TBM

ORIGINAL RESEARCH

Enhancing capacity among faith-based organizations to implement evidence-based cancer control programs: a community-engaged approach

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Cite this as: *TBM* 2017;7:517–528
doi: 10.1007/s13142-017-0513-1

Abstract

Evidence-based interventions (EBIs) to promote cancer control among Latinos have proliferated in recent years, though adoption and implementation of these interventions by faith-based organizations (FBOs) is limited. Capacity building may be one strategy to promote implementation. In this qualitative study, 18 community key informants were interviewed to (a) understand existing capacity for health programming among Catholic parishes, (b) characterize parishes' resource gaps and capacity-building needs implementing cancer control EBIs, and (c) elucidate strategies for delivering capacity-building assistance to parishes to facilitate implementation of EBIs. Semi-structured qualitative interviews were conducted. Key informants concurred about the capacity of Catholic parishes to deliver health programs, and described attributes of parishes that make them strong partners in health promotion initiatives, including a mission to address physical and mental health, outreach to marginalized groups, altruism among members, and existing engagement in health programming. However, resource gaps and capacity building needs were also identified. Specific recommendations participants made about how existing resources might be leveraged to address challenges include to: establish parish wellness committees; provide "hands-on" learning opportunities for parishioners to gain program planning skills; offer continuous, tailored, on-site technical assistance; facilitate relationships between parishes and community resources; and provide financial support for parishes. Leveraging parishes' existing resources and addressing their implementation needs may improve adoption of cancer control EBIs.

Keywords

Capacity building, Implementation science, Cancer prevention and control, Faith-based organizations, Health disparities

Implications

Practice: FBOs hold capacity to advance health programming, yet need additional implementation support, including resources and technical assistance, to carry out cancer control-specific interventions.

Policy: Efforts to enhance capacity among FBOs to implement community-based cancer control programs may improve the reach of existing evidence-based interventions to underserved groups.

Research: Future studies should test and compare strategies to improve capacity among FBOs to implement evidence-based interventions.

Introduction

Cancer continues to disproportionately affect racial/ethnic minority communities throughout the USA. Among Latinos, the largest racial/ethnic minority group in the USA [1], there were an estimated 125,900 new cancer cases diagnosed and 37,800 cancer deaths in 2015 [2]. The lifetime probability of dying from cancer is one in five for Latino men and one in six for Latina women, making cancer the leading cause of death among this population [3]. A significant proportion of cancer deaths could be prevented with routine cancer screening and follow-up care; indeed, colorectal cancer screening can reduce colorectal cancer deaths by at least 60% [4]. Unfortunately, screening rates among Latinos remain low. In 2013, only 66.5% of Latinos participated in recommended breast cancer screening, 76.9% in recommended cervical cancer screening, and 41.5% in recommended colorectal cancer screening [5].

A substantial body of research has focused on understanding the causes of racial/ethnic disparities in cancer screening and generating strategies to increase the use of screening modalities among underserved populations [6–9]. The past decade has also seen a proliferation in evidence-based interventions (EBIs) developed to improve screening rates among Latinos [10, 11]. Recognizing the importance of expanding the reach of existing EBIs, several calls have been made to promote adoption, implementation, and sustainability of EBIs within community-based infrastructures

Table 1 | Sample questions from the key informant interview protocol

Needs assessment	• What types of programs would you like to see offered in your community to help Latinos stay healthy that are not currently offered?
Role of churches in health promotion	• In your opinion, what is the role of parishes in promoting health? • Why should parishes get involved in health promotion, if at all?
Health education programs	• How do you think parishes can facilitate health education among Latinos? • Based on what you know or have heard about the parishes in your community, do you think that health education can be integrated into the regular activities of a parish?
Health services	• What kinds of health activities and services do you think may be appropriate for parishes to have? (Probe, if necessary: can you give me some examples?)
Cancer prevention and control	• Do you think parishes will be interested in cancer prevention efforts? • What specific things do you think parishes can do to help reduce the number of Latinos who die of cancer? (Probe, if necessary: what else can they do?)
Resources needed	• What kinds of resources might parishes need to be successful in promoting health? • What resources might they need to carry out cancer control programs?
Skills needed	• What specific skills do you think parishes may need to implement cancer health programs? Are there skills that they currently have? Are there skills they lack?
Health ministries	• What is your opinion about starting health groups or ministries in parishes to promote health? • (If a parish member): How do you think the other leaders and members of your parish would respond? • (If not a parish member): How do you think parish leaders would respond?
Technical assistance	• What assistance might a parish leader need to start a health group? • How might we get Latino parishioners interested in being part of a health group? • Do you think these groups would need ongoing support? If so, what kind? How should this support be provided? For how long?
Barriers to health program implementation	• What do you think would be some challenges of introducing health activities within parishes? • What might keep a parish from implementing cancer health programs? What specific barriers do you think might get in the way? • In your opinion, what things in the community may prevent parishes from having health programs?
Facilitators to health program implementation	• What do you think may encourage a parish to provide health programs to its members?
Community resources	• What resources are available in your community to support parishes in their efforts to promote health? • If you were to be involved in our project, how would you be able to assist parishes in your community to promote health, given your position and experience?
Snowball sampling	• Who else should we speak with that may be knowledgeable about parishes and the Latino community and willing to share their opinions with us?

where these programs can have maximal public health impact [12, 13]. EBIs to promote cancer control come in a variety of forms, and the intervention processes and materials employed by these programs can vary depending on the study population and setting. While each EBI has its own unique features, almost all programs rely on a set of common intervention strategies, including small-group education, one-to-one outreach, reduction of structural barriers, client reminders, and small media [6–9].

There has been longstanding interest in the role of faith-based organizations (FBOs) in extending the reach of EBIs to promote cancer control among ethnic minority groups, such as Latinos [14]. FBOs are potential catalysts in health promotion efforts, as they are present in most communities and often are involved in outreach efforts to promote spiritual health and physical wellbeing [14–16]. Acknowledging their potential to reach underserved audiences, many have recommended engaging FBOs as partners against cancer disparities [14]. Fortunately, today there are numerous interventions that have been implemented or tested within FBOs, many which specifically target behaviors related to cancer prevention and control [17–29]. However, most of these interventions have been implemented in African-American churches and by health professionals or high-skilled research personnel. Only few interventions have focused on Latino faith communities [17, 30–42], and none rely directly on church members for program adoption and implementation. Successful delivery of EBIs by FBOs will require that they have the knowledge and skills to identify, adapt, and subsequently implement these programs with fidelity (to not compromise intervention efficacy) [43].

Strategic community-based participatory approaches, including capacity assessment, are necessary to increase ownership, buy-in, and implementation of EBIs [44, 45]. Theory- and evidence-based culturally appropriate capacity building assistance has been proposed as one strategy to increase uptake of community-based cancer control EBIs among FBOs [46]. Despite the potential role of capacity building in promoting translation of EBIs into community settings, little research has focused on understanding *existing* capacity among FBOs to implement EBIs, or has explored the organizational capacities and resources still required by FBOs to successfully take on such efforts [47].

In this study, we conducted semi-structured qualitative interviews with 18 key informants in Massachusetts, representing diverse stakeholders from local health, social service, and faith-based organizations. Our goals were to (a) understand existing capacity for health program implementation among Catholic FBOs (hereafter referred to as "parishes"), (b) characterize parishes' resource gaps and capacity-building needs for implementing cancer control EBIs, and (c) elucidate strategies for delivering capacity-building assistance to parishes to promote uptake of EBIs. We focused on parishes, mindful that more than 50% of Latinos in the USA self-identify as Catholic [48], and because this study was conducted as formative research for a larger study evaluating a culturally appropriate organizational-level intervention to enhance parish capacity to implement cancer control strategies among Latinos [47].

Methods

Qualitative research methods provide rich, contextualized data about complex social and organizational phenomena that may be impossible or otherwise costineffective to obtain through traditional quantitative methods [49]. Qualitative methods have a unique role in implementation science in that they provide depth of understanding regarding factors and processes that may limit and/or facilitate adoption of evidence-based practices [50]. For this study, we sought the perspectives of local "key informants": opinion leaders who, because of their professional and community expertise, could provide useful information about the topics in question. The Harvard School of Public Health Institutional Review Board approved all research procedures.

The key informant interview protocol

A key informant interview protocol was used to guide the semi-structured qualitative interviews. The protocol was developed based on our prior qualitative research [51–53] and was designed to assess (1) interest among FBOs in engaging in health promotion in general, and cancer prevention/control in particular; (2) FBOs' existing capacity for health promotion; (3) training and resources needed to implement cancer control EBIs; and (4) strategies to enhance parishes' existing organizational capacity to implement cancer control EBIs.

Consistent with a community-based approach, the study was guided by a Community Advisory Board (CAB). This committee, composed of community experts representing faith-based, health care, and social service organizations serving the Latino community in Massachusetts, met on a quarterly basis to offer input on the cultural and linguistic appropriateness of interview questions and provide suggestions on edits to the protocol after it was pilot tested [54]. See Table 1 for sample questions from the interview protocol. The protocol was translated into Spanish by a certified translator.

Sampling and data collection

To identify individuals suitable for this study, we sought recommendations from the CAB and used snowball sampling, where existing study participants refer future subjects from among their acquaintances [49]. We sought perspectives from community stakeholders with diverse and complementary expertise in capacity building, FBOs, community partnerships, and leadership within Catholic parishes, and who

had affiliations with Latino-serving community organizations. Interviews were conducted by trained bilingual research assistants or by one of the principal investigators (M.T.). All interviews lasted between 30 and 60 min and were conducted in English or Spanish and by telephone or in-person, based on participants' preferences. Interviews were conducted until data saturation was reached (i.e., when we were no longer receiving any new information regarding facilitators and barriers to program implementation) [49].

Data management and analysis

Interviews were audio-recorded and transcribed. Transcripts were then reviewed for accuracy by the interviewers. We analyzed transcripts using a hybrid process of deductive and inductive thematic analysis [55]. First, initial codes were identified based on study objectives and prior research [52, 53]. Then, three research team members independently reviewed the transcripts, identifying new codes as new themes emerged from the data. Next, in a series of meetings, team members compared their codes. Following an iterative process, we developed a higher order-coding scheme, meaning codes were organized into superordinate and subordinate categories [55]. Redundancies in coding were eliminated and discrepancies resolved through team discussion. With this order-coding scheme in place, line-by-line coding was subsequently conducted by the lead author using QDA Minor 4.0® software [56]. No new codes were added during line-by-line coding. Major themes and concepts were identified and mapped into the sections described below.

Results

Description of study participants

Eighteen semi-structured interviews were completed between October 2011 and July 2012. Most interviews were conducted in English ($n = 14$); three were conducted in Spanish, and one was conducted in both Spanish and English. Half of the key informants were male, and half were female. Most key informants had a history of working with FBOs or Latino communities; that is, they either worked directly with leaders of FBOs to develop and implement programs to address community issues, or had collaborated with churches in the past to provide outreach and services to Latino communities. Those who did not have this history of partnership with FBOs had "on the ground" experience concerning the study's other areas of interests: community development, organizational capacity building, community assessment, and community health promotion. Of the 18 key informants, five held formal positions in a FBO: three were ordained leaders (pastors) of large Catholic parishes in MA and directors of Hispanic ministry, one was the Hispanic ministry coordinator of a parish, and one was a pastor of a large African-American church and had an extensive history providing funds and technical assistance to build capacity and strengthen FBOs in Boston. Hispanic ministry is the umbrella term to describe efforts by the US Catholic Church to reach out, spiritually and socially, to Latino Catholics, both immigrant and US-born.

Interest and capacity within Catholic parishes for health promotion

Key informants unanimously agreed that Catholic parishes would be interested in holding and/or sponsoring health promotion programs. Church doctrine about care of spiritual and physical health and a long record of commitment to bring this to action supported that conviction. All key informants acknowledged cancer as a major health issue among Latinos and believed that parishes should have an interest in collaborating with health care providers to improve the health of this population.

Key informants named attributes of parishes that would make them strong partners in health promotion and prevention efforts. First, supporting physical and mental health, especially among the underserved, is consistent with the Catholic Church's social teachings and mission. Second, Catholic parishes are ubiquitous throughout the state's geography and have potential to reach large groups of people, especially older adults. There are approximately 577 Catholic parishes in Massachusetts organized in four administrative bodies called dioceses that operate in a specific geographical territory and under the jurisdiction of a bishop. About 73 parishes offer Spanish-language services [54]. Together, these parishes serve an estimated 430,000 Latinos from all income levels and countries of origin, including undocumented immigrants who often cannot access health care. A large proportion of Latinos attend church at least once a week and as highlighted by one key informant, most Latinos perceive parishes as "safe spaces" that facilitate communal belonging and participation: "The Church is an appropriate place not only because it has the physical space but also because of the environment it cultivates. Latinos feel comfortable in church and pastors deliver messages in a way that resonates with people and in language they understand." Another key informant, a pastor, added, "The parish already has a captive audience so as soon as services are provided and are out there for the people … the response and the use of that service will be fantastic."

Third, parishes tend to cultivate a spirit of service and volunteerism among their members, which can be useful for recruiting volunteers to organize disease prevention programs. Fourth, clergy have influence on the beliefs, attitudes, and behaviors of their congregants, thus making them ideal allies in the effort to change behavior. Finally, a parish's physical infrastructure–church buildings, school facilities, and community meeting rooms–can typically accommodate large groups and hold workshops, health services, and large-scale events such as health fairs.

Pastors emphasized that many parishes are already involved in health promotion initiatives and some

have a formal "health ministry" that is led by parishioners. As illustrated by one key informant: "many churches are trying to make sure their congregation is healthy. I've seen it, pastors have reached out to us, and we've actually worked with their health ministry to provide onsite services."

Parish health ministry typically prioritizes providing care and accompaniment of the sick and the dying. Other initiatives mentioned include health fairs, education workshops, and community screenings. While parishes frequently participate in health programming, several key informants felt that their parishes could do more to promote physical health care. One pastor stated, "Catholic churches have done a good job on promoting health. I think they can do more by making it a bigger priority."

Informants acknowledged that health ministry does not exist in every parish. A parish that lacks a health ministry might find it difficult to mobilize support for health programs, but may be able to leverage the resources and capacities of other social-oriented ministries within the church to develop health initiatives.

Factors related to adoption and implementation of cancer control EBIs in parishes

While key informants underscored the importance of acknowledging existing capacity among parishes to advance health promotion efforts, they also identified resource gaps and the need for interventions to enhance parish capacity for sophisticated program planning/initiation. Factors perceived to promote or hinder adoption and/or implementation of cancer control EBIs were identified at the level of the parish leader, the health ministry, the parish, the diocese, and the larger external community.

Barriers and facilitators–parish leader factors–Key informants frequently mentioned that clergy and parish staff have limited knowledge about cancer control and other health care matters, posing a major obstacle for parish leaders who are interested in implementing cancer health programs. In addition, identifying interventions suitable for faith-based settings was viewed as a barrier. Without assistance from health professionals, most key informants believed that parishes would be unsuccessful in carrying out cancer control programs. While emphasizing the importance of obtaining "buy-in" of parish leadership, key informants also noted that pastors–given their busy schedules and many competing priorities–would not be the best champions for health programs and thus, identifying lay leaders within the parish to lead these efforts would be critical. One pastor stated, "Well, pastors are overloaded with work, so in my case I won't be able to add another layer of responsibility to my existing work load. However, I know several members of my church who will be thrilled to engage in this work." Another participant emphasized, "It's important to know that pastors are very busy and are wearing many hats, so parishes should start by identifying a trusted leader in their church who can organize the health ministry, and take it from there." Time constraints, perception of need, and existing knowledge and interest in health matters were considered the primary factors influencing pastors' decisions about adopting health programs.

Health ministry factors–Key informants viewed having a health ministry as a facilitator to health program implementation. The larger the parish (about 500 parishioners or more), participants noted, the more likely they are to have a health ministry. A health ministry's proclivity to adopting and implementing cancer control programs for Latinos was thought to depend on a number of factors, including the size and composition of the health ministry; the health ministry leader's commitment to reaching underserved populations; the autonomy, flexibility, and resources afforded to the health ministry by the parish; and the health ministry's history of health and social service programming, connections to other volunteer groups within the parish, and integration into the overall life of the parish. That is, parishes that lack organized health ministry or whose health ministry is small, decentralized, or lacks stable leadership were perceived to be less likely to adopt cancer control programs.

Furthermore, finding the volunteer resource base to lead health initiatives among Latinos was believed to be an issue for parishes with smaller congregations and no active health ministry or those with health ministry but without Latino leadership. Even in parishes with large Latino congregations (500 Latinos or more), over-commitment on the part of some volunteers was a concern. Some key informants noted that the same people are often asked to serve on multiple committees. Thus, interested members, especially immigrants with multiple jobs, may face significant time constraints to volunteer and participate in parish events.

Parish-level factors–One of the most frequent barriers to health program delivery, per key informants, is that parishes often lack financial and human resources to implement health programs. Parishes rarely have a budget for health care outreach or discretionary funding available to allocate to these activities. As stated by one pastor, "Parishes have more needs than there are resources … and part of the issue we need to figure out is how to make best use of the very limited resources." Another pastor emphasized, "If they come to us to implement a health program, we would need resources that we currently don't have, so that's a lot of responsibility to take on … the way we've been doing it is by inviting organizations to provide their services on-site, but the church can't, in my perspective, take the leading role. The Church should provide a platform for health care providers and educators to converse with the community but not the institution that takes the lead in providing health solutions. We just don't have the resources to do so right now." Large parishes with more resources such as hired personnel to work with Latinos and budgets to advance pastoral outreach programs

were perceived to be more likely to implement programs.

Some key informants mentioned that cancer control programming targeting Latinos would likely be managed by the Hispanic ministry office within the parish, so success also depends on how well this ministry is integrated into the larger life of the community. In some parishes, Hispanic ministry is highly integrated; in others, it functions as an independent or rather isolated unit. In the latter case, Hispanic ministry falls short from gathering enough support and mobilizing resources within congregation to promote health care programming.

Diocese-level factors–The key informants, particularly the parish leaders, noted that determining parish programming is not merely a local decision but in part needs to be in sync with the priorities set forth by the diocese to which the parish belongs. Even parishes committed to promoting health care initiatives are regularly impacted by decisions made at the diocesan level: pastoral plans with priorities unrelated to health issues, parish reconfigurations, allocation of resources, and change of personnel in central offices offering support to parishes are a few of the diocesan-level factors that may influence parish programming. A shared observation among key informants was that parishes with Hispanic ministry in general have fewer resources compared to parishes without this ministry. Recent research corroborated the observation: "the higher the percentage of Hispanic parishioners attending Mass in a parish the smaller the total of revenues and expenses" [57]. Any possible success related to health care initiatives in these parishes would depend mainly on training pastors and lay leaders to effectively use some of the few resources available to promote these matters and search for further resources using larger networks.

External and community-level factors–A parish's relationship to its community serves as a key determinant of cancer control programming. This includes the number and quality of partnerships a parish has with health care organizations (e.g., Catholic hospitals). Quality partnerships were those based on mutual trust, complementary strengths, information sharing, shared values, accountability, transparency about financial matters, long-term commitment, and a common vision (i.e., articulated goals with clear roles and responsibilities). With regards to values and how these shape collaborations, participants were clear to name ethical commitments inspired by their faith, particularly those related to respect for human life at all levels and social justice. Violations to these commitments would make partnerships with Catholic parishes unlikely.

Several key informants were external actors who played or could see themselves as playing a role in supporting health initiatives in Catholic parishes. These participants highlighted three major ways that they could support parishes in their efforts to promote health: (1) as advocates for the importance of health practices and programs among parish members and parish leaders, (2) as educators or trainers who contributed to capacity-building initiatives in parishes or shared health information with community members, and (3) as connectors, bringing together parish leaders working on health promotion with potential partners. Key informants emphasized that parishes with strong ties to health care organizations, social services agencies, and academic centers would be more confident in their ability to access and implement EBIs. However, participants noted that not all parishes have such connections.

In general, the decision to adopt certain health programs is significantly influenced by how the priorities of the parish and the larger external community interrelate. Such needs do not always coincide. For example, most parishes would prioritize taking care of the sick and the dying as integral to the religious mission of the Church. Disease prevention programs do not enjoy such priority status. Therefore, for cancer control programs to be better received, parishes may want to combine them with other types of programming (e.g., religious events, mental health programs, social services) that connect more directly with the local community's immediate needs and priorities.

Strategies for enhancing implementation of evidence-based cancer control programs

Key informants described several potential strategies to enhance the capacity of FBOs to deliver health programs. The six most cited strategies are described below.

Strategy 1: Work with existing health ministries and help to establish health ministry in parishes where it does not exist–Health ministries were recommended as the first strategy to enhance parish capacity for program implementation. As one pastor stated: "large or small, every church should have one." In parishes without a health ministry, informants recommended that researchers work with the pastor to identify a lay leader who can develop one, ideally a health care professional with proven commitment to the Church and interest in community outreach.

Strategy 2: Offer culturally appropriate interventions that are "easy to implement" and can be integrated into existing programs–Key informants unanimously believed that if parishes are to be successful at delivering health promotion or prevention programs, these interventions need to be low cost and easy to implement (i.e., simple, not time intensive), available in Spanish and English, religiously relevant (e.g., integrating religious teachings, scripture, rituals, and prayer), interactive (i.e., using participatory methods such as discussion, storytelling, role playing, panels), and they must fit into preestablished parish processes and activities (e.g., bible study, service events, potlucks, fundraisers). They emphasized that cancer control activities that can be easily integrated into existing parish events, such as the distribution of educational materials, may be more sustainable into the future, particularly in parishes with limited resources. One community leader stated, "I

think that if it's not done seamlessly, if you don't work with the parish to get them to see how they can weave it throughout what they're *already* doing, then I think it's going be a failure. If it's seen as an 'add-on' to those who are doing the work, if it's not viewed as something that's infused within and throughout, then I do not think it's going to work."

Key informants further discussed the value of integrating health information into weekly sermons and leveraging the skills, talent, and experience of existing ministries and groups. As one pastor shared: "At least as this church is concerned, the fastest and most effective mechanism would be to use the communities, the subcommunities that already exist … and enlist them in your battle … for instance, if the focus is breast cancer or ovarian cancer, we have a very powerful women ministry here."

Strategy 3: Provide practical "hands-on" learning opportunities–For parishes to implement EBIs, they need to be equipped with the skills to do so. The clergy and the parish staff need to participate in trainings while mindful of their time constraints. In many parishes, there is only one pastor who is responsible for thousands of families. Most parishes serving Latinos struggle financially and thus tend to have small staffs. All volunteers (i.e., lay leaders) charged with overseeing the implementation of programs must also undergo some training. Key informants suggested that to cultivate skills among parishes, it would be best to reach out to them directly in their own contexts. When asked about the content of these trainings, key informants mentioned working with researchers, basics of cancer control, identifying EBIs and adapting them to meet local needs, and links between faith and health. When asked about the skills parish leaders need to develop, key informants mentioned behavior change counseling, health promotion, and health education. Per several key informants, program evaluation and data analysis were capacities that some parishes lacked; therefore, interventions to promote EBI implementation should provide evaluation support and simple strategies for evaluating programmatic success.

Strategy 4: Offer continuous, tailored, and on-site technical assistance–Key informants stressed the importance of continuous on-site technical assistance for parishes embarking on health promotion programs. They stressed the importance of providing someone who can work one-on-one with parish members as they implement EBIs and help them to find solutions to challenges that may arise during the formation and implementation of programs. As emphasized by one pastor:

> "Offering resources and training opportunities is important, but even more important is having somebody [trained personnel] come and be faithful to this organization and the ministry… I think that personal presence is key and far more important than materials and print resources that you mail… if you can provide somebody who can filter and help us to navigate all the information needed to establish a sustainable health ministry … somebody who is reliable and can accompany the early stages of [developing] this group, that would be ideal."

In addition, regular "check-in" meetings were advised as a strategy to maintain accountability and ensure that implementation tasks are achieved.

Strategy 5: Leverage community assets by facilitating development of strategic intra- and inter-organizational partnerships–Key informants communicated the need of partnerships for health promotion efforts. Organizational partnerships were described in two levels: (1) *intra-ecclesial*–collaboration with diocesan offices, other parishes, Catholic hospitals, and other Catholic structures and organizations; and (2) *extra-ecclesial*–collaboration with other non-Catholic groups especially health centers and community organizers. Informants underscored the financial difficulties facing many parishes, particularly true of parishes serving impoverished areas–all of which rely on local weekly donations for income. Of course, these also contain the populations that would benefit most from EBIs. Informants proposed that collaborations among invested partners and pooling of resources may help to bolster implementation capacity and sustainability of programs. Strategies suggested for fostering partnerships included networking events, pastoral development and discipleship programs, and systems to facilitate inter-organizational exchange (e.g., shared databases or online platforms to facilitate joint projects). Several informants also raised the idea of having regional or diocesan meetings where parishes plan combined events, share experiences, and learn from one another's challenges and achievements. As explained by one participant: "Help to develop a network among parishes so they can learn from each other … And through that network you will build trust, you will build friendships, and it will become easier to roll out these programs."

Moreover, partnerships with health care providers and outside organizations such as public health departments were considered critical–given that parishes will need access to clinical expertise and additional resources to support EBI implementation (e.g., volunteers, money for food). Some participants supported the idea of forming a coalition, a group of dedicated laypersons, professionals, and community cancer survivors who could share expertise, resources, and ideas to tackle cancer health disparities.

Strategy 6: Provide financial support and material resources–Key informants believed that strategies to promote uptake of EBIs among parishes should include a funding mechanism (e.g., church donation, project stipend, training awards, mini-grants for special projects) to incentivize parishes, as well as provide resources for them to engage in this work. For example, key informants stressed that most parishes lacked the technology, computers, and/or software needed to develop and print educational materials. Because of these limitations, additional funding or resource provision to enhance a parish's capacity in these areas could be

Table 2 | Overview of qualitative findings

Existing opportunities, capacities, and assets	Existing challenges, resource gaps, and needs	Strategies to promote organizational capacity
Health programs are consistent with existing doctrine vis-a-vis social justice and holistic health	Not all parishes have an existing health ministry to plan and organize health programs	Work with the existing health ministry or help to establish a health ministry in parishes without one
Parishes are considered safe spaces that facilitate communal belonging and participation	Parish leaders have multiple priorities and competing responsibilities	Offer culturally appropriate interventions that are easy to implement and can be integrated into existing programs
Parishes have wide reach and access to Spanish-speaking and underserved populations	Parish leaders may not be aware of evidence-based health promotion/disease prevention programs	Offer continuous, tailored, and on-site technical assistance
Parish leaders have influence over members and have experience with outreach	Parish leaders may have limited knowledge about health issues	Provide practical "hands-on" learning opportunities while harnessing the existing skills of parish leaders and members
Parishes may have existing health ministries, support groups, communication channels, and physical infrastructures that can support implementation	Not all parishes have partnerships with health care and social service organizations	Leverage community assets by facilitating development of strategic intra- and extra-ecclesial partnerships
Parishes may already engage in health and social justice programming	Many parishes face financial difficulties and have limited resources for health programming	Provide financial support and material resources to facilitate programming

important for promoting cancer EBI implementation. Notably, key informants expressed that resource provision should be tailored to the needs of each parish. One community leader stated, "the resources should be based on the type of needs that the community has, or the type of church we are talking about … but yes, it's fair to say that all churches will need resources of some sort."

Table 2 outlines the key findings of this qualitative study.

Discussion

In-depth qualitative interviews with 18 key informants in Massachusetts explored the extent to which local parishes would be interested in health promotion and disease prevention, parishes' current infrastructure for doing this work, training and resources needed by parishes to implement cancer control EBIs, and strategies for enhancing parishes' existing organizational capacity for implementing EBIs. Key informants believed that parishes would be interested in cancer control efforts and have existing capacities. Parish missions, organizational cultures, physical spaces, communication channels, and volunteer resources were noted natural strengths that can be leveraged in efforts to address cancer health disparities among Latinos. Still, key informants highlighted several barriers to EBI adoption and implementation among parishes, ranging from inadequate knowledge and time among parish leaders to limited financial or human resources. The resource gaps and capacity building needs identified in this study provide several potential targets for interventions designed to improve adoption and implementation of EBIs among FBOs, and have informed the development of an organizational-level capacity enhancement intervention to promote implementation of cancer control programs among Catholic parishes in Massachusetts [47, 54, 58].

Few studies have tried to implement EBIs in FBOs [30, 59–61], and even fewer have tested capacity enhancement as a potential dissemination strategy for promoting wide-scale adoption and implementation in such settings. Indeed, a 2015 systematic review of capacity-building interventions identified only 29 empirical studies of capacity-building interventions conducted between 2000 and 2014 [62]; of these, only one study that built organizational capacity targeted cancer screening behaviors [63], only one was conducted in faith-based settings [64], and none were conducted specifically among Catholic parishes or for Latino populations.

The Body and Soul Study aimed to disseminate and evaluate the impact of a previously developed, research-tested dietary intervention for African Americans under real-world conditions [65]. This study showed that EBIs delivered collaboratively by community volunteers and a health-related voluntary agency could be effectively implemented in black

churches. However, when implemented without research or agency involvement and support, the program did not achieve results like those of earlier efficacy trials [61]. A process evaluation revealed program implementation issues ranging from need for additional training, resources, and assistance to support implementation [66]–all areas that were raised as concerns by our key informants.

In the present study, several recommendations were provided for enhancing the capacity of Catholic parishes to promote implementation and maintenance of EBIs for Latinos. The six most cited strategies included establishing health ministries, leveraging existing infrastructure, providing "hands-on" learning opportunities, offering continuous, tailored, and on-site technical assistance, fostering strategic intra- and interecclesial partnerships, and providing financial support and material resources. Some of these strategies have been previously suggested [67], yet the vetting by community stakeholders who have extensive experience working with Catholic parishes suggests that they may be suitable for Catholic contexts. Future research should empirically evaluate which among these strategies is most effective for local parishes. Very recently, the Expert Recommendations for Implementing Change Project published a comprehensive report that included 73 different strategies to enhance adoption, implementation, and sustainability of evidence-based practices in clinic practice settings [68]. There are many similarities between the strategies in this report and those suggested by our key informants. It will be important for future studies to assess the transferability of these strategies for community settings and to identify ways to modify them to make them acceptable for FBOs.

Of note, the ability of FBOs to implement an EBI will depend heavily on the characteristics of the intervention itself [69]. Data from this study suggest that EBIs that are relatively easy to implement, can be easily adapted for different audiences and settings, do not require highly trained staff or intervention-specific skills, and can be implemented with minimal personnel and financial resources may be more likely to be adopted by Catholic parishes. Moreover, the importance of assessing and addressing the "fit" of the intervention to the parish context and the individuals within the church [70] was a theme that resonated with many of the key informants. To facilitate adoption of EBIs, it will be important that interventions be developed specifically with FBOs in mind–or that intervention developers provide ways of framing EBIs so that they fit within varied organizational missions or values (e.g., by making explicit links between physical health and spiritual health, incorporating religious rituals or practices in intervention programs, or using other means to promote adaptability).

Study limitations and strengths

Several study limitations must be acknowledged. First, this study's small sample size limits generalizability. However, our goal was not to achieve a representative sample but to obtain the depth in perspectives and opinions supported by qualitative methods. Second, although the development of our qualitative coding scheme was a collaborative effort, subsequent line-by-line coding was conducted by only one author which may limit reliability. Given the number of total interviews and scope of the research study, solo coding by an experienced coder seemed reasonable. Moreover, several strategies were used to enhance the reliability and validity of study findings, including involving members of our CAD in the data interpretation and conducting regular team meetings to discuss progress in coding and clarify emergent ideas and insights. Third, this study sought to elucidate factors that may facilitate or limit implementation of intervention strategies commonly used across EBIs (e.g., small-group education, one-to-one outreach, small media). We did not focus on specific intervention programs in our discussions. Thus, additional research with specific intervention programs in mind are needed. Importantly, this study relied on data from key informants with a wide range of expertise, and thus, not all of them had in-depth familiarity with Catholicism or Latino ministries. As such, it is important that findings be interpreted with caution. Nonetheless, we interviewed key informants that were vetted by a CAB. Our interviews across a wide range of stakeholders, all of whom voiced interest in supporting efforts to enhance parishes' existing capacity for EBI implementation, pointed to community assets that can be leveraged in these efforts and highlights the value of employing a community-engaged approach to organizational capacity building.

Most Latinos in the USA self-identify as Catholic (about two thirds), and this study focuses only on Catholic FBOs. However, the study did not consider the fast-growing number of Latinos who are Evangelicals as well as others who belong to other non-Catholic denominations and their FBOs that serve them. Further research needs to look at similar dynamics in these other churches mindful of doctrinal differences and administrative structures impacting the implementation of health care initiatives.

Of note, Catholic parishes may differ from other FBOs. Commitments to charity and social justice are deeply rooted in Christian values that affirm the dignity of the human person, attend to the whole person, and care for the poor and vulnerable, thus making Catholic communities natural allies in efforts to eliminate health disparities. Moreover, Catholic parishes are part of a larger (diocesan) structure to which they are accountable, they all share fundamental doctrinal commitments and values, and their leadership structures are centralized, resting heavily on the pastor of a parish. Other organizational models (e.g., independent churches) and leadership structures (e.g., boards, committee of elders, etc.) may facilitate or limit EBI adoption and implementation. For example, FBOs with decentralized leadership structures–ones in which lay leaders play key and active roles in church programming–may have a unique capacity to adopt EBIs if implementation tasks can be distributed among

members of the lay leadership. Such a structure may be especially advantageous in FBOs without a resident priest pastor. Yet, the absence of a resident priest pastor may pose limits if clergy approval and participation is needed for EBI adoption [71]. Additional research is therefore needed across organizational models, denominations, and faiths. It is possible that aspects of the model described here may be adaptable to other FBOs or to capacity-building interventions to address other chronic conditions and disparities among marginalized groups.

Implications for research and practice

Overall, our study suggests that a capacity building intervention may be needed to facilitate adoption and implementation of cancer control EBI in parish settings. Notable barriers exist, including lack of knowledge of existing EBIs as well as limited financial resources and paid outreach personnel. However, that key informants conveyed optimism about parishes' willingness and ability to be active partners in cancer control, and the alignment between the Catholic Church's mission and health efforts, speak to the promise of capacity building interventions to bring parishes up to par with their interest in health promotion. A community-engaged approach to organizational capacity building can harness the skills and existing capacities within parish communities, while also leveraging the resources and assets of the wider community. Such a model empowers communities, and has the added potential to enhance implementation and sustainability of programs.

Our study speaks to the need for tailored strategies rather than a "one size fits all" approach for capacity enhancement of local parishes. Indeed, our key informants emphasized the tremendous variability among parishes regarding factors that may affect EBI implementation, including parish size, number of full time staff, size and composition of lay leaders and volunteers, relative proportion of parish members who are Latino, financial stability and resources, organizational culture and incentives for health activities, and skills of individual parish leaders. Parishes may have varying levels of interest in adopting cancer EBIs, as well as different baseline levels of existing capacity for implementation. Given these differences, our study findings suggest that a tailored, interactive, and community-engaged approach to capacity building may be promising for increasing implementation of EBIs among parishes. Capacity building assistance should therefore be offered based on a detailed understanding of programmatic capacity gaps within a given parish, as well as an understanding of that parish's operating environment and social context. Assessing the programmatic capacity of individual parishes through a needs assessment tool may be critical for the development of capacity-enhancement approaches and is highly relevant for future intervention research.

Acknowledgements: The authors gratefully acknowledge the time and insights provided by study participants. We also acknowledge the many contributions made by the project's Community Advisory Board.

Author contributions J.D.A. and M.I.T. were responsible for obtaining funding. J.D.A., M.I.T., H.O., L.T., and B.L. contributed to the design of the study, and implementation and coordination of the project. B.L. led the qualitative data analysis and writing. All authors helped draft the manuscript, and read and approved the final manuscript.

Compliance with ethical standards The manuscript has not been submitted to more than one journal for simultaneous consideration. The manuscript has not been published previously. The authors have full control of all primary data and agree to allow the journal to review their data if requested.

Ethical approval: All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

Informed consent: Informed consent was obtained from all individual participants included in the study.

IRB approval: The Harvard School of Public Health Institutional Review Board approved all research procedures.

Funding: This work was supported in part by the National Cancer Institute (U54CA156732, UMASS Boston/Dana-Farber Harvard Cancer Center Comprehensive Cancer Partnership Program), the National Institute on Minority Health and Health Disparities (R21MD005976), and through a cooperative agreement by the Centers for Disease Control and Prevention with the National Cancer Institute (U48DP001946, Massachusetts Cancer Prevention and Control Research Network).

Conflicts of interest: The authors declare that they have no conflict of interest.

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