



Improving African American Participation in U.S. Oncology Trials Through Community Partnerships, Trusted Messengers, and Decentralized Clinical Recruitment Strategies

Deryl Hasbifa

Independent Researcher, USA

DOI : <https://doi.org/10.55248/gengpi.07.1026.3302>

ABSTRACT :

Equitable participation in oncology trials is essential for generating evidence that reflects population diversity and supports fair access to emerging cancer therapies. In the United States, African American participation remains constrained by structural exclusion, unequal referral opportunities, financial burdens, geographic barriers, and mistrust associated with historical and ongoing discrimination. This proposed narrative review examines how community partnerships, trusted messengers, and decentralized recruitment strategies can address these interconnected challenges. The review will synthesize literature on partnerships with community organizations, churches, patient advocates, and local healthcare providers; communication delivered by trusted clinicians and community leaders; and recruitment models incorporating remote consent, telehealth, satellite clinics, and navigation support. Particular attention will be given to institutional accountability, culturally responsive communication, transparent eligibility criteria, and practical assistance with transportation, childcare, and digital access. A multilevel framework will connect community engagement with clinical referral practices and trial design, emphasizing shared governance and sustained relationships. Evaluation priorities will include recruitment, enrollment, retention, participant experience, and representativeness. The review aims to inform strategies that expand participation while safeguarding informed consent, reducing participation burdens, and strengthening equitable research access.

Keywords: African Americans; Oncology clinical trials; Community partnerships; Trusted messengers; Decentralized recruitment; Health equity.

1. INTRODUCTION

1.1 Oncology trials, representative evidence, and equitable access

Oncology clinical trials provide evidence for evaluating treatment efficacy, identifying adverse events, and establishing standards of cancer care [1]. Their clinical usefulness depends partly on whether enrolled participants reflect the populations who will receive the interventions [3]. Inclusive eligibility and enrollment practices therefore strengthen the relevance of evidence across differences in age, comorbidity, geography, and social circumstances [1]. Representative participation also concerns equitable opportunities to consider investigational treatments, although participation does not guarantee therapeutic benefit.

For African American patients, exclusion from research can restrict both participation opportunities and the evidence available to guide care [3]. Addressing this problem requires separating racial classification from biological explanation [2]. Race is a social construct, not a reliable substitute for genetic ancestry, individual tumor characteristics, or environmental exposures [2]. Accordingly, recruitment disparities should be examined through healthcare access, institutional practices, and lived conditions rather than attributed to presumed inherent racial differences in treatment response or willingness to participate [4].

1.2 African American participation and the recruitment challenge

Evidence from registration trials illustrates the scale and context of underrepresentation [3]. Loree and colleagues examined trials supporting U.S. Food and Drug Administration oncology approvals between July 2008 and June 2018, spanning solid tumors and hematological malignancies [3]. Among trials reporting Black participation, Black patients constituted 3.1% of participants, equivalent to 22% of their expected representation based on U.S. cancer incidence [3]. These findings describe an approval cohort, including internationally recruited trials, rather than current enrollment across all American oncology research [3].

Understanding this disparity requires following the pathway preceding enrollment [4]. Patients must access oncology care, encounter an available trial, satisfy eligibility requirements, receive referral, and be offered participation [4]. A systematic review identified trial unavailability and ineligibility as major barriers [4]. Importantly, another meta-analysis found similar agreement rates among Black and White patients when participation was offered [5]. Low enrollment therefore cannot establish unwillingness [5]. It may instead reflect missed opportunities, restrictive processes, and practical

burdens that remain invisible when institutions measure recruitment success solely through final enrollment totals rather than the preceding pathway [4].

1.3 Review objective, scope, and central argument

This narrative review examines community partnerships, trusted messengers, and decentralized recruitment as complementary approaches to improving African American participation in adult U.S. oncology trials. Navigation research supports addressing practical barriers alongside recruitment [6], while a culturally tailored breast cancer video intervention provides preliminary evidence for communication approaches [7]. Broader clinical research guidance will inform transferable implementation principles, with contextual differences identified explicitly [8].

The central proposition is that credible relationships must be matched by institutional arrangements that make participation feasible. Decentralized elements, including remote visits and local healthcare activities, offer potential flexibility but require appropriate oversight [9]. The review therefore connects community engagement, informed decision support, and accessible trial delivery within a multilevel framework. The following section explains how relevant evidence is identified, selected, and interpreted to develop this framework.

2. NARRATIVE REVIEW APPROACH

2.1 Review questions and conceptual boundaries

Three questions guide this review: which barriers restrict African American patients' opportunities to enter oncology trials; how community partnerships, trusted messengers, and decentralized strategies address those barriers; and which implementation conditions and outcomes should guide evaluation. Recruitment encompasses identifying, informing, and inviting potential participants; enrollment denotes entering a trial; retention concerns continued participation, as illustrated by navigation research [6]. Communication interventions are examined separately from enrollment outcomes [7]. Decentralization means selected activities conducted remotely or nearer participants, not necessarily replacing specialist centers [9]. These boundaries support a narrative synthesis with explicit objectives and appropriately qualified interpretations of available evidence [10].

2.2 Literature identification and selection

Evidence identification used targeted web searches on 11 October 2026 to locate PubMed records, accessible full texts in PubMed Central, publisher articles, and FDA guidance. PubMed and PubMed Central functioned as retrieval sources; direct database searches were not conducted. Searches combined phrases concerning Black or African American participation, cancer clinical trials, patient navigation, community partnerships, culturally tailored communication, and decentralized clinical trials. Additional searches located narrative review and implementation evaluation guidance.

Selection prioritized peer-reviewed U.S. oncology studies addressing participation barriers or recruitment interventions, including navigation research [6] and a breast cancer communication intervention [7]. Relevant FDA guidance informed institutional planning [8] and decentralized delivery [9]. Evidence from other research settings was considered for transferable methodological concepts, with contextual differences acknowledged. No exhaustive retrieval, duplicate independent screening, or systematic review designation is claimed [11]. This targeted approach supports transparent narrative interpretation while leaving database coverage and reproducibility limited within the present manuscript draft.

2.3 Evidence interpretation and limitations

Findings will be organized by barrier, intervention mechanism, implementation setting, and reported outcome. Empirical evaluations will be distinguished from conceptual recommendations, and enrollment outcomes separated from acceptability, feasibility, adoption, and sustainability [12]. Interpretation will consider study design, comparison groups, population characteristics, intervention definitions, and follow-up duration [10]. Reach and implementation context will inform judgments about transferability [13]. Framework use alone will not establish intervention effectiveness [14]. Heterogeneous measures and selected evidence preclude pooled causal conclusions. Documented effects and plausible mechanisms will therefore be reported separately, with uncertainty explicit. This framework guides the examination of exclusion across the oncology participation pathway.

3. MULTILEVEL BARRIERS TO PARTICIPATION

3.1 Institutional and clinical opportunity barriers

Institutional barriers arise before patients can express a preference about research participation. A suitable trial may be unavailable within the treating practice, while access to specialist centers may require referral beyond established care networks. Recruitment systems should therefore be evaluated for reach and organizational adoption, rather than judged exclusively by enrolled numbers [13].

Even when trials are available, referral can depend on clinician awareness, consultation time, research staffing, and discretionary judgments. Assuming that a patient cannot travel, understand consent, or adhere to visits may remove the opportunity to decide. A response is consistent screening of potentially eligible patients, documented referral decisions, and assistance offered before feasibility is presumed [21].

Eligibility requires similar scrutiny. Criteria protecting against foreseeable treatment toxicity or ensuring interpretable outcomes remain essential. However, exclusions involving stable comorbidities, previous malignancies, or treated brain metastases may warrant reconsideration when scientific justification is weak [15]. Broader eligibility should follow protocol-specific clinical assessment, not indiscriminate relaxation of safeguards [15]. Implementation must also distinguish adoption of screening procedures from their effectiveness in reducing exclusion [14]. Together, these measures

locate responsibility within research systems while preserving necessary clinical judgment and informed patient choice throughout recruitment.

3.2 Financial, geographic, and practical barriers

Financial and practical burdens can make an available trial inaccessible. Additional visits may generate transport expenses, parking charges, lodging costs, lost earnings, and demands on family members providing care. Treatment schedules can compound these pressures when research assessments require separate appointments. Recommendations for reducing financial barriers emphasize transparent costs and appropriate participant assistance [16]. Insurance coverage does not necessarily eliminate out-of-pocket expenses or indirect losses [16]. Patients need clear explanations of which services are research-funded, which involve routine care billing, and where uncertainty remains [16]. Household resources, paid leave, caregiving arrangements, and distance from trial sites determine how manageable these obligations become. Evidence from a financial assistance intervention suggests that travel and lodging support can reduce related concerns, without resolving overall financial hardship [17].

African American patients should not be treated as economically or geographically uniform. Assessment must identify individual needs rather than substitute racial assumptions for practical inquiry. Flexible scheduling, coordinated visits, and navigation should respond to documented circumstances. Their acceptability and feasibility also require evaluation alongside enrollment outcomes [12].

3.3 Institutional trustworthiness and communication barriers

Trust concerns must be understood within institutional relationships rather than framed as patient deficiencies. Historical research abuses can inform perceptions, while contemporary discrimination, unequal treatment, and inaccessible communication can reinforce doubt. Qualitative research with Black communities and cancer patients identifies communication, access, and institutional responsiveness as areas requiring improvement [18]. Institutions must therefore demonstrate trustworthiness through transparent explanations, reliable follow-up, respectful care, and accountability when concerns are raised [18].

Consent conversations introduce challenges. Unfamiliar terms may obscure the distinction between research and individualized treatment. Therapeutic misconception occurs when participants misunderstand the knowledge-generating purpose of research, even when personal benefit remains possible [19]. Randomization should be explained as assignment according to the protocol, not selection of the treatment presumed best for an individual [19]. Patients also need information about alternatives, potential harms, costs, and withdrawal.

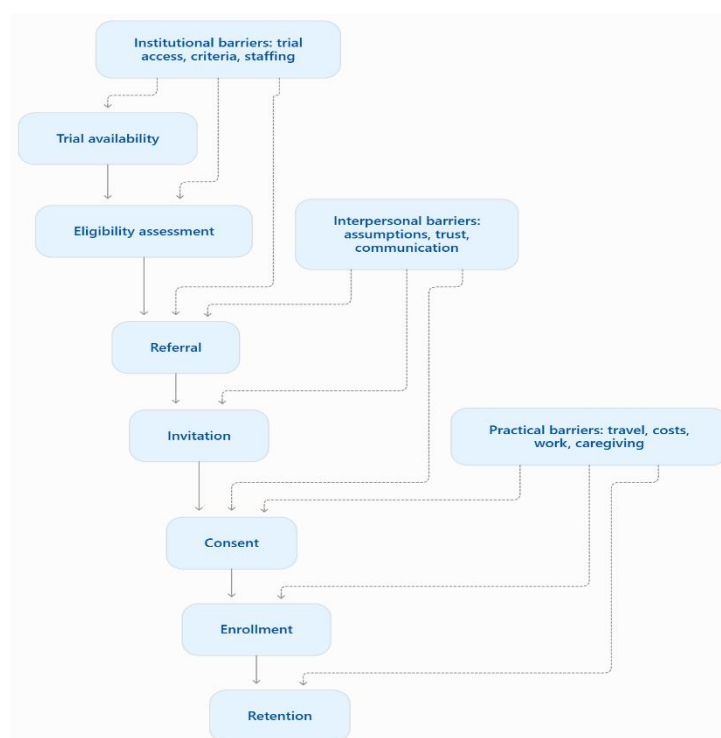
Providing information alone does not establish comprehension. Questions, teach-back, and opportunities for deliberation should support voluntary decisions. Communication should invite concerns without assuming that all African American patients share identical experiences, preferences, or reasons for declining participation [18].

3.4 Interacting barriers across the recruitment pathway

These barriers interact across the participation pathway. A patient may understand a trial and wish to enroll yet lack transport for repeated visits. Another may live near a specialist center but never receive an eligibility assessment or referral. Consequently, communication, navigation, and institutional process changes must be considered together [18].

An isolated intervention can improve one stage while leaving subsequent exclusions intact. Remote invitations cannot overcome unjustified eligibility restrictions, and travel reimbursement cannot correct missing referrals. Evaluation should examine reach across stages [13] and distinguish implementation success from participant outcomes [12]. Sustained community partnerships offer a mechanism for identifying overlooked barriers and shaping coordinated, evidence-informed responses. The next section examines how such relationships can improve recruitment conditions before individual enrollment decisions.

Figure 1. Multilevel barriers along the oncology trial participation pathway



4. COMMUNITY PARTNERSHIPS

4.1 Partnership development and shared governance

Community partnerships should connect research institutions with community health organizations, patient advocates, faith organizations, local clinicians, and cancer survivor groups. Their value lies in combining knowledge of local priorities with clinical and research expertise, rather than treating community networks as convenient recruitment channels [20]. Partner selection should consider relationships, experience, community reach, and perspectives absent from advisory structures [24].

Shared governance requires early involvement in defining recruitment priorities, reviewing participation burdens, and choosing acceptable engagement methods. PCORI's partnership expectations emphasize engagement, dedicated resources, compensation, and meaningful inclusion in decision-making [21]. Although developed for comparative effectiveness research, these principles offer transferable guidance for oncology recruitment.

Written agreements should specify responsibilities, decision-making authority, compensation arrangements, and procedures for resolving disagreements. Payment should recognize partners' time and expertise rather than depend on the number of participants recruited. Community representatives should help determine which decisions require consultation and which permit shared authority [21]. Sustained collaboration also requires contact between studies, discussion of findings, and responsiveness to criticism. Approaching organizations only when enrollment targets become difficult risks instrumental relationships that weaken credibility and limit opportunities for improvement.

4.2 Co-designing recruitment materials and pathways

Co-design translates partnership commitments into recruitment procedures. Partners can examine invitation language, consent explanations, outreach locations, appointment arrangements, and support services for relevance and accessibility. A community-academic study involving African American women illustrates how partnership can identify informational needs and appropriate outreach considerations [22]. Such evidence informs design without establishing that consultation improves enrollment.

Materials should explain research purpose, alternatives, uncertainty, and withdrawal without implying guaranteed therapeutic benefit [19]. Partners can identify confusing wording, culturally inappropriate assumptions, or communication channels that exclude residents. Suggested changes should undergo clinical and ethics review where required.

Feedback should include people who decline participation, using interviews, anonymous forms, or community discussions that preserve privacy. Declining feedback must remain acceptable and separate from clinical care. Teams should maintain a change log connecting recommendations to decisions: revised appointment times, clearer cost explanations, navigation access, or alternative contact methods. Reporting accepted and rejected suggestions, with reasons, demonstrates whether engagement influences practice rather than serving a role [21].

4.3 Connecting community engagement with clinical referral

Community engagement becomes actionable when outreach links to clinical teams. Local clinicians, navigators, and research coordinators should establish referral routes, responsibilities, and timelines for responding to inquiries. The NCI Community Oncology Research Program demonstrates an infrastructure for bringing cancer trials and care delivery research into community settings [23].

A referral pathway would record contact, permission to share information, clinical assessment, invitation, and enrollment decisions. Navigation can help patients coordinate appointments, identify transport needs, and communicate unresolved questions [25]. Tracking should identify where referrals stall while collecting only necessary information and protecting confidentiality.

Outreach staff should describe trials accurately and facilitate access, without promising eligibility, acceptance, or treatment benefit. Clinical teams retain responsibility for protocol-specific assessment; informed consent requires understanding that research differs from individualized care [19]. Community oncology practices need clear communication with specialist centers so that referral does not fragment treatment or leave patients uncertain about who manages clinical concerns.

4.4 Sustainability, accountability, and partnership risks

Sustainable partnerships require funding for coordination, partner compensation, training, and reporting beyond individual recruitment campaigns [21]. Teams should share accessible updates on decisions, participation experiences, and findings, while protecting confidentiality. Accountability includes explaining unmet commitments and identifying corrective actions [20].

Tokenistic engagement arises when organizations endorse recruitment but cannot influence its design. Representative involvement requires acknowledging differences within communities rather than appointing one organization to speak for all African American patients [24]. Table 1 connects partnership responses with communication and decentralized approaches. Partnerships establish channels for engagement; trusted messengers must then provide credible explanations and responsive answers. The next section examines that communication role and safeguards supporting voluntary, informed participation.

Table 1. Barrier-to-strategy mapping across the three recruitment approaches

Barrier	Community partnership response	Trusted messenger response	Decentralized response	Remaining implementation requirement
Limited awareness of trial opportunities	Co-design outreach with local organizations and survivor groups	Explain available opportunities and direct questions to research teams	Offer remote information sessions and preliminary contact	Maintain accurate trial information and accessible contact routes
Missing or inconsistent referrals	Connect community clinicians with trial teams	Encourage patients to ask about trial assessment	Facilitate remote consultations with specialist teams	Standardize screening, document decisions, and track referrals
Institutional mistrust	Share authority and demonstrate responsiveness to concerns	Discuss uncertainty, safeguards, and institutional responsibilities openly	Offer convenient contact options that preserve continuity	Establish accountability, confidentiality protections, and complaint procedures
Unclear research information	Review materials for relevance and clarity	Explain research purpose, randomization, alternatives, and withdrawal	Provide remote discussions with opportunities for questions	Assess comprehension and preserve voluntary decision-making
Travel and scheduling burdens	Identify locally relevant support needs	Explain available assistance without promising access	Use appropriate local assessments and remote follow-up	Ensure clinical suitability, coordination, funding, and participant choice
Digital exclusion	Identify preferred communication methods and access needs	Provide guidance and direct patients to technical support	Offer telephone and in-person alternatives	Supply accessible systems and support without requiring digital participation

5. TRUSTED MESSENGERS AND INFORMED DECISION-MAKING

5.1 Identifying credible messengers

Trusted messengers may include treating clinicians, community health workers, patient navigators, cancer survivors, and community leaders. Their roles should reflect patients' preferences and the questions being addressed. Community oncology networks provide clinical connections [23], while representative engagement requires acknowledging diverse experiences rather than assuming one messenger suits every patient [24].

Credibility depends on established relationships, relevant knowledge, transparent affiliations, and dependable responses. Navigators can connect communication with practical support [25], but clinical questions require qualified professionals. Survivors can describe personal experiences without implying that others will experience comparable outcomes.

Racial concordance may influence interactions, yet evidence does not justify treating shared racial identity as a guarantee of trust or communication quality [26]. Messenger selection should therefore combine participant choice with competence and accountability. Respectful listening and acknowledgment of uncertainty remain necessary regardless of whether patients and messengers share racial backgrounds.

5.2 Communicating trial participation clearly

Communication should explain the trial's scientific purpose, distinguish experimental treatment from established care, and describe foreseeable harms, potential benefits, and alternatives [27]. For randomized studies, patients need an explanation of assignment procedures and why researchers remain uncertain about comparative outcomes. Confidentiality protections, their limits, expected costs, and withdrawal rights should be addressed explicitly [27].

Plain language should replace unexplained terminology without removing clinically important distinctions. Teach-back asks patients to explain information in their own words, helping staff assess the clarity of their explanation rather than test patients' intelligence [28]. Misunderstandings should prompt rephrasing and further discussion [28].

Patients may need repeated conversations, written summaries, or opportunities to involve a chosen supporter. Staff should explain what is known, what remains uncertain, and who can answer unresolved questions. Expressions of hope must not become promises of therapeutic benefit [27]. Communication should also clarify which participation expenses are covered and whether withdrawal affects already collected data [27]. Understanding requires dialogue; a signed form alone cannot demonstrate an informed, voluntary decision free from inappropriate pressure [29].

5.3 Supporting decisions without undue influence

Decision support helps patients compare participation with available alternatives according to their values; it should not pursue enrollment regardless of preference. Consent must allow sufficient opportunity for consideration and minimize coercion or undue influence [29]. Messengers should disclose employment, research affiliations, and relevant incentives so patients can interpret their role.

Social standing, religious authority, or personal relationships must not be used to create obligations to participate. The Belmont Report identifies manipulation through controlling relationships as a threat to voluntary choice [30]. Patients should hear that refusal will not remove care or benefits to which they are entitled [29].

Central and local teams need responsibilities for scheduling, laboratory interpretation, adverse event reporting, medication reconciliation, and communication with participants. Remote technologies require suitability assessment and reliable data processes [32]. Written plans should specify how abnormal findings trigger escalation and who remains accountable for clinical decisions. Participants should receive contact details and understand where urgent concerns belong. Bringing activities closer to home must reduce burden without weakening monitoring or creating uncertainty about responsibility across participating care settings and research teams.

6.3 Digital inclusion and practical assistance

Digital inclusion requires more than making a platform available. Internet reliability, device access, digital confidence, disability accommodations, and opportunities for private communication can shape participation. Recommendations for equitable decentralized research emphasize designing around participants' circumstances rather than assuming universal digital access [34]. Technology selection should consider usability, training, and ongoing support [32].

Programs should offer telephone or in-person alternatives wherever clinically and operationally appropriate. Loaned devices, connectivity assistance, accessible interfaces, and technical help may support participation, but patients should not bear responsibility for resolving system failures [34]. Preferences should be reassessed when illness or treatment changes practical capabilities.

Digital access also does not eliminate lost earnings, transport needs, caregiving demands, or costs associated with remaining clinic visits. Decentralization should therefore complement flexible scheduling, navigation, transportation assistance, and reimbursement. Research using telehealth and local treatment illustrates possible reductions in travel burdens [33], while broader equity recommendations support assessing remaining access barriers [34]. Assistance should respond to documented needs without implying that acceptance creates an obligation to enroll or remain in research [29].

6.4 Operational limitations and safeguards

Operational challenges include data privacy, fragmented records, staffing requirements, coordination costs, and technical failures. Digital data collection requires clear access controls, appropriate systems, and explanations of how information is collected and used [32]. Teams must also identify whether remote procedures shift unpaid tasks onto participants or caregivers [34].

Hybrid options should reflect clinical requirements and individual preferences, allowing appropriate movement between remote and in-person contact. Convenience should not be equated with equitable enrollment. A survey examining decentralization tools measured reported likelihood of participation rather than demonstrating increased enrollment among African American patients [35]. Evaluation therefore needs pathway outcomes, participant burden, and subgroup comparisons.

These limitations reinforce the need for coordinated implementation. Community partnerships, trusted communication, and flexible delivery should operate within one program with defined responsibilities, resources, and measurable outcomes. The next section develops that integrated implementation and evaluation framework.

7. INTEGRATED IMPLEMENTATION AND EVALUATION FRAMEWORK

7.1 Combining the approaches into a recruitment model

An integrated recruitment model should assign functions rather than require every partner to perform every task. Community partners identify priorities, review outreach, and highlight burdens. Trusted messengers support understanding and questions. Clinical teams apply consistent eligibility assessment and referral procedures, while decentralized arrangements reduce avoidable travel and scheduling demands [34].

Institutions remain responsible for funding coordination, compensating partners, maintaining referral systems, and providing navigation and technical support. A named program lead should oversee communication between teams, document responses to community feedback, and ensure that unresolved clinical concerns reach qualified staff. Implementation planning should examine organizational capacity, external conditions, participant needs, and the fit between proposed procedures and existing workflows [36].

Figure 3 represents a framework, not a validated causal model. Its feedback loop connects participant experience with program revision. Reported willingness to use decentralized tools should inform design without being substituted for observed enrollment [35]. Institutions should review where opportunities are lost and adapt procedures accordingly. The model therefore combines relationship building with accountability, making equitable access a responsibility distributed across the research organization rather than assigned to community representatives.

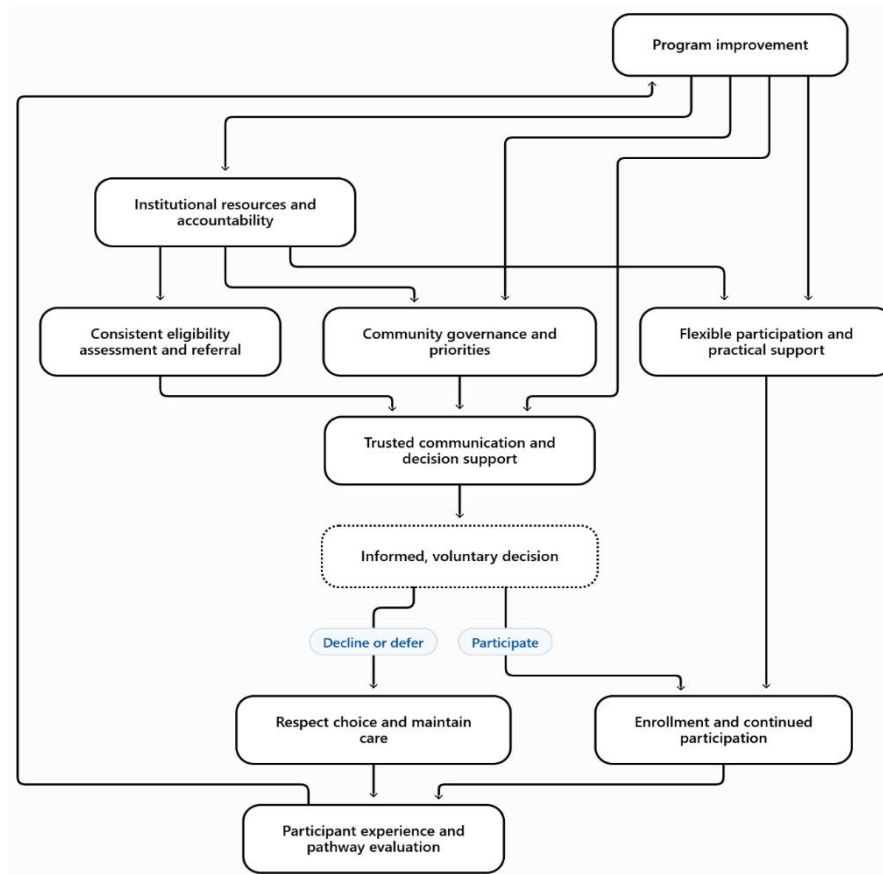


Figure 3. Integrated multilevel recruitment and participation framework

The framework proposes coordinated responsibilities and feedback. Arrows indicate operational relationships rather than established causal effects; informed decisions may also lead to declining participation.

7.2 Measuring equitable opportunities and outcomes

Evaluation should follow defined cohorts through assessment, preliminary eligibility, confirmed eligibility, invitation, consent, enrollment, and retention. Each proportion requires an explicit denominator and observation period. For example, invitation should be measured among confirmed eligible patients, while enrollment should be reported among those invited and those consenting. Documented exceptions and missing records require separate reporting.

Race and ethnicity data should use collection procedures, with categories and missingness explained [37]. Comparisons should also consider age, sex, cancer type, geography, and socioeconomic measures where sample sizes permit. Equity reporting requires describing relevant population characteristics and the circumstances influencing access [38]. Race alone should not be treated as an explanation for differences.

Assessment should include comprehension, perceived respect, participation burden, and optional reasons for declining or withdrawing. Small subgroup estimates need uncertainty intervals and privacy safeguards. Table 2 specifies indicators and responsibilities. Enrollment totals cannot establish equity when institutions do not know who was assessed, excluded, or never invited. Interpretation should therefore connect outcomes to pathway opportunities and context, while avoiding unsupported conclusions from incomplete demographic data or uncontrolled comparisons across differing patient populations.

Table 2. Implementation and evaluation indicators

Pathway stage	Indicator	Denominator or measurement method	Data source	Interpretation	Responsible team
Assessment	Screening coverage	Patients assessed ÷ patients in the predefined screening population	Clinic roster and screening log	Identifies patients overlooked before eligibility assessment	Clinical team and data staff
Preliminary eligibility	Potential eligibility	Potentially eligible patients ÷ patients assessed	Preliminary screening records	Describes screening yield; does not establish final suitability	Research coordinator
Confirmed eligibility	Eligibility confirmation	Confirmed eligible patients ÷ potentially eligible patients completing assessment; report incomplete assessments separately	Protocol assessment and clinical records	Identifies clinical exclusions and assessment losses	Investigator and clinical team

Pathway stage	Indicator	Denominator or measurement method	Data source	Interpretation	Responsible team
Invitation	Invitation coverage	Eligible patients invited ÷ confirmed eligible patients	Invitation and referral logs	Detects missed opportunities to offer participation	Clinical team and recruitment lead
Consent	Agreement to participate	Patients consenting ÷ patients invited	Consent records and optional decline feedback	Reflects decisions after invitation; requires comprehension and voluntariness assessment	Consent team
Enrollment	Enrollment conversion	Enrolled patients ÷ invited patients; also enrolled ÷ consenting patients	Trial enrollment database	Distinguishes recruitment outcomes from losses after consent	Trial coordinator
Retention	Continued participation	Participants meeting a predefined retention criterion at a specified time ÷ the corresponding enrollment cohort	Follow-up and discontinuation records	Separate withdrawal, loss to follow-up, progression, death, and planned completion	Follow-up team
Participant experience	Understanding, respect, confidence, and burden	Defined questionnaires, teach-back assessments, and optional interviews; report response rates	Participant feedback	Assesses decision quality and participation experience beyond enrollment	Evaluation team and community partners
Program delivery	Costs and responsiveness	Staff time, expenditure, support delivered, and feedback actions completed	Budgets, service logs, and decision records	Assesses feasibility, resource needs, and accountability	Program lead and institutional management

7.3 Implementation priorities and research gaps

Implementation should proceed in stages: assess local barriers, establish compensated partnerships, redesign referral and communication procedures, introduce clinically suitable participation options, and evaluate outcomes. Early pilots should test workflow feasibility and participant experience before wider adoption. Complex intervention guidance emphasizes context, program theory, stakeholder involvement, and iterative refinement [39].

Research gaps include comparative effectiveness, sustained retention, implementation costs, rural access, and variation across cancer populations. Studies should assess whether combined approaches improve opportunities for African American patients rather than merely increase overall enrollment. Transparent reporting of equity considerations remains important because trial reports can inadequately describe disadvantaged populations and relevant hypotheses [40].

Attribution presents difficulties. Changes in trial availability, staffing, eligibility, disease mix, or concurrent support programs may confound observed enrollment trends. Combined interventions also make individual component effects difficult to isolate [39]. Comparative designs, process evaluation, and economic assessment can clarify mechanisms and resource requirements.

This narrative review relies on targeted retrieval rather than exhaustive searching. Accordingly, guidance-supported practices and promising empirical findings must be distinguished from untested framework assumptions. Its practical implication is coordinated, accountable implementation, which the conclusion consolidates without treating the proposed model as established evidence.

8. CONCLUSION

8.1 Synthesis of the central argument

Improving African American participation in U.S. oncology trials requires attention to opportunity, informed choice, and practical feasibility. Community partnerships help identify local priorities and shape recruitment procedures. Trusted messengers support understanding through credible explanations, respectful dialogue, and acknowledgment of uncertainty. Decentralized arrangements can reduce selected travel and scheduling burdens when clinically appropriate. These approaches address interconnected conditions; none can independently resolve every source of exclusion.

Institutional accountability connects their contributions through adequate funding, consistent referral practices, coordinated support, and responsiveness to participant feedback. Research organizations must earn trust through their conduct rather than expect community relationships to compensate for inaccessible systems. Patients must remain free to decline or withdraw without pressure, while retaining care and benefits to which they are entitled.

8.2 Implications for oncology research practice

Research organizations should establish sustained community relationships, standardize opportunities for eligibility assessment and referral, provide credible decision support, and reduce avoidable participation burdens. Implementation should reflect local conditions, clinical requirements, and individual preferences, with responsibilities assigned across research and care teams.

Evaluation should track opportunities throughout the participation pathway and assess comprehension, respect, burden, and retention. Success means more equitable access to research consideration and better participant experiences, demonstrated through transparent evaluation rather than recruitment totals alone or presumed intervention effectiveness.

REFERENCE :

- Ladega-Adekeye, I. O., Ogunbayo, O. E., Olasunkanmi, A., & Temitope, O. J. (2026). Effectiveness of Noise Exposure and Hearing Conservation Programs among Construction Workers in Nigeria. *European Journal of Innovative Studies and Sustainability*, 2(2), 135–143. [https://doi.org/10.59324/ejiss.2026.2\(2\).09](https://doi.org/10.59324/ejiss.2026.2(2).09)
- Bejerano-Blázquez I, Familiar-Cabero M. On the Application of Artificial Intelligence and Cloud-Native Computing to Clinical Research Information Systems: A Systematic Literature Review. *Information*. 2025 Aug 10;16(8):684.
- Rhodes CD. *Culturally Responsive Academic Curricula for Schools and Communities: Addressing the Prevention and Interruption of Gun Violence Among African American Males* (Doctoral dissertation, Fielding Graduate University).
- Salehzadeh Niksirat K, Munyendo CW, Batista Leal Neto O, Katya M, Kouassi C, Ochieng K, Georgina A, Olayo B, Barras JP, Cattuto C, Aviv AJ. Reimagining Wearable-Based Digital Contact Tracing: Insights from Kenya and Côte d'Ivoire. In *Proceedings of the 2025 CHI Conference on Human Factors in Computing Systems* 2025 Apr 26 (pp. 1-23).
- Ogunbayo OE. Residential radon and public health in Springfield, Illinois: risk communication, policy gaps, and mitigation strategies. *IOSR Journal of Environmental Science, Toxicology and Food Technology*. 2026 Aug;20(8 Ser 1):60-74. doi:10.9790/2402-2008016074.
- Doubeni CB, Franco Z, Ahmed S, Karuppana S, Gorfine M, Cohn E. Building and strengthening organizational capabilities for community engagement. *Principles of community engagement*. 2025:69-94.
- Reynolds NR, Baker D, D'Aoust R, Docal M, Goldstein N, Grubb L, Hladek MD, Koirala B, Kverno K, Ling C, Lukkahatai N. COVID-19: implications for nursing and health care in the United States. *Journal of nursing scholarship*. 2023 Jan;55(1):187-201.
- Bhetwal S, Bastakoti R, Acharya N, Gupta GK, Bhandari AB. Benchmarking Local LLMs for Natural-Language-to-SQL Querying in Biopharmaceutical Manufacturing: An Empirical Benchmark on Consumer-Grade Hardware. *arXiv preprint arXiv:2606.01338*. 2026 May 31.
- López JM. *Clinical Trials: A Comprehensive Introduction for Beginners*. Juan Manuel Fernández López; 2025 Oct 24.
- Monnard K, Benjamins MR, Hirschtick JL, Castro M, Roesch PT. Co-creation of knowledge: a community-based approach to multilevel dissemination of health information. *Health promotion practice*. 2021 Mar;22(2):215-23.
- Kerkhoff AD, West NS, del Mar Castro M, Branigan D, Christopher DJ, Denkinger CM, Nhung NV, Theron G, Worodria W, Yu C, Muyoyeta M. Placing the values and preferences of people most affected by TB at the center of screening and testing: an approach for reaching the unreached. *BMC Global and Public Health*. 2023 Nov 21;1(1):27.
- Asante, A., Daramola, G., Davis, R. W., & Kumar, S. (2025). Environmentally Friendly Chelation for Enhanced Algal Biomass Deashing. *Phycology*, 5(3), 32. <https://doi.org/10.3390/phyecology5030032>
- Westbrook G, Hollen H, Naqvi O, Neuwald S, Hann N, Cox G, McFerron P, Wendelboe A, Bratzler DW. Achieving a healthy Oklahoma: cross-sector cooperation to improve public health preparedness and pandemic response. *Health security*. 2023 Oct 1;21(5):358-70.
- Chatio ST, Darko N, Zakariah-Akoto S, Willis A, A Nonterah E, R Jones C, Alale Aweeya J, Curtis F, Kunutsor S, Seidu S, O Ansah P. Community acceptability of cardiovascular risk screening in faith centres in the Kassena-Nankana districts of Northern Ghana: a qualitative study. *BMC public health*. 2025 Nov 5;25(1):3792.
- Samuel Addo. Causal AI for strategic business planning: uncovering latent drivers of long-term organizational performance and resilience. *World Journal of Advanced Research and Reviews*, 2025, 26(2), 895-912. Article DOI: <https://doi.org/10.30574/wjarr.2025.26.2.1738>
- Nyagabona SK, Haddadi S, Mtei RJ, Sunguya B, Kahesa C, Pallangyo CK, Wang CC, Van Loon K, Mmbaga EJ. Paving the Way for an Integrated Care Model: Experiences of Women Living With HIV and Breast Cancer in Tanzania. *JCO Global Oncology*. 2025 Dec;11:e2500330.
- Castellon-Lopez YM, Carson SL, Mansfield L, Garrison NA, Barron J, Morris DA, Ntekume E, Vassar SD, Norris KC, Brown AF, Casillas A. "The system doesn't let us in"—a call for inclusive COVID-19 vaccine outreach rooted in Los Angeles Latinos' experience of pandemic hardships and inequities. *International Journal of Environmental Research and Public Health*. 2022 May 10;19(10):5785.
- Doxzen KW, Adair JE, Fonseca Bazzo YM, Bukini D, Cornetta K, Dalal V, Guerino-Cunha RL, Hongeng S, Jotwani G, Kityo-Mutululuza C, Lakshmanan K. The translational gap for gene therapies in low-and middle-income countries. *Science translational medicine*. 2024 May 8;16(746):eadn1902.
- Ogunbayo O, Ajayi RO, Nasiru SO, Ajao OA. Environmental and public health effects of paraquat dichloride in the United States: a scoping review of environmental fate, exposure, poisoning, and health outcomes. *International Journal of Agriculture Environment and Bioresearch*. 2026;11(4):88-107. doi:10.35410/IJAEB.2026.1069.
- Bocchieri M, Craig R, Zhang X, Firestine AM, Long MD, Kappelman MD. Racial and ethnic differences in the degree of participation and retention in a decentralized cohort study of COVID-19 immunization in patients with inflammatory bowel diseases. *Journal of Clinical and Translational Science*. 2024 Jan;8(1):e31.
- Santoro E, Ascione R, Festa M, Maruti I, Ravot E. Decentralized Clinical Trials: experience and examples. *Tendenze*. 2022 Jun:69.
- Datar R. *Development of a Core Outcome Set for Studies Investigating Safety, Efficacy, and Implementation of COVID-19 Vaccines: A Collaboration with African American/Black Communities in Baltimore City, Maryland* (Doctoral dissertation, University of Maryland, College Park).
- Bhandari, A. B. (2026). Quality Control Frameworks for Electronic Health Record Data Workflows in Resource-Constrained Settings: A Structured Review with Implications for Global Health Information Management. *Current Journal of Applied Science and Technology*, 45(8), 1–16. <https://doi.org/10.9734/cjast/2026/v45i84728>
- Luningham JM, Akpan IN, Alkhatib S, Taskin T, Desai P, Vishwanatha JK, Thompson EL. COVID-19 clinical trial participation and awareness in Texas. *Human Vaccines & Immunotherapeutics*. 2024 Dec 31;20(1):2340692.
- Bouranis NG. Factors affecting clinical research enrollment among individuals with Alzheimer's Disease and related dementias. Portland State University; 2020.
- Oluwatobi Alebiosu. Comparative analysis of public-private partnership legislation driving electricity infrastructure expansion, renewable

- energy investment, and economic resilience nationally. *Int J Foreign Trade Int Bus* 2025;7(2):239-249. DOI: [10.33545/26633140.2025.v7.i2c.262](https://doi.org/10.33545/26633140.2025.v7.i2c.262)
27. Subcontractor UM, Scheidt PC. Subcontract No. 192517 October 12, 2005.
 28. Seixas AA, Moore J, Chung A, Robbins R, Grandner M, Rogers A, Williams NJ, Jean-Louis G. Benefits of community-based approaches in assessing and addressing sleep health and sleep-related cardiovascular disease risk: a precision and personalized population health approach. *Current hypertension reports*. 2020 Aug;22(8):52.
 29. Valente TW. Network interventions: Engaging social networks to accelerate diffusion, improve performance, and speed organizational change. CRC Press; 2025 Nov 25.
 30. Ogunbayo OE. Equitable participant recruitment in U.S. clinical research: a narrative review and multilevel framework. *International Journal of Advanced Multidisciplinary Research and Studies*. 2026;6(4):1345-1352. doi:10.62225/2583049X.2026.6.4.6734.
 31. Andrasik MP, Broder GB, Wallace SE, Chaturvedi R, Michael NL, Bock S, Beyrer C, Oseso L, Aina J, Lucas J, Wilson DR. Increasing Black, Indigenous and People of Color participation in clinical trials through community engagement and recruitment goal establishment. *PLoS one*. 2021 Oct 19;16(10):e0258858.
 32. Kuaban A, Croker AK, Keefer J, Valentino LA, Bierer BE, Boateng S, DiMichele D, Fogarty P, Gibson CM, Hood AM, Hubbard L. The roadmap to integrate diversity, equity, and inclusion in hematology clinical trials: an American Society of Hematology initiative. *Blood Advances*. 2025 Feb 25;9(4):687-95.
 33. Samuel Addo. Harnessing AI-powered financial forecasting tools to improve risk management, investment strategies, and overall corporate profitability across industries. *International Journal of Science and Research Archive*, 2023, 09(02), 1175-1192. Article DOI: <https://doi.org/10.30574/ijrsra.2023.9.2.0653>
 34. Ogunbe O, Grant JK, Ayoola AS, Bansah E, Miller HN, Plante TB, Sheikhattari P, Commodore-Mensah Y, Turkson-Ocran RA, Juraschek SP, Martin SS. Strategies for improving enrollment of diverse populations with a focus on lipid-lowering clinical trials. *Current Cardiology Reports*. 2023 Oct;25(10):1189-210.
 35. Ogunronbi S., Ogunbayo O. E., Mosuro O. A., Ogunlolu M. I., Ajao O. A., Majolagbe A., Ogunjobi T. T. Tinnitus Patterns and Severity Among Adults Aged 60–80 Years Attending a Tertiary Ear, Nose, and Throat Clinic in Nigeria. *SPC J. Med. Healthc*. 2026;2(2):143–152. doi: 10.48309/sjmh.2026.568789.1112
 36. Oyer RA, Hurley P, Boehmer L, Bruinooge SS, Levit K, Barrett N, Benson A, Bernick LA, Byatt L, Charlot M, Crews J. Increasing racial and ethnic diversity in cancer clinical trials: an American Society of Clinical Oncology and Association of Community Cancer Centers joint research statement. *Journal of Clinical Oncology*. 2022 Jul 1;40(19):2163-71.
 37. Areh J. *Improving Black Participation in Cardiovascular Clinical Trials: Business Strategies for Enhancing Representation and Promoting Health Equity* (Doctoral dissertation, Northeastern University).
 38. Swaby J, Kaninjing E, Ogunsanya M. African American participation in cancer clinical trials. *ecancermedscience*. 2021 Oct 25;15:1307.
 39. Oluwatobi Alebiosu. Engineering stakeholder alignment frameworks for resolving land rights, environmental compliance, and project delivery conflicts. *Int J Appl Res* 2024;10(12):401-412. DOI: [10.22271/allresearch.2024.v10.i12c.13917](https://doi.org/10.22271/allresearch.2024.v10.i12c.13917)
 40. Adedinsowo D, Eberly L, Sokumbi O, Rodriguez JA, Patten CA, Brewer LC. Health disparities, clinical trials, and the digital divide. *In Mayo Clinic Proceedings* 2023 Dec 1 (Vol. 98, No. 12, pp. 1875-1887). Elsevier.