Elderly persons of African American and Latino descent have lower rates of immunizations after adjustment for insurance and education. Interventions that use faith-based organizations (FBOs) are promising but have not been well evaluated. We examined the effectiveness of an FBO adult vaccination program in minority communities. From December 2003 through January 2004 and November 2005 through February 2006, 15 churches were randomized to intervention with onsite adult vaccinations or to comparison with no vaccinations. Participants were eligible if they had not been previously vaccinated with pneumococcal vaccine, did not regularly receive influenza vaccine, were aged ≥65 years, and had a clinical indication for vaccination. Baseline and follow-up surveys were conducted. Primary outcome was rates of influenza and pneumococcal vaccinations. The study sample (N=186) was 44% African American, 43% Latino, 8% White, and 3% Asian. Of those eligible, 90 of 112 (80%) in the intervention group used the influenza vaccine compared to 32 of 70 (46%) in the comparison group (P<.001). Of those eligible, 58 of 88 (66%) in the experimental group used the pneumococcal vaccine compared to 20 of 57 (35%) in the comparison group (P<.001). Participants in the intervention group were significantly more likely to receive influenza vaccinations (odds ratio [OR] 4.8, 95% confidence interval [CI] 2.5–9.4) and pneumococcal vaccination (OR 3.6, 95% CI 1.8–7.2). More than ninety percent of all participants reported willingness to participate in FBO education and promotion programs. This onsite, FBO adult vaccination program was effective in increasing vaccination rates and may be promising for decreasing racial/ethnic disparities in vaccination rates. (Ethn Dis. 2007;17[suppl 1]:S1-15–S1-22)

Key Words: Church, Faith-Based, Racial/Ethnic Disparities

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INTRODUCTION

Partnerships between faith-based organizations (FBOs) and academic institutions are a common means for conducting community-based research and implementing health promotion programs to reduce racial and ethnic disparities. Examples of such partnerships include cancer screening (breast, cervical, and prostate cancer), diet and nutrition projects, physical activity promotion, diabetes and hypertension screening and management, smoking cessation, HIV/AIDS prevention, mental health programs, and adult vaccination promotion and delivery programs.1–7 While these partnerships are not a new concept, interest in partnership has resurfaced in recent years, along with additional governmental and nongovernmental funding for faith-based initiatives.

Various reasons explain this recent increased focus on academic collaborations with FBOs. The partnerships can help academic or public health organizations to broaden models of health to include individual, social, spiritual, and environmental influences; to assist FBOs in implementing health projects; to support the existing assets of FBOs to improve the health of their members; to approach research in healthcare disparities among different racial and ethnic groups; and to recruit potential research study participants from within FBOs. Many FBOs have the infrastructure to execute health promotion programs (eg, volunteers, parish nurses) and a strong desire to improve the health of their congregations, but they often lack the expertise in implementing health programs and could benefit from technical assistance from either academic or public health institutions.

Faith-based organizations (FBOs) are establishing model programs for improving health outcomes, increasing primary prevention, and reducing disease mortality in under-served minority communities.8 With the publication of the report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care by the Institute of Medicine, the Commonwealth Fund Report, and other data on racial and ethnic disparities in incidence and mortality in cancer, heart disease, and stroke; quality of cardiac and diabetes care; hypertension management; and treatment of pain, interest has been renewed in developing community-based strategies to reduce or to eliminate racial and ethnic disparities.9 Reports have suggested that many of these disparities are explained, in part, by the poor interactions with the healthcare system experienced by many minorities, problematic communications between minority patients and their doctors, and difficulty understanding healthcare information and following medical care recommendations.10,11

Despite the promise of these programs, to date, observational or non-randomized, interventional research studies in FBOs have outnumbered randomized controlled studies in the published literature.12–24 More evidence- and outcome-based research in faith-based organization studies is needed, not only to assess the effectiveness of health programs, which is often necessary to sustain funding sources, but for community participation and project continuation. Partnership programs are increasingly asked to demonstrate cost-effectiveness and to meet the research expectations of faith-based leaders.20,25 Thus, the objectives of our study were to use an experimental design to assess whether church-based vaccine education increases the utilization of adult

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