African American STD Disparities Health Communication Project

#0920-0798

Section A: Supporting Statement

October 26, 2009

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DSTDP African American STD Disparities Health Communication Project

A. Justification

A. 1. Circumstances Making the Collection of Information Necessary

On January 9, 2009, CDC received OMB approval for the generic concept of health marketing (Health Marketing, 0920-0798) to provide feedback on the development, implementation and satisfaction regarding public health services, products, communication campaigns and information.

Under Health Marketing, OMB has agreed to expedite review of proposals for data collections for survey/informative materials development and customer satisfaction surveys only. OMB will generally review such requests within ten business days.

Background

Current epidemiological data on STD infections among African Americans show significant racial/ethnic disparities in these infections compared with Whites. According to CDC's 2007 *STD Surveillance Report*, African Americans accounted for approximately 48% of all chlamydia cases, 70% of all gonorrhea cases, and 46% of all primary and secondary syphilis cases in the United States (CDC, 2007). These numbers translate into rates of chlamydia, gonorrhea and syphilis that are 8 times, 19 times, and 7 times greater among African Americans than whites, respectively. HIV/AIDS infections in the United States follow a similar pattern in terms of disparities. An examination of data from the 33 states with name-based HIV/AIDS reporting further indicates that in 2005 African Americans accounted for 49% of new HIV/AIDS diagnoses, although African Americans make up only 13% of the U.S. population (CDC, 2008).

According to the Healthy People 2010 Report, "For individuals, effective health communication can help raise awareness of health risks and solutions, provide the motivation and skills needed to reduce these risks, help them find support from other people in similar situations, and affect or reinforce attitudes. Health communication also can increase demand for appropriate health services and decrease demand for inappropriate health services (U.S. DHHS 2000, p. 11-3)." At the community level, health communications "can be used to influence the public agenda, advocate for policies and programs, promote positive changes in the socioeconomic and physical environments, improve the delivery of public health and health care services, and encourage social norms that benefit health and quality of life (p. 11-3)."

While health communication campaigns are accepted tools in the promotion of health and the prevention of disease, our understanding of the potential of these health promotion

methods for affecting change around STDs and HIV among African Americans is limited. A recent review of literature conducted by RTI International for CDC identified very few well-evaluated health communication or social marketing campaigns that have addressed STD prevention among African Americans. At the same time, researchers in the area of STDs and HIV have suggested that health communication campaigns can play a role in addressing the STD and HIV disparity among African Americans.

There is a need for health communication campaigns that address the knowledge and informational needs of African Americans concerning STDs and HIV/AIDS that are positive and motivating and drive individual behavior change and community mobilization. To design health communications messages that address people's concerns and resonate with the experiences and realities of communities affected by STDs and HIV, we must collect consumer information.

Authorization to conduct this study is contained in the Public Health Service Act (42 USC 241) Section 301. A copy of the legislation is included in the attachments. (Attachment 1)

Privacy Impact Statement

Below we give (i) an overview of the data collection system, (ii) a listing of items of information to be collected and (iii) a statement on web utilization.

Overview of Data Collection System

The study team will collect data using methods standard to health communication formative development: 1) triad interviews (3 person), 2) individual interviews, and a 3) paper and pencil questionnaire.

This formative development will be conducted in two phases.

Our study population will include individuals from five U.S. communities representing eight audience segments stratified by age, gender, and urban/rural residence. The communities include Atlanta, GA; Spalding County, GA; Edgecombe County, NC; Chicago, IL; and Philadelphia, PA. These sites were chosen because of the large burden of STDs among African Americans in these communities.

Eligibility criteria for Phases I and II are the same: (1) Reside in a study community, (2) English-speaking, (3) African American, (4) heterosexual, (5) sexually active in the past 6 months, and (6) aged 18-45 years.

In Phase I, the formative stage, we will conduct both triads (n=48) and individual interviews (n=72), with all triad and individual interview participants also completing a paper and pencil questionnaire at the beginning of their interview, as well as a brief structured data collection activity at the conclusion. Participants will be a convenience sample of individuals from five urban and rural communities located throughout the United States that have been epidemiologically identified as being disproportionately affected by STDs and HIV. The respondent universe for Phase I is shown in Table A.1.1.

Table A.1.1. Phase I Respondent Universe Stratified by Gender, Locale, and Age

	Male		Female	
	18-29 yrs	30-45 yrs	18-29 yrs	30-45 yrs
Urban	6 triads, 9 IDIs	6 triads, 9 IDIs	6 triads, 9 IDIs	6 triads, 9 IDIs
Rural	6 triads, 9 IDIs	6 triads, 9 IDIs	6 triads, 9 IDIs	6 triads, 9 IDIs

Each triad will last approximately 1.5 hours and individual interviews will last about 1 hour. Triads/interviews will be held at a marketing facility or community based organization depending on city layout and participants' place of residence. A trained team member will moderate the triad/individual interview discussion using a semi-structured topic guide (see Attachment 2 for triad guide and Attachment 3 for individual interview guide) and another team member will take notes. The topics to be discussed include knowledge, perceived risk, and awareness of STDs; social and cultural determinants of STDs; stigma and community beliefs; and preferences for framing and communicating messages. The discussions will be audio recorded using digital recorders. Audio recordings will supplement notes and will be stored in a locked filing cabinet in the project leader's office. CDC staff members may also attend and view the triads from behind a one-way mirror.

Phase I participants will be asked to complete a brief paper-and-pencil questionnaire (see Attachment 4) before the discussion begins to collect basic data on socio-demographic characteristics; STD knowledge, attitudes, and beliefs; sexual behavior, and prior experiences with STD testing. At the conclusion of the Phase I data collection, participants will be asked to complete one of two activities (see Attachment 5): (1) Pile sorting of STDs or (2) Rating of STD attributes. Both of these activities are designed to explore reactions to different messages focusing on various combinations of HIV and/or STDs. For the pile sorting activity, we will present participants with 10-12 preprinted cards listing various STDs, including HIV, and ask them to sort the cards into piles in response to the statement, "Place the following STDs (written on cards) into piles of like or similar STDs. Please make more than one pile." For the Rating of Attributes, participants will be provided a list of STDs on paper and asked to rate each one on a

seven point scale along several attributes, including perceived seriousness, ability to cure, personal risk, and social acceptability.
In Phase II of the formative development, message development and testing, a smaller sample of individuals (n=36) will participate in individual interviews. These interviews will be conducted in two of the Phase I communities. This set of interviews will follow-up on findings from Phase I and provide feedback on the concepts/messages in development.

The follow-up individual interviews will last about 1 hour. A trained team member will lead the discussion using a semi-structured topic guide (see Attachment 6) and another team member will take notes. The purpose of this data collection is to obtain clarification on Phase I findings and to provide feedback on the concepts/messages developed in Phase I. We will assess participants' immediate reaction or receptivity to each concept/message and ask them to choose the one(s) that they believe would best motivate them to reduce their STD risk. The discussions will be audio recorded using digital recorders. Audio recordings will supplement notes and will be stored in a locked filing cabinet in the project leader's office. CDC staff members may also attend and view the triads from behind a one-way mirror. When interviews are conducted in the community settings, interviews will be conducted in a private setting. Situation permitting, members of the CDC team members sit in on the interview session.

Items of Information to be Collected
The following IIF (Information in Identifiable Form) items will be collected: name, mailing address, email address and phone number. This information will be collected for the sole purpose of recruiting participants for the study and reminding them of their scheduled data collection. Participants' names and other IFF will not appear in report or publication, nor will they be made available to CDC or publicly unless compelled by law. Additional information will be collected in the screening process to confirm eligibility. These data points will include participants' gender, age, martial status, education level, income range, African American identity, sexual orientation, sexual activity in the last 6-months, participation in a similar study in the last 6-months, and family members' employment in the marketing field.

In triads/interviews, information collected will include knowledge, perceived risk, and awareness of STDs; social and cultural determinants of STDs; stigma and community beliefs; and preferences for framing and communicating messages related to STDs and HIV/AIDS. All these non-IIF items will be aggregated into a report with no personally-identifiable markers to allude to the source of the opinion.

The paper and pencil questionnaire to be used in Phase I will collect additional demographic information; individual experiences with STD testing; knowledge, attitudes, beliefs about STDs/HIV; and sexual behavior.

At the conclusion of each Phase I triad/interview, participants will be asked to complete a pile sorting or rating exercise related to types of STDs, along with HIV/AIDS. This structured data collection will provide additional information on how participants organize and understand the potential types of sexually transmitted diseases in their community.

In Phase II, participants in the individual interviews will be asked question to clarify communication and marketing decisions and to evaluate prototype health communication materials.

No personally identifiable information will be transmitted to the CDC. Please see section A10 for further discussion.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

No websites are being developed as part of this project.

A. 2. Purpose and Use of Information Collection

CDC's Division of Sexually Transmitted Disease Prevention (DSTDP) is working to develop health communication interventions to address the high rates of sexually transmitted diseases (STDs) in the African American population**.** The purpose of this project is to inform the development of the communication intervention, along with testing of potential campaign messages and materials. The project's main activities are triads and individual interviews with African American men and women, ages 18-45 years. The amount of clearance time requested for data collection is approximately 24 months, to expire with OMB approval for the generic concept of health marketing (Health Marketing, 0920-0798) on 1/31/2011.

This project will address the following three objectives:

1. Investigate potential ways to raise awareness about the high prevalence rate of STDs and HIV across behavior groups, correct misconceptions about STDs, and reduce STD-associated stigma to promote prevention, testing and treatment. The role and impact of health literacy on raising awareness of these issues is to be explored.

2. Explore the perceived social, cultural, and systems-level determinants of STDs in African American communities and how they influence views and opinions of personal prevention strategies (including intent and self-efficacy) and testing behaviors, as well as possible communication interventions for addressing these determinants.

3. Explore whether audience members react better to prevention messages that focus on (1) an individual non-HIV STD, (2) bundling multiple non-HIV STDs, (3) combining HIV and other STDs, or (4) a complete reframing of the message that focuses on desired attributes and behaviors, rather than disease. This includes identifying core communication variables that may assist all NCHHSTP in integrating prevention messaging. It may include an exploration of concepts that destigmatize, empower, affirm, and promote self-worth in African American communities as a way of promoting STD/HIV prevention and testing.

Privacy Impact Assessment Information

IFF data is being collected for the sole purpose of recruiting and reminding participants of their scheduled data collection. For example, address information will be used to send participants directions to the interview location and to remind him/her of the appointment.

Participants in each location will be recruited either by RTI International or by a subcontracted community-based organization (CBO) or professional marketing firm. In cases where RTI conducts recruitment, prospective participants' names, mailing addresses, email addresses and telephone numbers will be collected. This information will not be shared with the CDC, with exception of individuals' first name, which will be used for identification in the data collection session. If a CBO or professional marketing firm does the recruiting, RTI will just receive the first name of the individual participating in the study along with their other non-indefinable screening information.

Although the contractor, RTI International, may have temporary access to information in identifiable form (IIF) for recruitment and scheduling purposes, this information will be destroyed once data collection is complete and will not be connected to response data.

If a breach of respondent information were to occur, the collection of IIF should have no impact on participants other than to potentially share that they participated in the study. Respondent privacy will be safeguarded through controls on physical records (use of locked cabinets for paper documents, which will be destroyed on a schedule maintained by the contractor), controls on electronic data systems (limited staff access to shared drive, and separation of IIF from response data), and administrative measures (contractor

employees will sign non-disclosure agreements). In the triad interviews, participants will also be briefed about the importance of not repeating information shared by other participants in the discussion.

A. 3. Use of Improved Information Technology and Burden Reduction

For this project, we will conduct triads (with 3 participants), individual interviews, and pen and pencil questionnaires. With participants' consent, we will audio tape triads/interviews to capture all information and assist with preparation of reports.

The use of electronic respondent reporting is not being utilized for two reasons. 1) For this type of project, while there are some qualitative software programs, the use of electronic reporting is typically not feasible, as opposed to quantitative studies which lend themselves to electronic reporting. 2) The small number of interviews being done does not justify the utilization of electronic reporting.

A. 4. Efforts to Identify Duplication and Use of Similar Information

In order to identify duplication and use of similar information, RTI International, under contract by CDC, conducted an extensive review of the literature by examining several large periodical journal databases. In addition to reviewing published information, we searched for "gray" literature by exploring the Internet. We also searched the Internet using several search engines, including Google, Yahoo, AltaVista, Medline, and Science Direct. We were unable to find duplication or the use of similar information. There is no other study that duplicates our proposed efforts.

A. 5. Impact on Small Businesses or Other Small Entities

This project does not impact small businesses or other small entities. We will schedule all triad and individual interviews at the convenience of the participant and we will not impact the participant's employer.

A. 6. Consequences of Collecting the Information Less Frequently

This is an ad hoc data collection (i.e., a one-time study with African American men and women living in high-STD morbidity communities). There are no legal obstacles to reduce burden.

A. 7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with the guidelines of 5 CFR 1320.5

A. 8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. The 60-day Federal Register Notice (FRN) for 0920-0798 was published in the Federal Register on May 14, 2008, Vol. 73, No. 94, pp. 27833-27834. The 30-day FRN was published on July 24, 2008, Vol. 73, No. 143, pp. 43241-43242. No public comments were received.

B. The CDC study team collaborated with RTI International staff (contractor) on the project design, screening instruments, and interview guides. CDC recognizes the importance of gaining valuable insights directly from experts in areas of STD and HIV prevention. In developing this project, we consulted with the individuals listed in Table A.8.1.

Table A.8.1. **Individuals Consulted During the Development Project**

Consultation	Title	Affiliation	Phone
Jennifer Uhrig, PhD, MHA	Senior Health Communication Scientist	RTI International	(919) 316-3311
Jon Poehlman, PhD	Health Communication Researcher	RTI International	(919) 541-7068
Joan Cates, PhD, MPH	Social Marketing Researcher	University of North Carolina Chapel Hill	(919) 843-5793

A. 9. Explanation of Any Payment or Gift to Respondents

Each participant in the health communication study will receive an honorarium to thank them for their time and effort in the study. The honorarium amounts are as follows:

Triads	$50.00
Individual Interview	$50.00

The honorarium amounts for participants were determined based upon the burden to the participants, taking into account the May 2007 average US hourly wage of $19.56 (Bureau of Labor Statistics http://www.bls.gov/oes/current/oes_nat.htm#b00-0000), the length of the interview, the fact that participants may have to travel a distance to and from the interview location, parking costs, and our previous experience conducting triads and individual interviews with consumers. The honoraria are intended to recognize the time burden placed on the participants, encourage their cooperation, and to convey

appreciation for contributing to this important project. Numerous empirical studies have shown that honoraria can significantly increase response rates (e.g., Abreu & Winters, 1999; Shettle & Mooney, 1999; Greenbaum, 2000).

A. 10. Assurance of Confidentiality Provided to Respondents

This project does not require IRB approval as the approved generic information collection (0920-0798) was determined to be public health practice and not research activities. (Attachment 7)

Personal information from potential participants will be maintained and protected to the extent allowed by law. We will make every effort to secure and safeguard participant's identity and/or information supplied by participants.

Although RTI staff will be managing the activities and implementing the actual triads/interviews, RTI will recruit participants either by working with community-based organizations in the project areas, or through utilizing the services of a marketing firm. CDC staff will also monitor and consult on recruiting. Each of these entities has procedures to protect the security of the data as outlined below:

- Community-Base Organizations (CBOs). CBOs will assist with passive recruitment of study participants (i.e., handing out study flyers to their clients). RTI would handle scheduling and consenting of participants. In some instances, interviews may be conducted in their facilities. CBOs generally prevent unmonitored access from the street or beyond the lobby for safety and to protect client information. Participant's access to the facility will be limited to the room where the interview is being held and to restrooms. We will ask CBO staff to remove private client information from areas where we will be conducting the project and to refrain from discussing clients in front of staff, and staff will not discuss project participants in front of CBO staff.

- Marketing Firms. Marketing firms may assist with recruiting and screening participants and may host some of interviews in their facilities. The marketing firms have security procedures in place to protect proprietary information; similar to procedures employed by RTI. Additionally, all study staff from marketing firms will sign a confidentiality agreement that will be returned to RTI. The marketing firms will hand RTI staff the screener form and the recruitment grid during the field visit.

- CDC. RTI will provide CDC with a copy of the recruitment grids (without first names and month/year of birth) and the interview transcripts after all interviews

are completed. The dataset will be stored at CDC on a shared drive that is backed up nightly. Only authorized staff will have access to project data on the shared drive through password protected computers.

Recruitment materials are shown in Attachment 8. RTI and/or the marketing firm will follow a screening protocol in identifying potential study participants (see Attachment 9). All personal identifiers (name, address, telephone number, e-mail address) will be recorded on the last page of the screener, which will enable recruitment staff to: 1) send reminder letters or e-mails and 2) make reminder telephone calls (see Attachment 10). The screeners will be destroyed after the triads and interviews are completed. Information from the screening process will be de-identified before being shared with CDC. RTI or its subcontractors will destroy participant information at the conclusion of the project.

RTI will follow a strategy of dividing personal information collected through recruitment screening from information gathered in the triads and individual interviews. During data collection, only first names will be used. The selection criteria and individuals' personal information will not be shared with other participants.

During the triads/interviews, an RTI note taker will enter the data directly into a Microsoft Word data matrix. The RTI note taker will use a password protected and encrypted RTI laptop for data entry and the data files will be kept on the RTI project share drive. The data will not contain any identifying information.

Information collected during triads/individual interviews, including paper and pencil survey forms, notes, and audiotapes of the interview sessions, will be keep for the duration of the project in a locked file cabinet at RTI or stored on a password protected network share drive and accessible only to select project staff. At the end of the project, tapes and other study materials will be destroyed within three days after acceptance of the final report by CDC.

Privacy Impact Assessment Information

Below we discuss information related to PIA.

Part A: Applicability of Privacy Act:
The Privacy Act is applicable under 09-20-0136 (Epidemiologic Studies and Surveillance of Disease Problems). However, privacy act clearance is not required, as determined by CDC's Confidentiality Privacy Office on June 27, 2007.

Part B: Information Safeguards:

RTI will take the following steps to safeguard participant's privacy.

Any project staff who will directly engage with participants during the study will be trained and apprised of their responsibilities to protect the privacy of participants. The highest discretion will be used when recruiting participants and in all other aspects of the study. Recruitment staff at marketing firms, if utilized in recruiting, will be also asked to sign a confidentiality agreement (see Attachment 11).

Participant's personal identifiers will only be collected as part of the screening process. Selection criteria used for screening will not be shared with participants, nor will any of their individual information be shared with other participants in the project. The screening information will be recorded on recruitment grids that will contain no identifying information so that no personal identifiers are shared with CDC. This information will be destroyed after completion of recruiting. When using marketing firms, no identifying information will be shared with RTI or CDC and the information destroyed after the triads/interviews are completed.

In conducting the triads/interviews, only a first name or pseudonym, selected by the participant, will be used as an identifier in recording the triad or interview conversations. Participants in the triad interviews also will be briefed to not share information from their discussion with people outside of the interview group.

Recruitment and study data will be kept in locked file cabinet or stored on a password protected network share drive. Only select staff members will have access to information collected during the course of the project.

Part C: Respondent Consent

Consent from respondents will be gathered in two ways. First, before a potential respondent is screened, he/she will be asked for their consent to be screened. This consent will be verbal as the screening will take place over the phone. Triad and individual interview participants will also complete a written consent form (see Attachments 12) and sign their consent prior to data collection.

Consent forms will be stored in a locked file cabinet at RTI throughout the duration of the project.

Part D: Respondents' enrollment by their own volition:

Participants will be informed that their participation is voluntary. Participants will have the option of refusing to answer any questions or terminating their involvement in the study at any time, without penalty.

A. 11. Justification for Sensitive Questions

Since the subject of this project is sexually transmitted diseases and its goal is to gather the insights of sexually active individual, we will ask two screening questions concerning participants and their sexuality: (1) sexual orientation and (2) sexual activity in the last six months. In the triads and individual interviews, we expect participants to discuss some potentially sensitive issues around sex, sexuality, and STDs. However, we are interested in these topics as a community concern and will keep the focus on community-level experiences related to STDs and HIV. Collecting such information is necessary to design health communications messages that address people's concerns and that also have fidelity to the experiences and realities of communities affected by STDs and HIV. In the paper-and-pencil survey, we will also ask questions about health beliefs and behaviors, as well as participants' history of incarceration and prior experience with STD testing. This information is important for interpreting potential difference in the information provided by participants.

Participants are informed during recruitment and at the start of the interview that we will be asking some questions that are potentially sensitive. They are also told that they have the option of not answering any question or to withdraw from the project if they become uncomfortable with what is being discussed.

A. 12. Estimates of Annualized Burden Hours and Costs

The total annualized response burden is estimated at 230 hours. Tables A.12.1 and A.12.2 provide details about how this estimate was calculated. Timings were conducted during our instrument development process to determine the overall burden per respondent. Administration of the screening instrument is estimated to take 10 minutes. Triads are estimated to take 1 hour and 15 minutes. Individual interviews are estimated to take 40 minutes. Completion of the Participant Demographic and Behavioral Pencil and Paper Questionnaire (Phase I only) is estimated to take 10 minutes. Completion of the Participant Domain Assessment Structured Data Collection (Phase I only) is also estimated at 10 minutes.

In Phase I of this study, we will complete an estimated 648 screenings for 48 triads with up to 144 participants, 72 individual interviews, 216 Participant Demographic and Behavioral Pencil and Paper Questionnaire, and 216 Participant Domain Assessment Structured Data Collection activities (108 pile sorts and 108 ratings). In Phase II, we will complete an estimated 96 screenings for 36 individual interviews. This data collection will take place over of a two year period and research activities are annualized over this period.

Table A.12.1. **Estimated Annualized Burden Hours**

Respondents	Form Name	No. of Respondents	Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
African-American Men and Women, Aged 18-45 Years	Triad and Interview Screener Form	372	1	10/60	62
	Phase I Interview Guide Used for Triad Discussions	72	1	1.25	90
	Phase I Interview Guide Used for Individual Interviews	36	1	40/60	24
	Participant Demographic and Behavioral Pencil and Paper Questionnaire	108	1	10/60	18
	Participant Domain Assessment Structured Data Collection	108	1	10/60	18
	Phase II Individual Interview Discussion Guide	18	1	1	18
TOTAL					230

Table A.12.2. Estimated **Annualized Burden Costs**

Respondents	Activity	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage	Total Respondent Costs
African-American Men and Women, Aged 18-45 Years	Triad and Interview Screener Form	372	1	10/60	62	$ 19.56	1212.71
	Phase I Interview Guide Used for Triad Discussions	72	1	1.25	90	$ 19.56	1760.40
	Phase I Interview Guide Used for Individual Interviews	36	1	40/60	24	$ 19.56	469.44
	Participant Demographic and Behavioral Pencil and Paper Questionnaire	108	1	10/60	18	$ 19.56	352.08
	Participant Domain Assessment Structured Data Collection	108	1	10/60	18	$ 19.56	352.08
	Phase II Individual Interview Discussion Guide	18	1	1	18	$ 19.56	352.08
TOTAL							$ 4498.79

In calculating the burden cost, we used the May 2007 average US hourly wage of $19.56. We used the mean hourly wage for all occupations in the United States Department of Labor, Bureau of Labor Statistics (May, 2007). Available online at: http://www.bls.gov/oes/current/oes_nat.htm#b00-0000.

Actual hourly wage rates will vary by education, work experience and other factors. The estimated annual cost to participants for the time burden for collections of information is $ 4,498.79

A. 13. Estimates of Other Total Annual Cost Burden to Respondents of Record Keepers

Respondents participate on a purely voluntary basis and, therefore, are subject to no direct costs other than their time to participate; there are no start-up or maintenance costs. We do not require any additional record keeping.

A. 14. Annualized Cost to the Government

The total annualized cost for this study is estimated to be $183,512.50. This includes the CDC FTE s and a contractor. (see Table A.14.1). Details of the annualized costs are contractor's costs are based on estimates provided by the contractor who will carry out the data collection activities. This is the cost estimated by the contractor, RTI, and includes the estimated cost of coordination with the CDC, data collection, analysis, and reporting.

Table A.**14.1. Estimated Cost to the Government**

Expense Type	Expense Explanation	Annual Costs (dollars)
Direct Cost to the Federal Government		
• CDC oversight of contractor and project	CDC Project Officer (GS 14, 0.50; GS 13, 0.25 FTE)	24,731 10,464
Subtotal, Direct Costs to the Government		35,195
• Recruitment and Data Collection (Contractor)	Labor hours and Other Direct Costs	105,817.50
• Analysis and Reporting (Contractor)	Labor hours and ODCs	42,500
Subtotal, Contracted Services		148,317.50
TOTAL COST TO THE GOVERNMENT		183,512.50

A. 15. Explanation for Program Changes or Adjustments

This is a new data collection.

A. 16. Plans for Tabulation and Publication and Project Time Schedule

The team will take notes on and audio record the triads/individual interviews.

During triads/individual interviews, a note taker will enter participant responses directly into a Microsoft Word file on a laptop computer. The audio recordings will be transcribed and supplement the notes.

All interview data will be analyzed using NVivo software package, or another suitable qualitative analysis software package. The software will help the team identify themes and trends across all respondents, and the data matrix will allow the team to identify specific trends for each question.

The responses to the pencil-and-paper questionnaire will be entered into an Excel spreadsheet and analyzed descriptively. Data collected through the structured data collection activity (e.g. pile sorting and ratings) will be analyzed through data reduction procedures. The ANTHROPAC Software package will be used to conduct these procedures.

A timeline for this study is provided in Table A.16.1

Table A.**16.1. Project Time Schedule**

Activity	Time Schedule
Begin recruitment for Phase II	1 weeks after OMB approval
Begin Phase I Interviews	6 weeks after OMB approval
Analyze and Summarize Data Phase I	12 months after OMB approval
Begin recruitment for Phase II	13 months after OMB approval
Begin Phase II Interviews	14 months after OMB approval
Analyze and Summarize Data Phase II	24 months after OMB approval
Deliver Draft Final Report	25 months after OMB approval
Deliver Final Report	31 months after OMB approval

A. 17. Reason(s) Display of OMB Expiration Date is Inappropriate

No exemption is requested.

A. 18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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