Focus Group Testing to Effectively Plan and Tailor
"Bring Your Brave" Communication Campaign Messages

Submitted under OMB No. 0920-0800
Focus Group Testing to Effectively Plan and Tailor
Cancer Prevention and Control Communication Campaigns
Generic Information Collection

Expiration Date 12/31/2017

Supporting Statement Part A

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- The goal of this project is to collect information needed to inform the ongoing development of the "Bring Your Brave" campaign, a digital and social media communication effort about young women and breast cancer (YWBC).
- Information will be collected from small, in-person focus groups consisting of young women and their female family members. Each mini-group will have two (2) to four (4) participants from the same family and is expected to last ninety (90) minutes. All focus groups will be led by a professional moderator using a discussion guide.
- The subpopulations to be studied are Ashkenazi Jewish women aged 18-44 and their female family member(s) with a family history of breast or ovarian cancer; African American or black women aged 18-44 and their female family member(s) with a family history of breast or ovarian cancer; and general public young women aged 18-44 and their female family member(s) with a family history of breast or ovarian cancer.
- These groups will explore how family dynamics, hereditary risk, and family medical history influence conversations about breast and ovarian cancer risks within young women's families and young women's perceptions of their individual risk.
- The resulting data will be used to identify what message tactics and material content are most likely to induce specific target audiences to take action related to identifying breast cancer risk for themselves and their families.
- Transcripts of the focus groups will be analyzed using conventional content analysis. This approach allows categories and ultimately themes within the data to be discerned. Informed

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

CDC requests OMB approval to collect information under an existing generic clearance, "Focus Group Testing to Effectively Plan and Tailor Cancer Prevention and Control Communication Campaigns," OMB No. 0920-0800 (exp. 12/31/2017). The respondent universe for this GenIC aligns with that approved under OMB 0920-0800.

The information collection for which approval is sought is in accordance with CDC's mission to conduct, support, and promote efforts to prevent cancer, reduce its risk, increase early detection and better treatment, and improve the quality of life for cancer survivors authorized by Section 301 of the Public Health Service Act (PHSA, 42 U.S.C. 241).

Approximately 11% of all breast cancer cases in the United States occur in women under 45 years of age. Occurrences of breast cancer among these women are often accompanied by higher risks of recurrence and death, compared to older women with the disease. These women also face unique and significant long-term, treatment-related side effects such as infertility, cognitive dysfunction, muscular and skeletal issues, and cardiac and vascular complications. They are also at an increased risk for developing new cancers and other co-morbid conditions.

In 2009, Congress established the Education and Awareness Requires Learning Young (EARLY) Act, section 10413 of the Patient Protection and Affordable Care Act (Public Law 111-148). The EARLY Act legislation specified the need to create an education and outreach campaign to highlight the breast cancer risks facing young women. Specific aims include:

1. "Increase public awareness regarding breast cancer in young women of all ethnic and cultural backgrounds, including particular risks faced by certain ethnic and cultural groups;" and

2. "Promote educational awareness, early detection, and risk-reducing practices among young women and increase the number of young women with breast cancer warning signs who seek immediate care."

In 2014, Congress reauthorized this legislation (Attachment A– Legislative Authority), re-emphasizing the importance of educating young women about breast health and breast cancer risk.

In response, the following year (2015), the Division of Cancer Prevention and Control (DCPC) of the Centers for Disease Control and Prevention (CDC) launched "Bring Your Brave," a public education and awareness campaign to promote breast health for young women ages 18-44 years.

Prior to launching the campaign, DCPC conducted 20 two-hour focus groups with young women audiences to assess existing knowledge, attitudes, and beliefs about breast and ovarian cancer and to identify opportunities for effective messaging to these audiences through the "Bring Your Brave" campaign. Groups were segmented by race and ethnicity and family history of breast or ovarian cancer.

The focus groups yielded many findings covering a variety of breast and ovarian cancer topics. Of note, groups revealed that race and ethnicity influenced both the likelihood of conversations taking place within families regarding medical histories, as well as the tone of these conversations. African-American women were most likely to say that these conversations did not take place or if they did take place they were difficult or uncomfortable. Ashkenazi-Jewish women said family medical history conversations were a normal part of family life and occurred frequently; the tone of these conversations ranged from light-hearted to serious. Many general population women stated that they discussed family medical history, but the tone and comfort level of the conversations varied widely.

While these groups were illuminating and guided the initial campaign, additional research with these populations is needed to refine key campaign concepts and messaging, particularly with regard to conversations about family history. The objectives of the research are to:

1. Explore how family dynamics, hereditary risk, and family medical history influence conversations about breast and ovarian cancer risks within young women's families and young women's perceptions of their individual risk.

2. Learn what breast cancer related questions/topics families within each of the target audiences are most interested in knowing more about.
3. Identify what message tactics and material content are most likely to induce specific target audiences to take action related to identifying breast cancer risk for themselves and their families.

New campaign messages are also going to be tested with these groups to determine clarity, salience, and appeal. The materials to be tested are summarized below in Table A1-A.

Table A1-A: Materials to be Tested

Item Code	Item Descriptor
A1	Ways to Reduce Breast Cancer Infographic
B1	Learn Your Family History Infographic (General Public Version)
B2	Learn Your Family History Infographic (African American Version)
B3	Learn Your Family History Infographic (Ashkenazi Jewish Version)
C1	Video: Lisa: Start the Conversation about Family History of Breast Cancer
C2	Video: Jackie – Taking Action for My Daughter
C3	Video: Cara – My Breast Cancer Journey
D1	Breast Cancer in Young Women Fact Sheet (General Public Version)
D2	Breast Cancer in Young Women Fact Sheet (African American Version)
D3	Breast Cancer in Young Women Fact Sheet (Ashkenazi Jewish Version)
E1	Payment for Genetic Services Fact Sheet

A professional marketing firm will recruit up to 48 respondents (the total number will ultimately be determined by how many family members choose to participate in focus group discussions). Focus groups for general public young women may include women of all races and ethnicities, with the exception of African-American women and Ashkenazi-Jewish women who will participate in focus groups specifically for these subpopulations. We will only recruit respondents with a known family history of breast or ovarian cancer. Separate focus groups will be held for each audience segment.

Each focus group will be conducted with 2-4 female respondents from the same family and will last approximately 90 minutes. A summary of respondents by audience segment is provided below in Table A1-B. The materials presented to each focus group, and/or the order of presentation of materials, will vary so that CDC obtains preliminary, qualitative information needed to assess acceptability and placement for each audience segment.

Table A1-B: Focus Groups, by Audience Segment and Location

Audience Segment [1],[2]	Focus Group Location (Two groups per location)	Materials to be Tested (in order of presentation)
General Public Women Ages 18-45 and their Female Family Members[3]	Miami	A1, B1, D1, C1, E1
	Miami	E1, A1, D1, B1, C1
	Dallas	C1, D1, B1, A1, E1
	Dallas	D1, B1, C1, E1, A1
African American Ages 18-45 Women and their Female Family Members	Miami	A1, B2, D2, C2, E1
	Miami	E1, A1, D2, B2, C2
	Dallas	C2, D2, B2, A1, E1
	Dallas	D2, B2, C2, E1, A1
Ashkenazi Jewish Women Ages 18-45 and Female Family Members [4]	Miami	A1, B3, D3, C3, E1
	Miami	E1, A1, D3, B3, C3
	Dallas	C3, D3, B3, A1, E1
	Dallas	D3, B3, C3, E1, A1
Total	12	

The focus groups will assess numerous qualitative dimensions that include, but are not limited to, breast cancer knowledge, attitudes, beliefs, behavioral intentions, information needs, and sources. Information on the tone, feel, and content that would most appeal to these women is needed to guide the finalization of campaign materials, as well as assist in determining best strategies for dissemination of campaign materials and messages. Discussions will be tailored to each audience segment. See Attachments B1-B3 for discussion guides and supplementary materials.

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1 Inclusion criteria for all groups: Include an 18-44 year old woman who is able to bring 1-2 female close blood relatives (grandmother, mother, aunt, first cousin, sister, daughter, niece) who are 18 or older. The family dyads/triads should each have a history of breast or ovarian cancer on either the maternal or paternal side. Include a mix of income levels; limit number of groups with a PhD or JD respondent to 1; and Latina/Hispanic families if possible. Prioritize family triads/dyads that have a member of their family who has undergone cancer-related genetic counseling and/or testing. Prioritize groups of three or four over dyads.

2 Exclusion criteria for all groups: breast or ovarian cancer survivors; work in a healthcare field or live with a healthcare provider; do not have a family history of breast cancer.

3 Focus groups for general public may include women of all races and ethnicities, with the exception of African American women and Ashkenazi Jewish women who will participate in focus groups specifically for these subpopulations

4 Will include a mix of practicing/religious and non-practicing/cultural

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

No web-based data collection methods will be used and, thus, there is no web content directed at children less than 13 years of age.

A2. Purpose and Use of the Information Collection

As part of the health communication process, CDC will conduct focus groups to test concepts, messages, and materials with target audiences. Formative evaluation will center around two main areas of inquiry:

- Qualitative assessments of the target audiences' knowledge, attitudes, and beliefs about breast cancer in young women, including risk factors for developing breast cancer at a young age, actions to reduce risk, and especially communication about the topic within families. Improved understanding in this area will allow the project team to tailor campaign content.
- Exploring what content and design elements the target audiences find most compelling within the "Bring Your Brave" campaign. Groups will test 3 existing key campaign messages and 2 new campaign concepts.

During the first half of the focus group sessions, respondents will be asked questions specifically related to the key central messages of the young women and breast cancer campaign to ascertain their general knowledge and attitudes toward breast cancer, with particular attention paid to understanding communication about family history. Respondents will be asked to share their experiences and describe how having family members with breast or ovarian cancer has impacted their family as a whole. Researchers will explore the family dynamics within each group to understand the facilitators and barriers to conversations about a family's history of cancer. Respondents will be asked what types of information they discuss with one another, if family members seem to influence one another's health decisions, and if there are any resources that could help their family discuss the issue more fully or comfortably.

Next, the moderator will lead respondents through a facilitated discussion about campaign materials. Following the discussion, questions on appeal, saliency, and understanding of the central messages will be asked in order to determine qualitative increases in knowledge and behavioral intentions. This qualitative data collection and analysis will determine whether the existing materials and new campaign concepts are adequate in communicating the key messages. Insights gained from the focus groups will determine if the campaign materials under development will motivate women ages 18-44 (including those in the general public and those representing racial/ethnic groups at increased risk for developing breast cancer at a young age) to respond to the calls to action and engage with activities promoted by campaign messages (clicking on ads, seeking additional information, learning family history, talking with a doctor, sharing) and the digital mode of delivery.

Along with information collected on saliency and clarity, increases in knowledge at the end of the session would suggest that the materials are appropriate in delivering the key central

messages. Persisting deficits in knowledge following the facilitated discussion would indicate that the materials are not clear, or may be culturally inappropriate for the particular audience. It is anticipated that the information collected will lead to refinement of existing materials, and development of new, targeted and more culturally appropriate materials.

By conducting formative evaluation through this information collection, campaign materials can be tailored to suit the audiences' preferences and educational needs. This will improve acceptance of the campaign materials and the success of the campaign overall.

A3. Use of Improved Information Technology and Burden Reduction

Electronic data collection methods have limited applicability to focus groups, other than video- or audio-taping discussions. However, whenever possible, DCPC staff will employ electronic technology to collect and process data in order to reduce respondent burden and aid in data processing and reporting efficiency.

Efforts have been made to design discussion questions that are easily understandable, not duplicative in nature, and least burdensome. In all instances, the number of items posed will be held to the minimum required in order to elicit the necessary formative or materials-testing data.

A4. Efforts to Identify Duplication and Use of Similar Information

Based on a comprehensive review of activities in CDC's Division of Cancer Prevention and Control, CDC has determined that the planned information collection efforts do not duplicate any other current or previous data collection efforts.

A5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A6. Consequences of Collecting the Information Less Frequently

As the health communication process illustrates, formative evaluation is a critical segment of a scientifically sound campaign effort. Formative evaluation, often encompassing concept, message, and materials testing activities, is essential in pre-testing materials to evaluate a wide variety of dimensions that include, but are not limited to, appeal, saliency, clarity, cultural appropriateness and readability/understandability. If a concept and/or a message is not tested, then resources could be expended without necessary attention and preparation paid to the overall communication objective. Forgoing testing can also increase the likelihood of unintended consequences from an irrelevantly perceived message and/or decreased credibility of an organization and/or a Federal health official.[5] Finally, if materials are not tested with the intended audience, a poor execution strategy could weaken a sound concept.

There are no legal obstacles to reducing the burden.

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5 Wallendorf, M. (2001). Literally literacy. *The Journal of Consumer Research, 27(4),* 505-511.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances. The activities outlined in this package fully comply with all guidelines of 5 CFR 1320.5.

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A8.A Federal Register Notice

This information collection is being conducted using the Generic Information Collection mechanism of Focus Group Testing to Effectively Plan and Tailor Cancer Prevention and Control Communication Campaigns, OMB No. 0920-0800. As required by 5 CFR 1320.8(d), a notice for public comments was published in the Federal Register on June 25, 2014 (Vol. 79, No. 122, pages 36064-36065). No public comments were received. The current submission does not require publication of an additional Federal Register Notice.

A8.B Efforts to Consult Outside the Agency

The proposed protocol and discussion guides were developed and reviewed extensively by DCPC staff and others directly involved in implementing the DCPC communications campaigns. There were no external consultations.

A9. Explanation of Any Payment or Gift to Respondents

Incorporating modest incentives to aid in recruitment acknowledges respondents' time and effort, boosts response rates, may improve the quality of information collected. Each focus group respondent will be provided with a modest gift of $75 for their participation in a 90 minute focus group. This incentive is based on market rates commensurate with the cities in which the data collection is to take place.

The most important aspect of an incentive plan may be its potential for reducing response bias, underreporting bias, and similar sources of error. Findings from the National Survey of Family Growth (a study in which childbearing and family planning patterns are collected from young women) demonstrated that incentives not only had positive effects on response rates, but they also increased the accuracy of reporting.[6] Incentives are necessary for qualitative information collections such as the proposed materials testing in order to ensure that those who are willing to participate are as representative as possible of the target audience, which in this case includes respondents of hard-to-reach racial and ethnic subpopulations, those with family medical histories, and young women who may have responsibilities for child care, etc. Failure to provide a basic incentive is likely to bias samples in the direction of well-educated individuals who are generally predisposed to be helpful (http://www.cdc.gov/nchs/nsfg.htm).

6 Lepkowski JM, Mosher WD, Groves RM, et al. Responsive design, weighting, and variance estimation in the 2006–2010 National Survey of Family Growth. National Center for Health Statistics. Vital Health Stat 2(158). 2013.

A10. Assurance of Confidentiality Provided to Respondents

A. Privacy Act Determination

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has reviewed this OMB submission and determined that the Privacy Act is not applicable. CDC will not create a record system for this project. CDC will not be privy to the last names, mailing addresses, telephone numbers or email addresses of any of the focus group respondents. These individuals will be recruited using the proprietary databases of a professional recruiting firm. Eligibility criteria will be established for all focus group respondents, and potential respondents will be screened during a telephone interview (see Attachments C1-C6 for screening instruments). No personal identifying information used in the recruitment process will be linked to the data collected in the focus group discussions. Thus, no personal information in identifiable form will be collected by CDC.

B. Safeguards

A minimum amount of demographic information may be retained in focus group notes for purposes of analysis, but will not be sufficient to identify respondents. Respondents will be informed that focus groups will be audio-taped and transcribed, and that tapes will be destroyed after completion of each report on findings. DCPC staff, in conjunction with Oak Ridge Associated Universities (ORAU), will collect and evaluate the audience research data.

Information provided during the groups will be kept private and secure to the extent allowed by law. Respondents' names or images will not be used in the final report. No statements made by respondents will be linked to them by name. Only members of the research staff will be allowed to look at the records. Respondents' names or other personally identifiable information will not be shown or used in the presentation of findings.

C. Consent

All information provided by respondents will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law. Informed consent will be obtained from respondents (see Attachments B1-B3 – Discussion Guides) and they will be informed that participation is voluntary; they do not have to answer questions if they do not want to, their responses will be treated in a secure manner, and they can stop participating at any time. It has been determined that these information collection activities are not generalizable and do not qualify as human subjects research and will therefore not require IRB review and approval.

D. Nature of Response

Respondent participation is entirely voluntary, as noted in the respondent information sheet (Attachment D).

A11. Justification for Sensitive Questions

The majority of questions asked will not be of a highly sensitive nature. However, some respondents may find thinking about and discussing the disease of cancer unpleasant. A portion of respondents could consider questions about race, ethnicity, or other demographic

characteristics to be sensitive, although such questions are unlikely to be highly sensitive. Additionally a portion of respondents may feel uncomfortable answering some questions about their individual cancer experiences, level of disease awareness, and/or adopted preventive behaviors (or lack thereof) associated with cancer. Questions about family history of breast or ovarian cancer are specifically needed for this research. Such questions, if asked, would be necessary for the purposes of a targeted communication campaign and thus to the information collection. To minimize psychological distress, the moderator will inform respondents that they do not have to respond to any questions they do not want to answer and they may stop participating at any time.

A12. Estimates of Annualized Burden Hours and Costs

CDC plans to collect information from up to 48 women ages 18-44 years, segmented into 12 focus groups according to target audience (African American women, women of Ashkenazi Jewish heritage, and general public young women),

Because the questions for each audience segment vary slightly, there are 3 customized versions of the focus group Discussion Guide (see Attachments B1-B3). Each focus group will last 90 minutes and will be comprised of up to 4 respondents.

Each respondent will be asked to provide feedback on 2 infographics, 2 factsheets, and 1 video. Respondents will be asked to write on the infographics and factsheets to identify areas of appeal, confusion, or concern. Each focus group Discussion Guide includes an example Response Sheet that will be used to collect written feedback on the video. Because the moderator will coordinate the distribution, completion, and collection of written responses on materials and Response sheets within the context of the focus group discussion, the burden associated with these activities is included in the overall 90 minute burden for the focus group.

Potential respondents will be recruited through standard commercial recruiting practices. Similarly, potential respondents will be screened for interest and eligibility using a screening form (see Attachments C1-C6). Based on previous experience recruiting focus group respondents from master lists of eligible or interested persons, it is estimated that three times the target number of needed respondents must be screened in order to yield the targeted number of respondents. The total number of respondents screened will be 108. The estimated burden per response for screening is three minutes.

The estimated burden to respondents is 94.5 hours, as summarized in Table A12-A below.

Table A12-A: Estimated Annualized Burden to Respondents

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
General Public	Screening Instrument for General Public Young Women	36	1	3/60	2

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Women Ages 18-45 and their Female Family Members	Screening Instrument for Family Members of General Public Young Women	108	1	3/60	6
	Discussion Guide for General Public Families (with a Family History of Breast Cancer)	16	1	1.5	24
African American Women Ages 18-45 and their Female Family Members	Screening Instrument for African American Young Women	36	1	3/60	2
	Screening Instrument for Family Members of African American Young Women	108	1	3/60	6
	Discussion Guide for African American Families (with a Family History of Breast Cancer)	16	1	1.5	24
Ashkenazi Jewish Women Ages 18-45 and their Female Family Members	Screening Instrument for Ashkenazi Jewish Young Women	36	1	3/60	2
	Screening Instrument for Family Members of Ashkenazi Jewish Young Women	108	1	3/60	6
	Discussion Guide for Ashkenazi Jewish Families (with a Family History of Breast Cancer)	16	1	1.5	24
	Total				**96**

Information will be collected over a one month time period. There are no costs to respondents except their time to participate in the focus groups. The total annualized burden to respondents is 94.5 hours.

B. Table A12-B presents the calculations for cost of respondents' time using two categories of mean hourly wages. Hourly mean wage information is from the U.S. Department of Labor, Bureau of Labor Statistics Web site (http://www.bls.gov/oes/2013/may/oes_nat.htm#29-0000) specifically originating from the Occupational Employment Statistics May 2013 National Occupational Employment and Wage Estimates, United States, Bureau of Labor Statistics. The total estimated annualized respondent cost (including the screening form) is $2,112.

Table A12-B: Estimated Annualized Cost to Respondents

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Total Burden Hours	Average Hourly Wage Rate	Total Cost
General Public Women Ages 18-45 and their Female Family Members	Screening Instrument for General Public Young Women	36	1	2	$22.33	$45
	Screening Instrument for Family Members of General Public Young Women	108	1	6	$22.33	$134
	Discussion Guide for General Public Families (with a Family History of Breast Cancer)	16	1	24	$22.33	$536
African American Women Ages 18-45 and their Female Family Members	Screening Instrument for African American Young Women	36	1	2	$22.33	$45
	Screening Instrument for Family Members of African American Young Women	108	1	6	$22.33	$134
	Discussion Guide for African American Families (with a Family History of Breast Cancer)	16	1	24	$22.33	$536
Ashkenazi Jewish Women Ages 18-45 and their Female Family Members	Screening Instrument for Ashkenazi Jewish Young Women	36	1	2	$22.33	$45
	Screening Instrument for Family Members of Ashkenazi Jewish Young Women	108	1	6	$22.33	$134

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Total Burden Hours	Average Hourly Wage Rate	Total Cost
	Discussion Guide for Ashkenazi Jewish Families (with a Family History of Breast Cancer)	16	1	24	$22.33	$536
	Total					**$2,145**

A13. Estimates of Other Total Annual Cost Burden to Respondents or Recordkeepers

There is no cost to respondent or recordkeepers.

A14. Annualized Cost to the Government

The estimated average annual cost to the Federal government for the proposed focus group activities is $115,493.00. This figure encompasses the salary of two GS-14 employees, communication contract costs, as well as fees for identifying and recruiting respondents, incentive payments, facility rental, and transcription.

Estimated Annualized Cost to the Government, per Campaign and Total	
Cost Category	Estimated Annualized Cost
Federal employee costs (adjusted for Atlanta) (10% FTE of 1 GS-14 Step 5 @ $116,808/yr) (2% FTE of 1 GS 14 Step 5 @ $116,808/yr) (5% FTE of 1 GS 13 Step 6 @ $103,025/ yr)	 $11,681 $2,336 $5,151 Subtotal $19,168
Contractual costs for focus group facility rental, focus group moderator, participant recruitment, and report on findings, per campaign	$96,325
Total	**$115,493**

A15. Explanation for Program Changes or Adjustments

This is a new, one-time information collection.

A16. Plans for Tabulation and Publication and Project Time Schedule

Statistical methods will not be employed to analyze focus group data, as it is not appropriate to report the percentage of focus group respondents who expressed a particular view (Carey, 1995;

Morgan, 1995; National Cancer Institute, 2002; Webb & Kevern, 2001).[7][8][9][10] Typically, not every respondent in a group comments on every issue discussed (Carey, 1995), and the course of discussion will vary across groups, with some topics emerging in one group and not in another (Carey, 1995; Morgan, 1995). Qualifiers such as "many," "several," and "few" will be used to describe the number of respondents who expressed a particular view.

Project Time Schedule

Table A16-1 presents the estimated timeline for conducting focus groups following receipt of OMB clearance.

Table A16-A: Project timeline for cancer communication campaigns

Activity	Time Schedule
Focus group recruitment	4-5 weeks after OMB approval
Focus group testing	6-12 weeks after OMB approval
Analysis of focus group results (topline reports)	12-20 weeks after OMB approval
Report Writing/Recommendations to CDC based on Findings	3-6 months after OMB approval

Focus group findings will inform campaign planning efforts, provide guidance on efforts to refresh existing materials, and aid in the sound development of new communication products for specific cancer communication initiatives. Additionally, findings will be disseminated through presentations and/or posters at meetings and publications in peer-reviewed journals. All abstracts, poster presentations, and manuscripts will undergo CDC clearance review prior to submission to conferences or journals.

A17. Reason(s) Display of OMB Expiration Date Is Inappropriate

The OMB expiration date will be displayed.

A18. Exemptions to Certification for Paperwork Reduction Act Submissions

No certification exemption is being sought.

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7 Carey,M. (1995).Comment: Concerns in the analysis of focus group data. Qualitative Health Research, 5(4),
487-495.

8 Morgan, DL: Why things (sometimes) go wrong in focus groups. Qual. Health Res1995, 5:516-522.

9 National Cancer Institute. (2002). *Making Health Communication Programs Work* (NIH Publication No. 02-5145). Bethesda, MD: Department of Health and Human Services.

10 Webb, C.,&Kevern, J. (2001). Focus groups as a research method:Acritique of some aspects of their use in
nursing research. Journal of Advanced Nursing, 33(6), 798-805.

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