Using Qualitative Methods to Conduct a Culturally Responsive Evaluation of the American Cancer Society's Partnering for Life Toolkit Program for African American Churches in the South

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For more information contact: Tiffany Burgess @ tiffany.burgess@icfi.com or tawana.thomas-johnson@cancer.org

Qualitative Data Collection in Evaluation	Culturally Responsive Evaluation
"Qualitative methods fill the gap in the public health toolbox; they help us understand underlying behaviors, attitudes, perceptions, and culture in a way that quantitative methods alone cannot. Qualitative methods are particularly suited to understand the how and why questions. Similarly, qualitative results help us understand social, political, and economic factors associated with contemporary and emerging health problems. They can also be useful in understanding facilitators and barriers to the implementation of new public health programs." (Ulin, Robinson and Tolley, 2004)	Culturally responsive evaluation(CRE) is an evaluation approach in which understanding a program's culture and the cultural backgrounds of program stakeholders are critical assessing the program's value, merit, and worth" (Askew et al., 2012; Frierson, et al., 2002; Kirkhart & Hopson, 2010). CRE is: "An evaluation is culturally responsive if it fully takes into account the culture of the program that is being evaluated. In other words, the evaluation is based on an examination of impacts through lenses in which the culture of the participants is considered an important factor…Moreover, a culturally responsive evaluation attempts to fully describe and explain the context of the program or project being evaluated" (Frierson, Hood and Hughes, 2002)

PROJECT OVERVIEW

Background: The American Cancer Society (ACS) is working to further advance its community health initiatives to decrease screening disparities in breast and colorectal cancer. To this end, ACS initiated integration of the Partnering for Life (PFL): Affirming Health Awareness and Well-Being Through Cancer Awareness toolkit into African American churches in the South. The ACS South Atlantic Division developed the PFL toolkit to provide awareness, education, and resources to churches and faith-based organizations to reduce the rate of cancer in the African American community.

The PFL toolkit supplies health ministry leaders with a 2-day, 10-module cancer education training program with practical and effective resources that work in harmony with their spiritual beliefs. From 2008 through 2013, ACS implemented the full version of PFL in several South Atlantic Division communities. In 2012, ACS received corporate funding from Walgreens to implement cancer prevention and early detection interventions. ACS used a portion of the funds for grants to six churches to implement PFL activities using the breast, colorectal, and/or nutrition modules in the PFL toolkit. Each of the six funded churches received $6,000 to implement an abbreviated PFL toolkit through their health ministry from November 1, 2012, to September 13, 2013 (as stated in the ACS Request for Applications [RFA]). In 2013, ACS contracted with ICF International (hereafter referred to as ICF) to conduct a culturally responsive process evaluation of the abbreviated PFL toolkit, specifically to assess implementation of three PFL modules: (1) breast cancer, (2) colorectal cancer, and (3) nutrition.

Design/Methods: Following the steps outlined by the Centers for Disease Control and Prevention (CDC) evaluation framework (Centers for Disease Control and Prevention, 1999) and principles of CRE, the ICF team (in partnership with ACS) designed a culturally responsive, qualitative case study evaluation of the abbreviated PFL toolkit curriculum in churches. The study purpose was to collect in-depth qualitative data about program implementation, facilitators, and barriers to implementation, and program sustainability. Qualitative methods were used to obtain a deep understanding of the context and church leaders' experiences implementing PFL. This method provided insight into the grantees' perceptions of PFL implementation, and thus helped the team best answer questions about barriers and facilitators, program sustainability, and potential for continued ACS partnerships with African American churches for PFL implementation, with the goal of reaching the broader African American community.

Development of the PFL Logic Model

Logic models provide a systematic and visual way to present the relationships among an intervention's inputs, activities, outputs, and outcomes that are essential to evaluation. These types of models are the foundation of an evaluation. Therefore, the ICF team started by developing a logic model to illustrate the inputs, activities, outputs of ACS, and the expected outcomes from the implementation of the PFL activities by the churches. Because the logic model identifies PFL's short- and long-term outcomes and the intermediate steps in the pathway to those outcomes, the team used it to guide decisions about many aspects of evaluation, including the optimal design (qualitative, case study design) and questions to include in data collection instruments to answer the evaluation questions. Logic models are organic, and, as such, the model was modified and refined during the evaluation process to provide an accurate and comprehensive picture of the PFL program.

Data Collection: Consistent with using qualitative data methods in evaluation, the ICF team conducted thorough reviews of ACS and church-provided documents about the PFL program prior to conducting site visits. The ICF team, in collaboration with leaders from each church, identified interviewees for the evaluation. The team conducted a total of five site visits to African American churches in the South. During the site visits, the team conducted 29 in-person interviews with Lead PFL Administrator(s)/Church Leadership, Primary Health Ministry Members, Partners/Other Stakeholders and ACS Community Health Advisors (CHAs). The ICF team also conducted 2 telephone interviews with ACS PFL staff, bringing the total to 31 interviews.

Data Analysis: All evaluation data were analyzed using thematic analysis. For each data source, a member of the ICF team examined the data for common themes and patterns necessary to answer the evaluation questions. This methodology allowed the evaluators to identify common threads throughout the data and triangulate data from the sources (documents, interviews, and observations) to answer questions. The team coded and analyzed notes using ATLAS.ti, a qualitative data coding and analysis program. A total of 20 different codes were developed, primarily according to the interview guide topic areas. To test coding accuracy and definition clarity, each coder independently applied the codes to two randomly selected interviews. Following each pretest, the project team compared coding for each interview, resolved differences, redefined existing codes, and ascertained the need for new codes. Once intercoder agreement was established at 80%, the team continued with independent coding of the remaining interview field notes.

Conclusion: The findings indicate that PFL is valued by participating African American churches and is viewed as a tool to raise cancer awareness in African American communities. Pastoral support and solid ACS partnerships were key facilitators to implementation. All participating churches sought to strengthen and sustain their relationship with ACS to adopt and implement the PFL, as well as to serve as "champions" to broadly promote the PFL toolkit with other churches and faith-based organizations. All of the churches expressed such an appreciation for the PFL program that they will continue to implement PFL activities, albeit not "at the same level" without continued funding for activities (e.g., through health fairs, workshops, seminars, other church events). To expand PFL reach and strengthen church partnerships, the ICF team recommended that ACS continue to promote the PFL toolkit on a national stage and engage local and nationally known partners. A final important take-away is that all respondents reported that they would recommend other churches implement the PFL toolkit.

DISCUSSION QUESTIONS

1. Why did the ICF team choose qualitative methods to conduct this process evaluation?
2. What are the key facilitators and barriers to conducting a CRE using qualitative methods?

AUTHORS (IN ORDER):

Tiffany Burgess, ICF International
Linda Baffo, ICF International
Jennifer Mezzo, ICF International
Ashani Johnson-Turbes, ICF International
Tawana Thomas-Johnson, American Cancer Society
Rentonia Morton, American Cancer Society
Kara Riehman, American Cancer Society