RESEARCH COMMUNICATION

Interest in Health Promotion Among Korean American Seventh-day Adventists Attending a Religious Retreat

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Abstract

Background: Little is known about interest in faith-based health promotion programs among Asian American populations. Among the Christian denominations, the Seventh-day Adventist (SDA) church is known to place a strong doctrinal emphasis on health. Objectives: To understand appropriate ways to develop and implement health promotion programs and to conduct research among Korean American SDAs. Methods: We collaborated with the North American Division of Korean SDA Churches which sponsors annual week-long religious retreats for their church members. We developed and administered a 10-page questionnaire at their 2009 retreat in order to assess socio-demographic and church characteristics, religiosity, perceived relationship between health and religion, and interest and preferences for church-based health promotion programs. Results: Overall, 223 participants completed our survey (123 in Korean and 100 in English). The sample consisted of regular churchgoers who were involved in a variety of helping activities, and many holding leadership positions in their home churches. The vast majority was interested in receiving health information at church (80%) in the form of seminars, cooking classes and workshops (50-60%). Fewer respondents were interested in support groups (27%). Some interests and preferences differed between English and Korean language groups. Conclusion: Korean American SDA church retreat participants from a large geographic area are very interested in receiving health information and promoting health at their churches and can potentially serve as "agents of influence" in their respective communities.

Keywords: Korean Americans - 7th-day adventists - religion - health - community-based participatory research

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Introduction

Health is the product of individual, social and environmental factors. Members of many minority communities underutilize services from mainstream health centers such as primary care clinics and hospitals for various reasons, including; lack of insurance, distrust, language and access barriers, etc. (Ackerson and Gretebeck 2007; Wells and Roetzheim 2007; Cheatham et al., 2008; Schueler et al., 2008). In these communities, social structures and institutions that are neither medical nor intrinsically health-related may play a significant role in health promotion. In fact, in the Korean American community in Los Angeles, it is commonplace to observe health fairs and other health promotion activities that are sponsored by churches, mission groups, social service organizations, schools and banks. Moreover, in our prior work, we discovered that several Korean American churches in the Los Angeles area have built dispensaries and clinics offering limited numbers of free or low-cost primary care and preventive services (Jo et al., 2010).

Among the various non-health entities, churches and other religious organizations in particular, have shown much promise as partners in health promotion. Several have described successful faith-based health initiatives in the African American and Latino communities (Tuggle 2nd, 1995; Lough, 1999; Eliason and True, 2004; Baruth et al., 2008; Giger et al., 2008; Luque et al., 2011). In our prior work, we have found that Korean churches are willing to work with health and educational institutions to promote and help deliver health in their community (Jo et al., 2010). As part of a larger effort to develop a health related intervention targeting Korean Americans at religious settings, we surveyed a group of Korean American Seventh-day Adventists convened at a religious retreat.

Among the many Christian denominations, the Seventh-day Adventist (SDA) church is known to place a strong doctrinal emphasis on health and wholeness. The church promotes vegetarianism and discourages the use of tobacco, alcohol, and illicit substances (Adventist.org). The NEWSTART program, embodying a message of health and wholeness [the acronym stands for Nutrition, Exercise, Water, Sunshine, Temperance, Air, Rest, and Trust in God] (White, 1905), is popular among many of the church members, and various forms of this program

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have been studied and reported by a few to have beneficial health effects (Henry and Kalynovskyi, 2004; Ashley and Cort, 2007; Slavicek et al., 2008). Given that health is an important part of their religious belief, this group represents a promising partner in future health work. We took this opportunity to describe and report our findings of this survey.

Our paper adds to the limited literature on faith-based health initiatives among Asian American populations (Juon et al., 2008; Ma et al., 2009; Teng and Friedman 2009; Jo et al., 2010; Kang and Romo 2010). We report interest in health promotion programs that could be offered at Korean American churches and preferences with respect to content and format of these programs among English and Korean-speaking retreat attendees. There is a growing number of literature on the Seventh-day Adventists and health, but to our knowledge, this is the first ever to describe health related work among Korean American Seventh-day Adventists.

Materials and Methods

The UCLA Institutional Review Board has approved our research protocol.

Study Setting

The Western Korean SDA Camp Meeting is an annual week-long religious retreat sponsored by the North American Association of Korean Seventh-Day Adventist Churches. Forty-nine churches from six states (Arizona, California, Colorado, Oregon, and Washington) are represented; over one thousand participants (approximately two-thirds Korean-speaking, and a third English-speaking) register to attend each summer. In 2009, the 26th annual retreat took place at a college campus in Northern California, with about 800 adults (18 year old and over) and 400 youth and children attending [Pastor Joseph Oh, personal communication, August 2010]. With "Restoration" as their theme, the program's focus was helping participants "experience ongoing and continual process of physical, mental, and spiritual nourishing, healing and rest" [retreat publication, page 38]. The first author (AJ) was invited as a speaker, and the organizers agreed to the proposed survey.

Survey development and field-testing

Our goal was to create a linguistically and culturally competent questionnaire that would assess perceived needs and preferences for church-based health interventions. Guided by the Health Behavior Framework (Bastani et al., 2010) and the results of our pilot work which included focus groups and in-depth interviews with key Korean church leaders (Jo et al., 2010), we developed a 10-page questionnaire to assess socio-demographic and church characteristics, religiosity, perceived relationship between health and religion, and interest and preferences for church-based health promotion programs. We also included free response items to elicit strategies to promote health interventions and increase participation.

When applicable, we drew a number of items from available bilingual questionnaires such as the California Health Interview Survey (CHIS), the AANCART core questionnaire (Choi, 2003), and those we used in our prior work with Korean Americans (Maxwell et al., 1998, 2000; Jo et al., 2008). All of the new items (approximately half of the questionnaire) were developed in Korean and English simultaneously, in parallel, by the first author who is a bilingual and bicultural Korean immigrant. Subsequently, a bilingual research staff and a consultant recruited from the community checked for accuracy of both versions. Any disagreements were resolved in group consensus meetings.

Final versions were field tested among six English-speaking and six Korean-speaking church-going Korean immigrants recruited by a partnering community based organization in Los Angeles, the Korean Resource Center. We asked responders to complete their questionnaires, while checking for appropriateness of the language, culture, ordering of items, skip patterns, and length.

Participant Recruitment

We employed several recruitment strategies. First, we spoke with several key leaders involved in planning the retreat. Using their suggestions, we outlined our approach, prioritizing the most feasible and time and cost efficient methods. These included making formal announcements at the main services, setting up tables at high-traffic areas such as the cafeteria and the sanctuary foyer, and visiting smaller group gatherings (i.e., Bible Study groups, prayer group meetings, social groups). In addition, at the conclusion of her health lectures, the first author (AJ) announced this survey and requested participation.

Survey administration

Questionnaires were completed in participants' preferred languages. Almost all (221) were self-administered. Face-to-face surveys were conducted with two participants who professed inability to read. Most took 15 – 45 minutes to complete. We offered bottles of water and snacks at the recruitment table. We also raffled 50 gift cards worth $10 each.

Data analysis

Statistical analyses were performed using Stata 9.1 software. We began with univariate analyses on all measured variables. We then performed bivariate analyses on key variables, assessing for any differences between the two languages. Chi-Square or Fisher Exact tests were employed on all categorical variables and two sample t-tests were used on all continuous variables.

We utilized the editing method (Miller and Crabtree 1994) to analyze the free response items on strategies to help promote and increase participation at health interventions. Using this method, we initially examined each of the written answers. We then extracted individual concepts from all of the answers and subsequently grouped these concepts into broader categories of themes.

Results

Response rate

We passed out a total of 339 questionnaires (153

Table 1. Participant Characteristics by Language of Survey

	Total sample	Korean language participants	English language participants	p-value
N	223	123 (55%)	100 (45%)	
Age (SD)	47.7 (18.0)	59.2 (12.0)	31.4 (11.2)	<0.001
Years of U.S. residence (SD)	26.2 (10.8)	27.5 (11.7)	24.7 (9.5)	0.05
Proportion of lifetime lived in the U.S. (SD)	0.61 (.27)	0.45 (0.17)	0.84 (0.21)	<0.001
	%	%	%	0.229
Gender				
Male	49	45	53	
Female	51	55	47	
Marital status				
Single	21	3	48	<0.001
Married or partnered	74	89	51	
Other	5	8	1	
Country of Birth				
Korea	80	100	54	<0.001
U.S.A	20	0	46	
Household income				
≤ $30,000	16	19	13	0.001
$30,001-50,000	13	19	7	
$50,001-70,000	10	14	4	
>$70,000	41	38	45	
Don't know	9	5	14	
No response	11	6	17	
Do you have health insurance?				
Yes	66	81	48	0.001
No	12	14	10	
Don't know	6	2	11	
No response	16	3	31	
Ability to speak English				
Well	75	56	99	<0.001
Not well	25	44	1	
Do you use internet?				
Yes	78	72	97	<0.001
No	13	21	3	
No response	9	7	0	
Do you use e-mail?				
Yes	49	44	56	<0.001
No	13	21	3	
No response	38	35	41	

Two sample t-tests for continuous variables and Chi2 and Fisher exact tests for categorical variables

English, 186 Korean) to retreat attendees 18 years old and over who presented to our recruitment tables or to our staff. Of these, 66% (100 [65%] English version and 123 [66%] Korean version) were completed and returned. Thus, about 28% of retreat attendees (223/800) completed the survey.

Socio-demographic characteristics

Table 1 reports socio-demographic characteristics of the survey participants. Average age of the total sample was 47.7 years old. The mean age of those who completed the survey in Korean (Korean language participants) was approximately 28 years older than that of those who completed the survey in English (English language participants). Male to female ratio was nearly one-to-one for both language groups. A greater proportion of the Korean language participants were married or living with a partner.

The length of U.S. residence was shorter for the English language participants, but the proportion of their lifetime spent in the U.S was significantly longer than that of the Korean language participants. All of the Korean language participants claimed Korea as their birth country while almost half of the English language participants chose the United States. Almost half (44%) of the Korean language participants, reported not being able to speak English well.

A quarter of the participants selected "don't know" or skipped the question on household income. Of those who responded to this question, more than half (51%) reported earning over $70,000. The two language groups differed significantly with respect to household income. Overall, English language participants reported higher incomes. Interestingly, despite lower income, more Korean language participants reported having health insurance (81% versus 48%).

Religion, spirituality, and health

Table 2 reports self-reported data on religion, spirituality and perceptions of relationship between health and religion. A little more than half of the total sample reported attending this retreat on a regular basis. Average home church size was about 200 members. Almost all (94%) reported attending church at least weekly, but Korean language participants reported higher frequency of church attendance overall. A majority (60%) reported holding at least one leadership position in their home churches (e.g., elder, deacon, or pastor), a greater proportion of them among Korean language participants (74% versus 40%). Almost all reported involvement in various church sponsored activities such as: choir, bible studies, community service projects and participating in worship services.

The most frequently selected reasons for attending church for both groups were "to maintain relationship with God" and "to fellowship with believers," with a slightly higher proportion of the Korean than English language group selecting "to maintain relationship with God" (98% versus 82%). There were statistically significant differences between the two language groups among reasons for church attendance. Overall, larger proportions of the English language participants selected social motivations, such as: to fellowship with other Koreans, habit or tradition, to meet friends, to keep connected with the Korean community.

The two groups selected a wide range of benefits that can result from church attendance, such as: improvement of spiritual, mental and physical health; gaining friends; receiving social support; and keeping a connection to the Korean culture. Overall, greater proportions of Korean language participants selected health related benefits (spiritual, mental, and physical health); and greater proportions of English language participants selected social benefits (gain friends/socialize, receive social support, keep connection to the Korean culture, and keep parents happy).

Most participants reported belief in the interconnectedness of physical, mental, and spiritual health. Additionally, more than half of the participants

Table 2. Religion, Spirituality, and Health

	Total sample	Korean language participants	English language participants	p-value
N	223	123 (55%)	100 (45%)	
Proportion of lifetime in faith tradition (SD)	0.80 (0.23)	0.75 (0.22)	0.88 (0.23)	0.001
Congregation size of home church (SD)	205 (269)	216 (238)	191 (305)	0.524
Years of attendance at home church (SD)	14.7 (15.6)	18.7 (18.8)	9.7 (7.7)	<0.001
	%	%	%	
Do you attend this camp meeting regularly?				
Yes	52	57	47	0.22
Current faith tradition				
Christian	97	100	93	0.003
Other or none	3	0	7	
How often do you attend church?				
< Weekly	5	0	12	<0.001
Once weekly	58	46	73	
> Weekly	37	54	15	
What is your role at your church?				
Member	39	26	57	<0.001
Pastor	8	11	3	
Elder/Deacon	47	60	30	
Other leader/staff (pastor's wife, church officer)	6	3	10	
Activities you're involved in at your church				
Bible study	59	57	61	0.537
Help other church members	52	49	56	0.283
Community service projects	38	30	48	0.006
Help lead worship service	31	20	45	<0.001
Choir	30	42	15	<0.001
Other	8	7	9	0.485
What are your reasons for attending church?				
To maintain relationship with God	91	98	82	<0.001
To fellowship with believers	83	83	83	0.988
To fellowship with Koreans	47	37	60	<0.001
For my children	47	54	37	<0.001
Habit / tradition	45	37	54	0.013
To meet friends	39	20	62	<0.001
To keep connected with the Korean community	28	15	44	<0.001
For my parents	25	20	30	0.096
What are the benefits of attending church?				
Improves spiritual health	94	99	87	<0.001
Improves mental health	74	85	60	<0.001
Gain friends / socialize	67	61	75	0.026
Improves physical health	56	71	37	<0.001
Receive social support	49	34	67	<0.001
Keep connection to Korean culture	34	23	48	<0.001
Keeps my parents happy	23	13	35	<0.001
Receive practical assistance (i.e., rides, help with job)	13	15	10	0.299
Networking for business	9	9	10	0.627
Do you believe physical health influences spiritual health?				
Yes	94	99	86	0.001
Do you think spiritual health influences physical health?				
Yes	98	99	96	0.105
Do you think mental health influences spiritual health?				
Yes	98	99	96	0.105
If someone gets sick, do you think it's because that person has done something wrong in the sight of God?				
Yes	9	13	5	0.069
No	87	82	92	
Depends	4	5	3	
If someone gets sick, do you think this is because something is not right between that person and God?				
Yes	12	17	5	0.008
No	85	78	94	
Depends	3	4	1	
Do you believe that one must set things right with God in order to get well from his or her illness?				
Yes	53	78	20	<0.001
No	45	18	78	
Depends	2	3	1	

Two sample t-tests for continuous variables and Chi2 and Fisher Exact tests for categorical variables

Table 3. Interest in Health Promotion Programs offered at Korean American Churches

	Total sample	Korean language participants	English language participants	p-value
N	223	123 (55%)	100 (45%)	
Age	47.7 (18.0)	59.2 (12.0)	31.4 (11.2)	<0.0001
	%	%	%	
Would you like to receive health information at your church?				
Yes	80	86	71	0.001
Do you think that the church is an appropriate place to discuss health related topics?				
Yes	88	89	88	0.726
Topics of interest at your church				
Nutrition	69	84	54	<0.0001
Family peace	61	73	47	<0.0001
Mental health	59	72	45	<0.0001
Physical activities	57	68	45	<0.0001
Healthy aging	48	58	37	0.002
Youth health	45	43	48	0.463
Cancer	37	41	32	0.104
Women's health	34	36	32	0.466
Bone health	27	29	24	0.392
Smoking cessation	27	30	23	0.251
Alcoholism	25	22	28	0.294
Men's health	25	28	22	0.292
Blood pressure	23	28	17	0.043
Diabetes	21	27	16	0.036
Eating disorder	21	15	28	0.008
Welcomed programs at your church				
Small group seminars	54	52	57	0.487
Cooking classes	52	59	46	0.055
Large educational seminars	50	51	50	0.799
Running groups	43	45	42	0.643
Free health clinics	42	46	39	0.535
Health fairs	41	43	39	0.318
Support groups (i.e., cancer)	27	19	37	0.002
Do you think it is appropriate to hear about health from your pastor?				
Yes	88	90	85	0.29
Which of the following are appropriate ways to hear about health from your pastor?				
In sermons	52	37	72	<0.001
Through Bible studies	48	31	68	<0.001
In small group workshops	59	51	69	0.007
In large seminars	45	31	62	<0.001
Privately, one-on-one	44	31	59	<0.001
Willingness to volunteer to help promote health in your church				
Yes	62	72	50	0.001
Depends on the program	31	25	39	
No	7	3	11	

Two sample t-tests for continuous variables and Chi2 and Fisher Exact tests for categorical variables

(53%) agreed that one must set things right with God in order to get well from his or her illness. However, only 10% agreed to the statement that sickness is a result of having done something wrong in the sight of God and only 12% agreed to the statement that sickness is a result of something not being right between God and the patient. The two language groups differed significantly in their view on the role God plays in illness and health. A slightly higher proportion of Korean language participants (17% versus 5%) responded affirmatively to the question "If someone gets sick, do you think this is because something is not right between that person and God?" A much higher proportion of Korean language participants (78% versus 20%) responded affirmatively to the question "Do you believe that one must set things right with God in order to get well from his or her illness?"

Health program interests and preferences

Table 3 reports preferences on health promotion programs. A very high proportion (88%) stated that church is an appropriate place to discuss health related topics. A majority (80%) indicated that they would like to receive health information at churches. They conveyed interest in a wide variety of health topics. A significantly larger proportion of Korean language participants than English language participants expressed interest in nutrition, family peace, mental health, physical activity, healthy aging, blood pressure, and diabetes. The younger and English language participants expressed more interest in eating disorders than the older and Korean language participants.

The two language groups were also open to a wide range of program formats including large and small group seminars, activity groups such as running and cooking classes, health fairs, free health clinics, and social support groups. Among these formats, the least favored was support groups. Fewer of the Korean language participants favored support groups than the English

Table 4. Facilitators and Barriers to Participation in Health Events/Research at Church

Facilitators of participation	Barriers to participation
Program level	
· Choose topics that are relevant to church members	· Bad timing of the event
· Train church leaders to promote health	· Length of the program
· Develop a relationship with the church	· Message is too scary
· Develop the program together with the church	· Inaccessible location
· Find ways to connect health and religion	· Wrong choice of program leader
· Focus on topics that are practical to the audience	· Uninteresting topic
· Have it in place of a sermon	
· Hold the event at a strategic location	
· Invite good instructors as program leaders	
· Invite health experts	
· Make everything free	
· Minimize participant burden	
· Use language appropriate materials	
· Use large gatherings like a camp meeting	
· Use personal testimonies	
· Use scare tactic	
· Use social networks	
Individual level	
· Announce in church publications or website	· Apathy or indifference
· Attend church	· Embarrassment about admitting illness to other church members
· Train church leaders to promote health	· Fear of breach of confidentiality
· Develop a relationship with the church	· Fear of judgment from church members by admitting one's illness
· Obtain Pastor buy-in	· Fear of losing reputation by utilizing free services
· Offer service (i.e., free blood pressure screenings)	· Fear of financial burden
· Offer food	· Lack of access
· Offer money or prizes	· Lack of awareness
· Pass out flyers or brochures	· Lack of child care
· Preach about importance of the program	· Lack of time
· Raffle	· Lack of transportation
· Recruit from church functions	· Laziness
· Send phone reminders	· Misconception about their own health
· Spread the word through small groups (i.e., Bible study groups, Mom's groups)	· Prior bad experience
· Use e-mail announcements	· Shyness
· Use mass media	
· Use social networks	
· Word of mouth	

language participants (19% versus 37%). Almost all (93%) expressed willingness to volunteer in projects that promote health at their churches.

A very high proportion of the participants (88%) agreed that it is appropriate to hear about health from their pastors. They consented to hearing about health from their pastors in various formats including: sermons, bible studies, small and large group workshops, and private one-to-one consultations. Overall, larger proportions of English language participants selected each of the formats than the Korean language participants.

Table 4 reports results of free response items on strategies to help promote health interventions and increase participation. We categorized these concepts into four broad areas: barriers and facilitators to participation at the individual and program levels.

Discussion

This survey captured a special group of Korean American SDA church attendees comprised of regular churchgoers, many holding leadership positions, involved in a variety of helping activities at their home churches. As a group, they are more assimilated and affluent than the Korean American population as a whole, among whom almost half (48.9% aged five years and over) do not speak English well, and about a third (32% of adults aged 18 and over) lack health insurance (Bureau of U.S. Census). Their ability to take time off work to attend a week-long spiritual retreat suggests that they have relative control over their work schedule and financial situation and that they place importance on their religious life.

In spite of their relative affluence, the group expressed strong desire for low-cost services like health fairs and free health clinics. It is possible that even those with greater means in this community are experiencing barriers to healthcare and health information. Alternatively, the interest in these types of low-cost health-promotion may be due to a large number of low-income and uninsured parishioners in their home churches. These leaders are likely responding with consideration to and on behalf of their co-parishioners. Hence, although they themselves may not require focused public health outreach efforts, they may have the potential to serve as "champions" of health promotion in their home churches and surrounding communities.

Most of the survey participants seem to believe that physical, mental, and spiritual health are closely interconnected. A significant proportion assented to the notion that one must set things right with God in order to

get well from illness, implying a belief that God may play a significant role in the healing process. However, only a few agreed to the notion that illness is a result of sin or a punishment from God, contradicting the commonly reported findings in the literature (Klonoff and Landrine 1994) as well as sentiments expressed by several church leaders in the interviews and focus groups of our prior qualitative work (Jo et al., 2010). Although definitive conclusions based on this survey about the prevailing beliefs linking sin and illness would be premature, we can venture at least three guesses about this apparent contradiction. First possibility is the dissonance between individual and normative beliefs. Although a majority of church members may not individually believe in the direct causality between wrongdoing and illness themselves, they may be under the impression that this is a common doctrinal belief among their fellow believers.

Second possibility, the items as written in our questionnaire may not have adequately teased out their beliefs on the relationship between wrongdoing and illness. Certain illnesses such as lung cancer and liver diseases are well known in this community to be related to specific activities such as smoking and drinking. Indeed, one of the denomination's core doctrinal teachings is to abstain from substances and treat the body as a temple of God (White, 1905). Hence, questions posed as "Can a person get ill as a result of certain wrong-doings such as smoking?" and "Does God inflict illness as a punishment for certain wrong-doings such as smoking?" may have yielded different results.

Third, this apparent contradiction may not be a reflection of the underlying values and disposition to health in the community as a whole rather than a narrow interpretation of religious doctrines in their perceptions of health. In other words, a church member's overall health beliefs and behavior may not be dictated directly or solely by their religious doctrines, but rather shaped by the values of the community and culture as a whole. Hence, while religious and spiritual tailoring may increase acceptability of the interventions to this community, incorporating religious doctrines into the interventions may not be as crucial to influencing their behavior.

English versus Korean language participants: There are noteworthy differences between the two language groups. Those who completed English questionnaires were younger, more assimilated, and reported more frequent use of technology (e.g., computer and e-mail). Those who completed Korean questionnaires were older and converted to SDA more recently, based on the proportion of lifetime spent in the Christian faith. Older age is perhaps a likely explanation for the higher reported health insurance coverage (i.e., Medicare) in the Korean language group.

Religious beliefs, practices, and preferences of the two language groups differed in certain areas. Overall, the Korean language group seemed more religiously and spiritually inclined in their reasons for attending church. A disproportionately larger group of Korean language participants agreed that one must set things right with God in order to get well from his or her illness (78% versus 20%). The younger English language participants were more likely to choose non-religious benefits of attending church than the older Korean speaking counterparts. Nevertheless, greater proportions of English language participants selected options to hear about health from their pastors through more traditional forms of evangelism such as sermons and Bible studies. Though seemingly contradictory, this most likely represents the younger group's openness to non-traditional roles of faith figures rather than a disposition toward health messages embedded in sermons and bible studies.

With respect to intervention planning, paying attention to religious and spiritual details and respecting religious boundaries may be more important to those who are older Korean-speaking church members. On the other hand, interventions involving technology such as internet and e-mails may reach a greater number of younger English-speaking groups.

In conclusion, we have found in this survey that retreat participants were interested in health and health promotion. They were receptive to collaborative health programs that may be beneficial to them and to others around them. In this paper, we have outlined and discussed these participants' socio-demographic and religious characteristics as well as their preferences that may be important to intervention planning and implementation.

We often think of community-based participatory research as partnering with community establishments that have on-going physical presence in local communities (e.g., clinics, churches, schools, and other non-profit organizations). This group of retreat participants is distinct from such entities in that they come from a wider geographic area and gather episodically. They are leaders of their home churches and are already involved in various types of helping activities. They are a special group of people who can potentially serve as "agents of influence" for health promotion in their respective communities, and hence represent an innovative community partner.

Finally, although all of the survey participants were Korean Americans from one Christian denomination, our results indicate that the two language groups do not share all of the same values and interests. While the differences may be due partly to age difference, our results indicate that even within the same ethnic population, it may be a mistake to implement identical programs that vary by language only.

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