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The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes

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Abstract

Clergy in the Mexico play a major role in addressing the health care needs of their congregants. With qualitative semi-structured key-informant interviews, this study explored the views of ten male Mexican religious leaders (mostly Catholic) about their understanding of their role in diabetes health promotion. The major themes from the qualitative interviews emphasized the importance of open communication between church leaders and their parishioners, the role of the church in diabetes programs, and the unique position of religious institutions as a link between physical and spiritual aspects of health. Implications for diabetes interventions are discussed.

Keywords

Diabetes; Religiosity; Mexicans; Self-management; Community health

Introduction

In Mexico, diabetes mellitus (DM) is a growing concern. In 2012, approximately 9.2 % of the population was diagnosed with DM (Instituto Nacional de Salud Pública 2012). DM is now the leading cause of death for Mexican women and the second for men; DM contributed to over 72,000 deaths (equivalent to 14.7 % of all deaths) in 2010 (Secretaría de Salud [SSA]). DM is a complex condition that can result in a number of physical complications, which can affect quality of life and well-being, and can also reduce life expectancy. Although the importance of engaging in diabetes self-care activities is well-established, older Mexicans do not always have the knowledge or motivation to engage in self-management or comply with their treatment (Baca Martínez et al. 2008).

Limited research has found that Mexicans use religion as a way of coping with chronic conditions (Castro Sánchez 2006). Religion spirituality may help diabetic people to cope with chronicity and/or social and physical disability (del Zavala et al. 2006). In other countries, studies have also shown that clergy may offer advice and guidance regarding health issues and health care utilization to their congregants with chronic diseases (Stansbury et al. 2012). Despite the major role that religious leaders may have on promoting

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health and wellness on their congregations (Webb et al. 2013), there is limited research on religious leaders' perceptions on health promotion and religion. Furthermore, research on this topic in Mexico is scarce. With the increasing rates of DM in Mexico and poor blood glucose control and self-management practices among diabetics (Fanghänel et al. 2011), understanding how religious leaders may influence health promotion behaviors and the development of health promotion programs can help guide and improve future efforts.

Background

DM is a major public health concern in Mexico, where DM rates are only expected to increase in the next decades (International Diabetes Federation 2013). DM requires lifelong treatment and self-management to reduce morbidity and mortality. Diabetics may need to change nutrition habits and increase their physical activity. In addition, they may need to perform a series of tests to make sure their blood sugar levels are controlled (American Diabetes Association 2007). For many people, these behaviors may be difficult to alter, especially when resources and services are scarce. Lack of diabetes specialists, shortfalls in diabetic medications and deficiency of self-management programs in Mexico are major challenges to the health care system (SSA 2010). This poses unique concerns for many people with DM. Poor disease management can cause long-term complications that may impose a financial burden on the patient, their families and the health care system (Pagán and Carlson 2013).

In many countries, researchers have suggested that one possible solution is to offer community-based diabetes education (Samuel-Hodge et al. 2009). Faith-based organizations (FBOs) have been presented as effective channels for the delivery of health promotion and prevention programs. Although they may not have the staff for conducting health promotion intervention programs, FBOs are considered key settings by researchers for this activity. Many FBOs have a long history of health education, health promotion and community outreach (Campbell et al. 2007). Health is part of many religious institutions' holistic mission, and some have health ministries in which they offer spiritual counseling and health services through special committees (Catanzaro et al. 2007). FBOs have resources and facilities that could be used to evaluate health interventions (Campbell et al. 2007). In addition, FBOs are culturally appropriate venues to conduct promotion activities (Catanzaro et al. 2007). Based on these considerations, researchers have explored the benefits of conducting health programs in FBOs. For over two decades, interventions ranging from nutrition and physical activity education (Young and Stewart 2006) to diabetes prevention and management (Dodani and Fields 2010) have been delivered in religious settings. These programs have been particularly useful for minority groups, which are more likely to lack health insurance and access to health services (Martin 2011).

Because the positive effects of health programs and partnerships FBOs are well-documented (Bopp et al. 2009), researchers and practitioners have shown increased interest in understanding the success of these programs and partnerships with FBOs. Faith leaders' involvement has been described as key in the success of a program (Bopp and Fallon 2011). Religious leaders are community gatekeepers who have access to community members and can deliver information to health care providers and the congregation (Williams et al. 2012).

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Faith leaders are important in developing and implementing health interventions (Webb et al. 2013). Religious leaders may encourage congregants to be part of an intervention and may be seen as role models (Baruth et al. 2008). With this in mind, researchers suggest that religious leaders must be involved from an early stage and throughout the process of the program (Campbell et al. 2007).

While religious leaders are important in successfully delivering health promotion programs in FBOs, to date, limited research has been conducted to understand pastors' views about health programs and most of them have been focused on Whites and African Americans. Given that religion can influence the way Mexicans deal with health issues (Castro Sánchez 2006; del Zavala et al. 2006), the purpose of this study was to better understand the role of religious leaders in promoting health in older Mexicans with diabetes.

Methodology

Design and Sample

Using purposeful and snowball sampling techniques, ten key informant interviews were conducted with religious leaders from three different denominations: Catholic Church (8), Evangelical Christian (1) and Jehovah Witness (1), in December 2011. These pastors were invited to participate in this study because they have been part of these communities for several years and have invaluable knowledge and extensive experiences with the church and its members. All key informants were males, 30–60 years of age. These churches were located in areas from lower- to upper-middle class housing (this was based on observation of surroundings). Religious leaders were very accessible. Although refusals were uncommon, one leader from a Protestant Christian denomination and one from the Catholic Church refused to be part of the study.

Procedures

Institutional Review Board (IRB) approval was granted prior to the study. All documents, the informed consent and interview questions were first developed in English and then translated into Spanish. Original materials were shared with qualitative researchers for feedback. Questions were refined after IRB staff reviewed original materials. After IRB approved the study, the investigator visited each pastor to explain the purpose of the study. An informed consent form and an interview guide were provided to respondents, and if the participant wished to participate, an appointment was made to return later. The informed consent explained the nature of the study, as well as potential risk and benefits of participating in the project. After informed consent was signed by participants, interviews were conducted in Spanish at their offices. The researcher is a native speaker. These semi-structured interviews were conducted in conversational mode, in person, and were 30–60 min in length. Interviews were recorded, and notes were also taken during the interviews.

Initial questions were broad to encourage respondents to speak openly and allow different themes to emerge. Religious leaders were asked about their relationship with the community and health problems in the community, specifically chronic conditions. Subsequent questions examined DM programs, relationships with health care providers and self-

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management strategies. Additional questions were prompted based on the individual responses from the interviewees.

Data Analysis

First, interviews were transcribed verbatim in Spanish. Analysis was ongoing throughout the study. The data were analyzed using qualitative content analysis. In this process, the raw data is clustered and organized into emerging themes. Transcripts in Spanish were categorized and organized into emerging themes and underlying concepts. A codebook was developed after reading all of the transcripts, then coding for themes. Direct quotes from religious leaders were included in the results section to capture their voice. Results then were translated into English by the researcher.

Findings from the Interviews

In general, members of the clergy are aware of the DM problem in Mexico. They have some basic knowledge about diabetes and diabetes self-management. They agreed that the church should have an active role in addressing the issue of diabetes within the congregation and the community. Programs available in these congregations are based on the resources available and professional experiences, such as food pantries and doctor consultation. Table 1 shows the themes and subthemes that emerged from the analysis of the data. There were three main themes that emerged from the transcripts about the role of the church in promoting the health of Mexicans with DM: (1) Maintain Open Lines of Communication; (2) Crossover between Spiritual and Physical Healing; and (3) Involvement in Diabetes Programs (See Table 2). There was considerable overlap in the ideas and themes reported by the informants.

Theme I: Maintain Open Lines of Communication

Communication was identified by all religious leaders as an important factor in understanding the needs of the congregation and the community. Spiritual leaders emphasized the importance of fostering social and community interaction, which is seen as a key element in connecting with the congregations. During the interviews many leaders reported that they felt an honest, solid and trusting relationship with churchgoers was important for their work. Informants indicated that regular and open lines of communication would allow priests to know the parish communities and their needs, and identify problems that need immediate attention. Knowing and understanding the members of the church were highlighted as very important because it fortifies ties and relationships within the congregation. Overall, respondents felt that such relationships play a key role in improving people's health care. They explained that there were many health-related concerns in these communities, and a number of people consult religious leaders about their conditions.

Informants reported strong ties with the community. For example, if someone misses a church meeting or event, church leaders often call them and/or go to their houses. Some respondents mentioned that they try to help the community to get informed about health-related topics (e.g., healthy diets, exercise). In fact, some of them have free or low-cost newsletters and magazines that they share with people both in and out of the congregation.

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Some of these magazines are edited and produced locally, while others are brought from Mexico City or other locations.

Understand Community Members—This subtheme emerged consistently when religious leaders described communication processes with members of the church. When asked about their congregations, all participants were able to describe them. One respondent said that people with DM and other chronic conditions attend church regularly. One participant said,

> Our community is generally composed of elderly people who face problems of various kinds, and diabetes is one of them. Other health issues include arthritis, cancer, obesity, disability and cardiovascular diseases. A lot of people with diabetes who come to church have it under control, but there are a number of people that we visit whose diabetes are not adequately controlled and they cannot come to church because they are having some complications.

Overall, respondents agreed that their role is to know their parishioners. Regardless of the situation, informants can provide a sense of comfort to individuals who talk about their experiences, they generally agreed. So they not only listen to parishioner's concerns and feelings, they also provide guidance and comfort. People are free to express and communicate their needs, whether they are looking for encouragement, motivation and maintaining a positive attitude or behavior, as described by these religious leaders. They said that they know about these diseases because the congregation tells them, often relating stories regarding family, friends or those directly affected. Congregants in their communities are willing to discuss their symptoms and concerns because dialog provides an opportunity for these church leaders to provide reassurance and hope to the person and family members.

Most religious leaders agreed that people put trust in them and rely on their advice, guidance *and* information regarding all aspects of their life. As such, they believed they had a strong influence on people's health behaviors following diagnosis. When asked about how those individuals afflicted with chronic conditions feel after diagnosis, one respondent said that "individuals usually began to ask '*God why me*?' and even blame him, including those who have a spiritual relationship with God and attend worship frequently. After talking with them, they reflect and understand that the condition happened because it was something natural." These pastors act as individual counselors. One participant commented,

> Churchgoers sometimes come in times of desperation, feeling hopeless and helpless, and the leaders offer some words of encouragement, comfort and try to help them feel better… offering support, encouragement, and inspiration to people can help with coping in difficult times…Mexicans need cheerful messages.

Theme II: Crossover Between Spiritual and Physical Healing

A widely held view from informants noted that the modern church has an important role in promoting health. Spirituality is a very important component of people's well-being, and therefore, spirituality has to be addressed according to their views on health. They made clear that their practices do not detract from medical programs and practices.

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Most informants discussed a more inclusive model that focuses on the whole person—spiritual, emotional, physical and social. Although churches focus on spiritual needs, pastors explained that physical problems are affected by spiritual issues and thus need to be addressed directly. One respondent said, “The spiritual health depends on the physical health and (it) is very important to be at peace with oneself.” Four pastors laid emphasis on taking care of the mind, body and spirit, or keeping a healthy mind in a healthy body. When asked about the relationship between faith and illness, one respondent shared the idea of the spiritual being or body and soul connection.

> Human beings are composed of body and soul. Many health issues begin as psychosomatic, and then peoples' emotional problems affect their health. Feelings, emotions and spiritual values can affect or benefit the body and the whole person. These factors are closely related.

One respondent explained that he tries to increase healthy behaviors within the community when asked what kind of advice they offer to parishioners. People can prevent and manage different chronic conditions including DM by going to the doctor, eating healthy and doing physical activity. “It is important to pray, but also (to) follow medical expert advice.” Similarly, another respondent recommends people go to the physician and follow medical treatment.

> It is important to follow the advice of science… faith does not replace biomedicine. Health care activities are strengthened with faith. For example, people need a healthy diet to regulate blood sugar levels, but faith helps with their mental and physical health such as mood…As a priest, I give advice to parishioners, to take care of themselves and not just rely on prayer. Faith is important, but one must also follow doctors' recommendations. Science and God are connected and both parts have to be followed for people to heal.

Faith as a Healing Instrument—This subtheme emerged when religious leaders described spiritual healing. Key informants work with several members of the community who are seeking spiritual direction. Participants felt that being able to provide spiritual guidance helps members to feel hope. Informants described a pattern for parishioners in which they typically visit the church with greater frequency when the disease begins, when they have critical moments that are difficult for them, and when the disease worsens.

> People have many spiritual needs when things fall apart. We have to explain and show them that this disease is not a punishment. It is a consequence of genes and/or self-neglect. It is important to remind them to love themselves because we also show our love to God by loving ourselves and respecting the gift of life.

According to these religious leaders, faith is important in the process of healing. These informants claimed that facing a disease requires faith and hope, which gives people strength to cope with their conditions. Some even mentioned that doctors have discussed with them the relationship between faith and coping. Leaders consistently reported that a person with faith has a better time coping than someone without faith.

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> A person with faith has joy, hope, and peace and does not blame others, whereas someone without faith thinks in a very negative way, punishes him or her and blames others… but faith can give people strength to cope with their illness. I tell them it is important to begin and/or continue quality of spiritual and physical life as there is always hope that they will get better and healthier.

Theme III: Involvement in Diabetes Programs

Leaders mentioned that they would like to get involved in DM education programs for the community. One participant explained,

> There is a lot that can be done about diabetes…I think a diabetes self-management program could be very useful and well-received in the community. We would need to provide training, promote and disseminate materials through the church. We could spread the word through parish groups and flyers.

Another leader said,

> The church can certainly help with health prevention and promotion. In my opinion, I think we need to 1) learn more about diabetes and make this knowledge accessible to people; 2) search for doctors who can volunteer to help raise awareness and spread information not only about health risks, but also work on prevention for children and younger adults.

However, leaders of these churches stated that they need to partner with health organizations and the government in order to best achieve these goals of community health outreach. They agreed that education programs need to be offered through the church. “The church would clearly be an excellent resource for starting a DM program. But it is essential to establish other types of programs at the government level. ‘The unity is the strength’.” Leaders expressed concern about DM and disease services, as one respondent explained,

> Obesity and diabetes will continue to rise. I believe that our health messages are spreading more, but there are also other health campaigns. The Government has implemented some health programs, but we all as leaders have to take initiative in this matter.

Receive Education and Educate Others—This subtheme emerged when religious leaders were discussing DM programs. Pastors talked about how receiving education was very important when they were talking about their knowledge of DM. They agreed that DM was one of the major causes of death in Mexico. Most of them colloquially defined DM as “a disease that is hereditary, due to genetic issues, but can also be caused by poor diet.” They explained that the advice given to parishioners is based on what they know, and sometimes they do not have enough knowledge to offer meaningful suggestions. “We are conscious that we have these problems in the state and the country, but there is little information we receive regarding chronic conditions in our seminary school.”

Pastors described how important it is for religious leaders to receive education about DM and self-management to help the community. One participant explained training and education that these participants received and offered:

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> Some pastors get different health care classes and certificates… some get trained in different universities around the world such as Rome, Germany and Spain and share what they learned with the community. For example, there is one father who teaches bioethics (about how to treat patients and the link between medicine, religion and spirituality) to physicians and other health professionals… also there are some physicians ordained as priests… if someone offered me a class about diabetes, I would take it.

Certain pastors also discussed how their agency in educating themselves would be beneficial to themselves and their parishioners. These pastors emphasized the role of emergent information communication technologies (ICTs) for this process, while also stating that the largest barrier to this self-education was the restraints placed on them in terms of knowledge and available time. One of the leaders said,

> It is our own responsibility, too. I, as a priest, could use the internet to search the topic and convey the knowledge to congregants… there are many ways, churches have computers and internet, but this depends on ourselves. I may be ignorant because I want to be, or because I do not how to take direct action or proceed, or because there is not time to investigate.

Partnership with Social and Health Care Organizations and Government—This subtheme was prevalent among religious leaders when they described their concern with DM prevalence and lack of programs that educate people with DM. Most informants mentioned that "as a religious leader it is our responsibility to encourage health care activities, but other social and political leaders have this responsibility as well. If we do not assume the challenge and responsibility, who will?"

Some of the respondents already work with some organizations such as *Caritas* (nongovernment organization), hospitals and the government. In Caritas, there are different programs to help the needy with food, shelter, treatment and similar care necessities, along with physicians with different specialties and practices that provide their services. Participants commented that Mexico has multinational pharmaceutical companies and other organizations that offer low-cost medical services (consultation with a physician costs approximately US $3.00) and have helped many families. Although some people use these alternatives, there are many people that have low incomes and cannot afford to pay their doctors' fees. One of the participants said,

> The church has the duty to help them. These people in need can come to us and if we cannot provide the services they require, we will reach out to other institutions that have the services. The church is the bridge to other institutions that have these services. So it is clear that a lot of people expect a lot from the church, but charity needs to be more organized.

While the topic of DM was not overtly mentioned by the respondents, their statements regarding this area of discussion indicates that there are already elements for a support system set in place. Furthermore, these religious leaders emphasized their willingness to begin coordinating health promotion outreach with official institutions through these existing support systems.

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Discussion

This study provides an understanding of how religious leaders perceived their role in diabetes-related programs. Based on the interviews with ten members of the clergy in Mexico, there were three major themes—*maintain open lines of communication about health, crossover between spiritual and physical healing and involvement in diabetes programs*. The results indicate support from religious leaders in health promotion for older people with DM. But this support relies on existing programs and resources. In these interviews, religious leaders' involvement with the health of people outside their denomination was different based on the mission of each church. For example, Catholic leaders offer health-related programs to everyone in the community. On the other hand, the lone Jehovah's Witnesses church reported using their resources for congregants.

The work presented here supports previous research on religiosity, health promotion and church-based programs. Other studies found that clergy play a crucial role for parishioners and are very involved with their members (Stansbury et al. 2012). These leaders provide spiritual guidance, but many of them embrace a holistic approach to health and the linkage between spiritual and physical health. This is not uncommon on various FBOs (Nordtvedt and Chapman 2011). Studies have found that if religious leaders are already involved in health-related programming, they are more likely to support health promotion activities (Catanzaro et al. 2007). These Mexican churches seem to be great sources of social support and service provision among their members. Some of them are already engaged in health ministries and other health promotion activities. These findings are consistent with Webb et al. (2013), who found differences between religious leaders' views about their church's involvement in health promotion programs. Different practices may impact their willingness to adopt health promotion programs.

Existing programs varied between and within the communities based on locations. Neighborhoods with higher income households reported having more programs available, which suggests that community-based programs should be structured to target those in need. Previous research has also mentioned that the majority of congregational health ministries are often in large communities located in wealthier neighborhoods (Lindner and Welty 2007). These communities have financial resources and volunteers to determine health needs, develop and run health ministries (Catanzaro et al. 2007). These leaders mentioned that if health-related activities are within their mission, they would find volunteers and resources to offer these kinds of programs in their congregations. It was discussed that some of these programs were often centered on the charisma of their church leader. But, it was noted that collaborative partnerships with health institutions may allow churches to use skills and resources that otherwise would not be affordable.

Implications

Despite the lack of church-based DM education and self-management programs in Mexico, there are some important implications for policy, research and practice. Findings from this study suggest that religious leaders are very involved and caring. They report providing formal and informal support in the form of hope, encouragement and financial support to people with health care needs. Clergy and volunteers (sometimes physicians and nurses) use

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their professional expertise and faith practices to provide a more spiritual care. In order to promote community health, often there are medical dispensaries and food pantries. Some FBOs offer educational and exercise programs and groups such as cooking classes, zumba and yoga. When FBOs lack assistance or input from health-related professionals, these groups provide information about institutions that could help individuals with health care needs. Finally, these leaders reported asking everyone to share their expertise and talents with those in need.

Key informants who participated in this study expressed interrelated concerns about implementing DM health education and promotion, such as a lack of DM programs and limited resources for volunteer physicians and health care professionals. There was concern about their lack of knowledge and varying abilities to offer educated advice and guidance for congregants with DM. Most informants would like to receive some form of education from health care professionals. In addition, some pastors mentioned that FBOs have limited financial resources to hire health care staff in some of these FBOs, and they may not have physicians or nurses that volunteer in their congregations. As a result, there are not congregations with programs that focus exclusively on DM education and management.

Religious leaders expressed that these programs are needed based on current rates of DM and obesity, especially because a number of priests reported having DM. Church help for people with DM is based on resources in current programs and services that congregations offer to the community. Programs in FBOs are based on their religious leader's active involvement, geographical locations and sociodemographic characteristics of the congregation. Using these findings as a platform for future implementation of health care policy, it will be important to increase partnerships between DM educators, government and other organization and clergy to provide more resources for people with DM.

Effective diabetes self-management programs require community resources and support. Thus, more resources are needed in these communities. A majority of the informants highlighted that if resources were available, they would happily start a diabetes self-management program for their congregations. It was suggested that Mexicans would be likely to attend self-management programs. Faith leaders need more health advocates to provide health ministry, as well as financial resources to create these programs. Although one informant mentioned that it was the responsibility of the government to support, organize and implement DM programs, the majority of key informants agreed that the church should take an active role in helping to prevent and manage DM in the community.

Key elements for faith-based programs include partnerships with the church and health professionals and supportive relationships (Rowland and Chappel-Aiken 2012). Respondents expressed that partnership with health care organizations, government and the media would be important to them. This assistance is needed to ensure proper health messages are delivered to the community. These partnerships have the potential to improve diabetes self-management (Samuel-Hodge et al. 2009), but there are a number of barriers that limit the involvement of health care organizations with FBOs: Attitudes and beliefs from health care professionals may be challenged; professionals may not see the relationship between religion, spirituality and health care; and there may be concerns about

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evangelization on patients and staff (National Center for Cultural Competence 2001). Discussions from both parties about goals and expectations from each member should help to address these barriers and facilitate collaborative relationships to provide health promotion programs to those in need (Sullivan et al. 2013).

These findings have important implications for health care professionals. Researchers in the US have already discussed the value of FBOs in health care and health promotion. Clergy are now considered members of the health care team through their work with patients in hospital visitations and serving in bioethics and pastoral care committees (Cobb et al. 2012). There are different resources that institutions can use to enhance the link between clergy and health organizations: (1) using electronic newsletters for both organizations with information about programs, support groups and other services in health care organizations and columns about spirituality and health; (2) creating databases with medical professionals that would like to volunteer in FBOs; (3) organizing sessions about religion, spirituality and ethics instructed by community clergy; (4) providing web sites, articles and other materials about health-related issues to parish (Weiss 2003).

Limitations and Future Studies

The present research has some limitations that include the use of a small and purposive sample which limits the generalizability of the results. Generalizability was not a goal of these interviews, and these findings should not be interpreted as representative of views about the role of FBOs in DM self-management programs. There are other religious denominations that were not interviewed, and their members are increasing at a faster rate (Secretaría de Gobernación 2013). In addition, all participants were males. Future studies should include female clergy members. It would be important to talk to these women and understand their opinions about the role of the church in health promotion and care for people with DM. Performing a national study of religious denominations and their involvement in health programs could help to determine whether these results apply to other FBOs and other regions in Mexico. More interviews should also be conducted with religious professionals (community clergy, chaplains and pastoral counselors), policy makers and medical professionals to determine the feasibility of establishing faith-based diabetes self-management programs in Mexican FBOs. It will be also interesting to interview congregants and other community members diagnosed with DM to determine whether they would be interested in participating in diabetes self-management programs. Last, key-informant interviews were the only method used in the present study. Future studies may want to include focus groups and survey instruments regarding the role of FBOs in health programs.

In spite of these limitations, these findings shed some light and contribute to the growing literature concerning diabetes self-management and health programs in FBOs. It also provides support for the argument of designing partnerships between faith- and health-based organizations to develop and initiate DM programs.

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Conclusion

With the increasing number of people with DM in Mexico, the health care burden for treatment and management of the disease and the importance of religious beliefs in Mexicans' daily lives, health care providers may need to work with FBOs to help people with DM achieve better quality of care. Right now, the Church is gaining or reclaiming an important role in promoting health and wholeness. Although the major role of many FBOs is to promote spiritual health, it can also influence physical and mental health. Based on what was discussed in these interviews, and the active role and responsibility that religious leaders have in health care and individual well-being, they need to encourage the development of diabetes self-management programs and motivate the community to participate in them. But religious leaders recognized the need to become more involved with medical professionals to address the needs of diabetics' older adults. Hopefully, these findings encourage health care professionals and religious leaders to establish these beneficial partnerships.

References

American Diabetes Association. Standards of Medical Care in Diabetes—2007. Diabetes Care. 2007; 30(Suppl 1):S4–S41.10.2337/dc07-S004 [PubMed: 17192377]

BacaMartínez B, Bastidas Loaíza MJ, Aguilar M, del R, De La Cruz Navarro M, de J, Gonzáles Delgado MD, Uriarte Ontiveros S, Flores Flores P. Nivel de conocimientos del diabético sobre su auto cuidado. Enfermería Global. 2008; 7(2)10.6018/eglobal.7.2.14691

Baruth M, Wilcox S, Laken M, Bopp M, Saunders R. Implementation of a faith-based physical activity intervention: Insights from church health directors. Journal of Community Health. 2008; 33(5):304–312.10.1007/s10900-008-9098-4 [PubMed: 18473154]

Bopp M, Fallon EA. Individual and institutional influences on faith-based health and wellness programming. Health Education Research. 2011; 26(6):1107–1119.10.1093/her/cyr096 [PubMed: 21984225]

Bopp M, Wilcox S, Laken M, Hooker SP, Parra-Medina D, Saunders R, et al. 8 steps to fitness: A faith-based, behavior change physical activity intervention for African Americans. Journal of Physical Activity & Health. 2009; 6(5):568–577. [PubMed: 19953833]

Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-based health promotion interventions: Evidence and lessons learned. Annual Review of Public Health. 2007; 28:213–234.10.1146/annurev.publhealth.28.021406.144016

Castro Sánchez, AE. El apoyo social en la enfermedad crónica: El caso de los pacientes diabéticos tipo 2. Revista de la Facultad de Salud Pública y Nutricio´n. 2006. Retrieved October 24, 2013, from http://www.respyn.uanl.mx/vii/4/articulos/apoyo_diabeticos.htm

Catanzaro AM, Meador KG, Koenig HG, Kuchibhatla M, Clipp EC. Congregational Health Ministries: A national study of pastors' views. Public Health Nursing. 2007; 24(1):6–17.10.1111/j.1525-1446.2006.00602.x [PubMed: 17214648]

Cobb, M.; Puchalski, CM.; Rumbold, B. Oxford textbook of spirituality in healthcare. Oxford: Oxford University Press; 2012.

del Zavala MR, Martínez OV, Whetsell MV. Bienestar espiritual y ansiedad en pacientes diabéticos. Aquichan. 2006; 6(1):8–21.

Dodani S, Fields JZ. Implementation of the fit body and soul, a church-based life style program for diabetes prevention in high-risk African Americans: A feasibility study. The Diabetes Educator. 2010; 36(3):465–472.10.1177/0145721710366756 [PubMed: 20508263]

Fanghänel Salmo´n G, Reyes Sánchez L, Escalante Herrera A. Registro multicéntrico internacional para evaluar la práctica clínica en pacientes con diabetes mellitus tipo 2: subanálisis de la experiencia en México. Gaceta médica de México. 2011; 147(3):226–233. [PubMed: 21743590]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Instituto Nacional de Salud Pu´blica. Diabetes mellitus: la urgencia de reforzar la respuesta en políticas públicas para su prevención y control. Instituto Nacional de Salud Pública; 2012. Retrieved from http://ensanut.insp.mx/doctos/analiticos/DiabetesMellitus.pdf

International Diabetes Federation. Mexico. Mexico Diabetes. 2013. Retrieved October 24, 2013, from http://www.idf.org/membership/nac/mexico

Lindner, EW.; Welty, MA. National Council of the Churches of Christ in the USA; 2007. Congregational health ministry survey report. Retrieved from http://www.anglicanhealth.org/Resources/PDF/AHN%20resources/Faith%20and%20health%20care/NCC%20health%20survey.pdf

Martin, LJ. New U.S. plan to improve health care for minorities. Webmd. 2011. Retrieved October 25, 2013, from http://www.webmd.com/health-insurance/20110412/new-us-plan-to-improve-health-care-for-minorities

National Center for Cultural Competence. Sharing a legacy of caring: Partnerships between health care and faith-based organizations. Georgetown University Medical Center; 2001. Retrieved from http://nccc.georgetown.edu/documents/faith.pdf

Nordtvedt M, Chapman LS. Health promotion in faith-based institutions and communities. American Journal of Health Promotion. 2011; 25(4):TAHP–1–TAHP–12.10.4278/ajhp.25.4.tahp

Pagán JA, Carlson EK. Assessing long-term health and cost outcomes of patient-centered medical homes serving adults with poor diabetes control. Journal of Primary Care & Community Health. 2013 2150131913489885. 10.1177/2150131913489885

Rowland ML, Chappel-Aiken L. Faith-based partnerships promoting health. New Directions for Adult and Continuing Education. 2012; 2012(133):23–33.10.1002/ace.20004

Samuel-Hodge CD, Keyserling TC, Park S, Johnston LF, Gizlice Z, Bangdiwala SI. A randomized trial of a church-based diabetes self-management program for African Americans with type 2 diabetes. The Diabetes Educator. 2009; 35(3):439–454.10.1177/0145721709333270 [PubMed: 19383882]

Secretaría de Gobernación. SEGOB; 2013. Asociaciones religiosas. Retrieved from http://www.asociacionesreligiosas.gob.mx/work/models/AsociacionesReligiosas/pdf/Numeralia/AR_por_tradicion.pdf

Secretaría de Salud. NORMA Oficial Mexicana NOM-015-SSA2-2010, para la prevención, tratamiento y control de la diabetes mellitus. 2010. Retrieved from http://cenavece.salud.gob.mx/programas/interior/adulto/descargas/pdf/NOM015DM.pdf

Stansbury KL, Harley DA, King L, Nelson N, Speight G. African American clergy: What are their perceptions of pastoral care and pastoral counseling? Journal of Religion and Health. 2012; 51(3): 961–969.10.1007/s10943-010-9413-0 [PubMed: 20978845]

Sullivan S, Pyne JM, Cheney AM, Hunt J, Haynes TF, Sullivan G. The pew versus the couch: Relationship between mental health and faith communities and lessons learned from a VA/Clergy partnership project. Journal of Religion and Health. 2013:1–16.10.1007/s10943-013-9731-0 [PubMed: 23334953]

Webb B, Bopp M, Fallon EA. A qualitative study of faith leaders' perceptions of health and wellness. Journal of Religion and Health. 2013; 52(1):235–246.10.1007/s10943-011-9476-6 [PubMed: 21409482]

Weiss, R. Make partners of your local clergy. Health progress. 2003. Retrieved from http://www.chausa.org/docs/default-source/health-progress/communication-strategies—make-partners-of-your-local-clergy-pdf.pdf?sfvrsn=0

Williams RM, Glanz K, Kegler MC, Davis E Jr. A study of rural church health promotion environments: Leaders' and members' perspectives. Journal of Religion and Health. 2012; 51(1): 148–160.10.1007/s10943-009-9306-2 [PubMed: 19960262]

Young DR, Stewart KJ. A church-based physical activity intervention for African American women. Family & Community Health. 2006; 29(2):103–117. [PubMed: 16552288]

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Table 1

Themes and subthemes derived from the key-informant interviews with religious leaders about their role in health promotion for Mexicans with diabetes

I	Maintain open lines of communication
	a. Understand community members
II	Crossover between spiritual and physical healing
	a. Faith as a healing instrument
III	Involvement in diabetes programs
	a. Education and educate others
	b. Partnership with organizations

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Table 2

Major themes derived from the key-informant interviews with religious leaders about their role in health promotion for Mexicans with diabetes

Maintain open lines of communication: Respondents mentioned that it is important to understand the needs of their congregation and their community. These pastors use different forms of communication to assist parishioners and the community with their needs, such as person-to-person, social media, newsletters and magazines. Supportive and cheerful messages to those affected with chronic conditions give people hope about the future and emotional support with the process of changing lifestyles as explained by these leaders.
Crossover between spiritual and physical healing: Overall informants viewed the mission of the church as helping the community with spiritual and physical healing. Both spirituality and physical health have to be addressed because they are intrinsically linked, and one depends on the other. Their message to people is to care for mind and body, with the use of prayer and healthy behaviors.
Involvement in diabetes programs: Due to lack of resources, currently there are not diabetes education programs offered at faith-based organizations. However, most of these participants would like to have a program at their church if they have funding. Religious leaders explained they need to get educated about diabetes, as well as strengthened teamwork for partnerships with social and health care institutions to better serve the community.