


**WORKING WITH
RELIGIOUS
CONGREGATIONS:
A GUIDE FOR HEALTH
PROFESSIONALS**





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INTRODUCTION

Working With Religious Congregations: A Guide for Health Professionals builds on lessons learned from church-based demonstration programs supported by the National Heart, Lung, and Blood Institute (NHLBI). While the recommendations are based on intervention activities in churches, reviews and comments from members of other congregations suggest that the strategies are useful in a variety of religious settings.

Today, a variety of health agencies such as State and local health departments, voluntary health organizations, managed care organizations, community hospitals, health coalitions, and others include congregations among the target audiences for their programs. This guide is designed to help professionals in health agencies reach out to religious congregations and work with them

to implement programs to reduce the risk of cardiovascular disease (CVD), especially high blood pressure and stroke. It does not instruct the health professional about the basics of developing a CVD risk reduction program (e.g., high blood pressure screening, smoking cessation). Instead, it provides information about how to:

- contact and recruit congregation members,
- train volunteer teams within congregations,
- implement effective CVD prevention programs,
- sustain momentum for continued activity, and
- monitor and evaluate congregation-based programs.

SUMMARY

- *Working With Religious Congregations: A Guide for Health Professionals* was prepared by the National Heart, Lung, and Blood Institute as part of its Stroke Belt Initiative.
- The term “congregation,” for the purposes of this book, means any house of worship—church, synagogue, temple, mosque, chapel, or other place where members of religious groups gather.
- “Clergy” includes pastors, ministers, priests, rabbis, and other leaders of religious congregations.
- “Health professional” refers to professionals in health agencies who want to implement cardiovascular risk reduction programs in congregations.
- “Health agencies” refer to State and local health departments, voluntary health organizations, managed care organizations, hospitals, health coalitions, and others.
- This guide offers health professionals the benefits of lessons learned from cardiovascular risk reduction activities in churches.

Health professionals can use the guide to incorporate congregation-based programs into existing or new efforts within their agencies to reduce CVD risk in the community. If a CVD plan with a defined target audience is already in place, the implementation of selected program components in religious congregations should fit in easily with current goals and objectives.

BACKGROUND

HISTORY OF NHLBI INVOLVEMENT IN CHURCH-BASED PROGRAMS

The NHLBI has a long history of promoting CVD intervention demonstration programs in churches. From the 1970's through the early 1980's, the NHLBI supported church-based programs in Georgia, Maryland, North Carolina, Illinois, and Tennessee. Those early programs focused on high blood pressure education, detection, and control, primarily in black churches. In 1987 the NHLBI produced a guide for working with churches, *Churches as an Avenue to High Blood Pressure Control*, which provided information on the development and implementation of high blood pressure programs. Representatives from many of the early church-based programs contributed substantially to the 1987 guide.

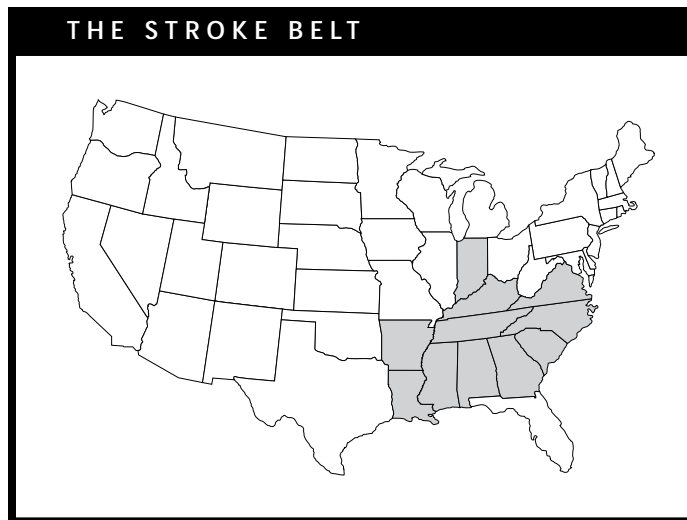
In 1990 the NHLBI funded a project at Johns Hopkins University to study the effectiveness of church-based interventions for CVD prevention and control. Initially the project focused on smoking cessation but later expanded to include nutrition and weight reduction. The interventions were effective, and the churches developed a strong ownership of the program. The members of Clergy United for the Revitalization of East Baltimore (CURE) wanted to disseminate what they had learned to other churches, so they joined forces with the American Lung Association to implement the project in churches in 15 targeted communities. This activity was supported by the NHLBI in 1992.

SUMMARY

- The NHLBI has a history of promoting church-based programs for preventing cardiovascular disease.
- The earliest church-based programs were in Georgia, Maryland, North Carolina, Illinois, and Tennessee.
- Lessons learned from early church-based projects and the Stroke Belt can be valuable to planners of new programs:
 - There is no single best approach.
 - Support from the clergy is essential.
 - The coordinator should be a person of vitality, vision, and commitment and have the trust and confidence of the clergy.
 - Project teams in churches can be very creative.
 - Church-based programs take time, but patience is rewarded.
- Reaching at-risk audiences through targeting congregations is a strategy that works.

THE NHLBI STROKE BELT INITIATIVE

In 1990 the NHLBI funded 11 pilot projects through State health departments (SHDs) to reduce the risk of stroke in the southeastern United States in the region called the “Stroke Belt.” At that time, the age-adjusted stroke mortality rates in the region were more than 10 percent higher than the U.S. average. These 1-year pilot projects demonstrated the capacity of



SHDs to design and implement approaches to reduce risk factors in the community. In 1993 the NHLBI provided extended funding to the SHDs to reduce the overall risk of stroke in the Stroke Belt. Four States (Louisiana, South Carolina, Tennessee, and Virginia) targeted black churches to implement programs. The lessons learned from the Johns Hopkins University study and the earlier NHLBI-supported church-based projects played a major role in the development of strategies for the more recent projects. Each project succeeded in recruiting churches, training teams within the congregations to carry out program activities, moving the teams to

action, and sustaining their actions over time. Moreover, the church teams were creative in devising ways to communicate health messages to their congregations.

The average time needed to complete each task was calculated based on the experience of the projects in Louisiana and Tennessee. It took about 2 months from the initial contact with the church to the point when the church leader committed the church to participate. It took 4 months from this commitment to the appointment and training of the church team. The first program event took place about 3 months after the church team’s training. Thus, it took about 9 months from the initial contact with the church to the first program event. This experience sends a clear message to health professionals: It takes time to implement health programs in churches. Some churches had programs up and running in several weeks; others took longer to recruit and set up.

Each Stroke Belt project used a different approach to recruit churches. The SHD in Virginia collaborated with the Baptist General Convention (BGC). The staff of the BGC did the actual recruitment among its affiliated churches. In Louisiana, the project coordinator started the program in her church. She then convinced the minister of her church to call the ministers of other churches to promote the program and to encourage them to implement a similar program.

The project in Tennessee initially approached five churches. After setting up their programs, clergy from the participating churches told other clergy about the project, and the project staff followed up with those who showed the greatest interest. In South Carolina, the project staff attended the main services of targeted churches. During the service, when visitors were recognized, they introduced themselves and their purpose; later they approached the clergy to ask the church to participate in their project.

The major lessons learned about church-based programs are the following:

- There is no best way for recruiting churches and sustaining their participation. Each church-based project used different approaches.
- Support from the clergy is essential. The clergy lend authority to the program, help promote and encourage participation, and can be advocates for other congregations interested in developing programs.
- The appointment of the right person as coordinator of the health care ministry or team is critical to keeping members motivated and committed to the screenings and other activities in the churches. Strong coordinators maintain a consistent flow of program activities.
- Project teams, working with the coordinator, can be creative in devising ways to communicate health messages to their congregations. Some ideas include conducting plays during services; healthful cooking demonstrations; “Gospelize” (exercising to church music); and letters from young people urging parents, guardians, and others who are significant in children’s lives to quit smoking. The health professional should encourage this creativity.
- Organizing and conducting health programs in churches take time, but patience is rewarded. In churches, a few volunteers do most of the work. Health professionals should know that this is normal and not give up.
- It is important to respect the church’s independence and attitudes toward health issues. For instance, churches may already have health programs in place and prefer not to adopt a new plan for designing health activities.

Working through congregations, as demonstrated by the churches involved in the Stroke Belt Initiative projects, is an effective way to convey CVD and stroke prevention messages and improve the community’s health. A few reasons are:

- A congregation offers, through its membership, a clearly defined and accessible audience.
- Congregations influence their members’ values and behaviors. Many address health and healing in their teachings.
- The clergy are motivated to help improve the well-being of congregation members, and members can be motivated through concern for each other.
- Congregations are an acceptable avenue for promoting health programs. Black churches have been especially receptive to such efforts.
- A health promotion program supported by the clergy will gain credibility among congregation members.
- Congregations offer access to populations that are of high priority for CVD prevention efforts—families, minorities, older people, and women.
- Congregations have members who volunteer to work on important projects.

HEALTH AGENCY PREPARATION

Preparation within the health agency for working with congregations on CVD risk reduction programs involves both staff preparedness and the identification of resources available to the project.

Health professionals should consider the following questions:

- Do they have available time and a flexible schedule? Working with staff members and volunteers in congregations often requires some evening or weekend hours.
- Are they comfortable working in the religious setting and responding to questions about personal beliefs?

SUMMARY

- The health agency must plan to have an adequate number of staff members and other resources for working with congregations to reduce cardiovascular disease risks.
- Health professionals should be knowledgeable about area churches, temples, and other houses of worship and understand
 - the link between faith and health,
 - the hierarchy of the congregation,
 - the authority of the clergy, and
 - the culture and customs of the congregation.
- The health professional should work with the congregation to determine what resources are necessary to implement programs; including funding, educational materials, and support from potential contributors in the community.



- Are they knowledgeable about CVD risk factors and intervention programs for at-risk populations and a credible presenter of health information?
 - Do they have adequate knowledge about the congregation? Such knowledge would include
 - basic religious beliefs that relate to health issues (Does the congregation teach personal responsibility for health? Acceptance of health problems?)
 - the organizational hierarchy (For example, is there a single member of the clergy or are there associate pastors? Do decisions require regional or diocesan approval?)
 - authority of the clergy in the congregation (Is the pastor or rabbi the uppermost authority, or is there a board or committee to which they answer? Does the congregation take instruction and advice from the clergy?)
 - specific culture and customs of individual congregations (Are members of the congregation conservative or casual in their dress and demeanor? How do they address the clergy and other members? What is the prevailing etiquette before, during, and after services?).
 - Are they sensitive to their position as outsiders, and do they recognize the requirements for interaction with congregation members?
- Preparation also requires estimation of the need for physical resources and how those needs will be met:
- What funds are available for congregation-based programs? What kind of monetary support will the health agency ask the congregation to provide?
 - Will the health agency provide appropriate educational materials? Are there other available sources (for example, voluntary organizations) of booklets and other materials?
 - What resources are available inside and outside the agency for data processing and evaluation?
- Once the agency has contacted a selected congregation to start a CVD prevention program, members of the congregation and active volunteers may be able to suggest additional sources for funds, materials, and services to support the program.

RECRUITING CONGREGATIONS

This section describes the information that should be gathered before contacting a congregation and strategies that the Stroke Belt Initiative projects used to recruit churches. Much of this information about a congregation can be obtained from directories, religious organizations, and census data. Calling congregations to learn of their involvement with health agencies may also be helpful.

Initial information about the number, size, and denominations of congregations in the community and the racial/ethnic groups they serve will help the health professional focus on the target population.

The clergy decide whether their congregations will participate in health programs; therefore, it is important that the health professional learn as much as possible about the congregation leaders. Gather information on:

- the number of clergy at each congregation;
- the special interests of the clergy;
- their education and training;

- their involvement with health agencies (Has the congregation worked with local organizations to conduct activities? If so, any established ties may be helpful for the initiation of health activities.); and
- the level of their interest in CVD prevention programs.

Religious organizations and interdenominational alliances at the local, State, and national levels can provide important information about congregations and clergy in the target area. Interdenominational alliances are groups of clergy from diverse denominations within the community; they work together on religious, social, civic, political, and health concerns. Some offer theological courses or training.

Many congregations have worked with health agencies and other community organizations to conduct health programs. The health professional should identify health agencies in the community that are working or have worked with congregations. Those agencies can provide valuable

SUMMARY

- The health professional needs to gather information about the congregations and the clergy before selecting a community and making contacts for recruiting.
- There are two basic strategies for selecting and recruiting congregations:
 - working through organizations of affiliated congregations; or
 - approaching congregations individually.

information on their experiences. The following points describe the basic information to collect:

- types of programs offered and types of activities conducted,
- number of participants,
- demographic characteristics of participants,
- partnerships with health agencies,
- partnerships with other organizations, and
- successes and failures.



BASIC STRATEGIES

The Stroke Belt projects used two basic strategies to recruit churches: (1) collaboration with the State affiliate of a national religious organization and (2) targeting individual churches. Ideally, the staff of an organization of congregations would agree to recruit affiliates. The organization's prestige and its active participation often can persuade a substantial number of congregations to take part. However, it takes time to establish such a relationship with an organization of congregations, so the health agency may have

to take the initiative in approaching the congregations. The health professional should always discuss the project with local organizations of congregations and obtain their support, regardless of their direct involvement.

The Virginia Department of Health (DOH) worked with the health care ministry of the BGC of Virginia to gain access to churches for its Stroke Belt Initiative project. The Virginia DOH's relationship with the BGC dates back many years; agencies that do not have such a relationship might have less success with this strategy. Moreover, the BGC of Virginia is one of a few organizations with a fully staffed health care ministry.

In other Stroke Belt projects, as mentioned previously, the health professionals contacted the churches directly. In Louisiana, the project coordinator started the program in her church and expanded it to neighboring congregations. The Tennessee SHD initially approached three churches where some of their staff were members or knew someone who introduced them to the clergy. This recruitment method involved fewer churches initially, but more churches joined in over time.

The South Carolina Department of Health and Environmental Control formed a church-based working group to develop a strategy for recruiting churches. The group included health professionals and representatives from churches—both clergy and church officers. Following the group's advice, health professionals attended church services to introduce themselves and the project to the clergy and congregation members.

MAKING INITIAL CONTACTS

Health professionals must discuss the program with the clergy before working with a congregation. By gaining the support of the clergy, particularly the leader of the congregation (minister, priest, or rabbi), other clergy and the congregation usually will embrace the vision of the program and work toward its success.

CONTACTING THE CLERGY

Usually, the most effective way to meet the clergy is through a friend who is a member of the congregation and who can recommend the agency and the program to the clergy. A health professional among friends or colleagues in the congregation also can be of great help. A health professional can understand program goals, inform the agency of programs already in place, and provide proper introduction to the clergy.

This person often understands the culture of the congregation and can help persuade the clergy to begin a CVD program.

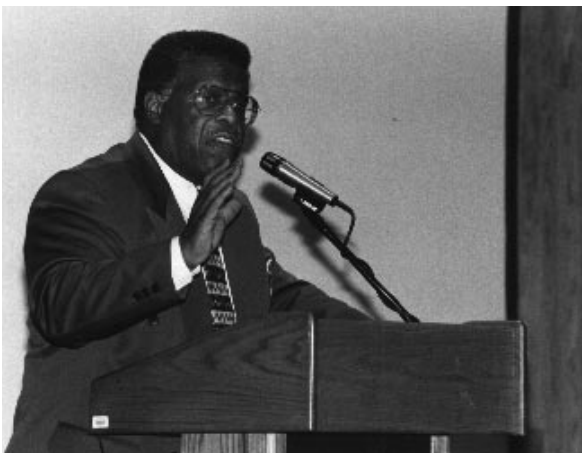
Another effective way to meet the clergy is for the health professional to make a personal introduction when attending the worship service. Getting on the agenda of a meeting of the local ministerial alliance is another avenue. This can increase communication and program visibility and may provide contact with and references to congregations interested in health care programs. The most common ways to contact the clergy include the following:

- Personal introduction—Identify a congregation member (such as a health professional or community leader) who will introduce the health agency and the program to the clergy; identify a member of a community organiza-

SUMMARY

- Support from the clergy increases the success of congregation-based programs.
- There are several ways to make initial contact with the clergy:
 - personal introduction by a congregation member;
 - a visit to services, with self-introduction, or a telephone call; and
 - an introductory letter and followup phone call.
- After contacting the clergy, set up a meeting to describe the project and ask the congregation to participate.
- In the first meeting, explain the benefits to the congregation and discuss the expectations of what the health agency will do and what the congregation will do. Together, the health agency staff and congregation members should make a formal commitment to working together in the CVD prevention program.

tion working with the congregation who supports the health agency or program and will introduce the agency staff; or form a working group that includes health professionals and clergy from participating congregations who can lend credibility to the health project and introduce agency staff. Once the program is implemented in a congregation, ask the clergy of the participating congregation to introduce the health agency staff and the program to clergy of other congregations. The clergy from participating congregations can be strong ambassadors for the program.



- Visit—Attend the worship service and make a personal introduction to the clergy. This shows an interest in the congregation and its members. This approach to contacting clergy requires timely followup and can be difficult if the personal introduction is omitted. Both methods—visiting the congregation and calling before the visit—have been successful in past projects.
- Introductory letter and followup call—Send a letter of introduction to the clergy and follow up with a telephone call within a week to set up a meeting. This method is less productive than a personal introduction, but it has worked. Having the name of a member who can serve as a reference for health agency staff can facilitate the necessary introductions.

- Research the clergy’s title (reverend, pastor, rabbi) and make sure the letter is addressed appropriately.

MEETING WITH CLERGY

Once the introduction has been made, the health professional should set up a time to describe the project and its benefits for the congregation and the community. During the meeting, it is important to explain clearly what the health agency will do and what is expected of the congregation when it agrees to participate.

In explaining the project, the health professional should:

- Describe the benefits to the congregation.

BENEFITS TO THE CONGREGATION

- Increased awareness and knowledge of CVD risk factors and ways to lower risk.
- Ability to identify behaviors that put members at high risk of CVD.
- Potential to reduce risk factors associated with heart attacks or strokes among congregation members.
- Decreased numbers of sick and shut-in members over time.
- Assistance in organizing support groups, exercise classes, and weight reduction programs to improve quality of life.
- More trained volunteers for educating members about CVD prevention activities.
- Strengthened community spirit among congregation members as they work together to achieve a common goal and open avenues into the larger community.

- Emphasize that members of the congregation, with support from the health agency staff, will need to organize and carry out program activities.



- Ask the clergy to name a coordinator (stress the importance of this role in membership participation and successful program implementation) who will
 - Establish a health team or ministry to plan and carry out activities,
 - Keep records of all program activities including participant outcomes,
 - Discuss and commit to confidentiality,
 - Analyze records and make reports, and
 - Provide the health agency with recommendations for translating new knowledge into effective actions.
- Describe typical health intervention activities—for example, screenings, demonstrations, followup activities, and surveys.
- Discuss program costs—the resources that will be provided by the health agency and ways the congregation can provide in-kind and supplemental funding to initiate activities and keep them going once the program is established.

- Explain the importance of including messages about health and the program in sermons and announcements.
- Talk about using witnesses (people who have CVD or their family members) and other key participants to promote the program.
- Suggest that program activities be announced in bulletins, newsletters, flyers, and other publications.

Points to mention about the health agency role may include:

- Training and orienting the coordinator,
- Assisting with training the health team or ministry,
- Providing program guidelines and materials,
- Assisting with evaluating the results of the program and training the health team to work independently of the agency,
- Providing information on the activities of other congregations participating in health programs, and
- Identifying potential network partners.

AGREEMENT TO PARTICIPATE

Once the clergy and/or governing board of the congregation agree to participate and the responsibilities of the health agency have been clarified, confirm the points of agreement in a letter to the congregation. The letter should clearly specify the discrete responsibilities of the congregation and the health agency. Emphasize the importance of clergy participation, appointment of a program coordinator, and the establishment of a team of congregation members to plan and organize activities. Also, be sure that the health agency can deliver what is promised.

ORGANIZING FOR ACTION— REMINDERS FOR HEALTH PROFESSIONALS

SELECTING A COORDINATOR

Selecting a coordinator is the first step in starting a program in a congregation. This person is critical to the success of the program. The coordinator is the leader who generates program interest, trains the team members, and mobilizes support and participation by congregation members. The coordinator is usually appointed by the clergy; if not, the method of selection is decided by the clergy. The health professional can offer advice in the selection of the coordinator and should describe the characteristics and skills of a successful coordinator. The health professional should:

- Explain the importance of appointing the right person—the coordinator is the key to the overall success of the project.
- Provide a list of the personal attributes of a successful coordinator (see below).
- Provide a job description or a list of the coordinator's roles and responsibilities.

Typically, a successful coordinator is someone who is an involved member of the congregation, is known to the clergy, and is recognized and respected by the congregation. The coordinator should have the following skills and attributes:

- Leadership skills—has vision, can provide direction and guidance, can delegate responsibilities, and can encourage and inspire others.
- Organizational skills—can provide structure, make plans, and arrange meetings and activities.
- Communication skills—can speak comfortably with the clergy and the congregation to provide and facilitate the exchange of information.
- Respect of peers—is liked by others and held in high regard.
- Experience—has directed and managed other programs in the congregation.

SUMMARY

- The first step in organizing a congregation-based program is selecting a coordinator. The clergy should make the appointment or decide how the coordinator will be chosen.
- A variety of people with different skills and backgrounds can contribute to the program.
- Team members must be oriented to the project goals, their responsibilities, supporting roles of health professionals, and background information from other projects.

Specific roles of the coordinator include:

- Generating enthusiasm—building interest to promote positive changes in health and creating an atmosphere that encourages congregation members to get involved.
- Promoting the program to the congregation—speaking to the clergy and congregation to give visibility to the program as well as managing the development of promotional messages, flyers, and bulletins.



- Assisting with the training of team members—working closely with the health professional to give the team an overview and rationale for health programs.
- Creating a program plan and timeline—working with the team to develop the activities for a CVD prevention program and assigning responsibilities and maintaining schedules according to the timeline.
- Helping to carry out program evaluation—making sure that a member of the team assists with distributing and collecting evaluation forms after each activity.

- Working with businesses in the community, such as pharmacies and health clubs, and recruiting organizations to provide resources (e.g., national organizations with local chapters, such as the American Heart Association, American Lung Association, and the American Red Cross). These organizations and others, such as the NHLBI, can provide skilled volunteers, educational brochures, and other materials.
- Implementing the program—working with the team to set the start date and accomplish goals on time, which lends credibility to the effort and influences the clergy and the congregation to stay involved.

TRAINING THE COORDINATOR

The health professional can use this guide to train the coordinator. Information in the guide will teach the coordinator how and why health agencies work with congregations to conduct CVD risk reduction programs. As described in this guide, especially in Appendix B, the Stroke Belt projects give background on effective CVD church programs and the lessons learned from these projects, and the other appendices to this guide provide valuable tools for implementing the program.

The health professional should have a one-on-one orientation meeting with the coordinator and cover the following topics:

- roles, responsibilities, and expectations of all players;
- goals of the project;
- description of the activity/project;
- support from the health agency;
- experience in other congregations;
- continuous communication with the clergy to keep them informed and involved;

- data on the prevalence of CVD and its risk factors;
- appropriate education, prevention, and control activities; and
- other background information.

SELECTING THE TEAM

The team should consist of individuals who work well with people, are willing to be trained, and are interested in health issues. Team members must make commitments of their time to be trained and assist with program activities. Volunteers need to feel valued and know that their contributions are making a difference. Laying out clearly-defined expectations and expressing appreciation by the coordinator, health professional, and sometimes an outside person such as a doctor will ensure the success of the team.

Many different people with a wide variety of skills and backgrounds can contribute to the program and assist the team. Health professionals in the congregation such as nurses, nutritionists, and health educators can provide assistance when necessary, such as with blood pressure screenings. Other professionals and properly trained individuals can serve in other roles.

The clergy usually appoint team members or announce the formation of a team and invite volunteers. In some churches involved in the Stroke Belt projects, the coordinator recruited team members who were then appointed by the clergy. However, based on experience in many churches, the Stroke Belt project staff concluded that teams selected and appointed by the clergy enjoyed greater support and generally performed better. Members who are known and trusted by the clergy will have the greatest success in implementing the program and stimulating participation by other members.

ORIENTING AND TRAINING THE TEAM

The purpose of the team is to plan and carry out specific activities to implement the program. Team members are involved in all parts of the program, including planning, recruiting other volunteers, preparing promotional materials, meeting with community groups for assistance, setting up activities for implementation, and evaluating the effectiveness of the project. The coordinator should convene a group orientation, usually conducted by the health professional, to discuss the following:

- roles, responsibilities, and expectations;
- goals of the project;
- confidentiality issues;
- assessment of team members' skills and talents;
- support from the health professional;
- experience in other congregations; and
- other background information.

The training sessions that follow the orientation should emphasize educating the team about CVD risk factors and effective ways to work together to achieve program goals. The team should devise strategies for planning, managing, and implementing the program. Specific tasks should be assigned to team members, and a timeline should be developed. Lines of communication must be delineated, so that after delegating responsibilities, the coordinator will know the appropriate points of contact. Future meeting dates should also be identified.

CONDUCTING THE INITIAL ACTIVITY

This guide gives health professionals insight about how to direct congregation teams to begin health promotion and CVD prevention programs in congregations. It is assumed that those deciding to implement activities using the guide already have established CVD prevention programs in other settings.

In work with religious congregations, community resources often determine the scope and content of the project. If CVD prevention and education programs already exist in the community, consider using them. The steps for developing the program include the following:

- Conduct a survey of the congregation to help the team understand the members, their knowledge of CVD risk factors, their interests and availability, and other pertinent information. The survey should be anonymous and self-administered and take no more than 5 to 10 minutes to complete. The member survey

can be useful in motivating the clergy and the congregation.

- The team should decide on goals and objectives, the congregation activities, and the necessary steps for implementation.
- Get started—move quickly to schedule and carry out the first and subsequent activities. Implement all activities as scheduled in the plan to maintain the program's credibility among congregation members and leaders.

SURVEYING THE CONGREGATION

A survey of the congregation provides the team with baseline information on the demographic characteristics, knowledge, interest, and availability of church members. The team can use this information to select risk factors to target and to choose activities of interest to the members who will attract the greatest participation. Data from the survey are also useful in scheduling program events at times convenient for members.

SUMMARY

- Users of this guide will assist congregations in implementing established CVD prevention programs.
- Working with established community programs in CVD program planning is more efficient.
- The team should follow three major steps to develop a congregation-based program:
 - survey the congregation to learn about CVD knowledge and interests,
 - set goals and objectives and plan a congregation activity, and
 - be creative with startup of congregation activities.

The survey should include the following items:

- demographics such as age and sex,
- knowledge/beliefs about CVD risk factors,
- existence of modifiable risk factors,
- interest in education and intervention activities, and
- availability for participation in education and intervention activities.

The method of administering the survey is important to ensuring a high rate of response. Poor response rates often result from long questionnaires, take-home questionnaires, open-ended questions, and concerns about confidentiality (especially if questions are personal or a signature is required). To improve response rates:

- keep questionnaires short, no more than one page;
- use simple questions; and
- have questionnaires completed prior to, during, or immediately following services.

The strategies used by the Stroke Belt projects to distribute surveys included printing the survey on the back of the church program, placing an insert in the church program, and telephoning members absent from service (although this can be time-consuming and is usually limited to impersonal questions).

Based on the experience of the Stroke Belt projects, an announcement from the clergy requesting members to complete the survey during or immediately following the service is the best method. The coordinator or other team member also may introduce the questionnaire and ask for the congregation's cooperation. Members must be assured that personal information will be held in confidence by the health agency and the team and that project reports will not include names of individuals.

Survey forms should be distributed and collected by a team member, or the congregation can place the forms in a designated box. Analysis of the survey results (including frequencies and cross-tabulations) can give the team insight for planning and can aid in evaluation. The results of the survey should be reported back to the congregation through a brief presentation after the worship service or through an insert in the congregation bulletin.



DEVELOPING A PRELIMINARY PLAN AND GETTING STARTED

A preliminary plan should include the following information:

- targeted risk factors,
- goals and objectives,
- strategies or action steps,
- timeline,
- evaluation indicators,
- resource list for materials and services, and
- followup activities.

An appropriate startup or kickoff event is an immediate activity that can show early success. A successful kickoff builds the morale and commitment of the team, ensures momentum for future activities, and stimulates interest and participation. For these reasons, this activity must be held as soon as possible. As previously mentioned, many churches in the Stroke Belt Initiative took 9 months or longer to conduct the first activity. Therefore, a good strategy to help overcome this delay is to pick a simple activity that the team can readily start and finish in a brief period. Then regular activities keep up the momentum. Targeting segments of the congregation (e.g., screening members of the choir) helps focus efforts and reach particular audiences.

Promotion strategies can include word-of-mouth and advertisements in the congregation bulletin and radio, television, and newspapers. Planning the activity requires several steps:

- Identify a specific kickoff activity for the congregation and for the community. For example, conduct a simple blood pressure screening event, healthy cooking demonstration, food-tasting event, or an event such as “High Blood Pressure Sunday” to raise awareness.
- Identify outside resources, suppliers of educational materials, and sponsors for gifts, if appropriate. The Stroke Belt projects used incentives to increase participation and generate enthusiasm. Food, prizes, games, and giveaways may spice up the event.
- Identify the duties and responsibilities of all team members.
- Schedule the activity. Check with community calendars in local newspapers to avoid scheduling conflicts with other events.

- Discuss with the clergy the importance of their role in facilitating the kickoff event. Kickoff and other events were more successful in the Stroke Belt projects when the clergy were involved in promoting the event. The clergy included a message in their sermons and gave the team full access to the communication media of the congregation. Mentioning the incentives (prizes and giveaways) also increases interest and involvement.



The clergy should endorse the activity enthusiastically. Congregation members who share personal experiences and testimonials are particularly helpful. For example, members can describe the experience of being told by a doctor that they were at risk of a heart attack and how lifestyle changes, such as losing weight and quitting smoking, have reduced their risk. One of the earlier church-based programs developed 52 brief health messages, “Minutes for Your Health.”¹ A team member or the clergy read one of these soundbites during the church service to raise health awareness and motivate members to modify their lifestyles.

1 B. Wayne Kong, Ph.D., J.D., Association of Black Cardiologists, Inc., 225 Peachtree Street, NE, Suite 1420, Atlanta, GA 30303.

Ideas for building program interest and participation include the following:

- short announcement or presentation during the major religious services;
- announcements in the congregation's media, such as weekly bulletins, newsletters, and computer-generated announcements to members;
- flyers that are posted or handed out;
- information given by word-of-mouth; and
- announcements via local religious radio and TV broadcast programs, area newspapers (e.g., in the religious calendar of events), community bulletin boards, and congregation advertisements.

Once the activity is under way, all participants should sign in, and assigned team members should record relevant data about each participant. Participants' concerns about confidentiality can be lessened by providing a statement indicating that all information collected during program activities will not be shared outside the project team and that reports to the clergy will not include participants' names. The activity should be evaluated by developing an activity assessment form. After participants complete the form, their feedback should be used to improve future activities. Finally, if feasible, a followup system should be designed to track persons identified as "at risk" to determine the outcome and effectiveness of the event.

The health professional can work with the congregation to determine whether there is interest in followup and whether there are resources to conduct followup activities. Some congregations may want to conduct only a few activities and have intensive followup; others may want more activities with less followup. The issue of confidentiality in followup must also be

addressed. A permission form at a screening site (e.g., for persons with high blood pressure) can include a statement requesting permission to make a followup call to remind participants to see a doctor. Followup activities greatly improve outcomes but are not always feasible.

FOLLOWING UP THE INITIAL ACTIVITY

TEAM MEETING AFTER INITIAL ACTIVITY

After the initial activity, the coordinator should schedule a team meeting to discuss team members' observations about the activity to determine what went right and what went wrong and come up with ideas to improve the next event. A summary report should be developed describing the event and the results, including:

- number of participants,
- demographics—age and sex,
- number and percentage of participants with self-reported or measured CVD risk factors, and
- number and percentage of participants referred.

To ensure confidentiality, keep records stored in a secure place where access is limited to those

responsible for record-keeping. In determining the best way to group data for routine data analysis, a program evaluator may be consulted. Evaluating these results will help:

- identify effective activities,
- pinpoint areas where additional effort is needed,
- compare different approaches,
- gain and maintain support for the program,
- share experiences with others, and
- plan the next event.

Activities should continue to be scheduled within a month after the initial activity or according to the plan's timeline. It is important to keep up momentum and team morale, maintain the project's visibility for the congregation and clergy, and target individuals found to be at risk for

SUMMARY

- The team should continue working after the initial activity.
- Hold a team meeting to discuss observations and analyze the project.
- Develop a summary report (including number of participants, demographics, and findings about their CVD risk factors) to provide feedback to the clergy and congregation.
- Schedule another activity soon after the first to maintain project momentum, team morale, and congregation interest.

CVD in the initial activity. Identify tasks and assign responsibilities to these areas:

- lead organizer,
- promotion,
- resource acquisition, and
- scheduling.

SOLICITING FEEDBACK ON THE ACTIVITY

The coordinator should arrange a meeting with the clergy to present a copy of the summary report and discuss the collective findings. The clergy are more likely to enthusiastically support future activities when they know that past activities went well and produced useful results. After



discussing the findings with the clergy, ask the clergy to announce the major findings to the congregation; in addition, a team member can provide details. Also, a description of the activity and the major findings can be published in the bulletin or newsletter. The publicity and the enthusiasm it generates will help encourage members to participate in future activities.

Team members and others who helped make the event successful should be acknowledged. It is also a good idea to review the goals of the program and announce the next program event.

PLANNING THE NEXT ACTIVITY

At this point, the team should be busy planning future activities. The health agency professional's role should be to provide direction and serve in a more consultative role (e.g., how to find resources, how to get members involved).

The coordinator and team should keep the momentum going by initiating the next activity as soon as possible and following the steps taken before the first event, which include:

- obtaining approval if necessary,
- scheduling the activity,
- promoting the activity, and
- contacting and securing outside resources.

The team should work to reach program goals and meet the needs of the congregation members, keep communication lines open, be creative, and have fun.

CONDUCTING THE ACTIVITY

The coordinator and team members should start the next program event and repeat steps to evaluate, follow up, and initiate future activities.

MAINTAINING THE PROGRAM

The health professional should encourage and support the coordinator to work with the team to maintain the health activities in the congregation. He or she should serve as a coach and consultant, as well as help provide necessary resources such as informational materials and community contacts. As more congregations become involved in the program, the most important role of the health professional is communicating with the coordinator. It is essential to maintain contact with participating congregations to assist the coordinator with strategies for maintaining the program.

An effective way to stay in touch and keep the program going is through telephone calls to the project coordinator. These calls serve multiple purposes: assessing how program activities are being implemented, identifying needs, solving

problems, praising performance, and reporting on activities at other congregations. The health professional also should encourage the coordinator to maintain communication with the team and the clergy.

The health professional should attend team meetings when possible. Team meetings offer an opportunity for the health professional to provide support in several ways—praise team performance, provide ideas for new project activities, report on activities at other congregations, and provide guidance for program planning and promotion. This usually results in a consistent flow of project activities. The health professional should arrange periodic meetings with the coordinators and key team members from all participating congregations to share experiences and ideas, promote joint ventures, and provide

SUMMARY

The health professional should

- communicate with the project coordinator to help maintain ongoing program activities,
- set the precedent in the initial activity for the project coordinator to take the lead and be prepared to maintain ongoing health projects,
- call the coordinator and attend some team meetings to offer encouragement and continuing support, and
- provide resources to help the team sponsor regular health activities.

encouragement. Church members in the Stroke Belt projects found these meetings to be helpful in generating ideas for new program activities and motivating team members to keep working with the program. These meetings also created healthy competition among the congregations. In addition, the health professional should always deliver promised resources and support on time.

The coordinator is responsible for keeping the clergy informed of progress and praising the team members for their accomplishments. In addition, the coordinator is responsible for staying in touch with the health professional to obtain needed resources and support for the program.

The team should continue to sponsor health activities regularly—at least once a month and more frequently if possible. The team and coordinator should maintain a steady flow of information about the program events to the congregation through announcements in newsletters and bulletins as well as through special flyers and posters. Other strategies include word-of-mouth communications from the team to the congregation and announcements during religious services by the coordinator, team members, and the clergy.

ASSESSING AND EVALUATING THE PROGRAM

Assessment and evaluation are important to the congregation-based health program. They help ensure continued support of the program by documenting the number of participants and identifying participants who need followup with health care providers. They also provide important information for improving the health program.

For each activity, a form should be developed that includes each participant's demographic information (e.g., age, sex), history of CVD risk factors, status of risk factors and other observations at the event, and knowledge of risk factors. A separate form for participants to grade their satisfaction with each activity should be included in the evaluation. Results of

this satisfaction survey should indicate whether the team reached its goals in terms of benefits to the congregation and individual members. All participants should complete the forms at each activity, and personal information should be confidential. Written reports should not include the names of any participants. Data can be coded (e.g., using letters, numbers) as a precautionary measure.

The team should plan how the activity forms will be stored and develop a filing system for records. Computer storage will be needed when there are a large number of participants. A team member with computer skills can help develop a record storage system.

SUMMARY

- Assessment and evaluation of the congregation-based program are important to ensure continued support.
- Evaluation forms should be developed for each activity to record participation and status of risk factors and permit participants to assess the activity's effectiveness.
- Confidentiality of participants' information must be ensured.
- Certain measures (e.g., blood pressure) are needed repeatedly to assess changes in risk factors of participants and aid in planning future activities.
- The team should evaluate each activity as it happens and the entire program at least once each year and determine if the benefits to the congregation are achieved.

A member of the team, the coordinator, or the health professional should analyze the activity forms. The following items may be included in the summary report, depending on the type of activities conducted:

- number and type of program activities,
- total number of participants,
- age and sex of participants,
- number of participants with elevated blood pressure or taking medication for high blood pressure,
- number of participants with high blood cholesterol,
- number of participants who are overweight,
- number of participants who have a high-fat diet,
- number of participants who have a high-sodium diet, and
- number of participants who use tobacco.

Sources for data analysis experts include:

- sponsoring health agencies,
- voluntary health agencies,
- university volunteers (e.g., graduate students or faculty members),
- team members with data analysis skills, and
- congregation members with data analysis skills.

The overall program should be evaluated at least once a year, and each activity should be evaluated as soon as it is completed.

APPENDICES

- A. Checklist for the Health Professional Working With Congregations
- B. State Profiles: Louisiana, South Carolina, Tennessee, and Virginia
- C. Sample Congregation Plan
- D. Sample Congregation Survey
- E. NHLBI Educational Materials

APPENDIX A

CHECKLIST FOR THE HEALTH PROFESSIONAL WORKING WITH CONGREGATIONS

Recruiting Congregations

- Gather information on the clergy _____
- Identify and contact health agencies in the area that
have worked with congregations _____
- Determine the availability of resources
(i.e., funding, educational materials) _____
- Develop a strategy for recruitment _____

Making Initial Contacts

- Introduce yourself to the clergy _____
- Meet with the clergy to describe the program and gain support _____
- Confirm the agreement between the agency and the congregation _____

Organizing for Action

- Offer counsel in the selection of a coordinator _____
- Educate and train the coordinator and team _____

Conducting the Initial Activity

- Facilitate the efforts of the coordinator and team to:
 - Survey the congregation _____
 - Establish goals and objectives _____
 - Develop forms for evaluation and discuss confidentiality issues _____
 - Plan a kickoff event _____
 - Promote and carry out the activity _____

Following Up the Initial Activity

- Provide direction and consultation to the coordinator and team as they:
 - Evaluate the program activities _____
 - Inform the clergy and congregation of each event's success _____
 - Schedule and promote the next activity _____

Maintaining the Program

- Establish regular communication with the coordinator _____
- Attend team meetings when possible to offer encouragement
and continuing support _____

Assessing and Evaluating the Program

- Teach the assigned team members to analyze the data and use the
information for followup and to improve future activities _____

APPENDIX B

STATE PROFILES: LOUISIANA, SOUTH CAROLINA, TENNESSEE, AND VIRGINIA

Louisiana

The Louisiana Department of Health and Hospitals (LDHH) has worked with churches for a number of years. During phase I of the Stroke Belt Initiative, the LDHH established high blood pressure prevention and control programs in 26 churches in the New Orleans area. The interventions consisted primarily of awareness and education activities, blood pressure screenings and followup, and heart-healthy cooking demonstrations. Some churches also conducted weight loss and smoking cessation sessions.

The phase II project was a 2-year effort to expand the program to churches in other areas of the State. The LDHH subcontracted with the National Kidney Foundation of Louisiana and the Natchitoches Outpatient Clinic to achieve this goal. The latter subcontractor concentrated its efforts in northern Louisiana. The subcontractors hired consultants from the targeted communities to recruit churches and help them organize and establish programs.

The consultants followed the procedure established in phase I for recruiting churches. In phase I, the project tried unsuccessfully to recruit churches through the State affiliates of national organizations of churches although the organizations were supportive of the project. Therefore, the project had to recruit churches individually through their clergy.

Thus, in phase II, the first official contact with the church was always made through the clergy because they usually determined whether the church would participate or not. However, the consultants frequently used other contacts within a church to get an introduction and initial

meeting with the clergy. At the meeting with the clergy, the consultants explained the purpose and nature of the project, the benefits to the church, the support that the project would provide, and the responsibilities of the church. After the overview, they asked the clergy to commit the church to participate in the program.

Once a church agreed to participate, the first step was to establish a health care ministry (HCM), an organization of the church responsible for organizing and implementing the health programs in the church. The clergy appointed the coordinator of the HCM. The clergy also introduced the program to the congregation during regular services and asked for volunteers to serve on the HCM. In some churches, the consultant was allowed to address the congregations to promote the program.

The consultant trained the members of the HCM. The 4-hour training session consisted of an orientation to the programs, risk factors for heart disease and stroke, referral and followup techniques, and medical record systems. The members also attended a course to become certified in blood pressure measurement.

The HCMs planned and carried out program activities in their churches. The consultant assisted the HCMs in planning and provided equipment for program events. The consultant was generally onsite for these events to answer questions and solve any problems. They also recruited health professionals to conduct educational sessions on nutrition, smoking cessation, exercise, and other topics.

Thirty churches agreed to participate in the program and established HCMs. The HCMs from 22 churches (156 members) attended the 4-hour training workshop and completed the blood pressure measurement course. Scheduling the training sessions was often a challenge. There were many cancellations, often on the night before the scheduled event. The consultants had

to maintain flexibility and work with the HCM to reschedule the training. Still, eight of the churches that agreed to participate did not attend a training workshop.

The HCMs at 16 churches conducted blood pressure screenings and other program events. The consultant supervised the initial blood pressure screening event at each church. Many of the churches reported a large attendance at their first screening and educational seminars. The remaining six churches with trained HCMs did not conduct a program event. Two churches decided not to conduct a screening because of the fear of liability issues. Another church decided that it was too much work. The three other churches did not schedule an event but indicated that they planned to do so.

The project contracted with a nutritionist to teach church members to prepare heart-healthy meals. Several churches identified the members whom their congregations considered to be the best cooks. The nutritionist worked with these people to modify their favorite foods into heart-healthy dishes. They served these heart-healthy selections to the congregations at food events held by the churches. Church members were always eager to try foods prepared by their best cooks. The members were not told that the food was heart-healthy until after they tried the food and said they liked it.

The nutritionist also prepared recipes of all the heart-healthy dishes served in the churches. The consultants distributed the recipes to the churches so that all members would have access to them.

The consultants kept a log of the dates of their initial visits with the clergy, when the clergy committed the church to participate, the training of the members of the HCM, and each program event. Analysis of these logs showed that it took an average of 46.4 weeks (10.8 months) from the initial visit with the clergy to the first

program event. The times ranged from 2.6 weeks to almost 2 years (22.2 months). However, eliminating the last three churches that took 18.8, 19.0, and 22.2 months reduced the average time to 8.3 months. The patience and persistence of the consultants in getting all the churches to participate was responsible for the longer time periods. Thus, the process of recruiting churches and moving them into action takes time. The consultants continue to work with three other churches to implement programs.

The consultants reported that keeping the HCM members motivated and committed to the screenings and other activities was difficult in many of the churches. They attributed the problem primarily to the leadership of the coordinator. HCMs with strong coordinators tended to maintain a consistent flow of program activities whereas those with weak leaders held activities much less frequently. Thus, it is very important to select a strong coordinator in the beginning because the clergy is generally unwilling to replace an ineffective coordinator.

The coordinators met with other key HCM members to discuss their experiences and share information between the churches. Difficulties in getting HCM members to participate actively in planning and carrying out program activities were a common theme. Some coordinators stated that sometimes they had to conduct screenings by themselves.

The churches agreed to submit monthly tally sheets summarizing their screenings and other activities. Some churches submitted these reports, but most did not, even after followup telephone calls and letters from the consultant.

Finally, after the conclusion of the project, many of the churches continue to hold screenings and other program activities. Three churches that did not hold an event during the project period indicate that they still plan to conduct screenings.

This shows that the benefits of programs to prevent heart disease and stroke are evident to the leadership of many churches. Projects like the Stroke Belt Initiative provide the stimulus for them to get started.

South Carolina

South Carolina has the highest age-adjusted stroke mortality rate in the United States. In 1994, the stroke mortality rate in South Carolina was 31.8 per 100,000 for whites and 65.4 per 100,000 for African Americans. Because of this disparity, the Center for Health Promotion of the South Carolina Department of Health and Environmental Control chose to focus its efforts in the African American community.

The goal for the South Carolina Strike Out Stroke (SOS) project was to improve hypertension awareness, treatment, and control among African Americans in the State. The project sought to increase the number of community-based programs to control high blood pressure among African Americans.

The Center for Health Promotion chose to work through three channels within the African American community: churches, the media, and beauty shops and barbershops. This capacity-building project included the development of training manuals for health professionals and lay volunteers to develop stroke prevention initiatives within each channel.

The project trained professionals to work with the faith community to implement stroke prevention initiatives. The training for professionals took place in a variety of settings, including the Minority Health Issues Conference. Trained area health professionals also taught local lay volunteers to start or expand health promotion efforts in the church.

The media channel stressed the importance of the African American media as an avenue to get positive cues and messages out to the community. It

targeted professionals either who do not know how to access this useful channel within their communities or who are unfamiliar with the availability of specific media resources for African Americans. Training was offered to health professionals through conferences that attract professionals statewide.

Health promotion staff members were trained statewide to use this important communication avenue. This activity continues beyond the contracted period of performance. The media package provides specific information on stroke and cardiovascular health, including camera-ready articles, public service announcements, and additional resources. One media component addresses radio stations and newspapers owned and operated by African Americans.

Beauty shops and barbershops are important channels to conduct health education about stroke prevention in African American communities. The project provided information to health professionals and State and local representatives of beauty shop and barbershop associations and hair care professionals in every region in South Carolina.

The staff made presentations to introduce SOS activities to statewide organizations about the availability of training for health advocates. To maximize the number of people who can take ideas back to their communities, the SOS coordinator gave presentations at State conventions, conferences, and special group meetings. These included the Palmetto State Barbers Association, the South Carolina African Methodist Church Youth Convention, and the State Baptist Conference.

The framework of the project was capacity-building of the community—among both health professionals and lay volunteers. This framework has provided opportunities to link with a variety of organizations statewide who are interested in reducing disease risks among African Americans.

The most critical outcome of this project has been that, because it was based on building capacity, the life and impact of the project will live well beyond the funding.

Tennessee

The Tennessee Department of Health (TDH) continued the efforts started in phase I of the Stroke Belt Initiative project with the metropolitan counties with the largest African American populations. Nearly 70 percent of all African Americans in the State live in these three counties—Shelby (Memphis), Davidson (Nashville), and Hamilton (Chattanooga).

The TDH coordinated services of three independent but related projects managed by the Chattanooga-Hamilton County Health Department, the Metropolitan-Davidson County Health Department, and the Preventing African American Strokes From the Use of Tobacco (PAAST, Inc.) Coalition. The goal of the project was to organize and enable African American communities in Tennessee to develop and carry out prevention and control programs targeted at the risk factors of heart disease and stroke.

In Memphis, the PAAST Coalition, formed during phase I, continued to provide leadership and community involvement to the project. They recruited and worked with five African American churches to develop and carry out programs for smoking cessation as well as nutrition education and weight management for their congregations. The coalition worked with the clergy and other church members to establish a health promotion team in each participating church. The teams were responsible for planning, conducting, and monitoring program activities. The coalition also arranged a training program for each of the health promotion teams. The training included a team-building workshop for skills development in smoking cessation, healthy eating, and weight reduction interventions.

Memphis also formed a youth mentor program to carry out smoking education, prevention, and cessation activities for adults and youths. Twenty teenagers age 15 to 18 were recruited and trained as youth mentors. The top three reasons given for joining the youth mentor team were helping others, informing people of the dangers of smoking, and helping friends and other people stop smoking.

The youth mentors received intensive training to prepare them as smoking cessation facilitators. The training focused on group facilitation, resistance skills, health behaviors and addiction, and the role of the African American family in health promotion and disease prevention. They conducted smoking cessation classes for adults and teenagers and made presentations on tobacco use to youth groups and adult organizations.

In Nashville, the local health department recruited and worked with African American churches to set up programs for smoking cessation, hypertension control, and weight reduction. During the first year, the staff targeted five churches to implement the project. Two other churches were added in the second year. In each church, the clergy appointed health promotion teams to plan and implement project activities. Each team included a coordinator, also appointed by the clergy.

The project staff trained the church teams and worked closely with them, especially during the early stages, to plan project activities. This included the needs surveys of church members and providing ideas for kickoff or initial projects. The project staff also attended team meetings when possible and provided encouragement to the coordinators and the members.

The church teams demonstrated that they could maintain an ongoing program within their congregations. They readily used existing education and risk factor reduction programs from voluntary health and other community agencies. The

teams also were very creative in devising other ways to communicate health messages to their congregations.

Innovative activities developed by the teams included a children's letter-writing campaign, production of a play about risk factors, and food-tasting demonstrations. The letter-writing campaign was both a contest and a health intervention. Children from the churches wrote letters asking a significant adult in their lives to quit smoking. Each child followed up at 3, 6, and 12 months to see if the significant adult was still smoking. The planners used the contest format to encourage maximum participation by the children and cooperation from the significant adults. A panel of church members and health department staff judged each of the letters and selected a winner for each age (ages 6 to 11). The contest winners each received \$50 and a certificate at a special awards ceremony.

One team decided to use drama to communicate health messages to their congregation. They asked a local playwright to write a play depicting what a typical African American family might experience when confronted with the need to lower its risk of heart disease and stroke. High school and college students performed the play during church services, and it was videotaped for future use when the actors were not available.

Food-tasting events played a major role in building support for and sustaining the program. At a meeting of the clergy from participating churches, the team from the host church prepared and served a heart-healthy meal. The clergy learned how the food was prepared only after they finished eating and acknowledged how good the food tasted. The taste of the food so impressed the clergy that most included messages about heart-healthy eating and the program in their Sunday sermons. Many of the teams also conducted food-tasting events for their congregations, using the same strategy.

The Nashville project succeeded in recruiting churches, training teams among the congregations to carry out program activities, moving the teams to action, and sustaining their actions over time. The staff kept logs with the dates of the completion of each milestone in each church. Analysis of these data showed that it took an average of 11.6 weeks (or 2.7 months) from the initial contact with the church to the point when the pastor committed the church to participate. It took another 20.4 weeks (or 4.8 months) from the commitment to participate to the appointment and training of the church team. The first program event took place, on average, 10 weeks (or 2.3 months) after training the church team. Thus, it takes about 42 weeks (or 10 months) from the initial contact with the church to the first program event.

The project in Chattanooga also attempted to work with churches, but initial efforts did not meet with much success. The project staff sought the counsel of the Nashville staff. After several discussions, representatives from Nashville visited Chattanooga to meet with local church leaders. The delegation from Nashville consisted of clergy members, members of the church teams, and staff. Following the meeting, churches in Chattanooga began implementing the program. Overall, activities in these churches continue beyond the official end of the project.

Virginia

The Stroke Belt project in Virginia is a unique collaboration between the Virginia Department of Health (VDH) and the Baptist General Convention (BGC) of Virginia to promote stroke risk reduction programs in African American churches. This 2-year project expanded the activities of the Virginia Cardiovascular Risk Reduction (VCRR) project to work with the BGC. The VCRR project conducts statewide hypertension detection and control programs.

The BGC is an association of more than 1,000 independent African American churches located throughout the Commonwealth of Virginia. These churches have more than 200,000 members. The BGC health care ministry (HCM) has a full-time director who is an ordained member of the clergy. The BGC-HCM has a history of working with health agencies to implement programs in member churches.

The VDH and the BGC-HCM agreed to focus on three risk factors—high blood pressure, smoking, and obesity. For more than 10 years, the VDH and the BGC-HCM have collaborated to conduct blood pressure screening in BGC member churches.

The director of the BGC-HCM recruited the churches, trained the volunteers, and supported their efforts. However, the expanded project required more than one person to coordinate and support the activities of local churches. Thus, the VDH and the BGC-HCM established a system where regional coordinators worked with the churches in their area. The BGC-HCM director recruited 10 volunteer coordinators from area churches.

The clergy at the regional coordinators' home churches pledged to support the efforts of the coordinator and to make their church the model for the region. The responsibilities of the regional coordinators were to recruit churches, assist the churches in organizing to carry out the program, train church team members, and deliver the programs and materials selected for implementation.

A group consisting of VDH staff, the BGC-HCM director, three regional coordinators, four blood pressure measurement (BPM) specialists, and one clergy member planned the high blood pressure component. To carry out the plan, the VDH staff and the BGC-HCM director trained the 10 regional coordinators. While supporting the churches already involved in hypertension detection, the regional coordinators

also recruited new churches and helped them set up HCMs. This increased the number of participating churches to 100. The coordinators certified 100 new specialists and recertified 50 specialists. Seventy-nine additional BPM specialists did not require recertification.

The certified specialists measured the blood pressures of 3,723 church members in FY 1995. Elevated readings were found in 265 people who were not under the care of a physician for high blood pressure. Referrals were made for 282 individuals with elevated readings who were already under treatment for hypertension.

The VDH and the BGC-HCM selected the smoking cessation program from Clergy United for the Redemption of East Baltimore (CURE)—an NHLBI-funded study. The American Lung Association (the local sponsor of the CURE Program) trained the regional coordinators to implement the CURE smoking cessation program. The BGC-HCM director and the regional coordinators revised the CURE materials to be more suitable to the BGC and renamed the program "Thank God I'm Free" (TGIF).

The regional coordinators conducted TGIF training for group leaders in seven regions. Although it was not difficult to get volunteers to participate in the group leader trainings, it was hard to get church members to attend the classes. The volunteers attributed the problem to the employment of many church members in the tobacco industry. Because these persons perceived the program as a threat to their livelihood, many pastors were resistant to the program. However, the group leaders conducted 16 courses for 115 participants. Sixty-eight of these smokers completed the course, and 26 (22.6 percent) were not smoking at the end of the course. To increase participation, local health department clinics offered classes away from the church, which provided greater confidentiality. The group leaders also offered self-help information as an alternative to group classes.

The BGC-HCM director convened a group consisting of regional coordinators, a member of the clergy, church volunteers, and VDH staff to select suitable nutrition and weight loss management programs for the project. The group reviewed existing programs and selected a locally developed program called TRIM. The group revised the TRIM materials and gave the program a new name because the old title was not an acronym for anything. The project staff felt that the program would have more meaning if the letters represented a relevant message—i.e., Taking Responsibility in Meal Management (TRIMM). The working group also selected an appropriate exercise video to complement TRIMM.

The BGC-HCM director and the VDH nutrition education coordinator conducted the first TRIMM training session for regional coordinators and assistants. Shortly before the end of the project, regional coordinators began training local volunteers to lead TRIMM classes. So far, the volunteer leaders have conducted three TRIMM classes with 100 participants. Twenty-two of the 100 participants lost weight.

The VDH and the BGC-HCM continue to implement all phases of the project since the conclusion of their Stroke Belt Initiative funding in September 1995.

APPENDIX C
SAMPLE CONGREGATION PLAN
(ADAPTED FROM THE TENNESSEE STROKE BELT PROJECT)

Name of Congregation _____
 Contact Person _____

Project Period _____
 Telephone No. _____ Fax No. _____

Objective(s)	Activities	Responsible (Congregation)	Responsible (Other)	Complete By	Comments
By February 15, 1996, introduce healthy foods to members through a food-tasting event.	1. Ask congregation members for favorite recipes.	Coordinator		11/5/95	
	2. Collect favorite recipes	Team		11/19/95	
	3. Have nutritionist analyze recipes		Nutritionist	12/1/95	
	4. Have nutritionist modify recipes		Nutritionist	12/15/95	
	5. Appoint a kitchen committee to prepare modified recipes	Team		12/22/95	
	6. Prepare new dishes for sampling by Team	Kitchen Committee, Team		1/6/96	
	7. Select dishes for the food-tasting event	Team		1/8/96	
	8. Schedule event	Team		1/14/96	
	9. Assign responsibilities	Coordinator, Team		1/14/96	
	10. Hold food-tasting event	Team, Kitchen Committee		2/4/96	
	11. Review and evaluate event	Team		2/15/96	

APPENDIX D
SAMPLE CONGREGATION SURVEY
(ADAPTED FROM THE TENNESSEE STROKE BELT PROJECT)

Please take a few minutes and complete this survey. The information will be used to plan health activities for the congregation and in the community. **DO NOT PUT YOUR NAME ON THIS FORM.**

(Family means mother, father, sister, brother, aunt, uncle, grandparents)

	Yes	No
1. Have you ever had a stroke?	_____	_____
2. Has anyone in your family ever had a stroke?	_____	_____
3. Do you have high blood pressure?	_____	_____
4. Does anyone in your family have high blood pressure?	_____	_____
5. Do you have diabetes?	_____	_____
6. Does anyone in your family have diabetes?	_____	_____
7. Do you smoke cigarettes?	_____	_____
8. Are you overweight?	_____	_____
9. Do you drink alcohol?	_____	_____
10. Do you add salt to your food after it is cooked?	_____	_____
11. Do you season your vegetables (e.g., greens, green beans) with salt pork, fat back, or bacon?	_____	_____
12. BEFORE TODAY, did you know that there are ways you can reduce your risk of stroke?	_____	_____

General Information

Age: _____ Sex: ___Male ___Female ZIP Code: _____

APPENDIX E
NHLBI EDUCATIONAL MATERIALS

The NHLBI Information Center is a service of the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. The Information Center provides information to health professionals, patients, and the public about the treatment, diagnosis, and prevention of heart, lung, and blood diseases.

NHLBI Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
Telephone: (301) 251-1222
Fax: (301) 251-1223

In addition, the National Heart, Lung, and Blood Institute maintains a World Wide Web (WWW) site at:
<http://www.nhlbi.nih.gov/nhlbi/nhlbi.htm>

The publications listed below are available on the NHLBI web site. To obtain printed copies of these publications, contact the NHLBI Information Center for price and availability.

#55-745

Colección de Ocho Folletos Fáciles de Leer Sobre las Enfermedades del Corazón

(Package of Eight Easy-To-Read Bilingual Booklets in Spanish and English on Preventing Heart Disease)

Take Steps—Prevent High Blood Pressure

Cut Down on Salt and Sodium

Learn Your Cholesterol Number

Protect Your Heart—Lower Your Blood Cholesterol

Watch Your Weight

Cut Down on Fat—Not Taste

Stay Active and Feel Better

Kick the Smoking Habit

#97-4050

De Corazón a Corazón: Guía para Organizar una Charla Sobre la Salud del Corazón

(From Heart to Heart: A Heart-Health Group Discussion Guide)

#96-4049

Libro de Recetas: Platos latinos ¡sabrosos y saludables!

(Delicious Heart-Healthy Latino Recipes)

#55-832

Package of Seven Easy-To-Read Booklets on Coronary Heart Disease in African Americans

Stay Physically Active—Energize Yourself!

Eat Less Salt and Sodium—Spice Up Your Life!

Lose Weight If You Are Overweight—Embrace Your Health!

Prevent High Blood Pressure—Protect Your Heart!

Learn Your Cholesterol Number—Empower Yourself!

Eat Foods Lower in Saturated Fats and Cholesterol—Be Heart Smart!

Stop Smoking—Refresh Yourself!

#97-3792

African American Heart Healthy Recipes

Discrimination Prohibited:
Under provisions of applicable public laws enacted by Congress since 1964, no person in the United States shall, on the grounds of race, color, national origin, handicap, or age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity (or, on the basis of sex, with respect to any education program or activity) receiving Federal financial assistance. In addition, Executive Order 11141 prohibits discrimination on the basis of age by contractors and subcontractors in the performance of Federal contracts, and Executive Order 11246 states that no federally funded contractor may discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Therefore, the National Heart, Lung, and Blood Institute must be operated in compliance with these laws and Executive Orders.

U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES

**Public Health Service
National Institutes of Health
National Heart, Lung, and Blood Institute**

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