Published in final edited form as:

Prog Community Health Partnersh. 2019 ; 13(2): 209–217. doi:10.1353/cpr.2019.0021.

Connecting Community to Research: A Training Program to Increase Community Engagement in Research

Tracy A. Battaglia, MD MPH¹, Jennifer Pamphile, BS¹, Sharon Bak, MPH¹, Nikki Spencer, MSW/MPH¹, Christine Gunn, PhD^{1,2}

⁽¹⁾Center of Excellence in Women's Health, Women's Health Unit, Section of General Internal Medicine, Department of Medicine, Boston University School of Medicine;

⁽²⁾Boston University School of Public Health, Department of Health Law, Policy, and Management

Abstract

Background: The Boston University Clinical & Translational Science Institute (BU CTSI) identified a local need to increase the capacity of members of a diverse inner-city community with no prior knowledge of research to partner with researchers along the research continuum.

Objectives: To design, implement, and evaluate an introductory-level capacity-building training using community pedagogy and providing information about current research and opportunities to partner with local researchers.

Methods: Guided by two advisory boards of community-engaged professionals and patients, the community engagement team of the BU CTSI designed, implemented, and evaluated the Connecting Community to Research (CCR) training program. We targeted existing community groups in Boston interested in partnering with an academic institution to advance the health of their community. Interactive trainings focused on principles of community-engaged research (CEnR), and how individual experiences might influence research. Each session offered real-time opportunities for participants to engage with local researchers on existing research such as joining a local research advisory group or institutional review board. Self-administered surveys captured participant experiences.

Conclusions: Over 1 year, we trained 100 community members and almost all participants felt that the objectives of the training program were met and the information was relevant. More than 50% of the participants took advantage of partnership opportunities with local researchers. A toolkit was designed and disseminated to support others to replicate the program. We demonstrated that an interactive training curriculum designed with a community-engaged pedagogy and supported by opportunities for engagement has the ability to successfully partner community members with academic researchers.

Keywords

Community-engaged research; community engagement; capacity building training; community academic partnership; research training program

The failure of traditional research to address ongoing and complex health disparities has led to an increased emphasis on Community Engaged Research (CEnR) as a vital tool for finding more effective methods to improve health outcomes.^{1,2} The Centers for Disease

Control and Prevention defines community engagement as “the process of working collaboratively with groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the wellbeing of those people,”³ and encourages community–academic partnerships.⁴ This approach stresses the need for community members to work with researchers as equal stakeholders. Well-known obstacles to CEnR include the lack of an ample pool of community members ready and willing to engage with researchers, as well as a mechanism to link community members to timely research partnership opportunities.⁵

This challenge was identified in our own experience within the Boston University Clinical & Translational Science Institute (BU CTSI). When the time came to expand our reach in surrounding communities, the Patient Advisory Group (PAG) of the BU CTSI suggested offering trainings for members of the diverse urban community. In line with the guiding principles of CEnR, which include “empowering all members through orientation and training,”⁶ we sought to identify educational tools to support this goal. Through a literature review, we identified several existing training programs intended to increase community capacity to partner in research, yet each had limitations. Most training programs were project specific, labor intensive, assumed an existing familiarity with research, or did not demonstrate community research partnerships beyond the project.^{7–10}

With the aim to increase the number and diversity of community members who are informed about, ready, and willing to engage in research, we created a training program to increase the capacity of community members, with no prior research knowledge, to engage throughout the research continuum. The Connecting Community to Research (CCR) training program sought to address the local need for community engagement in research, to provide partnering opportunities for community members and researchers, and to provide a platform to share information about current community based research.

METHODS

Overview and Design

Guided by two advisory boards, the community engagement team of the BU CTSI adapted preexisting curricula to design an interactive training program, called CCR, which aimed to increase the capacity of our diverse, urban community to partner with health services researchers. Over a 1-year period, we conducted and evaluated seven trainings in the Boston area, created a newsletter to retain participant engagement over time, and designed a toolkit for use by other communities. The project was reviewed by the Institutional Review Board of the Boston University Medical Campus and determined to be exempt before research activity.

Intervention Design

CCR Advisory Boards.—We partnered with members of the BU CTSI Community Advisory Board (CAB) to engage two stakeholder groups longitudinally (Figure 1): 1) an existing PAG and 2) a subset of public health professionals who formed the CCR Community Advisory Board (CAB). Established in 2014, the PAG includes six patients (five

females, one male; all non-White) with a vested interest in the health of their communities. Since then, they have met bimonthly with the community engagement team of the BU CTSI to provide input on the development, implementation, and evaluation of various research projects, including piloting and refining various activities of the CCR training program. PAG members receive transportation assistance, meals, and an honorarium for participation at each meeting. In 2015, the PAG recommended introducing community trainings as a means to engage more members with local researchers. Upon receipt of Eugene Washington Patient Centered Outcomes Research Institute funding in 2015, we formed the CCR CAB to complement the expertise of the PAG and implemented the first training 6 months later. CCR CAB members were public health professionals from the Boston area whose daily work was devoted to the health of the community. Representatives were invited to participate based on their prior professional experience and strong ties with the surrounding diverse, urban population of Boston. The CCR CAB consisted of 12 members; most (89%) identified as women and as White (78%). After signing a memorandum of understanding, which outlined expectations for membership, CCR CAB members participated in bimonthly conference calls to provide input on the development, implementation, and evaluation of the program. Members participating in at least half of scheduled meetings received a modest honorarium.

Development of Training Content

We used community-engaged pedagogy in the design of our curriculum,¹¹ which draws from adult learning theory, embraces co-learning, and is rooted in a deep respect for the prior knowledge and experiences of community partners. CCR was iteratively adapted from existing curricula including the Harvard Catalyst's Human Subject Training for Community Partners,¹⁰ the Tufts University CTSI's Building Your Capacity: Advancing Research through Community Engagement,⁹ and the Centers for Disease Control and Prevention's Storytelling template.¹² The curricula from Harvard and Tufts provide participants with a basic understanding of ethical biomedical and behavioral research and were previously vetted in Boston-area communities. The Centers for Disease Control and Prevention Storytelling template was included as an educational tool to help people deliver their experiences effectively. The synthesis of these existing curricula served as the basis for the interactive CCR program (Table 1). Trainings began with a brief ice breaker that culminated in an assessment of participants' experience with research. This was followed by two interactive activities to build foundational knowledge about how research and community advocacy intersect. Next, participants engaged in a two-part interactive lecture that provided instruction on each step of the traditional research process with concrete examples of how community members may partner anywhere along the continuum. After the lecture series, participants practiced communicating their own stories with researchers using storytelling.¹² Each session culminated with a discussion of real-time opportunities to partner with researchers.

Before each of the seven sessions, the training was adapted for the intended audience and amended based on feedback from prior trainings and input from the CCR CAB using an observe-plan-do-check-act improvement framework.¹³ Trainings were designed as 90- to 120-minutes sessions tailored to the specific community priorities/needs. Facilitators worked with the CCR CAB to identify partnership opportunities with varying levels of commitment

for the needs of each training group. For example, the CCR newsletter, was intentionally created as both a minimal opportunity to engage and a strategy to retain training participants' engagement over time. Examples of additional opportunities offered at the end of each session are described in Table 2. At the conclusion of all the sessions, we designed a toolkit with input from the CCR CAB for dissemination.

Study Population

CCR CAB members assisted the study team in identifying groups to participate in the training sessions. The target population included English speaking community groups in Boston who were already convening around a shared interest, but were new to partnering with researchers. For example, the project team delivered trainings to existing Patient and Family Advisory Councils¹⁴ at local health systems that serve vulnerable populations and the Boston University Partnership in Health and Housing Community Committee, a group of public housing residents. Two trainings were conducted as a breakout session during community health disparities conferences sponsored by local community based organizations, including Health Care For All¹⁵ and the Center for Community Health Education Research and Service.^{16,17}

Evaluation and Data Analysis

The team used a cross-sectional survey, adapted from the Community Service Attitude Scale¹⁸ to evaluate the effectiveness of the training. Anonymous surveys were completed by participants at the end of each training session. The survey consisted of demographics (categorical age, gender, race and ethnicity) and three main domains: 1) participant attitudes about the session (five questions); 2) participants' understanding of session components (five questions); and 3) intentions to participate in future research/advocacy (two questions). For each question, participants could respond with yes, no, or unsure. Participants' active research engagement was also tracked and reported.

Both response and research engagement frequencies are reported, first for the overall sample of participants, then by race (White vs. non-White) and gender. Bivariate analyses using χ^2 and Fisher's exact test compare responses by gender and race. Race responses were analyzed as White vs. non-White due to small sample size. All analyses were conducted in SAS v. 9.3.¹⁹ Any *P* value of less than 0.05 indicates statistical significance.

RESULTS

We conducted seven trainings over the course of 1 year, ultimately training 100 community members, 84 of whom completed an evaluation (84% response rate). On average, there were five participants per training (range 1–70). As shown in Table 3, 42% of participants were non-White with the majority over the age of 50 years.

Table 4 shows participants' attitudes about the training, whether the training met stated objectives, and participants' intentions to participate as an advocate in research by gender and race. Almost all participants reported the training as easy to understand (99%) and relevant (80%), although more female and non-White participants felt that this session was relevant to them compared with male and White participants. Almost all participants

reported objectives were met (94%–95%), with 83% reporting the session met the objective to “use my story to inform research.” There were no statistically significant gender or race differences in responses with the exception of “how research can address a community concern” where more females (97%) responded positively compared with males (80%). Although most participants responded positively in believing they could make a difference in the community (82%), only one-half (52%) of the participants indicated that they intended to participate as advocates in research. More non-White participants (76%) responded that they intended to participate as an advocate in research when compared with whites (34%).

Table 5 displays the demographics of the participants who did and did not participate in the opportunities offered at the end of each training. The majority ($n = 49$ [58%]) went on to participate in one or more of these opportunities, with most only participating in one opportunity ($n = 44$ [88%]). Significantly more non-White participants (58%) actively engaged in research opportunities than white participants (40%) and more women (90%) reported actively engaging in opportunities than men (6%). No statistically significant differences in engagement were found across age groups.

The most common activity reported was signing up to receive our quarterly newsletter ($n = 47$ [94%]), an activity we categorized as a minimal level of engagement. Only a select few took advantage of further trainings ($n = 4$) or actively participated as advisory group members ($n = 3$) for new research projects. Overall, four participants displayed the maximal level of engagement either by joining a specific PAG ($n = 3$) and/or the Institutional Review Board of the Boston University Medical Campus ($n = 3$).

Toolkit Development

The team developed a training toolkit complete with facilitators guide and customizable learning modules for other organizations looking to conduct their own CCR trainings. The toolkit is available online at <https://is.gd/CCRTToolkit>. Since June 2017, the toolkit has been downloaded by more than 100 practitioners across 23 states, the District of Columbia, and Puerto Rico.

DISCUSSION

The CCR training program was unique in its ability to successfully demonstrate the effect of a brief introductory training program on facilitating research partnerships with historically underrepresented community members. Designed in partnership with a PAG and CCR CAB, using the best practices of capacity building programs, and partnering with the BU CTSI, we were able to train a diverse population and connect them with research partnerships. Almost all participants felt that the objectives of the training program were met and women and people of color overwhelmingly felt that this training was easy to understand and relevant. Although 50% of participants reported that they intended to participate as research advocates, over time nearly 60% of participants actively partnered in opportunities. More women and people of color actively engaged in research opportunities. We demonstrated that an interactive training curriculum designed with an advisory group and supported by

opportunities for engagement has the ability to successfully partner community members with academic researchers.

The CCR team sought to address a notable gap in the literature by developing and documenting the impact of an introductory level community training on research partnership outcomes. Some aspects of existing training programs, ranging from competitive application processes to project/topic specific content, were incompatible with our goal to engage diverse communities with no prior engagement with research.^{9,10} One prior program focused on training and educating their community members on project specific research needs of the West Side Community Asthma Project. Although the sessions were adapted to the level of the learner, the content was specific to the given project and participants were recruited based on experience with asthma.⁷ CCR sessions were also adapted to community needs, but content was generalizable to any project regardless of prior experience. Other trainings we adapted, such as the Harvard CATALYST training program, were heavily focused on the protection of human subjects training, suggesting that community members would likely become involved as members of institutional review boards,¹⁰ an opportunity we viewed as a maximal level of engagement. The Build Your Capacity training program had both a competitive application process and a time intensive training curriculum culminating in a final research plan.⁹ Although valuable for their specific training purposes, such program requirements may create barriers to community members or groups who have yet to realize their capacity as partners in research.

In contrast with these existing training programs, CCR served as an introductory program that demonstrated how community members might begin to approach partnering in research projects. CCR focused on giving community members a taste of the subject by providing a fundamental understanding of research while building skills that could be adapted to any research partnership. Founded in community engagement pedagogy,¹¹ CCR was iteratively adapted using the best practices of existing curricula to train community members who had yet to be activated as research advocates but were willing to learn more. The major innovation of CCR was its attempt to sustain relationships with participants by providing opportunities of varying levels of engagement to practice the skills they had built. CCR not only evaluated participants' intent to engage as research advocates, but followed up over time to provide new opportunities for engagement through the CCR newsletter and track their actual active partnerships through the CCR CAB. This demonstrates the importance of longitudinal contact as a necessity for facilitating community-academic partnerships.²⁰

Both the PAG and CCR CAB of community engagement professionals were integral to the overall success of the training program. The PAG helped to identify the solution to our local need, develop the original concept of a short but practical introductory CEnR training, and piloted training activities. Consistent with peer reviewed research, our CCR CAB helped "to determine critical insight and ideas, introduce innovative questions, raise community and ethics concerns and offer knowledge of diverse cultures within the community."²¹ The community engagement professionals chosen to participate in CCR were fully immersed in the community and also had past experience working with researchers. The CCR CAB was critical to identifying training groups, amending trainings over time, reviewing evaluation data, identifying opportunities for research partnerships, and tracking participants' active

engagement in the research opportunities they suggested. As a result, we successfully engaged two marginalized populations, women, and people of color. Despite the National Institutes of Health's Revitalization Act of 1993, establishing guidelines for inclusion of women and minorities in clinical research, participation of these underrepresented groups remains persistently low^{22–24} making programs like CCR so vital.

We acknowledge that the CCR program had several limitations. Based on advice from our advisory groups, our recruitment methods did not allow for a pretraining survey, thereby limiting our evaluation to a descriptive post-training evaluation. Next, although more than 60% of participants are actively engaging post-training, we observed little moderate or maximal engagement. This finding may reflect the limited number of opportunities available and/or the fact that a onetime training is simply not enough to create maximal engagement for all community members. Future work should focus on the specific readiness and interests of participants to ensure research engagement opportunities match. Another limitation was that the trainings ranged from 1 to 70 participants, which limited generalizability but strengthened the customizability of the training. This variability in participants allowed us to design a toolkit that could be used for larger presentations or small groups. Finally, the training was only offered to members of the Boston community and only in English. Yet, the support from the BU CTSI (1 of 64 program nationally)^{25,26} during this program, make it ripe for dissemination in other academic settings where translational research is a priority.

Funded by the National Center for Advancing Translational Sciences, the Clinical and Translational Science Awards seek to shorten the time between discovery and application, a lofty goal which relies on the success of the community engagement program.²⁵ CCR takes us one step closer to successful community engagement by providing a platform for new and diverse community members to learn about and get involved in research. The toolkit has been and can be used to train patient and/or community advisory panels, to conduct presentations and to educate researchers about the importance of research advocates. The CCR Training toolkit is available for download at <https://is.gd/CCRToolkit>. One year after the development of the toolkit, a survey was disseminated to those who had downloaded the toolkit and will be used to make iterative changes to the toolkit. We see the CCR training and toolkit as a tool to support research programs in starting and building partnerships. By increasing the number of researchers who are aware of CEnR and are using this toolkit, we are opening the door for underserved communities to partner with researchers everywhere.

CONCLUSIONS

CCR demonstrates that inviting existing community advocacy groups to participate in capacity building training can increase the pool of community members ready and willing to engage as partners in the research process. Our evaluation suggests that longitudinal contact and an academic translational research program is necessary for success. Our toolkit has great potential for dissemination through the Clinical and Translational Science Awards network.

ACKNOWLEDGMENTS

The authors thank the Patient Centered Outcomes Research Institute (PCORI) for funding this project through their Eugene Washington Award (Contract #1195-BMC) and the Boston University Clinical and Translational Science Institute (BU-CTSI Grant Number 1UL1TR001430) for their continued support and dissemination of the CCR toolkit.

Further, we thank our CAB and the PAG for their contributions to the training content, evaluation and development of the CCR toolkit.

Finally, we thank the Boston community for their participation in the CCR training program.

REFERENCES

1. Michener L, Cook J, Ahmed SM, Yonas MA, Coyne-Beasley T, Aguilar-Gaxiola S. Aligning the goals of community-engaged research: Why and how academic health centers can successfully engage with communities to improve health. *Acad Med.* 2012;87(3):285–91. [PubMed: 22373619]
2. Drahota A, Meza RD, Brikho B, et al. Community-academic partnerships: A systematic review of the state of the literature and recommendations for future research. *Milbank Q.* 2016;94(1):163–214. [PubMed: 26994713]
3. CDC/ATSDR Committee on Community Engagement. Engagement CACoC Principles of community engagement. Atlanta: Centers for Disease Control and Prevention; 1997.
4. Ross LF, Loup A, Nelson RM, et al. The challenges of collaboration for academic and community partners in a research partnership: Points to consider. *J Empir Res Hum Res Ethics.* 2010;5(1):19–31. [PubMed: 20235861]
5. Andrews JO, Newman SD, Meadows O, Cox MJ, Bunting S. Partnership readiness for community-based participatory research. *Health Educ Res.* 2012;27(4):555–71. [PubMed: 20837654]
6. Minkler M, Wallerstein N. Community-based participatory research for health: From process to outcomes. Hoboken (NJ): John Wiley & Sons; 2009.
7. Tumiel-Berhalter LM, McLaughlin-Diaz V, Vena J, Crespo CJ. Building community research capacity: Process evaluation of community training and education in a community-based participatory research program serving a predominantly Puerto Rican community. *Prog Community Health Partnersh.* 2007;1(1):89–97. [PubMed: 19649164]
8. Crosby LE, Parr W, Smith T, Mitchell MJ. The community leaders institute: An innovative program to train community leaders in health research. *Acad Med.* 2013;88(3):335–42. [PubMed: 23348087]
9. Rubin CL, Martinez LS, Chu J, et al. Community-engaged pedagogy: A strengths-based approach to involving diverse stakeholders in research partnerships. *Prog Community Health Partnersh.* 2012;6(4):481–90. [PubMed: 23221294]
10. Catalyst Harvard | The Harvard Clinical and Translational Science Center. (2014). Community Partner Human Subjects Research Training: A basic training for community partners [PowerPoint slides].
11. Centers for Disease Control and Prevention, Public Health Information Network Communities of Practice Share success stories [cited 2018 Mar 1]. Available from: www.cdc.gov/phcommunities/resourcekit/evolve/tell_stories.html
12. Langley GJ, Moen R, Nolan KM, Norman CL, Provost LP. The Improvement Guide: A practical approach to enhancing organizational performance. Hoboken (NJ): John Wiley & Sons; 2009.
13. 188th General Court of the Commonwealth of Massachusetts. Session laws: acts 2008: chapter 35: an act to promote cost containment, transparency, and efficiency in the delivery of quality health care [Internet]. Boston (MA): General Court; 2008 Available from: <http://www.mass.gov/legis/laws/seslaw08/sl080305.htm>
14. All HCF. Patient and Family Advisory Councils (PFACS) [cited 2018]. Available from: www.hcfama.org/patient-and-family-advisory-councils-pfacs
15. Freeman ER, Brugge D, Bennett-Bradley WM, Levy JI, Carrasco ER. Challenges of conducting community-based participatory research in Boston's neighborhoods to reduce disparities in asthma. *J Urban Health.* 2006;83(6):1013–21. [PubMed: 17103339]

16. Center for Community Health Education Research and Service, Inc [updated 2015]. Available from: www.cchers.org/.
17. Shiarella H, McCarthy AM and Tucker ML, Refinement of a community service attitude scale, Annual Meeting of the Southwest Educational Research Association Proceedings, 35 pp., 1999
18. SAS Institute Inc. 2011 Base SAS® 9.3 procedures guide. Cary (NC): NSII.
19. Redman RM, Reinsvold MC, Reddy A, et al. A successful model for longitudinal community-engaged health research: The 2040 Partners for Health Student Program. *Fam Pract.* 2017;34(3): 341–6. [PubMed: 28407068]
20. Ahmed SM, Palermo AG. Community engagement in research: Frameworks for education and peer review. *Am J Public Health.* 2010;100(8):1380–7. [PubMed: 20558798]
21. Fisher JA, Kalbaugh CA. Challenging assumptions about minority participation in US clinical research. *Am J Public Health.* 2011;101(12):2217–22. [PubMed: 22021285]
22. Hamel LM, Penner LA, Albrecht TL, Heath E, Gwede CK, Eggly S. Barriers to clinical trial enrollment in racial and ethnic minority patients with cancer. *Cancer Control.* 2016; 23(4):327–37. [PubMed: 27842322]
23. Kwiatkowski K, Coe K, Bailar JC, Swanson GM. Inclusion of minorities and women in cancer clinical trials, a decade later: Have we improved? *Cancer.* 2013;119(16):2956–63. [PubMed: 23674318]
24. Luke DA, Sarli CC, Suiter AM, et al. The translational science benefits model: A New framework for assessing the health and societal benefits of clinical and translational sciences. *Clin Transl Sci.* 2018;11(1):77–84. [PubMed: 28887873]
25. Eder MM, Carter-Edwards L, Hurd TC, Rumala BB, Wallerstein N. A logic model for community engagement within the Clinical and Translational Science Awards consortium: Can we measure what we model? *Acad Med.* 2013; 88(10):1430–6. [PubMed: 23752038]

Figure 1. Timeline for stakeholder engagement from conceptualization of training program to first training.

CCR CAB = Connecting Community to Research Community Advisory Board; PAG = Patient Advisory Group; PCORI = Patient-Centered Outcomes Research Institute.

Table 1.

Connecting Community to Research Training Segments

Training Component	Activity or Lecture	Estimated Time (min)	Description
Ice breaker	Activity	15	Participants are prepared for the session by assessing their prior experience with research through an interactive activity
Researcher vs. advocate	Activity	10	Participants are engaged in an interactive activity to identify the similarities and differences between researchers and community advocates
CEnR 101: What is research and why do we do it?	Lecture	15	Participants are engaged in a brief lecture about traditional research vs. community engaged research.
CEnR 101: Research process	Interactive Lecture	25	Participants are guided through an interactive lecture on each step of the research process with examples for community participation.
Storytelling	Activity	20	Participants are engaged in an interactive exercise to practice effective storytelling, focused on how their lived experience is relevant to health research
Opportunities	Lecture	10	Participants are presented with loco-regional projects looking for community members as partners.

CEnR = community-engaged research.

Table 2.

Connecting Community to Research Partnership Opportunities by Level of Engagement

Level of Engagement	Opportunities to Engage as Research Advocate
Minimal: get informed	Receive our quarterly newsletter Participate in secondary training
Moderate: time-limited partner	Become a Patient-Centered Outcomes Research Institute Merit Reviewer
Maximal: longitudinal partner	Join a study specific patient advisory group Join the Institutional Review Board of Boston University Medical Campus

Table 3.

Demographic Characteristics of Connecting Community to Research Participants

Demographics	Participants (N = 84), n (%)
Race	
White	47(58)
African American	27(33)
Hispanic	4(4)
Other	4 (4)
Asian	2 (2)
Age (years)	
18–29	7 (8)
30–39	8 (10)
40–49	9 (11)
50–59	22 (26)
60–75	33 (39)
76–90	3 (4)
Female sex	67(80)

Two participants did not respond to questions about age and gender.

Connecting Community to Research Participant Attitudes, Understanding, and Intentions by Gender and Race (Percent Yes)

Table 4.

Evaluation Sections	Overall (N = 84)	Male	Female	P value	White	Non- White	P value
Section 1: Attitudes							
Presentation was easy to understand.	83 (99%)	15 (100%)	66 (99%)	.99	46 (98%)	35 (100%)	.99
There was enough time to learn material.	68 (83%)	11 (73%)	55 (85%)	0.32	42 (89%)	24 (73%)	0.17
This session was relevant to me.	66 (80%)	9 (60%)	56 (85%)	0.025	46 (65%)	34 (97%)	<0.001
I would recommend session to others.	62 (78%)	10 (67%)	51 (81%)	0.21	29 (64%)	31 (94%)	0.005
This session met my expectations.	60 (73%)	9 (64%)	50 (76%)	0.42	30 (65%)	28 (82%)	0.28
Section 2: Objectives							
How I can get involved in research?	75 (95%)	13 (93%)	60 (95%)	0.56	44 (94%)	29 (97%)	0.77
Differences between activists and researchers.	78 (94%)	14 (93%)	62 (94%)	0.3980	44 (94%)	32 (94%)	0.49
What is research?	75 (94%)	14 (93%)	59 (94%)	0.67	44 (96%)	29 (91%)	0.29
How research can address a community concern?	74 (94%)	12 (80%)	60 (97%)	0.0219	42 (93%)	30 (94%)	0.49
How to use my story to inform research?	63 (82%)	9 (69%)	52 (84%)	0.29	36 (78%)	25 (86%)	0.66
Section 3: Intentions							
I can make a difference in my community.	67 (82%)	12 (80%)	54 (83%)	0.72	34 (94%)	31 (89%)	0.16
Intend to participate as an advocate.	43 (52%)	8 (53%)	34 (52%)	0.46	16 (34%)	26 (76%)	0.0007

Table 5.
Connecting Community to Research Participants' Engagement in Available Opportunities ($N = 84$)

Demographics	Participants Partnering in Opportunities ($n = 49$)	Not Partnering ($n = 35$)	P Value
Race [/]			<0.001
White	18 (40%)	29 (83%)	
Non-White	29 (58%)	6 (17%)	
Age (years)			0.99
18–29	4 (9%)	3 (9%)	
30–39	5 (10%)	3 (9%)	
40–49	5 (10%)	4 (11%)	
50–59	13 (28%)	9 (25%)	
60–90	20 (43%)	16 (46%)	
Gender [/]			0.008
Female	45 (90%)	22 (65%)	
Male	3 (6%)	12 (35%)	
Number of opportunities			
1	44 (88%)		
2	4 (8%)		
3	2 (4%)		
Level of engagement			
Minimal	47 (94%)		
Moderate	3 (6%)		
Maximal	5 (10%)		

[/]Two participants did not respond to questions about race and gender.