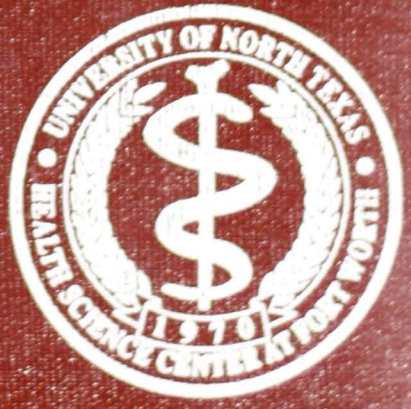
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One of the most important demographic trends taking place in the United States today is the rapid growth of the Hispanic/Latino population (Kostin, 2004). Hispanics are the fastest-growing minority group in the United States (Documet & Sharma, 2004; United States Census Bureau, 2003). This rapid growth will have a major impact on social, political and economic issues as well as on the health of the people in the United States (Kostin, 2004).

Throughout the county, church-based health interventions are being offered to individuals of differing cultural and ethnic backgrounds, however, retention of participants is often low.

The purpose of this qualitative research study was to determine the roles that social and behavioral factors play in motivating Hispanics to attend church-based health interventions. The study used qualitative methods. Focus groups were conducted at two church sites that were participants in the fall 2005 American Heart Association De Corazon a Corazon program with the highest retention rate of participating parishes. Both focus groups were audio-recorded, and recordings and field notes were then used to translate and transcribe the collected data. All data was entered into NVivo and coded to identify important themes and concepts.

Results identified key identified motivating factors that included familiarity with setting, desire to improve health, need to gain information, knowing others in the group, social and motivational factors, monetary benefits such as free health screenings and workshops and questions being answered in Spanish. It was determined that social factors play a major role in motivating Hispanics to attend church-based health interventions.

Through increasing our knowledge of motivational factors and influences on Hispanics to attend a church-based intervention, more effective health prevention and intervention programs can be designed and implemented in an effort to better reach this growing minority population and lessen the burden of minority health disparities. This is an area of research that needs to be further examined in order to prevent growing health disparities among the Hispanic population.

FACTORS THAT MOTIVATE HISPANICS TO ATTEND CHURCH-BASED HEALTH INTERVENTIONS

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FACTORS THAT MOTIVATE HISPANICS TO PARTICIPATE IN CHURCH-BASED HEALTH INTERVENTIONS

DISSERTATION

Presented to the School of Public Health

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Doctor of Public Health

By

Mary-Katherine Sanchez

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TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION TO THE STUDY

One of the most important demographic trends taking place in the United States today is the rapid growth of the Hispanic/Latino population (Kostin, 2004). Hispanics are the fastest-growing minority group in the United States (Documet & Sharma, 2004; United States Census Bureau, 2003). The health profiles of Hispanics are unique. Hispanics are faced with many health disparities; for example, Puerto Ricans suffer disproportionately from asthma, HIV/AIDS and infant mortality; Mexican Americans suffer disproportionately from diabetes (CDC, 2005). Hispanics also represent the ethnic group with the worst access to health care (Documet & Sharma, 2004; CDC, 2004; CDC, 2005); they have the largest percent of the people that have no health insurance. 37% of Hispanics have no health insurance. Hispanics also have the largest proportion of people who did not see a physician in the past year. Over 25% of Hispanics were reported to not have seen a physician in the past year (Documet & Sharma, 2004; CDC, 2004; CDC, 2005). Identified contributing factors to poor health outcomes and lack of access among Hispanics include language and cultural barriers, lack of access to preventive care (CDC, 2005), lack of health education opportunities, lack of health insurance coverage (CDC, 2005), and social factors.

As the minority population, more specifically the Hispanic population continues to grow, so will the number of persons with health disparities, if lack of access to care conditions continue. The future health of Americans will depend on reducing health

disparities among the growing minority populations (CDC, 2005). The CDC states that "eliminating racial and ethnic disparities in health will require enhanced efforts at preventing disease, promoting health and delivering appropriate care services (CDC, 2005)." This includes: the correct collection and use of standardized data, correct identification of high risk populations, and monitoring of the effectiveness of health interventions targeting those in minority and high risk groups (CDC, 2005). To accomplish the above and reduce health disparities it is necessary to accumulate knowledge about disease determinants, causes of health disparities, and knowledge about effective interventions for prevention and treatments (CDC, 2005).

PURPOSE OF THE STUDY

The purpose of this qualitative study was to explore the underlying factors associated with the motivational, social, and cultural reasoning of Hispanic individuals to participate in a church-based health education intervention. The study explored beliefs and attitudes, social pressures, and intentions of Hispanics to attend a health intervention. Throughout the county, church-based interventions are consistently being offered to individuals of differing cultural and ethnic backgrounds since churches are often seen as a gateway to the community for health intervention programs through serving as a direct connection to members of the community (Peterson, Atwood & Yates, 2002). However, retention of participants is often low, perhaps due to the lack of research and popularity of church-based health interventions. Through increasing our knowledge of motivational factors and influences on Hispanics to attend a church-based intervention, more effective health prevention and intervention programs can be designed and implemented in an effort to better reach this growing minority population and lessen the burden of health disparities.

RESEARCH QUESTION

The identified research question for this study was as follows: "What roles do social and behavioral factors play in motivating Hispanics to participate in church-based health interventions?"

DELIMITATIONS

The researcher invited Hispanic men and women over the age of 18 who participated in the American Heart Association De Corazón a Corazón program in the fall of 2005 at either St. Peters Catholic Church or Iglesia Bautista Central in Fort Worth, Texas to participate in a focus group study. Selection of this group influenced the outcome of the study, since the individuals who participated in the program at these two sites possessed the highest retention rate of participants in the American Heart Association De Corazón a Corazón Program in the Tarrant County Area. Focus group participants were limited to discussions involving the topic of study during each focus group. This also affected the study outcome.

LIMITATIONS

The researcher used the non-probability sampling technique of purposive sampling. Since participants were identified from those individuals who took part in a specific health intervention with a high retention rate in order to address a specific question and ensure that the sample adequately addressed the research question, the generalizability of the results for other participants and groups is limited.

ASSUMPTIONS

For the purpose of this study the researcher assumed that the participants were of there of their own free will, and that the participants responded to the questions openly and honestly. The research assumed that all participants could read and write in Spanish. The researcher did not assume that all participants could read and write in English. The researcher assumed that all participants had the cognitive capacity to understand and respond to questions posed in the focus group.

IMPORTANCE OF THE STUDY

The Hispanic population in the United States is continually growing. Health disparities among the Hispanics are also on the rise. To improve health in America we must address these disparities and work to lessen their burden (CDC, 2005). The CDC states that in order to lessen the burden of racial and ethnic disparities we must enhanced efforts to prevent disease, promote health more effectively and efficiently, and deliver appropriate care services (CDC, 2005). This requires improved identification of at risk populations, and monitoring of the effectiveness of health interventions targeting those in minority and high risk groups (CDC, 2005). We must increase our knowledge about the determinants of disease and learn more about what causes and contributes to health disparities. Through this knowledge we will be able to develop more effective interventions for prevention and treatment (CDC, 2005).

Through gaining an understanding of what motivates individuals to attend and participate in church-based health interventions we will gain vital information to improve future intervention and lessen health disparities. Without participation or attendance, a church-based health educational intervention is completely ineffective. Through the knowledge gained in this study more effective church-based health interventions can be designed and implemented. With a greater participant retention rate more individuals and members of specific cultural groups can be reached, thereby allowing public health professionals a greater opportunity to tackle health disparities and growing health problems.

CHAPTER 2

REVIEW OF LITERATURE

One of the most important demographic trends taking place in the United States today is the rapid growth of the Hispanic/Latino population (Kostin, 2004). Hispanics are the fastest-growing minority group in the United States (Documet & Sharma, 2004; United States Census Bureau, 2003). This rapid growth will have a major impact on social, political and economic issues, as well as the health of the people in the United States (Kostin, 2004). According to the United States Census, Hispanics or Latinos are considered individuals of Cuban, Mexican, Puerto Rican or other Spanish culture or origin, regardless of race (CDC, 2005). The federal government considers race and Hispanic origin to be separate and distinct concepts. Individuals of Hispanic origin may be of any race (CDC, 2005). In 2002, according to the US Census there were 37.4 million Hispanic/Latinos living in the United Stated. This represents 13.3 percent of the total population (US Census Bureau, 2003). The Census Bureau predicts there will be 87.5 million Hispanic individuals by the year 2040; Hispanics will account for 22.3% of the United States population (CDC, 2004; CDC, 2005; United States Census Bureau, 2003).

The greatest concentration of Hispanics is in the Southwestern states from Texas to California (CDC, 2005). According to the 2000 Census Bureau 32% of the Texas population was Hispanic, compared to 12.5% of the United States population (United States Census Bureau, 2005). The Hispanic/Latino population in Tarrant County has

more than doubled since 1990. Tarrant County reported a Hispanic population of 19.7% in 2000, while Ft. Worth, Texas had a population that was 29.8% Hispanic (Soto-Mas, 2004; United States Census Bureau, 2003). The projected population of Hispanics in Ft. Worth for 2005 is now 32% (United States Census Bureau, 2003).

Hispanics have unique demographics. Hispanics are more likely than non-Hispanic whites to be under the age of 18. In 2002, 34.4% of Hispanics were under 18, compared to 22.8 percent of their non-Hispanic white counterparts (United States Census Bureau, 2003). Few Latinos were 65 and older. 5.1% of Hispanics were reported as 65 or older compared to 14.4 % of non-Hispanic whites. Only 57.0% of the Hispanic population aged 25 and older had graduated from high school, compared to 88.7% of non-Hispanic Whites; and more than ¼ of Hispanics had less than a 9th grade education compared with 4% of non-Hispanic Whites (United States Census Bureau, 2003). Hispanics are also more likely than non-Hispanic Whites to be unemployed. In 2002, 21.4% of Hispanics were living in poverty, while 7.8% of non-Hispanic Whites were living in poverty (United States Census Bureau, 2003). In 2002 Hispanics accounted for 13.3% of the total U.S. population, but constituted 24.3% of the U.S. population living in poverty. There is also a disproportionate number of Hispanic children under the age of 18 living in poverty. 28% of Hispanic children live in poverty compared to 9.5% of non-Hispanic White children. Hispanic children account for 17.7% of all children in the United States, but account for 30.4% of all children in the United States living in poverty (United States Census Bureau, 2003).

In Tarrant County infant mortality is higher among Hispanics than compared to the state average (Soto-Mas, 2004). Other county-specific data indicates that age-adjusted death rates among Hispanics for select causes are higher specifically in: cardiovascular disease; heart disease; diabetes; stroke; all cancers; chronic lower respiratory disease; and diabetes (Soto-Mas, 2004).

According to the Centers for Disease Control (CDC) there is evidence that indicates that "race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations in all these categories (gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation) and demands national attention (CDC, 2005)." With the Hispanic population growing so rapidly and the large anticipated demographic changes over the next ten years, the importance of addressing health disparities among minority populations is magnified (CDC, 2005). According to the American College of Physicians, minority Americans do not "fare as well" as the majority when dealing with the health care system. This is true even after adjustments to take into account insurance status and income (Annals of Internal Medicine, 2004). Members of minority populations are reported to have less access to health care and lower-quality health care (Annals of Internal Medicine, 2004). The CDC reports that "relatively little progress has been made toward the goal of eliminating racial/ethnic disparities (American College of Physicians, 2004; Keppel, Pearcy, & Wagener, 2002)." Despite the fact that the population as a whole is healthier today, the gaps that existed between minority and non-Hispanic white groups 10 years ago, remain the same today (Annals of Internal Medicine, 2004).

There are approximately 39 million Hispanics living in the United States today (CDC, 2005). 9.7% of Hispanics are reported to be in poor or fair health. Approximately 35% of Hispanics under the age of 65 are without health insurance. 11% of children and 28% of adults are without a usual source of health care (CDC, 2005). The rates of Type-2 diabetes are 110% higher among Mexican Americans and 120% higher among Puerto Ricans than among non-Hispanic Whites (National Diabetes Education Program, 2004)). Strong predictors of health outcomes include socio-economic indicators such as poor education, inadequate housing, lack of insurance, lack of access to preventive care and stressful lifestyles (Bailey, 1987; Davis & Curley, 1999; Drayton-Brooks & White, 2004). Previously research conducted on promoting healthy lifestyles has always placed emphasis on individual factors rather than environmental (Morgan & Marsh, 1998) or socio-cultural factors (Palank, 1999). While individual choices play a role in health behaviors, behaviors are often part of a more complex decision process with factors such as cultural interpretations, environmental issues, and group specific attitudes, as well as social problem such as unemployment, poverty, homelessness, violence and literacy. (Ahijevych & Bernhars, 1994; Briscoe & Pichert, 1996; Drayton-Hargrove & White, 1999; Flaskerud & Winslow, 1998; Glanville & Porche, 1998; Jennings-Dozier, 1999; Morgan & Marsh, 1998; Palank, 1999). The more complex issues are the ones that need to be examined in great detail to better develop health behavior and lifestyle interventions (Ahijevych & Bernhars, 1994; Briscoe & Pichert, 1996; Drayton-Hargrove & White, 1999; Flaskerud & Winslow, 1998; Glanville & Porche, 1998; Jennings-Dozier, 1999; Palank, 1999). "Development of partnerships and investigations related to health

promotion within a social system such as faith communities with the goal to improve health outcomes of community level aggregates can serve to facilitate improvements in health status indicators in the areas of social support, mental health, nutrition, exercise, and smoking cessation among vulnerable populations (Van Olphen, Shultz, Israel, Chatters, Klem, Parker & Williams, 2003; Resinicow, Jackson, Wang, De. McCarty, Dudley & Baranowski, 2001; Resinicow, Jackson, Braithwaite, Dilorio, Blisset, Rahotep, & Periasamy, 2002; Stillman, Bone, Rand, Levine & Becker, 1993; Wiist & Flack, 1990; Drayton-Brooks & White, 2004)."

Health promotion has been defined "as a process of enabling people to increase control over and to improve health (WHO, 1987)." Literature and research has often and clearly documented the need for culturally relevant community-level health promotion and interventions (Collins, 1996; Edleman & Mandle, 1994; Flaskerud & Winslow, 1998; Glanville & Porche, 1998). In order to reduce health disparities researchers and public health professionals need to focus more attention on minority groups (Collins, 1996; Edleman & Mandle, 1994; Flaskerud & Winslow, 1998; Glanville & Porche, 1998). Specifically, there are currently many studies on church-based health interventions in African American communities, but few on church-based interventions in Hispanic/Latino communities. This is an area of research that needs to be further examined.

Modern technology and medicine do not consider churches to be a traditional health care setting; however, for centuries faith-based communities have been involved in

providing health care and services (Schank, Weiss, & Matheus, 1996). The church has a history of serving as the center of some communities; socially, politically and educationally (Peterson, Atwood & Yates, 2002; Hatch, Cunningham, Woods & Snipes, 1986; Kong, 1997; Tuggle, 1995). This is especially true for ethnically diverse and minority populations (Peterson, Atwood & Yates, 2002; Lasater, Becker, Hill & Gans, 1997). Research currently supports the need for community level, church-based interventions to culturally diverse populations (Davis & Curley, 1999; Kumanyika, & Charleston, 1992; Newsome, 1994; Palank, 1999; Thomas, Quinn, Billingsley, & Caldwell, 1994). Faith-based and church-based health interventions allow the opportunity for public health professionals to increase recruitment of ethnic minorities and track them in research, while providing valuable health interventions to culturally diverse populations (Resinicow et al., 2002; Stillman et al, 1993; Wiist & Flack, 1990).

Churches provide an inherent social support system (Peterson, Atwood & Yates, 2002; Campbell, Demark-Wahnefried, Symons, Kalsbeek, Dodds, Cowan, Jackson, Motsinger, Hoben, Lashley, Demissie, & McClelland, 1999; Eng, Hatch & Callan, 1985; Hatch & Lovelace, 1980; Lasater, Carleton & Wells, 1991). In a 3-year HARP study, the results and conclusions indicated that "individuals belonging to a defined community or organization, such as a church, are networked to provide influence in behavior change through support systems (Peterson, Atwood & Yates, 2002; Carleton & Lasater, 1987). The social networks within a church-based intervention can have a positive effect on the health outcomes derived from the intervention (Peterson, Atwood & Yates, 2002; Davis, Bustamante, Brown, Wolke-Tsadik, Savage, Cheng, & Howland, 1994). Churches are

also readily available. Almost every community in the United States has a place of worship. Approximately 60% of individuals have some association with a church (Peterson, Atwood & Yates, 2002; National Council of Churches, 1996). Having health promotion programs in a church also increases the number of individuals with access to those programs. Minority populations and those individuals of low socio-economic status and from vulnerable or underserved populations also have access to church based health interventions (Peterson, Atwood & Yates, 2002; Hatch et al., 1986; Castro, Elder, Coe, Tafoya-Barraza, Moratto, Campbell, & Talavera, 1995). Health promotion in churches also often involves the entire family. This family involvement results in a greater impact of the intervention.

The popularity of Church-based health promotion programs (CBHPP) is emerging (Peterson, Atwood & Yates, 2002). A recent study on CBHPP worked to identify key elements that contributed to the desired outcome of CBHPP. The elements identified were: partnerships, positive health values, community-focused interventions, health behavior change, and supportive social relationships (Peterson, Atwood & Yates, 2002). Churches form a gateway to the community for health intervention programs through serving as a direct connection to members of the community (Peterson, Atwood & Yates, 2002). In the Pawtucket Heart Health Program, 58% of the persons attending the health events were members of the sponsoring church, 24% were members at another church, and 18% were not member of any church (Peterson, Atwood & Yates, 2002; Lasater, Carleton & Wells, 1991).

Ethnically diverse and minority individuals may have feelings of alienation or threat in ordinary health care settings, but often feel comfortable in their place of worship (Peterson, Atwood & Yates, 2002). In a qualitative study 11 parish clients from two urban Catholic churches were interviewed on their perception of certain aspects of nursing care received within the congregational setting. Through the interviews participants identified that the church was "distinctive in promoting feelings of peace and caring (Peterson, Atwood & Yates, 2002; Chase-Ziolek & Gruca, 2000)." Those interviewed also stated that by having activities within the church, this made the services more accessible as well as user friendly; this increased accessibility produced better outcomes compared to their less accessible programs. CBHPP demonstrate cultural sensitivity and break through language barriers. There is documentation that "spirituality and religion are correlated to health and greater longevity (Peterson, Atwood & Yates, 2002; Mullen, 1990)." Spiritual health serves as a motivational factor when changing health behaviors and attaining health goals (Peterson, Atwood & Yates, 2002; Chapman, 1986; Castro et al., 1995; Chase-Ziolek & Gruca, 2000; Mullen, 1990). In a 3 year church-based study funded by the National Cancer Institute titled Compañeros en la Salud, designed to reduce the risk of breast and cervical cancer in metropolitan Hispanic/Latino women, and to increase their access to preventive health services, it was found that assessment of a church population is important since the vulnerability may vary significantly within the same geographic area (Peterson, Atwood & Yates, 2002; Thomas et al., 1994).

The study of individuals' attitudes toward changing health behavior is applied in this research. The Theory of Reasoned Action was developed in 1980 by Ajzen and Fishbein (Ajzen & Fishbein, 1980). In 1985 the theory was broadened to include perceived behavioral control. The theory then became known as the Theory of planned behavior. The Theory of Planned Behavior states that beliefs, attitudes, perceived behavioral control and social factors have a direct effect on the whether or not a certain goal is attained (Drayton-Brooks & White, 2004; Ajzen, 1985; Ajzen & Fishbein, 1980; Madden, Ellen, & Ajzen, 1992; Pender, 1986).

> *"Beliefs are the benefits and costs to achieving a certain goal. Attitudes are person's anticipated positive or negative outcomes associated with conducting a certain behavior. Control beliefs are perceived barriers or circumstances that help and/or prevent achievement of a desired outcome. Perceived behavior control has a direct effect on behaviors necessary for the attainment of a desired goal. According to the Theory of Planned Behavior (1988), there is a direct relationship between perceived behavioral control and behavior that will only exist when the person's perception of control and the person's actual control over a behavior are in agreement (Drayton-Brooks & White, 2004; Ajzen, 1988)."*

> *"Social factors include referents, subjective norms, and environmental factors. Referents are individuals and groups that have social influence or exert pressure to perform or to not perform necessary behaviors in order to be successful in achieving desired outcomes. Subjective norms are perceived social pressures from others to perform or not perform certain behaviors to achieve a desired outcome. Attitudes, subjective norms, and*

perceived behavioral control are determinants of behavioral intention and actual behaviors. Environmental factors include the constraints and the context of opportunity (Drayton-Brooks & White, 2004; Fishbein, Bandura, Triandis, Kanfer, Becker, & Middlestadt, 1991)."

Focus groups generate discussions among participants. Focus groups have been used in social research for more than 40 years (Brown, 1999), and have been identified as the best form of data collection for this study. Since individuals do not form their beliefs or attitudes alone, it is helpful to identify contributors to motivational factors and opinions in the natural context of human interactions, groups (Drayton-Brooks & White, 2004). "Complementary interaction often occurs in faith communities where consensus and differences in beliefs are commonly discussed (Drayton-Brooks & White, 2004)." Focus groups also enable vulnerable populations to feel safety in numbers and allow participants to draw confidence from the camaraderie that the focus group environment enables (Drayton-Brooks & White, 2004). Focus groups provide researchers an economical way to elicit participants' views and opinions (Cader, Derbyshire, Smith, Gannon-Leary & Walton, 2005)

Focus group interviews that are guided by the Theory of Planned Behavior have been successful in previous research. In nursing research investigators identified barriers and facilitating factors associated with Pap smears among African American and Latina women. It was concluded that group-specific measures of perception of control, acculturation, social support and subjective norms should be modified in the Pap Smear Questionnaire (Drayton-Brooks & White, 2004; Jennings-Dozier, 1999). In a qualitative

exploratory study based on the Theory of Planned Behavior, designed to document health perceptions, beliefs, attitudes and social pressures among African American women with faith-based support, it was concluded that health beliefs, attitudes, and behaviors are not developed outside of social systems. Therefore, the facilitation of healthy lifestyle behaviors would be best "assessed and influenced within a context of reciprocal social interaction such as a faith based community (Drayton-Brooks & White, 2004)."

CHAPTER 3

METHODOLOGY

Qualitative research was used to conduct the study of the role that social and behavioral factors play in motivating Hispanics to participate in church-based health interventions. The method of data collection used was focus groups. In the fall of 2005 the American Heart Association Cultural Health Initiatives Hispanic Task Force of Tarrant County implemented a cardiovascular program titled "De Corazon a Corazon" in Hispanic congregations among Ft. Worth, TX churches. Three Catholic churches and three Baptist churches participated in the intervention. The intervention consisted of pre-screenings (blood pressure, cholesterol, height, weight, glucose, and health behavior surveys) and post-screenings (blood pressure, cholesterol, height, weight, glucose, and health behavior surveys), and 5 cardiovascular health workshops (nutrition, fitness, stress, stroke and advocacy). Of the participating churches, all but two had less than a 50% retention rate. This is believed to be due to the lack of familiarity of church-based health interventions among the parishes. Focus group participants were recruited from those individuals who attended one of the two churches with the highest retention rate (over 50%), specifically St. Peter's Catholic Church and Iglesia Bautista Central, both located in Ft. Worth, TX. Criteria for recruitment were that the focus groups would be homogenous in demographics and health training; all participants would have completed the De Corazon a Corazon intervention. Homogenous focus groups were chosen since

the researcher was exploring the views and opinions of those individuals who attended the same intervention program (Brown, 1999).

Individuals who participated in and completed the De Corazon a Corazon Intervention at either St. Peter's Catholic Church or Iglesia Bautista Central were invited to participate in focus groups discussing their motivational factors for participating in the intervention. Two focus groups were conducted at each site for a total of four groups. Each focus group had no more than 12 participants, and no less than 4. The focus groups were voluntary and took place during the parishes regularly scheduled bible study; this corresponds to the time the health education classes took place. All participants were be asked to sign a consent form as well as fill out a demographic data information sheet consisting of age, sex, educational attainment, race/ethnicity, health insurance status and average annual income. All consent forms and questionnaires had prior approval from the University Of North Texas Health Science Center School Of Public Health Institutional Review Board, and are HIPPA compliant.

The qualitative technique of focus groups was chosen because this allowed the researcher to capture the "dynamic and interactive exchange among participants (Brown, 1999)." Focus groups generate discussions among participants. Focus groups have been used in social research for more than 40 years (Brown, 1999), and have been identified as the best form of data collection for this study. In this study they are based on social networks that are important in the Hispanic community. Focus groups allowed for the participants to communicate their views in an environment where they feel "safe, and can share ideas, beliefs, and attitudes in the company of people from the same socio-

economic, ethnic, and religious backgrounds (Drayton-Brooks & White, 2004)." Focus groups allow vulnerable populations to feel safety in numbers and allow participants to draw confidence from the camaraderie that the focus group environment enables (Drayton-Brooks & White, 2004).

Two moderators conducted each focus group. Focus groups were conducted in Spanish. The same moderators conducted all focus group sessions to ensure uniformity (Patton, 2003). Each focus group session was no less than 30 minutes and no more than 1.5 hours, since research states that focus groups with a duration of more than 2 hours, often result in fatigue or disinterest among participants (Brown, 1999). Participants at each focus group were given an incentive of light snacks, and non-alcoholic beverages. All questions posed were open-ended questions. Discussions were also encouraged by the moderators. The moderators used a list of pre-written questions as a guide for each focus group. All focus groups were tape recorded. Field notes were also taken during each focus group.

The study was based on the Theory of Planned Behavior and on Social Network research. A social network indicates ways in which individuals and organizations are connected through various "social familiarities" (Wales, 2006). Social network research assesses social influence and social environment over a specific behavior (Latkin, 1998) based on social familiarities. In this case we are assessing how social influences and environment can effect the motivation of an individual to attend a church-based health intervention. The Theory of Planned Behavior states that behavioral beliefs, attitudes toward the behavior, subjective norms, normative beliefs, control beliefs, and perceived

behavioral control all contribute to intention and the desired behavior (Ajzen, 1985). The goal of the focus groups was to identify the multiple motivational factors in each of the different levels that contribute to individuals' decisions to participate in a church-based health intervention.

All focus group responses were transcribed and translated into English. The investigator then independently reviewed each transcript looking for common themes, key words and phrases. Categories of coding were identified based on the participants' responses. The qualitative research software NVivo was used to further identify categories and similar responses were grouped into themes for comparisons and to produce concept maps. An analysis was then performed to look for with-in group, and across-group differences and similarities (Brown, 1999).

POPULATION AND SAMPLE

A total of four focus groups were conducted; two at Iglesia Bautista Central and two at St. Peter's Catholic Church, both located in Fort Worth, TX. Each focus group at Iglesia Bautista Central consisted of 6 participants. At St. Peter's Catholic Church the focus groups consisted of 6 participants and 4 participants. A total of 22 participants took part in the four focus groups. All participants were Hispanic. Of the 22 participants, fifteen were female and seven were male; sixteen were married, three were divorced and three had never been married; thirteen participants reported to not have any form of health insurance, while 9 reported they had some form of health care coverage such as health insurance, Medicare, or Medicaid. Twenty-one participants were between the ages of 34-64, one was older than 65 years.

PROTECTION OF HUMAN PARTICIPANTS

All participants were be asked to sign a consent form as well as fill out a demographic data information sheet consisting of age, sex, educational attainment, race/ethnicity, health insurance status and average annual income. Informed consents and demographic questionnaires were provided in both Spanish and English. All consent forms and questionnaires had prior approval from the University Of North Texas Health Science Center School Of Public Health Institutional Review Board, and are HIPPA compliant.

DATA COLLECTION PROCEDURES

Data was collected through focus group discussions and demographic questionnaires. Two moderators conducted each focus group, one moderator conducted the discussion, and the other conducted primarily observations and field notes. All focus groups were conducted in Spanish. All focus groups were audio-recorded. Focus groups ranged from 45 minutes to 1 hour and 20 minutes.

A pilot focus group was conducted prior to the study to refine the focus group discussion guide. Feedback was provided on the question guide, moderator skills and discussion flow. Changes were made in the discussion guide to improve the clarity of two of the questions.

INSTRUMENTATION

Focus group moderators used a guided list of questions to facilitate discussions. Each focus group session was audio-recorded with a micro-cassette recorder. Demographic questionnaire data was entered into SPSS. Focus group transcriptions and translations were conducted in Microsoft Word and analyzed using NVivo.

DATA ANALYSIS

Data analysis involved multiple steps. For the first focus group a certified translator transcribed the audio tape verbatim, in Spanish. Then the transcription was taken and translated. After the completion of the first focus group, the data analysis method was changed. For the next three focus groups the audio tapes were transcribed and translated simultaneously by one of the bilingual moderators. This method proved more effective and time efficient because the moderator had field notes as a guide for clarification when clarification was needed, the moderator had been in each of the focus groups and understood the context in which the questions were asked and answered. The moderator also re-checked the first focus group under this new method of data analysis to ensure that no data or concepts were lost.

Upon completion of the focus group transcription in English each document was then converted from a word document to a rtf (rich text format) file. This allowed for uploading into the qualitative research analysis program NVivo. Each document was then coded to identify major themes, and or concepts.

SUMMARY

In summary four focus groups were conducted at two sites, both churches were identified as participants in the Fall 2005 American Heart Association De Corazon a Corazon program and had the highest retention rate of participating parishes. All focus group session were conducted by two moderators (one served as an observer. All focus groups were audio-recorded, the recording and field notes were then used to translate and transcribe the collected data. All data was entered into NVivo and coded to identify important themes and concepts.

CHAPTER 4

RESULTS

Appendix A summarizes the demographic profile of the study sample. Through analysis of focus group data common themes and responses were observed throughout the study. A total of 43 main themes and sub-themes (see Appendix B) were identified through analysis of the four focus groups using NVivo.

In the fall of 2005 the American Heart Association Cultural Health Initiatives Hispanic Task Force of Tarrant County implemented a cardiovascular program titled "De Corazon a Corazon" in Hispanic congregations among Ft. Worth, TX churches. Three Catholic churches and three Baptist churches participated in the intervention. The Catholic churches were Our Lady of Guadalupe, St. George and St. Peter's. The Baptist Churches were Iglesia Bautista Central, Azle Ave. Baptist Church, and Primera Iglesia. Of the six participating parishes all but Primera Iglesia completed the DCAC program in its entirety. They withdrew from the program after their first session due to lack of participation.

The DCAC intervention consisted of pre-screenings (blood pressure, cholesterol, height, weight, glucose, and health behavior surveys) and post-screenings (blood pressure, cholesterol, height, weight, glucose, and health behavior surveys), and 5 cardiovascular health workshops, the workshop topics were on nutrition, fitness, stoke awareness, stress management and advocacy. All workshops were conducted in Spanish

and lasted anywhere from 45 minutes to 1 hour. All handout were also distributed in Spanish.

Our Lady of Guadalupe Catholic Church (OLG) is located in the North side of Fort Worth. OLG has approximately 3000 families registered in its Parish. Each weekend they offer three Spanish masses, one Bilingual mass and one English mass. Each weekend approximately 1700 Individuals attend the Spanish masses. The majority of parishioners are Spanish speaking Hispanics, as are the majority of individuals in its surrounding communities. Aside from masses the church also conducts all religious education classes in Spanish as well as adult bible studies, baptism classes and religious conformation classes. OLG has a history of offering health programs at their church. They offer annual flu shots, and health fairs. At the DCAC pre-screenings OLG screened 50 individuals, however only 5 individuals attended the first workshop and 3 individuals attended each workshop there after. The DCAC program was offered on Sunday mornings after the 8 am mass.

St. George is located in the northeast part of Fort Worth. St. George currently has approximately 600 families registered at their church. Each weekend St. George has two Spanish masses. St. George serves a total of 1600 individuals each Sunday, among those 1200 are Spanish speaking Hispanics. St. George also offers religious education in Spanish as well as adult bible study and a youth group. St. George hosts annual health fairs and flu shot events. The DCAC program at St. George was offered on Sunday mornings after the 8:30 AM mass.

St. Peter's Catholic Church is located on the west side of Fort Worth. St. Peter's has approximately 1600 families registered. St. Peter's offers one Spanish mass on Saturday evenings at 7:30 PM. This mass serves approximately 200-250 individuals weekly. The majority of parishioners at St. Peter's are English speaking. However the church does offer other Spanish speaking programs such as a Hispanic Parish council, a bible study and Spanish Choir as well as baptismal classes in Spanish. The DCAC program was offered on Monday nights at St. Peter's. At St. Peter's, 27 individuals attended the first DCAC screening, and 21 completed the program in its entirety with an average of 17 individuals attending each workshop. This parish possessed a retention rate of more than 50%.

Iglesia Bautista Central is located just west of downtown Fort Worth. Iglesia Bautista Central has approximately 60 families registered. All services at Iglesia Bautista Central are in Spanish, this includes bible study, religious education and all other parish events. They offer 3 services per week, two each Sunday and one on Wednesday evenings. They serve about 200 people per week. Iglesia Bautista Central has never before had a health event of any kind at their church. The DCAC program was offered at Iglesia Central Bautista on Wednesday evenings prior to their regularly scheduled service. Approximately 30 people attended the pre-screenings and approximately 19 attended the final workshop. There was an average attendance of 23 at each workshop. This parish possessed a retention rate of more than 50%.

Azle Avenue Baptist Church has 18 registered families and serves approximately 110 people each week. All their services are in Spanish only including bible study,

religious education, youth group and pastoral counseling. They do offer one bilingual bible study in addition to the Spanish programs. They also participate as a group in a weekly fitness program a the North side Community Center. This was the first time that a health program had been offered at their church. DCAC was offered on Saturday mornings at Azle Ave Baptist Church. 12 people attended the first DCAC screening and 5 people completed the program in its entirety, there was an average of 8 people at each workshop, there was a large turnaround at this church meaning many new faces would come to the workshops, but only to one or two and did not complete the program in its entirety. This church served as the pilot church for the focus group research.

Of the churches participating in DCAC in the fall of 2005, all but two had less than a 50% retention rate. This is believed to be due to the lack of familiarity of church-based health interventions among the parishes. Focus group participants were recruited from those individuals who attended one of the two churches with the highest retention rate, specifically St. Peter's Catholic Church and Iglesia Bautista Central.

At St. Peter's Catholic Church the focus groups were conducted in the same room where the intervention occurred. The room was located in the youth center and consisted of four couches with a rectangular table in the middle. At Iglesia Bautista Central the focus groups were conducted in a room off of the parish hall. It served normally as a room for the Sunday school children and consisted of a small rectangular table surrounded by plastic chairs.

During the focus groups, the following were most commonly identified as the social and behavioral factors that motivated individuals to attend to the church-based health intervention offered at their church.

SETTING

Setting was the most commonly observed response that focus group participants stated and was seen as a response across all four focus groups. Setting played a key role in the individual's choice to attend the faith-based intervention at their church. The category of setting was not sub-categorized. The following are statements from some of the focus group participants that illustrate the important role that setting played in their decision to attend a health intervention at their church:

"...I found it very motivational to come to classes here (at the church)."

"I felt very good because having it (the classes) at the church was good for me because it was a very convenient program and I didn't have to go far."

"I am not a member of any group outside the home, I just come to church."

"I would not have attended the classes if they were somewhere else, here I was more comfortable and secure, and if I had to go somewhere else

fasting for screenings, I would not have even tried. Here I knew I was comfortable."

"For me having the classes here was fabulous because of the confidence of the community in the church."

"Here (at the church) it allows more of us to come, there are many of us that do not drive, and since others are familiar with the area it allows them to bring us."

The above statements illustrate the importance of setting in the individuals' decision to attend the church-based health intervention. Setting was important because the church in itself also serves as a social support system for the attendees, not just because the church was close to home. This further supports the idea that social factors play an important role in motivating Hispanic individuals to participate in a church-based health intervention. In the Hispanic community the church often serves as the center of that community where all social and religious outings occur, this was strongly illustrated in the focus group responses. This is especially true for recent immigrants.

HEALTH

Through analysis of focus group data, health proved to be the second most commonly identified central theme. Participants from all four focus groups stated health was one of

the main motivational factors for their participation in the Church-based health intervention. The category of health was further subdivided into the following categories:

1) To feel better;
2) To learn about health;
3) To improve or learn about my health;
4) To improve my family's health;
5) Family history of chronic illness

Within the subdivided categories, "To Learn" was the most commonly identified theme or reason for participation of Hispanics in a church-based health intervention. Many individuals stated that it was important for them to learn about health, illness, and how to change their lifestyles to improve health in general. Two individuals stated:

> *"What motivated me to come was to learn. To learn what one can do to get better health."*

> *"What motivated me was to learn about sickness and diseases and everything about heart and cholesterol..."*

While learning was an important theme, leaning to specifically improve one's health was shown to be almost equally important. Across all four focus groups individuals identified wanting to improve their health and to learn ways to better their

health as a major reason for attending a church-based health intervention at their church. The following are statements from some of the focus group participants that illustrate sub-themes:

> *"When I heard the announcement it interested me because I was looking for health information about illnesses and stuff, and I wanted to know about me..."*

> *"(what motivated me to come was) to take care of myself, to know about health, about cholesterol and to treat my health better."*

> *"I am scared of cholesterol and having high cholesterol, I have no doctor or means to go to one; I wanted the health checks (screenings) to check my health, thank God for this program."*

Compared to other centrally identified motivational and social themes such as family or friend support, knowing other participants in the program, culture, language and group discussions; health was one of the most commonly stated central themes, specifically to learn about health and to improve ones own health. These two subdivided themes were identified across all four focus groups.

FAMILIARITY OF OTHERS

The third central theme identified through analysis of focus group data was "knowing each other." Focus group participants across all four focus groups stated that knowing other participants in the intervention contributed to their attendance. Participants felt more comfortable, as well as more motivated to complete the program by knowing other participants. The following statements illustrate this theme:

> *"Knowing everyone was very comfortable and beneficial (for me). It was nice to share the good information that was given to us with each other. If they had been strangers, I would not have learned as much from the stories of the other participants."*

> *"I liked it a lot (having the intervention at the church), it was nice to be with others from the church, and seeing them outside of mass but still at church."*

> *"The desire and peace spend with God and with the people who are here and go to church, and then coming to the classes at church, well it is very comfortable because they are the same people at church...., and it is more secure."*

Knowing others illustrates the importance of yet another social factor in motivating Hispanics to attend a church-based health intervention. Through the familiarity of family and friends individuals stated they felt comfortable attending a health program at their church. Without the familiarity and comfort, fewer individuals would have attended. Therefore when developing a health intervention having one at a location where there is a high familiarity level among peers, such as in a church setting increases the likelihood of the intervention being successful.

INFORMATION

Also identified, as a central theme across all four focus groups was "information." Participants stated in various ways that information was a contributor to their attending the church-based health intervention at their churches. The information category was not sub-categorized and included themes such as participants wanting to obtain health information, participants liking the information provided, and participants wanting to receive explanations of certain illnesses and diseases. Focus group participants stated the following:

> *"I wanted to come to find out more information about improving my health and getting healthier."*

> *I was motivated to keep coming because the first time (I came to class) I liked a lot how the explanations were given."*

"I was motivated to come to get more information about how to improve my life, my health and learn more about healthy eating...."

Through analysis of the focus groups it became evident that there was a strong linkage between information and health. Participants across all four focus groups stated wanting to obtain information as a means to improve health. A common theme identified for motivating individuals to attend the church-based health intervention at their church was to obtain information in order to improve their health as seen in the quotes above. This connection illustrates the importance of individuals to be ready to change their behaviors to improve health, and their awareness of the knowledge and information that it takes to do so.

SOCIAL FACTORS & MOTIVATION

Also observed through analysis of the focus group data were social factors. "family support," "friend support," and "group discussions" were seen as themes across all four focus groups. Although not mentioned as frequently as settings, health or knowing others in the group; family support, friend support and group discussions were frequently observed themes across all four focus groups. These findings made apparent the importance of the role of social support in a health intervention. It also showed how social support is not only a motivating factor for attendance, but for success as well. The following statements illustrate these themes:

"I was very comfortable to be here for the classes. It was nice and we were able to share our stories..."

"I felt more motivated having people here that I knew, like my sister was coming with me. Other family members that attend the church came also; we all got the same information, now we can really motivate each other to have a healthier lifestyle."

As in previous categories this category also illustrated the important role that social factors play in motivating Hispanic individuals to attend church-based health interventions. As previously stated and in agreement with previous research the Church is often the central social gathering place in a Hispanic community and provides its members with not only a place of worship, but also a place for social support, social interaction, a safe place and a meeting place.

Motivation was another centrally identified theme. Motivation was mentioned across all four focus groups. Motivation showed a strong link to social factors. This connection between motivation and social factors clearly indicates the importance of social support in an intervention setting. The following illustrate motivation as well as its strong link to social factors:

"It (the program) was a motivation, I was motivated having other "brothers" here in the same class."

"It was great since we all knew each other. Very comfortable being with family."

"For me it (the program) was a motivation, it was a motivation having others we knew here."

"I was very motivated to come because the classes were very motivating, the explanations were motivating for us to keep coming back....."

Motivation was closely linked to setting and social support. Individuals were often motivated because they were among family and friends and because they were at their church, a place where they felt confident and comfortable. This category also emphasizes the important role social factors play in motivating Hispanics to attend church-based health interventions.

MONETARY BENEFITS

Monetary benefits were mentioned numerous times across the focus groups. Monetary benefits included the health screenings. Many individuals mentioned that due to lack of insurance or adequate income, they would have been unable to afford to have

the health screenings done had they not been at their church through this program. Therefore, knowing they could obtain the health screenings free of charge was a motivation for them to participate in the church-based health intervention offered at their church. Also mentioned as a monetary benefit was the alternative forms of exercise that were free of charge and required no special equipment; participants stated that they were pleased to learn about alternative forms of exercise that they could do to improve their health that were low or no cost. Group participants stated the following:

> *"I don't have the money for a doctor, and when this program was here, I made the decision to come."*

> *"I don't have a doctor or the money to afford one, I was very happy when I heard this program was going to be free."*

> *"They (the educators) even showed us ways to exercise at home for free that we didn't know about. It was very helpful information."*

> *"More than anything, what interested me was to know about my health, here (in the United States) it is very difficult for us Hispanics, we do not have health insurance, and to go to a hospital here is not free. We must take advantage of being able to learn how to improve our health."*

LANGUAGE

Another commonly identified theme across the focus groups that motivated individuals to participate was language. Participants stated at various times across most focus groups that they were motivated to attend since workshops were conducted in Spanish and questions were answered in Spanish, also the literature handed out was in Spanish. The following quotes illustrate the important role that the workshops being in Spanish played in motivating individuals to attend the intervention.

> *"I felt comfortable being with you all and with all the people that came, it was close to my house so I could walk and classes were in Spanish because for me English would have been a problem."*

> *"I came because the classes were in Spanish. It was important because the classes were in Spanish because that is our native language."*

> *"It (the workshops) were in our language so we had the confidence to ask questions about anything, and they (the educators) were very prepared to respond to any questions we had."*

Language was important in motivating individuals to attend the church-based health intervention because it was a form of familiarity and communication. Language is also social. This category also ties back to the important role social factors play in

motivating individuals to attend a health intervention at their church. Focus group participants stated that they felt comfortable and confident asking questions and communication concerns and sharing stories because it was all done in their native language. They also expressed comfort in the language because it was not only in Spanish, but because they were in a familiar setting. This category illustrated close ties with setting, knowing others, and social support.

MISCELLANEOUS

The above themes were the most commonly observed themes identified through focus group analysis. Other themes that were identified, but were not mentioned across all four focus groups or were not mentioned with significant frequency (more than 12 times) include language, location, access and benefits to church:

1) The program was close to home
2) Time was already set aside for the church
3) Uncomfortable with physicians
4) Benefits to the church community

OTHER FINDINGS

Through analysis of the focus groups it became evident that of those who participated in the church-based intervention, to an overwhelming majority, the church is the only place outside of work and the home where socializing occurs. This indicates that among the Hispanic populations attending this program, the majority would not have

taken advantage of the opportunity had it been offered elsewhere. Among the participants in the focus groups, to most, the church is seen as the center of their community. Participants stated the following:

> *"I am not a member of any group outside the home, I just come to church."*

> *"On Monday nights I teach baptism classes, I am a member of the Hispanic Parish Council, I go from church to home and home to church, I am only a little step away from being a nun."*

> *"Most of my social interaction is at the church."*

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Hispanics are the fastest-growing minority group in the United States (Documet & Sharma, 2004; United States Census Bureau, 2003); with equally fast growing health disparities. To lessen the burden of these rapidly growing health disparities it is necessary to accumulate more knowledge about effective interventions for prevention and treatments (CDC, 2005) targeting minority populations (Collins, 1996; Edleman & Mandle, 1994; Flaskerud & Winslow, 1998; Glanville & Porche, 1998), specifically Hispanics.

Previously research conducted on promoting healthy lifestyles has always placed emphasis on individual factors rather than environmental (Morgan & Marsh, 1998) or social factors (Palank, 1999). While individual choices play a role in health behaviors, behaviors are often part of a more complex decision process with factors such as cultural interpretations, environmental issues, and group specific attitudes (Ahijevych & Bernhars, 1994; Briscoe & Pichert, 1996; Drayton-Hargrove & White, 1999; Flaskerud & Winslow, 1998; Glanville & Porche, 1998; Jennings-Dozier, 1999; Morgan & Marsh, 1998; Palank, 1999). The more complex issues are the ones that need to be examined in great detail to better develop health behavior and lifestyle interventions (Ahijevych & Bernhars, 1994; Briscoe & Pichert, 1996; Drayton-Hargrove & White, 1999; Flaskerud & Winslow, 1998; Glanville & Porche, 1998; Jennings-Dozier, 1999; Palank, 1999).

The social networks within a church-based intervention can have a positive effect on the health outcomes derived from the intervention (Peterson, Atwood & Yates, 2002; Davis, Bustamante, Brown, Wolke-Tsadik, Savage, Cheng, & Howland, 1994). Churches are also readily available. Almost every community in the United States has a place of worship. Approximately 60% of individuals have some association with a church (Peterson, Atwood & Yates, 2002; National Council of Churches, 1996). Having health promotion programs in a church also increases the number of individuals with access to those programs.

Modern technology and medicine do not consider churches to be a traditional health care setting; however, for centuries faith-based communities have been involved in providing health care and services (Schank, Weiss, & Matheus, 1996). The church has a history of serving as the center of some communities; socially, politically and educationally (Peterson, Atwood & Yates, 2002; Hatch, Cunningham, Woods & Snipes, 1986; Kong, 1997; Tuggle, 1995). This is especially true for ethnically diverse and minority populations (Peterson, Atwood & Yates, 2002; Lasater, Becker, Hill & Gans, 1997). Research currently supports the need for community level, church-based interventions to culturally diverse populations (Davis & Curley, 1999; Kumanyika, & Charleston, 1992; Newsome, 1994; Palank, 1999; Thomas, Quinn, Billingsley, & Caldwell, 1994). Faith-based and church-based health interventions allow the opportunity for public health professionals to increase recruitment of ethnic minorities and track them in research, while providing valuable health interventions to culturally diverse populations (Resinicow et al., 2002; Stillman et al, 1993; Wiist & Flack, 1990).

The findings in this study support current research in realizing that churches provide a superior location to have a health intervention. Churches are generally in the neighborhoods of their patrons, making them easily accessible, they also provide a comfortable a familiar location for individuals to socialize and learn. Our research also supports the idea that a strong social support system of family and friends provides motivation for an individual to attend a health intervention at their church. Churches provide an inherent social support system (Peterson, Atwood & Yates, 2002; Campbell, Demark-Wahnefried, Symons, Kalsbeek, Dodds, Cowan, Jackson, Motsinger, Hoben, Lashley, Demissie, & McClelland, 1999; Eng, Hatch & Callan, 1985; Hatch & Lovelace, 1980; Lasater, Carleton & Wells, 1991), not only the church itself, but its patrons as well. The social networks within a church-based intervention therefore have a positive effect on the health outcomes derived from the intervention (Peterson, Atwood & Yates, 2002; Davis, Bustamante, Brown, Wolke-Tsadik, Savage, Cheng, & Howland, 1994).

SUMMARY OF RESEARCH

The purpose of this study was to identify what roles social and behavioral factors play in motivating Hispanics to participate in church-based health interventions? Qualitative research was used to conduct the study. The method of data collection used was focus groups Three Catholic churches and three Baptist churches participated in a church-based health intervention in the fall of 2005. Of the participating churches, all but two had less than a 50% retention rate. This low retention rate may be due to the lack of familiarity with a church-based health intervention. Focus group participants were recruited from those individuals who attended one of the two churches with the highest retention rate (over 50%), specifically St. Peter's Catholic Church and Iglesia Bautista Central, both located in Ft. Worth, TX. It is believed that these parishes had a higher retention rate due to already established social and spiritual events occurring in the church, other than just the church services.

Two focus groups were conducted at each site for a total of four groups and 22 participants. Two moderators conducted each focus group. Focus groups were conducted in Spanish. All questions posed were open-ended questions. Discussions were also encouraged by the moderators. All focus group responses were transcribed and translated into English. The investigator then independently reviewed each transcript looking for common themes, key words and phrases. Categories of coding were identified based on the participants' responses. The qualitative research software NVivo was used to further identify categories and similar responses were grouped into themes for comparisons.

CONCLUSION

Social and behavioral factors play a significant role in motivating Hispanics to participate in church-based health interventions. After analyzing the responses presented by the focus group participants using NVivo, social and behavioral factors proved to be significant. Social and behavioral factors were amply reported across all four focus groups.

DISCUSSION AND IMPLICATIONS

The results of this study suggest that social and behavioral factors play a significant role in motivating Hispanics to attend church-based health interventions. Based on the research findings, having a Hispanic targeted health intervention at a predominantly Hispanic church, will most likely increase the participation rate of that intervention, as opposed to having it a different location or church with diverse membership. Through our research it was found that setting is the most commonly identified theme when determining the factors associated with participation at a church-based health intervention. It was also found that knowing others and social factors such as support from family and friends were significant contributors to the decision making process. All of these finding are linked to setting indicating that having the program at a church increases the likelihood of knowing others, and having friend and family support, thereby increasing the participation rate.

These findings illustrate the important role of social networks during a behavior modification intervention. The findings also indicated that there is a proportional relationship between success rate for behavior modification and intervention participation and social support. Having an intervention at a location where social support will be high, such as a church, should thereby increase the success of the intervention. Health promotion in churches often involves the entire family. This family involvement results in a greater impact of the intervention. According too our study findings participants across all four groups indicated family and friend support as a major factor that motivated them to attend the church based health intervention. In the case of having a program at

the church, not only was the church itself a source of social support, but the setting also provided individuals with further forms of social support such as family and friends. Also, not only was there greater social support, but that support did not end when the intervention ended, but continued in the home, as many participants were participating along side family members. This continued support in the home would not occur at this level in a workplace intervention.

According to our research, having a health promotion program targeting Hispanics take place in a predominantly Hispanic church also increases the likelihood of individuals participating in the program. Our study findings indicated that having a health intervention at the church allowed easier access to the program for many individuals, eliminating a major barrier that health promotion programs at other sites face. Individuals indicated that they either lived near by and could walk or had friends and family that could drive them. If they drove they were not worried about the cost of fuel since the churches were in their neighborhoods and they did not have to drive far.

Ethnically diverse and minority individuals may have feelings of alienation or threat in ordinary health care settings, but often feel comfortable in their place of worship (Peterson, Atwood & Yates, 2002). The research conducted supports previous research and demonstrates the need for more comprehensive church-based health promotion programs. Many of the focus group participants indicated that church was like a second home to them, they trusted the church and that they felt comfortable at the church. These feeling of belonging contributed to an individual's decision to attend the intervention. Having the intervention at a place that was familiar to the individual, a place where they

felt at home, and where they felt they belonged, contributed to their decision to attend the intervention. Many focus group participants indicated that they would have been a lot more apprehensive to attend the program had it been at a different site. Participants also indicated that due to the familiarity of others and the location they felt comfortable and confident asking questions. They also indicated an increased trust level in the program since it was being offered at their church, which most considered to provide only knowledgeable programs that would affect the parishioners in only a positive way.

The findings of this research study allows public health practitioners to better understand the role that social and behavioral factors play in motivating an individual to attend a church-based health intervention. Through this increased understanding, better interventions can be developed and implemented targeting the health of high-risk, underserved population, this thereby allows for more opportunities to lessen the burdens of health disparities among minority populations, in this case Hispanics. With the continual growth of the Hispanic population lessening the burden of health disparities among Hispanics is extremely important and this study provides valuable knowledge in this area.

Since participants were identified from those individuals who took part in a specific health intervention with a high retention rate in order to address a specific question and ensure that the sample adequately addressed the research question, the generalizability of the results are limited. Secondly, there may also be selection bias. It is possible that membership in a particular religious community may be more likely to draw people who are more likely to adhere to healthy lifestyles. Therefore, it is plausible

that people with healthy lifestyles or wanting healthier lifestyles are more likely to attend church and participate in religious activities (Holt, Haire-Joshu, Lukwago, Lewellyn & Kreuter, 2005).

RECOMMENDATIONS

Future research should further explore the role that social and behavioral factors play in motivating Hispanics to participate in church-based health interventions. This study illustrated the important role that social and behavioral factors play in motivating Hispanics to participate in church-based health interventions. Further exploration of this role will allow for health educators and program planners to develop and implement more effective interventions and be able to reach a high-risk population that possesses numerous health disparities. Through research and promotion to increase popularity, church-based health intervention will be able to better serve hard-to-reach populations with a culturally competent approach.

APPENDIX A

PROFILE OF STUDY SAMPLE

PROFILE OF STUDY SAMPLE

AGE	
18-25	0
25-34	3
35-45	9
46-55	7
56-64	2
65+	1
SEX	
Male	7
Female	15
RACE	
White	0
Black/African American	0
American Indian/Alaskan Native	0
Asian	0
Hispanic	22
Other	0
MARITAL STATUS	
Married	16
Divorced	3
Widowed	0
Separated	0
Never Married	3
HOUSEHOLD SIZE	
Live Alone	1
2 to 4	18
3 to 5	2
6 to 8	1
8+	
EDUCATION ATTAINED	
never attended school or only kindergarten	0
Elementary	4
Some high school	6
High school graduate or GED	4
Some College	4
College Graduate	4
HEALTH INSURANCE, MEDICARE or MEDICAID	
Yes	9
No	13
Don't know	0
RATE YOUR CURRENT HEALTH	
Excellent	0
Good	19
Fair	2
Poor	1
AVG. ANNUAL INCOME	
Less than $15,000	7
$15,0000 to $35,000	7
$35,000 to $55,000	5
$55,000 or greater	1

APPENDIX B

THEMES AND SUB-THEMES LIST (NODE LISTING)

NODE LISTING

Project: HCBHI
User: Administrator Date: 3/8/2006 - 12:16:46 PM

Nodes in Set: All Nodes
Created: 1/27/2006 - 11:33:03 AM
Number of Nodes: 43

1 (1) /Health

2 (1 2) /Health/To feel better

3 (1 3) /Health/To learn

4 (1 4) /Health/MY health

5 (1 5) /Health/family health

6 (1 6) /Health/Family History

7 (2) /Language

8 (2 3) /Language/classes were in Spanish

9 (2 4) /Language/Literature was in Spanish

10 (2 5) /Language/Questions were answered in Spanish

11 (3) /Convenience

12 (3 1) /Convenience/Close to home

13 (3 4) /Convenience/Already had time set aside

14 (3 18) /Convenience/do not drive

15 (4) /Information

16 (4 13) /Information/teach others

17 (5) /Cost

18 (5 6) /Cost/Money benefits

19 (5 7) /Cost/No Health Insurance

20 (5 8) /Cost/lower cost alternatives

21 (6) /Search Results

22 (7) /group discussions

23 (8) /Culture

24 (8 18) /Culture/uncomfortable with physicians

25 (9) /family support

26 (10) /friend support

27 (11) /Setting

28 (12) /benefits to our community

29 (13) /knew each other

30 (14) /Motivation

31 (15) /Socialization

32 (15 16) /Socialization/Only at Church

33 (15 17) /Socialization/Mostly at church

34 (16) /Church and physical health

35 (17) /Recruit more people

36 (17 18) /Recruit more people/propaganda

37 (17 19) /Recruit more people/Bulletin announcements

38 (17 20) /Recruit more people/phone calls

39 (17 21) /Recruit more people/longer sign up period

40 (17 22) /Recruit more people/some people don't prioritize health

41 (17 23) /Recruit more people/think health

42 (18) /personal treatment

43 (19) /to finish

APPENDIX C

DEFINITION OF TERMS

DEFINITION OF TERMS

Access- A means of approaching, entering, exiting, communicating with, or making use of (dictionary.com, 2005).

Cause- The producer of an effect, result, or consequence; the one, such as a person, event, or condition, which is responsible for an action or result; a basis for an action or response; a reason (dictionary.com, 2005).

Church-Based- Stationed at a place of worship (dictionary.com, 2005)

Disparity- The condition or fact of being unequal, as in age, rank, or degree; difference (dictionary.com, 2005).

Health- A condition of optimal well-being; soundness, especially of body or mind; freedom from disease or abnormality (dictionary.com, 2005).

Hispanics/Latinos- Hispanics or Latinos are considered individuals of Cuban, Mexican, Puerto Rican or other Spanish culture or origin, regardless of race (dictionary.com, 2005).

Intervention- To involve oneself in a situation so as to alter an action or development (dictionary.com, 2005).

Minority- An ethnic, racial, religious, or other group having a distinctive presence within a society (dictionary.com, 2005).

Morbidity- The rate of incidence of a disease (dictionary.com, 2005).

Mortality- The rate of loss (dictionary.com, 2005).

Motivation- Something that motivates; an inducement or incentive (dictionary.com, 2005).

Social network- A person-centered web of social relationships; linkages and people that may (or may not) provide social support & that may serve other functions in addition to that support (Cohen & Syme, 1985; Peterson, Atwood & Yates, 2002).

Social support- The helpful resources provided by another person, can be informational, guidance, emotional, instrumental and self esteem (Cohen & Syme, 1985; Peterson, Atwood & Yates, 2002).

Underlying- To be the support or basis of; account for (dictionary.com, 2005).

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