

## FAITH COMMUNITIES AND BREAST/CERVICAL CANCER PREVENTION: RESULTS OF A RURAL ALABAMA SURVEY

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### ABSTRACT

Limited research has been conducted in the area of faith-based health promotion programs. Data reported here are from a survey of faith communities in Walker County, Alabama for the following purposes:

1. To ascertain if breast and/or cervical cancer education was being offered by faith communities in Walker County, Alabama;
2. If so, what opportunities do faith communities provide;
3. To identify barriers that might inhibit the offering of breast/cervical cancer education to women in Walker County, Alabama; and
4. To determine the willingness of faith communities to meet with researchers to explore the option of providing breast/cervical cancer education to their faith communities.

A survey was sent to 218 faith communities that were listed in the *Daily Mountain Eagle* (Walker County newspaper). A total of 46 surveys were returned, for a response rate of 25%. Data were analyzed using SPSS 11.0 for Windows. Researchers with qualitative expertise conducted the content analysis. Less than 1% of the faith communities reported any involvement in breast/cervical cancer education. Barriers to offering breast/cervical cancer education included a lack of financial resources and a lack of clergy/spiritual leaders with experience in providing breast/cervical cancer education. In addition, breast/cervical cancer education was not seen as part of the faith community's mission. Ministers cited a lack of community resources and a personal lack of knowledge about breast/cervical cancer as reasons for not providing health promotion activities in this area. Ninety-nine percent (99%) stated that they would be willing to meet with the researchers to plan breast/cervical cancer education. One percent (1%) stated that such informational offerings would not be necessary.

### INTRODUCTION

Cancer is the second leading cause of death in the United States and is projected to become the number one cause of death for all age groups within the next 10 years (American Cancer Society, 2004). Breast cancer is one of the most common cancers in women and has a five year survival rate of 95% if caught at an early stage. Mammography continues to be the most efficient and reliable method for detection of breast cancer, however, close to 13 million women, over the age of 40, in the United States, have never had a mammogram (National Breast Cancer Foundation, 2005). Cervical cancer is also highly curable if caught early. However, significant numbers of women have never had a PAP smear, the only reliable way to diagnose cervical cancer.

Since cervical cancer symptoms are usually absent or negligible, it is often too late by the time a woman is diagnosed (American Cancer Society, 2003). A variety of reasons have been postulated for the fact that women are not being screened. Urban vs. rural residence, lack of knowledge, low educational levels, issues of access, race, income, cultural beliefs, mistrust of the health care system, and lack of physician referral are a few examples (Bushy, 2000; Esser-Stuart & Lyons, 2002).

Nationally, overall cancer mortality rates decreased during 1990-2000 and the concomitant reduction in breast and cervical cancer mortality was presumed to be the result of both earlier detection and improved treatment (Berry et al., 2005). However, not all states were fortunate enough to experience a reduction in breast or cervical cancer rates. Female breast cancer incidence increased by 4.2% in Alabama during 1996-2002. Cervical cancer rates also increased during that time frame (American Cancer Society, 2004).

Alabama is ranked 49<sup>th</sup> in women's overall health status (National Women's Law Center, 2001). In keeping with Healthy People 2010 objectives (USDHHS, 2000), Healthy Alabama 2010 Objectives were developed to assist in the reduction of health disparities and to improve the overall health status of all Alabamians. A primary objective is to increase the percentage of adults aged 18 and older who will receive breast and cervical cancer screenings (ADPH, 1999). Patient education, as part of primary and secondary prevention strategies, is a key factor in increasing the numbers of women who receive screening, thereby decreasing morbidity and mortality from breast/cervical cancer (CDC, 2004).

One segment of Alabama that is of particular interest to the researchers is women in rural Alabama. While there are numerous definitions for rural, most of the literature is in agreement that an area is rural if it has a low population density and is diverse (Lee, 1991). Rural populations are demographically different from urban populations since rural populations tend to be older, poorer, and less educated (Ormond, Zuckerman, & Lhila, 2000; Casey, Call, & Klingner, 2001). Studies have shown that women who are less educated and live in rural areas, such as those in Alabama, are less likely to be screened for cancer and are more likely to be diagnosed at a later stage in the disease (Boughton, 2000; Alabama Statewide Cancer Registry, 2004).

The delivery of preventive care, such as cancer screening, is often more difficult in rural areas. Rural communities have fewer hospitals and fewer physicians. Accessing resources is more cumbersome for rural women. Rural women travel greater distances for appointments and feel more isolated. They are less likely to know what services are available to them and are less confident about taking the necessary steps to access those services that they do know about (Ormond, Zuckerman, & Lhila, 2000; Lyons, 2004). Cultural factors such as race, ethnicity, and socioeconomic status may also be associated with poor breast/cervical cancer screening rates for women living in rural Alabama (Schootman & Fuortes, 1999). Thus, effective community-based interventions are needed to help alleviate disparity in prevention and screening services. Reaching the rural community through education regarding health promotion and disease prevention in the area of breast/cervical cancer is imperative for enhancing the health status of rural women. Community education or support groups sponsored by local faith-based communities could be useful in meeting the need for education and support regarding available services in rural areas.

Faith communities and health professionals can be dynamic partners in achieving health promotion outcomes. Faith-based health promotion can improve the health of community residents through education, screening, referral, treatment, and group support. Establishing collaborative partnerships between faith-based communities and health professionals has been successful in implementing health promotion programs in vulnerable, underserved populations (Peterson, Atwood, & Yates, 2002). However, establishing educational programs for rural communities can be problematic, particularly for “outsiders” or those health professionals who are unknown or new to the community (Dunkin, 2000). An initial distrust of the health care professional may be encountered (Bailey, 1998).

The purpose of this article is to report the results of a survey of faith communities in Walker County, Alabama. Faith communities were selected as the population for this survey because they can facilitate access to the lay community. These organizations exist in practically every community and have the ability to influence the hardest-to-reach populations (Tesoriero, Parisi, Sampson, Foster, Klein, & Ellenberg, 2000).

Walker County was selected as the site for this study because breast/cervical cancer related morbidity and mortality in this rural north Alabama County exceed both state and national rates. Walker County, Alabama was ranked #1 in cancer incidence and mortality rates by county, for males and females and all races combined (Alabama Statewide Cancer Registry, 2004).

Walker County, Alabama, is located in the foothills of the Appalachian Mountains and compares poorly with state and national levels of poverty and education. Using the federal definition of poverty, 16.5% of Walker County residents are below the poverty level compared to 16.1% of Alabama’s population and 12.4% of the United States (U.S.) population. In addition, 32.8% of persons ages 25 and older in Walker County did not graduate from high school compared to Alabama’s rate of 24.7% and the national rate of 19.6% (U.S. Census Bureau, 2000).

## METHOD

The purpose of this research was to ascertain what breast and/or cervical cancer education was being offered by faith communities in Walker County, Alabama; to identify barriers that inhibit the offering of breast/cervical cancer education; and to determine the willingness of faith communities to meet with researchers to explore the option of providing breast/cervical cancer education to their congregations. Each purpose was then formulated into a research question.

Prior to data collection permission was obtained to use the data collection instrument from the author of a previous study of faith communities (Tesoriero et al., 2000). The study design, survey instrument, and consent form were reviewed and approved by the University of Alabama Institutional Review Board for the Protection of Human Subjects before the study began.

Faith communities (n=218) in Walker County, Alabama comprised the sample for this study. All of the faith communities listed in the Walker County Church Directory, as published in the local newspaper, the Daily Mountain Eagle, were mailed a packet that included a letter of informed consent, the survey, and a stamped self-addressed return envelop. Of the 218 surveys that were mailed out, 52 were returned due to an incorrect

address or lack of a mail receptacle. Of the 52 surveys returned unopened, 21 of the faith communities were located and were sent another packet (total n=187). A follow-up phone call was made to the pastor of the faith community if the survey was not returned by a specific date. Overall, 46 of the 187 faith communities returned the survey for a response rate of 25%. The 25% return rate was within an acceptable range for mailed surveys (Fain, 2004).

## FINDINGS

Data were analyzed using descriptive statistics and content analyses. We used SPSS 11.0 for Windows to analyze the data. Table 1 depicts the characteristics of the faith communities that participated in the survey. Two researchers with expertise in analyzing qualitative data conducted the content analysis using the following steps:

1. Participant's comments were read several times,
2. Transcripts were broken down into key segments, and
3. Key segments were grouped into central meanings.

Table 1

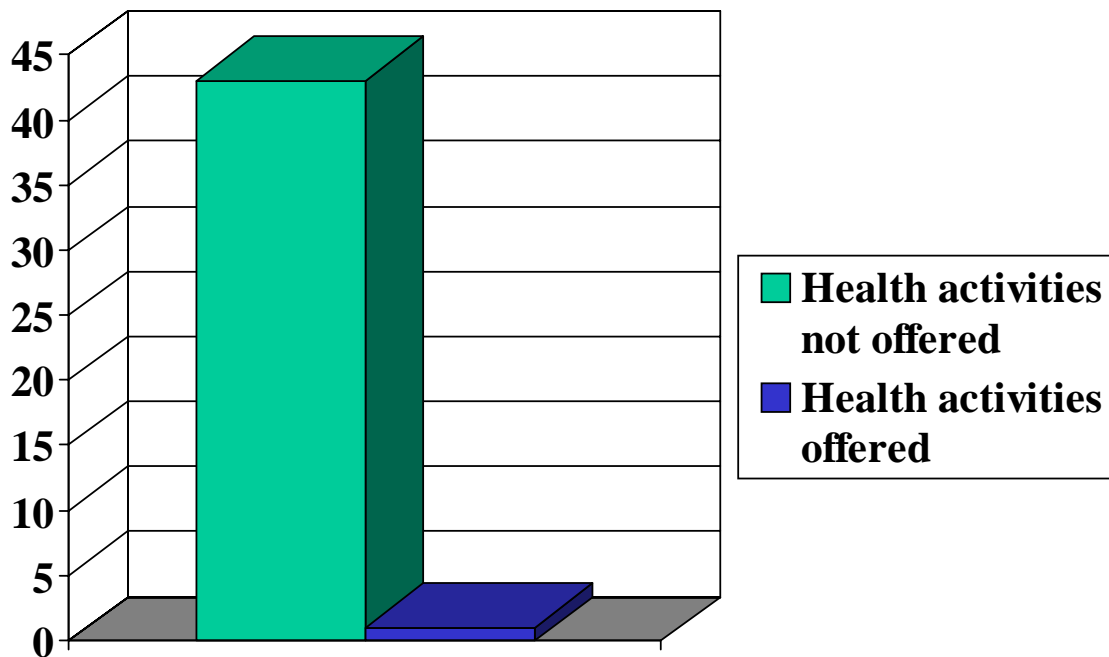
*Characteristics of congregations responding to survey (N = 46)*

Variable	Percent
Religious affiliation	
Protestant	70%
Catholic	0%
Jewish	0%
Other	30%
Racial/ethnic composition of congregation	
White	97%
African American	2%
Hispanic	1%
Other	0%

Another expert in qualitative research then followed the decision trail of the other two researchers to synthesize a central meaning that best described participant responses (LoBiondo-Wood & Haber, 2006). The three research questions were answered as follows:

**Question 1: What health activities, if any, are being offered by your faith community, particularly in the area of breast/cervical cancer?**

Forty-three of the 46 faith communities reported that they do not provide any breast/cervical cancer education to the community. Only one church reported that they distribute breast/cervical cancer literature once or twice per year. Thus, less than 1% of the faith communities in Walker County are involved in breast/cervical cancer education. (Figure 1)



**Figure 1**

*Figure 1.* What health activities, if any, are being offered by your church, particularly in the area of breast/cervical cancer ?

**Question 2: What barriers inhibit the offering of breast/cervical cancer education?**

Fifty-four percent of those surveyed identified financial constraints as barriers to breast/cervical cancer education in their faith communities. Fifty percent identified clergy/spiritual leaders' lack of experience or ability to provide education as a barrier. Forty-seven percent of the faith communities reported that breast/cervical cancer education was not part of their mission. Forty-three percent of the faith communities identified the lack of qualified staff to provide the education as a barrier. Thirty-seven percent identified that their own lack of knowledge about breast/cervical cancer was a barrier to providing education. (Figure 2)

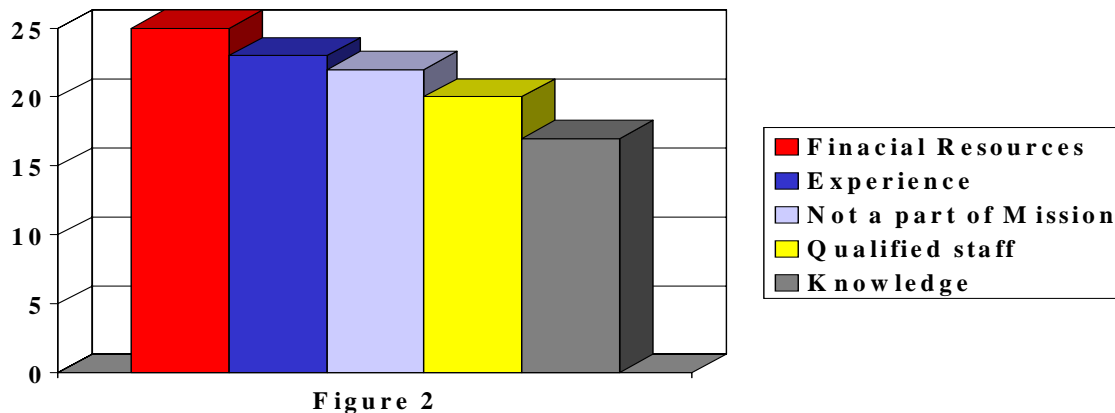


Figure 2. What barriers inhibit the offering of breast/cervical cancer education?

**Question 3: Would your faith community be willing to meet with researchers to explore the option of providing breast/cervical cancer education to your community?**

Forty three percent of the faith communities reported they were not sure if they would be willing to meet with the researchers, 30% replied that they would be willing to meet and discuss options for providing breast/cervical cancer education, 1% stated they would not be willing, and <1% stated that it would not be necessary to provide breast/cervical cancer education (Figure 3).

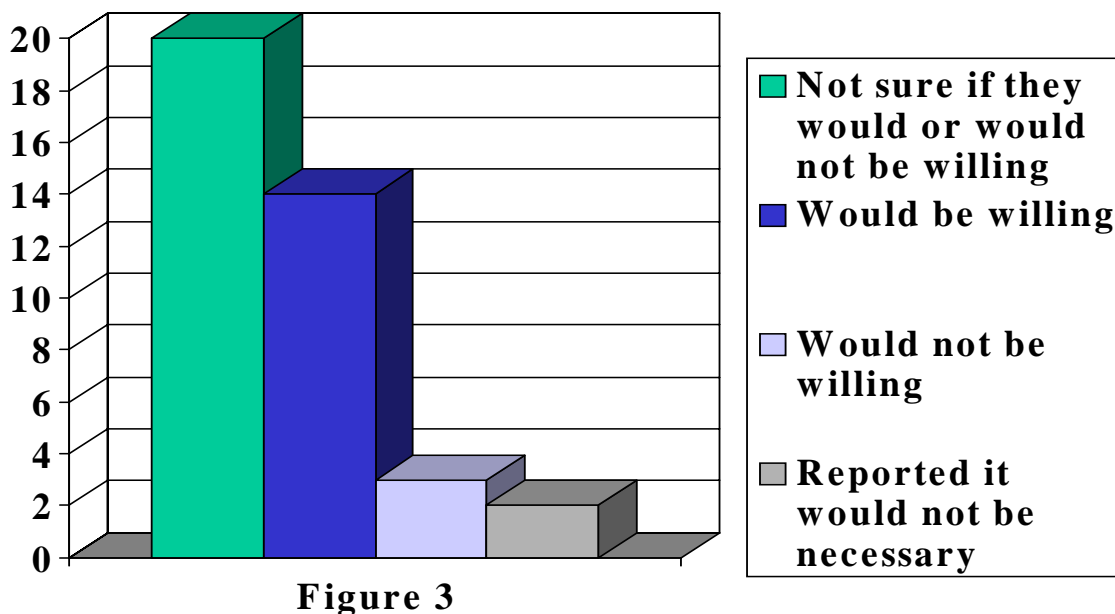


Figure 3. Would church representatives be willing to meet to discuss options for providing breast/cervical cancer education and prevention to your congregation?

Comments shared during the telephone follow-up calls added insight for the researchers. For example, some of the pastors reported that they were bi-vocational pastors and had a heavy workload. One pastor stated, "I have two other jobs in addition to pastoring this church. I didn't have time to fill out the survey." The researchers also sensed distrust and an unwillingness to pursue the issue. For example, one pastor stated, "I'll take it (survey) to the elders and discuss it," but the survey was not returned.

Some of the returned surveys had written comments indicating why they did not offer health related activities: "We are a small church, only 20 members" or "We are mostly an elderly congregation," or "We can't accurately answer all these questions due to our size." Many seemed uncomfortable with the topic of breast/cervical cancer. Comments included statements such as "The health issues you mentioned..." or "The conditions you stated in the survey..." which conveyed to the researchers that they were uncomfortable or embarrassed to say the words "breast and cervical."

## DISCUSSION

We found that only one of the faith communities was providing breast or cervical cancer education and preventive services to the community. This finding suggests that faith communities in Walker County, Alabama are not providing information about state and federally funded breast/cervical prevention programs such as the Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) (CDC, 2005). The ABCCEDP was established in 1991 and provides a vehicle whereby women over the age of 40 or who currently have breast problems, who are at 200% below the poverty level, and who have no insurance or are underinsured, may receive mammograms at no cost. This finding is important because it is possible that the residents of these faith communities do not have information available to them that could result in participation in screening services. Education about the importance of health screenings enhances compliance in rural communities (Cyrus-David, Michielutte, Paskett, D'Agostino, & Goff, 2002). Dunkin (2000) stated that rural residents do not use preventive screening services as often as people who live in urban areas. Faith communities could be the key to reaching a large number of rural women concerning breast/cervical cancer education and available services.

Similar to the findings of Ormand, Zuckerman, and Lhila (2000) our findings indicated that faith communities lacked financial resources and the professional staff that could provide breast/cervical cancer education. However, it is our supposition that individuals in the community are able to learn about primary prevention strategies and available services and could be taught by the researchers to pass this information on to others in the community.

As indicated in the findings some of the clergy appeared to be embarrassed at the mention of the words "breast" or "cervical". Such responses are not surprising in view of the sensitive nature of the topic. However, sensitivity may tend to diminish as individuals become acquainted with the importance of breast/cervical cancer education in saving the lives of women in their faith communities.

Age of congregation members as well as size of the congregation was a factor for one minister in deciding that his congregation did not need breast/cervical cancer education. The implication seemed to be that "older" individuals didn't need to worry

about breast or cervical cancer and that the small size of the congregation negated the importance of the task. When in fact, it is known that one woman in seven who lives to age 85 will develop breast cancer during her lifetime (National Breast Cancer Foundation, 2005).

The issue of distrust is an important one. Without trust it is impossible to breach the barriers that keep health professionals outside of the community “loop”. Because people in rural communities tend to refuse help or services offered or provided by people that are unknown to their communities (Dunkin, 2000) efforts need to be directed at getting to know who the community leaders are and establishing rapport with them. These individuals are likely to be members of the faith community and can provide an important function in convincing pastors of the importance of health care education.

### **CONCLUSIONS AND PLANS FOR FOLLOW UP**

Individuals in Walker County need health education about breast and cervical cancer. We are hopeful that a follow-up meeting with the faith communities who reported a willingness to meet with the researchers can be planned to explore the provision of breast/cervical cancer education and screenings. We plan to include nurse practitioners from our college that are well-known practitioners in Walker County. This should help address the issue of distrust and “outsiders”. In addition, the researchers have worked with two of the churches over the past few years in conducting community health fairs. Therefore, we believe it will not be difficult to establish rapport and gain trust as we offer interventions through faith communities. Also, since none of the faith communities are providing testicular and prostate cancer education or screening, we plan to include these additional topics so that the men in this rural county can also receive health intervention. Health education/promotion is imperative, especially in rural communities. Participants of these faith communities have the potential to not only receive potentially life saving messages, but to disseminate health information to others in the community that may not attend a particular faith community. Disseminating health information is vital in decreasing the morbidity and mortality of this rural community.

### **STUDY LIMITATIONS**

The selected sample was a convenience sample. The survey was only mailed to faith communities who were listed in the Walker County Church Directory as published in the *Daily Mountain Eagle*. Findings were based on self-reported, subjective data from the participants. The findings can only be generalized to the rural south and may not be representative of faith communities in other geographical areas.

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