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PAPER GOWNS, COLD HANDS, OR SOMETHING ELSE? BLACK WOMEN'S BARRIERS TO GYNECOLOGIC SCREENING

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in the College of Communication and Information at the University of Kentucky

By

Nadia Ayesha Sesay

Lexington, KY

Director: Dr. Donald Helme, Professor of Communication, Associate Dean for Research

Lexington, KY

2023

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ABSTRACT OF THESIS

PAPER GOWNS, COLD HANDS, OR SOMETHING ELSE? BLACK WOMEN'S BARRIERS TO GYNECOLOGIC SCREENING

Cervical cancer mortality burden is carried disproportionately by African American women. Early indicators of cervical cancer are identified through prevention screening, a procedure typically performed by a gynecologist. Ideally, the patient group with the most severe mortality would likewise be the group with the most robust communication exchange with their physician to prevent cervical cancer incidence. However, a slew of factors contributes to continued mortalities among Black women. This study uses semi-structured interviews (n=10) and the health belief model to examine one barrier to Black women's prosocial behaviors regarding routine gynecologic care—awkwardness, which here is conceptualized as social anxiety. The focus on awkwardness stems from the CDC health campaign, *Under the Paper Gown*, where awkwardness is the African American woman protagonist's main drive for averting her appointment. However, anxiety and awkwardness are under-cited in current literature on Black women's barriers to gynecologic care. Interviews revealed eight themes. The aims of the current exploratory study are twofold: Gain insight into Black women's perceived barriers regarding gynecologic care and learn whether the portrayal of awkwardness accurately captures the true experiences of said women.

Keywords: perceived barriers, health belief model, health campaigns, African American women, cancer prevention screening

Nadia Ayesha Sesay

July 26, 2023

PAPER GOWNS, COLD HANDS, OR SOMETHING ELSE? BLACK WOMEN'S BARRIERS TO GYNECOLOGIC SCREENING

By

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July 26, 2023

DEDICATION

This work is dedicated to those who have influenced my academic career (in no order): Dr. Jennifer Greer, Dr. Donald Helme, Dr. Kyra Hunting, Dr. Anthony Limperos, Dr. Aurora Occa, Treshani Perera, and Dr. Jennifer Scarduzio

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CHAPTER 1. Introduction

[Lacey] Amber!…what are you doing?

[Amber] I'm trying to familiarize myself with robes.

[Lacey] What?…Why!?

[Amber] Because! I have a gynecologist appointment tomorrow, and I'm never sure which way the robe is supposed to go. Like, is it like this…Ehhh? Or, is it supposed to go on like this…Uhhh? –*Under the Paper Gown*, Episode 1.

Routine gynecologic exams are an agreed-upon measure for detection of gynecologic cancers. Screening is useful to detecting cervical cancer, which alongside ovarian, uterine, vaginal and vulvar account for the main types of gynecologic cancers (Centers for Disease Control and Prevention [CDC], 2021). Despite the advantage of screening to an individual's health, such as detecting abnormal cells that may lead to cancer (CDC, 2022), cervical cancer incidence remains an area of concern and study. Specifically, lingering disparities in the outcome of cervical cancer among certain racial and ethnic groups is worrisome.

Non-Hispanic Black women, henceforth Black or African American women, experience disparities in the mortality of cervical cancer (Balzer, 2022; Arvizo & Mahdi, 2017). Some researchers have reported that cervical cancer mortality among Black women is twice that of white women (Nolan et al., 2014). Health communication scholars identify the plethora of ways that communication can improve gynecological screening uptake. These include enhancing patient-provider and interpersonal communication about gynecologic health and raising awareness of the benefits of routine screening through health campaigns. I find my interests aligned with the latter.

Another area communication scholars as well as government bodies like the CDC seek to remedy is the public's barriers to undergoing this highly beneficial health action. The precursor to undergoing cervical cancer screening is, of course, to visit the gynecologist. Given the cervical cancer race disparity and the medical determination that screening is one proven way to detect abnormalities that lead to cancer, this study investigates Black women's perceived barriers to visiting the gynecologist for routine care. I aim to learn about these behaviors in line with the representation of Black women's perceived barriers as presented in a gynecologic health campaign.

Under the Paper Gown, a CDC-led web campaign that encourages women to make and keep their gynecologist appointments, addresses the challenges that prevent some women from undergoing routine appointments. The web campaign stars African American comedian and author Amber Ruffin, the protagonist, and her real-life sister, Lacey Lamar. *Under the Paper Gown* portrays Ruffin's decision process to attend her gynecologist appointment, evolving from trepidation (i.e., the gangly paper gown she must don and the gynecologist's weirdly cold hands) to triumph (she attends the appointment). Ruffin's behavior is described as awkward and her uncertainties like an unknowingness about the use of the exam robe, add a silliness quotient to a serious issue—the barriers that prevent African American women from participating in gynecology appointments.

Barriers to gynecologic screening are a recurring topic in health literature. Nolan et al. (2014) examined Black women's barriers to undergoing cervical cancer screening and itemized fear, cultural beliefs, poverty, and systemic barriers as primary hinderances to routine gynecologic care. Although researchers study anxiety as a factor in gynecologic health experiences, I am not aware of studies that examine these two areas exclusively that also focus

on Black women uniquely. Additionally, I am not aware of an existing study that examines whether the anxieties portrayed in the *Under the Paper Gown* campaign reflect Black women's real-life perceived barriers toward gynecologist engagement.

This study employs a survey questionnaire and semi-structured interviews to explore Black women's barriers to attending a gynecologist appointment, utilizing the perceived barriers construct of the health belief model (HBM). HBM is a behavioral model that seeks to understand why people fail to adopt preventive health behaviors. Of HBM's six constructs (perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy), this study focuses on perceived barriers since those are factors that offset an individual's performing of a preventive health action. Barriers can also function as the individual's perceived consequences of adopting an action (Champion, 1984).

Research questions and the hypothesis examine how social anxieties may operate as a barrier for Black women's decisions to attend routine gynecologist appointments and whether women resonate with the presentations of barriers portrayed in *Under the Paper Gown*. During the semi-structured interviews, study participants will view *Under the Paper Gown* and will then be asked to reflect on how the portrayals of social anxiety reflect their own experience. This study also proposes a more encompassing research inquiry on the communication challenges endured by African American women during their gynecological appointments. Future implications from this study include the expansion of understanding about the barriers endured by minoritized communities that contribute to poorer health outcomes. Another implication is the development of culturally sensitive campaigns that dispel the inhibitions of undergoing routine gynecologic care.

This study centers cervical cancer detection as one main benefit of routine gynecologic care for a few reasons. First, Black women have the highest cervical cancer mortality among all racial and ethnic groups (Balzer, 2022; Arvizo & Mahdi, 2017). Second, according to Christy et al. (2021) Black women are 75% more likely to die from cervical cancer than white women. Third, as with many cancers, early detection reduces or reverses a patient's onset of cancer. As previously mentioned, cervical cancer screening is accomplished by visiting the gynecologist.

Fourth, unlike other gynecologic cancers, cervical may be prevented with a vaccine for Human papillomavirus (HPV). HPV is a prevalent factor in greater than 99% of cervical cancers (Goldfarb & Comber, 2022). Although three HPV vaccines are approved by the US Food and Drug Administration for use in the United States, HPV vaccine uptake remains lower among Black women compared to white women (Ojeaga et al., 2019). Further, Ojeaga et al. (2019) reports the same pattern when comparing knowledge that HPV causes cervical cancer: Staggeringly at 64% and 81% for Blacks and Whites, respectively. Furthermore, only 25% of Black women reported that a healthcare professional had ever recommended the vaccine. Although HPV vaccination is approved for pre-adolescents, college students of minoritized backgrounds remain under informed about their HPV-related cancer risk (Kellogg et al., 2019; D'Urso et al., 2007). Among Black college students who report being informed of the vaccine by a primary care provider, they are less likely than white peers to complete the multi-dose series required to gain full inoculation (Towner et al., 2022).

Cervical cancer screening is crucial to the prevention of cervical cancer. Christy et al. (2021) state that to reap the benefits of positive screening behaviors, Black women must perceive screening "to be useful, safe, and relevant" (p. 1676). These sentiments—usefulness, safety, and relevance—are antithetical to sentiments that often present themselves as barriers. In the HBM

theoretical framework, perceived barriers are perceived costs or disadvantages of adopting a recommended health behavior (Sutton, 2021). *Under the Paper Gown* depicts a litany of excuses—uncertainty about use of the exam robe, the gynecologist's cold hands, social awkwardness, plus others—as the protagonist's barriers to attending her appointment. Thus, understanding Black women's sentiments about gynecologist visits may consequently instill the behaviors that may lead to more frequent appointments and examinations. Therefore, the present study seeks to explore Black women's perceived barriers that emerge when attending to gynecologic care.

CHAPTER 2. Literature Review

This chapter begins by revisiting the health crisis that is the undercarriage of this study—disparities in cervical cancer mortality of African American women. Following the opening of the literature review is an overview of the development of mass media health campaigns and the utilization of YouTube—the host site of *Under the Paper Gown*—for the dissemination of health information. Then, I present a synopsis of *Inside Knowledge*, CDC's umbrella initiative to raise awareness of gynecologic health. A plot summary of *Under the Paper Gown* and discussion of health campaigns aimed at disparity populations follows the campaign review. Following the presentation of the focus campaign is an analysis of existing studies reporting Black women's barriers to gynecologic care. This chapter closes with a review of the HBM theoretical framework, then, finally, three research questions and one hypothesis.

2.1 Cervical Cancer Mortality

Cervical cancer is an avoidable mortality (Howard, 1987). The Papanicolaou (Pap) test and HPV screening can detect abnormal cells and determine the patients who need further treatment to avert the development of cancer. Steps to cervical cancer prevention can be taken even before the age of recommended screening. For instance, children as young as age 9 may receive the HPV vaccine (Chapman-Davis & Howard, 2023; Arvizo & Mahdi, 2017). Scholars in fact (Occa et al., 2022) study creative ways to deliver HPV vaccine messages to children, like through animated videos and interactive games. The HPV vaccine is deemed highly effective when administered prior to an individual's first sex encounter (National Cancer Institute, 2021). Siegel et al. (2023) report a 65% drop in cervical cancer incidence over the period 2012 through 2019 among young women who were first to receive the HPV vaccine.

Cervical cancers rarely occur in women who have been regularly screened and tested for cervical cancer before age 65 (American Cancer Society, 2023). Women should undergo routine screening from age 21 to 65. The type and frequency of screening are dependent on age. The recommendations set forth by the US Department of Health and Human Services (HHS) (2023) are that women aged 21 to 29 receive a Pap test every three years. Women aged 30 to 65 have three options for prevention screening: to undergo Pap test every three years, HPV screening test every five years, or both a Pap and HPV test every five years depending on doctor recommendation. Despite these precautions, American Cancer Society (2023) projects about 14,000 new cases of invasive cervical cancer and more than 4,300 fatalities from cancer to occur this year. This data demonstrates the opportunity for health communication to raise cervical cancer prevention awareness among individuals with a cervix.

2.1.1 *Cervical Cancer Disparity*

Cervical cancer disparity among Black women is a special concern. Notably, Christy et al. (2021) find that Black women are 41% more likely to develop cervical cancer than white women. The role of social determinants of health in exacerbating poor health outcomes across a spectrum of diseases is well-documented (Asare et al., 2022; National Cancer Institute, 2022; Towner et al., 2022; Mukerji et al., 2017; Collins et al., 2014). Overall, claim Towner and colleagues (2022), the disparity in outcomes of cervical cancer has worsened for Black women since the 1970s.

Routine gynecologic exams and the Pap test are an agreed-upon measure for detection of gynecologic cancers. The Pap test in particular “meets the full range of criteria for an effective screening modality (accuracy, acceptability, simplicity, minimal risk and minimal cost)” (Howard, 1987, p. 507). Marcus and Crane (1998) describe Pap screening as “so well entrenched

in our approach to public health that the lack of such screening is now considered one of the prime risk factors for invasive cervical cancer" (p. 25). Should Pap tests discontinue, the researchers claim, the percentage of cervical cancer mortality would increase as much as 300%.

Still, despite the promise of cervical cancer prevention achieved through routine testing, cervical cancer disproportionately terminates the lives of Black women. Thus, developing insight into Black women's perceived barriers to gynecologic health visits may inform communication interventions that aim to curtail the impact of health disparities on future health outcomes. Health campaigns are one tool used by communication researchers to convey beneficial health information.

2.2 Mass Media Health Campaigns

Health campaigns are long-applied tools for health promotion and behavior change. Campaigns have two overarching aims: To encourage prevention to mitigate future ailment or to promote cessation of a present unhealthy behavior (Bonfadelli, 2022). Noar (2006) identifies the drive for smallpox inoculation from the 1700s as one of the earliest known health campaigns.

Health campaigns have experienced an evolution of effectiveness. Noar (2006) outlines the trajectory of campaigns from minimal effects (high failure) of the mid-twentieth century to the present-day conditional effects (small-to-moderate) era. Willoughby and Noar (2022) conducted a metanalysis of mass media health campaign literature. Greater effects were realized for campaigns about cardiovascular disease, physical safety, HIV prevention, and nutrition, while the smallest effect was noted among adult smokers, to which the researchers determined that age and addiction are some conditions for campaign effect. Studies on cancer prevention behaviors such as screening were not included in their (Willoughby & Noar, 2022) analysis. Elsewhere a metanalysis performed by Anker et al. (2016) found that cancer campaigns had a

strong effect on positive behavior change. However, the specific behaviors targeted in those campaigns were not identified and multiple behaviors contribute to cancer prevention, such as screening, smoking cessation, and reduction in alcohol consumption. Overall, though, alignment with principles of campaign design, which were developed over decades of efforts of health intervention, distinguish present-day effective campaigns from the minimal effects era (Noar, 2006).

It is important to note that despite praiseworthy motivations to promote healthy behavior, public health campaigns can fall short of their objectives for a variety of reasons. As stated previously, addiction is one moderator of behavior adoption. Guttman and Salmon (2004) find that cultural differences may stymy the efforts of health campaigns: In Ethiopia, an illustrated campaign of foot washing as care for diabetic adult males reinforced gender stereotypes by depicting a woman washing her husband's feet. Later, I discuss some successes of campaign approaches in disparity communities, which are attributed to factors like cultural relevance, community engagement and celebrity.

Mass media distribution allows the campaign message to reach a wide and usually diverse audience. Bonfadelli (2022) outlines the combination of features present across public communication campaigns. These are a "preplanned set of communication activities, using a particular type of message for a short period [that] almost always use a multi-media approach" (p. 61). Despite the descriptor "multi-," *many* is not always best. Anker et al. (2016) found statistical significance between the number of dissemination channels and effect size: Increased channel use was associated with decreased effect size. This relationship is surprising. However, Willoughby and Noar (2022), referencing the conclusions of Anker et al. (2016), explain that the appropriateness of the channel is more crucial to the campaign effect than the number of

channels of distribution. Hansen et al. (2016) suggest that credible health promotion organizations like the CDC should utilize YouTube as a source for the dissemination of health information. Indeed, YouTube is the distribution platform of *Under the Paper Gown*.

2.2.1 *YouTube*

Founded in 2005, YouTube is a platform for creating and sharing user-generated content. Vereen et al. (2023) and Paek et al. (2011) identify two categories of YouTube video creators: laypersons and experts. The mélange of professional and amateur creators allows the platform to foster an "intermediary participatory culture" (Harris et al., 2021, p. 199) where both creator types foster co-productive relationship with themselves and externally with their viewers.

Public users of YouTube distinguish content created by experts and lay users by certain criteria, which are perceived similarity of the creator to themselves and the creator's perceived expertise. Perceived similarity to users is determined by values and shared demographics, whereas perceived expertise offers different cues—the appearance of or outright conveying of the creator's institutional knowledge or skill (Paek et al., 2011). Harris et al. (2012) note that source credibility and expertise are important factors among young people who seek health information on YouTube. Cues about source expertise, or lack thereof, allow users to determine salience of the message (Paek et al., 2011).

Public service announcements disseminated by experts, such as government agencies, are among the most viewed videos on YouTube (Paek et al., 2011). They are also relied upon as highly credible sources of health information. Walton et al. (2012) and Pandey et al. (2010) examined videos on YouTube from a range of creators with health information related to the H1N1 outbreak. Although CDC contributed 12% of videos deemed to distribute credible information about H1N1, 47% of total viewership was attributed to CDC (Pandey et al., 2010).

Marcus and Crane (1998) report the conclusions of several cervical cancer interventions that utilize mass media. Overall, campaigns that utilize mass media have larger effect than paper (letter and newspaper) campaigns alone. However, campaigns that utilize a combination of approaches has the strongest effect. These findings align with Noar's (2006) determination that campaigns utilizing media with other components have stronger effects than single-characteristic campaigns.

Health campaign efforts are also strengthened when they are aligned with guiding principles of health communication, like audience segmentation and formative research, theory application, placement of message to maximize exposure of audience segment, and outcome evaluation (Noar et al., 2010). Due to its utility as a medium for entertainment and information dissemination, advertisers and researchers use YouTube for the promoting of prosocial behaviors (Paek et al., 2011; Paek et al., 2010). CDC utilized both celebrity and sound information to promote gynecologic screening in *Under the Paper Gown* campaign, which is a sub-campaign of the agency's larger initiative to raise gynecologic health awareness called *Inside Knowledge About Gynecologic Health*.

2.3 Inside Knowledge About Gynecologic Health

Inside Knowledge About Gynecologic Health (*Inside Knowledge*) is a multimedia campaign that aims to raise women's awareness of the five main types of gynecologic cancer—cervical, ovarian, uterine, vaginal, and vulvar. CDC's Division of Cancer Prevention and Control in collaboration with HHS' Office on Women's Health developed the campaign following the Gynecologic Cancer Education and Awareness Act of 2005, which was signed into law in 2007. Known as Johanna's Law, it authorizes CDC to develop a national campaign to raise awareness on gynecologic cancers.

Following passage of Johanna's Law, CDC convened a panel of gynecologists, gynecologic oncologists, and other practitioners to discuss public awareness of gynecologic cancers (Rim et al., 2011). The CDC conducted 48 focus groups with a total of 408 participants aged 40-60 as well as focus groups comprised solely of medical practitioners (Rim et al., 2011). Campaign messages were refined from participant responses.

Inside Knowledge utilizes digital media and public service announcements on television, radio, and print outlets. Display ads have been placed in high-traffic areas like shopping malls and airports in major cities across the country, including Atlanta, Boston, Chicago, Dallas, Los Angeles, Miami, New York, and Washington, DC. The campaign appears in all 210 media markets in the United States (CDC, 2021).

An evaluation of *Inside Knowledge* completed in 2015 found that the campaign was effective in raising awareness of gynecologic cancers (CDC, 2021). From March 2012 to May 2012 CDC ran search engine campaign advertisements that appeared when users entered terms related to gynecologic cancer into Google (Cooper et al., 2015). When advertisements were combined with Internet promotion and television, visits to CDC web pages that provided gynecologic information were 65 times higher than in the three months preceding the campaign (Cooper et al., 2015).

Puckett et al. (2019) confirms the broad efficacy of *Inside Knowledge*, although noting that campaign elements resonate better with some audiences over others. For example, overall knowledge of gynecologic health increased among underrepresented and disadvantaged university students and women enrolled in substance abuse programs. The researchers concluded that existing exposure to education material moderated acceptance of campaign messaging. This

means that university participants are already accustomed to receiving learning material and thus may have been more receptive to *Inside Knowledge*.

From July 2012 to November 2013 CDC disseminated two *Inside Knowledge* advertisements on YouTube, utilizing two advertisement types. Pre-roll videos, which are often viewed by women, played automatically before the user's intended video. The user may elect to skip the advertisement type five seconds after it begins. Conversely, keyword-targeted advertisements appeared when users searched for information related to gynecologic cancers, and users initiate viewing. For both video types, users' viewing volumes surpassed industry averages, emphasizing YouTube as a popular and trusted resource gynecologic cancer information (Cooper et al., 2016).

The messaging of *Inside Knowledge* encourages women to understand what is normal for their bodies so that they may detect gynecologic abnormalities. It also educates women and their healthcare providers about the sign and symptom recognition, risk factors, and prevention of the main types of gynecologic cancers (Rim et al., 2011). Each cancer type has unique risk factors, symptomology, and methods of prevention (CDC, 2021; Rim et al., 2011). Cervical cancer is the only gynecologic cancer for which routine screening is recommended (Cooper et al., 2014; Rim et al., 2011). Therefore, messaging for cervical cancer focuses on completion of recommended screening (Rim et al., 2011).

Certainly, campaign effects are strengthened when intended audiences are exposed to the campaign. However, campaigns distributed on YouTube may experience some unique hurdles connecting with target audience and sustaining audience engagement. Health information videos produced for *Inside Knowledge* are delivered to the audience as advertisements in two formats as aforementioned: Pre-roll videos that allow the user to skip the health advertisement 5 seconds

into streaming and keyword-targeted listings that appear when users search terms related to the content (i.e., gynecologic cancer, cervical cancer screening). Although the video appears in search results users must click on the video to activate the video (Cooper et al., 2016). It is important to note that findings from Cooper and colleagues (2016) about women's propensity to watch the CDC's gynecologic cancer information advertisements on YouTube are limited to their process evaluation. Behavior intention—meaning, whether women would undergo gynecologic screening—was not assessed.

Under the Paper Gown is a new addition to *Inside Knowledge*. In the web series, the protagonist, Ruffin, overcomes her objections of seeing through with her gynecologist appointment. Rather than present a facts-heavy synopsis of the importance of maintaining regular gynecologic screenings (and the health dangers that arise when they are avoided), the campaign focuses on shedding light to the awkwardness or social anxieties women feel that may prevent them from seeing through with their appointment.

2.3.1 *Under the Paper Gown*

Under the Paper Gown is a CDC gynecologic health awareness campaign released on YouTube as a six-part web series in 2021 (Stam, 2021). The web series seeks to diminish the taboo of frank conversation about women's health with a gynecologist. CDC (2022) describes the objective of *Under the Paper Gown* as:

> When going to the gynecologist, many women feel too embarrassed to voice intimate questions and concerns, preventing them from getting the information and care they need. It's time for a change. We've partnered with comedy host, Amber Ruffin, and her sister Lacey to create a web series empowering women to overcome the awkwardness, and confidently speak up at the gynecologist.

The series opens with Ruffin's disorientation about the proper use of a bath robe, which symbolizes its clinical equivalent—the examination robe, or the paper gown. Throughout the six episodes, Ruffin works through her discomforts with humor, her relied-on tactic.

Born in Omaha, Nebraska, Ruffin is a writer, comedian, and television host. Multiple racist encounters endured by Ruffin fueled her ascent in comedy: In 2020, after the killing of George Floyd, Ruffin appeared on camera during "Late Night with Seth Meyers"—a show for which she is a writer and of which, when she joined in 2014, became the first Black woman to write for a late-night television show—to share testimony of her own encounters with police (Alford, 2022). Reflecting on the function of humor as a balm to racial injustice, Ruffin tells journalist Henry Alford, who penned her profile in *The New Yorker*, "If Black people didn't find the comedy in racism—which we always do—you'd have a bunch of f—in' *dead* Black people. We'd go insane." Ruffin co-authors two books with her sister, Lamar, and hosts her own talk show on Peacock called "The Amber Ruffin Show."

Ruffin also uses her platform for health promotion. In July 2022 she told viewers about her ordeal with fibroids. Ruffin said she promptly visited her gynecologist after waking up in a pool of blood despite wearing a tampon. She urged her audience to talk to their friends and family about fibroids because the health issue is more common than many may think. She also encouraged her audience to take notes of all symptoms that they believe may be related to fibroids and share them with their doctor. Ruffin corrected her fibroids with a hysterectomy and says that she had no regrets. In true comedian form she told *Essence*, "I was thrilled [to have the hysterectomy] ...To this day, every time I see a tampon, I laugh. I feel so frigging lucky" (Uwumarogie, 2022).

Ruffin's stature as a women's health advocate may had already been cemented due to her involvement in the CDC campaign, which debuted several months before her fibroid disclosure. I do not have data to confirm this relationship. However, I can empirically determine that as of July 2022 Ruffin had participated in at least two public announcements about women's health, amplifying a message to her viewer base and perhaps specifically to Black women. Celebrity activism, however, is a known and debated topic. Researchers study whether the public's adoration of a celebrity leads to engagement in other causes endorsed by that celebrity; they examine "the bridge" (Hunting & Hinck, 2017, p. 433) between celebrity endorsement and civic action. Despite the criticisms of celebrity endorsement, Hunting and Hinck (2017) argue that that the division between the celebrity and their rallying cause need not be separate.

Ruffin is perhaps then well suited to blend comedy and women's health in *Under the Paper Gown* where she plays herself. In Episode (Ep.) 1 she says, "I have a gynecologist appointment tomorrow and I'm never sure which way the robe is supposed to go," while fumbling with a bath robe as practice for the examination robe. That's just the start. In Ep. 4 she asks her sister if it is true that some women have four sets of labia. When her sister answers "No," Ruffin is taken aback and says she'll have to get herself checked out. When lamenting the foreboding extensive patient intake forms supplied by her clinician and the deficit of writing instruments provided to complete them, Ruffin asks, "How can there be so many questions and so little ink?" (Ep. 5).

Each episode concludes with a key message on gynecologic health and self-efficacy. These are: "Your gynecologist is there to help you, not hurt you" (Ep. 1); "Going to the gynecologist doesn't have to be awkward forever" (Ep. 2); "When something doesn't feel right, tell your doctor" (Ep. 3); "It's never too late to ask questions about your gynecologic health"

(Ep. 4); “Do yourself a favor and find a doctor you’re comfortable with” (Ep. 5); and, “It’s your body. Ask questions. Stay informed” (Ep. 6). Each episode’s description (Appendix A) reiterates messages of action and efficacy regarding gynecologic care. For example, the description of Ep. 6 reads:

> Amber drops in on her sister Lacey’s gynecologist appointment to impart (read as: brag about) some of the newfound wisdom and confidence she’s acquired over the past 5 episodes. Turns out, learning and growing is a lifelong process for all of us. Remember...it’s your body. Ask questions. Stay informed.

Overall, *Under the Paper Gown* uses “levity to raise awareness around a major issue—the health benefits of regular gynecological visits” (Ogilvy, n.d.). Humor is a tricky inclusion in campaigns that can raise awareness of the health issue while in some applications alienate the intended audience.

2.4 Use of Humor in Health Campaigns

Humor is an increasingly utilized component of health campaigns. This is because humor, which elicits positive emotion, enhances message acceptance (Bonfadelli, 2022). Humor is preferred to fear appeals that “are often rejected for the reason of selective attention and interpretation to avoid cognitive dissonance” (Bonfadelli, 2022, p. 65). Guttman and Salmon (2004) examined ethical issues across campaigns and noted that playing on fear to motivate behavior change can reflect a “dubious morality” (p. 539). Therefore, it can be assumed that *Under the Paper Gown* tackles the frustrating but lighter aspects of preparing for a gynecologist appointment—like bringing your own pens—rather than heavier topics like cervical cancer mortality.

Further, the appropriateness of humor is sometimes disease specific. Bonfadelli (2022) cautions the use of humor in campaigns related to COVID-19 vaccination given the gravity of the pandemic. However, the German government took a different approach; it introduced humor in the discussion of the COVID-91 pandemic. A pandemic-era YouTube campaign titled, "Be lazy, saves lives," shows elderly Germans in the future reflecting on their youth of the year 2020 and sharing fond memories of remaining indoors. The campaign message, described as "tongue in cheek," urged citizens to stymy the spread of coronavirus by "being lazy" and remaining indoors (Reuters, 2020).

Even when applied in more suitable contexts for more appropriate disease types, humor must be applied carefully. Campo et al. (2013) measured responses of women aged 18 to 30 to a campus-based health campaign on avoiding unwanted pregnancy. Formative research revealed that participants would not respond to irreverent behavior or humor communicated through embarrassment. Respondents indicated that humor should not chastise expectant young mothers.

Campaign humor has an upside. Humor is found to increase the likelihood of message and campaign sharing (Campo et al., 2013). The sharing factor may be particularly beneficial to social media campaigns, which are released on platforms whose sharing functionality is both intrinsic and encouraged (i.e., buttons to share media directly to email and the user's other social media accounts). Sharing of health information through social networks is an indirect route through which a health campaign may influence behavior change (Helme et al., 2011; Wakefield et al., 2010). After the message permeates social networks, behavior change may be achieved through interpersonal discussion or by influencing policy change. Scholars in fact have introduced the term masspersonal to describe the common compounding effect of interpersonal communication on mass media health campaigns (Willoughby & Noar, 2022).

Humor, like other campaign elements, must resonate with the intended audience as one measure of campaign's success. Campaign developers must also balance the lighthearted nature of comedic messaging with the audience's receipt of the intended message. In *Under the Paper Gown*, Ruffin's cluelessness at the purpose of the Pap smear reflects real-world data on women's understanding of the exam. Hawkins et al. (2011) found that women previously diagnosed with HPV or other gynecologic cancer "were no more likely than those without a diagnosis of these conditions to be aware of the link between the Pap test and cervical cancer" (p. 514). Although 93% of women in the United States reported receiving the Pap test, a much lower proportion of women between 18 and 34 years of age reported receiving the test (Hawkins et al., 2011). More recently, Lee (2022), conducting an online survey of women college students, determined that exposure to Internet messages about cervical cancer improves women's' knowledge and efficacy beliefs toward cancer prevention.

It is possible that Ruffin's comedic accoutrements are not humorous at all. Cusanno (2023) employs a "feminist new materialist and reproductive justice" (p. 1065) framework to study consent in pelvic examimations (PE). She spotlights the paper gown (which is referred to as paper drape) as an integral but often overlooked component of the cervical examination experience. Cusanno (2023) further describes how the unassuming paper drape amplifies its wearer's discomforts: "A paper drape blocking my view of the doctor who sits between my legs" (p. 1067). In this rendition the robe is less a product of Hollywood creation, and funny, and instead is possibly truer to the real-world partnership between the gown/robe and the patient undergoing screening.

The present study asks participants whether Ruffin's take on anxieties about gynecologic care resonate with their own experiences. By extension, this study may shed light on whether the

experiences of African American women while undergoing gynecologic care are potentially too severe to be portrayed humorously. The following section reviews campaigns whose intended audience are African Americans.

2.5 Health Campaigns Among Disparity Populations

Some published studies offer best practices for health communication scholars seeking to apply different approaches when aiming to connect with disparity populations. Researchers developing a campaign to raise depression awareness in Louisville, KY, a predominantly African American city, replaced medical jargon with recognizable and culturally relevant language cues. The researchers developed the campaign's messages using a community-based approach that sought and incorporated input from residents and other community stakeholders (Muvuka et al., 2020). Another demonstrated means of attaining community buy-in of a health promotion message—particularly in the Black community—is through engagement with churches (Hatch & Derthick, 1992). African American churches have been useful to promoting positive behaviors related to cardiovascular health (Sanusi et al., 2023) and diabetes (Newlin et al., 2012), among a list of other health concerns.

Community engagement as an important research approach applies not only to groups of racial disparity but also those of regional disparity, such as communities in Appalachia. (Of course, African Americans in Appalachia represent both racial and regional disparity). Lefebvre et al. (2020) studied whether an opioid intervention could decrease overdose deaths across 67 communities in Appalachia and decrease stigma toward opioid users in those communities. Researchers formed a coalition of community members and specialists to co-construct and implement the campaign. They identified four benefits of participatory collaboration, including

linguistic benefits which was similarly determined by the depression awareness campaign in Louisville, KY, and understanding of social norms.

Celebrity is also a boon to message resonance in disparity communities. To combat COVID-19 vaccine hesitancy in Black communities, rapper Juvenile reworked part of his 1999 hit song, “Back That Thang Up,” to “Vax That Thang Up” to promote vaccination uptake (Hawkins & Simon-Roberts, 2023). The PSA music video was developed through multiple intersections of pop culture and health promotion: The video was developed by a dating app for Black singles that partnered with Juvenile and recruited other rapper cameos. The final product was uploaded to YouTube.

Willoughby and Noar (2022) find that a health campaign’s success is in a major part attributed to the appropriateness of the campaign’s channel. Reiterating an earlier statement, a mass media outlet ill-suited to the campaign’s target audience will restrict exposure of the message and thus result in underwhelming behavior change among its target population. Stated differently, a mismatch will produce a small effect size. In Georgia, researchers partnered with CDC, which is headquartered in Atlanta, to encourage low-income African American women to undergo breast cancer screening. The campaign reached its target audience by utilizing Black radio stations that catered predominantly to African American interests to motivate screening behaviors (Hall et al., 2012). Yet, social media interventions targeted to disparity audiences are lacking in the total landscape of multimedia health interventions (Vereen et al., 2023).

This study seeks to investigate Black women’s perceived barriers to undergoing routing gynecologic care and examine their reactions to the character portrayed by Ruffin. The aim of the study is to learn Black women’s real-life testimonies about awkward and anxieties experienced with routine gynecologic care. As such, this study applies HBM—specifically, the

perceived barriers construct—to discover the psychosocial factors that are inhibitors to engaging in gynecologic care.

2.6 Contributing Factors to Black Women's Gynecologic Care Hesitancy

Before hypothesizing the barriers endured by Black women during the gynecologic care experience, it is important to acknowledge that researchers have explored a range of factors that "communicate powerlessness and alienation to patients" (Cusanno, 2023, p. 1067). These factors are institutional, structural, and interpersonal in nature. Nonhuman elements of the examination room—the exam table, exam procedures misaligned with cultural norms about nakedness, and the paper drape—are also determinant factors of the patient's comforts (Cusanno, 2023).

Arguably, historic racist medical malpractice primes African American women to feel a degree of uneasiness when engaging in various exam procedures. The field of gynecology is particularly fraught with a history of abuse and exploitation of African American women (Laughman et al., 2023). The physician named the "father of gynecology" (Laughman et al., 2023, p. 125) experimented on unanesthetized enslaved Black women. His findings formed the basis of the gynecology discipline. The egregious practice of forced sterilizations and hysterectomies also attest to historic cruelty. One infamous example of the former practice is the procedure executed on civil rights icon Fannie Lou Hamer. Hamer visited a white male doctor to address a uterine tumor. He instead removed Hamer's uterus, performing a nonconsensual procedure so commonly forced upon Black women it was known as the 'Mississippi appendectomy' (Early, 2021). (Ruffin's embrace of her hysterectomy, although a voluntary procedure, was perhaps even more notable given the history of the involuntary practice on Black women).

Wade et al. (2022) note a dearth of research centered on Black women's experiences with gynecologists. The researchers conducted semi-structured interviews with Black women to gain insight into these experiences and identified themes from thirty-nine participant responses. The themes were: Patients feeling ignored; having their intelligence insulted; receiving proper help and education; benefits of race and sex; discomfort due to sexual taboos; perceived medical racism; impact of other intersectional identities; and no impact. The researchers applied a feminist framework, which perhaps elicited themes above and beyond the oft-cited factors like cost, education, health insurance, and access (Ackerson, 2010).

Race and sex concordance is an acknowledged concern in the medical field. For the first time since its 2008 inception, the Physician Specialty Data Report 2022 reported race and ethnicity of physicians (Boyle, 2023). Women account for 60.5% of active physicians with a specialty on obstetrics and gynecology. Yet, only 5.7% of active physicians identify as Black or African American (Boyle, 2023). Given that statistic, *Under the Paper Gown* presents a somewhat idealistic scenario in which the actor who portrays the physician, Dr. Stewart, is a Black woman, thus mirroring the ethnicity of her patients Ruffin and Lamar.

Aside from contributing to the optics of an all-Black patient-provider team, Dr. Stewart exhibits behaviors that strengthen healthy patient-provider communication: The physician patiently tolerates Ruffin's quirky comments and explains, in plain terms, correct medical information in retort. Of course, with barely six percent of physicians identifying as Black or African American, Black patients are more likely to engage in race discordant interactions. An important factor in race discordant patient-provider communication is implicit racial bias. Penner et al. (2016) examined whether oncologists' racial bias affected their patients' treatment adherence. They examined pairs of Black patients and non-black physicians and determined that

higher bias corresponded with shorter patient interactions, less patient-centered communication, and consequently, less patient adherence to cancer treatment.

Nevertheless, *Under the Gown* portrays a social anxiety (awkwardness) barrier not recorded in the themes itemized by Wade et al. (2022) or as a byproduct of race discordance. Using the HBM framework, this study examines whether social anxieties as portrayed in *Under the Paper Gown* are true barriers in precluding Black women from participating in positive gynecologic behaviors. A review of HBM follows.

2.7 Health Belief Model

HBM was developed in the 1950s by social psychologists to explain an individual's failure to adopt preventative disease behaviors (Champion & Skinner, 2008; Rosenstock, 1974). The framework focuses on actions taken towards disease prevention; hence it is suitable for the aims of this study. The HBM framework has six predictive constructs regarding health behavior adoption: perceived susceptibility and perceived severity (which together measure perceived threat), perceived benefits to adoption of a health behavior, perceived barriers to adoption, cues to action, and self-efficacy (Chart 1) (Champion & Skinner, 2008). The final construct is a later addition to the framework that aims to expand its usefulness.

Figure 1. Health Belief Model Constructs

Construct	Definition
Perceived susceptibility	Beliefs about the likelihood of getting a disease or condition
Perceived severity	Beliefs about the consequences of a condition
Benefits to action	Belief in efficacy of the advised action to reduce the threat
Barriers to action	Belief about the tangible and psychological negative effects of the advised action
Cues to action	Mechanisms that trigger action
Self-efficacy	Belief in one's ability to take action

2.7.1 *Perceived Barriers Construct*

This study aims to explore Black women's perceived barriers of attending routine gynecologic appointments. Barriers impede upon the execution of positive health behaviors. In *Under the Paper Gown,* Ruffin believes that her anxieties (her awkwardness) are a major hurdle that inhibit her attending of a scheduled gynecologist appointment. This study also aims to assess whether the concerns expressed by Ruffin resonate with participants' own experiences. Therefore, this study focuses on the perceived barriers construct of HBM.

Scholars have issued several definitions of perceived barriers. Champion and Skinner (2008) define perceived barriers as "beliefs about the tangible and psychological costs of the advised action" (p. 48). Davis et al. (2013), while examining racial and ethnic differences in cancer prevention beliefs, define perceived barriers as, "the opinion that certain things will interfere with adopting the new behavior" (p. 385). Janz and Becker (1984) define perceived barriers as the negative beliefs that underpin an individual's decision to uptake a health action. Such beliefs may include cost, pain, inconvenience, and, particularly applicable to screening behaviors, detection of disease. Julinawati and colleagues (2013) cite studies examining perceived barriers to cervical cancer screening, identifying social class, education level and embarrassment as additional factors.

Women need to visit the gynecologist to participate in gynecologic prevention screening. Therefore, the preemptive step to undergoing screening is to visit the doctor. Patients report a range of factors that prohibit them taking this action. Some clinicians (Chapman-Davis & Howard, 2023) attribute their patients' reluctance to health education, transportation, and language. Tello et al. (2010) note depression, recent substance use, HIV-positive status, forgetting about the appointment, inclement weather, and fear of bad news as primary reasons for

gynecologic appointment avoidance. In that study, fear of PE and feeling violated by the examination attributed to 4% and 3% of responses, respectively.

Concerns about the bodily toll of visiting the gynecologist appear in other studies. Amy et al. (2006) cite embarrassment at being weighed and disrespectful treatment, including unsolicited weight loss advice, as concerns among obese women. Interestingly, perceived barriers increased in accordance with the patient's body mass index.

Ackerson (2010) notes that women who have experienced sexual trauma may exhibit lower Pap test frequencies than those who do not have those traumas. Kowalski and Brown (1994) identify a similar relationship between screening frequencies and physiology, which they defined as "physique anxiety" (p. 941). Women who normally experience anxiety may not undergo Pap screening at all to avoid heightened anxiety (Kowalski & Brown, 1994). Some of the anxiety related to screening is also attributed to concern over the physician's procedure and reaction to the patient's body, especially due to factors like size and odor.

The researchers found that anxiety was a significant predictor to willingness and frequency of screening. These conclusions, however, reflect a participant group of 82 white women. Black women may present different motivations to medical care broadly, and to gynecologic care specifically, due to reasons pertinent to historic mistreatment and contemporary social factors reviewed above. For my awareness, a study on social anxiety experienced by Black women patients in the gynecologic realm is not known. Therefore, this study identifies an important research gap that may contribute to cervical cancer health messaging targeted to African American women.

McCallum et al. (2012) explored the differentiation of barriers between young and older women for not engaging in cancer prevention screening, citing emotional avoidance for young

women, and, for the latter, shyness, and stigma. That young women experience emotional avoidance when contemplating gynecologic screening is captured in the findings of Ahmed et al. (2012), who report that nearly 70% of eligible students in a multi-ethnic university had never received a Pap smear. The students cite procrastination and fear as reasons for not undergoing the examination. Further, almost 93% of students in the study were not aware the student health plan provided free Pap tests.

Elsewhere health communication scholars (Schinkel et al., 2019) examined perceived barriers among Turkish-Dutch ethnic minorities in the Netherlands. Participants reported that their physician’s questioning style about health status that were too direct and incongruent with their cultural norms. Additionally, treatment recommendations, discrimination and power differentials enabled the participants' lack of involvement in their own healthcare. Burak & Meyer (1997) examined three barriers to college women’s gynecologic screening: Pain, embarrassment, and cost. They determined that screening behaviors within that group are complex and need further study. Thus, the following section introduces the research questions and hypothesis that will guide this study.

2.8 Research Questions and Hypothesis

Throughout *Under the Paper Gown* Ruffin raises objections to undergoing her gynecologist appointment. She fusses about much more than the robe and the doctor's cold hands. For example, In Ep. 1 Ruffin asks Lamar why her vagina changes color with her mood. In Ep. 3 Ruffin agonizes about having "vagogo," a fictional gynecologic disease she discovered from an Internet search while preparing for the appointment. In Ep. 4 she asks Lamar whether the health news she heard walking past the popular girls' lunch table in high school was true (to

which Lamar returns, "When did *you* sit at the popular girls' lunch table?"). Ruffin's behavior communicates her anxiousness for the looming gynecologist appointment to the viewer.

The present study asks whether Ruffin's objections reflect participants' true experiences. This question emerges from research by Kiernicki and Helme (2017), who examined the effect of visual incongruency in drug advertisements (for example, arthritis advertisements that include physically active people), persuasiveness and participant recall. In *Under the Paper Gown* the possible cue incongruencies are both visual (i.e., fumbling with the bathrobe) and verbal (Ruffin's inquiry about vagogo and stating that her last period was "March 37th"). Although their (Kiernicki & Helme, 2017) hypothesis on the effect of participants' elaboration was not supported, a question about the gap between Ruffin's portrayal, real life, and persuasion to adopt a health behavior nonetheless arises.

Therefore, the research questions are:

RQ_1: What are women's perceived barriers to attending gynecological appointments?

RQ_2: Does Under the Paper Gown display realistic barriers to attending the gynecologist as reported by participants?

RQ_3: What are the communication challenges African American women experience during gynecological appointments?

Ruffin's preoccupations are hindrances to completing the recommended health action, which is attending her gynecologist appointment. Ultimately though, sister Lamar's cajoling convinces Ruffin to follow through. Ruffin's stance is described as awkward. This study explores whether the presentation in *Under the Paper Gown* accurately reflects the study participant's own barriers that inhibit their performing of routine gynecologic examinations. Since there are no clinical, agreed-upon criteria for awkwardness, this study resorts to describing

Ruffin's sentiments as social anxiety. DSM-5 criteria for social anxiety (Mayo Clinic, 2021) include an individual's anxiety about social situations believing they will be scrutinized or viewed critically (exemplified by Ruffin's concern of the doctor being able to tell her sexual history by looking at her vagina—"It's not a crystal ball," Dr. Stewart tells her); and avoidance of anxiety-inducing situations (such as the appointment itself). Therefore, the hypothesis poses:

H_1: Social anxiety is a barrier to attending a gynecological appointment as reported by the participants.

This study is primarily a qualitative investigation. However, a survey questionnaire will be utilized to gather demographic information about participants. Together, they will examine the research questions and hypothesis. The following methods section will describe the participant sample, review recruitment and interview procedures, and include the survey questionnaire and interview protocol.

CHAPTER 3. Method

The objective of this study is to gain an understanding of the barriers that prevent African American women from attending gynecological appointments and consequently, not engage in preventative cervical care. This study utilized a survey questionnaire (Appendix B) to gather demographic information and behaviors related to routine gynecologic care for participants who (1) identify as African American, (2) identify as women, (3) are between ages 18 to 34, and (4) reside in the United States. The questionnaire concluded by allowing participants to opt-in to semi-structured interviews. The opt-in question informed participants that they will watch YouTube videos during the interview. However, any mention of *Under the Paper Gown* was excluded from the survey to avoid bias in participant responses due to exposure to the campaign.

This study collected data from 20 completed questionnaires (*N*=20) and 10 interviews (*n*=10). Perhaps traditionally, a study that utilizes a survey questionnaire and semi-structured interviews to collect data may be categorized as mixed methods. However tempting the labeling, titling a study 'mixed methods' is a designation not to be loosely applied. Researchers utilizing mixed methods should be certain their selection of qualitative and quantitative approaches integrate achieve the research objective. Tension points include that the researcher must determine their flexibility or rigidity in applying both approaches (Hunting, 2021). Some researchers, simply, may be too novice.

Therefore, while mixed methods applications to health communication research are exercised by scholars examining a range of women's behaviors related to sexual, reproductive, and gynecologic health behaviors (Francis et al., 2021; Merrill et al., 2018; Williams et al., 2013), a true mixed methods study remains aspirational. In this study the quantitative element of

this study is used only to get an insight to the participant sample. Results from the survey are not generalizable beyond the participant sample.

3.1 Participants

The present study consisted of a sample of women (*N*=20) (Table 1). Race and ethnicity representations were 85% (n=17) Black or African American, 5% (n=1) American Indian or Alaska Native, 5% (n=1) Asian, and 5% (n=1) Native Hawaiian or Other Pacific Islander. This study examined the gynecologic care experiences of African American women. However, participants were provided with the current race and ethnicity classifications established by the U.S. Office of Management and Budget. The broader offering of race and ethnicity allowed participants self-select the identity best suited to them. Furthermore, individuals of multiple heritages, especially those with Black or African American ancestry, may still embody the gynecologic care experiences of participants who select only Black or African American as their race and ethnicity.

Study participants ranged in age from 18 to 34 years of age, represented as ages 30-34, (n=9, 45%), ages 26-29 (n=6, 30%), ages 22-25 (n=4, 20%), and 18-21 (n=1, 20%). Providing participants the option to select an alternate gender identity on the survey questionnaire honors lived experience, as explained above with the race and ethnicity categorizations. Most participants (n=17, 85%) identified as women. One participant (5%) identified as a man and one participant (5%) selected "gender identity that is not provided". One participant (5%) did not respond.

Five participants (25%) had not obtained at least a bachelor's degree (they had a GED or Associate's degree), whereas 40% (n=8) had a bachelor's degree, 25% (n=5) had master's degrees, and 10% (n=2) had doctorate or professional (i.e., JD, MD) degrees. Participants self-

reported the number of gynecology appointments they had attended. Eleven (55%) participants had attended five or more gynecologist appointments, five (25%) had attended 1-2 appointments, two (10%) had never attended a gynecologist appointment, and one participant (5%) had attended 3-4 gynecologist appointments. One participant did not answer the question. Most participants, (n=15, 75%), had health insurance.

Table 1. Participant Demographic Variables

	Sample *N*=20	Interview Sample *n*=10
Age		
18-21	1	1
22-25	4	1
26-29	6	2
30-34	9	6
Gender Identity		
Woman	17	10
Other Identity	3	NA
Race		
Black or African American	17	10
Non-Black or African American	3	NA
Education		
GED or Diploma	3	1
Associate's Degree	2	2
Bachelor's Degree	8	4
Master's Degree	5	2
Doctorate or Professional	2	1
Health Insurance		
Yes	15	9
No	NA	NA
Gynecology Appointments Attended		
1-2	5	1
3-4	1	1
5 or more	11	5
None or zero	2	1

**Note*: The sum for each variable may not total 20 due to missing data

Half of the total sample (n=10, 50%) opted-in to interviews. Interview participants ranged in age from 21 to 34 years (*M* = 29.2; *SD* = 4.42). Although Pap smear screening is

recommended from age 21, the study sought participants as young as age 18. This is because young women aged 18 may have already begun attending gynecologist appointments without parental supervision. As young adults who may have begun exercising agency over health decisions, young women between the ages of 18 to 20 may have thus begun to cultivate their own perceptions, whether positive or negative, towards such appointments. These sentiments in turn may also affect behaviors toward future appointments and screening. Informed consent was obtained before completion of the questionnaire. Verbal consent was also obtained and recorded prior to the start of the interview. The following section reviews the recruitment procedures.

3.2 Design and Procedures

Distribution of the survey began after securing approval from the university's Institutional Review Board (IRB), which was obtained in May 2023. Participants were recruited by convenience and snowball sampling. Consistent with the recruitment proposal submitted to IRB, I posted the recruitment flier in locations with African American interest in a major city in a southern state. These included in pertinent locations on the campus of a large university, a Black heritage arts and culture center, and health clinic in an under-resourced community. I also distributed the recruitment flier at community events in June 2023 celebrating Juneteenth, a federal holiday commemorating the end of slavery. I also posted the study announcement to social media, including a Reddit forum dedicated to OBGYN-related topics, and to in-person networks. Examples of the latter include a group Black women yoga practitioners and volunteers at an organization promoting food equity. Email announcements of the study were sent to the historically Black sororities on the campus of the university. Recruitment took place between May 2023 and June 2023. The recruitment flier included a weblink and QR code that led to the survey. The survey questionnaire was developed in Qualtrics.

This study's recruitment flier also notified participants that the questionnaire may present the opportunity to take part in an approximately 40-minute-long interview–allocated as 15 minutes to watch YouTube videos and approximately 25 minutes for Q&A. After completing the survey, participants could opt-in to the interview by providing their email address in the final question of the survey. After identifying a participant's opt-in selection, I emailed affirmative respondents to coordinate a date and time for the interview. I sent an initial email and two follow up emails, after which I ceased initiating communication. Two participants who opted-in to interviews on the questionnaire did not respond my three email attempts to coordinate the interview.

3.2.1 ***Semi-Structured Interviews***

The semi-structured interviews (Appendix C) gathered information on participants' present knowledge about gynecologic care, experience communicating with their physician during their gynecology appointment, and responses to *Under the Paper Gown*. The interviews were conducted over Zoom and took place in a private setting to ensure confidentiality. No other persons were in the room with the researcher at the time of the interview. Tracy (2020) says that semi-structured interviews provide the researcher an approach that makes room for probes and flexible delivery of questioning. One participant had never had a gynecologist appointment. Therefore, in that interview, questions from the interview guide that inquire about the participant's feelings before the appointment were altered to ask the participant how she thinks she would feel in the moments leading to her appointment.

Participants were permitted to skip questions they did not want to answer. After describing their own experiences, participants watched *Under the Paper Gown* on YouTube. Since interviews were performed using Zoom, I initiated a screenshare so that participants

watched the videos from my laptop. *Under the Paper Gown* consists of six episodes. I saved all six videos to a YouTube playlist so that they played in succession. Each episode is approximately two minutes long, therefore the playlist run time was under 15 minutes in length. The interview closed by asking the participant to contribute additional insights that the planned questions did not cover.

The recording feature on Zoom was enabled so that a transcript automatically populated at the end of the interview. After obtaining all transcripts I listened to each interview while reading the transcript and adjusted the transcripts for missing and misspelled words. Any edits to the transcript I performed were done to ensure the transcript reflected the interviewee's responses verbatim. No words were added that the interviewee did not state. Words that were incomprehensible, even after listening to multiple playbacks, were denoted as "----?----" in the transcript. I also anonymized each transcript by labeling each interview "Participant_#," as in Participant_1, for the first interview and so on for all ten interviews. Later, pseudonyms were assigned during the analysis of transcripts. IRB granted approval for fifteen interviews; however, saturation was reached at the tenth interview. The cutoff aligns with the recommendations of Tracy (2023), who says that saturation is reached between the ninth and seventeenth interviews. Thematic analysis was conducted on interview transcripts.

Using an iterative phronetic approach (Tracy 2020; Tracy 2018) guided by the HBM framework, transcripts were analyzed to determine themes. Qualitative data collection was supported by a survey questionnaire that gathered demographic information of the participant sample. Specifically, the questionnaire recorded participants' age, gender, education, race, possession of health insurance, and number of gynecologic visits they had experienced. The questionnaire also recorded participants' anxieties about attending their appointment. Questions

that explored the latter area were inspired by a scale developed for HBM. An overview of the scale construction of HBM follows.

3.2.2. *Survey Questionnaire*

The survey questionnaire was adopted from the Instrument for HBM Constructs developed by Champion (1984), who refined existing scales for each construct of HBM. In Champion's (1984) scale, perceived barriers achieved internal consistency of .76, demonstrating sufficiency by the stipulations of Cronbach’s score. Construct validity was demonstrated through factor analysis and multiple regression. The scales focused on breast self-examination and breast cancer. Demographic questions asked participants to report age (intervals from 17-82), race (Black, White, or Missing), marital status, religion, and education. The present study modifies the age range to 18 to 34 and expands the race category to reflect current classifications established by the U.S. Office of Management and Budget. The scale developed by Champion (1984) concludes with an opt-in question for additional participation in interviews. The respondent’s contact information was recorded to affirm their willingness for added participation, as was the procedure followed in the current study.

Champion’s scale—sometimes called Champion’s Health Belief Model (CHBM) (Guvenc et al., 2011)—has been modified since its inception for culture and disease relevance. Guvenc and colleagues (2011), with permission from Champion, developed The Health Belief Model Scale for Cervical Cancer and the Pap smear Test to test the constructs among health behaviors of Turkish women. The resulting scale realized fourteen items for the perceived barriers subscale that related to concerns about cervical cancer, knowledge on arranging a Pap test, exchange with physicians, gender preference, and remembering to attend the appointment (Guvenc et al., 2011).

The present survey questionnaire, in alignment with Ampofo et al. (2020), gathers self-report demographic information including age, race, and education. One *Yes/No* question inquires the presence of health insurance since for some participants, the presence of insurance may motivate positive health behaviors. In accordance with Kowalski & Brown (1994), one question gathers the number of gynecologic appointments the participant has attended (from zero to 5 or more).

The questionnaire utilized 5-point Likert scales (*1=Strongly disagree* to *5=Strongly agree*) to measure participants' self-report anxiety pertaining to their gynecology appointment. Participants self-reported feeling anxious at appointments (*M* = 2.90, *SD* = 1.48); their anxiety making them want to skip their appointment (*M* = 2.78, *SD* = 1.63); their anxiety about the gynecologic examination (*M* = 3.11, *SD* = 1.329); experience feeling generalized anxiety (*M = 2.71, SD* = 1.45); and feeling comfortable talking to their gynecologist (*M = 3.74, SD* = .991). One question measured participants' preference to be seen by a Black woman gynecologist (*M* = 4.27, *SD* = 1.1).

Quantitative analysis was performed using SPSS version 28. Nonparametric One-way ANOVA tests were performed to determine the significance between the participant's reporting of feeling anxious about their appointment and the anxiety causing them to skip their appointment, and their reporting of feeling anxious about the exam and the anxiety causing them to skip their appointment.

Quantitative analysis provided insight to the participant sample. The primary data analysis method was the phronetic iterative approach. The following section provides the reasoning for the selection of this data analysis method and outlines the procedures followed to develop the codebook and themes of this study.

3.3 Qualitative Analysis—Phronetic Iterative Approach

Tracy (2018) places the phronetic iterative approach as the middle point between inductive and deductive analysis. Iterative analysis asks: "What are the data telling me?", "What is it I want to know?" and, "What is the dialectical relationship between what the data are telling me and what I want to know?" (Tracy, 2020, p. 210). When performing iterative analysis the researcher oscillates between their knowledge of the existing framework–focusing on aspects of data that may extend theory or apply to practical problems–and guiding research questions, while also considering emerging qualitative data.

The researcher is encouraged to be reflexive and consider, that is to recall past literature as well as their own interests and experiences. I practiced self-reflexivity by thinking of my own gynecological care practices, especially that most of my gynecologists thus far have been older white males and a few white females. I also reflected on health campaigns literature given the campaign evaluation component of this study. These considerations are sensitizing concepts that form my conceptual lens for this qualitative study. Tracy (2018) cautions that the researcher's conceptual lens should be held loosely as not to impose upon the data set but affirms that the phronetic iterative approach is suited to new researchers in qualitative research.

Themes from interview data were derived from qualitative coding, using an analysis process described by Tracy (2020). The researcher, Tracy (2020), asserts that "after reading across multiple disciplines over many years," (p. 213) there is no distinction among many words to describe the label used to describe manageable segments of qualitative data, including code and theme. Codes "symbolically assign a summative, salient…attribute for a portion of language-based or visual data," (Saldaña, 2016, p. 4). Said another way, a code is a word or brief

statement that summarizes one episode of data. Creating codes to derive conceptual categories helps open up or make sense of data (Tracy, 2020; Saldaña, 2016; Schreier, 2012).

Schreier (2012) states that although coding takes two forms–reductive and conceptual–coding in qualitative analysis typically adopts a conceptual approach as the first step in a comprehensive analysis. I began analysis by doing multiple readings of verbatim interview transcripts. To develop verbatim transcripts, I read the transcripts auto generated by Zoom along with audio recordings and filled in missing and misspelled words. Inaudible statements were noted and left blank; they were not filled in by the researcher's guessing.

I read verbatim transcripts twice before commencing the first coding phase. Deep immersion in data reflects the definition of qualitative analysis put forth by Tracy (2020), which reads, "qualitative analysis is about immersing oneself in a scene and trying to make sense of it," (p. 3). Starting with the first interview (labeled "Participant_1") I created codes that emerged in my mind for each segment of data. For some sections, each line (I coded line-by-line) received a single code while for other codes were applied to a sentence or two that captured an idea or scenario the participant expressed. However, where possible, I leaned toward line-by-line fractured coding to achieve a more vivid analysis of the data (Tracy, 2020). I completed manual coding for all ten interview transcripts.

Coding typically occurs in two cycles (Tracy, 2020). First level codes emerge in the first cycle. These codes directly reflect the data presented and are not interpretative. Tracy (2020) offers guiding questions to consider when working through this coding phase, such as, "What is happening here?" and "What are people doing?" (p. 215). Some of the codes I identified were *in vivo*, meaning they are pulled directly from the participant's statements (Saldaña, 2016) (see Figure 2). Tracy (2020) advises that codes that are verbs ought to be written as gerunds, meaning

that they end in *-ing* (i.e., hesitating), to note the participant's action. Some data also received more than one code. I wrote first level codes in the margins of the transcripts. After the manual layer I moved my work process to Microsoft Excel (Excel), typing codes and their supporting text into one spreadsheet. I recreated the first coding phase in Excel where, ultimately, I developed a codebook. I utilized the manual process for the initial engagement with data whereas software is useful for organizing budding observations.

Figure 2. First-level coding.

Code(s)	Supporting Text
"NAKED" (in vivo); UNSURE	I never quite know what to expect. All I know is like those appointments you just get naked.
VAGINA CODE-WORDING	I guess that they kinda take care of your – I don't know what to word for it – area down there.
"AFRAID"	Yeah, I felt afraid. I felt I felt so – intentions with how the doctor will perceive me and will perceive my my, you know, vaginal area?
NOT HESITATING	If it's just routine Pap, I have no issues going there.

In the second cycle of coding, frequent and similar codes are consolidated into categories that are later focused into themes. Using Excel, I performed this cycle by color-coding and grouping codes that represented similar ideas, then naming those categories.

Whereas adding codes to lines of data in the first cycle is "codifying", assembling codes into categories is "synthesizing" (Saldaña, 2016, p. 10). The axial or hierarchical codes (Tracy, 2020) developed for the second cycle are interpretative and provide insight to the data. For example, several participants described their experience attending their first ever gynecologist appointment (see Figure 3a). Many testimonies highlighted their push to attend, whether by convincing a friend to come, because their mother scheduled their appointment, or because there is an urgency that supersedes their hesitation to see a male physician. Therefore, I ascribed the axial code MOTIVATION TO ATTEND APPOINTMENT.

Figure 3a. Second-level coding.

Supporting Text	Code(s)	Axial/Hierarchical Code
I had to talk to a friend so we go together so I'm not alone. So I basically had to convince a friend that, hey girl, we have to do this.	"CONVINCE"; GOING; FRIEND	MOTIVATION TO ATTEND APPOINTMENT
Some reasons why I wouldn't schedule one or go is if my provider was a man. I do have an issue with that. But at the end of the day. If it's an emergency, you know I have to go.	"EMERGENCY"; GOING; GENDER	
So I I guess I started going regularly to the gynecologist when I was in high school, and so at that point it was like my mom who would schedule my visit and I would go.	"GOING"; PARENT	

For another example, I collapsed codes that related to participants' testimonies about race and gender preferences of their gynecologist to RACE/GENDER PREFERENCE (see Figure 3b). This decision was motivated by repeated codes including instances where the participant shared how race and gender similarity determined their comfort level for the appointment.

Figure 3b. Second-level coding.

Supporting Text	Code(s)	Axial/Hierarchical Code
I would, feel more comfortable if they were women of color or men of color if it comes down to it.	GENDER; RACE; "COMFORTABLE"	RACE/GENDER PREFERENCE
I had male doctors in the past, and it was very awkward and uncomfortable, even though they were professionals.	GENDER; "UNCOMFORTABLE"	
I recently went to a provider who is also an African American woman that I was a lot more comfortable with, and that seemed to have a completely different experience from what I'm used to.	GENDER; RACE; "COMFORTABLE"	

Developing themes is one step further, as themes are the outcomes of coding. Saldaña, (2016) says that this progression moves from real to abstract where first level codes are observational (i.e., answer 'What is going on here?') and the outcome grouping assigns codes to

concepts. Hierarchical groups show that codes share a higher level similarity, while the relationship between them is made known through a conceptual framework or theory (Saldaña, 2016). In the phronetic iterative approach, the researcher practices reflexivity and considers existing conceptual frameworks during analysis. Therefore, calling upon knowledge of HBM, one example of a theory related to the code in Figure 3a is cue to action:

MOTIVATION TO ATTEND APPOINTMENT → CUES TO ACTION

In the literature review for this study, Wade (2022) applied Black feminist frameworks to study race and sex concordance in gynecology. Recalling Figure 3b.:

RACE AND GENDER PREFERENCE → CONCORDANCE

The resulting codebook was divided into three sections reflecting the ordering of the interview protocol: Background questions, such as a participant's existing knowledge on gynecologic health and experiences asking their gynecologist questions, resulted in 18 hierarchical codes (Appendix D). Responses to the *Under the Paper Gown* campaign resulted in 5 hierarchical codes, and participants' descriptions of what awkwardness means to them—based on Ruffin's behavior in the campaign—resulted in 3 hierarchical codes (Appendix E). In total, 8 themes emerged. The next section reviews the themes, research questions and hypothesis in greater detail.

CHAPTER 4. Results

The research questions and hypothesis of this study investigate the perceived barriers to attending gynecology appointments, specifically examining the role social anxiety. The present study also investigated whether interview participants identified with the portrayal of the protagonist in the health campaign, *Under the Paper Gown*.

Qualitative data analysis of (n=10) participant interviews produced 8 themes: (1) Barriers to Scheduling, (2) Gynecology Knowledge Gaps, (3) Awkwardness Valence, (4) Vagina Talk, (5) Cues to Action, (6) Realism of Ruffin's Portrayal, (7) Approach to Questions, and (8) Black Women Physicians' Innate Understanding (Race and Gender Concordance). The hierarchal codes that support each theme are provided in Figure 4. The themes with supporting quotes at-a-glance are provided in Appendix F. This section will address all research questions and the hypothesis and review the qualitative and quantitative components of the analysis.

Figure 4. Themes and Corresponding Categories.

Barriers to Scheduling	Gynecology Knowledge Gaps	Awkwardness Valence	Vagina Talk
• Appointment Prep • Weighing Decision to Attend • Body Privacy	• Gyno Generalist • Knowledge Deficit • Self-Disclosure • Knowledge	• Awkward-Mindset • Awkward-Exposure • Awkward-Behavior	• "Vagina" Euphemisms

Cues to Action	Realism of Ruffin's Portrayal	Approach to Questions	Black Women's Innate Understanding
• First Visit • Companion Support • Formative Experience • Attending Regardless • Frequency and Comfort • Research and Information	• Props • Amber's Anxiety • Viewer Resonance • Appointment Prep	• Question-Motivated (Pre) • Question-Motivated (Post) • Doctor Rapport • Doctor Sentiment	• Doctor Ally • Doctor Type

4.1 Research Question 1

The first research question asks, "What are women's perceived barriers to attending gynecological appointments?" Half (n=5) of interview participants reported attending five or more gynecologist appointments. One participant, (10%), reported having attended 1-2 appointments and one other participant (10%) had attended 3-4 appointments. One participant had never attended a gynecologist appointment. Two participants did not self-disclose the number of appointments they had attended. Nine participants (90%) reported having insurance although no participant specifically addressed insurance as a factor to attending the appointment in their interview.

Qualitative data is provided for each research question and the hypothesis. Two themes address RQ_1: Barriers to Scheduling and Gynecology Knowledge Gaps. The following presents each theme, corresponding categories as noted in Figure 4 (categories with highest frequency are reviewed), and quotes to support each.

4.1.1 *Barriers to Scheduling*

This section reviews data supporting the theme Barriers to Scheduling along with three categories: weighing the decision to attend, appointment prep and body privacy. Taken together, the themes and subtopics support RQ_1 since they represent participants' hesitations to attending their gynecologist appointment.

4.1.1.1 Weighing Decision to Attend.

Participants revealed that they encountered multiple hinderances to scheduling their gynecologist appointment. Their reasons include cultural norms and structural barriers, like location, that limit access to the gynecologist's office. Participants also expressed a preference for seeing the attending physician over student doctors.

Social barriers limited Kali, age 28. She said of the challenge of scheduling an appointment: "In my home country it wasn't something that you were privy to have knowledge about unless you seek it unless you have the money to afford it. It wasn't something that was going to come easily for you." Among participants whose perspectives are rooted in a lived experience in the United States, home culture—in this case, the participant's literal dwelling—still functioned as a barrier to practice of gynecologic care. Daisy, 31, reflected, "I grew up with my dad, so we just never talked about stuff like that."

Participants who knew about the need of scheduling an appointment still endured barriers. Savannah, 22, explained, "Another reason I wouldn't schedule one is because scheduling issues like scheduling appointment, and then I end up having something come up." Cheyenne, 33, refers to the difficulty of securing the appointment despite her own willingness to be seen: "At least where I live it's hard to get an appointment with your OB [obstetrician], because they're always booked months and months ahead of time."

Francesca, 31, however indicated that proximity to the healthcare provider reduced this barrier:

> So, I've just attended usually out of ease. My gynecologist is convenient for me to attend. It's where I work. It's right downstairs. So, it is really convenient for me to get there, but also I think the scheduling at the gynecologist office has been easy, and they're flexible. If I ever need to reschedule, they never make it difficult or anything like that.

The present study incorporated a portion of a survey questionnaire utilizing HBM adapted by Guvenc and colleagues (2011) to examine cervical cancer and Pap test behaviors among Turkish women. Those researchers included a measurement for distance to health center for the barriers construct ("There is no health centre close to my house to have a Pap Smear

Test," Guvenc et. al, 2011, p. 433). Although the present study does not include a measurement for ease of access in its questionnaire, the afore-given disclosure by Francesca provides a qualitative response to location as a barrier for seeing through with a gynecologist appointment.

In instances where a gynecologist is not available, non-doctors including nurse practitioners and other qualified personnel may perform gynecological services like STD screening and Pap smears (Raleigh Gynecology, 2021). Francesca wondered about her provider's training level leading to her appointment: "Is there going to be a student or a resident, or someone that's going to see me in addition to my doctor?" Savannah was more explicit: "Another reason I wouldn't schedule one is... if the provider is like a medical student. I don't know I just have trust issues, and I prefer for them to be like a doctor or like one that's graduated." Daisy put it bluntly:

> I just wanted to reiterate that the biggest difference for me in terms of going versus not going was honestly like the provider...Because now that I do have someone that I'm comfortable with, it's not even something I think about versus before I just, you know, I just try to avoid that whole appointment altogether okay.

Savannah said that mistrust of medical students providing care led to her appointment avoidance. Physician trust and mistrust are motivating factors to appointment adherence. However, in their discussion on trust, no interviewees mentioned mistrust of the institution of healthcare—a byproduct of decades-long medical racism—as a reason to hesitate to seek gynecologic care.

4.1.1.2 Appointment Prep and Body Privacy.

Participants also cited the physical appearance of their vagina as barriers to their gynecology appointment. Some participants worried that they may be experiencing symptoms of

a health issue, such as having an abnormal vaginal discharge, that made them hesitate to see through with an appointment. For example, Cheyenne said:

> If I'm experiencing something else related to women's health and I don't know how serious it is, that's when you know I start to second guess myself as to whether I should go. Do I need to make an appointment for this?

Other participants expressed concern about whether they prepped their vagina in a satisfactory manner, specifically referencing pubic hair and odor. Kali, 28, gave insight into her worries ahead of her appointment: "Yeah, I felt afraid. I felt, I felt so—intentions with how the doctor will perceive me and will perceive my, my, you know, vaginal area? Was I smelling okay? You know. Should I shave or not shave?" Savannah expressed a similar concern about her vaginal area:

> Some of the feelings I've had leading up to the appointments [is] being nervous. Not knowing if it smells or it doesn't smell. Not knowing what the results are going to show. Not being prepared or like coming from the gym. You have your appointment right away, and you['re] just like what I do now? And that's all I would say about that.

Next, the second theme that supports RQ_1 is reviewed. Supporting categories are also provided.

4.1.2 *Gynecology Knowledge Gaps*

Knowledge gaps derived from qualitative data include shaky awareness of the processes and procedures during a gynecologic exam and only a vague understanding of the recommended frequency of appointments. Participants, however, expressed clear accounts of being naked during an exam. They distinguished nakedness as an aspect of visiting the gynecologist but

shared no other knowledge of the procedure or purpose of exam. Thus, category that supports this theme is knowledge deficit.

4.1.2.1 Knowledge Deficit.

The theme of gynecology knowledge gaps emerged from participants' response to the first question of the semi-structured interview that asked them about their baseline knowledge of gynecologic health (see interview protocol, Appendix C). Participants were informed that there were no right or wrong answers to all questions. Savannah said, "You have to go do a gynecologist test. I know they like, have to give you consent. You have to get our consent to be able to do it. The process doesn't take that long. That’s about it. Yeah." Although Daisy mentioned HPV and cervical cancer specifically, she still acknowledged her shortcomings:

> I, I think black women get HPV cancer or cervical cancer? I don't know. I know that we have some sort of disparity when it comes to like, I think, like cervical cancer or something. That's literally the only thing I know, like, you know, that has to do with like gynecological health like, and Black women. That's about it. Yeah.

After responding to the scripted questions (questions 1-9 in the interview guide) and viewing *Under the Paper Gown*, participants were invited to contribute additional insight (question 10). In responding to this freestyle question, some participants reiterated their shortcomings on gynecologic health knowledge. They compared their epiphanies to Ruffin's learning in the campaign. Charla, 31, divulged:

> I think [*Under the Paper Gown*] kind of reiterated something that I was aware of, but maybe in the back of the head that I don't know as much as I should know...I don't know as much as I as I should, and as much as I want.

Another knowledge gap that participants' responses revealed was the deficit of awareness of the advised gynecologic exam type and frequency of the exam for their age. Rebecca, 21, said of her knowledge of gynecologic health, "Young women should go, I think, when they reach the age of 21, or whenever they're like, sexually active. That's about it." In truth, The American College of Obstetricians and Gynecologists (2021) recommends cervical cancer screening begin at age 21, regardless of when a women becomes sexually active.

Francesca said of her knowledge of gynecologic health, "You know, just annual visits to get Pap smears. And, you know, looking for cervical cancer and making sure we're preventing there. That's probably about it...I don't really look into it very much more outside of that." Tracee, 32, also spoke of annual exams: "Um, things I know, I think things I know just include especially at my age making sure that I go every single year and get tested." Cheyenne recalled, " I've been told, instead of every year, that I should go every 2 years what they're telling me for a Pap." The screening recommendation for women in their thirties is different from all these testimonies. HHS (2023) establishes that women aged 30 to 65 should undergo a Pap smear either every three years, HPV screening test every five years, or both a Pap and HPV test every five years depending on doctor recommendation.

Participants who discussed their exam experience focused on one element, being naked. For some, recalling nakedness was the only part of screening they could recall; the purpose of being naked was divorced from the fact that they simply had to be naked. For example, Frances, 34, said, "All I know is like those appointments you just get naked." Echoing her sentiment Daisy said, "The getting naked, you're not sure what's happening, you know?"

Simply stated, knowledge gaps support Research Question 1 because a woman cannot attend a routine gynecologist appointment that she does not know is outstanding. The review of barriers continues with discussion of the hypothesis.

4.2 Hypothesis 1

The hypothesis states that "Social anxiety is a barrier to attending a gynecological appointment as reported by the participants." This study conceptualized awkwardness as social anxiety. This section begins with a review of the quantitative analysis results that investigated significance between participants' anxiety and their dismissal of their gynecology appointments. Quantitative analysis was also performed to test the independence between multiple factors related to participants' anxiety. Qualitative results revealing participants' attitudes towards awkwardness, their comfort talking about their vaginas, and their insight on how attending their appointments with another person reduced their anxiety are included in the discussion. Qualitative responses incorporate the themes Awkwardness Valence, Vagina Talk and Cues to Action. Results are supported with corresponding quotes.

4.2.1 *One-way ANOVA Results*

Nonparametric tests were conducted to investigate H_1. One-way ANOVA tests were performed to determine the significance between the participant's reporting of feeling anxious about their appointment and the anxiety causing them to skip their appointment ($F_{2, 17} = .591$, $p = .566$, ns), and their reporting of feeling anxious about the exam and the anxiety causing them to skip their appointment ($F_{2, 17} = .049$, $p = .953$, ns) (Table 2). The tests showed there is no significance. Therefore, the data concludes that a participant's social anxiety is not a barrier to attending their gynecologist appointment.

Table 2. One-way ANOVA Results, *p* < .05

Anxiety_Skip Appointment		Sum of Squares	df	Mean Square	F	Sig.
Anxious at Appointment	Between Groups	.556	2	.278	.591	.566
	Within Groups	7.056	15	.470		
	Total	7.611	17			
Anxious about Exam	Between Groups	.049	2	.025	.049	.953
	Within Groups	7.562	15	.504		
	Total	7.611	17			

**Note:* 5-point Likert responses were condensed to three categories: Agree, Disagree and Neutral.

Chi-Square tests for independence were conducted to examine whether there were any significant results for Q10 to Q 15 on the survey questionnaire. However, each cell contained an expected frequency less than 5 which violated the assumption for the Chi-Square test of independence, so those results will not be included here.

The following is a review of the themes and their related categories that correspond to H_1.

4.2.2 *Awkwardness Valence*

After viewing *Under the Paper Gown* participants reported their own definitions of awkwardness. Question 8 on the interview guide (Appendix C) asked, "What does being awkward look like to you?" and the follow-up prompt, "Based on your description, would you say that you ever felt awkward visiting the gynecologist?" Their responses showed that awkwardness manifested in three ways, as shown in Figure 4: As a mindset or feeling, a result of exposure during the PE, and as an inhibiting behavior.

For Tracee, feeling scared about her appointment channeled awkwardness: "I guess being so scared is what makes it so awkward." Francesca said that awkwardness is being "uncomfortable". She elaborated, "You know, just I guess you can just kind of sense the tension of not feeling relaxed or feeling like you can really be yourself." Participants like Jolene, 29, who described feeling awkward during the PE said, "I don't know. It's just awkward to have like

somebody in your body, I guess." Kali added, "Awkwardness in this context will mean even the thoughts of going to see the gynecologist who studies a woman's vagina is awkward in itself. It's very uncomfortable."

Others meanwhile attributed awkwardness to a behavior. Cheyenne said that awkwardness comes about "like a lot of curiosity, a little bit of anxiety and just the unknown, not knowing what to say, what to do, what to expect how to respond – behaving that way. That's that what looks awkward to me." A description of awkwardness by Daisy revealed that sometimes awkwardness stems from engagement with her physician: "It's just like, you know, being uneasy when they ask like, when the provider asks you questions, you're like, 'no', even though you do have a question, you just don't want to ask it. Yeah. I think that's it for me." Overall, awkwardness carried a negative valence. However, no person mentioned awkwardness, or social anxiety, as an outright barrier to attending their appointment. Participant responses do not show support of H_1.

4.2.3 *Vagina Talk*

Participants used several euphemisms for the word "vagina." Some alternate words used included "my privates" (Rebecca); "down below" (Cheyenne); and "down there" (Daisy). Jolene, when discussing her knowledge of the role of a gynecologist, said candidly, "I guess that they kinda take care of your—I don't know what to word for it—area down there." Kali used several code words including "your privacy" and "your woman side".

In the final episode of *Under the Paper Gown*, the tables are flipped, and Ruffin accompanies her sister, (Lacey) Lamar, to her own gynecology appointment. Upon entering her sister's exam room, Ruffin triumphantly says, "I'm a changed woman, Lacey. I'm confident. I'm grown. I know everything there is to know about...my vagina," adding a dramatic effect to

"vagina." However, no participants remarked that their takeaway from the campaign was a boost in confidence in saying "vagina". Despite the participants' uneasiness with stating the word vagina, no person confessed that the awkwardness they felt of conversation with the word was a barrier to attending their appointment. Participant responses do not show support for H_1.

4.2.4 *Cues to Action*

Cues to action is the third theme that pertains to H_1. Participants recalled experiences attending their appointment at the urging of a friend or parent. For them, the external stimuli led them to attend their appointment despite their own anxieties. Thus, support for H_1 is not found. For some participants, their friend's negative stories about their own PE experience induced anxiety for the participant when contemplating their own appointment. Participants who had attended more than one gynecologist appointment provided mixed responses as to whether overcoming anxieties of their first appointment gave them less anxiety to attending future appointments. Some participants felt more at ease to schedule and attend future appointments. Others disclosed that subsequent appointments did not necessarily bring ease to enduring future appointments.

4.2.4.1 First Visit and Companion Support.

Francesca's mother accompanied her to her first gynecologist appointment which happened when she was sixteen years old. She recalled:

> So, I, I guess I started going regularly to the gynecologist when I was in high school, and so at that point it was like my mom would schedule my visit and I would go. And I obviously I didn't love it. You know, it's kind of as a high schooler a traumatic experience when you first go.

Francesca said that her first gynecologist was her mom's obstetrician, who was male, attended to her mother while she was pregnant with Francesca. She added, "I'm pretty sure I cried [at] my first gynecologist because I was so nervous and uncomfortable...Being 16 and having a male exam in you, and all those things was very uncomfortable at first. He was like in his sixties." Francesca attended her appointment despite feeling anxious about her 60-year-old-or-so physician performing her exam. H_1 is rejected.

Tracee attended her first gynecologist appointment solo. She relied on "stories from friends and just stories online" which set her expectation of an unpleasant experience. Kali resorted to convincing a friend to accompany her to her first appointment. Interestingly, she fibbed about the pain of the experience so that her friend would also see through with her own appointment: "So, I basically had to convince a friend that, hey girl, we have to do this... So I went inside first. It hurt then I came out. She was like, 'was it good?' I had to give her some form of assurance, and then she also went." In both situations the women attended their appointments despite their anxiousness (or awkwardness of the situation). H_1 is rejected.

4.2.4.2 Frequency and Comfort.

Participants who had attended multiple visits shared how their first experience motivated behaviors for future appointments. Their responses show mixed results as to whether anxiety about attending their first appointment decreased with appointment frequency. For example, Kali said, "It was harder the first time...Once I was able to break through that shyness and make the doctor see me, it was easy for me to see him subsequently." Charla meanwhile still experiences discomfort:

> While I've gotten used to going it doesn't mean I'm necessarily comfortable going to each of them every time. It's the same sense of you know a little bit anxiety, and sometimes

> even a little bit of fear, or just being uncertain what to expect, even though it's something I typically do every year. Participants showed that they their appointments attend despite their discomforts.

4.2.4.3 Attending Regardless.

Participants expressed a resolve to attend their appointments regardless of their anxiety for the sake of their overall health, thus rejecting the hypothesis. Charla said:

> I'd like to know what my standings are regarding my health, so I find it important to go, so I think that kinda helps push me to go regardless of any type of stress, or maybe fear, when it comes to who I see.

For some participants, the PE tools are uncomfortable but are not a deterrent, as explained by Frances, "You should be used to that type of equipment, but I honestly...retract that—it doesn't get easier with time. It doesn't. But I still go." When the appointment is urgent, Savannah sets aside her preference for a woman gynecologist: "If my provider was a man...I do have an issue with that. But at the end of the day. If it's an emergency, you know I have to go." (Participants' desire for race and gender concordance with their gynecologist is reviewed in Research Question 3). Kali self-motivates:

> But eventually I had to overcome all those fears...I would have to yield myself, so I would have to debunk all of the negative notions I had [and] feel first of all, confident to myself...to just gather myself up and go for the sake of going because it just needed to be done.

Francesca recalled a more pleasurable experience that she preferred to engage in but was still not dissuaded: "So I can't say that I go into it like thrilled like, I'm going to get a pedicure or

something. But you know, I understand that that's something that I need to do for my health." Qualitative data do not show support for H_1.

4.3 Research Question 2

The second research question asks, "Does *Under the Paper Gown* display realistic barriers to attending the gynecologist as reported by participants?" Participants' collective responses guided this study to determine the theme of Realism. The theme is supported by the categories Props, Amber's Anxiety and Viewer Resonance.

4.3.1 *Realism of Ruffin's Portrayal*

Perceived realism heightens acceptance of prosocial messages. Nelson et al., (2015) state that there are three possible acceptance outcomes when individuals encounter a PSA. Acceptance outcomes are determined by how individuals identify with portrayals in the message: Individuals first consider whether the portrayal is realistic, then they weigh the similarity of the message to their lived experience, and third, determine how they will emulate what they see in the message. Participants displayed all three thought processes in their responses to *Under the Paper Gown.*

4.3.1.1 Props.

The title of the campaign *Under the Paper Gown* offers a spoiler about the object that is central to the series—the paper gown. Ep. 1 opens with Ruffin's jostling with a bathrobe in preparation for her forthcoming donning of the true exam garment. She says to her sister Lamar, "I'm trying to familiarize myself with robes because I have a gynecologist appointment tomorrow and I'm never sure which way the robe is supposed to go."

Although the gown remained a central element, even if in the title only as later episodes centered on different props, participants overwhelmingly did not comment on Ruffin's disorientation with the gown. Rebecca offered only, "I've never put so much thought into how to

wear the gown that they give you." Instead, participants focused on Ruffin's gripes about her gynecologist, especially the temperature of the doctor's hands. Francesca said Ruffin's behavior was "obviously dramatized" but agreed, "You know, their hands were cold." Daisy had an epiphany that indeed her gynecologist's hands always seem cold although she only thought about that after viewing the campaign.

Ruffin, who is a comedian, brought a comical approach to discussing her experience attending a gynecology appointment, including levity about the gown, the doctor's cold hands, and the shortage of pens to complete intake forms. Therefore, the literature review of this study discussed the effect of humor in health campaigns. However, no participants commented on humor as a memorable or impactful feature of the campaign, nor did they comment on having prior familiarity with Amber Ruffin.

4.3.1.2 Amber's Anxiety.

After viewing the campaign participants were asked to describe Ruffin's feelings about going to her gynecologist appointment (Question 5; see interview guide, Appendix C). Overwhelmingly they interpreted Ruffin's behavior as highly anxious. Francesca said that Ruffin's "confusion and anxiety...made [Ruffin] a little unrattled," while Jolene described Ruffin as "uncomfortable" and "nervous." Kali said that Ruffin appeared "afraid" and showed "feelings of fear and insecurity." Frances was matter of fact: "Obviously Amber was also anxious...She was curious." Other participants, like Cheyenne, noted Ruffin's evolution beyond awkwardness and anxiety as she gained confidence to take control of her gynecologic health: "So it seemed that she grew comfortable, but initially, she was really nervous and anxious. And I'd say, maybe a little scared of the potential judgment." Participants disclosed that Ruffin's representation most similarly resembled their first encounters with their gynecologists.

4.3.1.3 Viewer Resonance.

Resonance emerged when participants compared their early experiences to Ruffin's ordeal. Jolene said plainly, "Yes, definitely. I would say, probably because my first experience like hers was probably the same and accurate." Francesca confirmed, "I think when I first started going to the gynecologist I definitely agree." Kali felt encouraged that Ruffin reflected her early worries about her gynecologist's judgment:

> Yes, yes. It truly reflect [sic] my own experience. Given that I was asking questions also about whether or not the individual would judge me, would think, you know, would think wrongfully about me. And that's all that. And I see that's the same position I was in.

Other participants knew that Ruffin's actions were accurate even if they did not reflect themselves directly: "I do feel it's a realistic thing how she was portrayed. I just don't feel necessarily it aligns with me because I don't describe myself as a highly nervous person," remarked Tracee. Another relatable point that participants shared was that they felt empowered to ask questions at their future appointments. Participants' experiences asking questions and other communication challenges are reviewed in the following research question.

4.4 Research Question 3

The third research question asks, "What are the communication challenges African American women experience during gynecological appointments?" The themes that support this research question are Approach to Asking Questions and Black Women Physicians' Innate Understanding. Each theme with supporting qualitative results is reviewed below.

4.4.1 *Approach to Asking Questions*

The interview protocol (Appendix C) asked participants to share their experience asking their gynecologist questions. The participants were asked about their comfort speaking to their gynecologist before and exposure to *Under the Paper Gown*.

4.4.1.2 Participants' Reflections on Asking Questions Pre- and Post-Campaign Exposure.

Some participants, like Francesca, said that they have a natural inclination for asking questions and even arrive at appointments with a prepared list. Frances said that Ruffin's actions would not cause her to change her current behavior because she already practices unabashed questioning: "Any question I need to ask I'm going to ask. I don't care how I feel. Even if I do feel awkward, even if I feel anxious. I'm still gonna ask because I still need to know." Tracee described herself similarly, stating, "I've always been someone who asks a lot of questions because I feel like for me not to be nervous, I need to have the most clarity I can have."

Not all participants feel comfortable openly communicating with their gynecologists. Some participants attributed their question reticence to simply being unfamiliar with how to communicate with their doctor. Notably this experience was also linked to early gynecology visits. Cheyenne recalled: "There have been quite a few times in the past, especially when I was younger...I was just really anxious to go to that doctor, you know, to ask certain questions or to figure out what may be wrong or what's not wrong? What's normal? What's not normal?"

Yet others said that their comfort in asking questions was an external matter; they felt comfortable asking questions if the environment was conducive to Q&A. Charla said:

> There are quite a few quite a few of the videos that were almost the exact same scenarios or situations that I've been in from being afraid to ask questions...because the few times

> that you try it's been rushed, or the answer was kind of half answered leaving you still uncertain what the answer is. Or the atmosphere just wasn't even comfortable enough to bring the question up.

Tracee said that two types of professionals have the power to create an environment for friendly question exchange: "I feel like [nurses and staff around are] the ones who can make you a little more comfortable and can answer maybe like quick small questions you may be embarrassed asking a doctor about." Still, at some point participants must interact with the physician directly. Often, the physician sets the tone for the encounter.

4.4.1.3 Doctor Rapport and Doctor Sentiment.

Participants had favorable reflections on interactions during their appointments when the doctor led with light conversation. Daisy said, "So the current one I have, so she's really good...She usually asked me what's going on. Most of the time she also asked me about school. So, she, you know, sort of asked me, like personally how I'm doing first." Jolene added, "My doctor tries to like make conversation, trying to make me feel comfortable. Asking about my daily life, and then he'll proceed to you know do my checkup, or whatever."

Beyond just small talk to open the appointment, participants also said they appreciated it when doctors engaged in conversation about their health. Jolene said, "If I ask a question he'll come back and give me information, and then he'll ask like, 'well what are your like habits or your daily life'? Trying to pinpoint why the situation is what it is." Tracee appreciated her doctor's introspective questioning: "We can talk about you know have some small talk and then she gets right into it and will ask questions. And they are, you can say very detailed questions." Francesca attributes her fondness of her doctor due to the individualized attention despite her patient load, saying, "I know she cares for hundreds of patients, but I feel like in every response

to me it was very individualized to me and personalized to me like in that moment, I was her only patient to take care of."

While some patient-physician relationships are built over small talk and engaging in reciprocal questioning, others are reportedly more automatic and innate.

4.4.2 *Black Women Physicians' Innate Understanding*

Participants reflected on their appreciation of Black women physicians because Black women *just get it*. Two categories support this theme, Doctor Type and Doctor Ally.

In qualitative responses participants expressed their satisfaction of being cared for by a Black woman physician. "I recently went to a provider who is also an African American woman that I was a lot more comfortable with, and that seemed to have a completely different experience from what I'm used to," said Charla. Added Francesca,

> The value in having a gynecologist that is Black has been a lot bigger than I thought it would be.... I feel a lot more comfortable with my gynecologist now than I ever have in the past.... It's not any different questions than what we get asked at, you know, [a] similar visit as I would have had in the past. But I just think I feel more comfortable.

If a Black woman gynecologist was not available, a Black male gynecologist would be preferred. He would still "really knowing what's going on," Savannah explained.

Participants also disclosed uncomfortable feelings when dealing with male doctors. Cheyenne said, "I had male doctors in the past, and it was very awkward and uncomfortable...I felt very awkward, shy, and even ashamed sometime, when it came to sexual health and questions, and answering honestly, and things like that." Some mentioned white male doctors specifically. Daisy shared that she delayed refilling birth control to avoid meeting her doctor: "I don't know if race had anything to do with it, but he was an elderly man." She confessed that she

left a urinary tract infection (UTI) untreated for "probably like 4 days" until a friend urged her to address it. "Because just the thought of being in his office, I was like, I would, just, you know, see, if this [UTI] would just go away by itself. Yeah," she said.

Kali explained her feelings after arriving for her first gynecologist appointment and believing that the woman nurse who took her vitals would also perform the PE: "[A] tall white male walk into the room. And goodness. Truly, for one second I was taken aback, because already my expectation was to have received service from a female doctor only for a male to come."

The following section is a discussion of the results of this study.

CHAPTER 5. Discussion

This thesis is an exploratory study into the perceived barriers to gynecologic prevention screening as reported by African American women. Due to the qualitative nature of the study, results are not generalizable beyond the participants of this study. Nonetheless, this study produced important insights on perceived barriers to positive health behaviors about gynecologic health. Specifically, the goal of this study was to assess the anxieties African American experience when attending their gynecologist appointment. This study also afforded the opportunity to conduct a campaign evaluation of *Under the Paper* Gown. Findings from the study are discussed herein. The latter portion of this discussion explores the limitations of this study, practical applications, and suggestions for future research.

This study reveals interesting findings about African American women's perceived barriers to attending their gynecologist appointment. The viewer meets Ruffin in Ep. 1 while she is preparing to attend her appointment. It is understood that her appointment was already scheduled. However, participants expressed barriers to scheduling. This means that Ruffin is shown as preparing for a moment that may not even be accessible to the viewer. This introduction presents a conundrum. The campaign seeks to urge compliance with gynecologic visitation but assumes that awkwardness is the main barrier to attending the appointment. This study however revealed other barriers.

The area of knowledge deficits was somewhat unsettling. Participants showed that they were not sure about the type of screening (i.e., one participant said "HPV cancer test") and the recommended frequency of test by age they should receive. Multiple participants expressed a willingness to comply to routine screening. However, even with the urge for compliance, not knowing when a screening is due or the type of screening due still has the potential to result in

poor health outcomes. The campaign did not mention the age, real or fictionalized, of either character who attended their appointment. This is understandable because cancer screening guidelines change (i.e., as with recommended colon cancer screening decreasing from age 50 to age 45). So, the longevity of the campaign is preserved. However, a moderating factor for the viewer's compliance was unaddressed.

Comments on nakedness were also interesting although less surprising than screening awareness. Participants were uncomfortable being naked in their appointments. This discomfort is echoed by participants in other qualitative studies on women's perceptions of the PE, such as in Oscarsson and Benzein (2009). To underscore this statement, 21 out of 30 participants dropped out from Grundström et al.'s (2011) study on young women's PE experiences. In this study however I considered nakedness a subtopic of knowledge gaps. I made this decision because recollecting nakedness resonated strongly with participants, yet they were unable to recall other, and arguably greater, purposes of undergoing a PE. For example, Frances said, "All I know is like those appointments you just get naked."

The potential consequences for Frances' comment extend beyond her own perception. If Frances shares that sentiment among her friends, then potentially a group of women may shun the appointment because all they know if visiting the gynecologist is nakedness. Hence, an individual only knowing nakedness presents a knowledge gap. Due to a variety of reasons (see Amy, 2006) being naked before strangers will never be comfortable for many women. This identifies an opportunity in health campaigns research to address the more uncomfortable aspects of routine gynecologic care that perhaps even humor may inadequately tackle.

Participants were also uneasy saying "vagina." In a distinct moment in *Under the Paper Gown* Ruffin dramatically stutters when she says "vagina". The direct aim of the campaign was

not to instill comfort with the word. Even so, the inability of one campaign to alter discourse on vagina-naming (since Ruffin's act doubled-down the perception that the vagina is awkward) is not surprising. Kali's admission speaks loudly: "In fact, saying it alone is, is—it feels awkward if I should use the same word again. And so society has, you know, put a cup on the word, it's so difficult for you to talk about." When I couple participants' discomfort with nakedness and saying "vagina," I am reminded of the stigmatization of the female figure.

Surprisingly, no participants mentioned medical mistrust as a reason to avoid their appointment. The literature review of this study discussed some cases of Black women's racialized mistreatment when receiving healthcare. However, Hall (2023) suggests that some instances of gendered racism in the healthcare context are simply chalked to poor bedside manner. In those exchanges, Black women patients "slip into moments of 'it's cool'" (Howell, 2023, p.10) to disguise the psychological damage of a racialized encounter with their healthcare provider. The survival tactic is emotional armor. It is also labor. I wondered if my participants had similar encounters. If so, their stoicism is understandable even though unfortunate since a gynecologist appointment can be hard to secure to begin with, just like some participants confessed to be a barrier.

Other themes that emerged as barriers complement existing research in Black women's experiences in the healthcare ecology. For example, Ackerson (2010) cited factors like cost, education, health insurance, and access that deter Black women from completing routine appointments. Kali's insights into barriers to maintaining her gynecologic health in her home country were arresting. It is widely known that women living in low- and lower-middle-income countries experience significant barriers to healthcare. This issue is not to be ignored: Although approximately 85% of cervical cancer cases occur in those countries, access to quality

reproductive care, including gynecologic screening, often does not meet human rights standards (Mariani et al., 2017).

Qualitative data that corresponded to H_1 were surprising. Ultimately, participants overcame their social anxieties and attended their appointment, thus refuting the hypothesis. (Also, participants' true barriers to appointments were revealed by RQ_1). However as noted by Cheyenne, some participants at least contemplate the idea of not attending due to their feelings about the appointment: "I start to second guess myself as to whether I should go." The idea of skipping the appointment is considered even if not executed. Indeed, Ruffin encountered the same deliberation. In the end her sister, Lamar, urged her to go. Thus, Lamar functioned as a cue to action like the theme that arose in my analysis. Participants conveyed a negative valence to awkwardness, which may also provide insight to their motivation to overcome anxiety (and attend their gynecology appointment despite being tempted to do otherwise).

Lamar's presence led the participants to reflect on the benefit of having a companion accompany their visit. Some participants mentioned going to their first gynecologist appointment with their mothers, while some pulled friends along. Those with no companion, like Tracee, wished they had one upon reflection: "So I guess it would have been better if I had someone older than me or my mom to help me figure out how everything went."

Participants who desired companionship wanted their mothers, a friend, or someone older to accompany them on their appointment. I did not gather sibling demographic information from participants and no one disclosed whether they have a sister. I think the campaign did a fair job to pair Ruffin and Lamar; the essence of support recalls a real-life desire. At the same time, I wonder if the pairing was too literal. I wonder whether a friend’s duo or mother-daughter dyad would have elicited a different commentary or agreement from the participants.

Participants overall deemed Ruffin's journey relatable even if it did not reflect their current attitudes toward their gynecologist visit. For instance, Francesca reminisced on her own evolution after witnessing Ruffin's growth, saying, "I have felt like that before in the past when I first started going to the gynecologist." Many participants' comparisons to Ruffin's journey identified similarities to their early experiences. Another conundrum for the campaign emerges: CDC describes *Inside Knowledge* as a campaign for "Women of all ages, races, and ethnic groups, especially those aged 35 years and older" (CDC, 2023).

However, by age 35, women following the recommended screening guidelines would be far removed from their first visits to the gynecologist. Ruffin portrays someone who perhaps has never been to an appointment. This would imply that the campaign audience may be niche—women 35 years and older who have never visited the gynecologist, perhaps? That is an existent but incredibly specific sample.

There seems to be an incongruency between the message aims of the campaign, which is the umbrella imitative of *Under the Paper Gown*, and the target audience. To be fair, the campaign states it is for "women of all ages". In that case the distribution channels should be expanded. For example, a campaign targeted to young women who are just beginning their gynecological health journey may be better suited to social media platform like TikTok. As stated in the literature review, Willoughby and Noar (2022) determined that the appropriateness of the channel is more crucial to the campaign effect than the number of channels of distribution. To my knowledge however, viewer metrics of the campaign are not publicly available to further analyze this point.

The campaign is also described to be appropriate for "women of all races and ethnic groups." While this is true, the cast exclusively features minoritized women. Given the cervical

cancer mortality discussed in the literature review, there was a missed opportunity to emphasize the cervical cancer mortality disparity among African American women, especially given Ruffin's celebrity power.

Participants gave little comment to other main features of the campaign. There were many comments on Ruffin's anxiety but notably few nods to the comedy (and no audible laughter during the interview). Participants' rich commentary on Ruffin's anxiety compared to their sparse takeaways on her humor imply that Ruffin's feelings are more relatable than her disorientation over props like the paper gown. Perhaps this is because none of the participants would confuse or toy with their bathrobe for an exam robe. The literature review of this study cited Cusano (2023) who found the paper drape to be a blockage rather than an item of ridicule.

Alternatively, participants' seeming disconnect to the paper gown could be because the bathrobe may conjure feelings of relaxation and ease, whereas the paper exam robe is associated with an opposite encounter. After all a PE is "not a pedicure," as Francesca said. Perhaps the reason for participants' disconnection is that Ruffin's humor translated as awkwardness, which they deemed with a negative valence. There could be a larger issue as well: Perhaps African American women were not comfortable viewing an adult African American women portray herself so extremely aloof about the understanding of her health.

Participants also did not comment on the race elements of the campaign. For one, no one mentioned prior knowledge of Amber Ruffin. This study cited Hunting and Hinck's (2017) research on celebrity activism. The scholars also commented that celebrities slip between character and their real selves when highlighting social causes. However, if the viewer is not already aware of Ruffin, it is possible that they view the campaign and the roles of the sisters as being played by non-famous actors. This lack of recognition may have moderated other

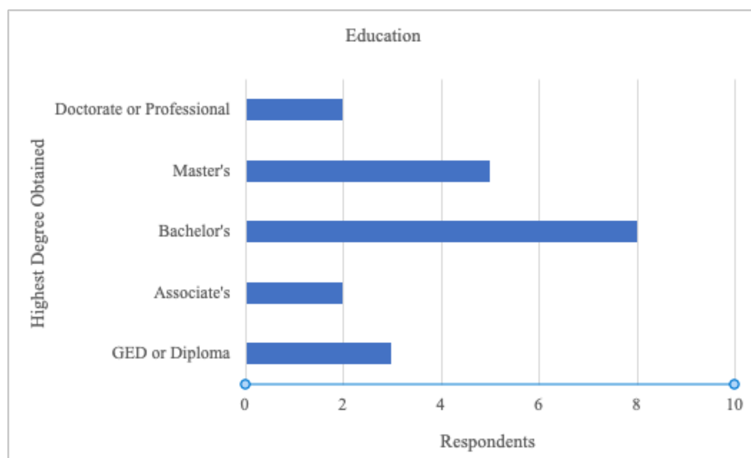
campaign elements since the character is not a celebrity telling them to visit the gynecologist. Perhaps a study controlling for advanced knowledge of Ruffin would provide insight on this matter.

They did not comment on whether the nearly all-Black woman cast of *Under the Paper Gown* factored into message salience. This could be because the campaign only subtly cued that African American interest may have been one intent of the campaign. Second, no participants commented on the fact that Ruffin's gynecologist, Dr. Stewart, was Black. This was surprising since they shared their own desires to be seen by a Black woman gynecologist in real life. Fewer than 6% of physicians in the US are Black. In a strange way, maybe seeing a fictional portrayal of a Black doctor-Black patient combination underscored that having that match in real life is a more often a fiction.

Still, the absence of commentary on Dr. Stewart seems to be misaligned to the findings of health communication research that examines message saliency. Lama et al. (2022) conducted focus groups to determine African American parents' responses to child-focused HPV campaign messages. Parents remarked that the absence of Black children in pro-vaccination commercials made them wonder if the message was meant for them. Also, they said that the visual of a white doctor serving African Americans hinted of White Saviorship. *Under the Paper Gown* featured a Black woman doctor that signaled that the campaign was design with African American interest in mind, even if this was not overtly mentioned. Admittedly, because the recruitment advertisement of this study sought African American women for a study on Black women's behaviors toward gynecologic health, participants may have been primed to know the racial interest of the lean of the campaign. No participants commented on this presentation but perhaps the audience target was understood.

But participants' lack of commentary on campaign items does not correlate to having no understanding of the campaign. Research indicates that the participant sample likely did understand the campaign. As stated in the literature review, Puckett et al. (2019), studying *Inside Knowledge* materials among students, determined that education moderated acceptance of campaign messaging. A bar graph generated for the participant sample (*N*=20) shows that the total sample of participants (100%) have at least a GED or Diploma while most have at least a Bachelor's degree and higher. Therefore, all interview participants (*n*=10) who viewed *Under the Paper Gown* had attained at least a GED or higher.

Figure 5. Participant Education Bar Graph, *N=20*



Under the Paper Gown aimed to portray a positive relationship between the sisters and their doctor. Dr. Stewart was kind, knowledgeable, and extensively patient with Ruffin's odd questioning. Dr. Stewart's demeanor underscored the patient-provider communication undercurrent of the campaign. Each episode of *Under the Paper Gown* conveyed a different theme. To refresh, they are: “Your gynecologist is there to help you, not hurt you” (Ep. 1); “Going to the gynecologist doesn’t have to be awkward forever” (Ep. 2); “When something doesn’t feel right, tell your doctor” (Ep. 3); “It’s never too late to ask questions about your

gynecologic health" (Ep. 4); "Do yourself a favor and find a doctor you're comfortable with" (Ep. 5); and, "It's your body. Ask questions. Stay informed" (Ep. 6).

Of all episode themes, participants overwhelmingly cited asking questions as their greatest takeaway of the campaign. The testimony from Rebecca, who has never attended a gynecologist appointment, is exemplar:

> It definitely encouraged me to prepare questions. If I do have any questions. When that time comes for me to schedule and stuff. It encouraged me to think about my body, think about things I'm curious about, things that I should know about and prepare myself for the appointments.

Qualitative data supporting RQ_3 revealed some communication challenges experienced by Black women when visiting their gynecologist. The doctor type and doctor ally categories revealed that participants prefer interacting with physicians of similar gender and race. In other words, Black women prefer to be treated by Black women physicians. Two participants currently are current patients of Black women gynecologists. I find that surprising since those participants correspond to 20% of my participant sample—a relatively large percentage that I suspect is significantly larger than in the general population. Participants whose current gynecologists are Black gushed about their satisfaction with their race-gender concordant provider. Francesca said:

> There's kind of something that you can't really you can't learn and so I just thought, like she would be able to relate to me on a little bit of a different level and take care of me in a different way. And so, because of that, I just felt comfortable asking her any questions.

To say that "Black women just get it" Is my note of self-reflexivity. As a Black woman, I understand what other Black women mean when they say that a fellow Black woman doctor "just gets it." The comprehension is difficult to elaborate on. In my attempt at a simple explanation,

the feeling is liberating, refreshing and authentic. So, when participants spoke of this innate understanding, I didn't question them further since I, too, "get it."

5.1 Limitations

There are limitations to this study. The survey questionnaire relied on self-report information. Therefore, selections like the number of gynecologist appointments participants have attended are unable to be verified. Also, one recruitment method was snowball sampling, a nonrandom sampling method. Because some participants were recruited through this method through the primary researcher's social media "friends" network, for example, they share commonalities with the researcher, such as having health insurance and having obtained an advanced degree. The participants may have also been heterogeneous cis-gender women. This study may have offered a greater plurality of experiences when visiting the gynecologist should a more diverse participant pool been obtained, especially individuals on the LGBTQ+ spectrum. Ep. 5 of *Under the Paper Gown*, which as aforementioned is the episode that urges viewers to find a doctor that is an ally, features a lesbian character named Jenny. She shares a unique perspective to the communication challenges of meeting a doctor who immediately asks "straight-centered questions" like when does Jenny expect to conceive.

Diversity could be implemented in other areas of the study as well. The mean age of interview participants (M=29.2) skewed closer the age of the primary researcher. Perspectives of younger women, who are maybe just beginning to attend their gynecology appointments, may have added variety to the reporting in the interviews. Finally, greater diversity in this sample may have been obtained by recruiting participants who reside different regions of the US. Five interview participants resided on the east coast and five resided in the south. Participants from

the Midwest or west coast were not included in the sample. They may have offered insights cultivated by a different set of social norms.

5.2 Practical Implications and Future Research

One of the most insightful outcomes of this study was to realize the knowledge gaps women have about the recommended gynecological screening protocol. The knowledge gap functions as a natural barrier to completing the appointment. As I stated elsewhere, a person cannot complete an appointment that they do not know is required. Health communication researchers can strive to close this gap with health education campaigns that provide general guidance on age and gynecologic screening type. Education campaigns should also disambiguate between the types of screening that may performed by a gynecologist—such as for STDs (i.e., chlamydia and gonorrhea) and HPV, and the Pap smear test—as there are frequency guidelines for those tests as well.

Another opportunity to raise awareness of gynecologic health screening is to target parents and guardians of young women. Participants expressed their appreciation for companionship during their appointment. In fact, *Under the Paper Gown* chronicled Ruffin's journey with her sister alongside her. For many young women, their mothers introduce them to their gynecologist in teenagerhood to receive birth control, as two participants shared. In their recollections on visiting the gynecologist as adolescents, neither participant said that their mothers discussed other aspects of gynecologic health, like HPV and the HPV vaccine or having early conversations that set the framework for future gynecologic screening.

Future study can measure viewer's behavior in the prolonged aftermath of viewing the campaign. No participant indicated that they had prior knowledge of *Under the Paper Gown* at any point in this study. Furthermore, because the study carefully avoided mention of the

campaign by name before the interview, it is assumed that the viewing of the campaign in the interview was the first time for all participants. The present study captured only immediate responses to the campaign. However, Helme et al. (2011) notes that viewing campaigns with others leads to after-the-fact conversations about the message. They note also that the viewer's lasting impression of the ad, more so than their immediate interpretation (as was gathered in this study), are the attitudes that carry into future conversation.

Future study can also expand the investigation of campaign elements of *Under the Paper Gown*. One investigation could be coding of the campaign with all HBM constructs, as performed by Quick et al. (2023) of the CDC's *Heads Up* campaign for concussion awareness. Another application of HBM could be a qualitative analysis of the campaign with the cues to action construct. Yet another expansion is to further investigate the campaign's realism. Specifically, health communication researchers may assess which campaign aspects perceived as real truly stimulate behavior change (Nelson et al., 2015; Helme et al., 2011). For example, participants reported that Amber's questioning empowered them to ask questions at their next appointment. However, although the desire to have a companion at their appointment was noted, no participant commented on whether they would seek a partner to accompany them to a visit. Notably, this absence was even noted for the participant had never visited the gynecologist.

Focus groups are a relied upon methodology for campaign evaluations that may be applied to future studies of humor in *Under the Paper Gown*. The method is useful for organizing a specific participant group to discuss a range of health topics. For example, Hall et al. (2012) conducted focus groups with low-income African American women to evaluate a pilot CDC mass media campaign that aimed to increase awareness of breast cancer screening. Occa et al. (2022) organized focus of groups of African Americans to investigate intentions on

enrollment in donor registries to develop experimental messages. In the semi-structured interviews of the current study, no participant described Ruffin as humorous despite the campaign's aim of levity. A future study organizing four to eight focus groups, which according to Tracy (2023) is the point at which saturation is reached, may reveal if a discussion on Ruffin's attempt at bringing humor to the gynecology setting would emerge in the group setting, where sometimes reactions, commentary and consensus may swell in an assembly of people.

CHAPTER 6. Conclusion

This exploratory study was a rewarding insight into the healthcare experiences of twenty Black women. The objective of the study was to investigate Black women's perceived barriers to attending their gynecologist appointments. The study applied the perceived barriers construct of HBM to explore their lived experiences. Additionally, this study incorporates a health campaign on gynecologic health, *Under the Paper Gown*. The campaign, which was developed by CDC, was selected because the health message is delivered by a Black woman protagonist, Amber Ruffin. The three other characters in the campaign are all women of minoritized groups. They are Ruffin's real-life sister, Lacey Lamar, and an African American woman actor who portrays the gynecologist, Dr. Stewart. A fourth character, Jenny, Ruffin's friend, is lesbian and speaks to the experience of LGBTQ+ persons who receive gynecologic care.

This study uncovers that despite women's awkwardness, which was conceptualized as social anxiety, they proceed with attending their gynecologist appointments. This study revealed that for this participant sample, other barriers prevent them partaking in the appointment. Those barriers include social and cultural factors, the type of physician they are scheduled to see, and their sheer unknowingness that they are due for an appointment.

This thesis contributes to literature on the experience of disparity populations in reproductive healthcare as well as to literature on health campaigns. Participants' responses to the campaign both confirmed the findings of existing studies on health campaigns but also diverged with important insight, notably the use of humor and realism in campaigns. Additional study on race concordance in campaign research and appropriateness of the distribution channel of a mass media campaign are areas of research to which this study contributes.

APPENDICES

Appendix A. *Under the Paper Gown*—Episode Descriptions.

Episode	Description
Ep. 1	Amber Ruffin is not looking forward to her gynecologist appointment tomorrow, and considers cancelling, until her sister, Lacey Lamar, reminds her that doctors aren't there for judging — that's what sisters are for.
Ep. 2	While waiting for the doctor, Amber recounts the most awkward gynecologist visit there ever was...her very first. A dumbfounded Lacey assures her sister that while she'll probably be awkward forever, going to the gynecologist doesn't have to be.
Ep. 3	After a night of frantically searching her symptoms online, Amber learns that when something doesn't feel right in her body, it's best to step away from the search bar and talk to your doctor instead.
Ep. 4	Amber makes a list of all the questions about women's health that she's been too embarrassed to ask over the years. And realizes, maybe her gynecologist is a more credible source than wherever she previously got her information.
Ep. 5	In the midst of a heated board game, Amber learns how important it is for her gay friend Jenny to find a doctor who understands her needs. And Jenny learns how bad Amber is at board games.
Ep. 6	Amber drops in on her sister Lacey's gynecologist appointment to impart (read as: brag about) some of the newfound wisdom and confidence she's acquired over the past 5 episodes. Turns out, learning and growing is a lifelong process for all of us. Remember...it's your body. Ask questions. Stay informed.

Appendix B. Survey Questionnaire

Yes/No

Q1 I am younger than age 18

Q2 I am older than age 34.

Q3 I reside in the United States.

Q8 I have health insurance.

Q4 My age is _______.

- o 18-21
- o 22-25
- o 26-29
- o 30-34

Q5 I identify as a _______.

- o Woman
- o Man
- o Gender identity that is not provided

Q6 I identify as _______.

- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o Hispanic or Latino
- o Native Hawaiian or Other Pacific Islander
- o White

Q7 My highest level of education completed is _______.

- o GED or High School Diploma
- o Associate's Degree
- o Bachelor's Degree
- o Master's Degree
- o Doctorate or Professional Degree (e.g. MD, JD, PhD, DDM)

Q9 I have attended _______ gynecologist appointment(s).

- o None or zero (0)
- o 1-2
- o 3-4
- o More than 5

Likert scale (Strongly agree—strongly disagree)

Q10 I feel anxious when visiting the gynecologist because I don't know what will happen.

Q11 Feeling anxious about visiting the gynecologist makes me want to skip my appointment.

Q12 I feel anxious when my gynecologist sees my vagina.

Q13 I tend to feel anxious most times in my everyday life.

Q14 I feel comfortable asking my gynecologist questions about my gynecological (vaginal) health.

Q15 I prefer to see a Black doctor for my gynecologist appointment

Appendix C. Interview Protocol.

Thank you for agreeing to speak with me today. We are scheduled for approximately 40 minutes together. Our time will be divided as 15 minutes to watch YouTube videos and 25 for the interview questions. Today we will talk about some feelings you experience when visiting the gynecologist. I will start with some questions then show you some videos on YouTube and then ask you a few more questions. There are no right or wrong answers. I encourage you to elaborate on your responses with stories and examples if you have any. Are you ready to begin?

1. My goal is to raise awareness about gynecologic health. So, I research health communication to understand how Black women think about and practice prevention. What are some things you know about gynecologic health?
2. Talk me through your decision process to determine whether you would [or would not] schedule and attend gynecologist appointments?
    a. What were some of your feelings in the moments leading up to your appointment?
3. Have any of those feelings made you feel like you did not want to attend your appointment?
    a. If so, can you elaborate?
4. Describe your interaction with the doctor (gynecologist) during your appointment.
    a. Please describe the experience of talking to your doctor and asking questions during the appointment?
5. For the next question I will play a few YouTube videos that discuss a person's feelings about a visit to their gynecologist. Each video is about 2 minutes long and there are 6 videos total. Feel free to jot notes if you would like. [Play *Under the Paper Gown*]
6. In *Under the Paper Gown* Amber makes her feelings about visiting the gynecologist known. How would you describe Amber's feelings?
7. Do you think that Amber's portrayal accurately reflects some feelings you may have about your decision to attend your gynecologist appointment?
    a. Probe: Why or why not?
8. The theme of the videos was that Amber felt awkward about visiting the gynecologist. What does being awkward look like to you?
    a. Based on your description, would you say that you ever felt awkward visiting the gynecologist?

9. What effect, if any, does Amber’s behavior have on your decision to discuss or ask questions about your health during gynecologist appointment?
10. What question did I not ask you about your experience that you think I should have asked?

Thank you so much for your time today.

Appendix D. Codebook Excerpt—*Hierarchal* Codes.

Hierarchal Code	*1L* Code(s)*	Supporting text
1. KNOWLEDGE	AGL (Age-gyno link) ARF-S (Knows specific appt. frequency) FHA (Family history awareness)	Well, let's see. I feel like it's changed over the years. When I was a teenager. I was told I was supposed to have my first gynecological visit at 18 and get like a routine Pap smear and anytime I'm having issues down below to go see my doctor. But recently I've been told, instead of every year, that I should go every 2 years what they're telling me for a Pap.
2. FORMATIVE EXPERIENCE	YTW (Youth/teen/early visits)	I definitely especially when I was younger. I was not comfortable with getting undressed. I had male doctors in the past, and it was very awkward and uncomfortable, even though they were professionals. You know, and they had good bedside manners.
3. KNOWLEDGE DEFICIT	KDG (Knowledge deficit on gynecology)	I think this kind of reiterated something that I was aware of, but maybe in the back of the head that I don't know as much as I should know.
4. GYNO GENERALIST	GG (Visits gyno for other reasons)	I've seen my guy now, for a lump in my breasts who referred me. But that's that's who I saw. So basically anything strictly relating to women's health. That's who I see. That's that's when I go to them.
5. BODY PRIVACY	WPP (Worry on exposing private parts)	Absolutely. Like a lot of things, she said was like totally relatable – the getting naked, you're not sure what's happening, you know.

6. COMPANION SUPPORT	AFV (Alone first visit) WCV (Wished companion visit) AcFV (Accompanied first visit)	I think maybe the very first time I went I felt like that and I was alone. So I guess it would have been better if I had someone older than me or my mom to help me figure out how everything went, so I do understand her anxiety with it.
7. WEIGHING DECISION TO ATTEND	NH (No hesitation) GL (Great location) DMA (Difficulty making appointment)	Another reason I wouldn't schedule one is because scheduling issues like scheduling appointment, and then I end up having something come up. Another issue is, if the provider is like a medical student. I don't know I just have trust issues, and I prefer for them to be like a doctor or like one that's graduated.
8. SELF-DISCLOSURE	SD (Self disclosure on appointment status)	I do think it's important to go to them as often as is necessary. Actually, right now. I'm a little bit behind for the year, but I did make them yearly. I go to my yearly visits.
9. DOCTOR SENTIMENT	DSN (Doctor sentiment neutral) DSP (Doctor sentiment positive) QD (Questions discouraged)	So I had a really good like relationship with mine. So that's sort of like what led me to actually get a Pap smear versus before I'm like meh. Okay.
10. DOCTOR TYPE	FD (Female doctor) BD-F (Black doctor-female) BD-R (Black doctor relates)	Another issue I wouldn't schedule one is that the provider is of a different race. I would, feel more comfortable if they were women of color or men of color if it comes down to it. Because I just feel like we have that personal connection of having similar issues and them really knowing what's going on.
11. DOCTOR RAPPORT	STO (Small talk occurs) BM (Bedside manner) QR (Question reciprocity)	And so, first of all, there was a little of tension and a little of you know –?--- in the room, but he assured me he was really friendly, looked through my vitals and said I was okay. If I had any questions I should ask.
12. QUESTION-MOTIVATED (PRE)	VIQ (Questions important) QE-D (Questions environment-dependent) QN (Asks questions by nature)	So I've always felt like talking to my provider and asking questions has been really easy, and I've never been afraid to ask any question or any at all.
13. APPOINTMENT PREP	SBA (Sentiment before appointment)	Definitely scary. I do worry about just anyone seeing me, you know it's my privates. A stranger looking at me would be very nerve racking.

14. "VAGINA" EUPHEMISMS	SOV (State of vagina) VCW (Vagina code words) SV (Saying "vagina")	Definitely scary. I do worry about just anyone seeing me, you know it's my privates. A stranger looking at me would be very nerve racking.
15. ATTENDING REGARDLESS	AR (Attends regardless)	So it wasn't an easy decision for me to open my privacy to someone, but it had to come with a whole lot of thinking. And – the word I'm looking for is comfortability – to know that, well, I need this for my health beyond my privacy. I need this for my health. Yes, that informed my decision.
16. FREQUENCY X COMFORT	FC-P (Freq. x comf.-positive) FC-N (Freq. x comf.-negative)	For the first time I felt awkward. Then going forward, I think it gradually dissipated, and I now started feeling more confident and more relaxed seeing the doctor. Yes.
17. FIRST VISIT	FVC (First visit comparison)	If if I reflect back on my very first appointment, and even subsequent ones that I've had that I didn't have to think too much about, it was harder the first time, and subsequently it's become easier for me to just pick up my bag and book an appointment and see the doctor when I need to. So it was just the first time that it was harder, and once I was able to break through that shyness and make the doctor see me, it was easy for me to see him subsequently.
18. RESEARCH AND INFORMATION	SOI (Sources of information) BGR (Background research)	Oh, I have never been, but scheduling an appointment I would go to my primary care provider and see if there's anyone already listed, and if not I would go and search for one, whether it's local or not. I'll get references, probably from other young black women, most likely. —-(?)---- to and then go through my choices.

**Note:* Line-by-line codes and gerunds summarized into abbreviated codes; three codes with highest frequency shown, where applicable.

Appendix E. Codebook Excerpt—*Hierarchal* Codes, Campaign Response.

Hierarchal Code	*1L* Code(s)*	Supporting text
19. PROPS	Prop-AR	No, mainly because I've never put so much thought into how to wear the gown, that they give you.
20. AMBER'S ANXIETY	ARF (Amber's feelings leading to appointment)	I could tell she was nervous. She was afraid of the doctor possibly being judgy.
21. VIEWER RESONANCE	RoP-A (Portrayal affirmative) RoP-NA (Portrayal not accurate) SF (Shared feeling about visit)	There are quite a few quite a few of the videos that were almost the exact same scenarios or situations that I've been in from being afraid to ask questions that I mentioned before, because the few times that you try it's been rushed, or the answer was kind of half answered leaving you still uncertain what the answer is.
22. QUESTION-MOTIVATED (POST)	MTA (Encouraged to ask questions on next visit)	She's definitely affecting me to ask more questions, and feeling like I should have a right to ask these questions and not be rushed out or have these questions ignored.
23. DOCTOR ALLY	DRA (Finding a doctor that is ideology and race aligned)	I think there was a last one of the last 2 or 3 videos about finding someone that understands. You know. That's an ally, and understands you and your community that can give you the space that you need to be comfortable and be knowledgeable and have less, if you know, maybe zero fear and less anxiety about going to these appointments in the future. Yeah.

Hierarchal Code	*1L* Code(s)*	Supporting text
1. AWKWARD-MINDSET	AWK-SCARED AWK-UNCOMFORTABLE AWK-ANXIETY	For me being awkward - I guess being so scared is what makes it so awkward.
2. AWKWARD-EXPOSURE	AWK-VAGINA	Awkward in this context would mean feelings of you know discomfort especially when it comes to discussing matters of the vagina. In fact, saying it alone is, is – it feels awkward if I should use the same word again.
3. AWKWARD-BEHAVIOR	AWK-ACTIONS	I would say it's not knowing what to say. just standing there psyching yourself out mentally and just not going through whatever you're trying to go do and just not doing it – just like standing there awkwardly.

Appendix F. —Themes and Supporting Quotes, At-a-a Glance.

Theme	Supporting Quote
Barriers to Scheduling	I just wanted to reiterate that the biggest difference for me in terms of going versus not going was honestly like the provider...Because now that I do have someone that I'm comfortable with, it's not even something I think about versus before I just, you know, I just try to avoid that whole appointment altogether okay.
Gynecology Knowledge Gaps	You have to go do a gynecologist test. I know they like, have to give you consent. You have to get our consent to be able to do it. The process doesn't take that long. That's about it. Yeah.
Awkwardness Valence	You know, just I guess you can just kind of sense the tension of not feeling relaxed or feeling like you can really be yourself.
Vagina Talk	I guess that they kinda take care of your—I don't know what to word for it—area down there.
Cues to Action	So, I basically had to convince a friend that, hey girl, we have to do this... So I went inside first. It hurt then I came out. She was like, 'was it good?' I had to give her some form of assurance, and then she also went.
Realism of Ruffin's Portrayal	I've never put so much thought into how to wear the gown that they give you.
Approach to Questions	Any question I need to ask I'm going to ask. I don't care how I feel. Even if I do feel awkward, even if I feel anxious. I'm still gonna ask because I still need to know.
Black Women's Innate Understanding	The value in having a gynecologist that is Black has been a lot bigger than I thought it would be.... I feel a lot more comfortable with my gynecologist now than I ever have in the past...

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Education

2023, *Anticipated*	M.A., Communication, University of Kentucky, *GPA 4.00*
2009	B.B.A., Business Administration, The George Washington University

Academic & Professional Positions

2023, *Fall*	**Graduate Student Instructor**, University of Kentucky
2023	**Health Communication Graduate Intern**, Kentucky Deptartment of Public Health
2022—Present	**Research Assistant**, University of Kentucky
2022—2023	**Teaching Assistant**, University of Kentucky
2021—2022	**Assistant to Assistant Dean of Inclusion**, University of Kentucky
2021	**Public Relations Consultant**, Upliftology, LLC
2020	**Account Manager**, Olu & Company
2014—2021	**Arts & Culture Journalist and Editor**
2014—2020	**Flight Attendant**, American Airlines
2011—2014	**Office Manager**, Summit Management Services, Inc. AAMC

Scholastic & Professional Honors

2023	Kentucky Department for Public Health Student Internship Program (competitive statewide internship award)
	Outstanding Mentor, Center for Graduate and Professional Diversity Initiatives, University of Kentucky
	Lexington Herald-Leader Fellowship, University of Kentucky
2022	Carozza Graduate Fellowship for Excellence in Health Communication, College of Communication and Information, University of Kentucky
2021—Present	Teaching Assistanceship, College of Communication and Information, University of Kentucky

	Student Travel Grant Award, College of Communication and Information, University of Kentucky
2007	Marcia Rosenthal Fellowship for Alumna of the Elizabeth J. Somers Women's Leadership Program, The George Washington University

Professional Publication & Conference Presentations

2023	Chen, H., & **Sesay, N. A.** Twitter message disseminators during the 2021-2022 Pandemic: A case study of We Can Do This COVID-19 childhood vaccination campaign. Submission to the 109th Annual National Communication Association Convention, November 16-19, 2023, National Harbor, Maryland. [Accepted]
	Sesay, N. A. From online support to cancer control: Analyzing cervical cancer testimonies using narrative typology. Submission to the 16th Annual National Conference on Health Communication, Marketing & Media, Atlanta, Georgia, July 19-21, 2023 [Accepted].
	McWhorter, K., Borie, C., & **Sesay, N. A.** Quality improvement of a short-term Shoulder to Shoulder Global study abroad experience program in Santo Domingo, Ecuador. Poster presented at the Consortium of Universities for Global Health, Washington, DC, April 14-16, 2023. [Accepted].
	Occa, A., Chen, H., Stahl, H., & **Sesay, N. A.** Communicating about clinical trials on US news media. Paper presented at the 73rd Annual International Communication Association Conference, Toronto, Canada, May 25-29, 2023. [Accepted].
	Occa, A., Chen, H., Stahl, H., & **Sesay, N. A.** Communicating about clinical trials on US news media. [Manuscript].
	Silwal, A., Francis, D. B., & **Sesay, N. A.** 'Who's Dancing with the Devil?' A mixed methods investigation of reactions to the authenticity of Demi Lovato's health disclosures. Poster presented at the 73rd Annual International Communication Association Conference, Toronto, Canada, May 25-29, 2023. [Accepted].
2022	**Sesay, N. A.** 'This year made me so tired, like soul tired': Addressing flight crew fatigue with principles of the high reliability organization. Abstract presented at the 20th Engaged Communication Scholarship Conference, Snowmass Village, CO, July 30-August 1, 2022. [Accepted].