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Assessment of Community Health by Neighborhood and Church Collaboration

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Background

San Bernardino County, California has health inequities with high rates of chronic disease, mental health problems, and risk behaviors that reflect some of the worst health outcomes in the state of California and the United States (Supervisors, 2016). Though faith-based partnerships have the potential to empower communities, reduce health disparities, and shift health care outcomes (Caldwell and Takahashi, 2014; Young, Patterson, Wolff, Greer, and Wynne, 2014) scant research of these partnerships exists in San Bernardino County, CA.

Purpose

Therefore, this community-based participatory action research assessed residents' demographic characteristics (age, education, marital status, ethnicity), spirituality, religiosity, social support, and physical and mental health using the Integrated Theory of Health Behavior Change (ITHBC) (Ryan, 2009), The research questions are 1) What is the relationship of the demographic variables, spirituality, religiosity, and social support, to physical health components (PCS)? 2) What is the relationship of the demographic variables, spirituality, religiosity, social support, and discrimination to mental health components (MCS)?

Methods

This correlational, comparative study included a quantitative survey with five measures administered to a convenience sample of adult residents (n = 267) within a mile radius of one local church in southwestern San Bernardino County. Data was collected in spring of 2017 at two local elementary schools, one trailer park, and one local church during a 6 week period. Spirituality was assessed using the Intrinsic Religiosity (Hoge, 1972). Religiosity was assessed using the first two items of the Duke University Religion Index (DUREL), (Koenig and Bussing, 2010). Social support was measured with the Medical Outcomes Study Social Support (MOS-SS) scale. Physical and mental health was assessed using the Short-form 12 (SF-12v2) physical health component and mental health component subscales (Ware, Kosinski, and Keller, 1995)

Results

Subjects were female, (n=199, 74.4%), 30 – 49 years old (n=125, 46.7%), married/remarried (128, 47.9%) with 153 (57.1%) having a high school diploma, some college, or an Associate's degree with only 30.7% (n=82) self-reporting as white with approximately 13.5% declining to state ethnicity. Spirituality was high (mean = 34.6, SD = 8.1). Religiosity was moderate [mean = 6.8 (SD = 3.1)]. Social support was moderately high [mean = 79.8 (SD = 17.7)]. Physical health was 67. 4 (SD = 22.8) and mental health 66.5 (21.5). Greater physical health was correlated with younger age ($r = -.25$, $p<.001$), non-White ethnicity ($r = .139$, $p = .035$), more education ($r = .26$, $p <.001$) and greater mental health ($r = .65$, $p < .001$). Greater mental health was correlated with

more education (r = .12, p = .049). Both physical health (r= .238, p<.001) and mental health (r= .390, p<.001 .) were correlated with social support.

Conclusions

These findings support the need for nursing and faith based institutions to collaborate in support of community health. To impact proximal and distal health outcomes for the community this study suggests the church will need to capitalize on strategies to support mental health, increase education, and provide social support structures beyond its own walls (Ansari, Soltero, Lorenzo, and Lee, 2017) , as well as creatively address spiritual and religious behaviors within the community (Persynaki, Karras and Pichard, 2017). This data offers the picture that a majority of respondents in the community are other than Caucasian, have a spirituality not necessarily connected to formal church attendance, with need of support to maintain or increase both physical and mental health. Ryan’s ITHBC concepts of knowledge and belief and social facilitation is supported as contributing to both proximal and distal health outcomes. The relationship of these concepts to the self-regulation skills and abilities requires further study. This research also supports a role for the church and nursing to collaborate in ongoing attentive assessment of the community’s unique perceptions of its needs. Further research is needed to study the knowledge and belief and self-regulation concepts of the theory and discern if spiritual or religious strategies effect the self-management behaviors necessary for whole person health (Pfeiffer, Li, Martez, and Gillespie, 2018). Connecting nursing’s distinctive of whole person care with the perspective of shalom the church brings offers strengthened intervention to empower the community, reduce health disparities, and shift health care outcomes.

Title:

Assessment of Community Health by Neighborhood and Church Collaboration

Keywords:

community health, community-based participatory action research and faith-based community health

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Abstract Summary:
Using Ryan's (2009) Integrated Theory of Health Behavior Change, this collaboratively conducted (neighborhood/church/university) community-based participatory action research assessed San Bernardino, CA residents' individual physical/mental/social/spiritual health and their relationships as perceptions of community health. Findings support the need for nursing and faith-based institutions to collaborate in support of community health.

Content Outline:

Background

1. San Bernardino County, California has health inequities with high rates of chronic disease, mental health problems, and risk behaviors that reflect some of the worst health outcomes in the state of California and the United States.
2. Though faith-based partnerships have the potential to empower communities, reduce health disparities, and shift health care outcomes scant research of these partnerships exists in San Bernardino County, CA

Assessment of Community Health by Neighborhood

1. This community-based participatory action research assessed residents' demographic characteristics (age, education, marital status, ethnicity), spirituality, religiosity, social support, and physical and mental health using the Integrated Theory of Health Behavior Change (ITHBC) (Ryan, 2009).
2. The research questions are 1) What is the relationship of the demographic variables, spirituality, religiosity, and social support, to physical health components (PCS)? 2) What is the relationship of the demographic variables, spirituality, religiosity, social support, and discrimination to mental health components (MCS)?

Main Point #2 – Methods of Assessment

1. This correlational, comparative study included a quantitative survey with five measures administered to a convenience sample of adult residents (n = 267) within a mile radius of one local church in southwestern San Bernardino County.
2. Data was collected in spring of 2017 at two local elementary schools, one trailer park, and one local church during a 6 week period.
3. Tools used to measure religious support, social support, physical and mental health are as follows: Spirituality was assessed using the Intrinsic Religiosity (Hoge, 1972). Religiosity was assessed using the first two items of the Duke University Religion Index (DUREL), (Koenig and Bussing, 2010). Social support was measured with the Medical Outcomes Study Social Support (MOS-SS) scale. Physical and mental health was assessed using the Short-form 12 (SF-12v2) physical health component and mental health component subscales (Ware, Kosinski, and Keller, 1995).

Results

1. Demographics: Subjects were female, (n=199, 74.4%), 30 – 49 years old (n=125, 46.7%), married/remarried (128, 47.9%) with 153 (57.1%) having a high school diploma, some college, or an Associate's degree with only 30.7% (n=82) self-reporting as white with approximately 13.5% declining to state ethnicity
2. Spirituality, religiosity and social support: Spirituality was high (mean = 34.6, SD = 8.1). Religiosity was moderate [mean = 6.8 (SD = 3.1)]. Social support was moderately high [mean = 79.8 (SD = 17.7)].
3. Physical and mental health: Physical health was 67. 4 (SD = 22.8) and mental health 66.5 (21.5).
4. Relationships/Correlations: Greater physical health was correlated with younger age (r = -.25, p<.001), non-White ethnicity (r = .139, p = .035), more education (r = .26, p <.001) and greater mental health (r = .65, p < .001). Greater mental health was correlated with more education (r = .12, p = .049). Both physical health (r= .238, p<.001) and mental health (r= .390, p<.001 .) were correlated with social support.

Conclusions

1. These findings support the need for nursing and faith based institutions to collaborate in support of community health. To impact proximal and distal health outcomes for the community this study suggests the church will need to capitalize on strategies to support mental health, increase education, and provide social support structures beyond its own walls (Ansari, Soltero, Lorenzo, and Lee, 2017) , as well as creatively address spiritual and religious behaviors within the community (Persynaki, Karras and Pichard, 2017).
2. This data offers the picture that a majority of respondents in the community are other than Caucasian, have a spirituality not necessarily connected to formal church attendance, with need of support to maintain or increase both physical and mental health.
3. Ryan's ITHBC concepts of knowledge and belief and social facilitation is supported as contributing to both proximal and distal health outcomes. The relationship of these concepts to the self-regulation skills and abilities requires further study.
4. This research also supports a role for the church and nursing to collaborate in ongoing attentive assessment of the community's unique perceptions of its needs. Further research is needed to study the knowledge and belief and self-regulation concepts of

the theory and discern if spiritual or religious strategies effect the self-management behaviors necessary for whole person health (Pfeiffer, Li, Martez, and Gillespie, 2018).

5. Connecting nursing's distinctive of whole person care with the perspective of shalom the church brings offers strengthened intervention to empower the community, reduce health disparities, and shift health care outcomes.

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Author Summary: Dr. Pfeiffer is an Associate Professor at Azusa Pacific University in the School of Nursing at the Inland Empire Regional Campus in San Bernardino, CA. She has a 15-year history in spirituality and health research to include spirituality and health in the community. Her current study strategically targets assessment and intervention to effectively intervene in the health of subjects' neighborhood and have church serve as a hub for community health and well-being.

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