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Interpretations of Interpretations: Combining Community-Based Participatory Research and Interpretive Inquiry to Improve Health

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Abstract

Background: Latina immigrants from Mexico suffer significantly increased morbidity and mortality from cervical cancer when compared with non-Hispanic White women, largely owing to lack of screening and appropriate treatment.

Objectives: To demonstrate that by combining the tools of community-based participatory research (CBPR) with the tools of interpretive inquiry, it is possible to address explicit community concerns surrounding a particular problem such as cervical cancer while also examining what other, perhaps less immediately visible, matters consume the time and attention of community members.

Methods: We first briefly discuss and compare CBPR as an approach to research and interpretive inquiry as a qualitative research method. We then provide a case study from our own research using a CBPR approach to examine beliefs and attitudes about cervical cancer prevention among Oregon Latinos. Methods in that study included extensive discussions

with our community advisory board (CAB) and *promotores* (community health workers) regarding barriers to cervical cancer screening for Latinas and community health concerns in general, and in-depth interviews with more than 50 Latino immigrants.

Conclusion: Combining the tools of CBPR with the tools of interpretive qualitative inquiry may allow researchers to address explicit community concerns while also examining what other, less immediately visible, issues consume the time and attention of community members. In our specific case, combining the insights of our community partners with the results of our interpretive analysis helped us shift the focus from cervical cancer alone to a focus on gender relations and family health as we design future interventions.

Keywords

Mexico, pelvic neoplasms, anthropology, education, sociology and social phenomena, health disparities

CBPR has emerged as a powerful tool for researchers and communities committed to social change and to improving community well-being.¹ Ideally, the issues addressed in projects using this approach are identified by the communities involved and build on community strengths and assets.² The process of defining and implementing projects can then serve as a catalyst for the creation of increased community cohesion, social capital, empowerment, and health.³ However, external funding mandates often predetermine the range of issues that can be addressed by communities and

their partners, thus determining a priori the types of problems that partnerships can attend to and impairing efforts to work chiefly on a community identified agenda. It has been suggested that researchers should address the tension between external funding mandates and internal priorities by identifying the conceptual linkages between fundable problems and the issues important to the community. In this way, programs can use the energy and insights surrounding local community issues as the engine that drives projects that can ultimately affect both proximal and distal determinants of health.^{2,4}

In this article, we argue that it is also possible to do the reverse: To use the insights garnered while working on funded mandates to help illuminate concerns in the community. In particular, we suggest that, by combining the tools of CBPR with the tools of interpretive inquiry, it is possible both to address explicit community concerns surrounding a particular problem and to examine what other, perhaps less immediately visible, matters consume the time and attention of community members. To make this argument, we first briefly discuss and compare CBPR as an approach to research and interpretive inquiry as a qualitative research method. We then provide a case study from our own research to demonstrate both the clear distinctions between the processes of CBPR and interpretive inquiry and the potential complementarity of their respective results.

CBPR AND INTERPRETIVE METHODS

Interpretive Inquiry

Interpretive research methods cut across multiple disciplines and subject matters, and there are several, sometimes competing, approaches to the practice of interpretive inquiry.^{5,6} Researchers using these methods bring specific lenses to examine, among other things, issues of gender, language, power, and resistance, continually unpacking, examining, and attempting to make sense of the myriad ways that individuals and communities behave.⁷ A common thread uniting all interpretive analysis is the assumption that reality, and therefore knowledge, is multiple, constructed, and evolving. That is, interpretive theory assumes that what any individual understands as being real or true is always the product of that individual's (or group of individuals') experiences and social interactions.^{8,9} Thus, the goal of interpretive research is not to uncover the objective truth, but rather to describe a particular version, or interpretation, of the truth, and to use a specific theoretical lens to attempt to understand that version.^{7,10,11} The point is to provide interpretations of interpretations. The ultimate goal is to produce enough understanding between people and cultures that conversations around common goals, problems, and solutions become possible.¹²

It should be noted that researchers who use interpretive theory to analyze their data often use qualitative methods to gather that data. However, although the analysis of all qualitative data does involve some interpretation (in determining

what is important, how it should be summarized, what it means), qualitative methods and interpretive approaches to analysis are not the same thing: Interpretive inquiry draws from a theoretical framework that assumes that there is no single, objective reality. Qualitative methods, however, are just that: Methods. They are used when investigators attempt to explain phenomena, whether those phenomena are assumed to be objectively "real" or not, without counting or measuring them, depending instead on the quality and richness of data.¹³ Thus, researchers with vastly different theoretical stances may use qualitative methods, each in very different ways and with very different epistemological assumptions.

CBPR

Interpretive approaches to knowledge strongly influence CBPR: Fundamental to CBPR is the question of who defines knowledge, who determines truth, and how power is constructed and deconstructed.¹⁴ Yet, whereas CBPR draws on interpretive theory, it is not itself a research method. Rather, it is an orientation to research, an approach to thinking about how research articulates with power, knowledge production, and community. Thus, interpretive approaches provide a theoretical foundation that guides practice in CBPR, but they do not necessarily guide data gathering and analysis.

Consequently, whereas research using CBPR often entails the use of qualitative methods, results of that research are rarely reported as "interpretation." Rather, focus groups, discussion sessions, and open-ended interviews that try to better understand issues and perspectives within communities are most often simply reported as objective truth as stated by the participants. Researchers may use standard methods of qualitative inquiry and are interpreting the data in the process, but rarely then take the next step, interpreting their interpretations through a particular theoretical lens. This is not a criticism. The point of CBPR is generally much more practical than that: The point is generally to make explicitly clear what communities need, what they have, and what they want to do. Theoretical interpretations of interpretations can wait.

CASE STUDY: CERVICAL CANCER SCREENING AMONG MEXICAN IMMIGRANTS

The project we discuss here began 5 years ago when two of us (JG and RCA) began discussing the problem of cervical

cancer within the Latino population: Latina women in the United States are less likely to be screened for cervical cancer (via the Pap smear) and are consequently significantly more likely to die from the disease than are non-Hispanic White women.^{15–17} RCA is director of *Familias en Acción*, a community based organization in Portland, Oregon, that works with a cadre of *promotores* (community health workers) to improve the health of Latino families in Oregon, particularly with regard to the prevention, management, and treatment of chronic disease. JG is an anthropologist and physician with experience in interpretive methods and a long-standing interest in cervical cancer prevention. Building on the intersection of their interests, and working with staff of *Familias en Acción* and a CAB, we developed a project to investigate social and cultural barriers to cervical cancer prevention among Latina immigrants and ultimately to create an intervention based on those findings. We received approval from the Oregon Health and Science University Institutional Review Board for all aspects of this research.

CBPR: Developing and Framing the Project

During this phase of the project, our goal was to solicit and accurately reflect opinions and concerns in the local Latino immigrant community regarding cervical cancer and the Pap smear. In accordance with the practices of CBPR, we began the project by contacting local community leaders (a local community organizer, two county health workers, two community health workers, and a stay-at-home mother) to form the project's CAB. This board meets approximately every 3 months, although meetings occur more frequently when the need arises. Three members of the CAB also agreed to become members of the research team as research assistants (RAs). They were subsequently trained in qualitative data collection, interpretive theory, and analysis, and in the responsible conduct of research.

The research team scheduled a discussion session with seven *promotoras* from *Familias en Acción*, all of whom were Latina immigrants. During this session, we asked the *promotoras* to identify and discuss barriers to cervical cancer screening specifically, and issues of concern to community health generally. We took detailed notes and at the end of the session asked the *promotoras* if we had correctly identified the issues of greatest concern. Based on results from this meeting,

on review of the literature, and on the team's initial research questions, the team then developed an interview protocol, which the *promotoras* reviewed. In addition, because the *promotoras* identified male attitudes as a barrier to screening, we also scheduled a meeting with seven male Latino *promotores* to review the interview protocol and to discuss cervical cancer and potential barriers to screening. Again, we took detailed notes and at the end of the session asked if we had correctly identified the issues of greatest concern. Both groups then met together for one final discussion session. At the end of the session, the team summarized important issues discussed and asked participants if anything had been missed. We met with our CAB immediately before beginning the discussion groups and immediately after completing them, asking what should be covered, what issues they felt were missed or were new, and their reactions to their results. The CAB made no changes to the protocol.

In both the discussion groups with the male and female *promotores* and in meetings with our CAB, participants stressed that current programs for Latinos in Oregon are missing two crucial elements: (1) A focus on family and (2) a recognition of men as members of the family. Both CAB members and *promotores* stressed that most social service and health-related programs targeting women's and children's health are aimed only at women, or occur during the work day when men cannot attend. Yet individual and family health care decisions are often made by couples together. As one woman remarked, "We need to bring men back to the table." Male *promotores* echoed that opinion, stating: "They [men and women] should be together. One alone is not the same." During these sessions, participants emphasized the importance in interviews of asking interviewees about who in the family is responsible to making health care decisions.

Both male and female *promotores* also emphasized that they are far less concerned about their risk for cancer than about maintaining the integrity of couples and families against stressors such as poverty, alcoholism, deportation, domestic violence, lack of health care, and parenting in an unfamiliar cultural context. As one *promotora*, describing her worries about her children and husband put it, "We are afraid, panicked," and cancer prevention is thus simply not a priority.

Based on these results, rather than asking only women about cervical cancer screening, we targeted both men and

women in-depth interviews. We divided questions into four categories: Social context (including why and when participants came to the United States and what that experience has been like), health care decision making, beliefs about the Pap smear, and beliefs about cervical cancer. We also included questions about how interviewees made decisions regarding their own health care and the health care of their families.

INTERPRETIVE INQUIRY: ILLUMINATING A SLICE OF THE TRUTH

During the second phase of the project, our goal was to use a particular theoretical lens, as well as community guidance, to better understand social and cultural barriers to cervical cancer screening. Based on JG's experience and expertise, we chose to analyze our data through a critical theoretical lens. Critical theory is concerned with issues of power and justice, with the ways that differences in power influence the construction of a social system, and with analyzing competing interests between individuals and groups in a society.¹⁸ Thus, we were not just examining what individuals thought and believed about cancer prevention, but also how differences in power and access to resources might have shaped those thoughts and beliefs.^{19,20} Based on results from the first phase of our project, we also chose pay particular attention to the role of men in women's health and health care decision making.

Using the protocol developed with the *promotores*, we interviewed 28 female and 23 male immigrant Latinos recruited through snowball sampling. We altered the interview protocol slightly depending on whether the interviewee was a man or a woman; otherwise, the same interview guide was used for all participants. Our initial plan was to have a the male RA interview male participants and the female RAs interview females. However, in the process of snowball sampling, many participants requested that they be interviewed by the same person who had interviewed the participant who had recruited them (i.e., if JM, a male, interviewed a man, and that man subsequently recruited a female participant, that participant might have requested an interview by JM as well). Therefore, interviewers and participants were ultimately not gender matched. The interview protocol served only as a guide, and RAs allowed participants to tell their own stories and probed further when they found comments or questions to be particularly interesting. How we probed was influenced by our initial theoretical perspective and by our interest in

men's influence on women's health care behaviors. Had we begun the project with a different model or theoretical perspective (i.e., the health belief model or symbolic theory), our questions and our analysis would have been different. Interpretive approaches do not aim to develop or reinforce encompassing theories or explanatory models. Rather, the aim was to illuminate a particular perspective on experience or behavior that might otherwise go unseen.

All team members read all of the interview transcripts. The team met monthly to discuss responses within each category and to discuss whether any patterns seemed to be emerging. We read the transcripts with our two research questions in mind: "How did participants think about the Pap smear?" and "How did participants think about cervical cancer?" We also read the transcripts alert to other issues or topics that seemed particularly important to participants, that were surprising to us, or that occurred often across interviews. After all the transcripts had been reviewed once, three project members re-read the interview transcripts and assigned codes to the relevant sections. As a team, we then sorted the different codes into potential themes, identifying what seemed to be the essence of each theme.²¹

Among the most striking themes that we identified in interviews were: that the Pap smear screened for sexually transmitted infections (STIs; the majority of participants believed this), that men were generally responsible for the spread of STIs, and that men's attitudes were a barrier for women seeking the Pap smear. To provide a brief example, Elizabeth, a 27-year-old woman from rural Mexico had moved to the United States illegally 2 years before the interview, having made the trip to be with her husband who had been migrating regularly on and off for years. She said that she was tired of always being alone. She had no insurance, and rarely sought health care. However, she had received a Pap smear a local free clinic about 8 months before the interview. The Pap, she explained, is necessary, "if the person with whom you have sex has other partners. One of those partners could be infected with some disease, and after sexual relations, your partner could have the same." She also noted, however, that even if a woman is concerned about her partner's fidelity, she might not get a Pap smear.

Although not every interview contained all of these themes, each theme was present in interviews with both

male and female respondents. Our interviews illuminated significant misunderstanding on the part of both men and women regarding the Pap smear. They also demonstrated that many of our participants felt that Latina immigrants do not make health care decisions for themselves and that both men and women believed that men, who were perceived as having more sexual freedom than many women, put women at risk for sexually transmitted diseases.

DISCUSSION

By approaching our research using the principles and practices of CBPR, we were not only able to help ensure that the research remained relevant to the community, we were also able to design the research so that we were interviewing the right people (both men and women) and asking relevant questions (regarding male influences on women's health care behavior). Unlike the process we went through in analyzing the in-depth interviews, we did not then try to interpret the *promotores* input or the advice of the CAB through a particular theoretical lens. We did not try to understand, for instance, the social or structural factors that might have led to community attitudes or how gender theory might explain the *promotoras* advice regarding the need to include men in our research.

By contrast, when we conducted and analyzed our in-depth interviews, we drew both on the reflections and advice of our community and on interpretive analysis and critical theory: Using CBPR led us to think in much greater depth about how gender relations affect women's health. A critical theoretical lens further refined that focus, leading us to examine how differences in power affect attitudes and behaviors, and the ways that the immigrant experience puts both men and women at greater risk for some diseases than non-immigrants. For example, a growing body of literature notes significantly increased risk for HIV and other STDs, largely because global economic inequalities necessitate that Latino men spend prolonged periods of time away from their families and communities.²²⁻²⁴ Therefore, the concern with STIs (both with regard to risk and prevention) that we noted

in our interviews may reflect this literature. Furthermore, in interviews both men and women affirmed that women often do not make health care decisions for themselves. Together, these findings suggest future interventions to increase cervical cancer prevention in this population must not only educate about cancer and STIs but must also be sensitive to, and address, issues of power and empowerment in relationships as well.

CONCLUSION

In sum, CBPR framed our research and kept it relevant to the community. Interpretive inquiry allowed us to deepen and broaden our understanding of the role of power and disempowerment (both within relationships and external to relationships) on women's cervical cancer screening behaviors. At our project's inception, our CAB stressed the need for men to be present in discussions of Latina health and health care, and they told us that immigrants in our community are concerned about their relationships and families. Results from our interviews reinforced these views. But the results also took us one step further, indicating that immigrant men need to be not just present in discussions of Latina health issues, they need to be central to those discussions. Our analysis suggests that among the Mexican immigrant population, disempowerment, both globally (as immigrants), and locally (within relationships), may be affecting women's health in unexpected ways, influencing both behaviors and beliefs and attitudes about preventive care.

By combining the insights of our community partners with the results of our interpretive analysis, we have been able to move our project forward in important ways, shifting the focus from cervical cancer alone to a focus on couples and family health as we design future interventions. We also move forward with the recognition that the price of immigration for Mexican families may not only be found in geographical separation and in the risks of migration itself, but also in more far reaching and unexpected effects of immigration on couples and on women's health.

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