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"We just want to tell the story": A mixed methods exploration of partners' motivations to join and stay engaged in community- research partnerships

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"*We just want to tell the story*": A mixed methods exploration of partners' motivations to join and stay engaged in community- research partnerships

Abstract

Community engagement and partnerships are at the core of public health. In order to address long-standing disparities, public health researchers must partner with community members and community-based organizations to co-create health interventions and programs. Community-research partnerships (CRPs)—one model for community partnerships—can increase the capacity and implementation quality of evidence-based and culturally responsive public health practices. While CRPs have been found to be effective, there is a need to address gaps in understanding perceived motivations and gains among and between partners, particularly in the context of engaging marginalized communities. This mixed methods study explored motivations to join and continue to engage in a CRP designed to transform health systems in Flint, Michigan. Using a survey and semi-structured interviews, 25 community and research partner representatives were invited to participate in the study to identify and describe motivating factors and perceived gains driving their engagement. Identified motivating factors were categorized as individual, interpersonal, organizational, and community level contexts. Findings demonstrate how motivational factors are dynamic and multi-dimensional with varied contexts, including intrinsic values in individual contexts, social support, relationships, and external organizational resources through interpersonal and organizational contexts, and demonstration of concrete outcomes in community contexts. Implications for longer term mutual benefits that equip the capacities of partners are discussed. Findings from the study can be used to improve design of CRPs by attending to factors that motivate marginalized communities to engage with the research process.

Community engagement and partnerships are at the core of public health (Nguyen et al., 2021; Robillard et al., 2022). Longstanding disparities among marginalized populations have underlined the need for engaging community members most directly impacted by social issues and trusted community-based organizations (CBOs) in the development of interventions, programs, and practices. CBOs have historical impetus in providing access to resources, responsiveness to community needs, and increasing capacity to facilitate social change in marginalized settings (Nguyen et al., 2021). CBOs are well-positioned to serve communities impactfully, given their history, knowledge, and reciprocal relationships with localized communities served (Smith et al., 2005; Wilson et al., 2012). This was evident throughout the COVID-19 epidemic (Demeke et al., 2022; Pixley et al., 2021; Roels et al., 2022; Washburn et al., 2022). Given the critical role CBOs play in mitigating health disparities among marginalized populations, health initiatives across the United States have prioritized community partnerships as a strategy to advance transformative solutions

that can address social issues (Fleming et al., 2023).

Community-Research Partnerships

The current study focuses on community-research partnerships—one model of a community partnership strategy. We define "community" as localized groups with a shared interest or mission and as the "foundation for relationships built between and among organizations and individuals" (Green et al., 2001, p. 20). Through community-research partnerships (CRPs), community members and CBOs engage with the research community to increase the capacity and implementation of evidence-based public health practices by developing culturally responsive components that can better meet community needs (Brookman-Frazee et al., 2012; Drahota et al., 2016; Garland & Brookman-Frazee, 2015; Noel et al., 2019; Spoth et al., 2007). CRPs can be powerful mechanisms to address systemic health issues in marginalized communities, including urban and rural settings and low-income communities (Abdulrahim et al., 2010; Gilbert et al., 2011; Meade & Calvo, 2001). CRPs aim to design research that centers different cultural contexts to enhance utility and meaningfulness of health programs with strong potential to build trust and community capacities. For example, CRPs created alongside Native American communities have focused on generating research with ethically and culturally appropriate strategies to implement evidence-based practices, while also building capacity to participate in the research process by engaging them as co-developers and decisionmakers (Gittelsohn et al., 2018; Jernigan et al., 2018).

The advantages from CRPs are well documented in terms of its potential impact to promote sustainable public health interventions within community-based settings (Spoth et al., 2011). However, the empirical base on motivations and mutual benefits gained among and between partners is limited in the context of researchers engaging with marginalized communities. Several motivation theories postulate that different motivational levels exist and may lead to varied outcomes driven by interactive contexts (Bandura, 1997; Ryan & Deci, 2000; Deci & Ryan, 2012); yet motivation theories have not been applied in understanding engagement within CRPs. These gaps make it challenging to develop meaningful approaches that foster community engagement. Scant evidence on motivations has demonstrated how community partners ground their decision to engage with CRPs based on perceived value of others' contributions, benefits that would likely occur through their engagement, considerations of concerns, and opportunities to learn and apply new knowledge or skills for their own settings (Behringer et al., 2018; Garland & Brookman-Frazee, 2015; Lau et al., 2020; Ortega et al., 2018). Accordingly, benefits from the perspective of community members in CRPs have been reported as benefits related to their organization's increased capacities to use evidence-based practices, increased number of opportunities to work collaboratively with other organizations, and increased abilities to learn about and address health-related issues impacting their communities (Butterfoss, 2006; Kamuya et al., 2013; Lasker et al., 2001; Meza et al., 2016; Ortega et al., 2018).

While mutual benefits from CRPs are optimal, community and research partners can also experience challenges throughout their participation in CRPs, such as lacking financial resources, limited time, institutional barriers, conflicting and/or unset expectations, or other limited capacities that prevent them from engaging fully as partners

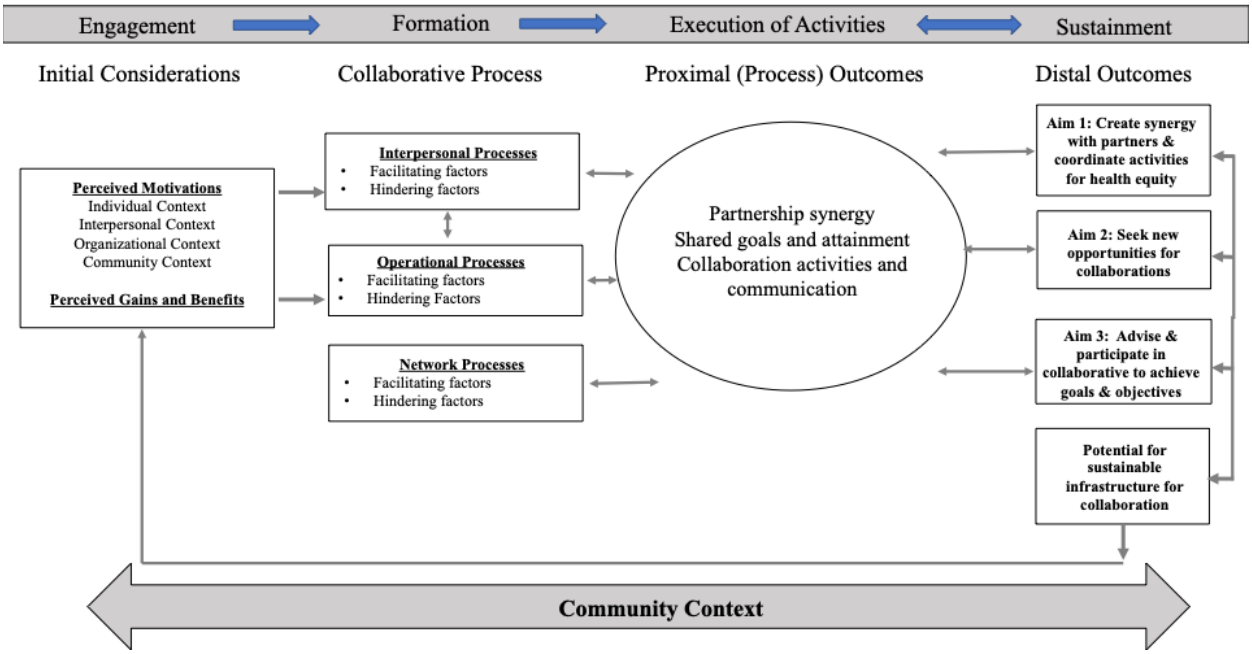
(Adsul et al., 2023; Bustos et al., 2024a; Caron et al., 2015; Pinto et al., 2015). Prior literature demonstrates that CRPs tend to benefit research partners more than community partners, potentially limiting access to mutual gains from a partnership and increasing mistrust of research institutions (Chupp et al., 2021). These challenges compromise what partners gain from a partnership, even from those that are well intended, underlining the importance of examining motivations and gains for engagement to enhance trust (Abdulrahim et al., 2010; Bustos et al., 2024a; Bustos et al., 2024b; Gomez et al., 2018).

The Current Study

As the use of CRPs increases, there is a growing need to better understand community partners' motivations for initial and sustained engagement (Calista et al., 2023; Griffith et al., 2010; Meza et al., 2016; Ortega et al., 2018). Bringing prominence to the experiences of community partners from populations that are marginalized is of particular importance, as recruitment and engagement strategies that work well for these populations is unclear and contingent on researchers' knowledge about their specific individual characteristics (Shaghaghi et al., 2011; Largent et al., 2018). To build the empirical base on perceived motivations and benefits of community partners, the current study applies an exploratory, mixed methods approach using the Model of Research Community Partnership (MRCP) to operationalize and examine key factors shaping engagement throughout the development of a CRP in Flint, Michigan (Brookman-Frazee et al., 2012, 2016; Garland & Brookman-Frazee, 2015; Lau et al., 2020).

An adapted version of the MRCP model outlines the development of CRPs, beginning from initial considerations for engagement phase, formation phase, execution of activities defined by proximal outcomes, and sustainment characterized by distal outcomes (Lau et al., 2020). In the adapted model (Figure 1), the "engagement" phase highlights initial considerations prior to the formation phase of a CRP, emphasizing partners' perceived motivations and concerns. Guided by socio-ecological models of context and given the importance of ensuring mutual benefits for both community and research partners, the study expands on the engagement phase, including community partners' perceived gains and motivations in initial considerations.

Figure 1. Adapted Model of Research Community Partnership (Lau et al., 2020; Brookman-Frazee et al., 2012)



Methods

Utilizing an instrumental case study, the current study applied a sequential mixed methods research design (QUAN → QUAL) to collect the breadth of motivational factors from key partners and the depth of those motivations and benefits to explain and contextualize experiences that are not made explicit through quantitative data. As part of a broader study, the current study focuses only on findings that identified partners' perceived gains, motivating factors to initially join the CRP at time-point 1 (T1) as well as their motivating factors to continue engaging with the CRP throughout the COVID-19 pandemic at time-point 2 (T2). This component of the study aimed to address the research question: what are partners' motivating factors to engage with the CRP at T1 and T2 and aimed to explore how these motivations may have shifted over time. The design included one data collection phase at time-point 1 and two data collection phases at time-point 2 during January 2020 and January 2021 (Creswell & Plano-Clark, 2011; Ivankova et al., 2006). For time-point 1 (January 2020), only the quantitative phase was carried out due to lack of responses from community partners during the onset of COVID-19 in March 2020. At time-point 2 (January 2021), the first phase included quantitative data that were collected and analyzed; in the second phase, qualitative data were collected to expand on the quantitative results. Institutional Review Board (IRB) approval was obtained from Michigan State University (MSU) at time-point 1 and continuation of the study was approved at time-point 2 (#CR00001249).

Study Setting

Flint is a majority African American community made up of over 81,000 people, with over 35% of residents who live in

poverty (Bureau USC; Carrera et al., 2019). Flint is also the largest city and county seat of Genesee County, Michigan, making it the 12th largest city in the state. Once the birthplace of General Motors, disinvestment has caused Flint to lose over half of its population, leading to less access to services and resources that can meet community needs (Hailemariam et al., 2020). In areas of Flint, health disparities have been widening due to the continued impacts from the water crisis and were exacerbated by the most recent public health pandemic (Johnson, 2021). Flint and its surrounding areas in Genesee County have faced longstanding and historical events that have compromised its local, social and economic state, facing "racial abandonment, scientific arrogance, government inaction, and direct harm" (Carrera et al., 2019, p. 3). The compounded impact of disinvestments and depopulation has resulted in higher rates of mental and physical health disparities, poverty and unemployment, as well as increased distrust in institutions, including academic research institutions, in the community (Allgood et al., 2022; Carrera et al., 2019, Hailemariam et al., 2020).

In Flint, relationships and collaboration with other sectors has become critical for the long-term success of the city's resilience and recovery (Carrera et al., 2019; Hailemariam et al., 2022; Hailemariam et al., 2023; Reckhow et al., 2019). Known for community activism, strength and resilience, Flint community members and CBOs have been propelled to navigate local crises together to meet their communities' needs (Hailemariam et al., 2020; Reckhow et al., 2019). Community partnerships, like CRPs, have been utilized for decades to amplify perspectives from Flint community members (Carrera et al., 2019; Citrin, 2001; Key et al., 2019; Hailemariam et al., 2020; Olabisi et al., 2023; Paberzs et al., 2014). Ongoing issues from the Flint water crisis, for example, came to light through strong research partnerships between community activists, healthcare providers, and researchers that prioritized the concerns of community members (Lewis & Sadler, 2021). Thus, there is a strong potential in fostering CRPs within these settings that rely on building relationships between researchers and community members to advance health solutions.

Context of Partnership

In response to the existing health disparities in Flint, a transdisciplinary collaborative research center was created in 2016 to advance sustainable solutions that eliminate disparities by implementing and disseminating community-based interventions that were centered on community needs and co-created through community partnerships (Ellington et al., 2022; Meghea et al., 2021). Funded through the National Institutes on Minority Health and Health Disparities, the center was designed to implement systems-level interventions partnered with community members and community-based organizations to improve social conditions and policies among underserved ethnic and racial minorities in Genesee County (Bustos et al., 2022; Ellington et al., 2022; Johnson-Lawrence et al., 2019; Injury Prevention Center, 2023; Lewis et al., 2021; Meghea et al., 2021). Within the center, there were three smaller cores that focused on special topics, including dissemination and implementation, methods, administration, partnerships, and evidence-based interventions (Ellington et al., 2022; Meghea et al., 2021). Among these cores was the Partnership Consortium Core (PCC)—a CRP designed to foster and coordinate activities that build trust, minimize duplication of efforts, and mobilize and leverage resources to encourage collaboration among community members and researchers. The leadership structure of

the PCC was made up of researchers and community leaders who were considered trusted representatives in addressing health disparities for Flint residents (Bustos et al., 2024a). Fostering trust with communities was reflected in how community representatives were included as core leaders involved in shaping the direction of the PCC.

Quantitative Data Collection Procedures

Sample. The PCC included 25 agency representatives within Genesee County, representing local, state and national agencies involved in public health efforts. All representatives from the PCC were invited to participate in this study. Inclusion criteria for the study included: (a) represent an active, participating agency in the CRP; (b) read and speak proficiently in English; and (c) be 18 years of age or older. A total of 23 partner representatives (3 academic, 20 community; 85% response rate) completed the quantitative survey at time-point 1 and 16 partner representatives (2 academic, 14 community; 59% response rate) completed the survey at time-point 2. Participating community representatives were leaders in public health agencies, representing social services (n = 3), direct health services (n = 7), and non-profit agencies (n = 10) serving Flint community members. Participating research partner representatives reported roles as faculty (50%), ethics review board administrator (25%) or research specialist (25%) employed at two different universities in the Midwest region. Partners' initial involvement with the CRP averaged at 23 months (SD = 13.356) with a range of 0 – 40 months (e.g., since the CRP began in 2016). Continued involvement with the CRP averaged 35 months (SD = 13.72) with a range of 12 – 52 months. Table 1.

Table 1
Overview of Participants

	T1		T2	
	Sample *n* (%)	**Duration of time with CRP (in months)**	**Sample *n* (%)**	**Duration of time with CRP (in months)**
All partners	23 (85)	M = 23.43 (SD = 13.35)	16 (64)	M = 35.63 (SD = 13.72)
Research	3 (75)	M = 26 (SD=17.32)	2 (50)	M = 41.50 (SD =15.78)
Community	20 (95)	M = 23.05 (SD=13.18)	14 (67)	M = 34.45 (SD =13.41)

Measures. ***Decision to Participate Questionnaire (DPQ).*** The 15-item Decision to Participate Questionnaire (DPQ) was used to identify community and research partners' motivations for participating in the CRP (Brookman-Frazee et al., 2012; Meza et al., 2016). For the current project, the DPQ was adapted as a multiple-response item that asked participants to select their motivations for joining the CRP at time-point 1 and their motivations for continuing their engagement with the CRP at time-point 2. An open-ended option was added to allow for additional text responses. Other survey items collected details on demographics, such as agency/institutional affiliation, agency role, duration of time involved with CRP, and their most important organizational contributions

to the CRP. The full survey that includes other aspects of the broader study has been published elsewhere (Bustos et al., 2022).

Procedures. To recruit for quantitative data collection, the first author and a research intern (second author) emailed all key partnering representatives of the CRP with details on the study purpose, participation incentives, expected data collection activities, and eligibility to participate. The intern was from the research center's Summer Scholars program and had established relationships from prior engagements; this was expected to facilitate the recruitment process. Once written consent was obtained, participants were provided with a survey link from Qualtrics. Participants were provided with a $15 gift card once the survey was completed in phase one of time-point 1. Given the impacts of COVID-19, participant incentives were raised to $50 with approval from the IRB. Modifications to participant incentives at time-point 2 also offered an alternative option of a $100 charitable donation that, in combination with an option to obtain the $50 gift card, was expected to increase participation from health care leaders (Conn et al., 2019; Parkinson et al., 2019).

Quantitative Data Analysis

For each time-point, nominal data from the DPQ survey item were analyzed using multiple response frequencies that were aggregated by partner type (e.g., community vs. research). Frequencies of motivating factors were then categorized as individual, interpersonal, organizational, and community level contexts. Any changes in responses over time were reported as observations of patterns by partner type due to unequal sample sizes.

Qualitative Data Collection Procedures

Sample. Using purposive sampling, all participants who completed the quantitative survey in the second phase (at time-point 2) were invited to participate in 30-minute individual interviews. A subsample of nine participants were interviewed, including two research partners (50% of all research partners in the CRP) and seven community partners (41% of all community partners in the CRP).

Measures. ***Semi-structured Interview.*** Quantitative data analysis from time-point 2 was used to develop questions for the semi-structured interview protocol. Questions were designed to elaborate and expand on survey responses, asking participants to share more about their perspectives on motivations for joining the CRP and share what they believed other research and/or community partners had to gain from the collaboration. The questions asked within the interview protocol were grounded on the Give-Get Grid Model, which collects community and academic partners' expected benefits, drawbacks, and contributions (Behringer et al., 2018; Southerland et al., 2013). These procedures followed a prior study approach that applied the DPQ with community providers (Meza et al., 2016).

Procedures. Recruitment for interviews began concurrently with recruitment for the surveys, but interviews occurred only after the survey was completed. An additional reminder email was sent to participants to schedule an interview on Calendly once they had completed the survey. The email included details on the study's purpose and connection to their previous participation in the quantitative survey to minimize confusion. Questions for the interview were also provided in advance to promote transparency. All interviews were completed by the first author who had certified training in qualitative research, conducted on Zoom's

HIPAA compliant platform, and lasted up to 30 minutes. Before starting the interview process, all participants were asked to provide verbal consent after reviewing the consent form again, in addition to their written consent obtained during the survey. Immediately after completing interviews, participants were provided with a $50 Visa gift card.

Qualitative Data Analysis

Qualitative data were analyzed using directed content analysis, a qualitative research technique that allows for iterative constant comparison approaches with inductive coding procedures (Bernard, 2006; Hsieh & Shannon, 2005; Ryan & Bernard, 2003; Willms et al., 1990). Interview data were transcribed using Rev, de-identified to assure the confidentiality of participants, and verified for accuracy. A priori coding schema was developed from the research questions and quantitative findings. Prior to coding, the coding team (first author and co-authors) completed a training to practice coding procedures and to finalize the coding schema. More detailed information on these procedures is published elsewhere (Bustos et al., 2024a). Once the coding schema was finalized, pairs of coders independently coded all nine transcripts to ensure transcripts were double coded for reliability. Any discrepancies were resolved using consensus discussions. Qualitative data saturation was determined when coders agreed that interview data and themes/codes were showing repetition or redundancy.

Emergent themes were identified by the extent of salience within and across interviews. Frequency of codes were quantized to present ever-coded (e.g., the number of transcripts that had the code assigned ever) and frequency counts (e.g., the number of times the code was assigned throughout all of the transcripts), which provided additional data to support the salience of the emergent themes (Bernard, 2006; Hsieh & Shannon, 2005). Guided by Self Determination Theory of motivation and ecological models, themes were categorized by different levels of context embedded in motivations: individual, interpersonal, organizational, and community. All interview transcripts were entered, coded, and analyzed in MAXQDA software.

Results

Perception of the Partnership

An emergent theme was added as *Perception of the CRP*, given how initial perceptions can shape engagement. Participant insights related to the CRP's identity helped broaden context of their motivations. Generally, both community and research partners viewed the partnership as having a unique framework that was indicative of listening to communities and that could be modeled for other partnerships with goals to advance health.

> *I think it's there in a very real way to work on health equity issues in a community, not just on paper, not just on an academic whatever, but to be involving and raising up the people in the community with services that are desperately needed to hopefully achieve equity, or at least advance equity, and looking at issues that are not just identified by academic, but by the people in the community who are dealing with the issues, all in very real ways.* (P002, Research partner)

Partners also perceived the CRP as a connector, a vehicle designed to bring people together for networking, creating relationships and fostering collaborations,

information and resources exchange, linking smaller partners with larger partners, and moving collaborative relationships in innovative ways.

> *It is a venue for collaboration of a broad swath of community organizations and community representatives to come together and break down barriers and start to work on developing common approaches to solving the problems that their missions are supposed to be dealing with... it's that place where folks' agencies can come together and collaborate.* (P005, Community partner)

Overview of Motivations

Quantitative and qualitative results were integrated to illustrate breadth and depth of different levels of motivations, focusing on categories related to *Individual, Interpersonal, Organizational, and Community* level contexts. At time-point 1, partners' motivations to initially engage with the CRP were categorized as 61% organizational, 54% interpersonal, 32% community, and 18% individual. When examined by partner type, results show that community and research partners reported motivations primarily in organizational (68%; 66%, respectively) and interpersonal (54.5%; 100%, respectively) levels. At time-point 2, partners' motivations to continue engaging with the CRP were categorized as 55.6% organizational, 48% interpersonal, 29.6% individual, and 22% community. Like time-point 1, community and research partners reported motivations primarily in organizational (62%, 100%, respectively) and interpersonal (52%; 100%, respectively) contexts (Table 2).

Table 2
Motivational Factors by Category for All Partners and By Partner Type (T1 and T2)

Category of Motivations	**CRP Partners (T1)**	**CRP Partners (T2)**
	n (%)	*n (%)*
Individual	5(17.9)	8(29.6)
Interpersonal	15(53.6)	13(48.1)
Organizational	17(60.7)	15(55.6)
Community	9(32.1)	6(22.2)
	Community Partners (T1)	**Community Partners (T2)**
	n (%)	*n (%)*
Individual	4(18.2)	7(33)
Interpersonal	12(54.5)	11(52.4)
Organizational	15(68.2)	13(61.9)
Community	7(31.8)	5(23.8)
	Research Partners (T1)	**Research Partners (T2)**
	n (%)	*n (%)*
Individual	1(33)	1(50)
Interpersonal	3(100)	2(100)
Organizational	2(66)	2(100)
Community	2(66)	1(50)

However, when frequencies of qualitative codes were computed, findings showed that partners tended to discuss more community (33%) and individual (27%) level motivations than organizational (25%) and interpersonal (13%) (Figure 2). Below, we examine each level of motivation more closely and expand on quantitative responses with qualitative data.

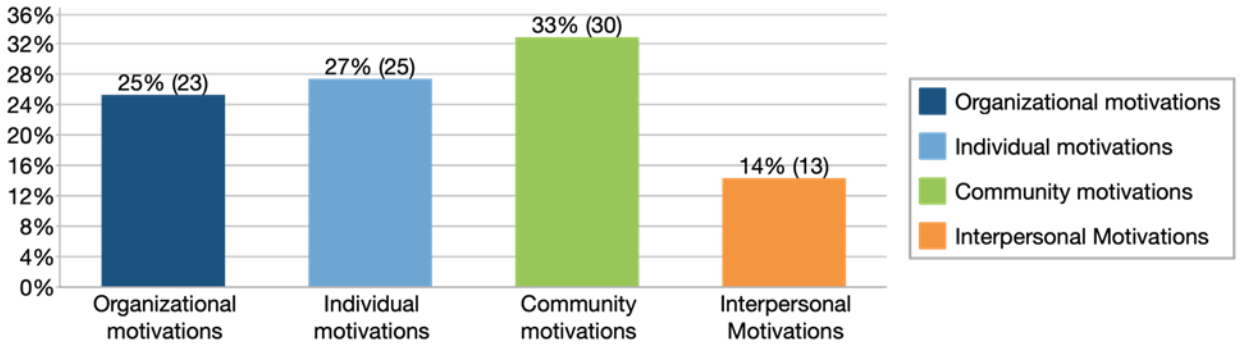


Figure 2. Frequencies of Qualitative Codes Across Transcripts by Type of Motivation

Individual Contexts

At time-point 1, motivations focused on individual level contexts were the least reported by both partners. However, community partners tended to report a higher variety of individual level motivations than research partners, emphasizing their motivations driven by the opportunity for future training/consultation (15%), participation in other research studies (10%), and time (10%) and fiscal (5%) implications of participation in a collaborative group. Research partners, on the other hand, only reported opportunity for future training/consultation (33%). At time-point 2, these patterns in responses shifted, with 50% of research partners reporting five different individual level motivations related to having pressure to implement evidence-based practices, participation in other research studies, fiscal and time implications of participation in a collaborative group, in addition to opportunity for future training/consultation. Community partners reported the same types of individual level motivations, with slight shifts toward more opportunities for future training/consultation (28.6%) (Table 3).

Table 3
Motivational Factors by Community and Research Partner (T1 and T2)

Category	**Motivations**	**Community (T1)**	**Community (T2)**	**Research (T1)**	**Research (T2)**
		n (%)	**n (%)**	**n (%)**	**n (%)**
Individual	Participation in other research studies	2(10)	2(9.5)	-	1(50)
	Fiscal implications of participation in a collaborative group	1(5)	2(9.5)	-	1(50)
	Time implications of participation in a collaborative group	2(10)	2(9.5)	-	1(50)
	Opportunity for future training/consultation	3(15)	6(28.6)	1(33.3)	1(50)
	Pressure to implement new evidence-based practices	-	-	-	1(50)
Interpersonal	Opportunity for networking with other community providers	12(57.1)	11(52.4)	3(100)	2(100)
	Experiences with other CAP members	4(19)	4(19)	1(33.3)	2(100)
	Other: Participating with CAP members adds richness to my work	-	-	-	1(50)
Organizational	The idea of collaborating with other community agencies fits with my agency's/program's philosophy	14(66.7)	13(61.9)	1(33)	2(100)
	Alignment of collaborative principles with agency/program policies	7(33)	5(23.8)	1(33)	1(50)
	Number of studies my agency/program is asked to participate in	1(5)	2(9.5)	-	-
	Reputation of CAP and/or the research team in the community	2(9.5)	3(14.3)	-	2(100)
	Administrative support for collaboration in order to develop a systematic process for adopting and using evidence-based practices	4(19)	2(9.5)	-	1(50)
	Opportunity to use the systematic process that is developed to help adopt and use new evidence-based practices within my agency/program	4(19)	4(19)	-	1(50)
Community	Need for a systematic process for adopting and using new evidence-based practices	7(33.3)	5(23.8)	2(66.7)	1(50)
	Need for adopting and using new evidence-based practices	1(9.5)	2(9.5)	1(33.3)	1(50)
	Other: Advance health solutions, add richness to my work	1(4.8)	2(9.5)	-	-

During qualitative interviews, both community and research partners elaborated on individual level contexts of motivations beyond factors listed in the DPQ. Both partners discussed how engaging with the CRP aligned with their prior work and allowed for a "*natural connection*" to expand community projects as well as provided opportunities for their professional development. Research partners emphasized mutual benefits in gaining opportunities to apply their prior experiences as researchers while also maximizing impact for their community-based research projects. For instance, one partner described the partnership "*mutually beneficial for both*" and like a "*force multiplier*" for impacts (P009, Research partner). Both community and research partners also mentioned how engaging with the CRP was in response to their desire to stay connected to the community: "*This is really something that I've always wanted to be a part of, something that I was a part of before*," (P002, Research partner). Another partner reiterated this, emphasizing their personal motivations to "*really seek community*" (P004, Community partner).

A majority of community partners described motivations related to their personal commitment to justice, having a personal role to serve, and having excitement about the potential growth opportunities to advance health solutions. One community partner expanded on how their motivations were an extension of their personal values: "*Equity is the cornerstone of everything that I do and recognizing that public health has the potential of helping entire communities*" (P006, Community partner). Relatedly, other partners were driven by their passions to serve others and a sense of hope to see changes reified in the Flint community: "*I keep going for the same reasons I got involved in boards...because I am passionate about health equity and I want to see them advance*" (P004, Community partner). Several other partners believed they had a personal mission to take on roles as leaders to identify health solutions for the Flint community and/or provide historical knowledge: "*As a citizen of the community, I have certain responsibilities that I need to fulfill*" (P008, Community partner). Others were motivated by their obligations to serve underrepresented communities: "*We have to make sure that those that are most vulnerable are provided assistance and support,*" (P006, Community partner). Of note, two partners indicated that they were not feeling motivated to stay engaged due to overwhelm, shifts in leadership, or COVID-19 impacts. Yet, they still wanted to forge ahead: "*We've got to somehow get the energy in a community that's already exhausted to forge ahead with more energy*" (P006, Community partner).

Interpersonal Contexts

At time-point 1, interpersonal motivations were the second highest category reported across partners. Both community and research partners reported motivations driven by the opportunity for networking with other community partners (57.1%; 100%, respectively) and prior or existing experiences with other CRP members (19%; 33.3%, respectively). At time-point 2, patterns of motivation responses changed slightly, with less community and research partners reporting the opportunity for networking with other community partners (52.4%; 100%, respectively). Patterns were found to be similar for motivations related to prior or existing experiences with other CRP members for community partners (19%), but not research partners (100%) (Table 3). This may have been due to not having new partners added to the CRP over the period of COVID, and thus focusing their engagement on nurturing those relationships in the second year.

Across interviews, community partners expanded on their motivating factors related

to having opportunities of collaborating with other community agencies. Overall, partners were motivated to continue engaging with the CRP to learn from others, build and strengthen relationships with partners to the point of gaining their trust: "*the piece that has been most fulfilling for me is getting to know some of our partners at a level where they're not just community partners, they are cherished friends because that's where you build the trust*" (P005, Community partner). A similar view was shared from an academic partner: "*it is a goal of mine to not only provide support, right?... this is all about building the relationship between* [CRP] *and our partners*" (P002, Research partner). Other partners were motivated to bridge connections between multi-cultural community organizations to expand partnerships beyond the usual players. For instance, one community partner shared, "*to help make that connection, bridge those communities, and communicate in between different communities that may not necessarily feel like they're connected with the larger community... That's why I keep coming back*" (008, Community partner). Another partner also felt motivated by the "*promise of bringing together various community agencies and stakeholders to improve health in Flint*" (P005, Community partner).

Organizational Contexts

Across both time-points, organizational motivations were the most frequently reported by both community and research partners. Community partners reported 6 different factors related to how the idea of collaborating aligned with their agency's philosophy (66.7%), the alignment of collaborative principles with agency/program policies (33%), administrative support for collaboration in order to develop a systematic process for adopting and using evidence-based practices (19%), the opportunity to use the systematic process that is developed to help adopt and use new evidence based practices within my agency/program (19%), reputation of the CRP and/or research team in the community (9.5%), and the number of studies their agency is typically asked to participate in (5%). Research partners reported two factors related to how the idea of collaborating aligned with their agency/program philosophy (33%) and the alignment of collaborative principles with agency/program policies (33%). At time-point 2, three more factors were reported by research partners but remained the same for community partners. More research partners reported motivations related to reputation of CRP and/or the research team in the community (100%), administrative support for collaboration in order to develop a systematic process for adopting and using evidence-based practices (50%), and the opportunity to use the systematic process that is developed to help adopt and use new evidence-based practices within my agency/program (50%). Any changes in distribution of responses for community partners were likely affected by the response rate at time-point 2.

Throughout the interviews, many community partners further described organizational level motivations, emphasizing mission alignment between the CRP and their agency/program and the CRP's reputation and infrastructure that offered support to build systematic processes to implement evidence-based practices within community agencies. Many partners shared how their respective organizations carried "*equity at the forefront*" in all efforts, aligning with the work of other CRP partners. One partner shared, "[Org] *has always been one to really work with partners and doing things with an equity lens has always been in the forefront of what we do*," (P001, Community partner). Another

partner elaborated on the alignment with collaborative principles: "*The idea of collaborating with community agencies fits with my agency's philosophy,* [CBO] *operates on that principle that agencies come together...as a community with other organizations to have one voice when working with other institutional types like public health and academic institutions*" (P005, Community partner). Other partners discussed the CRP's reputation, emphasizing their motivations to engage because of the importance of the CRP's goals to address health disparities as well as the leaders: "*the purpose of it has made it worth the while for me*," (P008, Community partner). Overall, partners believed that this alignment and shared vision, and collaborative principles were important motivating factors to continue to stay engaged throughout the COVID-19 pandemic.

Others described how the CRP's infrastructure facilitated the ability to create a collective voice centered in community priorities that could be propelled into action through the CRP, as well as develop good relationships along the way. One partner shared, "*the idea that there could be a place that would bring us together, so we move forward together and we're not competitors instead we're collaborators was really attractive to me*" (P004, Community partner). Another partner reiterated this viewpoint, "*what has been most gratifying is that we have a structure in place that can stand the winds and waves that come in communities*," (P007, Community partner). Thus, some felt motivated because they believed the CRP infrastructure would help alleviate challenges to collaborating with other community providers by bridging people to move toward a common objective.

Community Contexts

Community contexts of motivations were the third most frequently reported category in the quantitative survey, but most commonly discussed throughout interviews (Figure 2 and Figure 3). At time-point 1, community and research partners both reported the community need for a systematic process for adopting and using new evidence-based practices (33%; 66.7%, respectively) and the need for moving those processes into action by adopting and using new evidence-based practices (9.5%, 33%,respectively). At time-point 2, pattern of responses remained roughly the same, with slight changes observed due to unequal sample sizes.

Figure 3. Terms Most Frequently Used to Describe Motivations

With qualitative interviews, partners were able to expand on examples that connected their motivations to impact the Flint community more in depth. All partners described their motivations to eliminate health disparities and advance health in the community, beginning from their initial involvement. One community partner shared, "*I know everybody had the idea of advancing the health in Flint from the beginning*," (P005, Community partner). Similarly, another partner extended this view to their continued engagement: "*even as I stepped down as [ ], I still have tremendous interest in a community working ahead to advancing health equity... I want to see that happen*," (P004, Community partner). Research partners were motivated to engage with communities and provide information to improve impact. One partner emphasized that seeing and contributing to real world impact moving toward the elimination of public health disparities in the broader Flint community kept them engaged with the CRP: "*it's this ability to provide* [communities] *information. That is why I'm still involved*," (P002, Research partner).

Other partners expanded on motivating factors related to having a need for a systematic process for adopting and using new evidence-based practices to move health solutions forward. Partners discussed how they felt motivated to leverage collaborations made possible through the CRP to inform their processes with evidence-based practices. One partner shared, "*The need for systematic process for adopting and using new evidence-based practices, that's really something that has been lacking, particularly when we've been involved in research and it's kind of fallen away after the initial research is done. Even when it seems promising, there just wasn't mechanisms in place to actually have those practices sustained*," (P005, Community partner). This is worth noting due to the Flint community's historical experiences with research coming and going into Flint without any sustainable solutions. The same partner elaborated, "*I was very disappointed that there*

were so many research programs that had been done in Flint and after the research program was over, that was pretty much the end. So that's what inspired me to want to do this..." (P005, Community partner). Others discussed these motivations as tied to shifting the research paradigm in developing evidence-based practices to be community centered and practice-based. One partner shared, "*through some of these collaborations, we can shift the paradigm, that we don't have the academic partners coming up with great theories, when they put them into practice, they don't work the way that theory is, there's no two-way communication with practice*," (P007, Community partner).

Perceived Gains

When asked about what community partners had to gain out of the CRP, participants discussed gains related to building capacity in accessing tools and resources, opportunities for collaboration, organizational improvements, personal or professional growth, and opportunities to voice their story. All but one partner discussed gaining access to tools and resources through the CRP, such as funding, data management systems, best practices, and leveraging skills and expertise from others. One partner shared, "*There are things that the university has that it can bring to the table that as a community partner I don't have*" (P006, Community partner). Other partners emphasized access to grants and funding through the partnership: "*I need to partner with groups...because the academic institutions have access to grants, which lead to resources that can make a difference in a community*," (007, Community partner). Six partners elaborated on gains related to accessing opportunities for collaboration, where CBOs and community members can connect and communicate across other agencies. One partner shared, "*it makes the nonprofit that I work with more connected to the larger community because of my involvement,*" (008, Community partner). Gains related to organizational improvements were specific to the CRP's impacts on staff and partners' respective organizational capacity for data driven decision making: "*what helped us* [org] *see is that we weren't able to capture all the data in a way that was translatable so that we could even put it in the system, but we couldn't get it out... having this relationship with the university helped us to see that*," (P007, Community partner). Sharing skills and expertise through the CRP had also offered new learnings, skills, and enhanced understanding of roles partners can play: "*our community has learned some, so I think that's hopeful, that really helps*," (004, Community partner). Most importantly, community partners emphasized their increased abilities to voice their stories reflective of community knowledge and lived experiences while also building capacity to translate these stories into evidence: "*as a community rep, we just want to tell the story*," (007, Community partner).

Discussion

Using mixed methods with a case study design, this study explored initial and ongoing engagement in community-research partnerships by assessing partner motivations and gains. Key findings of the present research include: motivations are dynamic and multi-dimensional and require careful consideration for initiating and sustaining engagement; motivations related to individual contexts underline the role of intrinsic drives in engagement; relationships are motivating factors for bridging research with community practice; motivations related to community contexts are cross cutting, intersecting with other dimensions; and mutual benefits can extend into longer term benefits that equip the capacities of partners for sustained impacts.

First, results from the study suggest that motivations are dynamic and multi-dimensional, with context playing a role in sustaining engagement in the CRP. As aligned with prior literature, intrinsic drive, social support, external organizational resources and demonstration of

concrete outcomes can all deepen and maintain community partners' engagement with CRPs (Calista et al., 2023; Green et al., 2001; McKay et al., 2012; Pinto et al., 2015). This is consistent with motivation theories that have linked intrinsic motivations with intrinsic values and tangible outcomes (Ryan & Deci, 2000). These findings also highlight some shared motivations among community and research partners with a desire to engage in collaborative research and practice. Providing insight on community members' motivations for joining and engaging in a CRP may guide researchers who seek to meaningfully partner with community members. Current and future CRPs are encouraged to start with understanding partners' motivations and what they want out of a partnership to facilitate mutual understanding early on in the formation phase and ensure mutual benefits and fair participation throughout the process.

Additionally, findings on *individual contexts* provided more in-depth understanding on the intrinsic drive behind participation and engagement with CRPs, particularly those designed to address concerns that matter to marginalized communities. While research partners reported motivations related to opportunities for consultation in the beginning of their participation and having a pressure to implement evidence-based practices, they were able to expand their motivations connected to personal values. During interviews, research partners expanded on their motivations to having sense of community and a personal mission to advance health solutions in the community. This reflects a meaningful shift in motivations, moving from researcher's motives to benefit immediate research opportunities to benefiting broader community impact. It is important to acknowledge that researchers hold inherent biases embedded in their roles and obligations tied to their respective research institutions that often prioritize motivations to benefit research over communities (Israel et al., 1998; Wallerstein et al., 2019). The impacts from leaving these biases unaddressed is reflected in the historical harms done to communities from traditional research institutes, perpetuating issues of mis/distrust to date (Griffith et al., 2021; Wallerstein et al., 2019; Reverby, 2012). Bringing motivations to light can present opportunities to challenge biases and develop shared values that can foster trust for meaningful engagement.

Similarly, community partners also emphasized intrinsic drives related to their personal values aligned with social justice, as well as providing expertise from historical engagements with their communities. This is distinct from, yet related to, their mission as an organization and further demonstrates the multidimensional aspects of motivational factors. For instance, when asked about what kept partners motivated to continue engaging with the CRP, community partners emphasized wanting to continue moving their personal commitment towards health solutions forward as well as supporting the community along the way, regardless of their formalized roles or affiliations. Consistent with prior work, these findings underscore the importance of prioritizing the values, assets, and lasting dedication of community members, particularly from marginalized backgrounds, to achieve common good for their communities (Adsul et al., 2024; Green et al., 2001; Hailemariam et al., 2023; McKay et al., 2012). Aligned with motivation theories, these findings indicate how intrinsic drive, such as values, can motivate communities to collaborate with CRPs (Ryan & Deci, 2000). Community researchers and practitioners are urged to design strategies embedded with the intrinsic motivations of partners to center values and other personal assets that can cultivate inclusive spaces and propel collaborations more deeply.

Furthermore, community partners viewed their roles as instrumental to bridging connections with other communities and viewed relationships with researchers as critical for bridging research theories with community centered practices. This

reflects extrinsic motivations characterized as congruent with one's values and self-determined actions (Ryan & Deci, 2000). Findings on *interpersonal and organizational contexts* demonstrated how community partners are motivated to build, nurture, and leverage relationships that are needed for collective action to address health disparities in their communities and for shifting research paradigms. These results are consistent with prior literature that highlight the role of interpersonal factors, such as trust, social support, and good quality of relationships, in driving successful community engaged public health efforts (Bustos et al., 2024a; Bustos et al., 2024b; Gomez et al., 2021; Hailemariam et al., 2023; Israel et al., 1998; Mattessich & Monsey, 1992). Together, these results point to how relationships are fundamental to CRPs and can be leveraged for collaborative community research and practice that moves toward improved public health impact.

While *organizational* and *interpersonal contexts* were most frequently reported in the DPQ, *community contexts* were most often discussed throughout interviews and emphasized in connection to other motivations. Community is a cross cutting value that is embedded throughout other contexts. As demonstrated in prior community engaged scholarship, it is clear that Flint community partners are motivated to help their community because of their values and historical experiences in changing the community for common good (Hailemariam et al., 2020; Hailemariam et al., 2022; Hailemariam et al., 2023; Key et al., 2019; Lewis & Sadler, 2021; Olabisi et al., 2023). When asked about sustaining motivations throughout the COVID-19 pandemic, community partners highlighted the community's need to develop systematic processes that can maximize sustainability of public health interventions to address health disparities specific to the Flint community. This is due to community members' experiences with a lack of sustained efforts from prior research programs (Carrera et al., 2019). Research partners also shared how they wanted to see the impact of the CRP in eliminating health disparities. Prior literature has indicated that motivating factors focusing on the mission of public good rather than individual level motivations can lead to better collaboration (Varda et al., 2012). Other literature has suggested that partners may be more motivated to participate if they believe that their engagement with the CRP would lead to tangible outcomes (Ansell & Gash, 2007; Ryan & Deci, 2000). Studies engaged with marginalized communities, in particular, have also demonstrated how community members can be motivated because they want to be a voice for their community and contribute their knowledge and experiences to influence decisions, and ultimately help address community issues (Kamuya et al., 2013; McKay et al., 2012; Nicolaidis et al., 2011; Ortega et al., 2018). While ultimate impact of the CRP is beyond the study's scope, the findings suggest that partners perceived their efforts as contributing to concrete, sustainable outcomes for the broader Flint community. Thus, demonstrating how community partners' efforts can contribute to concrete and incremental change for their communities may be important for ongoing engagement.

Findings also extend the evidence base of perceived benefits gained from a CRP, underlining reciprocity. Consistent with prior studies, community partners described various gains through CRPs that relate to organizational improvements, professional development, accessing tools, resources, and other health expertise that can be leveraged to their benefit, opportunities for collaboration, and increased abilities to voice their knowledge and experiences grounded in the community (Butterfoss, 2006; Kamuya et al., 2013; Lasker et al., 2001; Meza et al., 2016; Ortega et al., 2018). Researchers are encouraged to attend to capacity building more closely when designing CRPs to incorporate mutual benefits to community partners. These findings may be particularly helpful in considering other incentives for partnership engagement that

extend into longer term benefits that equip partners to be successful without relying on researchers. By attending to mutual benefits, there are opportunities to prevent exacerbation of issues related to mistrust or in unmet expectations, which has already contributed to harm when working with marginalized communities (Abdulrahim et al., 2010).

Limitations

Limitations to the study relate to the design, data integration, sample, and instruments. First, using a case study approach may have compromised generalizability to other contexts. However, case studies can be powerful strategies when applied with mixed methods by adding more comprehensiveness to understanding social issues (Lalor et al., 2013; Yin, 2014). While full integration of data strands at both time-points was not possible, integration at time-point 2 allowed for more context that further elaborated on *sustained* engagement over time. Additionally, purposive sampling may have presented biases and overlooked some perspectives. However, qualitative data saturation was reached during data collection and analysis, consistent with best practices in the field (Hennick & Kaiser, 2022). Lastly, while the DPQ does not have established psychometric properties (Meza et al., 2016), the survey items were tailored to increase ecological validity by adapting items to the CRP's contexts.

Implications

Prior work on community-research partnerships have indicated how individual characteristics (e.g., partner perceptions, motivations) are absent in CRP research (Calista et al., 2023; Meza et al., 2016; Ortega et al., 2018; Ortiz et al., 2020). The majority of studies reporting on motivations in CRPs do not apply motivation theories and tend to focus on research-initiated partnerships or predominantly academic research perspectives (Behringer et al., 2018; Meza et al., 2016; Ortega et al., 2018). Findings from the current study amplify community partner perceptions alongside research partners. Findings offer insights into different types of motivational factors that may be critical for initiating and sustaining partners, particularly throughout challenging circumstances, like the COVID-19 pandemic. Future studies are encouraged to examine differences between community and research partners more clearly and how different motivating factors can lead to distinct patterns or impact quality of engagement.

Findings expand on factors included in the MRCP's initial considerations for engagement. The current study applied the MRCP to examine a CRP and organize findings for motivational factors and perceived gains. By collecting information on initial considerations for engagement, the study builds out the evidence base for what partners may be considering in their decisions to participate and continue engaging with a CRP. Of note, the study emphasizes how motivations and perceived gains should be examined *throughout the partnership process* and not just at the beginning of the CRP to ensure consistency, alignment and expose any reconciliations needed. Viewing these individual characteristics as dynamic throughout the CRP's development may emphasize the trust building aspect that needs to be embedded throughout partnerships.

Conclusion

While CRPs are known to provide several advantages, little is known about the motivational factors of community partners to participate in CRPs, particularly those from marginalized backgrounds (Calista et al., 2023; Griffith et al., 2010; Ortega et al., 2018). Yet, insight into what motivates partners to participate in CRPs is important to ensure the design of culturally responsive and meaningful partnership strategies (Carney et al., 2011). Using the MRCP, the study explored community and research partners' perceived motivations to participate and continue engaging with a CRP as well as perceived gains.

Different motivational factors were identified, emphasizing intrinsic drives in individual contexts, the role of social support and external organizational resources through interpersonal and organizational contexts, and demonstration of concrete outcomes in community contexts. Researchers and practitioners interested in deepening their community partnerships can use results to design CRPs that attend to partners' values and benefits for ongoing partnership engagement that meaningfully encourages marginalized communities to engage with the research process.

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