SOCIAL WORK IN PUBLIC HEALTH
2018, VOL. 33, NO. 1, 31–42
https://doi.org/10.1080/19371918.2017.1391149

Association between Social Capital and Self-Efficacy among Latinas in Nebraska

Athena K. Ramos, Dejun Su, Antonia Correa, and Natalia Trinidad

Center for Reducing Health Disparities, College of Public Health, University of Nebraska Medical Center, Omaha, Nebraska, USA

ABSTRACT

Ensuring the health and well-being of Latinas is critical given the size of the population and its rapid growth across the United States. Social capital may be a tool for alleviating some of the individual, neighborhood, and societal challenges that Latina immigrants face. This study uses bivariate tests and multivariate regression to assess the association between social capital and self-efficacy among Latina immigrants in the Midwest (N = 94). Self-efficacy was positively correlated with bonding and bridging social capital. Findings from a multiple regression model indicate that bonding and bridging social capital are significantly associated with self-efficacy after adjusting for the effect of related covariates. Public health interventions may benefit from building and fostering bonding and bridging social capital among immigrants as way to improve self-efficacy, promote health, and enhance public health practice.

KEYWORDS

Social capital; community development; immigrant social networks; Latinas; public health practice

There are more than 56 million Latinos in the United States, representing the largest minority group in the country (U.S. Census Bureau, 2016), and by 2060 Latinos will represent nearly 30% of the total U.S. population (Colby & Ortman, 2015). In most states, Latinos are the largest immigrant group (Krogstad, 2016), and nearly 60% of Hispanic immigrant women in the United States are from Mexico (Gonzales, 2008). The Hispanic/Latino population is growing throughout the country, but particularly in "new settlement" areas such as the Midwest (Ramos, 2016). Already, there are more than 204,000 Latinos in the State of Nebraska, comprising 10.7% of the total population of the state (U.S. Census Bureau, 2016). Of that, 34,490 are immigrant Latinas including 22,129 female immigrants from Mexico (U.S. Census Bureau, 2017).

Latinas have unique health and social needs. For example, Hispanic immigrant women often have less formal education than non-Hispanic women, and nearly one half have not completed a high school education. More than 70% are limited English proficient, speaking English less than very well (Gonzales, 2008). Almost 60% of immigrant Latinas are employed (American Immigration Council, 2017), often working in blue or pink collar jobs such as hospitality, cleaning, food preparation, personal care, or in other service-related jobs; however, they earn less money than non-Latina women (American Immigration Council, 2017; Gonzales, 2008; U.S. Department of Labor, 2017).

Unfortunately, Latinas often lack access to healthcare and health information, have lower levels of health insurance coverage, and may be geographically, culturally, and linguistically isolated from the healthcare sector (Ortega, Rodriguez, & Vargas Bustamante, 2015; Ramos, Jurkowski, Gonzalez, & Lawerence, 2010). Almost one third of Latina patients at community health centers in Nebraska had low levels of health literacy (De Alba, Britigan, Lyden, & Johansson, 2016). Latinas also face discrimination, isolation, and social exclusion in communities (Stacciarini, Smith, Wilson Garvan,

CONTACT Athena K. Ramos aramos@unmc.edu Center for Reducing Health Disparities, College of Public Health, University of Nebraska Medical Center, Omaha, Nebraska, 68198-4340, USA.

Wiens, & Cottler, 2015; Thomas, Chiarelli-Helminiak, Ferraj, & Barrette, 2016; Valdivia et al., 2008), particularly if they do not speak English or are undocumented.

Latinas may hold unique cultural health beliefs, which may affect their perception of disease etiologies, health behaviors, and ultimately health outcomes (Ramos, Correa, & Trinidad, 2016). Although clear health disparities have been documented in the literature, most behavior change theories have only been tested among White, middle-class norms (Arellano-Morales, Elder, Sosa, Baquero, & Alcántara, 2016). Previous studies have noted the importance of considering both gender and language in health promotion and community development interventions (Mansyur, Rustveld, Nash, & Jibaja-Weiss, 2016; Ramos, Correa, et al., 2016; Ramos, Trinidad, Correa, & Rivera, 2016; Soysa & Wilcomb, 2013; Yuasa et al., 2015), but few have specifically been tailored to Latinas.

For recent and undocumented immigrant women, social networks may play an especially important role in health—sharing important information, influencing health behaviors, and providing acess to services and resources (Concha, Sanchez, De La Rosa, & Villar, 2013; Fanning Madden, 2015; Starlard-Davenport et al., 2016; Thomas et al., 2016; Valdivia et al., 2008). Understanding these intricate social relationships may lead to improved overall health and well-being of immigrant and minority communities.

Social capital

Social capital, the connections between individuals, organizations, and communities characterized by the ideals of *confianza* (trust), reciprocity, and social cohesion, may directly affect individual well-being through its effects on health, social support, family welfare, and access to information and resources (Besser & Miller, 2013; Fanning Madden, 2015; Fitts & McClure, 2015; Fruechte, 2007; Matsaganis & Wilkin, 2014; Putnam, 2000). Two primary types of social capital have been conceptualized in the literature: (a) bonding social capital (strong ties between close-knit individuals) and (b) bridging social capital (weak ties between acquaintances) (Besser & Miller, 2013; Kim, Lim, & Park, 2015; Putnam, 2000).

Bonding social capital is particularly evident given the central role of the family within Latino cultures (Arellano-Morales et al., 2016). For Latinas, the concept of family is not just a nuclear family but instead encompasses the extended family, the *compadres* (godparent relationships with other families), and close neighbors. These close-knit relationships highlight the important emphasis placed on relationships with people (*personalismo*), which is prevalent in Latino cultures (Isasi-Díaz, 1996). It is through these relationships that social capital may provide access to tangible and intangible supports such as emotional support (advice, support, or friendship) or instrumental support (material assistance, information, and new social contacts) (Grootaert & Van Bastelaer, 2001). Research has documented that many individual, neighborhood, and community disadvantages can be offset, in part, by the social cohesion and social capital found in Latino communities (Alegria, Sribeny, & Mulvaney-Day, 2007; Dominguez & Arford, 2010; Fanning Madden, 2015; Fitts & McClure, 2015; Garza, Glenn, Mistry, Ponce, & Zimmerman, 2016; Molina et al., 2016; Ostir, Eschbach, Markides, & Goodwin, 2003; Torres, Erwin, Trevino, & Jandorf, 2013). Social capital may play a protective role, especially among female Mexican immigrants, mediating the relationship between acculturation and negative health outcomes (Archuleta & Teasley, 2013; Valencia-Garcia, Simoni, Alegría, & Takeuchi, 2012).

Furthermore, social capital may promote confidence and facilitate the development of skills as well as play a critical role in engaging individuals in collective action to improve communities (Dominguez & Arford, 2010; Starlard-Davenport et al., 2016; Thomas et al., 2016). According to a recent study, people with higher levels of bonding social capital also reported higher collective efficacy (Collins, Watling Neal, & Neal, 2014). Using social capital to motivate collective action has been linked to positive health-related outcomes (Burke et al., 2009; Carrillo Álvarez & Riera Romani, 2017; Kim et al., 2015; Matsaganis & Wilkin, 2014; Starlard-Davenport et al., 2016; Yuasa et al., 2015).

Self-Efficacy

Self-efficacy is defined as a belief and confidence in one's capacity to perform specific tasks (Bandura, 1994), and it is "widely used as a cognitive variable to assess human capital" (Yuasa et al., 2015, p.2). Self-efficacy influences how people feel and behave including their health, self-management of conditions, and satisfaction with healthcare encounters (Chen et al., 2013; Fry-Bowers, Maliski, Lewis, Macabasco-O'Connell, & DiMatteo, 2014). Self-efficacy has been studied as a general concept as well as within specific situations such as in identifying the need for mental health treatment (Arellano-Morales et al., 2016). It has been linked to mental health outcomes, various health-seeking and help-seeking behaviors, and well-being (Delara, 2016; Fry-Bowers et al., 2014; Soysa & Wilcomb, 2013; Yuasa et al., 2015).

Generally, self-efficacy can be enhanced through mastery of an activity or situation, seeing others be successful in similar situations (modeling), social persuasion, and reducing stressful reactions to particular situations (Bandura, 1994). Among Latinas, self-efficacy is often associated with strong family or other forms of social support (Mansyur et al., 2016). Engagement with professionals such as healthcare providers or health educators as well as participation in community development and health-related programming has been linked to higher self-efficacy (Chen et al., 2013; Yuasa et al., 2015); moreover, enhancing self-efficacy is associated with improved health outcomes (Burke et al., 2009; Fry-Bowers et al., 2014).

Purpose

This cross-sectional study was designed to explore social capital, community connectedness, and self-efficacy among Latinas who had participated in the Latinas, Tabaco, y Cáncer (LTC) group, an ongoing community-based holistic health promotion program designed for Spanish speaking immigrant women that focuses on enhancing social capital. This study responds to calls within the literature for gender-specific (Burke et al., 2009; Ramos et al., 2010) and immigrant-specific (Valencia-Garcia et al., 2012) research on self-efficacy and social capital. Therefore, the purpose of this analysis is to assess the association between LTC members' bonding social capital, bridging social capital, and self-efficacy while controlling for covariates such as age, marital status, education, employment, homeownership, and English-language proficiency. We hypothesized that bonding and bridging social capital would significantly predict self-efficacy.

Method

Participants

To participate in the study, participants had to be at least age 19 years and be a member of the Latinas, Tabaco, y Cáncer group. This group strives to (a) increase personal and family healthy decision-making, (b) increase community capacity for positive social change, and (c) increase overall well-being by promoting healthy lifestyles as individual women, wives, mothers, and engaged community members. The group is structured to meet every other month for a 3-hour large group meeting, and approximately 30 to 50 women attend each meeting. Trusted bilingual and bicultural women lead the group meetings using an interactive approach that addresses the cultural, spiritual, physical, social, and emotional components of health promotion. During these large group meetings, participants are provided with information on particular health issues such as the importance of tobacco-free policies, breast cancer screening, or risk factors for heart disease. The four standard components of these large group meetings include (a) an educational presentation on a specific health topic (1 hour), (b) lunch and conversation (1 hour), (c) community resources and partner presentations (30 minutes), and (d) project planning time (30 minutes). There is ample time for *convivencia* (networking and dialogue with other women), and childcare and food are always provided free to participants. In addition to the bimonthly meetings, members have the opportunity to participate in community events such as parades and health fairs, *promotora* (community health

Table 1. Demographic Characteristics of Participants

Characteristic	*n* (%)	*M* (*SD*)
Age (Years)		43.6 (12.4)
19–40	45 (50.0)	
41–64	38 (42.2)	
Older than 65	7 (7.8)	
Immigrant status		
Immigrant	88 (96.7)	
Nonimmigrant	3 (3.3)	
Latino subgroup		
Mexican	77 (81.9)	
Central American	9 (9.5)	
Puerto Rican	4 (4.3)	
Other	4 (4.3)	
English proficiency		
None/not at all (Limited English Proficient)	64 (70.3)	
Well/very well	27 (29.7)	
Relationship status		
Married	58 (61.7)	
Not married	36 (38.3)	
Educational attainment		
No formal schooling	5 (5.6)	
Elementary (Grades 1–8)	27 (30.3)	
Some high school	14 (15.7)	
High school graduate/Graduate Equivalency Diploma	21 (23.6)	
Some college/technical training	10 (11.2)	
College graduate	12 (13.4)	
Employment status		
employed	30 (34.1)	
Unemployed	11 (12.5)	
Homemaker	45 (51.1)	
Student	2 (2.3)	
Annual household income		
Less than $10,000	22 (29.3)	
$10,000–$19,999	20 (26.7)	
$20,000–$35,000	27 (36.0)	
More than $35,000	6 (8.0)	
Number of children		2.0 (1.5)
Housing status		
Own home	35 (37.6)	
Rent	50 (53.8)	
Other arrangement	8 (8.6)	

worker) trainings, and other culturally relevant health promotion activities. Members are also encouraged to connect with each other outside of structured group activities.

Being a member of LTC was defined by having attended at least one regular meeting ($N = 254$), and an active member was defined as participating in an LTC meeting within the last year ($N = 131$). A total of 94 women (49 active members and 45 inactive members) completed the survey for a response rate of 37% among all members. The response rate may seem low; however, the participation in the group is voluntary and the survey included all members including those who had not been active in the last few years. As highlighted in Table 1, a majority of respondents were immigrants (96.7%), of Mexican heritage (81.9%), had less than a high school diploma or its equivalent (51.7%), spoke primarily Spanish in the home (76.9%), had a low level of acculturation (70.3%), and had at least one child (84.0%). The mean age of respondents was 43.6 years, $SD = 12.4$.

Data collection

The survey was pilot tested with eight LTC members prior to implementation with the full group, and no changes to the questionnaire were necessary. All LTC members were initially mailed a letter

explaining the study and requesting their participation at the June 2013 meeting. A member of the research team described the research study, obtained informed consent, and administered the survey to members present at that meeting. The LTC survey included measures encompassing six general areas: (a) current health status; (b) tobacco behaviors and knowledge; (c) readiness, motivation, and self-efficacy; (d) sense of community, community connectedness, and social support; (e) program and process improvements; and (b) demographics. Research team members assisted participants who needed help to complete the survey by reading the questions and recording the responses accordingly. Forty-two women participated in this meeting, and a total of 31 questionnaires were completed. Some women elected not to participate due to time constraints related to family care responsibilities.

Those members who were unable to participate during the meeting were called and sent a follow-up mailing with the survey notice, narrative consent, and a copy of the survey to complete and return by postage-paid mail to the research team or at an upcoming LTC meeting. An additional 31 participants completed the survey by mail, and the remaining 24 surveys were completed during group meetings as participants were present and willing to participate.

The study was approved by the University of Nebraska Medical Center Institutional Review Board and was conducted between June 2013 and April 2015. The survey took approximately 30 minutes to complete and was available in English and Spanish; however, only one person completed the survey in English. All participants who completed the survey received a $5 gift card to a local grocery store in recognition for their time.

Measures

Next, measures of social capital, self-efficacy, and covariates that were used in the study are described.

Social capital

Bonding and bridging social capital were assessed. First, a composite measure of bonding social capital (relationships with other group members) was adapted from the Connectedness to the LGBT Community Scale (7 items), which had good internal consistency, $\alpha = .78$ (Frost & Meyer, 2012). The current measure was based on five statements with which participants could either disagree (0) or agree (1). Items included (a) I feel a bond with others in LTC, (b) I really feel that any problems faced by other LTC participants are also my own problems, (c) I can get what I need from LTC, (d) Participating in LTC is a positive thing for me, and (e) I am proud of the LTC group and its members. Because this measure had not been used previously with Latinos, the measure was translated into Spanish by a native Spanish speaker who was trained in health research translation and reviewed by another trained translator to ensure accurate translation. A total score was derived by summing the positive responses on the items, $M = 4.60$, $SD = .81$, and adequate reliability was found in this sample, $\alpha = .66$. *High bonding social capital* was defined as scores falling at or above the mean. To ensure that the bonding social capital measure was adequate, a bivariate correlation was conducted between bonding social capital and a group engagement scale. Bonding social capital was significantly positively correlated with group engagement, $r = .45$, $p = .01$.

Bridging social capital was measured using 10 items adapted from element 4D.4 of the World Bank's Social Capital Assessment Tool, Household Survey (Krishna & Shrader, 1999). This measure has been used in other research with Hispanic immigrants in the Midwest (Ramos, Carvajal, Leon, & Trinidad, 2017). Respondents were asked whether they had engaged in any of the following activities over the last year: actively participated in an association, made contact with an influential person, made the media interested in a problem, participated in an information or election campaign, talked with other people about a problem, contacted an elected official, made a monetary or in-kind donation, notified the police or court about a problem, or volunteered for a community or charitable organization. Response options were dichotomous, no (0) and yes (1), and a total score was derived

by summing the positive responses, $M = 3.10$, $SD = 2.73$. Participants were classified as having high bridging social capital if they responded positively to at least three of the 10 questions based on a median split. Good internal consistency for the bridging social capital measure was found in this sample, $\alpha = .85$. To ensure convergent validity, a bivariate correlation between the bridging social capital scale and a measure of collective efficacy was conducted and found to be significantly positively correlated, $r = .23$, $p = .05$.

Self-efficacy

Self-efficacy was measured by the General Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995), a validated scale that has been used in practice and research with Latinos (Yuasa et al., 2015). This scale includes 10 items to assess optimistic self-beliefs and ability to cope with a variety of difficult life demands. Sample items included, "I can usually handle whatever comes my way" and "I am confident that I could deal efficiently with unexpected events." Response options ranged from 1 (*not at all true*) to 4 (*exactly true*). Scores for each item were summed, and total scores could range between 10 and 40, $M = 30.05$, $SD = 5.99$. High internal consistency was found for the GSE in this sample, $\alpha = .93$.

Covariates

Age, marital status, education, employment, homeownership, and English-language proficiency were used as covariates. Age was a continuous variable. Marital status was dichotomized into married (1) or not married (0). Education level was assessed by a single question, "What is the highest grade or year of school you completed?" There were six categorical response options 1 (*never attended school*), 2 (*elementary [Grades 1–8]*), 3 (*some high school [Grades 9–11]*), 4 (h*igh school graduate/Graduate Equivalency Diploma [GED]*), 5 (*some college or technical training*), and 6 (*college graduate or higher*). Employment and homeownership were respectively dichotomized into employed for wages or not and homeowner or not. English language proficiency was assessed using a single question, "How well do you speak English?" Response options included 0 (*not at all*), 1 (*not very well*), 2 (*well*), and 3 (*very well*). English language proficiency was used as a measure of acculturation. As such, a binary variable was created, and those that spoke English well or very well were considered to have high acculturation (1) and those who did not speak English at all or did not speak English well were considered to have low acculturation (0).

Analysis

SPSS version 23 was used to analyze all of the data. First, basic descriptive statistics were calculated, and appropriate data transformations were made. Then, reliability analyses were conducted on the bonding social capital, bridging social capital, and general self-efficacy scales. Composite scaled variables were created and centered. Next, bivariate analyses were conducted, and Pearson's correlations were used to assess the strength of the relationships between bonding social capital, bridging social capital, and self-efficacy. Lastly, a multivariate regression model was used to examine the influence of bonding social capital and bridging social capital on self-efficacy while controlling for age, marital status, education, employment, homeownership, and English-language proficiency.

Results

More than 70% of participants had high bonding social capital, and 38.6% of participants had high bridging social capital. Correlations were conducted to assess the strength of the relationships between the study variables. Self-efficacy was significantly positively correlated with both bonding social capital, $r = .40$, $p < .01$, and bridging social capital, $r = .25$, $p < .05$ (Table 2).

Table 2. Correlations between Bonding Social Capital, Bridging Social Capital, and Self-Efficacy

	Bonding Social Capital	Bridging Social Capital	Self-Efficacy
Bonding social capital	1.00		
Bridging social capital	0.06	1.00	
Self-Efficacy	0.4**	0.25*	1.00

*$p < .05$. **$p < .01$.

Table 3. Multivariate Regression Model Predicting Self-Efficacy

	b	*SE*	β
Bonding social capital	2.82	0.81	0.37***
Bridging social capital	0.48	0.23	0.23*
Age	0.00	0.05	0.01
Married	2.35	1.38	0.20
Homeowner	1.12	1.34	0.10
Education	0.70	0.46	0.18
Employed	3.85	1.65	0.28*
Limited English Proficient	−0.98	1.64	−0.08
(Constant)	23.83	3.82	
	$F = 5.14$***		
	$R^2 = .43$		

*$p < .05$. ***$p < .001$.

Multivariate regression analysis was conducted to further examine the relationships between bonding social capital, bridging social capital, and self-efficacy (Table 3). The overall regression model for self-efficacy was significant, $F(8, 55) = 5.14$, $p < .001$. The model accounted for 42.8% of the variance in self-efficacy. Both bonding and bridging social capital were significantly associated with self-efficacy. Being employed was also a significant predictor of self-efficacy.

Discussion

The purpose of this article was to investigate the relationship between social capital and self-efficacy among members of a Latina immigrant women's health promotion group in the Midwest. These results indicated that both bonding and bridging social capital were significantly associated with self-efficacy. In fact, nearly 43% of the difference in self-efficacy was due to differences in bonding and bridging social capital. This is consistent with previous studies observing a similar relationship between social capital and self-efficacy (May et al., 2015; Yuasa et al., 2015).

Nurturing self-efficacy among immigrant Latinas is important. Often times, when immigrants come to a new country they face a downward trend in social mobility—losing the social status that they had in their home country, decreasing their confidence in their skills and abilities, and losing a sense of belonging (Burke et al., 2009). This downward trend in social mobility may increase the risk for a wide variety of physical and mental health concerns including high levels of stress (Alcántara, Chen, & Alegría, 2014; Concha et al., 2013). Being employed or participating in community groups may aid immigrants in developing stronger bonding and bridging social capital (Collins et al., 2014) by allowing for opportunities to develop new friendships, be engaged in meaningful activities, support their families (financially and emotionally), and be exposed to new resources, information, and ideas. This in turn may also assist in maintaining some sense of social status, a feeling of belonging, and ultimately serve to rebuild their self-efficacy. Strong self-efficacy and social capital can help immigrants to regain that status that they once had and eventually grow their social mobility. Without efforts that address the social context of individuals' lives, community health promotion programs will continue to face serious challenges in proving effectiveness and furthering community capacity.

Research has shown that immigrant communities have traditionally been marginalized and disenfranchised, and in some cases, this has led to personally mediated and internalized racism (Jones, 2000). Members of immigrant communities may not feel like they can improve their individual conditions or those of their community, resulting in a sort of collective fatalism. Community-based programs should focus on building social capital among immigrant Latina participants thereby creating a network of positivity, social solidarity, and confidence. This network may further activate a wider social system that can improve not only self-efficacy, but also collective efficacy. Molina et al. (2016) suggested that being active and volunteering, such as our measure of bridging social capital, may improve not only the health of the individual, but also the health of the extended social network including family and friends that surround the individual.

Traditionally, immigrant communities have had less access to accurate, reliable, culturally, and linguistically appropriate information. Oftentimes because formal channels for health or other types of information may be unknown or nonexistent, immigrants obtain information through their social network and typically through the close relationships with family and friends (bonding social capital). Understanding how these social networks operate within a community can strengthen community outreach and engagement efforts; however, more community resources are needed to ensure equitable access to information and culturally specific programming.

Community-based interventions should be tailored to Latinas and should consider language and literacy (in English, Spanish, or other indigenous languages), educational level, culture, and other structural factors (e.g., scheduling, transportation, and childcare) when developing such programs (Arellano-Morales et al., 2016; Ramos et al., 2013). Engaging with potential program participants and incorporating cultural values such as *familismo* (family involvement), *personalismo* (warm, friendly relationships), and *confianza* (trust) in designing social capital-based interventions may help ensure that these programs are relevant, meaningful, and efficacious with Latinas. Perhaps, there is also an opportunity to use *promotoras* (community health workers) as coaches to build self-confidence and share resources with Latina immigrants.

Clearly, successful community-based interventions empower participants to change behaviors and to take action—anything from changing one's diet, to participating in a community event, or even talking with a legislator. Accounting for these actions is imperative to proving the impact of health promotion programs and successfully changing community norms. A simple social capital assessment could be incorporated into a program's design and be used later as an outcome evaluation measure for community-based programs (Grootaert & Van Bastelaer, 2001). Because the concept of social capital is ever changing, efforts to better define, measure, and track social capital could lead to valuable insights that may assist in designing and implementing effective public health interventions and more relevant health behavior theories.

Limitations

The current study was limited in that it relies on self-reported, cross-sectional data from a small sample of female participants, which limits our capacity to infer about causality. All participants since the inception of the program in 2005 were invited to participate, rather than solely those who have been active within a more recent timeframe which may have affected the responses and the response rate. LTC participants may not be representative of all immigrant Latinas or even those in Nebraska. Women may differ greatly from their male counterparts. Our sample was drawn from a women's group in an urban midwestern city, which may represent a different context than that of urban centers in other areas of the country or that of rural communities. This study did not ask about length of time a participant had been in the United States And, therefore, we are unable to discuss differences between recent immigrants and long-term immigrant residents. Finally, the measures of social capital that were used do not fully address the diverse connotations of the concept of social capital within the literature.

Conclusion

Ensuring the physical, mental, and social health and well-being of the Latina population is significant for the health and well-being of the state and the nation. Building and enhancing social capital fosters self-efficacy and connects individuals to other people, organizations, resources, and opportunities to become meaningfully engaged. The present study found that bonding and bridging social capital significantly predicted self-efficacy. The study extends current knowledge on the relationship between social capital and self-efficacy among Latina immigrants in the Midwest, and it may help to refine public health programs. Social capital can be an asset for health promotion among immigrant populations and other underserved communities. Interventions that strengthen and support protective social factors can lead to improved health outcomes and enhanced quality of life among immigrant community members by building self-efficacy, providing culturally and linguistically appropriate information, fostering connections to community resources, and teaching and modeling tangible transferable skills. However, more must be done to build social and economic power within immigrant communities. The true solution to eliminating health disparities and achieving health equity lays in building community capacity and power over the long term.

Because social capital and self-efficacy are culturally mediated, more culturally specific research is necessary. This would allow for a better understanding of the underlying meaning and conceptualization of these constructs among Latina immigrants within the United States. Additionally, future research should incorporate objective measures of social capital as well as longitudinal designs to assess causality and the impact of social capital on physical and mental well-being among Latina immigrants. Individual and community levers for enhancing social capital among immigrants (e.g., transnational ties or sense of community) should also be explored. Finally, more public health interventions may consider incorporating social capital, rather than solely disease-specific, individual-focused education, to foster self-efficacy and empowerment of participants. These interventions should be documented and evalutated to advance culturally-relevant public health practice.

Funding

This project is supported in part by Region 6 Behavioral Healthcare through funding provided by Nebraska Department of Health and Human Services/Tobacco Free Nebraska Program as a result of the Tobacco Master Settlement Agreement.

Acknowledgments

Thanks to all of the women who participated in this study and continue to participate in the Latinas, Tabaco, y Cáncer group. The authors wish to express their appreciation to Stacey Coleman and Matt Flege for their time in reviewing this article.

References

Alcántara, C., Chen, C.-N., & Alegría, M. (2014). Do post-migration perceptions of social mobility matter for Latino immigrant health? *Social Science & Medicine*, *101*, 94–106. doi:10.1016/j.socscimed.2013.11.024

Alegria, M., Sribney, W., & Mulvaney-Day, N. E. (2007). Social cohesion, social support and health among Latinos in the United States. *Social Science & Medicine*, *64*(2), 477–495. doi:10.1016/j.socscimed.2006.08.030

American Immigration Council. (2017, March 8). *The impact of immigrant women on America's labor force*. Retrieved from https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force

Archuleta, A. J., & Teasley, M. (2013). Acculturative stress among people of Mexican descent: The role of acculturation, social capital, and family role expectations. *Social Work in Mental Health*, *11*(4), 311–333. doi:10.1080/15332985.2013.766297

Arellano-Morales, L., Elder, J. P., Sosa, E. T., Baquero, B., & Alcántara, C. (2016). Health promotion among Latino adults: Conceptual frameworks, relevant pathways, and future directions. *Journal of Latina/O Psychology*, *4*(2), 83–97. doi:10.1037/lat0000051

Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), *Encyclopedia of human behavior* (Vol. 4, pp. 71–81). New York, NY: Academic Press. (Reprinted in H. Friedman [Ed.], Encyclopedia of mental health. San Diego, CA: Academic Press, 1998).

Besser, T. L., & Miller, N. J. (2013). Social capital, local businsses, and amenities in U.S. rural prairie communities. *Journal of Rural Studies*, *32*, 186–195. doi:10.1016/j.jrurstud.2013.06.004

Burke, N. J., Bird, J. A., Clark, M. A., Rakowski, W., Guerra, C., Barker, J. C., & Pasick, R. J. (2009). Social and cultural meanings of self-efficacy. *Health Education & Behavior*, *36*(Suppl 1), 111S–128S. doi:10.1177/1090198109338916

Carrillo Álvarez, E., & Riera Romani, J. (2017). Measuring social capital: Further insights. *Gaceta Sanitaria*, *31*(1), 57–61. doi:10.1016/j.gaceta.2016.09.002

Chen, W., Wantland, D., Reid, P., Corless, I. B., Eller, L. S., Iipinge, S., … Webel, A. R. (2013). Engagement with health care providers affects self-efficacy, self-esteem, medication adherance and quality of life in people living with HIV. *Journal of AIDS Clinical Research*, *4*(11), 256–270.

Colby, S. L., & Ortman, J. M. (2015). *Projections of the size and composition of the U.S. population: 2014 to 2060*. U.S. Census Bureau. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

Collins, C. R., Watling Neal, J., & Neal, Z. P. (2014). Transforming individual civic engagement into community collective efficacy: The role of bonding social capital. *American Journal of Community Psychology*, *54*(3/4), 328–336. doi:10.1007/s10464-014-9675-x

Concha, M., Sanchez, M., De La Rosa, M., & Villar, M. E. (2013). A longitudinal study of social capital and acculturation-related stress among recent Latino immigrants in South Florida. *Hispanic Journal of Behavioral Sciences*, *35*(4), 469–485. doi:10.1177/0739986313499005

De Alba, A., Britigan, D. H., Lyden, E., & Johansson, P. (2016). Assessing health literacy levels of Spanish-speaking Hispanic patients in Spanish at federally qualified health centers (FQHCs) in the Midwest. *Journal of Health Care for the Poor and Underserved*, *27*(4), 1726–1732. doi:10.1353/hpu.2016.0158

Delara, M. (2016). Social determinants of immigrant women's mental health. *Advances in Public Health 2016*, 1–11. doi:10.1155/2016/9730162

Dominguez, S., & Arford, T. (2010). It is all about who you know: Social capital and health in low-income communities. *Health Sociology Review*, *19*(1), 114–129. doi:10.5172/hesr.2010.19.1.114

Fanning Madden, E. (2015). Cultural health capital on the margins: Cultural resources for navigating healthcare in communities with limited access. *Social Science & Medicine*, *133*, 145–152. doi:10.1016/j.socscimed.2015.04.006

Fitts, S., & McClure, G. (2015). Building social capital in hightown: The role of confianza in Latina immigrants' social networks in the new South. *Anthropology & Education Quarterly*, *46*(3), 295–311. doi:10.1111/aeq.12108

Frost, D. M., & Meyer, I. H. (2012). Measuring community connectedness among diverse sexual minority populations. *Journal of Sex Research*, *49*(1), 36–49. doi:10.1080/00224499.2011.565427

Fruechte, K. (2007). *Community capitals: Social capital*. Brookings, SD: South Dakota State University Cooperative Extension Service.

Fry-Bowers, E. K., Maliski, S., Lewis, M. A., Macabasco-O'Connell, A., & DiMatteo, R. (2014). The association of health literacy, social support, self-efficacy, and interpersonal interactions with health care providers in low-income Latina mothers. *Journal of Pediatric Nursing*, *29*, 309–320. doi:10.1016/j.pedn.2014.01.006

Garza, J. R., Glenn, B. A., Mistry, R. S., Ponce, N. A., & Zimmerman, F. J. (2016). Subjective social status and self-reported health among US-born and immigrant Latinos. *Journal of Immigrant and Minority Health*. doi:10.1007/s10903-016-0346-x

Gonzales, F. (2008, May 14). *Hispanic women in the United States, 2007*. Pew Hispanic Center. Retrieved from http://www.pewhispanic.org/2008/05/08/hispanic-women-in-the-united-states-2007/

Grootaert, C., & Van Bastelaer, T. (2001). *Understanding and measuring social capital: A synthesis of findings and recommendations from the Social Capital Initiative* (World Bank, Social Capital Initiative, Working Paper No. 24). Washington, DC: World Bank.

Isasi-Díaz, A. M. (1996). *Mujerista theology: A theology for the twenty-first century*. Maryknoll, NY: Orbis Books.

Jones, C. P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, *90*, 1212–1215. doi:10.2105/AJPH.90.8.1212

Kim, Y., Lim, J. Y., & Park, K. (2015). Effects of health literacy and social capital on health information behavior. *Journal of Health Communication*, *20*, 1084–1094. doi:10.1080/10810730.2015.1018636

Krishna, A., & Shrader, E. (1999, June). *Social capital assessment tool*. Paper presented at the Conference on Social Capital and Poverty Reduction, Washington DC.

Krogstad, J. M. (2016, September 15). *10 facts for National Hispanic Heritage Month*. Pew Hispanic Center. Retrieved from http://www.pewresearch.org/fact-tank/2016/09/15/facts-for-national-hispanic-heritage-month/

Mansyur, C. L., Rustveld, L. O., Nash, S. G., & Jibaja-Weiss, M. L. (2016). Hispanic acculturation and gender differences in support and self-efficacy for managing diabetes. *Diabetes Educator*, *42*, 315–324. doi:10.1177/0145721716640905

Matsaganis, M. D., & Wilkin, H. A. (2014). Communicative social capital and collective efficacy as determinants of access to health-enhancing resources in residential communities. *Journal of Health Communication*, *20*(4), 377–386. doi:10.1080/10810730.2014.927037

May, S. F., Flores, L. Y., Jeanetta, S., Saunders, L., Valdivia, C., Arevalo Avalos, M. R., & Martinez, D. (2015). Latina/o immigrant integration in the rural Midwest: Host community resident and immigrant perspectives. *Journal of Latina/O Psychology*, *3*(1), 23–39. doi:10.1037/lat0000029

Molina, Y., McKell, M. S., Mendoza, N., Barbour, L., Berrios, N. M., Murray, K., & Estwing Ferrans, C. (2016). Health volunteerism and improved cancer health for Latina and African American women and their social networks: Potential mechanisms. *Journal of Cancer Education*. 1–8. doi:10.1007/s13187-016-1061-y.

Ortega, A. N., Rodriguez, H. P., & Vargas Bustamante, A. (2015). Policy dilemmas in Latino health care and implementation of the Affordable Care Act. *Annual Review of Public Health*, *18*(36), 525–544. doi:10.1146/annurev-publhealth-031914-122421

Ostir, G., Eschbach, K., Markides, K., & Goodwin, J. (2003). Neighbourhood composition and depressive symptoms among older Mexican Americans. *Journal of Epidemiology and Community Health*, *57*(12), 987–992. doi:10.1136/jech.57.12.987

Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. New York, NY: Simon and Schuster.

Ramos, A. K. (2016). Welcoming immigrants: An opportunity to strengthen rural communities. *Journal of Extenison*. *54*(3), 1–8. Retrieved from http://www.joe.org/joe/2016june/comm1.php

Ramos, A. K., Carvajal Suarez, B. M., Leon, M., & Trinidad, N. (2017). Sense of community, participation, and life satisfaction among Hispanic immigrants in rural Nebraska. *Kontakt*, 4, 308–320. https://doi.org/10.1016/j.kontakt.2017.09.005

Ramos, A. K., Correa, A., & Trinidad, N. (2016). Perspectives on breast health education and services among recent Hispanic immigrant women in the Midwest: A qualitative study in Lancaster County, Nebraska. *Journal of Cancer Education*, *31*(4), 666–672. doi:10.1007/s13187-015-0886-0

Ramos, A. K., Rajaram, S., Gouveia, L., Duko, Y., Toure, D., Zhang, A., & Manske, S. (2013). *Health profile of Nebraska's' Latino population*. Omaha, NE: University of Nebraska medical Center, College of Public Health and the University of Nebraska at Omaha, Office of Latino and Latin American Studies. Retrieved from http://digitalcommons.unmc.edu/promot_report/2/

Ramos, A. K., Trinidad, N., Correa, A., & Rivera, R. (2016). Partnering for health with Nebraska's Latina immigrant community using design thinking process. *Progress in Community Health Partnerships: Research, Education, and Action*, *10*(2), 311–318. doi:10.1353/cpr.2016.0022

Ramos, B. M., Jurkowski, J., Gonzalez, B. A., & Lawrence, C. (2010). Latina women: Health and healthcare disparities. *Social Work in Public Health*, *25*(3/4), 258–271. doi:10.1080/19371910903240605

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston (Eds.), *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35–37). Windsor, England: NFER-Nelson.

Soysa, C. K., & Wilcomb, C. J. (2013). Mindfulness, self-compassion, self-efficacy, and gender as predictors of depression, anxiety, stress, and well-being. *Mindfulness*, *6*(2), 217–226. doi:10.1007/s12671-013-0247-1

Stacciarini, J. R., Smith, R., Wilson Garvan, C., Wiens, B., & Cottler, L. B. (2015). Rural Latinos' mental wellbeing: A mixed methods pilot study of family, environment and social isolation factors. *Community Mental Health Journal*, *51*(4), 404–413. doi:10.1007/s10597-014-9774-z

Starlard-Davenport, A., Booth, B., Kieber-Emmons, A., Topologlu, U., Hogan, W., & Kieber-Emmons, T. (2016). Shaping social networks to reduce health disparities: The nexus between information dissemination and valid discussion. *Health Systems and Policy Research Journal*, *3*(2), 1–10.

Thomas, R. L., Chiarelli-Helminiak, C. M., Ferraj, B., & Barrette, K. (2016). Building relationships and facilitating immigrant community integration: An evaluation of a cultural navigator program. *Evaluation and Program Planning*, *55*, 77–84. doi:10.1016/j.evalprogplan.2015.11.003

Torres, E., Erwin, D. O., Trevino, M., & Jandorf, L. (2013). Understanding factors influencing Latina women's screening behavior: A qualitative approach. *Health Education Research*, *28*(5), 772–783. doi:10.1093/her/cys106

U.S. Census Bureau. (2016). *State & county quick facts: Nebraska*. Retreived from http://www.census.gov/quickfacts/table/PST045215/00,31.

U.S. Census Bureau. (2017). *Selected characteristics of the foreign-born population by region of birth: Latin America. 2016 American Community Survey 1-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table

U.S. Department of Labor. (2017, May 18). *Foreign-born workers: Labor force characteristics – 2016*. Retrieved from https://www.bls.gov/news.release/pdf/forbrn.pdf

Valdivia, C., Dozi, P., Jeanetta, S., Flores, L. Y., Martinez, D., & Dannerbeck, A. (2008). The impact of networks and the context of reception on asset accumulation strategies of Latino newcomers in new settlement communities of the Midwest. *American Journal of Agricultural Economics*, *90*(5), 1319–1325. doi:10.1111/j.1467-8276.2008.01224.x

Valencia-Garcia, D., Simoni, J. M., Alegría, M., & Takeuchi, D. T. (2012). Social capital, acculturation, mental health, and perceieved access to services among Mexican American women. *Journal of Consulting and Clinical Psychology*, *80*(2), 177–185. doi:10.1037/a0027207

Yuasa, M., Shirayama, Y., Osato, K., Miranda, C., Condore, J., & Siles, R. (2015). Cross-sectional analysis of self-efficacy and social capital in a commuity-based healthy village project in Santa Cruz, Boliva. *BMC International Health & Human Rights*, *15*(15), 1–6. doi:10.1186/s12914-015-0054-y