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Marketing a Healthy Mind, Body, and Soul: An Analysis of How African American Men View the Church as a Social Marketer and Health Promoter of Colorectal Cancer Risk and Prevention

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Abstract

The Centers for Disease Control and Prevention ranks colorectal cancer (CRC) as the third most commonly diagnosed cancer among men in the United States; African American (AA) men are at even greater risk. The present study was from a larger study that investigates the church's role as a social marketer of CRC risk and prevention messages, and whether religiously targeted and tailored health promotion materials will influence screening outcome. We used an integrated theoretical approach to explore participants' perceptions of CRC risk and prevention and how promotion messages should be developed and socially marketed by the church. Six focus groups were conducted with men from predominately AA churches in the Midwest. Themes from focus group discussions showed participants lacked knowledge about CRC, feared cancer diagnosis, and feared the procedure for screening. Roles of masculinity and the mistrust of physicians were also emergent themes. Participants did perceive the church as a trusted marketer of CRC but believed that promotional materials should be cosponsored and codeveloped by reputable health organizations. Employing the church as a social marketer of CRC screening promotion materials may be useful in guiding health promotions and addressing barriers that are distinct among African American men.

Keywords

African American; cancer prevention; church-based health promotion; community-based participatory research; health communications; health disparities; religion and health; social marketing; tailored or targeted interventions; theory of planned behavior

Men's health among minorities in the United States is a growing public health concern. Griffith, Gunter, and Watkins (2012) acknowledge the critical need for identifying the relationship between masculinity and health behaviors and outcomes, particularly for people

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from diverse populations. They further cite diseases prevalent in men and health promoting interventions for men as pertinent (Griffith et al., 2012).

Men are often socialized to project strength, individuality, autonomy, stoicism, and physical aggression (Himmelstein & Sanchez, 2014). Although these social orientations combine to increase health risks and risk-taking behaviors, emotional distress, and diminished health promoting behaviors (Mahalik, Pierre, & Wan, 2006), African American (AA) men continue to have higher death rates of disease than their gendered counterparts (Centers for Disease Control and Prevention n.d.). Thus, what is ultimately gathered from scientific inquiry is that AA men have poorer health and health outcomes than the rest of the U.S. population and are exposed to an expansive range of social and environmental determinants that adversely affect their health. What is concluded from this research is that male gender is an important social determinant that intersects with health outcomes (Griffith, Metzl, & Gunter, 2011).

Within the past several decades social determinants of health have been posited as plausible explanations for most health disparities. Unfortunately, we have only begun to scratch the surface characterizing key influences that define race and gendered health disparities. Analysis of individual-level factors fails to explain the overwhelming disparities in mortality and morbidity among U.S. minority men in general, and AA men in particular. This is especially true among those with a cancer diagnosis. AA men carry the heaviest cancer burden when compared with other racial groups in the United States (American Cancer Society [ACS], 2014) and have a 15% higher incidence rate for all commonly diagnosed cancers and a 34% higher death rate than Caucasian men (Jemal et al., 2008; Jemal, Siegel, Xu, & Ward, 2010). Although mortality rates for other cancers such as prostate and lung are declining among AA men, colorectal cancer (CRC) has a widening disparity in mortality rate (DeSantis, Naishadham, & Jemal, 2013).

CRC is one of the most detectable, curable, and treatable cancers if found early (ACS, 2014). Although tests are recommended at age 50 (U.S. Preventive Services Task Force, 2008) and are largely available, screening uptake among AA men is suboptimal and has been linked to several predictive factors (Bass et al., 2011; Christy, Moser, & Rawl, 2014). These factors that include lack of access to health care (Reynolds, 2008), late diagnosis (Oliver et al., 2012), and other factors (ACS, 2014) are often linked to adverse risk perceptions and misconceptions that exist among many AA men about CRC. Conversely, there are also predictive factors in facilitating health promoting behavior.

An established body of research documents the impact of community organizations among AA. Faith-based organizations (FBOs) or AA churches are trusted and stable community organizations in the AA community (Lincoln & Mamiya, 2001) and have considerable influence on screening uptake among AA through health promotion (Campbell et al., 2004; Holt et al., 2012). Successful spiritual health promotion interventions have integrated FBOs as an integral part of the process (Holt et al., 2009). These approaches capitalize on the FBO affiliation and affinity with church populations and inform critical components of health interventions that target AA. Targeted interventions that emphasize population-level characteristics (i.e., cultural) and tailored interventions that focus on individual-level factors

(i.e., psychological) improve efficacy of health programming in church-based and other populations (Allicock, Campbell, & Walsh, 2011).

Identification of predictive factors that delay or facilitate health behavior can further inform innovative health programs designed to increase colorectal cancer screening (CRCS) among AA men. We theorized that the adoption and execution of social marketing principles by FBOs based on a socioecological perspective would affect perceptions of CRC risk and subsequently screening behavior. Social marketing is an approach that integrates marketing concepts to promote voluntary behavior change by reducing perceived and actual barriers and increases perceived advantages (Andreasen, 1994). This approach includes a marketing mix of tactics used to target a specific segment. We also explored beliefs about CRC and CRCS to identify possible barriers that would impede or facilitate CRCS. These constructs were used to inform CRCS targeted and tailored message content for AA men.

Method

The present study used a community-based participatory research approach with a Community Advisory Board (CAB) and research team members who were also community members. This process is mutually beneficial as it allows researchers to conduct research in an equitable way (Israel et al., 2003).

Setting

Focus groups (FGs) were held at participants' churches to allow for open discussion among the participants and moderators. Churches were selected from a network of interdenominational churches in the bi-state area of Kansas City, Missouri, and Kansas City, Kansas. AA men in both Kansas and Missouri suffer from higher cancer death rates compared with AA women, and Caucasian men and women (Wyandotte Department of Health; Jackson County Public Health) and reflect national disparities (U.S. Census Bureau, 2011).

Study Design and Measures

These data were from the larger, 5-year pilot intervention study sponsored by the National Cancer Institute. The pilot intervention was designed to test the efficacy of a culturally and religiously targeted intervention to increase CRCS among AA in church populations. The six exploratory FGs for the present study were stratified by gender; however, this article highlights significant differences that arose in the men's FGs.

FGs were 2 hours and included a meal, survey, consent process, and semistructured discussion. All discussions were audio-taped and transcribed. Prior to the FGs, a survey was administered to capture demographic, CRCS, and CRC knowledge. Questions were modified from a larger study that queried AA about their perceptions of CRC (Greiner, Born, Nollen, & Ahluwalia, 2005).

The discussions followed a semistructured format guided by the theory of planned behavior (Ajzen, 1991) and social marketing principles. Core discussion questions, determined by the research team and CAB members based on earlier interviews with pastors (Lumpkins,

Greiner, Daley, Mabachi, & Neuhaus, 2011), focused on the following: experiences with cancer and CRC; CRC prevention, early detection, and treatment; and barriers to screening (see Table 2 for questions). Additional questions were incorporated to capture participants' thoughts about the social marketing approach and to query them about FBOs as social marketers of tailored and targeted CRC risk and prevention communication materials. Social marketing components served as questions and probes from the marketing mix or 4 Ps of product, price, place, and promotion (see Table 2).

Recruitment

A purposive sampling technique was used for the study. Men included in the study were recruited during worship services and other church events by research faculty, students, and church leadership who were also CAB members. This process included presentations by research staff, recruitment flyers in church bulletins, and announcements by church pastors and health ministry leaders during worship service and other church venues. Recruitment began in August 2012 and concluded in March 2013.

Study Participants

Twenty-eight men participated in six FGs over a 7-month time period. Eligibility criteria included being AA male, member or regular attender of a predominately AA church, and at least 35 years of age. The original guidelines required participants to be at least 50 years of age; however, because of interest in the project by younger church members and low recruitment, researchers chose to recruit individuals who were 35 years and older.

Data Collection and Analysis

Data collected from surveys and FGs were analyzed by the principal investigator, other research faculty, and student researchers to establish a baseline where categories and themes were uncovered. Thematic text analysis and coding were used to explore how AA men view the church as the primary social marketer of colorectal health promotion and their thoughts about cancer risk and prevention. This type of methodology elicits descriptive information and can help elucidate a targeted population's perspectives about a narrowly focused research topic (Patton, 2002).

Over an 8-month period three coders (principle investigator, graduate student, and research faculty member) read all transcripts individually and met to inductively determine an initial code list, develop a codebook, and code data from all six FGs. After the initial code list was created, all coders went through an iterative process to finalize the codebook. After developing the codebook, the coders deductively coded each transcript and met again over 3 months to ensure coding was similar and to make adjustments to the codebook. After all coding was completed, the primary coder cross-checked a sample of the codes for intercoder reliability; few to no differences were found. The team met again to compile coding notes into thematic statements and then finalized and interpreted the themes. All coding was done by hand because some team members were not familiar with software. This process of coding was adopted from Daley et al. (2010), where data analysis involves community members in the coding process.

Results

AA men who participated in the study ($N=28$) were between the ages of 35 and 80 years, and the majority had some type of health insurance. Three individuals knew the recommended age to screen for CRC; 60% of participants reported that they had received an endoscopic exam (colonoscopy or sigmoidoscopy) compared with only 47% who had completed a fecal occult blood test at some point in time. All participants 50 years and older had talked to their doctor about getting screened for colon cancer.

Analyses led to key themes concerning facilitators and barriers for health promotion of CRCs among AA men (Table 2). The themes identified included the following: (1) Constructed familial loss and personal fears about cancer and colon cancer outcome, (2) Positive spiritual and religious influence on cancer health promotion and cancer outcome, (3) Knowledge gap and deficiency of colon cancer information exposure and awareness among AA, (4) Masculinity among AA men concerning colon cancer screening, (5) Mistrust of doctors and the U.S. health system (Corbie-Smith, Thomas, & St. George, 2002), and (6) Guarded trust in the church and pastor as gatekeepers of CRC promoted information to church members. Each of the themes discussed below have been arranged to reflect social marketing principles and constructs from the theory of planned behavior.

Social marketing concepts that participants discussed at length were the *place* of the promotion and the *promotion* of CRC and CRCs. Most men felt that people had limited knowledge about CRC. In addition, they felt strongly that the church should be a primary promoter of CRC. There was, however, one FG that said health information created by the church should not be promoted to outsiders.

Knowledge Gap and Deficiency of Colon Cancer Information

The general consensus among participants was that they were deficient in knowledge about CRC risk and symptoms, but were somewhat aware of the types of screenings. Participants stated that this deficit in knowledge was prevalent among AA men and could be addressed through increased exposure and awareness through media and other information channels.

Prostate is the one I hear about ... you don't hear much about colon cancer, but you hear a lot about prostate cancer in the papers and on the news and about the new procedures.

Guarded Trust in the Church and Pastor as Gatekeepers of CRC Promoted Information

Even though the general consensus was that the church could be used as a vehicle to increase communication about CRC among congregation members, there was not agreement that the church should be the *primary* sponsor of CRC health promotion materials when compared with traditional sponsors such as the American Cancer Society or the Centers for Disease Control and Prevention.

When a particular pastor or church organization goes forth and says something, it carries a meaning behind that, you know? I just think if Bishop (unnamed) says something or Apostle (unnamed) says something then you know, they'll have a

gathering or it goes farther ... someone has respect for them and it carries weight, they'll follow and go with it.

Attitude Toward the Behavior

The theory of planned behavior asserts that attitude is determined by an individual's strong belief about an outcome or attributes of performing a certain behavior (behavioral beliefs). Data analysis revealed both positive and negative attitudinal barriers to CRC prevention activities.

Constructed Familial Loss and Personal Fears About Cancer Outcome

The first reoccurring theme was the fear that participants expressed they had about losing a family member to cancer and/or being diagnosed and ultimately dying. These fears were defined among AA men in terms of witnessing the loss of someone in their family after being diagnosed and subsequently dying from cancer. Fear was expressed through personal suffering, hopelessness, and devastation. These perspectives are exemplified by the following statement:

Death. The first thing that comes to mind is death. (A) short lifespan. Although some people, sometimes they, you know, I guess they overcome it or, you know, go through it and beat it. The first thought that comes to mind, that person is going to die soon.

There was no differentiation of the fear between cancer types (e.g., prostate or colon). To many, cancer was simply a death sentence or translated into a hopeless situation. Cancer myths such as the spread of cancer also surfaced and reified prevalent cancer myths (Greiner et al., 2005) and cancer fatalism (Powe & Finnie, 2003) among this population.

Positive Spiritual and Religious Influence on Cancer Promotion and Outcome

Out of these experiences emerged a second reoccurring theme that faith in God would either help cancer patients overcome the disease or inspire them to get screened for cancer.

Some people claim other miracles have been done in the days past, in the years past but I still believe that God is still healing people today. So when I go for checks, like I went for my colonoscopy, my attitude is well, for that, you (God) are the doctor of doctors.

Many of the participants also used the FG as a way to reflect on their personal beliefs about God and how this could factor into a positive outcome.

Subjective Norm

Subjective norms are both the belief of whether referent others who are important approve or disapprove of a specific behavior and also the motivation of an individual to do what these referent others think should be done (Ajzen, 1991). Some of the barriers to screening were the obtrusiveness of the tests and the idea that an individual's masculinity was threatened.

Masculinity Among AA Men Concerning Colon Cancer Screening

Many of the men indicated that there was a sense that AA men were a bit proud and embarrassed to screen for cancer. Other studies have also shown that CRC screening is seen as intrusive and/or a violation of manhood among AA men (Christy et al., 2014; Reynolds, 2008). Participants believed that it was necessary to stress and communicate to *other* AA men that it was necessary to screen for this type of cancer in order to save lives.

I got scared, I got real scared. And we all like to joke a lot and like to laugh and everything, so you know, I just kept telling people I'm going into the hospital to get violated, they going to violate me. I'm getting a tube ran up the inside of me. Everybody was laughing, but deep down inside I was really scared, you know because I didn't know why I was going in there.

Perceived Behavioral Control

Identification of an individual's perceptions about environmental factors to screening such as health care and access to screening could affect an individual's perceived control over behavior. Participants had a general mistrust of physicians and costs associated with seeing a physician and the health care system in general.

Mistrust of Doctors and the U.S. Health System

Mistrust of doctors and the health care system among AA is well documented in the literature (Agrawal et al., 2005; Washington, 2008). AA males in this study perceived doctors to be motivated by money rather than genuine concern for the patient. A small percentage of participants dissented from this view and stated they could trust the treatment by their physician.

My dad said to love many and trust few and that doctor's one I don't trust.

Discussion

Participants in this study saw the church as a trusted organization to create and market CRCS promotional materials to congregants. The consensus was that this type of promotion would be beneficial when targeting older AA faith community members and those affiliated with the church, but not necessarily the community at large. Participants saw the value of cosponsorship with organizations such as the ACS or local medical organizations.

Tailored and targeted information marketed from the church has the potential to move beyond traditional methods and appeal to AA men in church populations. Social marketing concepts have been widely applied to health behavior change campaigns (DiGuseppi, Thoreson, Clark, et al., 2014; Evans, 2006; Lefebvre & Rochlin, 1997); however, most of these have been developed by outside entities. Health education strategies that include social marketing campaigns conducted by and with the community have the potential to achieve long-lasting health behavior change because individuals are receiving and exchanging information from influential others they encounter on a regular bases. Important too are the influential church leaders who are seen as not only the gatekeepers of spiritual life-saving information but also health educators. Participants in this sample revered their pastors and

other church leaders and had a genuine respect for communication within the church setting. In some cases participants indicated that they would only screen for CRC if their pastor or another church member re-enforced or introduced the importance of screening and preferred these individuals communicated health messages from the pulpit. Participants felt that if the messages were imparted from this setting, more congregants would carefully listen to the information.

Participants lacked knowledge and understanding about the epidemiology of CRC and importance of CRCS recommendations. A study that examined the association between CRC knowledge and CRCS modalities showed that participants who had heard about tests for CRC reported higher knowledge scores (Tseng, Holt, & Shipp, 2009). Participants in the present study also had the perception that *others* did not know about CRC and the types of screenings available because conversations had not yet occurred in their church community.

An application of theory of planned behavior constructs in this exploratory study also confirmed existing literature on fear of CRC and CRCS (Bass et al., 2011; Rodgers & Goodson, 2014), gender norms (Christy et al., 2014), and mistrust in physicians and the health care system. The topic of colon cancer fears was prevalent and perceived as a death sentence. Additionally, even though these men had reported screening completion, they also discussed the procedure in terms of their own experiences and perceived others' experiences as an invasion of privacy, an affront to manhood, and also a fear of encountering an uncomfortable and embarrassing medical experience. Other barriers included lack of trust for primary care providers and the health care system, which are well documented in literature as factors that contribute to health disparities among AA (Benkert, Peters, Clark, & Keves-Foster, 2006; Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010) and AA men (Reynolds, 2008). Participants perceived the physician as an opportunist and expressed a devalued patient–physician relationship. Some dissented from these views and drew from their own positive personal experiences with their physician. The mistrust of medical personnel and health systems among this sample uncovers existing perceptions about CRC risk and prevention. These barriers may distort knowledge of CRC risk, attenuate efforts toward prevention, and perpetuate negative beliefs and attitudes among AA men.

Some limitations of the study included the number of individuals per FG and the prevalence of one denomination in the sample. In two of the FGs there were only three participants and most of the FGs were held at Baptist churches. Participants also self-selected into the study after being recruited at the church and about a third were younger than 50 years, the recommended age for CRCS. The rationale for inclusion of these individuals was to capture what church members thought about cancer and cancer screening and how they perceived the church as a social marketer. Those who were younger than 50 also reflect a growing concern among public health professionals as CRC diagnosis is more common before the age of 50 among AA (Oliver et al., 2012).

Implications for Practice

Data from this study have both research and practical implications. Theoretically, the results show that AA male church members see themselves as capable of CRCS when other

influential people screen (i.e., pastor). However, they also felt vulnerable because of testing and procedural barriers. Limited knowledge about screening, fear, perpetuated roles of masculinity, and mistrust in physicians minimized perceived control for screening. Facilitators identified included faith and trust in the church, pastor, and influential peers, which are also potential motivators to overcome screening barriers. These faith and trust factors were seen as a core part of what resonated with these participants and how to impact attitudes toward screening behavior.

Practically, this information is useful to health promoters, educators, and providers concerning the impact of church-sponsored and church-marketed health promotion materials among AA men. Results yielded will inform a feasibility study that will test the effectiveness of church-sponsored health promotion materials sponsored and marketed by churches. These findings also show that employing churches as a social marketer of CRC risk and prevention health promotion materials among men can be useful in strengthening health communication and subsequently screening behavior outcomes among this population.

Church-based health promotion programs developed by church communities have the capacity to address CRC disparities among AA men. An established body of research shows the impact that church-based programs have on cancer prevention behavior among AA (Campbell et al., 2004; Campbell et al., 2008; DeHaven, Hunter, Wiler, Walton, & Berry, 2004) but only a dearth of studies have focused on CRC health promotion targeting AA men. The present risk that AA men face from CRC calls for health programs that address prevalent barriers.

Results from this study suggest that AA churches in the Midwest are open to becoming social marketers and are positioned to become strong marketers of CRC prevention locally. Through communication and health promotion training by experts to churches and shared cultural experiences by the church, these exchanges can fuel successful community-engaged communication action teams to inform and develop effective marketing campaigns within the church and surrounding community.

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Table 1

Selected Pre-Focus Group Survey Results of African American Male Church Members.

Characteristics	Participant (N = 28)
Demographics	
African American	100%
Average age (years)	65; range = 35-80
Marital status	
Married/living with a partner	67.9%
Divorced/separated/widowed	17.9%
Single/never been married	3.6%
Other	10.7%
Average income level	\$1,800-2,399 per month; range included less than \$400 a month to more than or equal to \$4,200 a month
Colorectal cancer screening	
Has the respondent ever completed fecal occult blood test?	46.4%
Has the respondent ever completed endoscopic (sigmoidoscopy and/or colonoscopy) exam?	60.7%
Has the respondent ever brought up testing for colorectal cancer with the physician?	21.4%
Knowledge of recommended age to test for colorectal cancer	10.7%

Table 2

Integrated Theory with Themes and Quotes From Focus Groups with African American Male Church Members.

Sample/selected questions	TPB (constructs)	Quotes	Theme
Semi-structured guide questions			
Experiences with cancer	Beliefs/attitudes toward colorectal cancer and screening		
When you hear the word cancer, what comes to mind?		<p>“Death. The first thing that comes to mind is death. (A) short lifespan. Although some people, sometimes they, you know, I guess they overcome it or, you know, go through it and beat it. The first thought that comes to mind, that person is going to die soon.”</p> <p>“Some people claim other miracles have been done in the days past, in the years past but I still believe that God is still healing people today. So when I go for checks, like I went for my colonoscopy, my attitude is well, for that, you (God) are the doctor of doctors.”</p>	<p>Constructed familial loss and personal fears about cancer outcome</p> <p>Positive spiritual and religious influence on cancer promotion and outcome</p>
Experiences with colon cancer	Beliefs/attitudes toward colorectal cancer and screening		
When you hear the word colon cancer, what comes to mind?		<p>“It’s surprising because my wife had been to the doctor and had her physical and stuff, she was working, and all of a sudden she came up with colon cancer. I mean it seem like it just came up on her overnight.”</p>	Reoccurring theme of constructed familial and personal loss
Barriers to screening			
How comfortable would most people be bringing the things up (screening) with their doctor?	Subjective norms	<p>“I got scared, I got real scared. And we all like to joke a lot and like to laugh and everything, so you know, I just kept telling people I’m going into the hospital to get violated, they going to violate me. I’m getting a tube ran up the inside of me. Everybody was laughing, but deep down inside I was really scared, you know because I didn’t know why I was going in there.”</p>	Masculinity among African American men concerning colon cancer screening
How does cost figure into the decision of whether or not to get screened?	Perceived behavioral control	<p>“Anything that’s concerned with that dollar bill, I don’t care what you say, you can’t trust them (doctor). They go to that money.”</p>	Mistrust of doctors and the US health system
Social marketing questions			
Product	Social marketing components		
Colon cancer prevention/early detection and treatment			Knowledge gap and deficiency of colon cancer information
When it comes to preventing colon cancer, are there any ways that people can keep from getting colon cancer?		<p>“I had never really heard about colon cancer until he (the doctor) said I’m gonna schedule you for a colonoscopy and I’m saying “Well, what is that?” He then said “I want to check your colon for polyps and this and that.” I then said “How do they do this?” Then when he said what they were going to have to do, it instilled more fear, you know but it was something that I went ahead and done.”</p>	
Place			

Sample/selected questions	TPB (constructs)	Quotes	Theme
Do you feel the church could be used more to transmit or relay these types of health prevention messages?		“God should stay in the church. It’s the church, you know, so this is how he (the pastor) gets his message out. It’s not the media itself, it’s the people that are going to take it out of context.”	A guarded trust in the church and pastor as gatekeepers of CRC promoted information
Promotion Do you feel the church is most effective in getting cancer prevention messages across to church members?		“When a particular pastor or church organization goes forth and says something, it carries a meaning behind that, you know? I just think if Bishop (unnamed) says something or Apostle (unnamed) says something then you know, they’ll have a gathering or it goes farther... someone has respect for them and it carries weight, they’ll follow and go with it.”	Reoccurring theme of the guarded trust in the church and pastor

Note. TPB = theory of planned behavior; CRC = colorectal cancer.