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Using Community Feedback to Improve Community Interventions: Results from the Deep South Network for Cancer Control Project

Theresa A. Wynn-Wallace, PhD [Program Director] [Associate Director]

Center Administration, Division of Preventive Medicine, University of Alabama at Birmingham

Abstract

The Deep South Network for Cancer Control (DSNCC), initiated in 2000, is a dual state, community-based participatory research infrastructure comprised of academic and community partners committed to reducing cancer disparities among underserved African Americans in twelve designated counties of the Alabama Black Belt and the Mississippi Delta, two historically underserved areas of the country. Local residents trained as Community Health Advisors as Research Partners implemented a three-tier community action plan (CAP) focused on promoting cancer screening, physical activity and nutrition. Breast, cervical and colorectal cancer screening, healthy eating habits and physical activity levels increased among many, but not all, African American women in the 12-county DSNCC coverage area. Seeking to improve our reach to include participants who reported they had never heard of DSNCC or participated in the CAP, we conducted in-depth conversations with community residents about reasons for selective nonparticipation and ways to improve participation in DSNCC community health interventions. Three patterns and their associated themes described ways to improve the penetration of CAP strategies and tailor them to effectively reach underserved African Americans in the intervention counties. We conclude with lessons learned for future interventions.

Keywords

Community-based participatory research; African Americans; cancer screening; physical activity; nutrition

Background

Despite improvements in the overall health of the nation, health disparities continue to persist and are widening for some population groups. For many health conditions such as heart disease, stroke, cancer and diabetes, African Americans bear a disproportionate burden of disease, death, and disability as compared to the rest of the population. These disparities are especially pronounced among African Americans living in the south, where obesity rates soar. Mississippi and Alabama continue to lead the nation with obesity rates greater than 35 and 30 percent, respectively.¹ Obesity is increasingly linked to racial and ethnic disparities in

breast, cervical and colorectal cancer, and, in addition to programmatic efforts to improve cancer awareness and access to screening, physical activity and other weight management interventions in high risk communities may contribute to reducing disparities. Recognizing the importance of involving racial and ethnic minority populations in efforts to address health disparities, the National Cancer Institute (NCI) launched the Community Networks Program (CNP) in 2005. The purpose of the CNP is to improve access to -- and utilization of -- beneficial cancer interventions and treatments in disparity communities. CNP grantees help ensure that communities and populations experiencing a disproportionate share of the cancer burden have the resources to address cancer disparities through community-based participation in education, research and training.² The University of Alabama at Birmingham's Deep South Network for Cancer Control, known as DSNCC henceforth, is one of the 25 participating CNP institutions.

The DSNCC, initiated in 2000, is a dual state infrastructure comprised of academic and community partners committed to reducing cancer disparities among underserved African Americans in Alabama and Mississippi. We developed strategic academic-community partnerships and collaborations during DSNCC I (2000-2005) effectively establishing one of the largest cohorts of African American grass-root, community volunteer networks to increase breast and cervical cancer screening.³ Colorectal cancer was added as a third cancer screening priority in DSNCC II (2005-2010) and we emphasized promoting healthy behaviors and lifestyle changes in the areas of physical activity and nutrition, as well as transitioning to evidence-based programs.⁴

Under DSNCC II, local residents trained as Community Health Advisors as Research Partners (CHARPs) implemented a three-tier community action plan (CAP) focused on promoting cancer screening, physical activity and nutrition in eight Alabama and four Mississippi counties. As described in detail elsewhere,⁵ specific components of the CAP entailed: 1) conducting cancer outreach activities (e.g., paint the town pink events, media advertisements, health fairs) in zip codes where cancer screening rates were low; 2) identifying women who were never or rarely screened and assisting them to schedule and keep cancer screening appointments; and 3) implementing WALK! Feel Alive, a local promising practice to encourage physical activity, and the NCI's evidenced-based Body and Soul intervention aimed at increasing the intake of fruits and vegetables among African Americans.

Breast, cervical, and colorectal cancer screening, healthy eating habits, and physical activity levels increased among many, but not all, African American women in the 12-county DSNCC coverage area (data not shown).⁶ DSNCC III sought to improve our reach to include participants who reported they had never heard of DSNCC or participated in the CAP. This paper reports the results of in-depth conversations with community residents about reasons for selective nonparticipation and ways to improve participation in DSNCC community health interventions.

Method

A multi-site qualitative descriptive study was conducted. Using existing community networks and resources, CHARPs in each of the 12 DSNCC counties identified and recruited current, former, and non-DSNCC participants who were African American residents of the county, age 19 and older, and agreed to participate in one of three information-gathering strategies based on their prior level of involvement with the DSNCC. Non-DSNCC participants were invited to take part in a focus group while current and former DSNCC participants were invited to take part in a roundtable discussion or individual interview. Upon agreeing to participate, members were notified by phone or letter of the date, time and location of their session. Focus groups and roundtable discussions were usually held at five or six o'clock in the evening at a local community center, health department or library and lasted approximately one hour. Light refreshments were served and circular seating was arranged to create a relaxed environment. Sessions were facilitated by trained DSNCC community health educators with the assistance of the county coordinators. Former DSNCC Walk! Feel Alive or Body and Soul team leaders deemed by the CHARPs as key were invited to take part in an individual interview. Key informant interviews were conducted by telephone based on the participant's availability. Each session began by reviewing the purpose of the study, discussing basic ground rules and the study's confidentiality clause with assurances that pseudonyms would replace their names in the transcripts, and signing of consent forms.

Similar data was collected from each of the information gathering strategies. Focus groups and roundtable discussions were similar in format; however, the focus groups were more directed as participants had no prior experience with the DSNCC. After receiving a 5-10 minute overview of DSNCC's past effort to increase cancer screening, improve physical activity levels and promote healthy eating, non-DSNCC participants were asked how they would tailor each CAP campaign to fit the needs of their community and make participation possible for most residents, particularly underserved African Americans. Current and former participants, who took part in roundtable discussions and key informant interviews, were asked a similar question, but asked to respond based on their firsthand knowledge of the CAP campaigns. Dialogue was encouraged among the current and former participant groups to highlight aspects of the program that facilitated or hampered continued participation. As needed, the facilitator probed for further clarification and asked participants to elaborate on their responses using examples.

All protocols and topic guides were developed by the DSNCC investigative team, reviewed and refined by community advisory board (CAB) members and approved by the University of Alabama at Birmingham's Institutional Review Board. Participants received a \$15 gift certificate in appreciation for their assistance.

The audiotapes and co-facilitator session notes were transcribed verbatim by a trained transcriptionist who was familiar with the dialects and used pseudonyms or numbers as identifiers. Transcripts were reviewed independently by the DSNCC investigative team (n=4) and CAB members (n=3). Using precepts of qualitative descriptive research described by Miles and Huberman,⁷ interviews were read first to attain a general sense of the whole.

Key codes were then identified on subsequent readings using the participant's words to describe concepts and ideas. Once major themes had been identified, the transcripts were reread in their entirety to assure consistency of coding and theme identification across interviews and cross-group analyses were conducted. Upon completion of first-level coding, the themes were further categorized into patterns of responses from the perspectives of current, former and non-DSNCC participants that were common across all interviews and captured the highest conceptual level. Review and discussion of themes, interrelationships and patterns involved the full investigative team and CAB. As needed, coded sections of text were read and reread to assure common understanding. Patterns and data summaries were reviewed by the CHARPs for coherence.

Findings

From April to June 2011, 109 non-DSNCC participants and 200 current DSNCC participants took part in 12 focus groups and 12 roundtable discussions, respectively, and 25 former DSNCC participants engaged in key informant individual interviews. All of the attendees were African-Americans; 98% were females, age 40 years and older, and a long-term resident of one of the eight Alabama or four Mississippi DSNCC counties.

Findings were similar across all three information-gathering strategies and participant types. In general, all participants expressed feeling more concern about their overall health than ever. They were alarmed about their poor health status, body weight and the amount of medication needed to relieve medical conditions. Additionally, they considered themselves to be living in a fast-paced world where many traditional ways (e.g., food preparation and sedentary lifestyle) appeared to be doing more harm than good. Yet, they were optimistic that programs like WALK! Feel Alive and Body & Soul, if revised and expanded, could improve personal and community health and well-being. Overwhelmingly, the programs were praised as being "enjoyable," "fun," "much needed," "very good" and "wonderful." They saw WALK! Feel Alive and Body & Soul as opportunities to make a significant difference in cancer prevention and improving health. Three patterns and their associated themes described ways to improve the penetration of CAP strategies and tailor them to effectively reach underserved African-Americans in the intervention counties. The patterns were identified as: "Season is Ripe;" "Promoting Healthy Messages;" and "Going Beyond."

Season is Ripe

There was overwhelming enthusiasm and support for the CAP campaigns; even the non-DSNCC participants indicated that they thought the campaigns could definitely work in their communities and churches. As one DSNCC non-participant articulated,

"I think that the [programs] can work. Several of us are part of the same congregation. Many of us are interested in becoming healthier. **I think it is a very ripe season!** ... there is so much sickness and disease that we have--group health disparities and some other things...everyone is health conscious. We all want to live longer. People want to do and feel better."

Timing turns on the increasing personal burden of health concerns yet respondents also articulated that, to make the programs succeed, *addressing reasons for nonparticipation* is

required to reach the previously unreached. In this theme, they described various reasons for nonparticipation and ways to address them. Major reasons included access, fears, fatalism or resistance, and CAP program demands. Not everyone has had the opportunity to participate; despite success in most areas, some communities have not been reached. Targeting the previously unreached by promoting cancer awareness and screening activities in zip codes where there is no or limited DSNCC interventions was the first strategy proposed.

Some people are fearful. Participants described fear of privacy invasion or loss of benefits. “Many people will not participate because they don’t want things shared...these days, people want to keep their personal information private because they are afraid they will cut off government benefits that they are receiving.” Many do not have insurance or access to follow-up care. Letting people know about free screenings and other sources of health care that do not impact benefits was identified as an important factor to overcome nonparticipation. As well, one participant noted that “the biggest fear is if you take the test and you will discover you have something.” Giving personal testimonials was heralded as a way to overcome fears. Several of the DSNCC former and current participants expressed a desire to speak at churches, businesses, civic groups and community events where a large percentage of African Americans gathered regularly. They agreed it was time to “reconnect with volunteers so they can implement the message in their own lives and communities.” According to non-DSNCC participants, connecting with someone who has been there could overcome nonparticipation by dispelling myths and overcoming skepticism. This resonated with one DSNCC participant: “Health is a big issue; if I explain it to them they may take part in it.” Others insisted: “Tell your story, your personal testimony. Get a person who will give cheerful news to be a witness. Hear from a cancer survivor. By sharing stories, certain cancer related myths will be dispelled.” As one woman said, “I am a breast cancer survivor for 14 years and I used to belong to [name] support group and we used to do just that. It helped the other ladies who had breast cancer by walking and talking about it. It helped a lot.”

Others are “set in their ways,” “figure they are beyond help and don’t care or want to take or make the time” and are skeptical that their actions will not make a difference. As one person noted, “We as a people think ‘Well, I am going to die from something [so it doesn’t matter what I do],’” so we enact a fatalistic attitude. In addition to personal testimony, refining the CAP programs to combine elements of Body and Soul and Walk! Feel Alive in a more consolidated format was suggested. Revising the CAP could address participants’ time constraints while delivering key information to overcome inadequate understanding of the effects of risk factors and highlighting the possibilities for improving well-being or extending healthy life. “When we know better, we do better.” Of importance, respondents also warned that we all need to recognize that change will be slow as “breaking from tradition will bring resistance.”

Promoting Healthy Messages

All participants confirmed the overall goal of promoting healthy messages by using approaches that appeal to the community. Four themes (*italicized below*) specified strategies for accomplishing this. Participants told us that it was time to move past compartmentalizing

health by diseases and focus on the individual's overall health and wellness. Integrating WALK! Feel Alive, Body & Soul and Cancer Awareness and Screening into one comprehensive program could accomplish a focus on health as lifestyle. As several participants noted, "When you have a food festival to promote healthy eating, also have physical activity classes and appointments for cancer screenings available." "For example, when you promote nutrition, have exercise classes and health screenings underway at the same time." Another participant replied, "Given the time constraints of a working family, you have to focus your program on healthy eating and exercising and stress the benefits of doing both of those things." Another punctuated this approach stating, "People want to be healthier; but you need to eat right because exercise alone won't do it."

Garnering community support for promoting healthy messages was stressed: "Get someone with high leadership skills and who is positive to support." Many highlighted the importance of getting pastors and 'first ladies' involved in promoting the revised program.

"Get the pastor to approve and support...when the pastor says he wants the church to do this, the congregation will follow. If you have the pastor's support, then you have the opportunity to train the people...just go in there and talk to him and talk to the pastor's wife, the first lady. The first lady can influence the minister."

As well, pastors and others can help by *modeling healthy behaviors*. "Basically, you lead by example...people need to see healthy behavior in church so they can go home and do it." As one participant recounted:

"I attended a conference and this minister was the facilitator. He decided that when they had fellowship dinners that they could no longer make certain foods. He had opposition from members and he hosted the first meal. They enjoyed it! The congregation began to see the benefits of eating healthy. [We went on] to have a food fest ... prepared healthy dishes and had people try them and see how they were prepared. We have the recipe, calorie, fat content, etc. In doing that you can invite other local pastors and wives [to work together and spread the message]."

Training more pastors and getting pastors to talk with each other about ways to promote cross-church activities were suggested strategies.

Tailoring the message to fit the needs of the community was stressed as a crucial way to improve participation and present the message. One way to do that is through advertising. For example, participants suggested that we advertise DSNCC success stories using outlets such as newspaper, TV, radio, church announcements and brochures, as well as venues that appeal to younger audiences. Specifically, "reach the youth with life-saving messages through social media like Facebook and Twitter." Another recognized that, "for the adult population that may not be into social media, you can distribute cancer screening brochures in churches, libraries, laundromats, or grocery stores." Others noted that it would be important to "have health fairs to help people learn and bring your videos because we react quicker to what we see than what we hear." Framing print and visual media messages through the lens of knowing the importance of family history could help tailor messages to address individual fears. "Many people are still afraid to say the word cancer, let alone talk about it. So the discussion has to be presented in a non-threatening manner." Another

participant supported group activities as a way of tailoring the message while simultaneously motivating and challenging participants to put healthy lifestyle and cancer screening messages into practice:

“Sometimes it works better if you are in a group than by yourself... We get to talking and laughing and you don’t realize you walked a mile.”

“Make it a competition... Put something up, put a quarter in a jar every time you get ready to walk and whoever lose the most weight or walk the furthest get the jar... Once you start doing it, then that will motivate you to do it more. You’ll begin to like it. You’ll begin to move more. Once you get out there and say ‘I’m going to meet my friend today’ ... even if it is ... at 8 o’clock in the morning. It was so much fun to walk around the track at the old park. We were all together. We liked that. ... As a group we can walk to show support of mammography. We can walk every day to support. That would encourage someone else.”

Finally, all respondents suggested *providing incentives* that are relevant for the activity with progressive enhancements and rewards. Among the many options mentioned were:

“Start out with something small, inexpensive and save larger, more appealing items toward the end. Have some healthy refreshments, give cookbooks, placemats (with healthy serving tips), aprons, coupon books for healthy foods. Once you get people involved, then you need to do a little awards ceremony. Give them certificates and trophies just so people will be motivated to do this. We all like to be a part of something that will help us.”

“Have a drawing once a month, it doesn’t have to be much - \$10 or \$15 gift card and everyone will be excited to try to win it.”

“Coupon vouchers from some of the larger companies for purchasing healthy items.”

“Put the message on T shirts, sweat bands, water bottles, bracelets, pens, reusable bags, pedometers. I think people sometimes get addicted to the pedometers.”

“[And, for larger items], jackets, gloves or earmuffs for winter, shoe inserts or thick heavy socks, Velcro leg weights, walking shoes as a prize. And, of course, money answers everybody’s problems.”

“Focus on certain screenings on certain months and make the incentives match. Maybe send out birthday reminders for annual screenings.”

Going Beyond

All participant groups identified that the current CAP needed to go beyond its current reach. CHARP leaders are well-trained and want to lead this charge as project spokespersons or ambassadors. As one suggested, creating the slogan: “Come on and try it... you’ll like it,” is one way to expand the message. They identified the need to include colorectal and prostate cancer as part of their focus and expressed desires to expand the reach of their message and activities including the following themes:

- *reaching out to men and children,*

- *developing new approaches and techniques*, and
- *involving new venues and partners*.

Getting more males and children involved was a major consideration.

“We have to get more men involved. Prostate cancer ought to be included. In the black community, men are left on the outside of any social dynamic force. Until we include them, husbands and boyfriends won’t participate.”

Respondents recommended modifying the CAP to place a greater emphasis on not only prostate cancer, but cervical, colon and rectal cancers. “People readily know what the pink ribbons stand for, but not necessarily the meaning of other ribbons.” One suggestion was to approach the inclusion of men and children “as a whole family.” One participant shared how her family had approached this with the younger children.

“My sister demonstrated breast self-exam with the younger kids. My daughter didn’t know and she should have...not only my children, but we got to get the message out and children could take it back home and tell their parents what they learned.”

Getting the children involved by “recruit[ing] ‘junior’ CHARPS (K-12) to get their ideas could create a focus on teens and their peers” and facilitate spreading the message to their families. Also, by capitalizing on the important role of women to reach out to their significant others, men and children could be included. As one participant attested:

“I think we already have women. Women are the primary recruiter. I mean women do everything, they are the natural leader. They are the leader on the type of food we eat. They are the backbone for parenting children. For getting men involved, they can take the lead here too...they can say ‘I value your life. I want you around and I want you to have this prostate screening.’”

Getting people excited about the programs was described as key. *Developing new approaches and techniques* could revitalize the involvement of current participants and extend the reach to nonparticipants. “It’s the members that will be spearheading the programs. Varying the information delivery including the availability of printed and visual materials, expert speakers, testimonials, health fairs...” is needed. Some suggested including “ways to exercise at home” and creating new approaches, such as, “ballroom dancing, line dancing, prayer walking;” “soup days, fruit days, vegetable day,” “starting a community garden” and multiple other ways to vary the presentation of the message and increase community enthusiasm.

Importantly, these participants suggested that expanding beyond the current church-based focus of DSNCC programming is crucial if the CAP is to succeed in as-yet unreached areas. *Involving new venues and partners* will be a requisite for future success.

“Church is the largest community-based organization that reaches the greater number of persons and it is a good source to pass info if we can get unity among the churches. In a community, they could do the same things. Their emphasis on health could be the same. All churches talking about nutrition and a specific

behavior, I think it would affect a great number of people. But I am also aware that the church is losing its grounding in the community... you will reach some people in the church, but the majority of people will be outside the church.”

In addition to strengthening the church connections by such things as training of more pastors and health ministers, they suggested utilizing the knowledge and expertise of former and current DSNCC participants to reach beyond the church. Engage with, for example, mayors and local media to expand the reach of the message:

“Get the mayor involved so the community as a whole can begin to hear about it. People can get excited... you just have to get information out”

“...use public sources of communication with the community – local newspapers and radio stations to get them involved. Get people to keep hearing it! You have to get the message out.”

Seeking new places and spaces for active living was also emphasized. Combine CAP activities for physical activity, nutrition and cancer awareness and form alliances with schools, civic groups and fraternities to make the revised program a success. Community centers, schools, park and recreation facilities, among others, were mentioned. One participant boldly suggested that communities could “develop a proposal to get a genuine activity center that will encompass all the community health habits as well as recreation for kids for the summer. We need a place for old people, kids, men and women.”

Others advised specifically targeting the previously unreached zip codes. Two strategies were suggested: 1) Promote cancer awareness and screening in zip codes where there is no DSNCC presence. “Many residents only travel to town on certain days or for a particular reason, if the program is only focused in or around the town square, then you are going to miss many people.” 2) Use a boots on the ground approach by focusing on door-to-door campaigns and starting neighborhood canvassing events. One participant said, “Target other areas and places in the county. We have to move beyond their comfort zones.” Others echoed those sentiments by saying, “Lets promote healthy messages in places like Wal-Mart, Dollar Tree and at little league games.” Many acknowledged that we cannot wait for individuals who need the help to come to us; we have to come to them.

Discussion

Aiming to improve upon a 14 year, sustainable, community-based infrastructure for cancer awareness in the southern African American populations of eight Alabama and four Mississippi counties, we engaged a wide-ranging cohort of community members to tailor DSNCC community interventions to improve current programming and reach previously unreached high-risk populations. Seven of the eight Alabama counties are located in the area of the state known as the Alabama Black Belt, a region named for its dark soil and soaring poverty rates among African Americans.^{8,9} Two of the four Mississippi counties are located in the Delta, an area referred to by some as the “third world country” in the heart of America.¹⁰

Despite the bleak picture that various reports portray of these underserved regions/areas of Alabama and Mississippi, our experience has been a positive collaboration with lay and professional residents from these communities who embraced the opportunity to address their own concerns in partnership with academicians. This community-driven partnership has laid the groundwork for new opportunities to reach as-yet-unreached persons to address cancer health disparities in these high-risk communities.

Our work is embedded in an increasing focus on the influence of community voice in addressing and resolving health issues and disparities. For over 50 years, researchers have recognized the need for a more active role of communities in health care – what Mold refers to as “choices” and “voices.”¹¹ Community-based participatory approaches have emerged as a response to conventional approaches that have failed in producing sustainable change in health status among marginalized populations.¹² Similar to other studies conducted in this paradigm, our findings highlight common reasons for nonparticipation such as access to information, fear of screening efficacy (fatalism), fear of a “bad” result.^{13,14} In many such studies, trust of health care providers or others attempting to implement programs is identified as a major concern. While some participants did note fear of privacy invasion or loss of benefits from screening opportunities, in our study, even among non-DSNCC participants, mistrust in DSNCC programs was not communicated. Rather, they expressed an underlying assumption of trust and conviction that the “season is ripe” as they delineated ways to address the next problem in this long-standing DSNCC partnership: reaching those we haven’t yet reached. Multiple specific strategies to address barriers were specified as ways of “Promoting the Message” and “Going Beyond” to extend the DSNCC reach. One of the most notable recommendations was to expand beyond the church as the centerpiece for program implementation. The African American church has been a focal point for most community intervention studies in this population. Recognition that the “church is losing its grounding” in these Bible belt communities calls us to rethink our strategies for reducing health disparities among African Americans and has significant implications for other similar intervention studies. Our findings reflect the success of DSNCC in building an iterative CPBR process where mutual trust, equitable partnerships, and community knowledge and decision making are central to designing and enacting community-driven approaches to overcome cancer health disparities.

Our study is not without limitations. First, by employing CBPR and focus group methodologies in specific communities, our findings cannot be generalized to the general public. However, we did verify the relevance and resonance of our findings with other similar studies including prior needs assessment data from previous DSNCC activities¹⁵⁻¹⁹ and formative evaluations conducted in Alabama by the CDC-funded REACH US project.²⁰ Second, most participants were women, reflecting DSNCC’s primary and initial focus on breast cancer awareness and screening activities. Intentionally including more men as respondents could have provided more robust findings, particularly regarding ways to reach men as programming is expanded to include colorectal and prostate cancers.

By integrating grassroots wisdom with academic standards, we learned five valuable lessons that will help guide us during the next iteration of DSNCC:

Lesson 1: Straight and Narrow is the Way. While past CAP campaigns attempted to be broad in its approach by implementing county-wide activities, we learned that tailored strategies (e.g., personal testimonies about DSNCC, door-to-door outreach efforts, neighborhood canvassing), that are implemented by trusted and credible key leaders like CHARPs, is a viable way to “reach the unreached” with life-saving messages.

Lesson 2: Let Me Tell My Story. In the initial iterations of DSNCC, CHARPs’ roles and responsibilities were defined primarily by the DSNCC staff. Through the CBPR process, CHARPs, with technical assistance from the staff, are ready and willing to assume a leadership role. By listening to their community, they want to design different, but meaningful CAPs that impact people where they live, work, worship and play, moving beyond the church as the centerpiece to encompass more far-reaching elements of the community for activities.

Lesson 3: Don’t Follow the Yellow Brick Road. There was unanimous consensus that we need to expand and implement CAP campaigns in areas other than the county seat or the town square. Reaching the unreached may call for going down dirt roads and side streets that are truly off the beaten path.

Lesson 4: One Stop Health. Instead of segmenting programs by health topic or disease focus, we were encouraged to combine all our efforts under one banner and see the community holistically. In doing so, various alliances can be formed, programs leveraged, resources pooled and manpower minimized.

Lesson 5: Stop Preaching to the Choir. Usually health and wellness topics and/or events appeal to those who are more health conscious than the general population. As a result, the healthy stay healthy and the sick remain sick, thereby widening the health disparity gap. To break unhealthy generational habits, we were strongly encouraged to make a concerted effort to involve males and the youth in the CAP.

Conclusion

Designing meaningful community interventions requires the active participation and expertise of community partners and academicians to create programs that support health and healthful behaviors. When both sectors are working toward common prevention priorities, health improvements can be amplified and accelerated. When communities exercise their voice, reality-based strategies for solving health concerns are generated. In our case, the community feedback and recommendations we received from current, former and non-DSNCC participants enabled us to retool our current CAP to support community-driven, CHARP-implemented interventions designed to reach the unreached during the third iteration of DSNCC III (2010-2015).

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