CE 2.5 contact hours

ABSTRACT: *Faith communities provide a place for Latino congregants to discuss health information. A pilot study using focus groups and semistructured interviews explored how Latino faith community members define the meaning of health and examined their perceptions and attitudes surrounding health promotion and maintenance. Four themes emerged that reflect participants' health beliefs, with faith as a uniting force. Results support the faith community as a means of fostering health promotion for Latinos.*

KEY WORDS: *culture, faith community nursing, focus groups, Hispanic, Latino, nursing, Social Ecological Model*

Faith communities frequently serve as resources in areas where access to health information is limited. Latinos are at risk for lack of healthcare access and support (Pérez-Stable, 2016) and at increased risk for chronic illnesses, such as hypertension and diabetes (Campbell et al., 2016). The nursing profession has an obligation to reduce health disparities (American Nurses Association [ANA], 2015). Decreasing Latino immigrants' risk for chronic health conditions requires access to healthcare resources for effective health promotion. Latino immigrants with limited English proficiency may be unable to effectively access preventative health services (Cristancho, Peters, & Garces, 2014). Faith communities frequently engage in outreach to marginalized communities (Allen et al., 2015; Leyva et al., 2017), and thus offer an opportunity for health promotion by nurses. Faith community nurses (FCNs) promote health, wellness, and minimization of illness in faith communities (ANA & Health Ministries Association, 2017). The intersection between faith communities and health is an important platform to explore health promotion from a faith-based perspective, as well as to explore the meaning of health among Latinos.

BARRIERS TO HEALTH PROMOTION FOR LATINOS

Immigrants to the United States frequently encounter barriers to healthcare access due to lower socioeconomic status and lack of health insurance (Becerra, Androff, Messing, Castillo, & Cimino, 2015). Cultural insensitivity among healthcare providers, lack of bilingual providers, and discrimination act as barriers to resources, creating stressful situations for many immigrants (Ingram, Schachter, de Zapien, Herman, & Carvajal, 2015; Molina & Simon, 2014) and leading to increased risk-taking behaviors (Galvan, Wohl, Carlos, & Chen, 2015). Many Latinos believe that faith communities and God provide support and emotional strength and are trustworthy to help cope

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with daily stressors (Ingram et al., 2015; Leyva et al., 2017).

OPPORTUNITIES FOR HEALTH PROMOTION

The Social Ecological Model (SEM) provides a framework for understanding the complex interrelations among personal and environmental factors (Figure 1). The SEM emphasizes the multiple dimensions (physical, social, cultural, and personal), the multiple levels (peers, family, and community), and the dynamic levels of complexity under which people live (McLeroy, Bibeau, Steckler, & Glanz, 1988). Individual-level dimensions include personal beliefs and attitudes about faith or perceptions of how faith relates to health. Relationship-level dimensions include how families influence their own beliefs about health and illness. Community-level dimensions include the social and physical environments of neighborhoods such as violence, the presence of recreational programs, churches, or family-friendly work policies. Societal-level dimensions include educational, racial, and economic disparities and how these social and cultural factors can influence behaviors.

By Martin J. Mikell and Julia Snethen

PERCEPTIONS OF HEALTH PROMOTION AND MAINTENANCE AMONG LATINOS in Faith Communities

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However, the meaning of health in Latino faith communities may differ from other settings and further clarification is needed to inform FCN practice. The SEM permits closer examination of the influence of faith communities on health and how faith and health intersect in marginalized communities. This pilot study was designed to investigate how Latino parish members define the meaning of health and to examine their perceptions and attitudes surrounding health promotion and maintenance.

METHODS

Design and Sample

An Institutional Review Board approved the qualitative focus group design using the Social Ecological Model for this study. Inclusion criteria were designed to represent diverse parishioners from predominately Latino faith communities (hereafter referred to as parishes) using a convenience sampling method. The study was described in Spanish during presentations at pastoral council meetings and masses at two urban Latino parishes. Focus group discussions took place at two geographically separate parishes, once in each location, over a 3-month time frame. Each discussion session lasted 60 to 90 minutes.

Participants were first- or second-generation Latino adults who met the inclusion criteria: (a) parish members, (b) age 21 or older, (c) able to speak and read in Spanish, and (d) able to participate verbally in Spanish in a small group discussion. Data collection began with a demographic questionnaire followed by open-ended questions meant to evoke discussion. The investigator conducted focus groups in Spanish, and a bilingual and bicultural interpreter facilitated communication. Interview questions were structured to allow for multiple participants to answer the same question using a data saturation method as described by Fusch and Ness (2015).

Measures

Researchers collected participant demographic characteristics using a 13-item questionnaire with questions in English and Spanish. A stress measure was administered to participants using a Visual Analog Scale, with 0 representing no stress and 10 representing severe stress. The researcher developed and pilot-tested the scale during the current study.

Questions for the participants addressed these items: (1) how they defined health; (2) if they believed that illnesses could be prevented; (3) how cultural practices maintain health; (4) how foods maintain health or cause illness; and (5) how the faith-based community facilitates or inhibits health promotion and maintenance.

Analytic Strategy

The focus groups were digitally recorded and transcribed verbatim, and then back-translated into English by a bicultural/bilingual Spanish interpreter.

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From the preliminary analysis, an initial coding scheme was derived from the data along with a code book. The research team was comprised of a doctoral student and nurse researcher with expertise in qualitative methodology. The research team read and reread the translated responses individually and identified major themes and subthemes by hand using an inductive approach (Braun & Clarke, 2006). The team reviewed and resolved coding discrepancies by mutual discussion between the team members. The responses were then placed into groups by theme for subsequent analysis.

RESULTS

Two focus groups were completed. All participants preferred to speak in Spanish (N = 12). Participants' average age was 42 years (SD = 6.3) with a range of 31 to 55 years. Participants lived in the United States for 20 years on average with a range of 4 to 35 years. Most participants (58%) were employed full- or part-time and had a middle school or high school education (75%). Among all study participants, those who were employed (n=4) could write in English and half of those (n=2) earned less than $20,000 annually.

Participants reported stressors due to job insecurity, spousal illness, and lack of health insurance. The level of reported stress was higher for those who were employed than for those who were unemployed. Participants who could write in English were more likely to be employed when compared with those who could not write in English. Females reported slightly more stress than men, and stress was also higher in participants born in Mexico compared with those born elsewhere.

The research team completed a thematic analysis of focus group data which reflected the domains of the Social Ecological Model (Dahlberg & Krug, 2006) (Figure 1). Four themes emerged from the study: 1) health is physical and emotional; 2) limited control over health; 3) habits and cultural beliefs are hard to change; and 4) social community is a source of strength.

Individual domain: Health is physical and emotional

Participants believed health has both emotional and physical dimensions. Physical health was defined as the absence of disease or not being in a hospital. Participants relied on physician evaluations as a way to support their health perceptions, as stated by participants:

> *For me it means that I am not in the hospital. That I have gone to the doctor and he hasn't found high pressure or diabetes. Nothing like that.*

> *But for me, physically, go to the doctor, getting your physical that he checks everything and know that everything was right.*

Emotional health was defined as having a positive outlook. However, many participants' daily stress was perceived as disruptive to health. Perceived stress caused individuals to feel emotionally unhealthy, and people were not able to engage in activities that mattered to them. However, service to others in their parish was, in a way, restorative to their emotional health, as seen in the following comments:

> *But, that's physical; mentally it's very different. We are talking about stress, worries, those are other illnesses. But mentally, we are probably not very good.*

> *Mentally, you can feel down, and that doesn't help you to keep moving forward.*

> *For me, there are two kinds of health, the physical health and the mental health. For me, mental health is to think very positively, and help people to accomplish projects that benefit the community.*

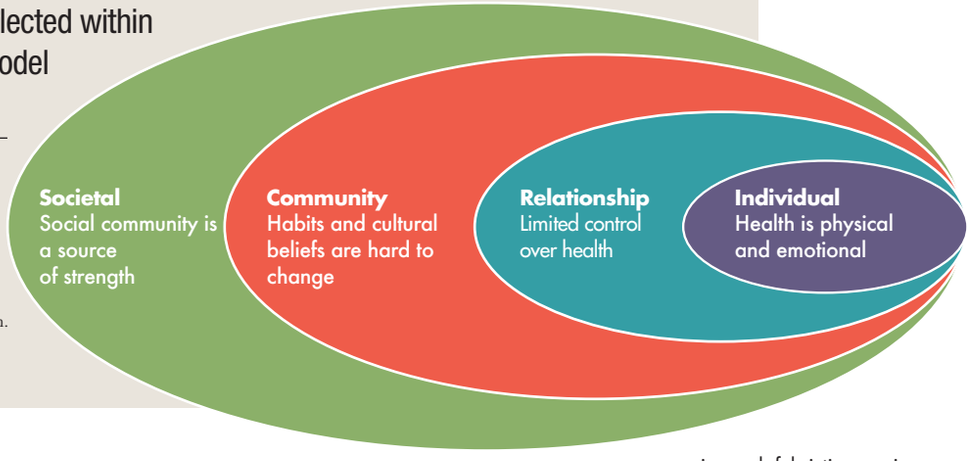
Relationship domain: Limited control over health

Participants expressed they did not feel in complete control over their health, as genetics and family history were unavoidable. On the other hand, participants endorsed the perception that illnesses were preventable but would necessitate changing deeply rooted cultural practices:

> *My brother has diabetes, and also my dad is diabetic. And my grandfather died cause he was diabetic too. And when I was pregnant, but now I don't have that, but I was diabetic when I was pregnant. So that really grows in our family.*

> *I think that illnesses run in the blood that we have. But, we can do some things to prevent. Because the customs that we have had since we were kids, if we change all that.*

Figure 1. Themes Reflected within the Social Ecological Model



Note. Used with permission from Dahlberg L. L., & Krug E. G. (2002). Violence: A global public health problem. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 3–21). Geneva, Switzerland: World Health Organization.

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Decreasing Latino immigrants' risk for chronic health conditions requires access to health-care resources for effective health promotion.

Relationships between participants and their employers were not healthy nor conducive to health-promoting cultural practices, like eating as a family. Fast food became a convenient alternative for those who lived alone, as well as caused families to eat in shifts.

> *The people that come here, normally they come by themselves. So, what's easiest for them or us? The most easiest is to eat at McDonalds®* [fast food restaurant]. *Don't cook, because you're alone. Your work absorbs you.*

> *And also, we are a hard-working class. I have to go, just to be done, I think that, the problem here with Latinos in the US is one, we work too much. Work takes priority. We have sedentary lives. We don't cook. We have to buy quick, because we have to work the next day, and we don't have time.*

> *I eat, like my wife, she starts working at 6 or 7 at night. And I start at 8 and I'm done by 5. What we do is, my wife, for example, cooks on Mondays, she cooks for two days. And the rest of the week, when our kids get home, they have to go to the fridge, to the frozen food, then to the microwave, they eat until the mom or dad gets there to feed them. It's because of our work situation, and it has to be this way because, there is no other way, how to have a routine of eating.*

Community domain: Habits and cultural beliefs are hard to change

Participants believed that food made one strong, yet their customs of food preparation and even the food itself were perceived

Sidebar: Cultural Respect for Latinos

Community is a highly significant facet of life for Latinos, who are people of Latin American descent. Latinos and Hispanics—persons of any Spanish culture or origin—have a collectivistic culture where group activities, decision making, and accountability are held in high regard (Centers for Disease Control and Prevention [CDC], n.d.). This is in contrast to American culture where individualism is valued.

For faith community nurses (FCNs), understanding this cultural norm offers insight into creating stronger relationships with Latino community members. Health promotion and teaching in small and large groups, often with family members present, can produce stronger impact as community members interact with each other about the material and how to apply it. Training and integrating lay Latino health promoters is a highly profitable avenue for ongoing health teaching and motivation, creating a stronger community network (Chwedyk, 2014).

The family, a microcosm of the community, is a significant driver in health promotion and long-term change for improved health (National Center for Cultural Competence [NCCC], 2005). Including family members in nurse–patient conversations and planning is wise. Religion and spirituality are also strong components in Latino culture, more so for older generations of immigrants. Using churches for community gatherings can attract more individuals who are undocumented and consider the church a safer environment (Chwedyk, 2014).

Although lack of knowledge about Latino culture may appear as a barrier for non-Latino FCNs in making meaningful connections, developing cultural respect enhances the relationships.

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The national Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) are meant to promote health equity, improve care quality, and eliminate healthcare disparities (National Institutes of Health, 2017). This occurs as health organizations and providers implement culturally appropriate services in a culturally competent manner.

Cultural competence in working with Latinos involves

—Greater self-determination in the community based on what the residents want and need health wise.

—Working in collaboration with established formal and informal groups: neighborhood, advocacy, social, ethnic, religious.

—Understanding that as the FCN transfers health and wellness knowledge to the clients, the nurse is reciprocally receiving knowledge and skills in Latino cultural understanding.

—Recognizing that respect for authority is a cultural norm that can lend healthcare personnel greater undue influence or power than the FCN may intend (NCCC, 2005).

Understanding gender roles enables an FCN to devise plans to reach subgroups. For example, developing a program for men's health seems futile because Latino men often have a machismo mindset and tend to avoid personal health-related discussions. FCNs who empower family members with knowledge and action steps for the men in their homes can still make an impact (Chwedyk, 2014). As well, elderly women may speak only Spanish and feel intimidated by non-Latin healthcare professionals. Meeting in a comfortable setting such as a church with only women present and using Spanish language interpreters can be more effective with this demographic.

In maintaining cultural respect, the FCN who understands health and wellness beliefs of Latino culture can avoid placing his or her own health and wellness values on the people being served. For example, the use of traditional or home remedies such as herbs and teas, or holding to health advice obtained from family, neighbors, community members, or traditional healthcare providers rather than evidence-based facts, are common practices among Latinos. The FCN needs to respect these while offering updated healthcare information alongside traditional medicine (CDC, n.d.).**—Karen Schmidt, BA, RN, *JCN* Contributing Editor**

as unhealthy. In spite of this, participants voiced strong emotional ties to their cultural foods, as seen in the statements:

Yes, if the people know how to eat things that are healthy, and not to eat so many things that make them sick, they will be healthier.

My husband yells at me because I use too much salt. And he takes away from me, understands me, it's going to be bad for you, 'I'm going to die anyway.' May be the day I get sick, I'll understand it was something serious, that he was talking about.

El mole, los tamales, tacos dorados, el pozole [traditional Latino foods] that is poison for us. And that is what we eat.

Concerns for personal safety were significant barriers to health-promoting behaviors, limiting exercise attempts as reflected in the following quotes:

I live near 17th and Beecher [streets], *and my house I have not opened my doors but for three times, I am afraid, I don't go out at all. Even though there are cameras, only if I see someone I know, otherwise I don't open the door.*

Right now I don't work, I'm just sitting on the computer, because I don't have things to do. I go walking in other neighborhoods where I feel comfortable walking. But where I live, I'm afraid [to walk outside].

In addition to community barriers, the inclement weather of the Midwest made physical activity challenging. Participants reported that during cold weather, their sedentary time increased and was copied by their children, as seen by the comment:

Another thing, the state we live in with the cold state that smells, when the cold snow starts, what you do is you go from work to home. And we don't exercise the body at all. What happens when we are at home? The first thing is the TV, and lying down and then the same routine the next day. And that same way of living is being followed by our kids.

Societal domain: Social community is a source of strength

The larger community lacked accessible activities for Latino youth, contributing to inequities in access to goods and services. Youth sport programs were expensive, and many families were unable to pay for sports, as reported by a Latino parent:

What I think we need in the community, the Mexican, the Latino community on the south side, we need programs that are accessible for families and kids. Because, I received bulletins, information, sports for the kids, for the parents, but truly, you don't have the money to pay for it. Because we have to pay for everything. I have not received anything that has a free program to play soccer with the kids, or basketball or something like that, or swimming. Everything you have to pay for.

Societal barriers to health promotion, such as lack of health insurance, made health maintenance challenging for many. Participants lacked access to a healthcare provider, leading to delays in seeking treatment or prevention:

Sometimes it's also important to have insurance. Who would you take care of? Who has health insurance and one who doesn't. Doctors say, the one who has it.

You avoid going to pay a doctor. You just find a way to make it more affordable, cheaper. I mean, that's where it is. We don't have the doctor for prevention.

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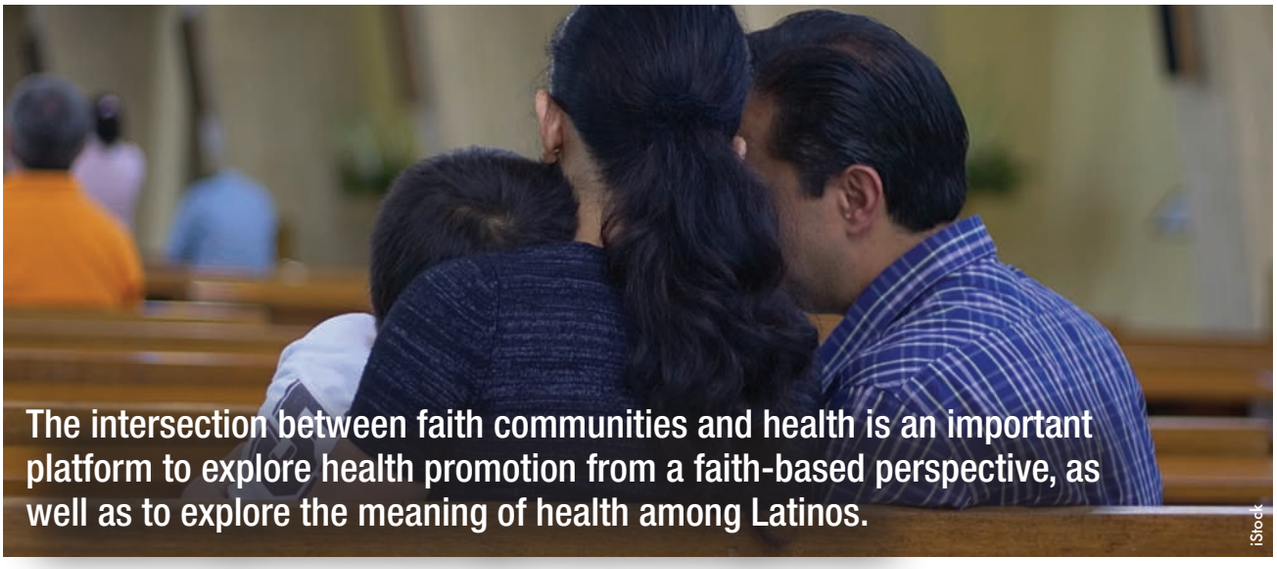

Yes, and when the problem is sometimes worse, like a cough or something, even though the cough may be bad, you don't go till you feel that you can't breathe.

Despite these barriers, participants believed their parish and faith in God were unifying. In the same way Jesus taught us to love our neighbor, participants openly expressed their faith and love for other parishioners, particularly those facing illness. These faith connections cultivated empathy toward others, as seen in the comments:

We need to stay strong, and as a union. And accept because, sometimes you do it so they feel better. And you get worried because you see them sick.

We come back to the same thing. Family, and always God, we have God and our family. That's it. From the time that I have been in groups and in church, most of the people I know from those groups.

DISCUSSION

Participants defined health as having physical and emotional dimensions. Although there was support for a connection between faith and perceptions of mental health, participants relied on factors outside of their parish to define physical health. Participants believed physical health was determined by healthcare providers (i.e., not being diagnosed with illness) and not their reliance on either faith or God. However, service to others in the community was seen as promoting emotional health, embodying Jesus's invitation: "Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls" (Matthew 11:29, ESV). The fact that participants defined their individual domains of physical health based on assessments by healthcare providers, and not on faith, was an interesting contradiction given the many barriers they faced in accessing healthcare services.

Participants' emotional health was an important factor in the individual Domain of the SEM. Having a positive outlook, positive relationships, and a reliance on faith are important for emotional health in Latinos (Ingram et al., 2015). A meaningful, emotional health-promoting activity for participants was their faith-based service and their commitment to God and a family-centered life. Service to the community is again reflected in Jesus's words: "In the same way, let your light shine before others, so that they may see your good works and give glory to your Father who is in heaven" (Matthew 5:16, ESV). Here, Jesus urges us to serve others and to lead selfless lives. Participants defined emotional health as serving others, so perhaps individual perceptions of health promotion and maintenance occur indirectly in Latino parishes through service. Maintaining positivity and a sense of well-being is important among Latinos (Ingram et al., 2015; Schwingel & Gálvez, 2016), and when participants connected with their faith, combined with a sense of selflessness, their emotional health was restored.

Participants believed that food made them strong, yet they did not view their cultural foods or how they prepared them as being health promoting, as reported previously (Castro-Rivas, Boutin-Foster, Milan, & Kanna, 2014; Lilo, Muñoz, & Cruz, 2019). Although cultural dietary patterns and preferences were important, participants internalized non-Latino white health promotion biases as the dominant narrative in their definitions of health. To participants, health was relational, but to be healthy, one needed to assimilate into the American lifestyle. Participants understood that food was connected to health, particularly in Latino cultural practices like eating as a family. However, employer relationships and societal barriers frequently impacted health maintenance, limiting opportunities for physical activity and reducing their time to prepare healthy foods for themselves and for their family.

Participants saw health and illness originating from their family history and customs, factors that were not always under their control. Latinos believe some illnesses could be passed to future generations, but also believe that illnesses were inflicted on them as a form of punishment from God, which is consistent with prior research (Giacinto et al., 2016;

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Web Resources

- **Think Cultural Health:** www.ThinkCulturalHealth.hhs.gov
- **National Center for Cultural Competence:** https://nccc.georgetown.edu
- **MultiCultural Resources for Health Information:** https://sis.nlm.nih.gov/outreach/multicultural.html
- **National Institute on Minority Health and Health Disparities:** https://www.nimhd.nih.gov

Sandberg, Rodriguez, Howard, Quandt, & Arcury, 2017). Participants pathologized their cultural practices, invisibly shaped during childhood, as something to be controlled or illness would result. Participants did not feel they had control in their employer relationships. At the same time, they were proud of their work ethic (Fleming, Villa-Torres, Toboada, Richards & Barrington, 2017; Valdez, Amezquita, Hooker & Garcia, 2017). Having a family-friendly workplace that pays a livable wage and permits flexible scheduling is needed if the goal for employers is to promote healthy relationships through work.

Implementation of structural changes in the environment of parishes can foster changes in health behaviors (Arredondo et al., 2017). People are more physically active and more likely to walk if the environment is conducive to walking (Sallis et al., 2009). However, participants reported community characteristics were unhealthy and they feared for their safety. Safety concerns frequently limited healthful behaviors for Latino women, further contributing to health disparities as seen previously (Keller et al., 2013; Larsen, Pekmezi, Marquez, Benitez, & Marcus, 2013). Participants also perceived that fees for organized sports were societal-level barriers to their children's participation, reflecting the additional barriers faced by marginalized communities that contribute to health inequalities. Again, participants did not include faith or reliance on God in defining their community health; rather, they spoke of the societal-level characteristics that visibly shaped their daily lives and those of their children.

CONCLUSION

The intersections between faith and health offer opportunities for FCNs to make connections with persons where they worship. Approximately 48% of Latinos in the United States report being Catholic (Pew Research Center, 2019). Using culturally relevant health-promoting strategies, FCNs can link faith and health at the individual, relationship, and community levels (See Sidebar: *Cultural Respect for Latinos*). Making connections in parishes builds trust and health simultaneously through faith, because to nurses, health and faith are inextricably linked. Embedding Scripture with health promotion is one approach that was found to successfully build connections between mind, body, and spirit (Leyva et al., 2017; Schwingel & Gálvez, 2016).

Leyva et al. (2017) suggest leveraging parishes to enhance health promotion through use of parish health ministries and community health centers. Collaborations between parishes and nurses will need to be creative in order to build mutual partnerships and to share community-based health-related resources, as seen previously (Ingram et al., 2015; Larsen et al., 2013). FCNs can leverage faith relationships as a way to overcome barriers to health promotion, particularly for Latino women who can encounter obstacles to physical activity (Larsen et al., 2013). Participants viewed service to others in their faith community as health-promoting; future interventions in parishes should include faith-based community service. Parishioners can serve as role models in what it means to "let your light shine before men" (Matthew 5:16) and inspire others to selfless service.

Acknowledging that the Latino demographic is heterogeneous, a limitation of this study is that it was carried out in a sample that predominately self-identified as Mexican. One objective of the study was that the first author, who is a non-Latino white and not a member of either congregation, could build trust with the Latino faith community. Walking alongside and identifying oneself with the community is an important first step. Conversely, as most participants were born outside the United States, they potentially had a diversity of perspectives and had not completely acculturated to life in the United States. The results from this study can inform FCNs about the dual nature of how health is defined by Latinos, which has not been completely explored in the literature.

As Jesus directs us to glorify God in our good works, approaching health promotion from a faith perspective provides additional support for Latino parishes as safe places where nurses can connect faith and health, address disparities in health outcomes, and increase access to health programs.

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