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Dealing With Diversity: Recruiting Churches and Women for a Randomized Trial of Mammography Promotion

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There is little documentation about the recruitment process for church-based health education programs. In this study, the authors recruit African American, Latino, and white churches and women members (age 50 to 80) for a randomized church-based trial of mammography promotion in Los Angeles County. Efforts to enhance recruitment began 10 months before churches were invited to participate and included a variety of community-based strategies. Subsequently, 45 churches were recruited over a 5-month period through group pastor breakfast meetings and church-specific follow-up. In close collaboration with the 45 churches, the authors administered church-based surveys over 6 months and identified 1,967 age-eligible women who agreed to be contacted by the program team. It was found that an extended resource intensive period of relationship-building and community-based activities were necessary to conduct church-based programs effectively, particularly among older and ethnically diverse urban populations.

Creating partnerships between public health and faith communities is advancing as a popular strategy to prevent disease and promote health, particularly in low-income urban areas and among certain minority groups. These partnerships are promoted as a way to build continuity between clinical and community settings, increase access to care for the underserved, enhance effectiveness of behavior modification programs, and contribute to the sustainability of community-based initiatives.¹ Such is the interest in this area that a recent special issue of *Health Education & Behavior* (December 1998) was devoted to exploring the relevance of faith communities for public health and health education. For example, Chatters et al. suggested several specific ways in which religious institutions

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could be significant allies for health educators, in community needs assessment and in planning and implementing health promotion and disease prevention activities.²

Previous research has identified particular ways in which religion can promote well-being, both within congregations and through outreach to the community.³⁻⁵ Religious communities can be empowering for members⁶ and act as buffers to life stressors through tangible support shared among members.^{7,8} In the area of prevention, faith communities are taking an increasingly visible role, reflected in the proliferation of faith-based health programs in AIDS, depression and mental illness, nutrition, physical fitness, substance abuse, teen suicide, and unwanted pregnancy.⁹ More recently, church-based programs have focused on cancer control.¹⁰⁻¹³ As Maton and Wells note, outcome evaluations of these efforts are rare.⁵ However, such evaluations are increasingly important, as funders, health departments, and even hospitals consider investing increased resources in programs based in faith communities.

Evaluation has varied meanings among disciplines. Some disciplines call for broader use of randomization to increase the strength of scientific evidence in community health research,¹⁴⁻¹⁷ yet few randomized trials of church-based programs have been conducted or published. For example, a recent review of religious-based cardiovascular disease prevention trials found only six projects that met rigorous scientific criteria (including random assignment of intact groups to intervention and comparison conditions).¹⁸ Furthermore, because most of these trials were in progress when reviewed, conclusions about effectiveness could not be determined.¹⁹ Previous work has used elements of experimental design to evaluate church-based programs, usually by randomly assigning churches^{12,20-22} or participants within a single church²³ to intervention and minimal intervention groups. One study reported assigning churches to a true control group (no intervention),²⁴ and another used a delayed intervention (implemented after completion of the 2-year follow-up survey).²⁵ Few studies randomly selected churches to participate,^{13,20,25} and even fewer studies provided detailed descriptions of the recruitment process.²⁰

The purpose of this article is to describe our experience of recruiting and retaining an ethnically, racially, and denominationally diverse group of churches and women (age 50 to 80) for a randomized church-based trial of mammography promotion. The rationale for conducting church-based mammography promotion is described more fully elsewhere.^{10,11} Briefly, we evaluated the efficacy of working with churches to organize, implement, operate, and maintain breast cancer education activities. Churches provide many advantages as a base for promoting health among low-income groups and minority groups, particularly older women.⁹ Churches can also provide leadership, social networks, outreach, and a particular worldview conducive to health promotion.⁴

Over a period of approximately 5 months, we recruited 45 churches (18 African American, 15 white, and 12 Latino) and 1,967 age-eligible women to participate in a 3-year intervention program. We report our experiences with particular attention to (1) how we recruited churches, how we followed up with specific churches, and what were the participation incentives; (2) how we collaborated with participating churches to recruit eligible women through a women's health survey at each church; and (3) what were the final recruitment results and the relative successes among churches of different sizes and ethnicities.

Our experiences will inform researchers considering an experimental design with churches, as well as health educators who desire to work with the faith community. Very little has been documented about the process of recruiting churches and their members for

health promotion programs, especially in comparison with the existing literature on recruiting patients in clinical trials. Moreover, much of the structure of our recruitment process could be generalized to others designing health interventions in partnership with churches, including implementation programs and evaluation trials.

PROGRAM DESCRIPTION

The Los Angeles Mammography Promotion in Churches Program seeks to assess the efficacy of church-based mammography promotion for low- to moderate-income women in three ethnic groups: African American, white, and Latino. The study tests barrier-specific counseling strategies for motivating women age 50 to 80 to initiate and maintain breast cancer screening. The specific design compares mail counseling and telephone counseling with a minimal intervention group. Although the interventions do not include mammograms specifically, the counseling transmits information to participants about mammography facilities in their communities, including whether they offer free or low-cost mammograms, and addresses the concerns of participants. The interventions, therefore, are designed to enable and facilitate screening. The study also examines the overall efficacy of church-based health promotion.

Much of the project's recruitment plan builds on existing networks of community relationships developed by several members of the project team. The outreach team responsible for recruitment included three full-time community outreach workers, a half-time outreach director, and a full-time project director. The outreach team (1) recruited and maintained relationships with participating churches and women over a 3-year period; (2) trained and supervised the telephone mammography counselors at intervention churches; (3) collected information on community mammography resources (facility information, available financial and language assistance, transportation) to share with church committees and participants; (4) documented process information about church-level factors and activities that affect program development; and (5) encouraged the development of church-based health ministries or committees that conduct church-based health promotion activities.

RECRUITMENT

Recruitment followed a two-phase approach: recruitment of churches and recruitment of women. Efforts to enhance church recruitment began approximately 10 months before churches were actually invited to participate. Some steps taken to enhance recruitment included the following: (1) hire community and religious consultants; (2) conduct focus groups with pastors and active female church members to discuss recruitment strategies and overall reactions to the program; (3) obtain letters of support from prominent local and national organizations that promote health and faith partnerships, such as the Greater Hollywood Health Partnership and the Carter Center; (4) form a community advisory committee comprising religious and community leaders, health care professionals, researchers, and other community experts; (5) establish media outreach and other communication channels to promote continuing awareness of and trust in the project; and (6) assemble a culturally and racially diverse outreach team.

Church Information Survey

We enumerated churches in a 245 square mile area in southern Los Angeles County. We selected this geographic area based on estimates of the numbers of low-income African American, Latino, and white women, the number of religious congregations serving these groups, and the proximity of a major county hospital that had agreed to provide mammograms and follow-up for women without a regular health care provider. Ultimately, we identified 1,324 churches in our project area and through multiple efforts obtained 875 responses to the church survey (66%). Of these, 661 churches were found to be “potentially eligible,” with the following parameters: (1) it operated as a church in the project area; (2) it was not predominantly Asian (since this group was eliminated from the study by the funding agency); (3) it has operated consistently for more than 3 years; (4) it has at least 45 active female members who are age eligible and with annual household incomes less than \$25,000; (5) it has a membership that is at least 60% African American, white, or Latino; and (6) it is not currently engaged in any type of breast cancer health program.

Using these criteria, we found that 140 churches were eligible for random selection (71 African American, 45 white, and 24 Latino). Because we desired to recruit approximately equal numbers of African American, white, and Latino churches, we produced three computer-generated randomized lists by predominant ethnicity of eligible churches and proceeded to actively recruit the first 24 churches in each of the three lists.

Church Recruitment Process

Our church recruitment plan included a two-stage process: first, project-sponsored breakfast meetings for groups of eligible pastors to present basic information about the purpose of the project, along with participation benefits, and then church-specific follow-up to explore participation through meetings with the pastor and/or church governing body and project presentations at church services and meetings. We sent letters to pastors of the 72 selected churches to thank them for returning the church information form and invite them to participate in the program. The letter also notified them of an informational breakfast meeting where they could learn more about the program. In addition, pastors who were members of our community advisory committee made telephone calls to encourage the pastors to participate in the program. Outreach workers then called pastors of churches assigned to them to introduce themselves and discuss the project, congratulate the pastor on being selected to participate, and confirm their participation in one of the pastor breakfast meetings. We encouraged pastors to bring another church leader to these breakfasts who might become involved in the program.

The pastor breakfast meetings took place in local restaurants at key geographic locations throughout the study area. Members of the outreach team and the pastors of the community advisory committee attended the breakfast meetings. Each meeting lasted approximately one and one-half hours and was attended by approximately 20 to 25 pastors or church representatives. The general format of the meetings included the following: (1) introductions of the outreach team, community advisory committee members, pastors, and other representatives of selected churches; (2) a welcoming prayer, after which followed breakfast and informal conversations; (3) a motivational talk from a community advisory committee member (pastor) about the role of faith communities in health promotion, followed by a 20-minute slide presentation by the project director or community

outreach director about the need for the program, overall goals, and benefits for participating churches; and (4) a question-and-answer session and discussion of next steps.

At the end of the sessions, we asked each pastor to fill out a brief questionnaire to facilitate appropriate follow-up by the outreach team. This questionnaire inquired about pastors' interest in the program, any additional information they needed, their church's decision-making process with regard to participation, and their preferences for follow-up meetings at their churches. In addition, we gave participants a one-page program fact sheet and a draft of the participation agreement to be discussed in follow-up meetings.

Four informational breakfast meetings were held over a 2-week period in May 1995 for the first group of invited churches. Of the 72 churches invited initially, 45 (63%) sent representatives to one of these breakfasts. If the pastor or other church representative was not able to attend any of the breakfast meetings, we offered to visit the church and present the program to the pastor and, often, to a church group. Of the 72 churches invited originally, only 4 requested such appointments in lieu of the pastor breakfasts.

Once a church declined to participate, or did not respond after multiple attempts to contact over 2 to 3 months, we replaced it with the next church on the respective random list and followed similar recruitment procedures as outlined above. Two additional pastor breakfasts were held nearly 3 months after the initial breakfast meetings to accommodate the newly invited churches. The final results of church recruitment are provided below.

Consequently, recruitment of churches took a staggered approach. We moved through the various stages of recruitment with some churches just as we began to recruit additional churches replacing those that declined. After the pastor informational meetings, outreach team members made follow-up visits to individual churches to explore participation. We made every attempt to conduct the follow-up visits within a few weeks after the informational meeting, although this depended on the pastor's schedule.

The actual number of follow-up visits per church varied. In some cases, the pastor required very little additional information and one follow-up visit was sufficient to move the church to the next stage of recruitment, that of recruiting individual women. This was most often true in the Roman Catholic churches, which tended to be more hierarchical in structure. At the other end of the spectrum were the Protestant, predominantly white churches. These churches used a decision-making process that included some type of church board, a governing body that often met, at most, once a month. Thus, it was not uncommon for the decision about participation to take 2 or 3 months. Among most African American churches, a pastor could make the decision to participate, although often he preferred to gain prior approval from a women's auxiliary or group within the church before agreeing to participate in the program.

Incentives Offered

Throughout all phases of church recruitment, we stressed that we sought to form a partnership with participating churches to work together against breast cancer. Yet, we also tried to minimize the amount of time required of pastors, since we realized that virtually all of them were already overburdened. Earlier pastor focus groups reinforced the need to provide tangible benefits to churches, in particular, some kind of minimal intervention for the control group.

We offered to all churches, regardless of assignment, a library of resource materials on cancer and cancer prevention and assistance with starting a health committee or working with an existing health committee. In addition, all churches received computer hardware, software, and a printer, as well as computer training for at least one church member or

staff. We contracted with a local computer training center to provide the training, which involved 7 hours of classroom learning on the operating system and software programs of the computer donated to the church. After attending the training, participants were allowed to attend an additional 6 hours of a refresher training class within 90 days of the initial training. A modest honorarium was given to at least one member at each church to compensate partially for their assistance in recruiting participants. Finally, among churches assigned to the intervention groups, several female church members received training and stipends to serve as peer mammography counselors. This training, described in full elsewhere,²⁶ involved approximately 12 hours of workshop training and 8 to 12 hours of on-site training at the church-based telephone counseling centers. Project team members facilitated this training, which covered background information on breast cancer and mammography, common barriers to mammography, counseling techniques, community resources for mammography, role playing, and documentation and phone center procedures.

Participation Agreement

Once a church received the necessary internal approval to participate in the program, we requested that two people from the church, the pastor and a board member or other representative, sign the participation agreement. We wanted to ensure that there was church “ownership” of the program in case the pastor changed during the program. The participation agreement listed the initial benefits of participation and the church’s responsibilities. These responsibilities included the following: (1) confirm that the church has approximately 45 female members who meet program criteria (age, income, education), (2) help to recruit and encourage women to participate in the program, (3) designate a church coordinator (described below), (4) form a church health committee to assist in the survey of women, and (5) provide some security and insurance against theft for the program-donated computer. Finally, the participation agreement outlined the terms of random assignment and the expected duration of the project.

Recruitment of Women

Once a church signed a letter of agreement, we recruited women participants. We asked pastors to appoint a female church member to serve as church coordinator for the program. Although these were essentially volunteer positions, we did provide very modest stipends for these women (\$150 for each coordinator per year). In appointing these women, we asked pastors to consider women who were in the target age group, were natural leaders in the church, were respected and trusted by the women in the target age group, and had time to devote to this project. In some churches, particularly in the more heterogeneous churches, multiple coordinators were necessary to facilitate recruitment among diverse groups.

In addition to appointing church coordinators, we also requested pastors’ assistance in developing a cadre of church volunteers to help recruit women participants. Often, the church coordinators were primarily responsible for recruiting volunteers to assist in administration of the women’s health survey (described below). We also hoped that some of the volunteers, through their involvement in the recruitment of women, would become invested in the project and serve as members of an ongoing group committed to promoting health at their church.

Table 1. Strategies Used by Churches to Recruit Women

Publicized Program	Personalized Recruitment	Used Diverse Methods
Notices in church bulletins	Recruited volunteers	Surveys at church services, meetings, programs, and outreach ministries
Announcements during services by pastor and coordinator	Set recruitment goals	Open houses and special recruitment events
Announcements at church and community events	Invited women to informal gatherings	Recruitment in nearby churches, community centers, and senior citizen centers
Program flyers	Stressed confidentiality	Door-to-door canvas of neighborhood near church
Presentations for key church and community groups	Candid discussion of concerns	Phone or face-to-face surveys
Articles in local and religious newspapers	Telephone calls and home visits	Recruited friends, relatives, neighbors, and coworkers
	Stressed program benefits	
	Conducted church in-reach and outreach activities	

Women's Health Survey

To facilitate recruitment and screen women at the individual churches, we developed a brief questionnaire (English and Spanish versions) and a one-page question-and-answer sheet to be distributed to potentially eligible women. The RAND Human Subjects and Protection Committee approved these forms and procedures. We also applied for and were granted a certificate of confidentiality from the U.S. Department of Health and Human Services, which enabled us to assure participants that their identities would be withheld from all persons outside the project.

The questionnaire was mainly used to determine age eligibility and provide contact information so eligible women could be contacted for enrollment in the study. Thus, the women's health survey served as an initial screen to the baseline telephone survey. The questionnaire also included questions on other demographics (ethnicity, language ability, education, literacy, household income), mammography screening history, church attendance, and religiosity. We desired this information to tailor program educational materials. Furthermore, because income and education are correlated positively with mammography screening,²⁷ we wanted to prioritize participation among more "needy" groups.

Because participating churches varied greatly in size (from 100 members to more than 16,000), ethnic composition, and organizational structure, we worked closely with the church coordinators or pastors to develop a church-specific recruitment plan for women. Most of the planning work was done with individual coordinators and volunteers during meetings at their churches and, sometimes, in their homes. We also convened interchurch coordinator meetings to discuss recruitment challenges and successful strategies for recruiting women. Three such luncheon or dinner meetings were held at participating churches at key geographic locations in our project area.

Strategies to Recruit Women

Table 1 summarizes the various strategies used by churches to recruit eligible women. First, we encouraged churches to publicize the program within their own congregations and communities. Our community advisory committee played an important role in get-

Table 2. Results of Church Recruitment by Predominant Ethnicity of Church

Outcome	African American (<i>n</i> = 37)		White (<i>n</i> = 45)		Latino (<i>n</i> = 24)		All Churches (<i>n</i> = 106)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Recruited	18	49	15	33	12	50	45	42
Not enough eligible women	5	14	3	7	3	13	11	10
Not interested or no time	3	8	13	29	2	8	18	17
No response	11	30	14	31	7	29	32	30

ting the word out to the broader community and encouraged us to place articles in local and religious newspapers.

Second, we worked with the church coordinators and volunteers to personalize recruitment and set realistic recruitment goals. We hoped that each church would recruit at least 30 to 40 age-eligible women with low incomes or low education. However, because churches wanted to open participation to all age-eligible women, we did not restrict participation based on reported income or education. We trained volunteers on the overall purpose of the women's health survey and elicited their ideas about the best methods to administer the survey in their respective churches. Because volunteers sometimes assisted women in actually filling out the forms, we asked each volunteer to sign a pledge of confidentiality. Some churches preferred to sponsor informal gatherings for women after church services. We attended these meetings to answer questions and encourage candid discussions of concerns. A few churches decided to make telephone calls and home visits to eligible members.

Third, we encouraged churches to use diverse methods to administer the women's survey. These included distributing questionnaires during services, meetings, programs, and outreach ministries. Some churches went beyond their own congregation, since their idea of "community" included those they desired to serve (neighborhood residents, the poor, the elderly). In fact, several churches were initially interested in participating in the program because it was a concrete way to develop an outreach program. More proactive churches recruited from community centers, surrounding neighborhoods, neighborhood grocery stores, and housing projects, as well as from volunteers' own pool of friends, neighbors, and coworkers. Finally, some smaller churches requested that they be able to recruit participants from other churches not already participating in the program. This practice was more common among African American churches accustomed to "fellowshipping" with other congregations and non-African American churches in which the denominational structure facilitated this strategy.

FINAL RECRUITMENT RESULTS

Church Recruitment

Table 2 provides the results of church recruitment by predominant ethnicity of the congregation. Over the 5-month period, we successfully recruited 18 African American churches, 15 white churches, and 12 Latino churches. Of the African American churches, 9 (50%) were Baptist, 1 was Roman Catholic, and the other 7 were of various

**% of Eligible Women
Recruited (50-80 years)**

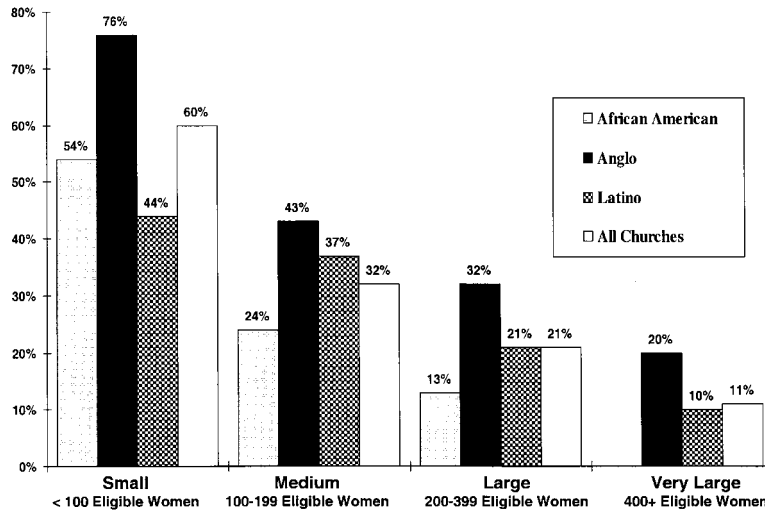


Figure 1. Proportion of women recruited by church size and predominant ethnicity.

Protestant denominations (Methodist, Lutheran, Congregational, Church of Christ, Church of God in Christ, Church of the Living God, and Seventh Day Adventist). Of the white churches, 4 were Methodist, 3 were Lutheran, 2 were Episcopalian, 2 were Reformed, 1 was Congregational, 1 was Community, 1 was Christian, and 1 was Baptist. Of the Latino churches, 9 (75%) were Roman Catholic, 1 was Baptist, 1 was Foursquare, and 1 was nondenominational.

As shown in Table 2, white churches had the largest percentage of unsuccessful recruits (67%). Comparatively, half of the attempted African American and Latino churches (49% and 50%, respectively) were eventually recruited. Interestingly, of the 13 white churches that were “not interested or too busy,” 7 stated that they did not have a pastor or were facing some internal crisis (e.g., one church was dissolved during this time). Even among those white churches ultimately recruited, 4 (26%) of the churches experienced a change of pastor during the 5-month recruitment period. Overall, the African American and Latino churches were less likely to say that they were not interested or too busy (8% each vs. 29% for the white churches).

Recruitment of Women

The women’s survey was completed by 2,535 women from 45 churches. Of these, 1,967 (78%) were deemed age eligible and consented to be contacted by the project. The proportion of eligible women who were ultimately recruited varied by church size and predominant ethnicity. Figure 1 gives the approximate percentage of eligible women recruited by ethnicity and size of the eligible pool based on the amount actually recruited over the total estimated amount of age-eligible women at these churches. The percentage of eligible women recruited decreased as the size of the pool increased across all ethnic groups.

Predominant ethnicity of the church did not always correlate with ethnicity of the women recruited from the church. This was particularly true among some Roman Catholic churches (9 of 10 in the Latino category). Even though these churches were predominantly Latino in total membership, we realized through our survey that in some of these churches, the ethnicity of women in the 50+ age group tended to be African American or of an ethnicity other than Latino.

Characteristics of Participants

Table 3 gives participant characteristics by participant ethnicity (not the predominant ethnicity of the church). As noted, there were statistically significant differences between ethnic groups on all variables except for the proportion of participants that were members of the churches. Overall, Latino participants were younger, had less formal education, were less literate, were less able to speak English, had poorer health status, and had lower household incomes than the African American or white participants. Similarly, Latino women were much less likely than other groups to report having had a mammogram in the previous 2 years.

However, with respect to variables related to church participation, Latino women were more similar to women of other ethnicities, although some statistically significant differences remained. High proportions of all ethnic groups reported they were members of the churches that recruited them, and there were no statistically significant differences between them. Latino women reported fewer years at their churches than other groups, reflecting the fact that many are immigrants. Still, the fact that the average duration of membership in churches is 12 years for this predominantly immigrant group shows that the Latino population sampled is relatively stable. A majority of women of all ethnicities reported that they attended church services at least every week. Slightly less than one-third of the women across all groups reported attending church activities (other than services) at least every week. Latino women, however, were less likely to attend church activities at least monthly. Rather, they reported attending activities a few times per year or never.

DISCUSSION

The challenges faced in recruiting churches and women for this church-based trial of mammography promotion are similar to the challenges reported from clinical trials: the recruitment process took longer than investigators originally planned, and the eligible pool was often overestimated.²⁸ Moreover, as suggested by Areán and Gallagher-Thompson, recruiting older adults who are ethnic minorities is particularly difficult and involves much effort on the part of the researchers.²⁹

The time and resources required to personalize recruitment were substantial. These included five project team members dedicated almost exclusively to this task over a 6- to 9-month period. In addition, many recruitment-enhancing activities took place in the 10 months before churches were actively recruited. When one considers this level of effort, and the fact that we fell short of our recruitment goals, one might ask whether this approach is really worthwhile. A cost-effectiveness analysis under way will help to answer this question. The literature includes very few controlled studies (using random assignment of intact groups) of religious organizations. Of the few that are reported, most are currently under way, so results are not yet available.¹⁸ A definitive answer to the ques-

Table 3. Participant Characteristics by (participant) Ethnicity

Characteristic	African American (<i>n</i> = 586)	White (<i>n</i> = 774)	Latino (<i>n</i> = 480)	Other or Unknown Ethnicity (<i>n</i> = 127)
Age (mean years)*	61.7	66.0	59.5	63.1
Education (%)*				
≤ 6th grade	2.7	0.9	66.9	3.9
7th-11th grade	11.8	7.9	11.4	10.4
High school graduate	83.5	91.2	21.7	85.7
Reading ability in native language (%)*				
A little/not at all	1.9	0.3	25.2	7.0
Somewhat well	6.9	3.2	22.6	12.7
Very well	91.2	96.5	52.2	80.3
English-speaking ability (%)*				
Very little/not at all	2.5	0.9	77.4	4.3
Somewhat well	7.9	4.3	8.6	20.3
Very well	89.6	94.8	14.0	75.4
Self-reported health status (%)*				
Excellent or very good	30.0	55.0	12.3	40.8
Good	40.4	33.1	21.7	37.8
Fair or poor	29.6	11.9	66.0	21.4
Annual household income (%)*				
< \$15,000	41.5	18.8	80.2	40.0
\$15,000-\$25,000	15.8	14.6	10.6	12.9
> \$25,000	42.7	66.6	9.2	47.1
Had mammogram in previous 1 to 2 years (%)*	69.9	80.4	37.2	66.7
Member of this church (%)	88.1	86.9	87.1	83.1
Average number of years at this church (mean years)*	19.3	24.4	12.4	18.7
How often attends church services (%)*				
Once per week or more	70.3	71.5	74.7	74.7
Two to three times per month	11.8	12.6	7.0	8.4
Once a month	4.2	3.0	1.8	4.2
A few times per year	8.1	4.9	10.9	4.2
Never	5.6	8.1	5.7	8.5
How often attends church activities (%)*				
Once per week or more	30.0	28.4	32.7	29.0
Two to three times per month	10.9	15.5	2.5	17.4
Once a month	8.9	15.7	3.4	8.7
A few times per year	38.0	27.1	31.2	23.2
Never	12.4	9.1	34.5	21.7

**p* ≤ .001.

tion of whether such an approach is worth the effort may be premature. Certainly, whether to pursue a randomized approach would depend on the particular project circumstances (time frame, funding, etc.), objectives, and eventual study results. We anticipate that by establishing relationships with a broad range of churches, future recruitment in the population will be much easier and better justify the level of resources expended initially. This

discussion is intended to highlight the lessons learned from our experiences that may inform practitioners considering such work with churches, as well as health educators and researchers who might desire to work with the faith community.

What Have We Learned About Recruiting Churches?

Church recruitment was a very dynamic process, particularly because of our replacement strategy (i.e., replacing churches only after attempting recruitment for 2 to 3 months). Originally, we hoped to recruit 72 churches, 24 of each ethnicity. By the end of the recruitment process, we had exhausted the pool of eligible white and Latino churches but not that of African American churches. Because we had set a time limit for church recruitment and were not comfortable inviting more churches than we could accommodate, we did not approach all eligible African American churches. Given the relatively high rates of nonresponse and decisions not to participate, we now recognize that we could have contacted more churches. However, this strategy probably would have resulted in an even greater imbalance in the number of churches per ethnic group.

There were fewer Latino churches in the pool of eligible churches (24), since they tended to be either large Roman Catholic churches or newer and much smaller Protestant churches with few age-eligible women. Although there were more white churches, initially, in the eligible pool, many were “in transition,” meaning that they did not have a pastor or were in severe financial crises. This reflects the enormous demographic changes in the Los Angeles area that have caused many congregations to greatly diminish and have led churches with long-standing relationships to local communities to question their missions.

In one of the few other church-based randomized trials that involved enumeration, random selection, and random assignment, Lasater et al. reported a 65% recruitment rate.²⁰ However, their study was limited to three denominations: Catholic, Baptist, and Episcopalian. Furthermore, although ethnicity of participants was not reported, Lasater et al. restricted church enumeration to congregations that were 94% English speaking. In contrast, we recruited churches from three predominant racial/ethnic groups, two language groups, and a broad range of denominations. This led to many logistical challenges.

The actual process of recruitment varied from church to church. Given the diversity of our churches, we could not take a standardized approach to recruitment. Nevertheless, the pastor breakfast meetings were a time-effective strategy for presenting information about the project and seemed to facilitate recruitment by creating a critical mass. Pastors and church representatives were able to meet the entire outreach team, community advisory committee members, and other pastors whose churches had been selected. Thus, there was an overall sense of being able to participate in something much larger and more important than could be communicated in an individual meeting. Follow-up meetings with the pastor and other church leaders were critical for developing church-specific approaches to recruitment. During these meetings, we attempted to learn about the power structure of the church, both formal and informal, and address concerns and questions about the program.

The nature of the concerns expressed by pastors and other church leaders varied. Although it is always difficult to generalize, and there is substantial diversity within any one group, we present some impressions based on general observations. For the African American churches, the personal church affiliation and religious commitment of those outreach team members assigned to the church were very important. We found it necessary to participate in church services, functions, and special programs to gain acceptance

and trust, to help personalize recruitment, and to establish building blocks for an effective partnership. Because of past studies that were exploitative and offered little or no tangible benefits to the community, African American church leaders were concerned about the possible mistrust and fear that research protocols and institutions might invoke in their community. For the white churches, the concerns tended to focus on whether there were sufficient numbers of low-income women in the target age group and whether the governing board would give approval. Among Latino churches, the Roman Catholic churches tended to have very large pools of eligible women, so their questions focused on whether the priest could mobilize a large enough volunteer crew to recruit eligible women. Some priests were also concerned about the program not providing the mammograms, since a large portion of their members, many of them immigrants, lacked health insurance.

The role of the incentives in recruitment varied as well. The computer equipment and training were welcome resources in all churches, particularly the African American churches, which were least likely to have a computer prior to the program (61% of the African American churches had computers before the program vs. 67% of the Latino churches and 80% of the white churches). The free training and modest stipends for church coordinators and peer counselors seemed to be more significant among the Latino churches, perhaps due to the limited educational and employment opportunities for many of the members. The health committee assistance and educational materials were valued by those churches that already had an interest in starting such a program or were attempting to revive an effort that had previously failed.

Throughout the recruitment process, the fact that members of the community advisory committee and outreach team had long-standing personal and professional ties to the religious community was critical. This underscores the importance of investing in ongoing relationships with community gatekeepers over time³⁰ and of funding agencies providing support for the year of community outreach and networking necessary in community programs. In addition to these relationships, we drew on a wide range of experience among the outreach team that included diverse skills in language and cultural sensitivity, working with low-literate populations, community organization, public health education, survey research, and various church ministries.

What Have We Learned About Recruiting Women Within Churches?

Ideally, we would have preferred to build relationships with these churches over a period of time before starting to recruit women within the churches, but we were constrained by the grant timeline. We should note, however, that adjustments were made to the timeline throughout the recruitment process to “network,” and as a result the project became a 2-year intervention instead of a 3-year intervention. Even with the adjustments, we had to move quickly to recruit women immediately upon receiving approval from the church decision makers. Because we asked the pastor to appoint a church coordinator, we were almost completely dependent on the pastor’s judgment with regard to the most appropriate woman for this role.

The most successful coordinators were those who had a high interest level in health-related issues, particularly in breast cancer; were respected among their peers; had good communication skills; and had time available to dedicate to the recruitment efforts. The age of the women mattered less than these characteristics. In addition to the coordinators, the quality and quantity of the volunteer pool at the church played a big role in recruitment success. When an existing women’s group took on the project, there was greater success in reaching women within the church and in conducting various forms of outreach. Some

women's groups even assigned a particular member to recruit the older, more resistant female members.

Overall, less personalized approaches were less effective in recruiting. For example, merely announcing the program during services, without an organized effort of follow-up from church members, yielded few participants for the program. We had hoped to use church membership lists as a sampling frame, but most churches did not have up-to-date lists. This is probably due to the ongoing demographic changes in our communities and the constrained resources of many churches. Studies of communities in which church membership (and the population) is somewhat more stable and churches have more resources to invest in such a database could make use of such a resource.

The larger, more heterogeneous churches presented particular challenges. We attempted to address these challenges by (1) having multiple coordinators, (2) recruiting larger groups of church volunteers to cover multiple worship services, and (3) attending services as project staff to assist in these efforts. However, these additional resources are costly, and we had to settle for merely reaching a smaller proportion of the congregation on some occasions.

The results of our eligibility survey indicate that we reached only the more active members of the congregations. Wells et al. found a similar result among church-based cardiovascular screenings.³¹ Our findings were most likely influenced by the nature of recruitment (a defined time period and one-time enrollment) and the limitations of using a self-administered questionnaire in this population. A longer period for recruitment or a "rolling recruitment," along with more opportunities to collaborate with church staff and volunteers to promote in-reach and outreach efforts and personalize recruitment, is necessary for reaching larger numbers of women, especially less active members. Enrollment could be further streamlined by eliminating the self-administered survey and replacing it with a sign-up sheet that would contain names and phone numbers of potential participants (collected through group meetings). Then, enrollment, questions, and concerns could be discussed on the telephone.

Although we consider the diversity of our participants an important contribution to the field of public health and faith community collaborations, we also believe that recruiting among diverse groups is more challenging than targeting one or two ethnic groups. Moreover, the contrasting demographic profiles of the women recruited have important implications for our program. The reason that we did not find the expected numbers of low-income African American and white women is not entirely clear, given that project areas were chosen based on census tract income data. It may be that many women commute to their churches and, thus, do not represent the income tract data. Similarly, our finding that 70% of African American participants and 80% of white participants reported a mammogram in the previous 2 years was somewhat unexpected. Recently, however, researchers using surveys such as the California Behavioral Risk Factor Survey have found a dramatic rise in mammography screening rates in Southern California, from 57% in 1995 to 75% in 1995.³² Possibly, low-income and underscreened women are less likely to be active church members, less likely to be church members at all, or less likely to reside in the areas where their churches are located.

Limitations

The strength of this study is that we established a thorough randomized recruitment process while personalizing recruitment for the varying ethnic and denominational contexts. In contrast to many previous studies in religious settings, we can say something

about generalizability and external validity of the study. However, there are limitations to a randomized approach, particularly in diverse community settings. Recruitment in such settings must build on relationships; thus, it is only natural to want to approach known entities (e.g., particular church leaders). For a randomized recruitment, much more networking and relationship building must occur up front, at the same time that other grant or program activities are scheduled, so that the study is not left with volunteer churches. Moreover, the resources necessary to personalize recruitment across various cultures and denominations might be excessive for many programs.

Implications for Practice

Despite the limitations of a randomized approach, some lessons learned through our recruitment experiences can be applied to health education practice within faith communities. For example, the most time-effective and cost-effective strategies for recruiting churches and women were those that combined group processes with individualized follow-up. Similarly, health promotion within faith communities may be most effective when it combines group health education activities with individualized educational efforts. Such an approach builds on the nature of faith communities, which emphasizes individual and social aspects of religious practice.⁴ Moreover, the strategies can build on the lay and “natural” helping systems internal to many communities such as churches.³³⁻³⁵ Such support systems can extend beyond the religious setting as members form part of each other’s friendship, work, and neighborhood social networks.³⁶

Another lesson learned is that practitioners need to understand the political, economic, and social factors affecting members of faith communities. For example, we found a great need for mammography promotion efforts among Spanish-speaking Latino women but faced more challenges recruiting this population, most likely due to anti-immigrant fears generated by California legislation passed shortly before recruitment began. Proposition 187 (which has been successfully challenged in court) denied undocumented immigrants and their children access to public education and health care. Latinos were often targeted during these political campaigns and, thus, afraid of filling out forms with their contact information. Churches are often considered the “last safe haven” for immigrants, and key religious leaders have been very vocal in defending their rights. Thus, there is great potential in working with these churches to provide health education and advocacy for Latinos. As suggested by Maton and Pargament, many disciplines (e.g., psychological, religious, legal, and health) can work together to empower certain disadvantaged groups and help address the underlying social and economic conditions.⁴

Finally, although we emphasize the great potential of working with churches for community health promotion, we must acknowledge the many burdens placed on churches in urban areas such as Los Angeles. Because of welfare and immigration reforms, increasingly churches are expected to fill in for government support and relief, yet are understaffed and in financial crisis themselves. Thomas et al found that within African American churches, the availability of paid clergy and other paid staff to provide consistent leadership to various programs is necessary if the church is to continue working in community health outreach.³⁷ Thus, to develop partnerships with churches, researchers and health educators must find ways to offset the expenses incurred by additional research and program requirements. At the same time, researchers and health educators should consistently link their work with faith communities to concrete action on policy issues that affect congregational members and their communities. The most appropriate method is to form long-lasting partnerships that do not terminate with the end of a grant or pro-

gram but, rather, grow over time through long-term infrastructure grants, strong commitments, and community collaborations.

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