Evaluating a Media Strategy to Provide Health Messages to Medically Underserved Populations

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Declarations of interest: none.

Funding: This work was supported by the following: Department of Defense/ Dept. of the Army –USAMRAA, W81XWH-10-2-0057; National Institutes of Health/ National Cancer Institute, P30 CA138313; and National Institutes of Health/National Cancer Institute, P20 CA157071.

Acknowledgement: The authors would like to acknowledge Dr. X, a South Carolina physician, for conducting the CGHI radio broadcasts for African Americans and the medically underserved and for allowing us to evaluate his broadcasts.

Abstract: For nearly every category of chronic disease, blacks with African American ancestry (AAs) bear a disproportionate disease burden in comparison to their non-Hispanic white (NHW) counterparts. The purpose of this study was to evaluate perceptions of a radio-based health communication strategy, geared towards AA adults and the medically underserved. The radio broadcast, titled "Closing the Gap in Healthcare, Inc. (CGHI)," is delivered by a well-known AA male physician in South Carolina. The mission of CGHI is to decrease health disparities in a four-county area of the South Carolina coastal region, defined as the "Lowcountry," by providing evidence-based health information to a broad community audience via radio broadcast messaging. To evaluate the impact of the CGHI, investigators conducted 12 focus groups (FGs) with community members from the broadcast coverage area to evaluate responses to FG questions based on 11 attributes of effective health communication. Potential FG participants were identified/recruited via a South Carolina-based marketing firm. The FGs conducted in the Sea Islands were culturally and racially homogenous. The investigators developed a FG interview guide. Before each FG started, the informed consent process was administered to each participant. Each two-hour FG was digitally recorded.

Keywords: Health disparities■Social marketing/health communication■ Qualitative evaluation

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https://doi.org/10.1016/j.jnma.2018.10.002

INTRODUCTION

Health disparities in the U.S. and in South Carolina

In the U.S., for nearly every category of disease, blacks with African American ancestry (AAs) bear a disproportionate disease burden in comparison to their non-Hispanic white (NHW) counterparts. For example, the 2016 diabetes prevalence rates were 13.2% for AAs and 7.6% for NHWs.[1] The age-adjusted diabetes mortality rate per 100,000 in year 2013 for AAs was 39.5% and 18.6% for NHWs.[2] In South Carolina, 1 in 8 AAs has been diagnosed with diabetes, and the state ranks 16th highest in the nation in rates of diabetes among AAs.[3]

According to the U.S. Department of Health and Human Services, Office of Minority Health, in 2011, the age-adjusted prevalence rate of cardiovascular disease among AAs was 7.0%, compared to a prevalence rate of 6.3% among NHWs.[4] In 2010, the age-adjusted cardiovascular mortality rate among AAs was 229.5%, compared to a rate of 179.9% among NHWs.[4] In South Carolina, where cardiovascular disease is the second leading cause of death, AAs have a higher probability of developing ischemic heart disease than NHWs, and have an average 10-year lower life expectancy.[5,6]

Cancer disparities are also evident in the U.S. Between 2008 and 2012, for all cancer sites, cancer incidence rates were 12% higher among AA males than among NHW males, and cancer death rates were 27% higher among AA males. During the same time period, cancer incidence rates were 6% lower for AA females than for NHW females, but cancer death rates were 14% higher among AA females.[7] In South Carolina in 2013, the cancer incidence rate for AAs was higher than for NHWs (444.0 vs. 436.9, respectively), and the cancer mortality rate for AAs exceeded that of NHWs (196.8% vs.167.4%, respectively).[8]

Figure 1. Conceptual framework: attributes of effective health communication.

STUDY RATIONALE

The purpose of this study was to evaluate perceptions of a radio-based health communication strategy that is focused on AA adults and the medically underserved. The radio broadcast is titled "Closing the Gap in Healthcare, Inc. (CGHI)," and it is delivered by a well-known AA male physician in South Carolina ("Dr. X").

The mission of CGHI is to decrease health disparities in the coastal region of southeast South Carolina (defined as the "Lowcountry area") by providing evidence-based health information about highly prevalent diseases such as diabetes, cardiovascular disease, and cancer to community members via radio broadcast messaging. The CGHI is broadcast approximately eight times per day, starting at 6:30 a.m. and ending at 7:30 p.m. The topics of the health messages change on a monthly basis.

No formal evaluation of the impact of CGHI has been conducted to date. Therefore, the investigators conducted focus groups (FGs) with members of communities from the broadcast coverage areas of the radio stations on which CGHI was aired. The FGs were designed to assess CGHI's effectiveness by evaluating responses to FG questions based on Healthy People 2010's 11 Attributes of Effective Health Communication (Figure 1).[9]

CONCEPTUAL FRAMEWORK

The conceptual framework of the current study is based on the 11 Attributes of Effective Health Communication. According to this framework, health promotion interventions must include specific elements in order to effectively communicate health information to community members.

These elements or attributes (Table 1) include 1) accuracy, which is the validity of the information content; 2) availability or the extent to which the health information content is made accessible to community members; 3)

Table 1. Attributes of effective health communication.

Attributes of Effective Health Communication
• ***Accuracy:*** The content is valid and without errors of fact, interpretation, or judgment.
• ***Availability:*** The content (whether targeted message or other information) is delivered or placed where the audience can access it. Placement varies according to audience, message complexity, and purpose, ranging from interpersonal and social networks to billboards and mass transit signs to prime-time TV or radio, to public kiosks (print or electronic), to the Internet.
• ***Balance:*** Where appropriate, the content presents the benefits and risks of potential actions or recognizes different and valid perspectives on the issue.
• ***Consistency:*** The content remains internally consistent over time and also is consistent with information from other sources (the latter is a problem when other widely available content is not accurate or reliable).
• ***Cultural competence:*** The design, implementation, and evaluation process that accounts for special issues for select population groups (for example, ethnic, racial, and linguistic) and also educational levels and disability.
• ***Evidence base:*** Relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulate practice guidelines, performance measures, review criteria, and technology assessments for telehealth applications.
• ***Reach:*** The content gets to or is available to the largest possible number of people in the target population.
• ***Reliability:*** The source of the content is credible, and the content itself is kept up to date.
• ***Repetition:*** The delivery of/access to the content is continued or repeated over time, both to reinforce the impact with a given audience and to reach new generations.
• ***Timeliness:*** The content is provided or available when the audience is most receptive to, or in need of, the specific information.
• ***Understandability:*** The reading or language level and format (including multimedia) are appropriate for the specific audience.

balance, which is the extent to which the information that is presented addresses the risks and benefits of specific health behaviors; 4) consistency or the concordance of the content of the health information with information that the community has received from other sources; 5) cultural competence, which is the extent to which the design and implementation related to the information presented are tailored to the health information-gathering styles or approaches of specific population groups; 6) evidence base or the reliance of the information that is presented on relevant scientific evidence; 7) reach, which is the maximization of the dissemination of the health information in the population of interest; 8) reliability, which refers to keeping the health information that is presented up to date and current; 9) repetition or the reinforcement of the information that is presented; 10) timeliness, which means providing the content of the information at a time when the community/audience of interest is most receptive to this information; 11) understandability, which refers to ensuring that the information that is presented is tailored to the reading level and/or language of the community/audience of interest.

METHODS

Setting

The CGHI broadcast area is largely rural with pockets of urban areas. This Lowcountry region has a population of 788,890. Table 2 compares the sociodemographic characteristics of the Lowcountry with those of the U.S. as a whole.[10–15]

African Americans are the primary focus of the information presented through CGHI. The Lowcountry region of South Carolina is home to a unique cultural group of African Americans, the Sea Island population. This is one of the most genetically homogenous groups of blacks in

Table 2. Sociodemographic characteristics of the 5-county region in comparison to the sociodemographic characteristics of the U.S., 2017.

County Name	Size of Population	Non-Hispanic White	African American	Median Household
United States	325,719,178	76.6%	13.4%	$55,322
South Carolina	5,024,369	68.5%	27.3%	$46,898
5-County CGHI				
Broadcast Region				
In South Carolina				
Bamberg County	14,381	36.0%	60.5%	$32,321
Berkeley County	217,937	63.9%	24.5%	$54,484
Charleston County	401,438	68.9%	27.3%	$54,931
Colleton County	37,611	59.3%	37.6%	$33,918
Dorchester County	156,456	68.5%	25.8%	$56,345

the United States, and has distinctive cultural practices, including an English-based Creole language, unique cuisine, and strong family ties.[16–18] To include the perspectives of AAs of Sea Island ancestry in the evaluation, the investigators conducted FGs in the Sea Island areas of South Carolina in the broadcast region in addition to other areas of the region.

Given the large geographic region of the broadcast coverage area of CGHI, the investigators conducted 12 FGs within the broadcast coverage area (Table 3). The FGs conducted in the Sea Islands were ethnically and culturally homogenous.

The Sea Islands FG sites included the following three locations: Edisto Island, Wadmalaw Island, and Yonges Island. The other nine FG locations consisted of the following: Summerville/Ladson, Moncks Corner/Goose Creek, West Ashley/James Island, McClellanville/Awendaw, Walterboro, Bamberg, Charleston, North Charleston, and Huger.

Identification and recruitment of study participants

Potential FG participants were identified via a South Carolina-based marketing firm that used a database based on magazine subscription lists as well as community advertisements in the recruitment geographic area.

Marketing firm staff conducted a short eligibility screen with people who were identified through the database or who responded to advertisements, to ensure that they were AA and ages 21 years and older.

The structure of the FGs was based on Kohler et al.'s suggestion to include eight to 10 participants per group.[19] To obtain this number, the investigators invited 15 participants to each group. Eligible and interested people were sent a written confirmation of their FG date, time, and location, and received a reminder call the night before their scheduled FG sessions, which took place in a convenient venue within the participants' communities.

FG guiding questions

The investigators developed a FG interview guide (Appendix A) to assess participants' perceptions of the extent to which the CGHI met the 11 Attributes of Effective Health Communication. Other FG questions

Table 3. Focus group schedule.

Location (City in South Carolina)	Date/Time
Summerville/Ladson	February 21, 2012, 4:00 PM
Moncks Corner/ Goose Creek	February 21, 2012, 6:00 PM
West Ashley/ James Island	February 22, 2012, 12:00 PM
McClellanville/ Awendaw	February 22, 2012, 4:00 PM
Walterboro	May 22, 2013, 12:00 PM
Bamberg	May 22, 2013, 4:00 PM
Charleston	May 23, 2013, 12:00 PM
North Charleston	May 23, 2013, 4:00 PM
Huger	March 15, 2014, 11:00 AM
Edisto Island	April 11, 2014, 11:00 AM
Wadmalaw Island	April 11, 2014, 2:00 PM
Yonges Island	April 12, 2014, 11:00 AM

were related to health myths/misconceptions and sources of health information.

Institutional Review Board Processes

The investigators obtained Institutional Review Board (IRB) approval at MUSC to conduct the FG study. Before each FG started, the informed consent process was administered individually to each participant. All participants were consented individually. After all informed consent and HIPPA forms were signed, each participant completed a short background form to denote his/her socio-demographic characteristics.

FG procedures

At the start of each FG, the moderators described the confidentiality ground rules. Each 2-h focus session was digitally recorded.[20] No personal identifiers were reported in FG and interview transcripts, and no participant was identified by name in any reports or publications resulting from this study. After each session, participants signed receipts, and each received a $55 gift card to thank them for their time.

AA female investigators conducted the FGs with the general AA population. An AA female investigator with expertise in working with the Sea Island ethnic group of AAs conducted the FGs with the Sea Island ethnic group of AAs.

Analysis

The investigators used Microsoft Word to code and analyze the transcripts from the digital FG recordings. A national expert in qualitative analysis developed this method.[21] Digital recordings of FGs were transcribed into a tabular format containing columns for speaker ID and speaker comment, respectively.[21] Formatted transcripts were analyzed using rigorous content analysis methods for systematic theme identification.[21–23] Codebooks were developed by reading and rereading all transcripts, outlining and organizing the key themes addressed by participants as they related to the study purpose and the factors related to effective health communication. Descriptive statistics were used to characterize the themes reported in the FGs.

RESULTS

Findings are presented as a summary of major repeating patterns (themes and subthemes) in the data as they related to the 11 Attributes of Effective Health Communication (See Figure 1). Other findings are presented under more emergent theme headings. Data, samples, or models can be accessed by contacting the Corresponding Author of this manuscript.

Accuracy

In seven (7) of the 12 FGs in which participants had heard the broadcasts, participants explicitly said the information in CGHI broadcasts was correct. For example, a participant stated: “I believe 100% of what Dr. X says.”

Availability

Six people in five different FGs suggested that the broadcasts have longer segments/time slots to ensure availability of the health content. They reported having heard the CGHI broadcasts frequently on different radio stations, often while at work or driving in their cars. There was no clear preference for a specific time of day to hear the broadcast, although two people suggested that the broadcasts be played during the same time daily to allow listeners to hear the broadcasts based on a set schedule.

Balance

The pros and cons of certain medical procedures such as cancer screening were not clearly understood by FG participants. They did not seem to understand that the moderator was seeking information related to the balanced presentation of benefits, risks, or presentation of diverse perspectives on the targeted health issue.

Consistency

In two of the 12 FGs, participants said that the information provided on CGHI was consistent with what they heard from other sources. Four people cited actual differences from information obtained from other sources: “Dr. X said to get a colonoscopy every 10 years; however, (some of the participants’) other doctors said to get a colonoscopy every 5 years;” “Dr. X said to exercise 30 min per day; however, Dr. Y (a national AA male U.S. fitness expert) recommended exercising for an hour 3 times per week;” “Dr. X said AA women should start getting mammograms at age 40; however, other sources said AA women should get a mammogram at age 50.”

Cultural competence

Participants in all 12 FGs said the CGHI broadcasts were culturally relevant for AAs. They stated that they trust Dr. X “because he is rooted in the Black community” and “has our best interests at heart, and genuinely cares.” They expressed this in a variety of ways: “Dr. X is really in touch with and cares what is happening with AAs;” “Dr. X’s broadcasts are geared towards number one killers of

AA people;" and "Dr. X is covering all the stations that AAs listen to for information/entertainment." Participants in three of the 12 FGs added that in the future, the CGHI health messages would need to address a broader spectrum of the population and not just focus on AAs.

Theodosia and Sefus

Participants in seven FGs stated that the fictional Sea Island characters *Theodosia* and *Sefus*, who were included in several broadcasts, were culturally relevant. *Theodosia* and *Sefus* speak with a colloquial Sea Island dialect, and their segments use humor to convey health information (such as *Theodosia* encouraging *Sefus* to ride his bicycle up and down a hill to get more exercise to manage his diabetes, rather than having someone push him up the hill and then riding his bicycle down the hill). They said, the characters were "perfect for older listeners but might not appeal to younger audiences" while others stated that the characters would appeal more in areas where the Sea Island dialect is spoken.

Participants in 7 FGs stated that the broadcasts with the Sea Island characters *Theodosia* and *Sefus* contained good information, and participants in 11 of the 12 FGs said that *Theodosia* made them think of the caring way in which a matriarch or their grandmother, "auntie," cousin, or wife might talk to them. Participants in 9 of the FGs also said that the combination of humor and serious health information caught listeners' attention, while a few participants stated that the humor might get in the way of the health message. However, about 12 people said, "The *Theodosia* character was an embarrassment or was stereotyping AAs." None of these participants were from the Sea Islands where the Sea Island dialect is spoken. The Sea Island FG participants said that they liked the *Theodosia* and *Sefus* characters.

Evidence base

One participant stated that he/she trusted Dr. X's messages because "Everything Dr. X says has been proven to be true." Another said, "He is a straight shooter and researches everything."

Reach

Participants in three FGs cited examples of their relatives, older people, co-workers, friends, cohorts at the barbershop, and children listening to the broadcasts. They explicitly stated that the broadcasts appeal to people of all ages and that the broadcasts, which were focused on men, used humor to convey complex health information.

Participants in three FGs stated that more work needs to be done to broaden the reach to younger AAs. Their suggestions to reach younger AAs included:

- Developing a Facebook page/account for CGHI
- Creating the ability to Google CGHI on YouTube
- Creating a Twitter account and following broadcasting news alerts with health messages on mobile phones
- Putting broadcast messages on hip-hop and gospel stations
- Avoiding using *Theodosia* as a character when appealing to youth (maybe use a student who avoided checkups but had to have one to get into college)
- Putting broadcast messages in magazines that target young people (*e.g., Geechee One*, *Grime Scene*)
- Aiming content at promoting a healthy lifestyle
- Surveying the youth to see what media outlets would work best for them

Many participants across 12 FGs provided suggestions as to how CGHI could extend its reach to all populations. The social media dissemination suggestions included: placing Internet advertisements on web pages, making guest appearances on the Internet radio, advertising the CGHI website more, having Dr. X ask everyone who is a Facebook friend to "like" his page to get connected to additional people, enabling pop-up ads on kindles, creating a YouTube presence, creating a CGHI app for smartphones that pop up infomercials, and sending out weekly text messages or email alerts with health information.

The faith-based dissemination suggestions involved using church engagements to host health forums in churches to target men in particular; posting messages on church bulletin boards; developing a DVD to be distributed to churches, and sending Dr. X questions generated from watching the DVD.

Other dissemination suggestions included conducting workshops at centralized locations such as town halls and libraries; providing health insurance and free/affordable health care access; putting CGHI broadcasts on primetime TV; and distributing recorded segments to movie producers to be featured on advertisements on DVDs and at the beginning of movies, to college campuses to be used during healthcare seminars, to doctors' offices to be played for patients seated in the waiting areas, and to churches to be shared with congregations. Additional suggestions included disseminating information to barbershops and developing articles for health magazines and small-town newspapers.

Reliability

Participants in all FGs said that they trust CGHI and Dr. X as sources of reliable information. Many in four FGs said, "They trust him because he is a good educator and because he is not selling anything; he is doing a public service."

Repetition

Some participants in two FGs stated that the CGHI segments were aired frequently enough while some participants in five other FGs said they should be aired more frequently.

Timeliness

Some participants in 10 of the 12 FGs cited examples of hearing information on CGHI when they were most in need or most receptive to it, stating:

- "It makes it easier for men to call a doctor when they hear their symptoms on the radio."
- "It reminds me of preventive health and lifestyle changes I need to practice to stay healthy (diet, exercise, filling prescriptions, not skipping doses of medications, cutting down on smoking, losing weight, using protection during sex)."
- "It reminds me to get checkups, do follow-ups, and do screenings."
- "It reminds me to develop a checklist, and ask more questions when I visit my doctor."
- "It may change some peoples' minds if issues are explained in a way they can understand."
- "It convinced me to try to influence my relatives to practice better lifestyle regimen to counter health issues."

Understandability

All participants stated that the CGHI content is easy to understand. It was described in the following terms: "plain English;" "simple;" "to the point;" "clear, detailed, and easily-understood."

Importance of CGHI broadcasts

In all 12 FGs, participants gave many reasons as to why the broadcasts were important to them: "It's important to have these broadcasts because men don't talk to each other about health concerns;" "They cover informative topics you would not normally think about;" "They educate older people who listen to the radio;" "It is the only doctor's advice poor people without insurance are going to hear;" "Create awareness of health problems that affect AAs/Blacks;" "Provide us with knowledge we need to make health-conscious decisions;" "Provide information we may need/want to share with family and friends."

LIMITATION

As in all FG research, not all members of each FG responded to each of the moderator questions, so no frequency of response analysis across all participants could be done.

DISCUSSION

This paper presents data from 12 FGs conducted in the South Carolina Lowcountry to evaluate the effectiveness of the CGHI radio broadcast based on the 11 Attributes of Effective Health Communication. Repeated patterns in findings expanded on themes identified as factors for effective health communication, as expected: accuracy, availability, balance, consistency, cultural competence, evidence base, reach, reliability, repetition, timeliness, and understandability.

This study is the first formal evaluation of the CGHI. The results have direct applicability to health communication efforts in other geographic regions of the U.S. that focus on minority and medically underserved communities. The study sample also includes the perspectives of a culturally and genetically unique group, the Sea Island ethnic subgroup of AAs.[16]

The FG participants affirmed that the CGHI broadcasts met the 11 Attributes of Effective Health Communication. The study participants stated that the broadcasts were perceived as a reliable source of health information, and expressed appreciation for the lay language used to convey health messages and health tips in each broadcast, as well as the incorporation of humor.

The FG participants identified the following as the most important topics for future CGHI broadcasts: AA men's health issues; cancer overall (breast cancer and screening, colon cancer and screening, and prostate cancer and screening); diabetes and diet restrictions for people with diabetes; heart attacks, strokes, symptoms, high blood pressure, and high cholesterol; dental health; good nutrition and weight control; gout; arthritis; smoking cessation; how to get affordable health insurance; how to find a doctor that will accept the health insurance; Medicare parts A-D; AA men's health issues; how diabetes, heart attack, and stroke are interrelated; childhood and adolescent obesity; HIV; managing diabetes and its impact on the feet; kidney disease and preventing dialysis; eye care - glaucoma, cataracts, and diabetes eye issues; healthy eating; emphasis on prevention; mental illness; AAs and skin cancer; women's health; domestic abuse; osteoporosis; lupus; colon cancer screening guidelines; breast cancer diagnosis in men; and breast cancer guidelines for women, particularly at what age to begin and end receiving mammograms.

The focus of the CGHI on specific health issues that are of major relevance to the AA community seemed to be a major point of favor with the listening audience, many of whom are medically underserved. Additionally, the FG participants from the Sea Island communities viewed the Sea-Island themed broadcasts favorably; whereas the FG

participants who were not from the Sea Island communities stated that they did not like the broadcasts that were delivered using the Sea Island dialect.

Many FG participants also stated that the CGHI broadcasts helped them to take action to maintain or improve their own health by prompting them to contact a physician if they experienced disease symptoms; make lifestyle changes related to diet, exercise, smoking cessation, and medication adherence; and obtaining health screenings.

CONCLUSION

In conclusion, the FGs also identified helpful sources of health information other than CGHI broadcasts, the importance of CGHI broadcasts to FG participants, and important health topics for AA audiences identified. Based on the FG participants' recommendation for CGHI broadcasts to be aired on television as well as on the radio, the CGHI leaders collaborated with a local television station to broadcast health messages on television for six months. The outcomes related to the televised broadcasts are in the process of being evaluated.

Future research could be conducted to evaluate if the AAs and other populations such as Asian Americans, Hispanics/Latinos, and Native Americans in the defined geographic region benefitted from the CGHI radio broadcasts in learning how to manage or seek treatment for chronic diseases such as diabetes, cardiovascular disease, and cancer.

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APPENDIX A. FOCUS GROUP MODERATOR'S GUIDE: DR. F, PRINCIPAL INVESTIGATOR STUDY: EVALUATING A MEDIA STRATEGY TO PROVIDE HEALTH MESSAGES TO MEDICALLY UNDERSERVED POPULATIONS IN SOUTH CAROLINA

I. WARM-UP AND EXPLANATION (10 min)

A. Introduction.

1. Good evening. My name is Dr. F. I work at the University.
2. Thanks for coming.
3. Your presence and participation are important. Your thoughts and comments will be valuable in helping us to evaluate the Closing the Gap in Healthcare radio series and improve the health messages delivered through its radio broadcasts.

Purpose.

1. What we are doing here today is called a focus group. It's a discussion to find out your opinions – like a survey.
2. We are interested in all of your ideas, comments and suggestions.
3. Each of you is very important, and all of your comments – both positive and negative – are welcome.
4. There are no right or wrong answers.
5. Please speak up – even if you disagree with someone else here. It important that I hear what each of you thinks.

B. Procedure.

1. We will be audiotaping our discussion. Everything you say is important to us, and we want to make sure we don't miss any comments. Later we'll go through all of your comments and use them to prepare a report on our discussion. However, all of your comments are confidential and will be used only for research purposes. Nothing you say will be connected to your name. Each of you has been given a nametag with a number on it. You will be referred to by your number throughout the entire focus group session. Therefore, DO NOT state your name when you respond. Also, if any questions make you uncomfortable, feel free not to answer them.
2. You don't have to wait for me to call on you, but please speak one at a time so the tape recorder can pick up everything.
3. We have many topics to discuss, so I may change the subject or move ahead. Please stop me if you want to add anything.

Ice Breaker and Introductory Questions

We are looking at a set of criteria that are important to making good health messages.
Some of these criteria may be more important than others.
Your responses to the following questions will help us to decide which criteria are most important.
What media channels, such as TV, radio, newspapers, or the Internet, have been most helpful to you as sources of health information?
How important have the Closing the Gap radio broadcasts been to you or others you know?
In what ways have the broadcasts been important to you?
What have been the topics of the Closing the Gap Broadcasts that have been the most helpful to you? How did that information help you?

Availability

1. How good do you feel the radio is as an approach for reaching you with the Closing the Gap health messages (Probe: What other approaches might be better? E.g., Internet, television, magazines, newspapers, Facebook, Twitter, etc.)?
2. At what time of day do you typically listen to the Closing the Gap broadcast? (Probe: What are you usually doing while you listen to the broadcast? (E.g., driving, eating, doing household chores, etc.) (Probe: What would be your preferred time to listen to the broadcast? Does it come on at that time? What makes this your preferred time?) (Probe: How does this time fit best into your schedule?)

Timeliness

1. How often have you heard health information on the Closing the Gap broadcasts that was helpful to you? Did you get the information at a time when you really needed it? (Probe: What was going on in your life that made this information most helpful to you?)

Balance[Play recorded Closing the Gap broadcasts (1 on cancer screening and others on randomly selected topics)]

1. Theodosia character: What are your thoughts about this character? (Probe: Was her way of talking helpful in providing health information? If so, in what ways? If not, in what ways?)
2. Do you feel that the Closing the Gap broadcasts provide health information in a fair and or unbiased way? (Probe: If so, what are some examples? If not, what are some examples?)
3. Let's think about an example such as cancer screening. To what extent do you feel that the Closing the Gap broadcasts provide information about how cancer screening can be potentially helpful or harmful?
4. Do you ever get the sense that you are being asked to do health-related activities without fully understanding the pros and cons of these activities? (Probe: What are some examples from the broadcasts?)

Consistency

1. Does the health information that you have received from the Closing the Gap broadcast give the same message as the health information that you have received from other sources? (Probe: If not, do you remember what the differences were? What were the other source(s) of information?
2. Which source of information do you think was most correct? (Probe: How did you come to this conclusion?)
3. Have other health messages you have heard or read in the media (i.e. newspaper, radio, TV, brochures, magazines) been consistent with the information you have heard on Closing the Gap in Healthcare Broadcasts?
4. Has the information on particular health topics been consistent and or the same throughout the Closing the Gap in Healthcare Broadcasts?

Accuracy

1. How much of the information that you have heard on the Closing the Gap broadcasts do you think was correct?

Reliability

1. To what extent do you trust or believe the information that you have heard on the Closing the Gap in Healthcare broadcasts?
2. To what extent do you trust or believe Dr. X as a source of information?
3. Does it matter who delivers the message of the Closing the Gap in Healthcare broadcast? (Probe: Would you still listen if someone else's voice were on it?)

Reach

1. How often do your friends and relatives listen to the Closing the Gap in Healthcare broadcast?

Repetition

1. How often have you noticed that the same Closing the Gap broadcasts are being aired? Do you think that the broadcasts are aired enough times? (If so, please state your reasons. If not, please state how often, and when you think they should be aired.)

Cultural Competence

1. Do you believe that the information you hear on the Closing the Gap in Healthcare broadcasts speaks to the culture of African Americans?
2. Do you feel that the health messages are expressed in a way that is culturally correct?
3. Have you ever been offended by the way any of the broadcasts were conducted?

Understandability

1. How often have you heard words or terms in the Closing the Gap broadcasts that you still did not understand when the broadcast had finished? What were those terms?