Advancing community-engaged research to promote health equity: considerations to improve the field

In this article the authors provide an overview of the different types of community-engaged research (CER), key insight on the utility of leveraging CER to promote health equity, and practical steps to operationalize CER principles in public health research. The content also emphasizes the importance of diversifying academia and the field of public health—an issue that is not only critical to health equity, but a timely concern that is being actively debated.

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The COVID-19 pandemic rapidly increased attention and concern over health inequities that have historically plagued communities of color. Lack of quality healthcare access, housing instability, discrimination, and economic deprivation are among the numerous inequities encountered by marginalized individuals and groups with devastating interacting and cumulative impacts on their health and wellbeing.

Community-engaged research (CER) has long held promise in public health as an orientation to research[1] to help address health disparities and inequities.[2] CER is an asset-based approach that shifts away from a deficit model to emphasize existing community assets, resources, and knowledge.[3] This approach can strengthen community capacity – taking into account unique historical, structural, sociopolitical, and cultural factors influencing community health.

CER comes in many forms and names, including community-participatory partnered research, community-academic research partnerships, and community-based participatory research (CBPR).[4] CBPR is a gold standard in CER as a collaborative approach based on principles that include fostering co-learning and capacity building for all members.[1,5] Ideally, it equitably involves community partners and researchers in the entire research process from question identification to dissemination.[4,6]

CER is a paradigm shift to conducting science that can integrate minoritized voices and communities of color as equal collaborators – a step in the right direction to achieve health equity for all people that can be a challenging exercise in humility and openness.[5] Across all CER forms is the premise that community members and/or organizations contribute to the formation and design of research questions, approaches, and solutions. Theoretical community engagement models focus on patient/consumer involvement in developing an intervention, peer/lay-delivered interventions, and community empowerment.[2] Examples of strategies include building partnerships and coalitions to reflect diverse perspectives,[7,8] convening a community advisory board for input,[9] and reviewing data with community members to identify interventions.[10]

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A wide breadth of research can benefit from a CER approach, including translational research to increase the relevance of research for communities and bridge the gap between research findings and actionable practice and policy.[7,11] A CBPR policy approach that spans context, CBPR processes, and policy strategies can lead to equitable

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policy changes and improve health outcomes.[12]

A concern around growing interest in CER is the 'dangers of co-optation as this label is loosely applied to include research and intervention efforts in search of funding that do not truly meet the criteria for this approach'.[6] Some of these criteria are process focused since CER relies on relationships, communication, and trust.

There are several important challenges to consider before undertaking this type of work. First, it is a time consuming process[4] that entails developing and maintaining relationships between entities that may be unequal in power and social status. Another barrier is the misalignment between the time and effort needed to establish and maintain authentic partnerships and academic expectations for researchers to accumulate data for grant proposals or to publish peer-reviewed articles. The current climate may inadvertently promote research that treats community engagement as a transactional process for recruitment – *further sowing distrust against research institutions and science in marginalized communities*. For instance, relying on community partners as volunteers can be exploitive and unethical, particularly if there are stark differences in economic and social status between partners. These actions can further add to the long history of mistreating disenfranchised groups in the name of science.

CER that is *community-based* is the best opportunity for the field to mitigate previous insensitivities and damage. How might we, as a field, reverse course and encourage transformative research that is critical and long in coming? A start is to be more intentional in how we describe communities. Language is powerful and can reinforce existing frameworks. Too often, the narrative in health disparities is to consider communities as 'vulnerable', which implicitly confers the quality of defenselessness or passivity and conceals the factors that led to vulnerability. We encourage shifting away from terms connoting inherent deficits and, instead, adopting language such as historically marginalized or medically underserved, which emphasize inequities due to institutional neglect and exploitation.

Another step is to consider the role of CER in diversifying the research field. In addition to investing in and supporting initiatives to promote a diverse research pipeline with representation from marginalized communities, academic and research institutions need to invest and train investigators to conduct CER using published texts[1,5,11] and should offer fellowships and training programs for early career scholars and graduate students.

Next, researchers and funders should pay careful attention to descriptions of partnerships and their collaborative processes in proposals. How will the research study involve and be of benefit to the community? Is the study aligned with the broader needs of the community? Are individuals or organizations being compensated for their time and effort (or are there clear agreements with an employer if the responsibilities are being integrated into an individual's scope of work)? What are the power and social dynamics and how do these change over the course of a project? Did partners agree to a communication plan that reflects each person's preferences? These are all fundamental questions for authentic CER that is community-based.

Finally, institutions should incentivize and reward the use of CER approaches. For instance, institutions should value CER efforts as contributions to scholarship in merit and review processes. These contributions may include translational research products (e.g. policy or research briefs) or efforts to disseminate findings to a community audience. Funders and journals can expand their aims to mention CER, solicit products focused on CER, and invite experts with CER experience to serve on editorial and review boards to signal interest and build this expertise within the scientific community.

Involving the very individuals and organizations negatively impacted by inequities and health disparities in research is necessary to promote health equity. As logical as this may seem, achieving this goal requires a paradigm shift in the incentive structure and process of conducting public health research.

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CONFLICT OF INTEREST

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