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Recruitment of African American Churches to Participate in Cancer Early Detection Interventions: A Community Perspective

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Abstract

This article describes the process used to engage and recruit African American churches to serve as participants in two multi-year behavioral cancer research interventions from a community perspective. Community-based organizations used purposive sampling in engaging and recruiting advisory panel members and churches to participate in these interventions. Trust, respect, open dialogue with participants, and commitment to address community health needs contributed to successful engagement and recruitment of African American churches to serve as participants in these cancer research projects. Our results may help others engage and recruit African American churches to participate in future interventions.

Keywords

African American churches; cancer research; recruitment; community-based participatory research

Introduction

Despite the high prostate, breast, and colorectal cancer incidence and mortality rates occurring among African Americans (Alcaraz et al., 2016; DeSantis et al., 2016), it is still difficult to engage, recruit, and retain African Americans churches to participate in health

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studies and research interventions concerning these diseases (Campbell et al., 2007; Paskett, DeGraffinreid, Tatum, & Margitic, 1996; Sankere et al., 2015). African American participation in clinical trials and health research also remains challenging, thus prompting the use of enhanced research recruitment strategies to obtain adequate health data from this vulnerable population (Jones, Steeves, & Williams, 2009).

African American churches have a long history of serving as effective community venues to connect underserved populations with health information (Aaron, Levine, & Burstin, 2003; Campbell et al., 2007; Chatters, Levin, & Ellison, 1998; Levin, Chatters, & Taylor, 2005; Markens, Fox, Taub, & Gilbert, 2002; Whitt-Glover, Borden, Alexander, & Kennedy, 2016). Religious attendance has also been shown to be protective of both physical and mental health and a source of social support for congregants (Aaron et al., 2003; Lincoln & Mamiya, 1990).

Methods

The research team employed purposive sampling also known as subjective sampling techniques to engage, recruit, and retain African American churches for participation in two cancer research interventions, Men's Prostate Awareness Church Training (M-PACT) and Health through Early Awareness and Learning (Project HEAL). The first intervention, M-PACT, was a four-year randomized controlled trial supported by the American Cancer Society. M-PACT sought to train church members whom their pastors or other church leaders selected to serve as peer educators for members of their church. These peer educators, referred to as Community Health Advisors (CHAs), were trained to promote increased prostate awareness and to educate African American men about informed decision-making for prostate cancer screening (Saunders et al., 2013). The second intervention, Project HEAL, was a five-year cancer early detection implementation trial supported by the National Cancer Institute. The Project HEAL intervention compared two strategies for training lay peer CHAs to implement workshops on evidence-based strategies for breast, prostate, and colorectal cancer early detection through African American churches (Holt et al., 2014).

Both interventions required the engagement, recruitment, and retention of content specific experts to serve as advisory panel members, as well as churches to provide focus group participants, serve as pilot sites, and participate in trial interventions. Assisted and supported by the research team, church leaders performed the functions of engaging, recruiting, and retaining peer educators. Church leaders were also asked to help their appointed CHAs engage, recruit, and retain qualified church members to participate in the educational workshops that were presented at their church site (Santos et al., 2017; Saunders et al., 2015).

Primary recruiters for M-PACT and the exclusive recruiters for Project HEAL were an African American man, the Executive Director of Community Ministry of Prince George's County (CMPGC), a non-profit organization that faith leaders founded in 1973 to promote collaboration across Prince George's County, Maryland; and two African American women who worked for CMPGC. Additional major recruiters for M-PACT were an African

American woman, the Executive Director of Access to Wholistic and Productive Living Institute (AWPLI), a non-profit organization formed in 2008 to promote sustainable health across Prince George's County and an African American man who worked for AWPLI. All of the recruiters were well known and respected by a wide range of church leaders across Prince George's County.

For both interventions, the goal was to engage and recruit African American churches, 20 participant churches for M-PACT and 14 additional participant churches for Project HEAL. The churches participated in only one of the two projects. Inclusion criteria for African American churches to participate in M-PACT included having between 150–500 church members, having at least 50 church members who were men 40–72 years of age, being located in Prince George's County, and not having hosted a prostate cancer program during the past year (See Table 1).

Inclusion criteria for African American churches to participate in Project HEAL included having between 150–500 church members, having at least 25 church members who were men 40–75 years of age and at least 25 church members who were women 40–75 years of age. The church had to be located in Prince George's County, and not have hosted a breast, prostate or colorectal cancer program during the past year (See Table 1).

For each intervention, the team recruited an advisory panel consisting of faith leaders, health education specialists, and other community members to provide the research team with their views regarding the proposed project. Advisory panel members provided valuable feedback about the strategies the team proposed to use to engage the churches and the cultural appropriateness of the proposed educational materials and procedures. The advisory panels also offered guidance and assisted in identifying churches for engagement and recruitment to serve as potential participants in the interventions. Unless stated otherwise, the processes and practices discussed in this article applied to both interventions.

Barriers to Successful Recruitment

Barriers and perceptions of barriers to the successful recruitment of African American churches to participate in health interventions rest on various historical, cultural, and logistical issues (Dancy & Wilbur, 2004; Jones et al., 2009; Whitt-Glover et al., 2016). As discussed by Dancy & Wilbur (2004), these historical and cultural issues may lead to power difference barriers and conceptual barriers. Power difference barriers include the existence of perceived unequal authority between leaders of African American churches targeted for recruitment and the university research team conducting the intervention. Power differences often generate mistrust and can negatively affect or derail successful recruitment of potential participants. Conceptual barriers are ways of viewing an ethnic group that hinder the researcher from gaining an adequate understanding of, in the case of these interventions, African Americans and African American churches. As the principal investigator was a Caucasian woman and she was affiliated with a predominately white university, both power difference barriers and conceptual barriers were potential challenges in successfully engaging and recruiting African American churches to participate in M-PACT and Project HEAL.

The research team, consisting of academic researchers and leaders from the supporting community-based organizations, decided the community partners would take the lead in engaging, recruiting, and retaining advisory panel members and churches to participate in M-PACT and Project HEAL. The team selected this approach to avoid or overcome the above potential barriers and to improve overall projected recruiting success (Breslau, Weiss, Williams, Burness, & Kepka, 2015; Dancy & Wilbur, 2004).

Community partners can also possess views that serve as conceptual barriers to the successful engagement, recruitment, and retention of possible participants (Watts, 2003). Initially, the African American man charged with leading the recruitment of participants for M-PACT, believed that reports about the infamous Tuskegee Syphilis Study and other records of health interventions that resulted in abuse of African American participants would make it more difficult to gain the targeted church leader's agreement to enroll the church in the proposed intervention. However, multiple studies conclude that limited general knowledge of these reports, not specific details, were recalled within minority and other ethnic groups (Corbie-Saint, Thomas, Williams, & Moody-Ayers, 1999; Katz et al., 2009). During the recruitment of participants for M-PACT and Project HEAL, church leaders did not mention the Tuskegee Syphilis Study or similar reports of abuse. During the recruitment efforts for participation in M-PACT, one pastor stated his view that members of the African American community did not like the terms "research" or "study". However, a lack of trust of researchers and those conducting studies did not surface as a significant barrier to engagement, recruitment, and retention of participants for the two interventions.

Initially, some recruiters were concerned that African American community members and church leaders would not perceive that the research focused on health issues, conditions, or problems that were particularly prevalent in their community. There were also concerns that the church leaders would not readily view the interventions as a source of education or services that met the church community's needs or as a benefit to them, their family members, or their loved ones. As discussed later, the team implemented activities that kept these possible concerns from interfering with achieving the goal of engaging, recruiting, and retaining participants for the interventions.

Practical logistical barriers to the church leaders' agreement to participate in the health interventions included the presence of competing church activities, scheduling conflicts, and limited open time available on the church's calendar of activities. As a barrier to his agreeing to enroll his church in M-PACT, one pastor offered that his church lacked qualified and available candidates for nomination to serve as CHAs. This pastor expressed that the men he considered qualified to lead the project workshops were already committed to other leadership positions, so he chose not to participate in the project. Other church leaders did not expressly decline to participate in the project.

Developing Trust

The existence or development of trust between the targeted participants and the research team, or at least some members of each of these groups, enhances effective engagement, recruitment, and retention of participants (Hippolyte, Phillips-Caesar, & Winston, 2013; Markens et al., 2002). Trust might exist based on previous relationships or be developed

during the course of the preparation or implementation of the intervention. The research team may gain a level of trust by including team members that already enjoy trust with potential targeted participants (Markens et al., 2002). Whether it is already developed, built as part of the preparation or implementation of the intervention, or imported to the research team, the existence of trust facilitates the engagement, recruitment, and retention of advisory panel members and African American churches as participants (Campbell et al., 2007; Sankere et al., 2015).

The interventions incorporated and relied on trust in multiple ways. Prior to the start of the interventions, the community-based organizations had already developed trust with advisory panel members and church leaders targeted for engagement, recruitment, and subsequent retention as participants in the interventions. The community-based organizations came to realize that through their previous years of collaborating with local faith-based organizations and providing human service support to community members, they had formed a foundation of trust with potential participants. A level of trust appeared to exist between the research university and the targeted church leaders at the start of the projects. The research team's expression of commitment to collaborate and support the participating churches beyond just the proposed specific funded period of the interventions and their later follow through in meeting this commitment enhanced this trust. Team members also built internal trust within the team through bi-weekly team meetings, hosting meetings at various team member sites, and expressing respect and appreciation for team members' unique contributions and roles in developing and implementing the interventions.

While building on the lessons they learned regarding establishing trust with the church leaders, the recruiters also learned to assist participating churches in mitigating obvious barriers to participants' attendance to educational workshops. To avoid or minimize the obvious barrier of participants' absences from the workshops, recruiters and other team members learned to encourage CHAs to schedule workshops during times or events that the targeted participants had already planned to engage in church activities. For example, one pastor who taught the Men's Sunday school class and served as the CHA for his church, presented the prostate educational workshop to men during their scheduled Sunday school class in lieu of presenting the traditional Sunday school lesson. Recruiters also learned to encourage CHAs to avoid scheduling workshops during the same or overlapping times of other planned church activities that would interfere with attendance at the M-PACT or Project HEAL workshops. The research team exercised flexibility and deference to the scheduling needs of the participating churches. CHAs scheduled the workshops to fit the needs of their church and the research team adapted their schedules to ensure needed research team members, as promised, were present at each appropriate workshop a church conducted.

Results

In engaging, recruiting, and retaining advisory panel members and churches as participants for the interventions, the recruiters implemented a community engagement process that included: assessing, developing relationships, agreeing, recruiting, and maintaining relationships (Shea et al., 2017). These activities were replicated in engaging, recruiting, and

retaining the participation of the various component organizations or groups involved in the interventions using Community-Based Participatory Research and community health development strategies (Burdine, McLeroy, Blakely, Wendel, & Felix, 2010).

From a community member's perspective, it appeared that from the initial meetings between the principal investigator and the executive director of the lead community-based organization, both parties assessed each other to determine their compatibility and desire to serve as potential partners in developing and implementing the proposed interventions. To delineate their expectations, the principal investigator and executive director of the lead community-based organization signed a single page informal memorandum of understanding that outlined and documented in broad terms each of their responsibilities in developing and implementing the projects. From 2008 to the start of the M-PACT Project in 2010, the principal investigator and executive director of the lead community-based organization obtained letters of support from local pastors as part of their development activities and conducted other planning activities and meetings. Through this process, they developed positive relationships and both the principal investigator and leader of the lead community-based organization agreed to their roles as researcher and community partner.

The principal investigator assessed and recruited a second community-based organization, Access to Wholistic and Productive Living Institute, to serve as a community partner and assist with recruiting the participants needed for the M-PACT intervention. The two community-based organizations successfully engaged, recruited, and retained eight advisory panel members, two focus group churches, two pilot churches, and 19 trial churches for the project. The lead community-based organization served as the exclusive community partner for Project HEAL. Again, the community partner used this community engagement process in successfully engaging, recruiting, and retaining participants for this intervention, which included eight advisory panel members, five usability testing participants, two pilot churches, and 13 trial churches. Both community partners used a community engagement process that included assessing and developing relationships; agreeing, recruiting, and maintaining relationships in their engagement; and recruitment and retention of the advisory panel members and the participating focus group, pilot, and trial churches.

Gaining Access to Potential Participants

To gain access to potential participants, the designated recruiters from the community-based organizations reached out by phone or conducted personal visits to contact potential advisory panel members and leaders of targeted churches. To show respect for the role of the churches, recruiters generally avoided trying to contact church leaders before, during, or after their designated worship service times or even on the day of their scheduled worship services. Recruiters conducted multiple phone calls or visits to each church site to reach administrative staff members and establish appointments to meet with the church pastor. In some instances, recruiters visited the church sites multiple times just to gain access to church administrative staff members as church officials often locked the church buildings during non-worship services times.

Engagement

Appointments with pastors primarily occurred on Tuesdays through Thursdays, as most pastors were occupied preparing their sermons on Fridays and possibly Saturdays and most viewed Mondays as their day off. The use of business cards that identified the recruiter, the project, and the recruiter's relationship with the project (e.g., community partner) facilitated gaining access to the potential participant churches and their leaders. In addition, the recruiters used colorful flyers that briefly described the project and what the participating church would receive that facilitated engaging potential participants. The well-known and positive reputations of the community-based organizations were important contributors to their success in accessing and engaging participants to serve in both M-PACT and Project HEAL.

Introducing the Project

During introductory meetings with targeted pastors, recruiters wore shirts that identified and linked them to the project. The recruiters provided a brief overview of the proposed project and reviewed, discussed, and asked the pastor to sign the project's approved informed consent form. The pastor often made the decision to participate without consulting others, but some pastors wanted others in the church to agree to participate before they would agree to the church participating. In those instances, the recruiter spoke to the group or groups needed to facilitate gaining the agreement of the church to participate. As a result, recruiters provided overviews of the project to congregations, assembled Bible study and/or prayer groups, Sunday school classes, or other leaders or groups, as needed, to advance the recruitment of the church into the project. Once the pastor agreed to participate, the pastor or a designated representative signed the required informed consent form.

Following the team's randomization of the church to a particular study condition, the church leader signed a memorandum of understanding that outlined the principal investigator's responsibilities and the participating church's responsibilities in implementing the project. Ideally, the pastor would then complete a church survey instrument that responded to questions concerning the profile of the congregation, characteristics of the congregation, receipt of technical assistance, health ministry activities, and environment around the church. Pastors however seldom completed this instrument during this meeting, as they often needed more time to gather information to respond to the questions posed in the survey. The recruiter chose not to push to complete the survey at that time to avoid possibly inconveniencing or annoying the participant. The team considered a church as recruited and enrolled in the intervention once the principal investigator also signed the memorandum of understanding.

Cultural Issues

During the engagement and recruitment processes, the recruiter tried to avoid or minimize negative effects of possible cultural biases and issues that the potential participant might harbor. As previously stated, one pastor directly pointed out that he believed African Americans did not like to participate in "studies" or "research". Other pastors showed sensitivity and unease with statements that highlighted the negative health outcomes that exist among African Americans. In an effort to avoid or minimize possible negative

responses, recruiters minimized their use of the terms “study” and “research” when talking with potential participants. They also did not dwell on discussing negative health outcome statistics that exist among African Americans.

Gaining Consent and Agreement to Participate

To gain pastors’ and others’ agreement to participate in the intervention, recruiters found they needed to state clearly what the project would provide to participants. Recruiters discussed the project as a potential part of the pastor’s ministry when talking with pastors or as part of the ministry of the church when talking with other church leaders and members. Recruiters exercised a great deal of patience and persistence as they sought to gain pastors’ and others’ consent to participate. As previously stated, recruiters attended prayer and Bible study sessions, and made presentations to various church groups and sometimes, the full congregation when needed to gain the pastor or church leader’s agreement to participate.

Recruiters from the community-based organizations also adopted a humble approach in their efforts to gain agreements to participate in the project, particularly when a male recruiter was seeking the agreement of a male pastor or other male church leader. Some pastors expressed competitive type statements or comments about their church’s human services outreach to community members as compared to their perception of community-based organizations’ performance of similar outreach. Therefore, as members of community-based organizations, recruiters endeavored to avoid statements or comments that would lead to comparisons between their organizations and the targeted church’s performance in outreach or the recruiters commented about their performance in outreach only in humble terms.

The recruiters showed respect for advisory panel members and church leaders throughout the engagement, recruitment, and retention processes even when the potential participant chose not to participate in the project. This enabled the recruiters, if needed, to consider the potential participant as a candidate to participate in a later project.

Maintaining the Relationship and Enhancing Trust

The team implemented several actions to maintain positive relationships with recruited participating churches and to enhance the trust between the research team and targeted church leaders. The team expressed a commitment to continue collaborating with and supporting the churches in researching or implementing other health activities during the project period and even after the grant period. To meet this commitment the team provided participating church leaders support and assistance in obtaining evidence-based materials in response to needs expressed primarily by their designated CHAs. The team provided an honorarium to enrolled churches to defray their expenses for hosting workshops in church facilities and to CHAs for completing the intense training to become certified, recruiting individual workshop participants, and facilitating the workshops. The team also mailed newsletters to participating churches each season of the year. The colorful newsletters provided feedback concerning project activities, information on other health topics, and links to other health information and resources responsive to the participants’ expressed interests. Team members also participated in health fairs that several participating churches

hosted. CHAs and other leaders and members from participating churches also attended research team-sponsored social gatherings.

As promised during the recruitment process, the team conducted follow up sessions with the churches and provided an aggregate report of what the team learned during the projects. During these sessions, the team also solicited views and expressions from church participants of their needs for additional education and support from the research project team and their preferences for other health promotion activities. The team provided educational materials and support in response to these requests, which helped maintain relationships with churches participating in M-PACT and Project HEAL, and will potentially facilitate the later recruitment of churches to participate in other health interventions.

Conclusions

The initial existing trust between the community partners' organizations and targeted participants, along with the research institution's positive reputation in the community, facilitated the successful engagement, recruitment, and retention of the needed participants in M-PACT and Project HEAL. During the implementation of the projects, the researchers and community partners' demonstration of respect for the participating churches and individual participants further enhanced this trust. The team's commitment and actions implemented to educate participants about breast, prostate, and colorectal cancers and to assist them in addressing their related health issues, resulted in achieving a high level of participation in the projects. Participation in the projects at the individual level (289 men in M-PACT and 375 men and women in Project HEAL) is discussed elsewhere (Santos et al., 2017; Saunders et al., 2015). Community-based Participatory Research principles were used in the development of the research proposals and implementation of the interventions which led to the continuing development of positive relationships among the intervention participants (Burdine et al., 2010). Those components included community-based organizations that served as community partners, advisory panels, participating churches, CHAs, and individual participants. Key contributing factors to the team's successful engagement, recruitment, and retention of participants in M-PACT and Project HEAL were trust, respect, open dialogue with participants, and the research team's delivery of quality prostate, breast, and colorectal cancer education. These factors may also form a foundation for achieving success in recruiting African American churches for future health interventions and may contribute to building long-term partnerships between researchers and community members.

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Biography

Jimmie L. Slade, Master of Arts in International Relations, a retired US Army colonel, is also a graduate of the US Army War College. As Executive Director of Community Ministry of Prince George's County, an interfaith based nonprofit organization formed in 1973, he serves as a community partner with the School of Public Health, University of Maryland and Johns Hopkins Center to Reduce Cancer Disparities. His health disparities research involves community-based participatory research at the grassroots level. He is a founding member of the Maryland Community Research Advisory Group and chairs the Prince George's County Community Advisory Group.

Table

Church Inclusion Criteria

Attribute	M-PACT	Project HEAL
Size of Congregation	Between 150–500	Between 150–500
Number of Potential Participants	At least 50 Men, Age 40–72	At least 25 Men Age 40–75 At least 25 Women Age 40–75
Denomination	As appropriate for the spiritually-based intervention material	As appropriate for the spiritually-based intervention material
Location	Prince George's County, Maryland	Prince George's County, Maryland
Readiness	Not hosted a prostate cancer educational program during the past year	Not hosted a breast, prostate, or colorectal cancer educational program during the past year
Infrastructure	Church has a Health Ministry or men's group that is willing to support the program	Church has a Health Ministry or volunteer base that is willing to support the program

Note: Spiritually-based nature of the intervention is discussed in (Holt et al., 2014; Saunders et al., 2013).