

Bridging Research, Accurate Information and Dialogue (BRAID):

A novel strategy to build community trust

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ABSTRACT

Background: Efforts to promote COVID-19 vaccination uncovered the effects of longstanding structural racism and perpetuated the erosion of community trust in science and public health institutions. Rebuilding trust is a priority to overcome barriers to vaccine uptake. Bridging Research, Accurate Information and Dialogue (BRAID) is a model that combines several evidence-based approaches to nurture trusting relationships with community experts, leading to the dissemination of accurate, timely, and acceptable COVID-19 vaccine messages.

Objective: To describe an innovative community-engaged participatory research model with the potential to build trust and spread accurate health information through social networks.

Methods: BRAID provided safe spaces for a series of facilitated conversation circles involving trusted community experts and invited clinicians and scientists. Community experts were encouraged to share their experiences, raise concerns, and ask pandemic-related questions in an informal setting. Community experts were empowered to codesign and coproduce accurate health messages acceptable to their communities. To gain insight into the process of building trust, dialogues involving 22 community experts were transcribed and coded, and post survey data from 21 participants were analyzed.

Conclusions: BRAID is a manualized community engagement model that aims to build the trust needed to improve COVID-19 vaccine uptake in historically marginalized communities.

Through BRAID, participants developed increased trust in health systems and research. By empowering community experts to share information through their established social networks, BRAID has the potential to amplify the reach and impact of communications regarding health topics that are controversial and divisive, such as COVID-19 vaccination.

KEYWORDS: Community-Based Participatory Research, Community health partnerships, Community health research, Power sharing, Health promotion, Trust, Vaccine hesitancy, Motivational interviewing, Health disparities

Partnership Description:

This BRAID project was implemented in partnership with Bronx Health REACH; a coalition of over 80 community-based organizations, health care providers, faith-based institutions, housing, and social service organizations formed in 1999 to eliminate racial and ethnic disparities in health outcomes in the Bronx. Recognized in 2007 as a Center of Excellence in the Elimination of Disparities by the Centers for Disease Control and Prevention, Bronx Health REACH provided feedback on the BRAID manual, helped modify the guide, identified community experts to participate in BRAID conversation circles, obtained informed consent, collected pre- and post-surveys, acted as co-facilitators, and participated in writing and revision of this manuscript. NYC CEAL and CDC Foundation grants helped support this work.

INTRODUCTION

Achieving health equity has become a priority for health systems. By committing to meaningful community capacity building, anchor institutions like hospitals, can strengthen trust and catalyze change.(1) Poor COVID-19 booster uptake in many communities shows that disinformation, confusing messaging, inconsistent implementation, and fear of an unknown product, continue to contribute to mistrust and vaccine hesitancy.(2, 3, 4, 5) Although it is self-evident that health systems must earn trust by becoming more “trustworthy,” it is often not easy to achieve.

Bridging Research, Accurate Information and Dialogue (BRAID) is a novel community trust-building approach that was developed and implemented to improve COVID-19 vaccine acceptance in diverse communities.(6) BRAID responds to the complex social and cultural dynamics of COVID-19 in a measurable and scalable manner. It closely aligns with the core principles of the “Assessing Community Engagement Conceptual Model.”(7) In this paper, we first outline the evidence-based trust building strategies that informed BRAID, then describe the model’s components, and finally share the experiences of stakeholders in our feasibility pilot study.

Evidence-Based Trust-Building Strategies Informed BRAID

In communities of color, the drivers of medical mistrust and vaccine hesitancy are multifactorial, involving beliefs about the vaccine, providers, and the health system. Mistrust is further fueled by historical and personal experiences of unethical practices and poor health care.(8, 9, 10) Mistrust arises from power imbalances and information asymmetry.(11, 12)

At the population level, “authentic community investment,” both monetary and otherwise, are needed to build community trust.(13, 14) In contrast to short-term interventions, authentic investment encompasses meaningful commitment to community capacity building by creating opportunities for stakeholder codesign and co-implementation to overcome barriers and increase sustainability.

Inevitably, community members’ encounters with health systems either reinforce or undermine mutual respect and trust. Institutional transparency and genuine responsiveness to community concerns are paramount, as is accountability for promoting diversity, inclusion, and respect.(15) For example, Quinn and colleagues found that perceptions of a healthcare system’s racial fairness were associated with increased influenza vaccination trust and uptake.(16) Health systems’ acknowledgement of their contributions to historical practices and policies that engendered systemic racism and disparate health outcomes are necessary.(17, 18, 19)

Any effort to build trust must be responsive to community member’s evolving understanding of health, particularly in circumstances with rapidly changing or contradictory health information and misinformation.(20) Person-centered approaches based on *what matters* most to individuals and communities are essential when mistrust is widespread.(14, 18, 21, 22) Clear communication of medical concepts in natural language and using authentic stories that resonate with the community is vital(23, 24) as is balancing power dynamics, transparency about goals and motivation, cultural humility and valuing lived experience.(25)

Community members empowered to share information through established social networks can amplify the reach and impact of trust-building strategies leading to behavior change.(26, 27, 28, 29) For example, Kelly et al. demonstrated that “community popular opinion leaders” increased HIV knowledge and reduced risky sexual behaviors.(26, 27, 29) The Surgeon

General’s “Community Toolkit for Addressing Health Misinformation” offers strategies to make peer influencers more effective.(30) For example, peers can model and reinforce desired behavior change.(26, 31, 32) Unfortunately, with widespread circulation of conspiracy theories and disinformation campaigns, peers sharing accurate information often meet resistance,(27, 33, 34, 35) requiring strategies to diffuse conflict and promote dialogue.

Overview of the BRAID Model

Bridging Research, Accurate Information and Dialogue (BRAID) is a novel community engagement model developed by a team of outreach staff, clinicians, and researchers with experience in community-based participatory research (CBPR).(31, 32, 36) BRAID incorporates evidence-based strategies and aligns with AAMC’s Principles of Trustworthiness, including respecting community expertise and cultivating ongoing bilateral communication.(37) Community partners’ significant feedback on the structure and feasibility of BRAID contributed to an implementation manual and a semi-structured interview guide.

By providing safe spaces, BRAID enables an ongoing collaboration involving community members, clinicians, and scientists. The name and imagery of “BRAID” emerged from an exciting brainstorming session with our diverse team. We elicited feedback from stakeholders at community and faith-based organizations to confirm cultural acceptability and appeal. Figure 1 depicts key processes and phases of the BRAID model.

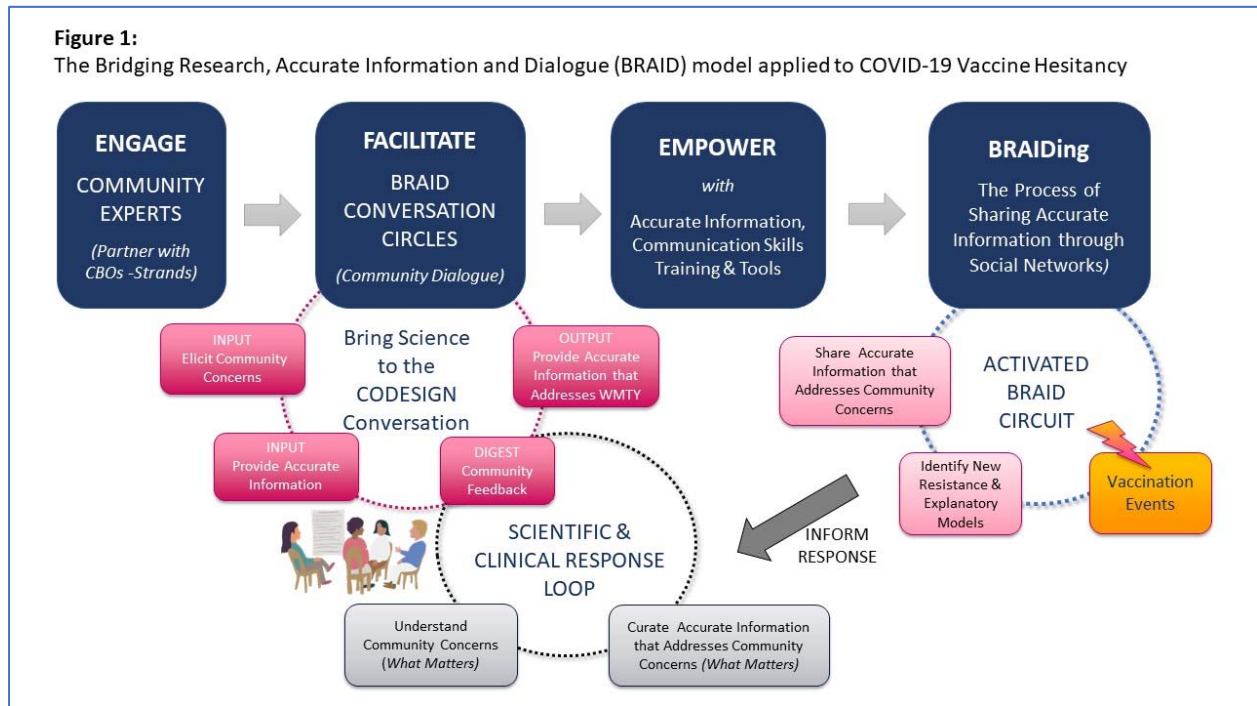


Figure 1: The Bridging Research, Accurate Information and Dialogue (BRAID) model applied to COVID-19 Vaccine Hesitancy

BRAID seeks to leverage and strengthen trusted messengers, increasing their capacity to share health information.(21, 38) Aligned with CBPR principles, these community experts are compensated for providing insight and expertise.(39, 40) Table 1 provides a description of each stakeholder’s role and responsibilities in the BRAID model.

Table 1: HERE

Community experts’ work is carried out in a series of ongoing **BRAID Conversation Circles**. Community experts always drive the direction and pace of these conversations. The Conversation Circle shares features of focus groups and town hall meetings but are more

dynamic and offer greater flexibility than these other approaches (Table 2). Consistent with the international “**What Matters to You**” movement, BRAID conversations focus on community experts’ priorities.(41, 42, 43) Experts may decide to invite clinical and/or scientific guests” to respond to questions that arise. Together, these Conversation Circle strategies serve to empower community experts (7, 12, 44, 45, 46)

Table 2: HERE

The skills of the **BRAID facilitator** are central to creating a safe space for open and frank dialogue. Ultimately, open dialogue between community experts and medical/scientific guests is intended to lead to coproduction of accurate messages that are culturally aligned with the community’s values. Facilitators must have experience working with culturally diverse populations and possess the ability to balance the power differences between medical professionals and lay community members. We have incorporated the core principals of Motivational Interviewing (MI) into facilitator training, (44, 45) and care is taken to ensure that facilitators’ opinions and biases are not injected into the conversation.

Once health messages have been co-developed, community experts are encouraged to actively share them with their social networks. This process is called “BRAIDing.” Because of their status as trusted messengers, community experts are ideally positioned to transition into the role of “BRAIDers.” Even with their experience, it is expected that BRAIDers will encounter resistance when disseminating health information, especially with topics that are highly charged and polarized. BRAIDers are trained to address this resistance using motivational interviewing techniques. Such discordant encounters provide insight into circulating myths and

misinformation. BRAIDers can then share this insight back to the BRAID Circle to inform the co-creation, with invited clinicians and/or scientists, of new messages (see Figure 1).

BRAID Feasibility Pilot

METHODS

To explore community attitudes related to COVID-19 vaccination, between May 2021 and June 2022, we piloted the BRAID model in historically marginalized communities in Bronx, NY. The Bronx is one of the most diverse counties in the nation and was New York City's (NYC) first borough to have a majority of people of color. During the height of the pandemic in 2020, the county also experienced some of the highest number of COVID-19 cases, hospitalizations, and deaths in NYC. Two local CBOs, Bronx Health REACH and the Mosholu Montefiore Community Center (MMCC), were engaged to identify and recruit local trusted messengers including community health workers, youth leaders and faith-based leaders, to participate as community experts in a series of BRAID conversation circles. One of our authors (DG) who is also a member of the Motivational Interviewing Network of Trainers (MINT), served as the primary conversation circle facilitator. A CBO partner staff member (MBZ) was trained to use an MI adherent approach to co-facilitate circles.

BRAID was approved by the Albert Einstein College of Medicine IRB. Informed consent was obtained from all community participants and invited clinical and scientific experts. Overall, twelve BRAID Conversation Circles were convened including four orientation circles and eight follow-up circles. All circles were conducted virtually in English on Zoom. Interviews were recorded and transcribed.

Participants completed pre and post surveys online, before and after each circle, using Survey Monkey. The pre-survey collected demographic information, COVID-19 vaccination status, participants' trust in institutions, and level of comfort sharing their concerns within the group as well as with sharing COVID-19 information with their social networks. The follow-up pre and post surveys collected similar information, without participant demographics. (See appendix #1 for surveys). Since participants completed the follow-up pre and post survey multiple times, we analyzed the responses on their first and last completed surveys.

Transcripts from recorded interviews were coded and analyzed using inductive thematic analysis in Dedoose, following grounded theory principles.(47, 48, 49) Descriptive statistics for study participants and survey responses were obtained using SPSS.(50) Themes and subthemes identified along with full methodology details are available elsewhere.(6)

RESULTS

Twenty-two unique community members (BRAID Community Experts) participated in BRAID dialogues and 17 (77%) returned to attend at least one follow-up conversation circle. The maximum number of circles attended by a participant was five. The mean age of community experts was 35.2 (SD = 16.69). (Table 3). Three Montefiore infectious disease specialist clinicians and a public health representative from the Bronx Borough President's office with expertise in local vaccine data attended the follow-up BRAID conversations to address community experts' questions raised during the initial dialogues. Of the 22 participants, a total of 21 completed a pre and at least one post survey. Although the primary purpose of this publication focuses on the feasibility and acceptability of BRAID as a model, in Table 4 we display some descriptive survey data related to experience participating in BRAID. In general participants felt respected as subject matter experts (90%), and that the BRAID conversation

circles were safe spaces for sharing their points of view or concerns (95% extremely or quite comfortable). Participants indicated that BRAID also improved their readiness (comfort and confidence) and intention to share accurate information about the COVID-19 vaccine to their communities and/or social networks (90% and 95% respectfully). For this paper we focus on BRAID model feasibility from the perspective of community experts, CBO's and scientists and clinicians.

BRAID's influence on Community Experts' Trust and Engagement

BRAID conversation circles are an effective way to build trust among community influencers with potential to shift behaviors such as vaccine uptake. In our study, most participants reported that their BRAID experience strengthened their trust of both health systems and research (Table 4). One community expert commented:

“if I had more experiences like this in the past with my experiences with health care providers, I feel like that would have boosted my confidence and getting the vaccine.”

Community experts greatly appreciated access to clinical experts and felt that it prepared them to transition to the BRAIDer role.

“It feels like Christmas. . . I am getting so many questions answered and information I can share with others.”

They also valued the casual nature of the dialogue which allowed them to connect with clinicians and scientists on a human level.

“I love it when healthcare providers are able to talk to patients as equals and I definitely sense that I've been getting that through this whole research community-conversation.”

Personal disclosures played an important role in establishing a basis for trust. For example, during one circle, two invited clinician researchers shared that, as mothers, they themselves also struggled with the decision to vaccinate their children. In addition to the clinical and research experts, participation of community health workers (CHWs) from the sponsoring CBOs also contributed to engagement, openness, and trust. CHWs were able to broaden the discussion by sharing stories from the field with culturally relevant approaches and voices, which resonated with the larger group about COVID-19 concerns they had encountered in the community.

As participants became empowered with information, there was a notable shift in their narratives. One example is especially illustrative: Even though her husband had “*almost died from COVID*,” one participant was initially reluctant to push her older son to get vaccinated because she “*didn’t want that tension with [her] loved ones*.” Even so, she appreciated the safe space to brainstorm within the group about ways to discuss vaccination with others. At her second circle, this mother stated, “[I have] *figured out my angle*.” During her third circle, she proudly announced that she had successfully leveraged “*motherly guilt*” to get her son vaccinated. As another participant put it, “*Using the information shared with us by the BRAID team, we were better prepared to inform the communities*.”

Clinician and Scientists Perception of BRAID

Feedback was collected from four participating clinicians and scientists who agreed that the experience was extremely valuable and would influence their future patient interactions. One clinician shared:

“I gained firsthand insight into how structural racism contributes to longstanding distrust. . . it was humbling. . . Participating in BRAID helped me see that trust is NOT a privilege, it needs to be earned [by HCPs].”

Another noted that:

“Building trust is incredibly important and requires ongoing education and dialogue with community members.”

All expressed willingness to participate in future circles.

CBO Perspective

Our CBO partners expressed appreciation of the opportunity to collaborate with the research team to implement BRAID. The process itself helped CBO partners gain skills and insights into communicating, educating and partnering with, rather than simply accessing, community experts. These lessons learned have implications for future work and trainings. CBO partners described BRAID as *“an effective strategy for connecting clinical experts with health-seeking community members who are already somewhat equipped to act as trusted messengers.”* They noted that existing trust earned by CHWs intimately involved with the community, facilitated engagement of the community members in BRAID. The CBO partners also touched on the issue of trust, and during the analysis process noted that community experts became more talkative and shared more in subsequent circles highlighting their growing trust in the process, trust and familiarity with the other community experts, and the increasing comfort with their role as an expert.

CBO partners also felt that BRAID was an effective way to educate the public about the COVID-19 vaccine, without coercion or judgement, with potential for downstream dissemination through social networks. The accurate information shared by the clinical experts *“filled in the*

gaps and directly answered the questions we heard in the field and the answers . . . could potentially be shared with others in the community.”

DISCUSSION

Implications for Practice

This paper introduced BRAID and our early implementation experience adapting the model to address COVID-19 vaccine mistrust. Public health agencies and scientific institutions often lack sufficient trust from underserved populations, particularly historically marginalized communities. BRAID can be utilized to leverage existing community relationships to share information and build new trust between community and anchor institutions over time. All stakeholders participating in the model found it to be meaningful.

BRAID is an adaptable process model based on principles of CBPR and MI. It has been manualized and so can be readily deployed around many health topics when trust needs to be established or repaired. By providing insight into what matters most, BRAID conversation circles provide ongoing community perspective that can inform health systems strategies. Awareness of what is acceptable and responsive to the community’s needs will facilitate the evolution of programs and infrastructure that can meaningfully improve equitable care. BRAID has the potential to enhance the role of community advisory boards or stakeholder panels. BRAID Conversation Circles also directly benefit the participants by building skills around finding and accessing reputable sources of information, directing the path of scientific discussion, and strategies for disseminating accurate data back to their communities. CHW’s work well as BRAID participants because of their trusted messenger status, broad community networks and awareness of rapidly changing community priorities and concerns. Their insight

resonated with other participants and propagated deeper trust and richer conversation within the BRAID circles.

Strengths & Limitations

All BRAID participants lived or worked in the Bronx. The transferability of these data may therefore be limited by our study setting. However, our purposeful recruitment of participants from diverse communities with high health needs also functions as a strength. The utility of the pilot survey data is also a limitation, as the BRAID surveys were not anonymous, which may have led to social desirability bias in responses. The survey tool was not tested prior to use and the survey results were not sufficiently powered for anything beyond descriptive statistics, limiting the utility of these data. The rich qualitative data gathered during the BRAIDing circles does, however, provide depth and insight into the strengths and feasibility of the model.

FUTURE DIRECTIONS

In the future, we envision establishing a registry of BRAIDers as an infrastructure for ongoing bilateral communication between the community and the health system. If such a registry had been in place prior to the pandemic, it would have been possible for BRAID to counter misinformation about COVID -19 locally in real time. Experienced community experts who already know and trust the BRAID process could be mobilized quickly according to their areas of expertise and interests, to gain feedback on emerging health and social care issues including research. Given that the model was shown to be feasible earlier on in the pandemic, when information was rapidly changing, we imagine it to be adoptable to other contexts, such as chronic disease prevention, mental health and wellness promotion, and other key public health

priorities. Note that BRAID sessions might be even stronger and more influential if they are implemented within well-defined settings, such as a Spanish-speaking church community or a mosque serving a West-African population. In this approach, BRAID circles may be led by community influencers who are well-known in that social setting. Lessons learned can be shared widely throughout the BRAID network, forming the foundation for a *Learning Health Care Community*.(51)

Our next step is to study the capacity of BRAIDers to disseminate accurate coproduced messages to their social networks. During our pilot work we learned that BRAIDers often encountered discord when sharing information. To help prepare future BRAID cohorts to navigate potentially contentious interactions, we adopted MI training for Community BRAIDers. (see highlights in Table 5). In the future, we will continue to evolve communication skills training and tools to increase BRAIDER self-confidence and self-efficacy in sharing information.

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Table 1: BRAID model roles and responsibilities

Role	Stakeholder Description	Responsibilities
Strands	Community Based Organizations (i.e. Faith-Based Organizations, Community Centers, Schools, Food Pantries, Libraries, Barber Shops, etc.)	<ul style="list-style-type: none"> Identify and invite community members who are already trusted messengers within their communities to participate in BRAID conversation circles Provide administrative and technical support to operationalize BRAID circles CBO staff can be trained as BRAID conversation circle facilitators
Community Experts	Community Members who are viewed as “trusted messengers” in their community (i.e. Community- and faith-based leaders, community center staff or patrons, teachers, library staff and patrons, food pantry staff and patrons, elected officials, barbers or hairdressers, shelter staff or patrons)	<ul style="list-style-type: none"> Participate in BRAID conversation circles and share their expertise about circulating health beliefs and “what matters” most to their community Provide feedback on how accurate information may be received by the community Contribute to codesign and coproduction of health messages that would be acceptable to the community
Scientists & Clinicians	Clinical, scientific and public health experts who are able to effectively communicate and relate to the community. They may be affiliated with the local academic medical center or departments of health.	<ul style="list-style-type: none"> Participate in conversation circles when invited, to listen and learn about <i>what matters</i> to the community Share up to date accurate information and/or data about the vaccine, or other area of focus, using lay terms Use person centered communication skills to share information and check for audience understanding Connect with community participants on a personal level to establish commonalities and build trust
BRAIDers	Community experts who have participated in BRAID conversation circles and have transitioned to disseminate accurate information to their social networks.	<ul style="list-style-type: none"> Disseminate co-produced health messages through social networks Participate in BRAID network activities Help identify and recruit trusted messengers within their social networks to participate in BRAID
Facilitators	Individuals with strong group facilitation skills including research team members, CBO leadership or staff, or current BRAIDers.	<ul style="list-style-type: none"> Orient community participants and invited clinicians and scientists to BRAID processes Facilitate conversation circle dialogues using motivational interviewing skills (i.e. reflective listening) to evoke what matters most to the community Maintain BRAID parking lot of community expert’s questions and concerns Guide community experts as they prioritize future BRAID circle agenda topics and determine whether to invite clinical and scientific experts to follow-up circles Coordinate with the health system to invite the appropriate clinicians and scientists to follow-up circles

Table 2: Differences between BRAID Conversation Circles, Focus Groups and Town Halls

	BRAID Conversation Circle	Focus Group	Town Hall
Goal	To build trust with the community over time and engage them in co-design processes and dissemination	To gather information from participants based on what the investigators want to understand	To share information with community and answer their specific questions
Approach/ Design	Community Directed & Collaborative Community Experts set the agenda and drive the conversation. <ul style="list-style-type: none"> Health messages are co-developed with the community and scientific/medical experts 	Investigator Directed <ul style="list-style-type: none"> Investigators drive the interview to gather information from participants based on what the investigators want to understand 	Leader Directed <ul style="list-style-type: none"> Leaders usually decide the agenda and direct the flow of information, usually from the top down. Leaders/moderators may elicit attendee feedback on the information shared.
Participants	Community Experts: <ul style="list-style-type: none"> Respected and trusted community members from target community or affinity group Positioned to rapidly disseminate accurate information downstream to other community members through their established social networks. 	Community Members: <ul style="list-style-type: none"> Representative of target community but may or may not be well connected and/or trusted Not positioned to or tasked with disseminating information. 	Community Members/ Constituents: <ul style="list-style-type: none"> Open to all members of community, even those who are not well connected and/or trusted May not be positioned to or tasked with disseminating information.
Compensation	<ul style="list-style-type: none"> Participants are compensated for sharing their expertise about their community and for participating in co-design processes 	<ul style="list-style-type: none"> Participants receive incentives for participating in research study 	<ul style="list-style-type: none"> Participants are usually not compensated for attending
Facilitation Style	Conversational Guiding Style <ul style="list-style-type: none"> Open-ended questions to elicit what matters most to the community Reflective listening statements Clinicians and scientists “ask permission” before sharing information or advice. Bilateral communication <ul style="list-style-type: none"> Community questions and concerns are addressed by clinical experts using lay-terms and/or collected (parking lot) to be answered later 	Question/Answer <ul style="list-style-type: none"> Scripted or semi-scripted questions used to direct conversation Participants respond to prompts/questions Unilateral communication <ul style="list-style-type: none"> Participant concerns and questions are collected but usually not answered or addressed, directly 	Open Forum <ul style="list-style-type: none"> Planned presentation usually followed by community Q&A Not all participants get a chance to raise concerns or questions Bilateral communication <ul style="list-style-type: none"> Community questions and concerns may be addressed by expert panelists who may not use lay language/terms. Questions that cannot be answered during the forums usually remain unanswered
Structure	<ul style="list-style-type: none"> 6-10 participants Group meets multiple times for 60-120 minutes Participants have a central and active role during and after meeting <ul style="list-style-type: none"> Share co-designed messages downstream 	<ul style="list-style-type: none"> 6-12 participants Group meets once usually for 60-90 minutes Participant involvement in research is limited and ends after meeting 	<ul style="list-style-type: none"> Large groups can be 100+ Group meets between 1- multiple times -may consist of same or different members Participants may not be tasked with any action after the townhall.
Dissemination	<ul style="list-style-type: none"> Participants empowered to share co-designed curated messages through their social networks (2-4 weeks) 	<ul style="list-style-type: none"> Researchers conduct focus groups until they have collected enough data to offer “insights into the attitudes, perceptions, and opinions of 	<ul style="list-style-type: none"> Some information is shared with stakeholders and decision-makers to inform or change policy. (3-6 months)

	<ul style="list-style-type: none">• Participants help recruit additional trusted messengers - (BRAIDers)	participants," data is analyzed and reported or published (2-6 months)	
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Table 3. BRAID Participant Characteristics

Participant characteristics	Total (%) (n=22)	Mean (SD)
Age (y) range 18-64		35.21 (16.69)
18-34	11(50)	
35-54	4 (18)	
55 and older	4 (18)	
missing	3 (14)	
Gender		
Male	13(59)	
Race/Ethnicity		
African American/Black	13(59)	
Hispanic/Latinx ^a	8(36)	
Other	1(5)	
Received Vaccine at time of first circle^b		
Yes	14(64)	
No	8(36)	
Number of BRAID Sessions attended^c		2.72 (1.22)
1-2	15(68)	
3-5	7(32)	

Abbreviation: BRAID, bridging research accurate information and dissemination.

^athree participants in the Hispanic/Latinx category also identified as African American/Black race. None of the other participants in the Hispanic/Latinx identified a race.

^bBased on self-report of having received at least one dose of the COVID-19 vaccination at time of orientation circle

^cNumber of BRAID sessions attended per individual participant, out of a maximum of 5 sessions offered

Table 4. BRAID Pre and Post Session Survey Responses

BRAID Survey Responses^a	N=21 (%)
Pre-BRAID	
How comfortable do you feel sharing your point of view and concerns in the group today? ^b	
Extremely/quite comfortable	15 (71)
Slightly/somewhat/not comfortable	6 (29)
How comfortable do you feel in sharing information about COVID-19 with your own personal networks? ^b	
Extremely/quite comfortable	11(52)
Slightly/somewhat comfortable/not comfortable	10 (48)
Post-BRAID	
How comfortable did you feel in voicing your point of view and concerns today? ^b	
Extremely/quite comfortable	20 (95)
Slightly/somewhat comfortable	1 (5)
How comfortable do you feel in sharing information about COVID-19 with your own personal network? ^b	
Extremely/quite comfortable	19 (91)
Slightly/somewhat comfortable	2 (9)
During the meeting I felt respected as a subject matter expert in what matters most to my community ^c	
Strongly agree/agree	19 (91)
Neither agree nor disagree/disagree	2 (9)
Participation in BRAID conversation circles improved my comfort and confidence to share accurate information about COVID-19 with my community and/or social network ^c	
Strongly agree/agree	19 (91)
Neither agree or disagree/disagree	2 (10)
I intend to share information about the Covid-19 vaccine with my community and/or personal network this week ^c	
Strongly agree/agree	20 (95)
Neither agree or disagree/disagree	1(5)
Participation in the Conversation circles improved my trust if the healthcare system ^{c, d}	
Strongly agree/agree	17 (81)
Neither agree nor disagree	3 (14)
Participation in the Conversation circles improved my trust of research ^c	
Strongly agree/agree	18 (86)
Neither agree nor disagree	3 (14)

Abbreviation: BRAID (Bridging Research Accurate Information and Dialogue).


^aSelected items from pre and post BRAID surveys, pre survey results are based on the earliest survey completed and post results are based on the latest post response based on the N=21 participants with pre/ post survey data

^bResponses collapsed from the following 5-point scale: extremely comfortable; quite comfortable; somewhat comfortable; slightly comfortable; not comfortable at all

^cResponses collapsed from the following 5-point scale: strongly agree; agree; neither agree nor disagree; disagree; strongly disagree

^dIncludes one missing response, N=20

Table 5: Examples of Motivational Interviewing Communication Skills Training for BRAIDers

Use ASK-TELL-ASK (Elicit-Provide- Elicit) when sharing accurate information or advice		
Skill	Example	
ASK (elicit) <ul style="list-style-type: none"> • Permission to share information or advice • What they already know or want to know 	<p><i>“Would it be OK to share some information about how what happened in Tuskegee led to strict protections being put into place to ensure that what happened then would never happen again”</i></p> <p><i>“Tell me a bit about what you know about how research participants are protected today so Tuskegee can never be repeated.”</i></p>	
TELL (provide) <ul style="list-style-type: none"> • Limited amount of information in clear language 	<p><i>“Because of what happened in Tuskegee the Belmont report was creates which put strict protections in place for research participants”</i></p>	
ASK (elicit) <ul style="list-style-type: none"> • What they think of what you said or • Teach back to check for understanding 	<p><i>“What are your thoughts about what we just discussed?”</i></p> <p><i>“Could you tell me back what we just talked about to see if I was able to make it clear?”</i></p> <p><i>“If a friend or family member asked you to tell them about what you learned about safety measures to protect participants in clinical trials, what would you say?”</i></p>	
Use Reflective Listening Skills when responding to community members’ concerns. <i>This demonstrates that you are actively listening and trying to understand their perspective.</i>		
 <p><i>Community Member Statement</i></p>	Examples of Reflective Listening Statements	Type of Reflection
	<i>“You don’t want to be experimented on.”</i>	Simple reflection
	<i>“You don’t trust research because of what happened in the past”</i>	Take a guess
	<i>“You are concerned that by participating in research you may be putting yourself at risk”</i>	Paraphrase and continue
	<i>“You are angry about the injustices of the past”</i>	Reflect an emotion
<i>“You would NEVER participate in a research study”</i>	Amplified negative reflection	