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# Recruiting African American Churches to Participate in Research: The Learning and Developing Individual Exercise Skills for a Better Life Study

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## Abstract

Physical activity among African Americans (AA) is low; effective intervention strategies are needed. Community-based settings are useful for delivering health-related interventions in racial/ethnic minority communities. This article describes strategies used to recruit churches for participation in a 22-month intervention designed to increase physical activity levels in AA women. Initial recruitment efforts, led by AA study staff, included direct mailers, phone calls, and in-person meetings with church representatives. After 10 months, only five churches were enrolled. Seven community members with existing partnerships/contacts in the faith community were subsequently hired and an additional 26 churches were enrolled within 6 months. Overall response rate was 45%, and churches required 3.5 ± 3.0 months of multiple contacts prior to enrollment. The main primary contacts within churches were individuals with personal interest in the program and pastors. Prior relationship between the research team and churches did not appear to influence church enrollment as much as community member recruiters. The current study identifies several potential strategies that may be useful for increasing success in efforts to recruit AA churches into studies. Additional research is warranted that tests and compares a variety of recruitment strategies to determine the most successful strategies for recruitment in different populations.

### Keywords

recruitment; church; Black/African American; physical activity; intervention

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## INTRODUCTION

The health benefits of physical activity (PA) have been well documented (U.S. Department of Health & Human Services, 2008), yet PA remains low among racial/ethnic minorities and women, particularly African American (AA) women (Centers for Disease Control and Prevention, 2007; Kimm et al., 2002). Previous research has demonstrated that recruiting racial and ethnic minorities into research studies can be challenging. Some of the challenges include fear and/or suspicion of research institutions and their motives; difficulties with the recruitment process because of narrow eligibility criteria, cultural factors, influence of family members, emotional stress, and inconvenience; and difficulties with establishing appropriate community partnerships (Paskett et al., 2008). While traditional advertisement may be used for recruitment, previous recruitment experience indicates that more novel, labor-intensive, and simultaneous strategies are required to recruit AAs specifically (Kennedy et al., 2005; Paskett et al., 2008).

Churches may be an ideal setting for health promotion among AAs because of the church's central role in spiritual guidance, communication, social support, and networking in AA communities (Giger, Appel, Davidhizar, & Davis, 2008; Goldmon & Roberson, 2004). Several studies have identified linkages between faith/spirituality and health (Chester, Himburg, & Weatherspoon, 2006; Underwood & Powell, 2006). AA women are more likely than AA men and men and women from other racial/ethnic groups to report attending church and other religious practices. Churches in the AA community are potentially effective settings for health behavior change programs because they emphasize health promotion while offering convenience for program participation and for dissemination.

Frequently cited reasons for nonparticipation among churches from other studies vary and include conflict with existing programs and outreach efforts, previous negative experiences with participating in research, discomfort with randomization process or control condition, belief that health-related issues were best managed in health care settings, difficulty with recruiting a sufficient number of participants, changes in pastoral leadership or other internal church issues, and changes in willingness to participate in the study after initially agreeing to participate (Allicock et al., 2012; Austin & Claiborne, 2011; Derose et al., 2000; Samuel-Hodge et al., 2006; Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001). Wilcox et al. (2007) worked directly with the Bishop over an entire church district of over 500 churches to randomly assign churches to a study arm. A primary reason for churches declining participation in the Wilcox study was pastors wanting to submit lists of interested members for participation in the study, rather than submitting entire church rosters as requested by study investigators. In addition, church leadership changed, and the study team was required to rebuild the partnership with new church leadership. Churches in the Wilcox study knew their randomization assignment ahead of time, which could also explain the lower response rate among churches in the delayed intervention group.

Previously published studies recruiting churches primarily used research staff for recruitment and mostly recruited a small number of churches (Duru, Sarkisian, Leng, & Mangione, 2010; Holt, Lewellyn, & Rathweg, 2005). Studies that recruited a larger number of churches reported partnering with pastors or other respected community leaders who

served as “study ambassadors” and encouraged participation from their colleagues (Derose et al., 2000; Kaplan, Calman, Golub, Ruddock, & Billings, 2006; Voorhees et al., 1996).

The Learning and Developing Individual Exercise Skills (L.A.D.I.E.S.) for a Better Life study focused on using existing social support networks and linkages between faith and spirituality to increase PA among low-active and sedentary AA women. This article describes strategies used to recruit AA churches for this 22-month PA intervention.

## METHOD

Details of the L.A.D.I.E.S. for a Better Life study have been described elsewhere (Whitt-Glover, Goldmon, Karanja, Heil, & Gizlice, 2012). Briefly, L.A.D.I.E.S. integrated key concepts from two behavioral theories—social ecological theory and social cognitive theory. Key concepts of focus from social ecological theory included the importance of leverage points for influencing adult behavior, including features of the social environment (e.g., faith tenets related to health behaviors; existing supportive relationships among members of the same congregation) that can influence behavior (Stokols, 1996). Key concepts of focus from social cognitive theory included self-efficacy, incentives or values placed on and external reinforcements for health behavior, and social support received from the individual’s environment as it relates to supporting health-related behaviors (Bandura, 1997; Baranowski, Perry, & Parcel, 1997). L.A.D.I.E.S. intervened on participants through their existing support networks (women from their own congregations participated in groups together), and the intervention included content designed to increase self-efficacy, enhance incentives associated with improved health, and further improve existing social support networks.

The study was conducted in a suburban community in North Carolina. Churches were recruited to participate in a cluster randomized, controlled trial focused on increasing daily PA in AA women. Randomization occurred at the church level, and churches were assigned to a faith-based intervention, a secular intervention, or an information only control group. Within each church, 15 underactive (i.e., achieving ≤ 150 minutes per week of moderate to vigorous PA) adult AA women were recruited to participate in the study. All participants within a church received the same intervention. Both the faith-based and secular intervention groups met 25 times in group sessions with other women from their church over a 10-month period. Faith-based and secular curricula were taught by trained community health workers, who were AA women familiar and comfortable with working in church settings and teaching health-related content and who had previous experience working with AA women. The faith-based intervention group received information about PA that incorporated faith tenets and used biblical scriptures to illustrate session content. The secular intervention group received information about PA from a secular perspective and used nonfaith-based readings to illustrate session content. Control group participants received *Exercise & Physical Activity: Your Everyday Guide From the National Institute on Aging!* The guide provided detailed information designed to assist individuals with starting and maintaining an exercise program. Control group participants were encouraged to review the materials and follow the plan for increasing PA on their own over a 10-month period. All participants were followed for an additional 12 months after the end of the intervention or self-guided

materials review phase to assess PA maintenance. Churches and study participants were enrolled in the study for a total of 22 months. The study was approved by Copernicus Group Independent Review Board. Participants provided individual informed consent prior to enrolling in the study.

## RECRUITMENT AND ENROLLMENT PROCEDURES

### Identifying Churches

Churches were solicited to participate in the study primarily through existing contacts, including churches that previously participated in programs led by the research organization that was conducting the study. A partnership was formed with an ongoing program, *Body and Soul*, that was focused on assisting churches with adopting policy and environmental supports for PA but did not provide direct health-related programming. Other churches were identified via business listings and through windshield assessments that were conducted while driving in communities where participating churches were located.

### Recruitment Materials

Recruitment materials included a letter and brochure describing the study, mailed directly to churches that were identified as churches that included predominantly AA parishioners. Where possible, materials were addressed to a specific individual within the church and were signed by the recruitment team member with whom the participant was familiar. Churches were invited to contact the study team if the church was interested in participating. Study staff made follow-up calls to churches within 1 week of the mailing to ensure the letter was received and to schedule a meeting with a decision maker in the church who could provide approval for the study. Members of the study team made at least five attempts, at different times during the day, to contact someone at each church.

An additional 5-minute video was created after the first 10 months of recruitment to promote the study that featured one of the study investigators (MVG), who is an ordained clergy, discussing the importance of faith and health. The video also included footage of and testimonials from women participating in the study, and the study principal investigator (MCW) providing health statistics regarding physical inactivity. A revised study brochure was created that incorporated images and testimonials from current study participants. Revised materials were mailed to churches that had been previously identified but that were nonresponsive after initial contacts, and additional follow-up phone calls were made to attempt to schedule a time to speak with someone from the church about the study.

### Recruiters and Recruitment Procedures

Initially, the study team was responsible for recruitment efforts. All study team members were AA and familiar with AA church practices. None of the study team members were born or raised in the community in which the study was being implemented, though all resided in the community at the time the study began. During the first 3 months of the study, the team member who was also an ordained clergy (MVG) was reassigned to a church outside the community in which the program was taking place and no longer had a daily presence in the community.

When a church indicated interest in participating in the study, a member of the study team set an appointment with a representative from the church to provide an introduction to the study. Meetings were held in locations mutually convenient for the church representative and the recruitment team. During the initial meeting, the study team reviewed a one-page overview of the study, the study brochure, and video and explained the requirements of the study participants. Churches were asked to identify a site captain who would serve as the liaison between the church and the study team and who would assist with identifying potentially interested individuals for study participation and scheduling information sessions that were led by the recruitment team and that explained study procedures to potential study participants. After the meeting, a letter was mailed to the church representative thanking them for their interest, reminding them of the requirements for the church to participate in the study, and requesting the name of a church site captain.

After limited recruitment success during the initial 10 months of the study, seven community members were invited to assist with recruitment of churches. Community members were individuals who had existing partnerships/contacts with churches in the community of focus. All community member recruiters were AA; five were women and two were men. One recruiter was the coordinator for the aforementioned *Body & Soul* program, and one recruiter was part of a family of well-known, prominent clergy in the community. Recruiters were hired on a contract basis and, due to budgetary constraints and the temporary nature of the position, were paid a stipend for each church recruited rather than hired as study staff. Recruiters did not receive a stipend until churches were enrolled, a sufficient number of women were recruited from each church, and baseline data collection was complete.

## RESULTS

Table 1 describes churches that enrolled in the study. Based on sample size calculations, the goal was to recruit 30 churches to participate in the study, with 12 to 15 women enrolled from each church. During the first 10 months of recruitment (March 2010-January 2011), the research organization enrolled five churches. After the community recruiters were hired in March 2011, 26 additional churches were enrolled within a 6-month period (March 2011-October 2011); 6 churches were enrolled by the research organization and 20 churches by the community recruiters. Churches that enrolled in the study reported that congregations were made up of 75% or more AAs and were primarily women. Just over half of the churches reported having a health ministry/committee (55%) or a health person/health team (66%). Only 17% of churches reported having a health or wellness goal for the congregation.

Sixty-nine churches were invited to participate in the study (Figure 1). A total of 31 churches were eventually enrolled in the study, representing 30 groups; the overall response rate was 45% (31 enrolled of 69 churches approached). Twenty-one churches (30%) did not respond to any outreach attempts. Forty-eight churches (70%) responded to the initial request to allow the study team to provide information about the study. Of these, seven (15%) could not be reached for further follow up after the initial contact, one (2%) was no longer interested in the study because they could not identify a site captain, and nine (19%)

were interested in the study but could not recruit the required number of participants. Two churches could not recruit a sufficient number of participants for the study and were combined to form one group.

Table 2 provides further detail regarding church recruitment: 11 (35%) were recruited by the research organization, and 20 (65%) were recruited by community recruiters. Among the 20 churches recruited by community recruiters, the recruiter, who was from the family of well-known, prominent clergy, recruited 11 (55%) churches. Only two recruiters successfully recruited the church in which they were a member. On average, church recruitment required 3.5 ± 3.0 months of multiple contacts prior to enrollment (range 0–9 months).

Of the churches with which initial contact was made ($n$ = 48), 12 churches (25%) contacted the research organization directly in response to a mailer or word of mouth and 36 churches (75%) responded to active recruitment efforts. The research organization had existing relationships with 29 churches (60%) through previous/ongoing programs ($n$ = 18) or other personal contacts ($n$ = 11). Contact persons at churches who assisted with getting the church enrolled in the study were pastors/clergy ($n$ = 11), the pastor's wife ($n$ = 1), the health ministry leader or coordinator ($n$ = 6), or another contact person ($n$ = 13).

## DISCUSSION

This article reports on the strategies used to enroll churches in a research study. Community recruiters were successful at recruiting churches into the study. Having a prior working relationship with churches may have played a role in recruitment success. A variety of individuals were helpful in enrolling churches in the study. The time needed to recruit churches varied and ranged from immediate agreement to participate to repeat contacts over 9 months.

The response rate of churches for the current study was ~45% for a 22-month study that included 10 months of group sessions and 12 months of follow-up. Response rates of churches may vary by the perceived intensity (e.g., length, number of contacts) of the project by potential participants, the health behavior targeted in the project, and whether the project focuses on the entire church or selected individuals within the church. For example, a church-based diabetes self-management education program that included individual counseling, 12 weeks of group sessions, mailed postcards, and 12 monthly telephone calls from a diabetes educator reported a response rate of 20% (Samuel-Hodge et al., 2006). A randomized controlled trial comparing three church-based nutrition and PA strategies that lasted for 1 year reported a response rate of 37% (Yanek et al., 2001). Studies with fewer required contacts (e.g., onetime screenings or interviews) report higher response rates (Aycock, Kirkendoll, & Gordon, 2013; Derose et al., 2000; Holt et al., 2005). Other studies reporting high response rates from churches recruited convenience samples (Allicock et al., 2012; Davis-Smith et al., 2007; Duru et al., 2010). Wilcox et al. (2007) partnered with the 7th Episcopal District of the African Methodist Episcopal Church. A representative sample of churches from the district were randomly assigned to participate in the immediate intervention ($n$ = 20) or the delayed intervention ($n$ = 23) to evaluate the study. Response

rates within these churches were 55% for the immediate intervention churches and 39% for the delayed intervention churches.

The current study required 3 to 9 months per organization for recruitment, and the entire recruitment period lasted 16 months, underscoring the importance of providing adequate time and resources when recruiting for community-based studies. In a similar study, efforts to enhance church recruitment began 10 months prior to inviting churches to participate and included hiring community/religious consultants, conducting focus groups with members of the priority population to outline recruitment strategies, obtaining letters of support from respected leaders from the religious community, creating a community advisory committee, establishing community outreach channels, and assembling a diverse outreach team (Derose et al., 2000). Another study reported requiring three to four calls to pastors just to secure initial meetings (Holt et al., 2005).

Individuals involved in the church recruitment process may affect willingness to participate in research. In the current study, seven community members were hired to assist with recruitment efforts based on their familiarity with the community. By far, the most successful recruiters were those who were born and raised in the local community *and* who were actively working with churches in the community in other capacities, or were considered trusted community members/leaders. Involvement of trusted community members/leaders is critical, particularly for churches in the Southern region of the United States where church members tend to remain at one church for years and, in many instances, generations. Additionally, a social connection may be critical for establishing a relationship with the church. In the present study, one very successful recruiter was coordinating a similar effort to promote healthy environments in churches and was already known within the church community for her work in faith and health. Another very successful recruiter was from a family with a history of pastoring and training pastors in churches in the community.

Given the negative history of AAs in research (Mays, 2012; Njoku, 2013), it is also possible that churches may have been more receptive to messaging from nonaca-demic community-based recruiters. Although the research firm conducting the current study was not affiliated with a university, it is quite possible that community members viewed the research organization similar to other academic research institutions. Focus groups with pastors identified the slow pace of research, the need for immediate action to address health concerns, and disconnect between science and faith as concerns for participating in research (Corbie-Smith et al., 2010).

Community recruiters used a variety of approaches to contact individuals from churches. The recruiter who was coordinating other health-related activities worked closely with health ministry contacts to gain access to the church. The recruiter from the family of pastors used personal contacts with pastors and pastor’s wives to gain access to churches. Previous studies reported using existing community contacts and churches that participated in previous projects as recruitment strategies (Duru et al., 2010). Flexibility is critical for the success of community-based projects given the changing needs within communities.

In the current study, we employed a cyclical process allowing us to adapt the recruitment process to the needs of the community and study participants while maintaining and promoting the integrity of the research. It is not clear which recruitment materials were most useful for engaging churches in the current study. We used a combination of mailings, brochures, flyers/bulletin inserts, a promotional video, and drop-in visits. The increase in recruitment occurred in conjunction with hiring community-based recruiters. We did note, however, that many contact persons from churches and participants within churches noted that they recognized someone from the video and, in several cases, stated "If [insert name] is doing it, then it must be okay." This statement, again, highlights the importance of social connections and respected community leaders/members when recruiting for community-based studies. In fact, social connections might be more important than the content of the study itself. Participating organizations that recognized someone from the study materials or had a close personal connection with the recruiter were less likely to listen to or ask questions about the presentation describing the study or question the study-related procedures prior to agreeing to participate.

Previous studies have highlighted the importance of actively involving the pastor in recruitment efforts (Baruth, Wilcox, & Saunders, 2013). In the current study, the pastor was the primary point of contact for 11 churches (~35%), but he or she typically assigned a liaison to work with the study team. Only one church pastor, who was female, remained actively involved throughout the study as a study participant. Most churches involved in the study did not have full-time church staff, which made reaching church personnel via telephone or scheduling in-person visits difficult. Anecdotally, we observed that about three fourths of churches in the current study had fewer than 75 members. If pastors are not full-time and congregations are small, the influence of the pastor may be minimized. National data indicate that nearly half of pastors are not full-time, and bivocational pastors tend to be more common in smaller and AA churches ("A Conversation With Frank Page," 2014). Additional data suggest that bivocational pastors are more likely to limit their pastoral responsibilities to preparing the sermon, leading worship, and performing specific ceremonies; churches with bivocational pastors may rely on other volunteers for day-to-day church operations (Bickers, 2004).

The present study has some limitations. We did not collect information from churches to identify which strategy most influenced their decision to enroll in the study. Anecdotally, churches frequently cited knowing the community recruiter or recognizing someone from recruitment materials as reasons for expressing interest in the study; few contacts cited an interest in health as the sole reason for interest in the study. We did not mail information about the study to all 250+ minority-serving churches in the community. We were aware that many of the churches were in outlying areas of the county and would be unlikely to come to a central location in the county for study-related events based on prior experience. We also did not mail information to churches with mixed congregations because we were told that advertising a study including only one racial/ethnic group could be construed as divisive by congregation members. Finally, we chose not to mail information directly to churches with congregations with fewer than 50 members because, historically, churches of that size have been unable to recruit sufficient participants for research studies. It is possible that mailing materials to a wider audience could have yielded 30 churches without having to

attempt additional in-person recruitment approaches. Strategies employed for recruitment in the current study may not be generalizable to churches outside the Southern region of the United States or to churches that are not primarily AA. The current study also has several strengths, including the detailed information about recruitment strategies and individuals critical to recruitment success.

Strategies are needed to help influence health-related behaviors in segments of the population most affected by poor health. Churches may be an appropriate venue for health promotion. The current study identifies potential strategies for increasing success in efforts to recruit AA churches into studies. Additional research is warranted to determine the most successful strategies for recruitment of different populations.

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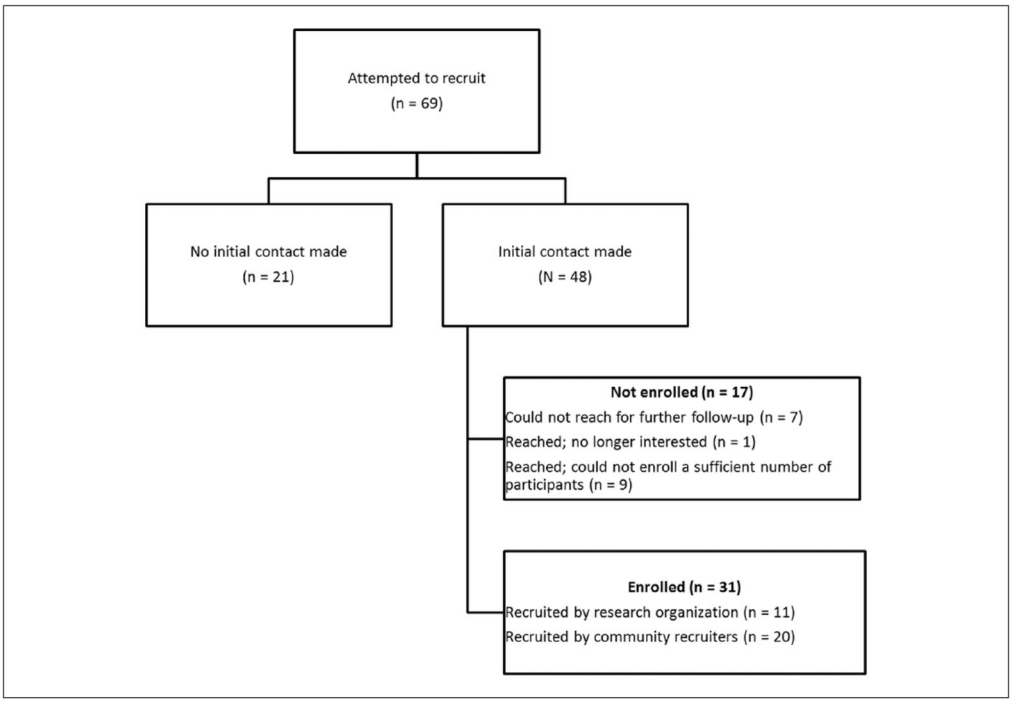


**FIGURE 1.**
Flow of Churches Invited to Participate in the Study

## TABLE 1

Baseline Characteristics of Churches Enrolled in the L.A.D.I.E.S. for a Better Life Study

| Variable Name | Faith-based, *n* (%) | General, *n* (%) | Control, *n* (%) | Total,[a] *n* (%) |
|---|---|---|---|---|
| Congregation ≥75% African American | 9 (100) | 9 (100) | 10 (100) | 28 (100) |
| % Women in congregation | | | | |
| ≤25 | 0 | 0 | 0 | 0 |
| 26–49 | 1 (13) | 5 (56) | 0 | 1 (5) |
| 50–74 | 5 (63) | 4 (44) | 5 (100) | 15 (68) |
| >75 | 2 (25) | 0 | 0 | 6 (28) |
| % Youth <18 years in congregation | | | | |
| <25 | 6 (75) | 3 (38) | 4 (80) | 13 (62) |
| 26–49 | 1 (13) | 5 (63) | 1 (20) | 7 (33) |
| 50–74 | 1 (13) | 0 | 0 | 1 (5) |
| >75 | 0 | 0 | 0 | 0 |
| % People >65 years in congregation | | | | |
| <25 | 4 (50) | 7 (88) | 2 (50) | 13 (65) |
| 26–49 | 3 (38) | 1 (13) | 2 (50) | 6 (30) |
| 50–74 | 1 (13) | 0 | 0 | 1 (5) |
| >75 | 0 | 0 | 0 | 0 |
| Churches with health ministry/committee | 5 (56) | 4 (40) | 7 (70) | 16 (55) |
| Churches with health person/team | 6 (67) | 4 (40) | 9 (90) | 19 (66) |
| Health promotion budget | 2 (22) | 0 | 1 (10) | 3 (10) |
| Health or wellness goal for congregation | 1 (11) | 2 (20) | 2 (20) | 5 (17) |

NOTE: L.A.D.I.E.S. = Learning and Developing Individual Exercise Skills.

[a] Three churches did not submit a baseline survey.

**TABLE 2**

Description of Churches Enrolled in the L.A.D.I.E.S. for a Better Life Study

| Site | Church Denomination | Who Recruited | Recruitment Time in Months[a] | Contact Person During Recruitment | Prior Relationship With Research Organization | No. of Participants Enrolled | Randomization Arm |
|---|---|---|---|---|---|---|---|
| 1 | AME Zion | Recruiter | 2 | Pastor | Previous program | 15 | General |
| 2 | Baptist | Research organization | 2 | Contacted us | Previous program | 24 | Faith-based |
| 3 | AME Zion | Recruiter | 7 | Contacted us | None | 23 | General |
| 4 | Nondenominational | Recruiter | 1 | Contacted us | None | 14 | Self-guided |
| 5 | Baptist | Research organization | 0 | Personal contact | Previous program | 18 | Faith-based |
| 6 | Baptist | Research organization | 1 | Contacted us | None | 16 | Self-guided |
| 7 | Nondenominational | Research organization | 1 | Health ministry leader | Previous program | 13 | General |
| 8 | Baptist | Research organization | 2 | Pastor | Previous program | 18 | Self-guided |
| 9 | Baptist | Research organization | 2 | Health ministry leader | Previous program | 17 | Faith-based |
| 10 | Baptist | Recruiter | 1 | Health ministry leader | None | 16 | Self-guided |
| 11 | Baptist | Research organization | 1 | Contacted us | None | 14 | General |
| 12 | Baptist | Recruiter | 1 | Pastor | None | 16 | Faith-based |
| 13 | Nondenominational | Recruiter | 1 | Pastor | None | 15 | Self-guided |
| 14[b] | Nondenominational | Recruiter | 6 | Personal contact | Previous program | 8 | General |
| 15 | Baptist | Recruiter | 4 | Pastor | None | 19 | Faith-based |
| 16 | Nondenominational | Recruiter | 1 | Personal contact | None | 13 | Self-guided |
| 17 | Baptist | Recruiter | 2 | First Lady | Previous program | 16 | Faith-based |
| 18 | Nondenominational | Recruiter | 1 | Pastor | None | 16 | General |
| 19 | Seventh-Day Adventist | Recruiter | 7 | Pastor | Previous program | 13 | Self-guided |
| 20 | CME | Recruiter | 6 | Health ministry leader | Previous program | 16 | General |
| 21 | Nondenominational | Recruiter | 5 | Contacted us | None | 17 | Faith-based |
| 22 | Pentecostal | Recruiter | 6 | Pastor | None | 14 | Faith-based |
| 23 | Baptist | Recruiter | 9 | Pastor | None | 17 | Self-guided |
| 24 | Baptist | Recruiter | 2 | Pastor | None | 15 | General |
| 25 | Baptist | Research organization | 8 | Personal contact | Previous program | 17 | Faith-based |
| 26 | Nondenominational | Research organization | 0 | Health ministry leader | Previous program | 17 | Self-guided |
| 27[b] | Nondenominational | Recruiter | 6 | Personal contact | Previous program | 15 | General |

| Site | Church Denomination | Who Recruited | Recruitment Time in Months[a] | Contact Person During Recruitment | Prior Relationship With Research Organization | No. of Participants Enrolled | Randomization Arm |
|---|---|---|---|---|---|---|---|
| 28 | Nondenominational | Research organization | 2 | Pastor | Previous program | 15 | Self-guided |
| 29 | Baptist | Recruiter | 7 | Personal contact | Previous program | 14 | Faith-based |
| 30 | AME | Research organization | 6 | Personal contact | None | 14 | General |
| 31 | Nondenominational | Recruiter | 9 | Health ministry leader | Previous program | 14 | General |

NOTE: L.A.D.I.E.S. = Learning and Developing Individual Exercise Skills; AME = African Methodist Episcopal; CME = Christian Methodist Episcopal.

[a] Defined as time from initial contact to baseline data collection at the church.

[b] Churches were combined because, at the time group sessions began, neither church had a sufficient number of women to form a full group.