A qualitative exploration of the community partner experience in a faith-based breast cancer educational intervention

Elisa M. Rodriguez1*, Janice V. Bowie2, Shannon Frattaroli3 and Andrea Gielen4

Abstract

Although community partner engagement is a key component in faith-based health promotion/disease prevention intervention research, the perspective of community partners on their experiences in the intervention process has been infrequently investigated. Semi-structured in-depth interviews were conducted with 12 African-American community partners [i.e. four pastors and eight lay health co-ordinators (LHCs)] from eight churches in greater Baltimore, MD, USA, that engaged in a breast cancer educational intervention that followed a community-based participatory research (CBPR) approach. Audiotaped interviews were transcribed, coded and content analysis was used to identify themes across the codes. Findings show that pastors support a holistic approach to health and that LHCs act as a link between the pastors, participants and academic researchers. In addition, pastors and LHCs emphasized that the religious and/or spiritual program elements should not overpower the importance of reaching participants with critical health information regardless of their religious or spiritual beliefs. Study findings suggest that faith-based educational intervention efforts that follow a CBPR approach are important in promoting cancer awareness in the African-American community. Including community partner assessment can further elucidate critical intervention impacts and helps to address health disparities in underserved communities.

Introduction

Faith-based health promotion/disease prevention interventions implemented in the Black Church are becoming increasingly mainstream research efforts in the field of public health [1, 2]. The influence and use of community-based participatory research (CBPR) principles [3] are highly relevant to faith-based health promotion/disease prevention due to the centrality of partnership engagement required to plan and implement these types of interventions. In addition, the application of CBPR principles facilitates the involvement of key informants (e.g. pastors and lay health workers) in planning and implementing an intervention and conducting research that is culturally sensitive and appropriate in a unique sociocultural environment (i.e. Black Church) [4].

The Black Church as a setting for health promotion programs taps into a central position within African-American communities. The church in the lives of many African-Americans is a source of spiritual and social support, especially for women
Faith-based breast cancer educational intervention

who account for the majority of church members [5]. Black religious institutions have long played an integral role in helping to provide access to community health resources [6]. In addition, black religious institutions have served as an empowering force within many African-American communities with respect to their efforts in political mobilization and social movements [7, 8]. The role of the Black Church in the African-American community extends beyond religious beliefs and practice and has the ability to influence the quality of life for many African-Americans through its involvement in varied and numerous secular activities [9–12].

Can a Faith-Based Participatory Intervention Study Increase Breast Health Care Participation in African American Women? A Randomized Comparison was a faith-based breast cancer educational intervention study that employed a CBPR approach in part by recognizing and applying ‘eight key principles of community-based research’ (see Table I for list of principles and illustrative examples of their application in the faith-based study) [3]. The research was funded by the Susan G. Komen foundation and involved eight African-American churches in the greater Baltimore, MD, USA, region. Each pastor from the participating churches designated a lay health co-ordinator (LHC) to represent their church community and participate in the planning, implementation and follow-up of the intervention programs. Using the theme of the churches’ annual women’s day, each LHC designed and hosted a program at their church. The scope of their programs was determined by random assignment to one of three formats: a ‘standard’ program that included a focus on overall health, a ‘breast health’ care program that focused exclusively on breast health issues and a ‘comprehensive’ care program that addressed all relevant cancer sites. The study was designed to measure the relative impact of these three program formats on participants’ reported screening knowledge, attitudes and behaviors. Results from the baseline survey data collected during the Women’s Health Day programs are presented elsewhere [13].

The purpose of this qualitative inquiry was to obtain critical feedback from the community partners (i.e. pastors and LHCs) who engaged as collaborators on the faith-based study and gain a more complete understanding of the intervention impacts beyond what was measured by the initial study objectives. This study sought to explore the attitudes, beliefs and experiences associated with the health promotion/disease prevention intervention process among community partners in a faith-based breast cancer educational intervention study that followed a CBPR approach.

Methods

Study recruitment

We designed an assessment using qualitative methods because of our interest in better understanding and describing the intervention process as perceived by our community partners. We sent letters to the pastors and LHCs from the eight churches who partnered in the faith-based study inviting them to participate in a process evaluation of the project. We recruited four African-American male pastors (age range = 34–61 years) and eight African-American female LHCs (age range = 40–70 years). In another paper, we discussed the selection factors used by pastors for choosing an LHC from their respective church for study participation [13]. We conducted key informant interviews with the study partners who responded to our invitation letters. The process evaluation interviews were conducted at the end of the 3-year study (i.e. May 2004 to May 2007) during March 2007 through April 2007.

Data collection

We conducted semi-structured, in-depth interviews with the pastors and LHCs who were partners on the faith-based study in order to accomplish our study aims. Semi-structured interviews are an established method for addressing process evaluation questions [3, 14]. We developed two interview guides (one for the pastors and a second for the LHCs) to assist in structuring the interview and to ensure that the interviewer addressed the main topics of interest. Pastors and LHCs served in
different capacities as study partners; therefore, we created separate interview guides for these two groups of key informants. The interview guide for the pastors included discussion of the following topics: reasons for participating, community partner expectations from a cancer educational intervention, requirements for participating in health promotion research, description of the community partner role, the role of the church in the health of the community, dissemination of results, recommendations for future health promotion research efforts implemented in a faith-based setting, church community’s capacity to sustain health promotion programs and role of faith and spirituality in cancer educational interventions.

The guide for the LHCs included discussion of the following topic areas: how did they become involved in the project, description of the LHC role, description of the LHC experience, program feedback received from the intervention participants, dissemination of results, recommendations for future health promotion research efforts implemented in a faith-based setting, church participation in other health programs and role of faith and spirituality in cancer educational interventions.

The interviews with pastors took place at the churches; we conducted most of the LHC interviews at the academic institution (one interview took place in an LHC’s home). The first author, who was also a research assistant on the faith-based intervention study, conducted all the interviews. The interviews were ~1 hour long, and respondents were paid 25 dollars to thank them for their time. The interviewer digitally recorded the interviews.
and took notes. A transcriptionist prepared verbatim transcripts of each interview.

**Data analysis**

We compared the transcribed interviews with the recordings for accuracy and completeness. We began the coding process by hand coding a subset of the interview transcripts. The first author coded two pastor interviews and two LHC interviews and created a coding dictionary based upon the codes developed from this initial review of the data. A second coder read through the transcripts and reviewed the resulting codes to assess the comprehensiveness and consistency of the primary coder’s approach. Based on suggestions from the secondary coder, we revised the coding dictionary and transitioned to an electronic format. Using NVivo 7 (QSR International Pty Ltd), we uploaded all the pastor and LHC interview transcript files and coded the interviews electronically. During this phase, we expanded and refined the initial set of codes to better reflect the common elements that existed across the full data set. This iterative style of analysis is a recognized characteristic of the qualitative research method [15].

An additional phase of coding refinement occurred when we examined all the codes associated with a particular interview guide topic for convergence. This additional refinement served to further clarify our understanding of the coded data and is consistent with the concept of convergence as applied to coding qualitative data [15].

We then used qualitative content analysis [15] to identify themes across the codes. Interview data for the pastors and LHCs were organized as separate data sets. The interview guide question topics were used as a framework for categorizing codes related to the interview guide topics. Categorizing the data in this manner facilitated our ability to manage the data and improved the consistency with which we examined the interview guide topics. We identified patterns inductively by analyzing codes associated with interview guide topics. Response patterns include codes that we applied to more than one key informant interview when discussing a particular interview guide topic. Examination of the response patterns across the data sets ultimately led to the emergence and identification of themes. We report the final results as two sets of dominant themes that we derived from the analysis of the pastor interviews collectively and the LHC interviews collectively. Themes are representative of the major categories or topics that were identified across the response patterns. In addition, the collective results derived from the pastor and LHC interviews were compared in order to identify the presence of cross-cutting discussion topics.

**Results**

The faith-based educational intervention study was a collaboration involving academic researchers and eight Black Churches located throughout the greater Baltimore, MD, USA, region. The partner churches represented a variety of Christian denominations, a range of church sizes and presence of a health committee in the church (Table II). Community study partners included eight pastors and eight LHCs, one pastor and LHC from each of the partnering churches. Of the eight pastors and eight LHCs who participated as research collaborators, we successfully recruited 12 key informants (four pastors and eight LHCs). Four of the initial eight pastors were unable to participate in the process evaluation interview study component. We further

| Table II. Characteristics of Black Churches participating in pastor and LHC interviews (n = 8), 2007 |
|-------------------------------------------------|--------|------|
| Christian denominations                        | %      | n    |
| Baptist                                         | 25     | 2    |
| Methodist                                       | 12.5   | 1    |
| Presbyterian                                    | 12.5   | 1    |
| Pentecostal                                     |        |      |
| Church of God in Christ                         | 37.5   | 3    |
| Apostolic                                       | 12.5   | 1    |
| Church size                                     |        |      |
| Range of active members                         | 75–1300|      |
| Churches with a health committee                | 75     | 6    |
discuss the reasons and/or causes for pastors’ non-participation in the interview study component and the potential implications of this result in our review of the findings. Findings described below are organized according to the major pastor level and LHC level themes that reflect their experiences as study partners. Illustrative comments are included where appropriate.

**Pastor theme: a commitment to holism**

When asked to describe their role, most pastors started the interview with a biblical reference and stated the importance of presenting the ‘Word of God’ to their congregations. In addition, many pastors also described a holistic perspective about the need to nurture the spirit, mind and body. Participating in the study provided a mechanism to practice this holistic approach to pastoring. Pastors expressed their hope that the project would continue to increase awareness and education within their congregations and that the participants would benefit from research findings. There was an urgency and eagerness expressed by the pastors for taking part in health research to inform their communities about improving their health. The expectation that, as partners, they and their congregants would benefit from their participation was clear. Pastors expressed an appreciation and need for the medical science perspective and health professional role in educating the community on topics such as cancer prevention:

If we can learn from this illness or disease then we can provide preventive methods through education. We want to educate the community as well as our church population with the knowledge that we glean from the health professionals … as well as educate ourselves and become more informed so that when we are trying to console or counsel families we can articulate in a way that we can bring a science perspective as well as spiritual and emotional support.

Pastors described their appreciation for the medical science perspective in terms of receiving information and guidance from health care professionals on topics concerning advanced medical technologies and the use of alternative medicines for prevention and treatment.

Spiritual health and physical health are equally important to pastors in creating harmony and wellness among their members. Pastors’ expectations as community partners involved in a cancer prevention project, their requirements for participating in health promotion research and their reasons for participating in the study were topics of discussion which all included an emphasis on the need for a comprehensive and all-inclusive approach to health promotion/disease prevention programs implemented in the church:

I feel that any effort that can inform the constituents or members on how to live better and more productive lives coincides with spiritual direction. When we are informed concerning natural and physical issues it brings harmony with what we are trying to convey spiritually so to enrich to better the congregation any type of information that will better inform them on how to take care of this body is quite welcome.

The church as a source of information about a variety of topics that extend beyond religion was also reinforced by pastors when they discussed the church’s role in community health. The notion of offering information, and access to resources for the benefit of the community, was a priority to all the pastors we interviewed. For our interviewees, community health was a priority with ongoing efforts in each of their congregations. The church was characterized by pastors as a ‘focal point of the community’ and as a ‘clearinghouse of information’ where church and community members could learn about and gain access to needed resources in addition to spiritual guidance. Pastors welcomed the opportunity to partner in community health research and described the health of the community as both a priority and shared responsibility with respect to their efforts and those of the ‘medical science community’.
LHC theme: a link between the community and research

The LHCs described their role in terms of the activities they participated in such as meetings and training sessions, as well as providing the ‘link’ between the church and the project. As described by one interviewee:

I was considered the go-between person between the project itself and taking information back to the pastor and to my church and participants.

Meeting new people, building relationships and gaining information were common terms used to describe the LHC experience. Building relationships was described as central to the LHC experience. One LHC cited the ‘group camaraderie’ and described the visible ‘excitement about the project’ that resulted from the relationships she had developed as an LHC. Others discussed an increase in their own awareness about breast cancer and how their increased knowledge allowed them to ‘... do better and educate and link people to programs’. The ability to link people to resources was also expressed as a benefit of the LHC experience:

I was able to personally connect not just through the churches but in the street you know ... people walk up to you and will tell you things and a lot of people don’t have insurance. I was able to link people ... so that’s been a plus in being a part of this program.

LHCs expressed their appreciation of ‘genuine concern’ from the research staff as a positive experience. LHCs felt that the research team valued their comments, suggestions and questions. One LHC described the experience as ‘empowering myself to take better care of myself as a woman and to just really get out there and educate people’. Receiving feedback from participants was described as part of having a positive experience as an LHC. One LHC shared her experience with supporting a study participant through a breast health care procedure:

I did go with one young lady to get her mammogram because she was so afraid and she had a few complications but I stayed with her and we worked through it. It turned out that she didn’t have to have any type of surgery, but that experience let me know that it’s needed ... that the information they are getting is needed and you need to stay with them.

The term ‘love’ was used by the LHCs to describe their feelings about working as part of a research team. LHCs described the research experience as rewarding, exciting and informative. Another LHC expressed her feelings about the research staff specifically:

I loved it because you know working with you all, getting to know you all and everybody was so humble and I don’t think it’s just because it was faith-based. I think it was the sensitivity to humanity and that you all cared about the people and it wasn’t about your roles, ‘oh I’m a doctor’ it wasn’t about the letters behind your name it was really about you all wanting to get the information out and wanting to educate a people in the community. So I enjoyed that.

One LHC described the research experience as something that allowed her to ‘feel good’ and that she felt as though she was ‘doing something to help others’.

In addition, the research team experience was described by LHCs as a partnership. The concept of partnership was discussed by LHCs in terms of linking and sharing information. All the LHCs felt and agreed that they were partners in the research project. The LHCs described their role in planning and hosting the intervention programs as a major contribution to the study which they felt reflected their level of involvement in the research process as well as reflected the partnership process. LHCs described the decision-making style as a democratic process involving the LHCs and academic researchers as equals and reflective of their role as research partners.
**Cross-cutting topics**

The topics presented in this section include common themes reflected in both the pastor and the LHC interviews.

*The church’s ability to continue health programs*

The church community’s ability to continue to offer health promotion programs was characterized as ‘necessary’ by both pastors and LHCs. Pastors and LHCs discussed the community’s critical need for and limited access to health care and social services. Additionally, most pastors and LHCs expressed a need for health care experts to speak at church health programs, provide information and answer questions. Having an understanding of ‘where people are at’ and ‘where people are coming from’ in their personal situations was described by all pastors and LHCs as a specific sensitivity health professionals needed to have when working with community members.

Funding and health promotion materials were also described by pastors and LHCs as material resources the church needed to continue to conduct health programs. One pastor described the church as a ‘catalyst for a bevy of programs’ and also stated:

> I think good health programs border on having good common sense and that’s what doctor’s and the church are for. I think the church plays a vital role in meeting the needs of the entire community and I would like to see the churches have resource guides. I think that is something that needs to be implemented.

Pastors and LHCs supported a prevention focus when describing health promotion programs in the church and listed the need for ‘data’ and the ‘facts’ to be presented by health care professionals. One pastor specifically described what he felt the most useful information to share with the church during health promotion programs is and stated:

> The current data that is available concerning how many people are being affected by said disease, the preventive measures that are available, and how it can benefit an individual if he or she involves themselves before they have an illness or a disease.

*Faith and spirituality in cancer prevention programs*

When asked to describe their perspective on faith and spirituality in cancer prevention programs, pastors and LHCs felt it was necessary for ‘medical science’ to be acknowledged in the church. Pastors and LHCs were supportive of following ‘the doctor’s advice’ and supported medical consultation as being a part of ‘God’s will’. One pastor described faith-based health programs as ‘God’s call to wholeness’ and also stated that ‘It is not the will of God that any of us would be in illness’. Pastors and LHCs also discussed personal accountability and responsibility with respect to illness and ‘doing the right things to stay healthy’. A combination of spiritual healing and medical healing was supported by pastors as a whole and described by one pastor as:

> Medical science is a tool for which God will use for healing. I don’t fight medical help I think it’s just a tool that God uses through the doctor. I think it’s necessary to inform the congregant if the doctor has told you to stay away from salt then you need to stay away from it, if the doctor has shown you where your cholesterol is high and you can’t eat certain foods stay away from them.

In addition, LHCs described their perspective on the role of faith and spirituality in cancer prevention programs in the church as a source of strength and support. Faith was discussed by LHCs as important to the healing process:

> You have people with cancer that feel that God is going to heal everything. ‘I don’t have to do what the doctor says and I don’t have to take any medication.’ I don’t believe in that but I do believe that the person’s faith regardless of what it
is in conjunction with and what it is they need to take care of themselves with will bring about a healing.

Including spiritual or religious messages in health promotion programs was described as essential by LHCs, ‘it is necessary because a lot of women are close to their church members and they may not go outside of the church to talk about different things that have happened to them as far as health’.

Pastors were all inclined to have academic research partners defer to their expertise when incorporating any spiritual/religious components into the program. Providing ‘spiritual guidance’ and incorporating the religious messages or scripture as part of the health program was seen by pastors as the role of ‘clergy’. Pastors and LHCs felt that if the researchers involved were members of a faith community or ‘believers’, then their input concerning incorporating religious messages or scriptures would be welcomed:

… now if said person genuinely was a believer then his or her personal experience would be welcomed. But these folks are very sharp they can read through, it’s like politicians, all politicians, first thing when they come to the church they are going to quote a scripture but we all know the person is just quoting the scripture, he doesn’t believe it, it’s not applicable to his life or his lifestyle he’s just in that setting and to make you at ease with him …

While pastors described a holistic view of health, they did not require that health programs include spiritual or religious information. Pastors explained that it was more important to provide the necessary health information in a way that would reach all persons regardless of religious affiliation. LHCs believed that health information and spiritual or religious messages work together and help to give hope to the church and community members; however, they also agreed that the messages should be expressed in ‘plain language’ and remain ‘inclusive’. Pastors and LHCs felt that it was important to share the health information in a way that would reach as many people as possible and that the spiritual or religious messages should not overpower the health information being presented, but instead come together in a way that would reach the church members as well as community members who were not a part of the church. As one LHC said:

Faith-based can be whatever religion … we come from different churches with different denominations, and we may all believe different and even worship a little different but the common goal we understood was the health … but whatever we believed is what brought us together and allowed us to do what we do. You are going to get different results but health is the ultimate goal, so I like that.

Faith-based health promotion interventions
The concept of all-inclusive or comprehensive programs was also discussed in terms of offering ‘broad-based’ interventions that include information from all sides and ‘all people’ regardless of their particular faith or religion. Involving different nationalities and designing health programs to include men and women were examples of the types of comprehensive programs pastors and LHCs recommended. One pastor explained the diversity of the membership in his church as ‘mixed in various ways’ and further stated:

My congregation is more African Americans but there are others involved in my congregation that includes Caucasian and Hispanic. There are many age groups as well. I have them from the cradle and I have a 104 year old in the congregation. So we are diverse in our age groups and ethnicity.

Most LHCs advocated for a cooperative effort, which they described as groups of churches working together to plan, sponsor and implement one large event. Both pastors and LHCs felt that a group effort would bring benefit and information to more people. Pastors and LHCs reported that they would
like to continue partnering with health care professionals and academic researchers in health promotion programs. Common health promotion/disease prevention topics of interest discussed by both pastors and LHCs included all cancers, diabetes, heart disease, high blood pressure and obesity.

Discussion

Community partner assessment represents a significant and critical gap in evaluating CBPR in general and more specifically cancer prevention studies that involve a CBPR approach. This information is important in facilitating effective faith-based cancer prevention interventions that seek to address cancer health disparities in underserved populations. Several important themes emerged from the qualitative data that have implications for planning, implementing and further evaluating faith-based health promotion interventions for African-Americans.

A holistic approach was described by pastors with respect to their pastoral role and how they perceive their role in promoting health in the church in partnership with health care professionals. Pastors who participated in the Los Angeles Mammography Promotion in Churches Program also supported a holistic approach in their ministries and in how they perceived an individual’s well-being [12]. An appreciation of holism can be crucial to partnership engagement and further partnership building.

In addition to the pastors describing their holistic approach, they also discussed the church’s role in community health. Broadly examined, our findings suggest that faith settings not only represent more than a religious or spiritual place of worship to its members and surrounding community but also act as a trusted source of secular information and resources. The Black Church is an established and widely recognized point of access for reaching underserved and higher income populations. As a community institution that addresses an array of social needs, its leaders should be considered as a source for engagement and partnership in addressing health disparities within the African-American community.

LHCs discussed their responsibility of linking the research project information back to the church by way of keeping the pastor apprised of research activities and findings, in addition to linking the church and community participants to intervention activities and health care resources and information. The use of LHCs or advisors is a common component often present in faith-based health promotion/disease prevention programs; however, the understanding of their role as a link between the church, community participants and research team has not been fully appreciated or evaluated in the literature. In a similar study, the lay health advisor is described as ‘a highly effective component of the cancer educational program in their role as trained community educators and liaisons between the community and medical providers’ [16]. Through our interviews with LHCs, we were able to better understand their role in terms of their individual experiences, as well as qualitatively capture critical impacts made by the program which would have otherwise gone unnoticed and undocumented. Academic partners may want to consider more creative ways of documenting critical experiences that occur during the intervention research process but may fall outside of traditional outcome-oriented study aims. For our particular project, it may have been useful to discuss journaling with the LHCs and provide them each with a journal where they could write down thoughts, experiences and questions concerning the intervention research process. This activity could help to document program impacts, as well as aid in assessing the CBPR process.

Pastors and LHCs all saw the importance of continued faith-based health promotion/disease prevention efforts and their appreciation of health care professionals and medical expertise in providing beneficial health information. Community partners recognized that churches require resources to offer and maintain health programs in the church. Pastors discussed the flexibility to designate a church member, such as an LHC, to provide a link to the project as discussed in detail above. Involving and training church members to participate as lay health advisors is one effort which can help to ensure program sustainability, increase the capacity
of the individuals involved, as well as become an asset to the church [3, 10]. In addition, access and exposure to health care professionals were emphasized by community partners as serious needs of the community. The health care access issue was described by pastors in terms of lack of knowledge on how to navigate the health care system.

The church as a setting for health promotion programs also presents the opportunity for participants to communicate face-to-face with health care professionals in a familiar setting. Church-based health programs have ‘met with considerable success in identifying members of at-risk populations, making referrals to health care providers, and reaching communities with interventions that have prevented or reduced subsequent morbidity’ [2]. Continued faith-based health programming can help to keep the church and community members informed and aware of needed health care resources.

Community partners were supportive of faith and spirituality in cancer prevention programs in that they viewed the church and their spiritual and religious beliefs as supportive and strengthening with respect to the healing process. The role of the Black Church in the lives of African-Americans has been well documented as a source of spiritual and religious support with respect to a variety of health issues and concerns [1, 2, 5, 10–12]. The incorporation of spiritual or religious messages was perceived by community partners as acceptable, but with certain requirements stipulated by pastors and LHCs. Pastors emphasized the importance of their role in bringing the spiritual and/or religious elements to the health programs. LHCs were concerned with the spiritual and/or religious messages not overpowering the health information being delivered. Both pastors and LHCs felt that the health information presented should be accessible to church and community members regardless of spiritual or religious beliefs.

The incorporation of faith and spirituality components in a faith-based intervention requires the involvement of the faith community in deciding whether, how and to what extent these elements are appropriate for the community. The role of faith and spirituality in any faith-based intervention will vary based on the religious organizations, faith partners involved and objectives of the research. Cultural sensitivity should always be considered in the planning and delivery of faith-based health promotion programs.

Health promotion/disease prevention programming that is broad based and inclusive of multiple health topics, various ethnicities, different religious denominations and both genders were described favorably by pastors and LHCs. Based on this feedback, we raise the issue of whether the tailored and targeted nature of many interventions is too narrow and if some African-American communities have been saturated with single-topic health programs and would welcome comprehensive programs that deliver information about wellness and preventive behaviors that affect a variety of health outcomes.

Limitations in structuring more comprehensive health promotion/disease prevention programs may be partly influenced by the funding resources available. Although the definition of CBPR emphasizes the identification and definition of the health problem or issue as coming from the community, in practice this is often not the case [17, 18]. More often, an opportunity for potential collaboration comes to the attention of the academic researcher and the community is then engaged in order to assess the level of community interest with respect to participating in the project and whether the health topic is viewed as a priority by the community. Time, financial and in-kind resources are also instrumental factors in structuring a comprehensive program, which ties back to the availability of funding, the guidelines of the granting institution with respect to the funding time period, the amount of funding available for carrying out the proposed study and the commitment to the practice of CBPR by academic institutions [3, 18].

Health promotion program evaluation with respect to gaining the feedback of community partners is sparse in the literature; however, as shown by this qualitative exploration, the community partners were involved as active and equal members of the research team with respect to the CBPR approach applied in this particular breast cancer educational intervention study. The involvement of
community partners in research activities can help

to enhance the quality of the process and the results
obtained [3, 19–21]. Assessing their level of in-
volvement with respect to the success and impact
of the intervention is a complex process to evaluate;
however, this level of evaluation with respect to
assessing the influence of CBPR principles in con-
junction with the research objectives and process
represents a critical gap in the literature. Qualitative
evaluation methods prove a useful tool in helping to
better understand the subtleties, however, critical
aspects that occur within a CBPR approach.

Based on our sample and methods of data collec-
tion, our findings are limited to a description of
salient topics and commonalities in experiences of
the community partner role as related to this partic-
ular faith-based intervention study. The potential
for social desirable responses given on the part of
the interview participants is also a possible limita-
tion in that interviewees may have been reluctant to
disclose criticisms of the research and partnership
process to the interviewer since this person was also
an academic study partner. This particular limita-
tion may have been mitigated to an extent in that
specific items asking for critical feedback of the in-
tervention and partnership process were included
in the pastor and LHC interview protocols and asked at
various times during the interview. In addition, all
the original participating pastors were not available
for interviews due to reasons related to employment
changes (i.e. change in church leadership) or specific
health status changes (i.e. deceased), which may
further limit or bias the scope of our findings with
respect to the topics discussed in this paper.

Pastor turnover as a factor that can impact faith-
based health promotion/disease prevention inter-
vention research studies has received little to no
attention in the literature. We did not specifically
research the potential implications of pastor turn-
over in this qualitative study component but rather
focused on the remaining participants and the expe-
riences they were able to share as partners in re-
search. While the pastor turnover rate did affect
the overall response rate, it did not prevent the
completion of the initial intervention study objective;
although, we cannot state with certainty that

the reflected viewpoints would have been the same
or different as those represented in the study.

The primary role of the pastors in the participa-
tory study was to designate a female lay leader to
serve on his behalf for several reasons: first, pastors
have limited time and serving on a research study
may not be among their highest priorities; second,
this was a breast cancer study and the pastors, as in
most cases, were males and finally, women, more
than men, make up church membership and gener-
ally head ministry programs [5]. A secondary in-
tention of the study team was to enhance the
capacity of these LHCs for their respective health
ministry programs. In addition, the role of the LHC
as a link to the research project between the church
leadership and participants provided consistency
throughout the research team collaboration process
as well as continued involvement of the community
research partners during periods of transition within
the churches (i.e. pastor turnover events).

The inclusion of multiple perspectives at the
community partner level was a major strength in
the design of this research. The focus of the re-
search also represents a formative area of study with
respect to better understanding the community part-
ner role and experience in faith-based health pro-
motion/disease prevention intervention research
which has received limited attention in the litera-
ture, although faith-based health promotion pro-
grams in addition to CBPR approaches continue
to gain increased use and application in the field
of public health.

Funding

Department of Health, Behavior and Society at the
Johns Hopkins Bloomberg School of Public Health;
Susan G. Komen for the Cure (POP0403187).

Acknowledgements

The authors would like to acknowledge the invalu-
able partnership of the pastors and LHCs who par-
ticipated in this qualitative study and shared their
experiences as collaborators on the research project.
Conflict of interest statement

None declared.

References


Received on July 14, 2008; accepted on January 28, 2009