

THE DEVELOPMENT OF A COMMUNITY ACTION PLAN TO REDUCE BREAST AND CERVICAL CANCER DISPARITIES BETWEEN AFRICAN-AMERICAN AND WHITE WOMEN

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The purpose of this project was to establish a coalition of academic, state, and community-based organizations to develop a community action plan (CAP) to eliminate breast and cervical cancer morbidity and mortality disparities between African-American (AA) and Caucasian women. The project targeted rural and urban low-income AA women in Alabama. Based on the logic model, community capacity building was implemented, followed by the development of a community-driven CAP.

For community capacity building, a coalition comprising 12 organizations was established, and a network of 84 community volunteers was formed. Community needs assessments identified 3 levels of barriers to breast and cervical cancer screening: 1) individual, 2) community systems, and 3) healthcare provider. Based on these findings, a community-driven CAP was developed. Our results indicate that a coalition of diverse organizations can partner and develop CAPs to improve the health of their communities. (*Ethn Dis.* 2004; 14[suppl 1]:S1-54-S1-62)

Key Words: African-American Women, Breast and Cervical Cancer, Community-Based Models, Early Detection, Health Disparities

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INTRODUCTION

A number of demonstration projects funded by the Centers for Disease Control and Prevention (CDC) in response to the Racial and Ethnic Approaches to Community Health (REACH 2010) are underway in more than 32 communities across the United States. The goal of these projects is to eliminate health disparities in 6 priority areas, including cardiovascular disease, diabetes, HIV infection/AIDS, breast and cervical cancer screening, infant mortality, and child and adult immunizations.¹

Phase I of these projects included a 12-month planning period that focused on building community capacity, developing community coalitions, and establishing networks of community volunteers, whose purpose was to design community-driven strategies to eliminate disparities in one of the target areas. The goal of these projects was to actively involve the coalition members in every aspect of the design, implementation, and evaluation of these community action plans (CAPs).

Breast and Cervical Cancer Burden in African-American Women

Breast cancer is the second leading cause of death among American women.² In 2003, the American Cancer Society (ACS) predicted that 211,300 new invasive cases of breast cancer would occur in the United States, and an estimated 39,800 women would die of breast cancer. Breast cancer death rates among African-American women increased at a moderate rate for many

years, and recently appeared to have leveled off at approximately 31 per 100,000.² Despite this stabilization, the death rate among African-American women is still higher than the death rate in White women.³ The 1992 to 1999 average annual age-adjusted death rate for African-American women was 37.3, compared to 29.3 in White women.⁴ Similarly, in Alabama, the 1998 to 2000 age-adjusted death rate for breast cancer in African-American women was 30.4, and 24.8 for White women.⁵ Whether this is due to later stages of diagnosis, or to an increased likelihood of being diagnosed with estrogen-receptor-negative tumors, the causative factors are still unknown.³

While the benefits of mammography and clinical breast examination are uncertain, due to variable quality of the evidence, and the inconsistency of results across studies, research has shown that screening by mammography, clinical breast examination, or both, may decrease breast cancer mortality rates in women.⁶ Some reports show that timely mammography screening among women aged 40 years or older could prevent 15% to 30% of all deaths from breast cancer.⁷ The ACS recommends that women 40 years of age and older have an annual mammogram, an annual clinical breast examination, and perform monthly breast self-examination.² Despite these guidelines, African-American women are less likely to undergo mammography screening.⁸ This may be attributable, in part, to socioeconomic variables, cultural beliefs, attitudes, knowledge of risk, and inadequate access to care.³

Since the introduction of the Pap test in the 1950s, the incidence and mortality rates of invasive cervical cancer fell notably by more than 70%.⁹ In spite of the obvious benefit of the Pap test, women are still dying from this preventable and curable disease.¹⁰ The ACS estimates that 12,200 new cases of invasive cervical cancer will be diagnosed, and that 4,100 women will die from this disease, in 2003.² Research shows that a large proportion of women, particularly elderly African-American women, and middle-aged poor women, have not had regular Pap tests. In some areas, as many as 75% of women over 65 reported not having had a Pap test within the previous 5 years.^{10,11} Some studies show that the following may play a significant role in increasing the healthcare divide between African-American and White women: lack of health insurance; childcare requirements; transportation issues; mistrust of the healthcare system; cultural views of invasive treatment; low levels both of the perceived seriousness of the diseases, and of belief in the importance of early detection; and healthcare provider prejudice or bias.¹²

It is clear from previous research that attempts to increase rates of cancer screening have been met with low participation by the women at highest risk. One factor associated with low participation is failure of researchers and public health programs to fully involve the community. The Alabama REACH 2010 Project is a community-based program that focused on eliminating disparities in breast and cervical cancer screening in 6 rural Black Belt counties, and 3 urban counties, in Alabama.¹ As predicated by the CDC's call for proposals, the Alabama Phase I project's main objectives were to: 1) build a coalition whose members represented community, academic, and state institutions; 2) conduct a community needs assessment to address breast and cervical cancer screening disparities; and 3) develop a CAP to eliminate breast and cer-

vical cancer health disparities between African-American and White women. This manuscript describes how the Alabama REACH 2010 project addressed this challenge by building a coalition, assessing community needs, and finalizing a CAP to address disparities in screening for breast and cervical cancer. Phase II activities will be described in a separate publication.

METHODS

The Alabama REACH 2010's targeted geographical area included 6 counties that extended across a 50-mile-wide band of rich, dark soil through the west central portion of the state. These rural counties are in what is known as the 'Black Belt' region of Alabama, and included Choctaw, Dallas, Lowndes, Macon, Marengo, and Sumter; the 3 urban counties were Mobile, Montgomery, and Tuscaloosa. In the Black Belt counties, 50% or more of the population are African Americans. The average per capita personal income for these counties is \$15,200, and, according to the 2000 US Census,¹³ approximately 24% of this population lives below poverty level, and 5% are unemployed. Additionally, data from the Alabama Department of Public Health's Center for Health Statistics¹⁴ indicate that the target counties are characterized by lower accessibility to health care, with relatively low ratios of physicians, registered nurses, and hospital beds. From the above data, it can be concluded that the target counties represent an underserved population.

The overall methodological design of the Alabama REACH 2010 Project was guided by a logic model.¹⁵ The logic model links program inputs and activities to program outcomes, and, ultimately, to the main goal of the project. Program inputs include resources that go into the program; activities are actual events or actions that take place; outputs are the direct products of program

activities; outcomes are the impact of the program; and the goal is the overall mission of the program.¹⁵ For the Alabama REACH 2010, those steps of the logic model translated into the following chain of activities: community capacity building and implementation of a community-driven targeted action plan that will lead to wide spread behavior change and ultimately; the reduction/elimination of breast and cervical cancer health disparities (Figure 1).

Phase I of the Alabama REACH 2010 project lasted for 12 months, and was divided into three stages. Stage I (3 months) was devoted to community capacity building (coalition and community network building). Stage II (6 months) focused on conducting the community needs assessments, and the final stage (3 months) involved the actual development of the CAP.

Community Capacity Building (Stage I)

Coalition Building and Community Volunteer Network Building

In Phase I, the focus was on coalition building. During this phase, members of an existing partnership entitled "The Alabama Partnership for Cancer Prevention and Control Among the Underserved," which comprised a volunteer group of health professionals, researchers, and community-based advocates, who had participated in previous cancer related activities, were invited by the Alabama REACH 2010 Central Coordinating Organization (CCO) team to serve as collaborators for the Alabama REACH 2010 project. In order to insure the involvement of the coalition members at the inception of the project, those who agreed to participate were asked to give their input during the preparation of the grant proposal that was submitted to CDC. Following the grant award announcement, the group participated in a series of joint meetings and conference calls to finalize the coalition's organizational structure. In addition, coalition members were asked to

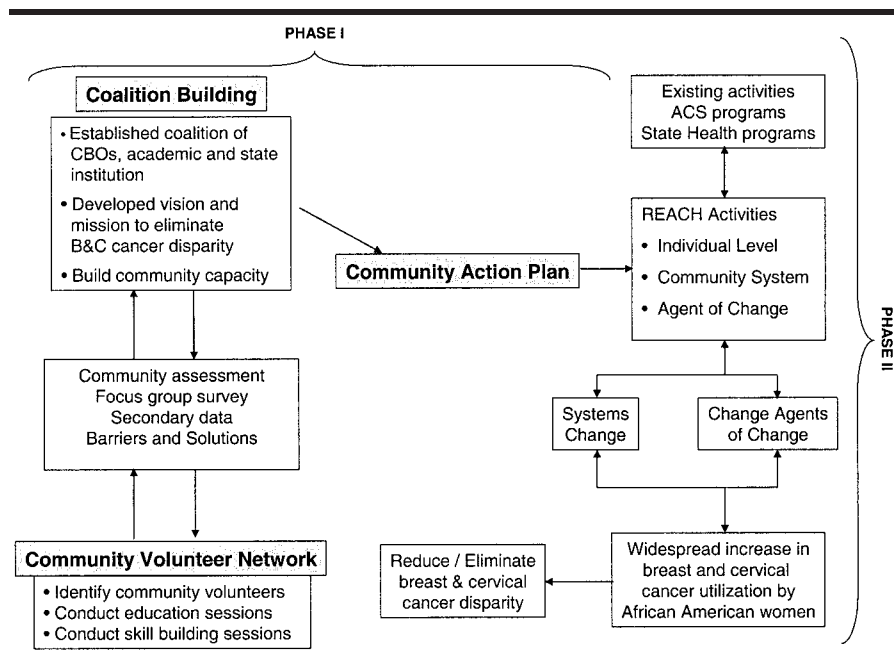


Fig 1. Alabama REACH 2010 Logic Model (Phase I and Phase II). CHA=community health advisor

identify 8–10 interested community members from their respective counties to serve as Phase I lay community volunteers to assist the CCO and coalition to recruit focus group participants and develop a population-specific CAP.

Community Needs Assessment (Stage II)

The community needs assessment utilized a focus group discussion format. The focus group discussions provided a public forum for the discussion of breast and cervical cancer. This method required selecting a purposive sample that would generate the most productive discussions on women’s perspectives on breast and cervical cancer.¹⁶ Therefore, women were identified and invited by the coalition members and lay community volunteers through community advertisements in their county to participate in the focus groups. Targeted women received a letter explaining the purpose of the study, the focus group format, and that they would receive a \$15 gift certificate as compensation for their time and travel. Those who responded to the invitation, and agreed to

participate in the focus group, were sent a confirmation letter with the time, and a map providing directions to the focus group meeting place. One focus group was held at a community center in each county. Light refreshments were served at each session to help create a social atmosphere in which the women had the opportunity to mingle and get acquainted. Focus group participants were representative of African-American women residents and community leaders in the targeted rural and urban counties in Alabama. Protocols for the focus groups on breast and cervical cancer were developed by members of the coalition and approved for use by the Institutional Review Board (IRB) of the University of Alabama at Birmingham.

Prior to participation in the sessions, women were given program materials describing the purpose of their involvement in the focus group. Consent forms were explained and signed by the participants before continuing. Any woman who asked for assistance, or appeared to need it, was helped by one of the research assistants or project investigators. After signing the informed consent

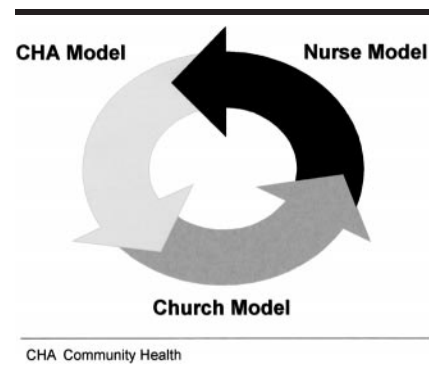


Fig 2. REACH 2010 Integrated Model

form, participants were given a \$15 gift certificate. This marked the beginning of the discussion session.

At each focus group meeting, participants and members of the research team sat around a rectangular table. The facilitator began each session by describing the purpose of the study and discussing the basic ground rules (eg, all members’ comments were important and there were no right or wrong answers to the questions) for the sessions. Participants were informed that they did not have to answer questions they felt were not appropriate. They were reminded of the confidentiality of the study, and that no names would appear in the transcripts of the sessions.

Sessions were recorded using an audio recorder, and a directional microphone was placed in the center of the table. Research assistants were present to observe the sessions, take notes, and handle technical difficulties. Since all the focus group participants were African-American women, African-American investigators of the research project, trained in the use of focus group techniques and protocols, facilitated the sessions. Protocols and questions used in the sessions, were developed using the methods outlined by Morgan¹⁶ and Krueger.^{17,18} Items were developed to elicit participants’ views, without superimposing the cultural biases of the facilitators. Questions were open-ended and kept as simple as possible. Care was taken to word questions so they would

not be directive. Throughout each session, the facilitators used comprehensive probes to fully explore the meaning of the responses. In addition to probes, participants were asked to tell how they felt about specific terms, as well as to provide detailed information about their attitudes, beliefs, and actual experiences.

Focus group sessions began with a general question regarding women's perceptions of the word "cancer." Subsequent questions inquired about breast and cervical cancer, advantages and disadvantages of early detection, possible barriers for early detection, and factors that might deter women from complying with follow up and treatment.

Focus Group Data Analysis

Qualitative data were analyzed using the methodology described by Miles and Huberman, such that the participants' responses were transcribed and coded independently by 2 researchers.¹⁹ After the initial coding, the researchers identified patterns jointly. These were analyzed further, and categorized into patterns of responses. Data analysis was an ongoing group effort of the investigators and data collectors who met at regular monthly meetings. Transcriptions of sessions were reviewed by the facilitators, and revised to coincide with their notes. In cases where it was difficult to determine what was said on the tapes, team members were consulted. If a reasonable reconstruction of the comments could not be made, then the statement was left blank. The investigators had in-depth knowledge of the data, since they were present at its collection.

Each transcript was read in its entirety to get a sense of the whole. Individual units in the form of responses to questions, or themes from each transcript, were identified and coded, using the participants' own words, whenever possible. Similar codes were clustered and given an initial category label. Data collection and analysis took place in concert, and as additional data were an-

alyzed, comparisons resulted in revising codes and categories. Through ongoing analysis, the concrete language of the codes was transformed into more conceptual terms. After analysis of the total data set, larger themes that encompassed the categories were identified and described.

Community Action Plan (CAP) (Stage III)

This phase included analysis of the information from the needs assessment and the scheduling of meetings to conceptualize and finalize the CAP. Through a series of meetings, the coalition members and representatives of the lay community volunteers' network reviewed findings of the formative evaluation of focus groups. Based on these results, a list of strategies suggested by the members were discussed, and a draft of an agreed-upon intervention strategy for the CAP was prepared. The academic representatives of the coalition provided the coalition members with the scientific evidence needed for the chosen intervention strategies in the CAP.

In order to involve the community in the development of the CAP, community leaders and other targeted county representatives and agencies (eg, ACS) were invited to attend a one-day workshop to discuss the proposed CAP and provide feedback. Following the one-day workshop, coalition members reviewed all recommendations given during the workshop, and finalized the formulation of the CAP.

RESULTS

Community Capacity Building (Stage I)

Coalition and Community Volunteer Network Building

A coalition comprising multi-disciplinary, ethnically diverse members, was formed. The coalition included 2 academic institutions (The University of Alabama at Birmingham, which served

as the Coalition Central Organization [CCO], and The University of Alabama), state institutions (Tuskegee University National Center for Bioethics, the Alabama Cooperative Extension System, and the Alabama Department of Public Health), and a number of faith-based and community-based organizations (the National Black Church Family Council, SISTAs Can Survive Organization, House of Hope, Tuskegee Area Health Education Center, B&D Cancer Care Center, and Alabama Family Health Center). Although the coalition was fairly large, the membership felt that it was crucial to recruit additional members to join the coalition. Two additional agencies joined the REACH 2010 coalition: the Alabama Quality Assurance Foundation (AQAF) and the American Cancer Society (ACS). Following the initial meeting, the group participated in a series of joint meetings and conference calls to finalize the coalition's name and mission, and to set short and long term goals. In addition, the coalition defined the roles of each member and established an organizational structure for the coalition, including the election of officers, a voting system, and methods of communications among the coalition members.

This initial group became the Alabama Breast and Cervical Cancer Control Coalition REACH 2010 Steering Committee. The chair was a member of a community-based organization, and the co-chair was a member of a state institution. These 2 individuals worked in tandem with the CCO. The mission of the coalition was "to bring together diverse, passionate, committed individuals to empower the community to eliminate the breast and cervical cancer morbidity and mortality gap between White and African-American women in Alabama." During this phase, members of the Coalition Steering Committee also addressed specific tasks that focused on promoting further coalition building, developing and implementing the community needs assessment, and de-

Table 1. Breast and cervical cancer focus group findings

Questions	Identified Themes	Barriers
Individual level		
Question: what do you think of when you hear the words breast and cervical cancer?	Fear Death Depression Danger Fatalism Change in body image	Denial Lack of awareness/knowledge Lack of education Lack of insurance
Community system level		
Question: what hinders you from participating in breast and cervical cancer early detection and screening activities?	No reminders from family or spouse to adhere to cancer screening Limited number of physicians Limited public transportation Limited information about screening procedures	Lack of transportation Lack of support from family/spouse Lack of access to primary care physicians Overbooking of clinic appointments Negative information and uncomfortable examinations Preventive medicine not affordable
Agents of change level		
Question: what hinders you from participating in breast and cervical cancer early detection and screening activities?	Inattention of providers to their health problems Did not feel comfortable talking with providers	Health providers belittled their complaints Did not stress follow-up visits Spent limited time talking with them

veloping the CAP. Coalition members also successfully identified and recruited 84 community volunteers to serve in the REACH 2010 lay community volunteers' network. Each volunteer was consented by a member of the CCO staff, and was asked to participate in a one-day central training workshop, and a 2-day skills-building session, which imparted information on REACH 2010 programmatic issues, ethical principles of research, and community-based outreach strategies. Following the completion of training, volunteers were responsible for attending project-related meetings to keep abreast of project updates; promoting the project and its mission among their peers and key leaders; and meeting regularly with their coalition representative and the CCO staff to develop a tailored CAP for the REACH 2010 project. Further, this network of lay volunteers was instrumental in assisting the CCO staff and coalition recruit participants to take part in 9 focus groups throughout the target counties.

Community Needs Assessment (Stage II)

Nine focus groups were conducted, and included a total of 115 African-

American women with an average age of 45 years. The majority of the participants were high school graduates, married, and employed full time. The number of participants in the sessions ranged from 3 in Lowndes County, to 21 in Tuscaloosa County. The qualitative analysis identified 3 levels of barriers to early detection and treatment of breast and cervical cancer: 1) individual, 2) community systems, and 3) healthcare provider. Table 1 presents the main results of the focus groups.

Individual Barriers

The women tended to associate "breast and cervical cancer" with "fear, death, depression, and danger." Although the women were aware of methods of early detection and screening for cancer, they had a fatalistic view of potential health outcomes once cancer was diagnosed. The fear surrounding cancer seemed to be steeped in a combination of experience, myth, and legend, in these communities. However, women in urban areas, and those with more cancer information and resources, were more likely to view early detection and treat-

ment as important to their survival of cancer.

Community Systems Barriers

The likelihood that women would obtain early detection and screening was hindered by lack of family or community support, transportation, and access to the healthcare system and primary care physicians. Women reported that over-booked appointments at healthcare clinics were a barrier for them to comply with regular mammography and Pap smear screening. In addition, community members' negative experiences with uncomfortable exams, treatment side effects, and fear of death, negatively affected women's decisions to get mammograms and Pap smears. The women discussed the immense physical and psychological barriers to good health care within their counties. Further, having money and insurance were not enough to make these women feel safe.

Healthcare Provider Barriers

The women indicated that they saw inadequate healthcare providers as the source of much of the problem. They felt that some providers had poor inter-

Table 2. Community Action Plan (CAP) Multilevel Model

	Objective	Target	Approach (Strategies)
Individual level	Increase utilization of Pap Smear, mammogram, and clinical breast exam	Rural and urban African-American women	CHA will disseminate information, support, encourage, and assist women to navigate healthcare system to get screening
Community system level	Implement programs, policies, and practices to facilitate utilization of Pap smear, mammogram, clinical breast exam	Health department clinics, other clinics in targeted areas, churches, work sites, community based organizations in Alabama	CWG and REACH coalition will provide education, training, policy information, organizational development, and consultation
Change agents level	Change the agents of change attitudes and practices of breast and cervical cancer to facilitate women's access to screening	Healthcare providers, ministers, community leaders, legislators, administrators of clinics and HMOs in the state of Alabama	CWG and coalition members will provide education, training, disseminate information, lobbying and political action

CHA=community health advisor; CWG=core working group; REACH=racial and ethnic approaches to community health.

personal skills that made communication and the receipt of “good health care” difficult. They also reported that occasionally providers belittled their complaints, while almost always overbooking appointments, and keeping them waiting.

Development of the Community Action Plan (CAP) (Stage III)

Two main issues guided the rationale and the identification of the CAP framework. First, the coalition felt strongly that the CAP should address the 3 categories of breast and cervical cancer screening barriers identified, and should include activities targeted toward the individual women, and the community systems, as well as toward healthcare providers and other leaders in the community. Second, they felt that CAP activities needed to be implemented by lay individuals from the targeted communities (eg, Community Health Advisors [CHAs]), rather than by outsiders, and should be assisted by representatives from the healthcare system (nurses) and churches within their communities.

Address Identified Barriers

To address the first issue, the Multi-level Approach Toward Community Health (MATCH) theoretical frame-

work was the most suitable model to guide the CAP.^{20,21} The MATCH framework addresses 3 target levels: the individual, organizational, and governmental. In the Alabama REACH 2010 project, these translated to the individual (community women), community systems (health systems, worksites, schools, etc), and agents of change (providers, leaders, legislators, etc). For each target level, the coalition defined an objective, target group, and appropriate strategies for the intervention (Table 2).

Individual Level

The CAP objective is to increase utilization of breast and cervical cancer early detection measures, including mammograms, Pap smears, clinical breast exam (CBE), and pelvic exam. The target group is rural and urban low-income African-American women, aged 40 years and older, who reside in the Alabama REACH target counties. Specific strategies focused on educating women about the benefits of breast and cervical cancer early detection; disseminating information about resources for low cost or free mammograms and Pap smears; addressing women's fears and myths about screening and treatment; providing women with positive messages about outcomes of screening and treatment; and enhancing women's utilization and

compliance with breast and cervical cancer screening methods.

Community Systems Level

The CAP objective is to implement programs, policies, and practices that will enhance women's utilization of mammograms and Pap smears, as well as follow-up treatment. The target groups include health department clinics, churches, worksites, and community-based organizations in Alabama, particularly in the REACH project area. Strategies focused on the development and implementation of health programs at churches to encourage women to obtain mammograms and Pap smears; the implementation of policies and practices in health clinics to reduce waiting time; reducing the complexity of procedures and forms needed to determine eligibility for Medicare or Medicaid; and the allocation of 2 healthcare appointments each week for women with vouchers provided by the Alabama Department of Public Health Early Detection program. In addition, the program proposes to implement policies at worksites to provide incentives (paid time off, eg, 2 hours) for those who get a mammogram; to provide transportation to health clinics by working with church vans and West Alabama Transportation System; and to implement a media campaign to increase the communities'

awareness of REACH 2010 in Alabama, and of its goals to eliminate health disparities in breast and cervical cancer screening and treatment.

Agents of Change Level

The CAP *objective* is to change attitudes, knowledge, and practices toward breast and cervical cancer screening to eliminate barriers, and to facilitate women's access to the recommended screening methods. *The target groups* include healthcare providers (physicians, nurses, etc), ministers, community leaders, legislators, and administrators of clinics or organizations. *Strategies* focused on implementing educational programs for church ministers and leaders to gain their support for a healthy community, especially in the area of breast and cervical cancer prevention and control. Information about the REACH intervention will be disseminated among healthcare providers, and their support will be solicited to facilitate women's access to breast and cervical cancer screening and treatment. Attention will also focus on representatives of Health Maintenance Organizations (HMOs), who will be expected to develop policies and procedures in clinics that are providing care to our target population. The coalition aims to educate and partner with leaders of organizations such as the ACS, and the Komen Foundation, to solicit their support of the REACH 2010 project.

DISCUSSION

Some studies attribute low income, low education, and fear as reasons for disparities in rates of mammography screening between African-American and White women.^{12,22-25} Other studies suggest that these disparities may be the result of physicians not recommending mammography screening as often to African-American women as they do for White women.²⁵⁻²⁷ While our results support these findings, we also found that a sense of fatalism, lack of com-

munity support, and lack of clear understanding of the risk for getting breast cancer, and the need to get a mammogram, attributed to low screening rates. A major finding in our needs assessment was women's perception of the health-care system and health providers. While previous studies indicated that physician recommendation is the major reason for women getting a mammogram,^{25,27} women in our study described physicians as a deterrent to their getting a mammogram. These findings suggest that women in the target counties would like their physicians to give them more personal attention, listen to their complaints, and respect their time. The women also needed a community infrastructure to remove some of the system barriers that exist in their communities in order for them to adhere to recommended breast cancer screening.

Eliminating health disparities requires innovative approaches that can have a positive impact on the population at risk. In an effort to address breast and cervical cancer morbidity and mortality disparities between African-American and White women, the Alabama REACH 2010 project elected to mobilize the community, which is part of the population at risk, in the form of a coalition. This coalition took an active role in identifying problems, and in developing a CAP to address these problems. It has been shown that empowering grassroots organizations and other agencies with vested interests in the community by including them in a coalition not only increases the likelihood of connecting to difficult-to-reach, at-risk individuals, but also mobilizes the community and participating organizations around a health issue.²⁸

The development of the CAP was community driven and emphasized a multi-level approach that needed to go beyond the individual level. Within this approach, the coalition proposed specific strategies, which are being implemented in Phase II of the project, aimed at targeting community healthcare sys-

tems and agents of change, because these entities can affect the adoption of health behaviors.²⁹ In fact by including members of the target population in the conceptualization and planning of the CAP, there is a greater chance that the program will actively encourage and support local ownership and empowerment, and be an effective outreach and prevention health model.³⁰

As with much research utilizing focus groups, this study had shortcomings. The first limitation is that the women were recruited from 9 counties in Alabama, and their responses may be unique to this geographical area. Another limitation involved the actual recruitment strategy. Although participants received both written and personal invitations, the research team did not identify or attempt to reduce potential barriers and logistical problems preventing attendance (eg, transportation and child care needs, location). Furthermore, the women who actually attended the focus group sessions may differ in some ways from the targeted woman in the community. For example, the focus group participants may be more likely to be screened for breast and cervical cancer. Nonetheless, the focus groups provided a unique opportunity to identify and discuss barriers to screenings for breast and cervical cancer.

Another limitation is the use of coalitions in the development, implementation, and sustainability of community action plans. These are new approaches and there is little research reporting on the long-term effectiveness of these approaches on reducing health disparities. However, as a unified group, the coalition can maximize power and influence over an issue, pool resources and expertise, share responsibility for an issue, which can facilitate coordinated action, and minimize duplication of services.³¹

CONCLUSIONS

By including the community in identifying goals, and creating an in-

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creased awareness of the problem and methods to accomplish risk reduction, a large aspect of health disparity may be overcome. In this project, during the development process of the CAP, the coalition recognized that individual behaviors were strongly influenced by the infrastructure and social norms of their community.

Also, by including the target audience's suggestions in the development of an intervention through needs assessment, this audience would be more likely to identify with the goals of the program, have a greater awareness of the problem in their area, and work together in a unified approach to improve the breast and cervical health of African-American women.^{30,31} If this is to occur, it is paramount for the CCO and coalition to work together in an effort to keep the grassroots organizations informed and involved, as well as nurtured, and to build capacity at the local level. By maintaining an open dialog among the partners, and keeping them engaged in every aspect of program development, including getting their input on modifications that are made, these partners will recognize that they have important contributions to make in the overall success and effectiveness of these approaches.

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REFERENCES

1. Ma'at I, Fouad M, Grigg-Saito D, et al. REACH 2010: a unique opportunity to create strategies to eliminate health disparities among women of color. *Am J Health Stud.* 2001;17(2):93-106.
2. American Cancer Society. *Cancer Facts & Figures.* 2003.
3. American Cancer Society. *Cancer Facts & Figures for African Americans.* 2000-2001.
4. Jemal A, Murray T, Samuels A, Ghafoor A, Ward E, Thun MJ. Cancer statistics 2003. *CA Cancer J Clin.* 2003;53(1):5-26.
5. Alabama Department of Public Health. Cancer mortality: female breast cancer special report. Available at: <http://ph.state.al.us/chs/HealthStatistics/Mortality/cancer.htm>.
6. National Cancer Institute. Breast cancer screening. Available at: <http://www.meb.uni-bonn.de/cancernet/304723.zhtml>.
7. CDC Cancer Prevention and Control. The National Breast and Cervical Cancer Early Detection Program, 2002 program fact sheet. Available at: <http://www.cdc.gov/cancer/nbcedp/about.htm>.
8. McCarthy EP, Burns RB, Coughlin SS, et al. Mammography use helps to explain differences in breast cancer stage at diagnosis between older Black and White women. *Ann Intern Med.* 1998;128(9):729-736.
9. American Cancer Society. *Cancer Prevention and Early Detection Facts and Figures.* 2000.
10. National Cancer Institute. Cervical cancer screening (PDQ). Available at: <http://cancer.gov/cancerinfo/pdq/screening/cervical/healthprofessional/>.
11. Mandelblatt J, Gopaul I, Wistreich M. Gynecological care of elderly women. Another look at Papanicolaou smear testing. *JAMA.* 1986;256(3):367-371.
12. Institute of Medicine. Unequal treatment: what healthcare providers need to know about racial and ethnic disparities in healthcare. 2002. Available at: <http://www.nap.edu/catalog/10260.html>.
13. US Census Bureau. Profile of selected economic characteristics. 2000. Available at: <http://factfinder.census.gov>.
14. Alabama Department of Public Health. Center for Health Statistics. Available at: <http://ph.state.al.us/chs/HealthStatistics/Graphs/doctors.PDF>.
15. CDC. Tobacco information and prevention source. Chapter 2: describe the program. Available at: http://www.cdc.gov/tobacco/evaluation_manual/ch2.html#box1.
16. Morgan DL, Scannell AU. *Planning Focus Groups.* Thousand Oaks, Calif: Sage; 1998.
17. Krueger RA. *Developing Questions for Focus Groups.* Thousand Oaks, Calif: Sage; 1998.
18. Krueger RA. *Moderating Focus Groups.* Thousand Oaks, Calif: Sage; 1998.
19. Miles MB, Huberman AM. *Qualitative Data Analysis: A Source Book for New Methods.* Beverly Hills, Calif: Sage; 1984.
20. Simons-Morton DG, Simons-Morton BG, Parcel GS, Bunker JF. Influencing personal and environmental conditions for community health: a multi-level intervention model. *Fam Community Health.* 1988;11(2):25-35.
21. Simons-Morton BG, Brink SG, Simons-Morton DG, et al. An ecological approach to the prevention of injuries due to drinking and driving. *Health Educ Q.* 1988;16(3):397-411.
22. Witmer A. Community health workers: integral members of the healthcare work force. *Am J Public Health.* 1995;85(8):1055-1058.
23. Underwood SM. Development of a cancer prevention and early detection program for nurses working with African Americans. *J Continuing Educ Nurs.* 1999;30(1):30-36.
24. Thomas SB, Quinn SC, Billingsley A, Caldwell C. The characteristics of northern Black churches with community outreach programs. *Am J Public Health.* 1994;84:575-579.
25. Coyne CA, Hohman K, Levinson A. Reaching special populations with breast and cervical cancer public education. *J Cancer Educ.* 1992;7(4):293-303.
26. Hawley ST, Earp JA, O'Malley M, Ricketts TC. The role of physician recommendation in women's mammography use: is it a 2-stage process? *Med Care.* 2000;38(4):392-403.
27. Artemis feature article. Barriers to breast cancer screening. 2001. Available at: <http://www.hopkinsmedicine.org/breastcenter/artemis/200102/feature3.html>.
28. Kreuter MW, Lezin NA, Young LA. Evaluating community-based collaborative mechanisms: implications for practitioners. *Health Promot Pract.* 2000;1:305-307.
29. Green LW, Kreuter MW. *Health Promotion Planning: An Educational and Ecological Approach.* 3rd ed. Mountain View, Calif: Mayfield; 1999.
30. National Cancer Institute. *Sowing Seeds in the Mountains: Community Based Coalitions for Cancer Prevention and Control.* Bethesda, Md: NCI; 1994. NIH Publication No. 94-3779.
31. Rice RE, Atkins CK. *Public Communication Campaigns.* 2nd ed. Newbury Park, Calif: Sage; 1995.