



Use of Community Listening Sessions to Disseminate Research Findings to Past Participants and Communities

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Abstract

The purpose of this sequential, explanatory mixed methods study is to determine changes in attitudes towards research, trust in medical researchers and the process, and willingness to participate in research among African Americans immediately after receiving past study findings in a community listening session (CLS). We developed and implemented four CLSs with a total of 57 African Americans who were either past research participants or members of the community-at-large. In the quantitative (dominant) phase, 32 participants completed pre-post surveys and 10 of those participants completed the follow-up semi-structured interviews. Paired samples t-tests and McNemar's test determined bivariate differences between pre- and post-surveys. Thematic analyses determined emerging themes to further understand these differences. There was a significant increase in: (1) perceived advantages of clinical trials pretest ($M = 26.63$, $SD = 5.43$) and post-test ($M = 28.53$, $SD = 4.24$, $p < .01$); and (2) in trust in medical researchers from pre to post ($M = 36.16$, $SD = 10.40$ vs. $M = 27.53$, $SD = 9.37$, $p < 0.001$). There was no significant difference in pre- and post-tests as it relates to perceived disadvantages of clinical trials and willingness to participate. Qualitative analysis yielded the following themes: (1) sharing research results and the impact on attitudes towards research; (2) community listening sessions: a trust building strategy; and (3) satisfaction with the community listening session. Community listening sessions hold promise as a method that researchers can use to simultaneously disseminate research findings and positively impact research perceptions and potentially participation among racial and ethnic minorities.

Keywords Dissemination · Listening session · Community · Trust · Past research participants

Introduction

Dissemination of research findings to past research study participants and community-at-large is an emerging priority [1]. It is necessary to bridge the translation gap across all disciplines from basic research to communities [2]. Furthermore, it is commonly requested by past participants and desired by community members-at-large with a preference for results post-study or throughout the study at different research phases [3]. Studies have explored preferential strategies for research dissemination according to past research community members and community-at-large [3–6]. Example strategies include town hall meetings, emails, radio, and social and/or traditional media [3, 4]. However, we identified little to no evidence-based strategies to disseminate research findings and the impact on an outcome of interest (e.g., willingness to participate in research) [7].

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Launched in the 2017, the Meharry Community Engagement Core (MCEC) seeks to engage the community to eliminate health and healthcare disparities among racial/ethnic minorities and socioeconomically disadvantaged populations. The dissemination of disparities research findings to past research participants and the community-at-large, using culturally-appropriate strategies along with training researchers to engage in this effort, are major foci of this core [4, 8]. The MCEC sought to explore the radio as an evidence-based strategy to disseminate study findings to past research participants and the community-at-large. The idea of using radio to disperse results of research studies to community emerged from an associate director of MCEC with endorsement by the Core's Community Advisory Board (CAB). Exploration of this channel for research dissemination is ideal since radio remains one of the most powerful, yet effective tools for communicating to Americans and continues to extend its' reach. Furthermore, 66% of African Americans listen to the radio outside the home and 34% listen to the radio inside the home [9].

The purpose of this mixed methods study was to examine the impact of community listening sessions (CLS), one strategy for research dissemination, on African Americans attitudes, trust in medical researchers and the process, and willingness to participate in research. The research question for the quantitative phase was: Did positive attitudes, trust in medical researchers and the process, and willingness to participate in research increase among African Americans throughout the Southern United States who participated in CLSs between February and July 2020? The research questions for the qualitative phase were: (1) How does the CLS listening sessions impact African Americans' attitudes towards research, trust in medical researchers and the process, and willingness to participate in research? (2) What are participants overall acceptance and satisfaction with the CLS? The overall objective was to determine the feasibility and acceptance of the CLS to disseminate study results among African Americans?

Materials and Methods

Development of Community Listening Session (CLS) Program for Research Dissemination

Members of the dissemination team of the MCEC developed the CLS program to disseminate study results to past research participants and the community-at-large. A CLS is a qualitative research method where people of diverse backgrounds and perspectives express their views on an important issue such as research study findings via radio [10]. The team is comprised of multidisciplinary researchers with extensive experience in community engagement and

research dissemination. Based on the MCEC CAB feedback, MCEC dissemination team researchers drafted the goal, protocol for the CLS via radio, tips for effective communication via radio (e.g., be conversational in nature or use "community friendly" terms), and the disclosure statement to be signed by the researcher. Further review of the literature was conducted to identify information past research participants and community-at-large wanted to receive post-study and incorporated into the protocol. The MCEC CAB reviewed the final protocol to ensure it addressed the needs of the community. The CAB approved the three 15-min segments. Key elements they perceived should be emphasized were the researcher and their qualifications to do the research, the results, next steps, and how the community-at-large can be involved in future research. Researchers were provided a brief overview of the CLS by a member of the dissemination team prior to program implementation.

Final CLS Program

The final CLS program, entitled "Meharry Research Spotlight Series", aired on the Fisk Radio Station *Jazzy 88* in Nashville, Tennessee. *Jazzy 88*, owned and operated by Fisk University, is an educational, community-based radio station. It is the first African American AM station operated in Tennessee established in 1973 [11]. For CLS implementation, community members were invited to Meharry Medical College to listen to researchers disseminating study results live. The final program had three 15-min segments (See Table 1). Major components include provision of researcher background, study background and rationale, purpose, method, research findings, and next steps. This allows for the past participants and community-at-large to understand the entire research process, the results, and how their results can or will be used. However, we allow fluidity in the program for researchers as it relates to disseminating study results to accommodate researchers current stage of research and to promote dissemination of study findings throughout the research process. Examples include researchers discussing: (1) findings from a completed study; (2) preliminary results at different phases of the research study, or (3) a current research study and the past studies which led to the study.

These programs were led by the Associate Director of MCEC, who hosts the weekly program "Health Watch" with *Jazzy 88*. Example content for these programs included importance of research, breast cancer research, and human papillomavirus (HPV) cancer and importance of vaccination. The participants were then given the opportunity to call in and ask the researcher questions. During the COVID-19 pandemic, our program was transitioned to the online Zoom platform. The participants listened to recordings from past sessions and the researcher was present to provide the

Table 1 Content for radio community listening session program

Segment 1: Introduction of the research process and study	<p>Researcher introduction</p> <p>Describe study purpose</p> <p>Highlight research process</p> <p>Discuss community's role (if applicable)</p>
Segment 2: Introduction of researcher	<p>Provide researcher background and qualifications to conduct study</p> <p>Rationale for the work</p> <p>Identify the health disparity being addressed</p>
Segment 3: Discussion of study results and next steps	<p>Identify top two to three results</p> <p>Describe next steps as a researcher</p> <p>Emphasize what the community can do with results</p> <p>Provide advice to community members to be involved in study's and the dissemination of study results</p>

similar experience in participants being able to have access to the researcher and ask questions.

Research Design

We employed a sequential, explanatory mixed methods design to investigate the impact of the dissemination of research findings in 4 CLS (2 in-person and 2 online). Specifically, we explored the impact of these sessions on attitudes (i.e., advantages and disadvantages of clinical trials), trust, and willingness to participate in research. We further sought ways to improve the implementation of this program. Researchers first collected and analyzed quantitative data (survey), then used the results to design a follow-up qualitative semi-structured interview to explain initial quantitative results [12]. Meharry Medical College Institutional Review Board approved this study under Protocol Number 19-04-912.

Participants

The convenience sample comprised of African Americans located in the Southern United States. We recruited using word of mouth, community-based organizations, flyers, and an existing database of MCEC community partners. The pre-post study inclusion criteria included being African American, male or female, and 18 and over. Participants for the qualitative phase were individuals who: (1) met the survey inclusion criteria; (2) completed the survey; and (3) agreed to participate in follow-up interviews.

Quantitative (Phase 1)

Study Design

We administered a survey using a cross-sectional, mixed mode (online and face-to-face) survey design to 57 African American community members. This survey asked questions related to trust in medical researchers, attitudes towards research, and willingness to participate in clinical research.

Surveys were distributed in-person or online, depending on the mode of delivery of the CLS.

Survey Development and Measures

The survey was developed using previously validated scales and demographic variables in the literature. Each measure is briefly described below.

Trust in Medical Researchers

Section one consisted of a 12-item, validated scale measuring participants trust in medical researchers. Developed by Mainous et al. [13], the response options were a 5-point Likert scale based on agreement. This scale had negatively worded (4 items) that were reverse coded for scoring purposes. A high score indicates low levels of trust in biomedical research. Example items were “Usually, researchers who make mistakes try to cover them up.” and “Medical researchers unfairly select minorities for their most dangerous research studies”. Cronbach's alpha, used to measure internal consistency was 0.905.

Attitudes Towards Research

Section two consisted of questions on participants attitudes towards medical research developed by Kennedy and Burnett [14]. This scale consisted of two validated subscales—a 7-item subscale on advantages to research participation and a six-item subscale on disadvantages to research. This scale was based on a 5-point Likert scale on agreement. A high score indicates high levels of perceived advantages and high levels of perceived disadvantages. Example items on the disadvantaged subscale were “Losing one's privacy” and “Experiencing side effects. For the advantages scale, example items were “Helping to delay disease.” and “Doing something positive for self.” One item was unintentionally removed from the advantages scale “Advantages of clinical trials: Doing something positive for self.” Cronbach's alphas

were 0.864 and 0.860 for the advantages and disadvantage subscales, respectively.

Willingness to Participate in Research

Section three consists of two questions on participants willingness to participate in medical research. Question one asked “Would you take part in a research study in the future?”. Question two asked, “If your family has a disease and needed new treatment or drug, would you be willing to participate in a research study? The answer options were yes/no/not sure.

Acceptance/Satisfaction of Radio Community Listening Session

Four items were used to rate the CLS in section four. A high score indicates high levels of satisfaction. Example statements include “The radio speaker clearly expressed ideas.” or “The radio speaker/researcher seemed knowledgeable about the topic.” Response options were a 5-point Likert scale based on agreement. Cronbach’s alpha was 0.960.

Demographics

Age was a continuous variable. Gender was represented with categories of male and female. Race was represented with Black or African American, American Indian/Alaska Native, Asian, Native Hawaiian or other Pacific Islander, White, or more than one race. Single, common-law, domestic partner, separated, divorced, married, and widowed were the categories for marital status. These categories were collapsed to common law, married, and other (single, domestic partner, separated, divorced, and widowed). Employment status included the categories employed full-time, status employed part-time, unemployed, stay at home, retired, disability, and other. Employed (part-time and full-time) and other (i.e., unemployed, stay at home, retired, disability, and other) was the dichotomized variable for employment. Education had seven categories- GED or HS diploma, no high school diploma, some college, associate degree, bachelors’ degree, master’s degree, and doctoral degree. Education was dichotomized to some college and lower and associate’s degree and higher. Last, participants were asked if they had ever participated in research with the response options yes/no/unsure. This item was dichotomized to yes and no/unsure.

Data Collection

We implemented four CLS between February and July 2020 to disseminate study results from studies of researchers at Meharry Medical College. Two sessions were conducted in-person at Meharry Medical College where participants

listened to live sessions, and two were conducted online via Zoom where participants listened to recordings and the researcher was present for participants to pose questions directly. Our goal was 15 participants per CLS. On the day of the radio show, participants provided written consent if in-person and via REDCap if attending the online listening session. Participants listened to the 45-min radio segment. Pre- and post-surveys were implemented in-person or with a link to a Redcap survey to evaluate these strategies collectively. Participants were compensated with a \$20 gift card.

Statistical Analyses

We used version 25 of the IBM Statistical Package for the Social Sciences (SPSS) to analyze the data. Prior to analysis, survey responses were recoded, and sum scores calculated for scales, as needed, per instrument scoring instructions. Participant demographics were summarized for those completing the pre-survey only and both pre- and post-surveys. Five were completed in-person and 28 completed online. Data analyses were conducted on those who completed the pre- and post-surveys. Paired samples t-tests for continuous variables and McNemar’s test for categorical/binary variables determined bivariate differences between pre- and post-surveys of trust, disadvantages of clinical research, advantages of clinical research, and willingness. Differences between pre- and post-survey scores were calculated for each question. Stratified by survey, independent t-tests were then applied to determine if differences exist between those that took the survey online versus in-person. We set the significance alpha level at $p < 0.05$.

Qualitative (Phase 2)

Interview Protocol Development

To obtain a deeper understanding of the impact of CLS, we developed an 11-item interview protocol to further explore the significance of survey items in the quantitative phase. We also explored participant acceptance/satisfaction with the CLS and the researchers. Additionally, we wanted to explore participants overall views towards dissemination and strategies to improve our efforts, topics that were not studied in the quantitative phase.

Data Collection

We conducted semi-structured interviews with 10 CLS participants who agreed to be contacted for follow-up interviews. Trained in qualitative research, the first and second authors conducted the semi-structured interviews via Zoom. Participants provided verbal consent prior to the interview. These interviews were audio-recorded and transcribed by

Zoom and notes taken by the first or second authors. Participants were compensated a \$20 gift card.

Data Analysis

Thematic analysis was conducted in which codes and themes were created. Data were independently analyzed by the first and second authors. Axial coding was used to place codes into categories. Coders independently coded each transcript and compared codes until inter-coder agreement was reached at 100%. Constant comparison method was used to compare codes and identify emerging themes to better understand the role CLS played in influencing attitudes, trust, and willingness among the participants. Thick, rich descriptions, peer debriefing, and investigator and data triangulation was used to establish rigor [15].

Results

Quantitative Results

A total of 57 participants completed the CLS, six in person and 51 online. Of these, 32 completed the pre- and post-test surveys. This yielded a 58.5% overall response rate. When comparing those who completed the pre-test only versus those who completed both pre- and post-test surveys, there were no significant differences by participant characteristics

or mode of delivery (i.e., online versus in-person) (Results not shown.)

Demographic characteristics of the study participants that completed pre-post surveys are provided in Table 2. The population was majority female (87.5%) with a mean age of 44 years. About 81% indicated that they have an associate degree or higher. About 80% are in a common law or traditional marriage. Nearly half (46.9%) indicated previous participation in research.

Univariate Pre-Post Analysis

Table 3 summarizes the outcomes variables (i.e., trust in medical researchers, advantages or clinical research, disadvantages of research, and willingness to participate in medical research) and tests for pre- and post- intervention changes.

Bivariate Analysis: Overall Sample and by Mode of Delivery of Community Listening Session

There was a significant increase in perceived advantages of clinical trials pretest ($M=26.63$, $SD=5.43$) and post-test ($M=28.53$, $SD=4.24$, $p<0.01$). Perceived disadvantages of clinical trials decreased slightly among participants, but this change was not significant. There was a significant increase in trust in medical researchers from pre to post ($M=36.16$, $SD=10.40$ vs. $M=27.53$, $SD=9.37$, $p<0.001$).

Table 2 Baseline characteristics for participants completing pre-post tests (N = 32)

Characteristic	Mean	SD
Age (years)	44.03	18.78
Characteristic	N	%
Employment		
Employed (full-time, part-time)	21	70.0
Other (unemployed, retired, and disability)	9	30.0
Gender		
Male	4	12.5
Female	28	87.5
Education		
Some college and lower	6	18.8
Associates degree and higher	26	81.3
Marital status		
Common law	16	50.0
Married	9	28.1
Other (single, separated, divorced, widowed)	7	21.9
Ever participated in research		
Yes	15	46.9
No/unsure	17	53.2

* $p<.05$; ** $p<.01$; *** $p<.001$; Numbers per category may not equal total n due to missing values

Table 3 Pre-post changes in trust in medical researchers, advantages of clinical trials, disadvantages of clinical trials, and willingness to participate in clinical trials (unadjusted), overall

Paired samples t-test						
	Pre		Post		t-test	p-value
	Mean	SD	Mean	SD		
Advantages of clinical trials	26.63	5.43	28.53	4.24	−3.690	0.001**
Disadvantages of clinical trials	19.25	5.70	19.06	5.52	0.340	0.736
Trust in medical researchers	36.16	10.40	27.53	9.37	8.650	<0.001***

Mcneemar test: percent of people willing to participate in research, pre-test and post-test					
	Pre		Post		p-value
	N	%	N	%	
Willingness to participate	18	56.3	20	64.5	.500

* $p < .05$; ** $p < .01$; *** $p < .001$; Data are means and standard deviations for advantages of clinical trials, disadvantages of clinical trials, and trust in medical researchers (1-strongly disagree to 5- strongly agree) for CLS objectives

Willingness to participate in research slightly increased from pre-post but was not significant.

After stratifying by mode of delivery (online versus in-person), we further sought to explore if any differences exist in the mean score of the pre- and post-surveys using a paired t-test. For those that attended the CLS online, there was a significant difference in trust pre and post responses ($p < 0.001$), decreasing from an average score of 35.3929 to 26.3571, and advantage pre and post responses ($p = 0.002$), increasing from 26.5357 to 28.4286. For those who took the survey in-person, there was a significant difference in trust pre- and post- survey ($p = 0.01$), decreasing from 37.75 to 31.75.

We tested the mean difference in pre-post-scores between online and in person. Initially, the differences in variance between pairs of pre- and post-surveys for in-person versus online was performed using Levene's test and determined the variance of each pair of groups were not different [trust ($p = 0.152$), disadvantage ($p = 0.536$), advantage ($p = 0.782$), and willingness ($p = 0.254$)]. Using these results, a two-tailed independent t-test was conducted, and we found there was no difference in online and in-person means in pre-post scores for the trust ($p = 0.267$), disadvantage ($p = 0.926$), advantage ($p = 0.725$), and willingness ($p = 0.595$) surveys. This indicates that the deletion of a single question did not have a significant impact on the scores of the two groups.

Satisfaction Post-session: Descriptives

Participants indicated their level of satisfaction with the CLS. Majority of the participants strongly agreed or agreed that the researcher was clear ($n = 28$; 87.5%) and knowledgeable ($n = 27$; 84.4%) on the topic. In addition, the majority found the segment excellent ($n = 28$; 87.5%) and perceived

the research presented will benefit the health of our communities ($n = 28$; 87.5%). (Results not shown.)

Qualitative Results

Three themes with related subthemes emerged from the data: (1) Satisfaction with the Community Listening Session; (2) Sharing research results and the impact on attitudes towards research; (3) Community Listening sessions: A trust building strategy. These themes reflect the interview questions and the outcome variable, trust, found significant in the quantitative data findings in relation to survey questions. Subthemes and participant quotes are noted in Table 4.

Sharing Research Results and the Impact on Attitudes Towards Research

When asked about sharing research study results with participants, all agreed it was important and methods for dissemination should be tailored or targeted to the desired audience. Interviewees noted that sharing research results increased past participants and the overall community's understanding of the research process and how their participation impacted healthcare practices (e.g., better care and advocacy for others). Further, it informed their future healthcare decisions. One participant further understood why certain diseases and medication affected ethnicities differently, reducing the feeling of being a "guinea pig" while seeing altruism and need for her participation in more research.

Community Listening Sessions: A Trust Building Strategy

In each interview, concerns about trust were stated explicitly, or implied when expressing concerns about engaging with

Table 4 Themes, subthemes, and sample quotes from participants

Theme	Subtheme(s)	Participant quotes
Satisfaction with community listening session	Community listening session experience	“It was an interesting experience, I’d never done something like this before, I would be willing to participate again.” “I like how accessible it is. I like this I was able to be with researchers, and that felt super comfortable for me. I liked the fact that it felt like everyone was learning.”
	Researcher	“...we don’t always get all of the information that we need, and especially getting information from Black doctors, that’s very important...the fact we have Black doctors explain these things to us that—I like that.” “I remember him being informative. He explained things to the best of his ability, and it was easy to understand what he was saying.”
Sharing research results and the impact on attitudes towards research	Importance	“It allows communities to know what is being done and the impact it will have.” “I think having studies presented, having research presented back to me, allowed me to make a decision on what I wanted for healthcare treatments moving forward.”
	Information concerns	“...it is great to have a larger reach, but sometimes I have concerns about how the messages will be interpreted.” “...how much information could you give would not understand, because not everyone understands the same words to mean the same things.” “Information can be skewed and altered really quickly.”
	Audience segmentation	“I keep going back to my whole thing is that who we’re targeting and how you’re going to reach them and what age group.”
Community listening sessions: A trust building strategy	History	“So people feel like, ‘Here we go again,’ just using Black bodies to do research on and you know, and then we’re going to be discarded...” “We have to be able to trust the medical community with our lives. That’s not something we do based on our history.”
	Trust-building strategy	“You can tell that he (the researcher) had a sense of community. He was wanting to make sure the information was presented in a way that I can understand what they are saying, “...but I think going forward, that (community listening session) would be a good way to create engagement and interest.”

the medical community, the research process, and information sharing. The explicit mentions of trust were centered on past research abuses, the needs for discussion with community, and the need for more researchers of color. When discussing trust, one framed their remarks about the lack of trust due to being used in research and then discarded. Notably, another participant stated for trust to be established, there must be a statement or conversation of past abuse, researchers and institutions must build bonds with their local communities, and be clear in their intentions. For the CLS, specifically, providing results back to the community was an important step in gaining trust from these past participants and the community-at-large. For those who participated in the CLS online, the availability of the researcher to answer questions, demonstration of honesty and vulnerability in not

knowing all answers, and informing the next steps in the research process emerged as key strategies to building trust.

Satisfaction with the Community Listening Session

When describing their individual CLS experience, all participants stated they liked the CLS. Most of the interviewees, six of ten, stated they liked the conversational environment of the CLS as it made it easier to learn and understand the presented information. All interviewees provided a positive response about the featured researcher for the online CLS. Participants found the researcher informative and engaging. The information and researcher were easily accessible. One participant stated they appreciated the researcher engaging in the question and answer session. However, a few

participants indicated the session was lengthy but understood the rationale.

Discussion

To our knowledge, this is the first study to explore if disseminating past research findings via CLS could improve attitudes, trust, and willingness to participate in research. Hence, this study makes a significant contribution to the literature. We observed a significant increase in levels of trust post after disseminating past study results via CLSs. The information provided in the CLS allowed participants to better understand the research process and to feel valued by the researchers. Cunningham-Erves et al. [4] found that disseminating study results via town hall meetings increased participant trust in medical researchers and the research process. Collectively, these findings suggest the dissemination of study findings as a part of the research process could help address the longstanding history of mistrust in researchers, a major barrier to research participation in underrepresented research groups [16, 17].

Few studies have explored if disseminating results can change attitudes towards research [1, 4, 7, 18]. For example, Heerman et al. [7] disseminated aggregate research findings to past participants via 1 page text summary, 1-page infographic, a 2-min video, and a web-link to aggregate results. Willingness to participate in research increased 73% among respondents. In our overall sample, results demonstrated a significant increase in perceived advantages and a significant decrease in perceived disadvantages as it relates to clinical trials. These results confirmed our hypothesis that disseminating research results can help participants understand the research process while allowing the participants to see the perceived benefits and lessening some of the perceived barriers to clinical trial participation. Demonstrating to research participants and the community-at-large that their participation is informing healthcare practices with no intentions to invoke harm is important in the dissemination process and could essentially influence research outcomes. Unlike past studies [18, 19, 7], the dissemination of study findings via CLS did not influence willingness to participate in research. This could be due to a myriad of reasons including the small size sample, type of research being disseminated, or the channel or source of communication. Future work on a larger scale should explore the impact of disseminating research findings on willingness to participate in clinical research, and if channels used to disseminate research play a role in the degree of willingness to participate in research.

Surprisingly, there were no significant differences in trust, perceived advantages, perceived disadvantages, and willingness by the CLS being given online or in-person. This suggests that providing past research participants and

community members with study results in person with live airings or online using past recordings can yield similar outcomes. However, our online participants in the CLS discussed the added benefit to having direct access to the researcher and being able to ask questions. Because this was a pilot study, future work should further explore whether mode of delivery of the CLS can have a moderate effect on attitudes, trust, and willingness.

Last, overall participants were satisfied with the CLS. Interviewees discussed how they appreciated that the researcher disseminated the results to past research participants and the community-at-large. Online dissemination of research findings with access to a researcher that was relational and conversational was highlighted among participants. This further suggests that researchers should be available to the participants to increase understanding of research process, results and how they can affect their healthcare and outcomes, and steps to be taken post-study. Next steps include determining if this strategy could be an evidence-based approach that could stand alone and/or a part of a multi-component intervention for increasing trust, attitudes, willingness, and ultimately participation in research.

Lessons Learned

Over 80% of the participants indicated they were satisfied with the CLS, and significantly increased perceived advantages and trust in medical researchers and the process. Furthermore, qualitative results indicate CLSs are a trust-building strategy to increase research participation and can positively impact attitudes (e.g., altruism) towards research. Based on these results, we provide the following recommendations for researchers: (1) Include and budget for a dissemination plan in research proposals as return of results can be beneficial in increasing trust and perceived advantages towards research participation, which are major barriers to research participation; (2) Provide results in context to the larger research problem to help past research participants and the community-at-large to understand the research process and their contribution; (3) Be honest and transparent on outcomes and implications; (4) Be available to answer questions on study results, if and/or how past research participants and community-members-at-large can apply them, and next steps in research; and (5) Be culturally appropriate and sensitive in the delivery of study findings.

Limitations

Among participants that attended the CLS and completed pre- and post-test, approximately half were prior research study participants. We did not collect information about past experiences, whether positive or negative. This additional information may have helped to further explain overall

impact of the CLS on attitudes about research, trust in medical researchers, and willingness to participate in research in the future. The participants were mostly female, limiting the ability to gain the male perspective and explore any differences between male and female perspectives. Transitioning to the Zoom platform for the CLS was necessary due to COVID-19-related social distancing mandates, provided a way to continue data collection, and resulted in information that can indeed inform future dissemination efforts. However, it limited the sample sizes available to evaluate the different modes of data collection, which may have provided greater insight into the impact of online or in-person radio CLS. Last, our CLSs did not focus distribution of study findings only. Therefore, we cannot state that providing research results alone contributes to our findings.

Conclusion

Community listening sessions hold promise as a method that researchers can use to simultaneously disseminate research findings and positively impact research perceptions and potential participation among racial and ethnic minorities research perceptions.

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Data Availability Dataset generated and analyzed during this study are not publicly available due to ethical restrictions.

Declarations

Conflict of interest The authors have indicated they have no financial relationships relevant to this article to disclose. The authors have no potential conflicts of interest to disclose.

Ethical Approval All study procedures involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Institutional Review Board at Meharry Medical College (IRB #: 19-04-912).

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