMed: 19713270]
17. Parker RG, Easton D, Klein CH. Structural barriers and facilitators in HIV prevention: a review of international research. *AIDS*. 2000; 14(1):S22–S32. [PubMed: 10981471]
18. Arcury TA, Austin CK, Quandt SA, et al. Enhancing community participation in intervention research: farmworkers and agricultural chemicals in North Carolina. *Health Educ Behav*. 1999; 26(4):563–578. [PubMed: 10435238]
19. Minkler, M., Wallerstein, N., editors. *Community-Based Participatory Research for Health: From Process to Outcomes*. 2nd. San Francisco, CA: Jossey-Bass; 2008.
20. US Census Bureau. Data derived from Population Estimates. Homestead; Florida: State and county quick facts. <http://quickfacts.census.gov/qfd/states/12/1232275.html>. Published 2000. Accessed November 4, 2011
21. Freyder PJ, O'Toole TP. Principle 2: the relationship between partners is characterized by mutual trust, respect, genuineness and commitment. *Partnersh Perspect*. 2000; 1(2):19–25.
22. Becker, AB., Israel, BA., Allen, AJ. Strategies and techniques for effective group process in CBPR partnerships. In: Israel, BA., Eng, E., Schulz, AJ., Parker, EA., editors. *Methods in Community-Based Participatory Research for Health*. San Francisco, CA: Jossey-Bass; 2005. p. 52–72.
23. Rhodes SD, Hergenrather KC, Montañó J, et al. Using community-based participatory research to develop an intervention to reduce HIV and STD infections among Latino men. *AIDS Educ Prev*. 2006; 18(5):375–389. [PubMed: 17067250]
24. Andrews OJ, Newman DS, Meadows O, et al. Partnership readiness for community-based participatory research. *Health Educ Res*. 2010
25. Eisinger A, Senturia KD. Doing community-driven research: a description of Seattle partners for healthy communities. *J Urban Health*. 2001; 78(3):519–534. [PubMed: 11564854]
26. Calleson DC, Seifer SD, Maurana C. Forces affecting community involvement of AHCs: perspectives of institutional and faculty leaders. *Acad Med*. 2002; 77(1):72–81. [PubMed: 11788329]
27. Examining Community-Institutional Partnerships for Prevention Research Group. Building and sustaining community-institutional partnerships for prevention research: findings from a national collaborative. *J Urban Health*. 2006; 83(6):989–1003. [PubMed: 17082993]
28. Freire, P. *Education for Critical Consciousness*. New York, NY: Seabury Press; 1973.
29. Beeker C, Guenther-Grey C, Raj A. Community empowerment paradigm drift and the primary prevention of HIV/AIDS. *Soc Sci Med*. 1998; 47:831–842. [PubMed: 9690828]
30. Wallerstein N. Powerlessness, empowerment, and health: implications for health promotion programs. *Am J Health Promot*. 1992; 6:197–205. [PubMed: 10146784]
31. Wallerstein N, Baker R. Labor education programs in health and safety. *Occup Med State Art Rev*. 1994; 9:305–320.
32. De la Vega E. Considerations for reaching the Latino population with sexuality and AIDS/AIDS information and education. *SIECUS Rep*. 1990; 18:1–8.
33. Freeman ER, Brugge D, Bennet-Bradley WM, Levy JI, Carrasco ER. Challenges of conducting community-based participatory research in Boston's neighborhoods to reduce disparities in asthma. *J Urban Health*. 2006; 83(6):1013–1021. [PubMed: 17103339]
34. Strickland CJ. Challenges in community-based participatory research implementation: experiences in cancer prevention with pacific northwest American Indian tribes. *Cancer Control*. 2006; 13:230–236. [PubMed: 16885920]

35. Israel, BA, Eng, E, Schultz, AJ., Parker, EA., editors. *Methods in Community-Based Participatory Research for Health*. San Francisco, CA: Jossey-Bass; 2005.
36. Parker EA, Schulz EA, Israel BA, et al. Worker partnership: community-based lay health advisor intervention in an urban area. *Health Educ Behav*. 1998; 25(1):24–45. [PubMed: 9474498]
37. Jackson EJ, Parks CP. Recruitment and training issues from selected lay health advisor programs among African Americans: a 20-year perspective. *Health Educ Behav*. 1997; 24:418–431. [PubMed: 9247822]
38. Rhodes SD, Foley KL, Someta CS, et al. Lay health advisor interventions among Hispanics/Latinos: a qualitative systematic review. *Am J Prev Med*. 2007; 33(5):418–427. [PubMed: 17950408]