

Assessment on Public Knowledge, Attitudes, and Practices Relating to Ebola Virus Disease (EVD) Prevention and Medical Care in Guinea

**Supporting Statement - Part A
Justification**

**NEW
Emergency Request**

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Assessment on Public Knowledge, Attitudes, and Practices Relating to Ebola Virus Disease (EVD) Prevention and Medical Care in Guinea

- **Goal of the study:** To rapidly evaluate current knowledge, attitudes, and prevention and control practices regarding Ebola Virus Disease (EVD) in Guinea using a national sample. The rapid assessment aims to identify barriers and gaps in knowledge, attitudes, and practices (KAP) that contribute to the persisting Ebola outbreak in Guinea.
- **Intended use of the resulting information:** To rapidly inform the development of a national, evidence-based strategy for health promotion, social mobilization, and deepened community engagement that are reflective of the on-the-ground realities and socio-cultural context of Guinea in order to identify prioritized areas of intervention and vulnerable group needing targeted EVD prevention/control strategies necessary to move towards zero new infections of Ebola. In addition, the results of the assessment will provide some insight regarding the reach and potential impact of prior EVD related health promotion and social mobilization efforts in Guinea.
- **Methods:** Nationally representative cross-sectional assessment through multi-stage cluster sample of 6,000 individuals from 3,000 households randomly selected from all regions of Guinea. Brief interviews will be conducted with 150 community leaders within randomly selected clusters.
- **Population to be studied:** See above.
- **How information will be analyzed:** Categorical analysis weighted for over- or under-sampling of selected regions and subgroups using post-stratification adjustments in SPSS. National and regional level estimates will be calculated for all indicators. In addition, the national estimates will be disaggregated by (i) clusters of low versus high intensity of social mobilization interventions, (ii) clusters of high versus low/no cumulative incidence of EVD, (iii) sex, (iii) gender, (iv) education, and (v) age category.

Ebola Virus Disease (EVD) Prevention and Medical Care in Guinea

A. Justification

1. Circumstances Making the Collection of Information Necessary

According to the World Health Organization (WHO), as of April 20, 2015, Guinea has recorded a total of 3,140 laboratory-confirmed cases and 2,361 EVD-related deaths since the beginning of the EVD outbreak in West Africa that started in early 2014. Cases have occurred in all regions of the country and have resulted in transmission to residents of the neighboring countries of Liberia and Sierra Leone that, in turn, have experienced national epidemics for more than a year. As of May 5, 2015, the current incidence rate is approximately 46 new cases in the last 21 days. The Guinea government and its international partners have made a commitment to try to get the incidence rate down to zero cases within 42 days. This collection is designed to provide additional information to help achieve that goal.

There are no current, reliable nation-wide sources of information from recent, nationally-representative surveys or published literature about the knowledge, attitudes, and practices (KAPs) of Guineans regarding EVD and factors that may be driving the epidemic, however there are daily reports from health workers that demonstrations and resistance to EVD prevention and control efforts continue in many parts of Guinea. A KAP assessment during the current epidemic in Guinea was funded and conducted by the United Nations Children's Fund (UNICEF), with data collected in December 2014. The UNICEF KAP survey did not provide a complete picture of KAP in Guinea, a highly diverse nation of 10.6 million people who live in 34 different prefectures in eight (8) administrative regions covering highly varied environments, rely on varied food sources and hygiene methods, have limited access to health care, affiliate with hundreds of tribal groups, and speak multiple languages. It involved collection of data from focus groups and/or interviews of residents and community leaders of only 14 prefectures that were not randomly selected. It did not collect data from some prefectures that have reported cases during the current outbreak. While the UNICEF assessment provided some baseline indicators, it did not collect information on KAP related to key EVD prevention and control activities, including stigma and discrimination experienced by Ebola survivors that may underlie resistance, attitudes about case finding, use of Ebola treatment units, services for Ebola survivors, potential EVD medical treatments and vaccines now being evaluated in Guinea, and the public's understanding of the barriers to ending this devastating national epidemic.

Since early 2014 and starting in one rural forested region, the epidemic has rapidly evolved to affect numerous prefectures across the nation; rural, peri-urban, and urban areas; and persons with highly varied characteristics and habits. Due to the rapidly evolving nature of this epidemic, it is essential to track how changes in KAP over time are associated with burden of disease, exposure to recent EVD-related prevention and control measures, EVD care seeking, and experiences of survivors. It is also important to assess attitudes toward new prevention and

control interventions identified during the epidemic that are now being evaluated in Guinea, such as safer hygiene and burial practices and screening candidates for a WHO EVD vaccine trial [that is not supported by Centers for Disease Control and Prevention (CDC) funds].

With funding from the CDC Foundation, Sierra Leone assessments illustrate how KAP among the public constantly shifted after exposure to EVD interventions. The KAP-2 assessment in Sierra Leone (October 2014) found that over 30% of respondents rejected alternatives to traditional burials that did not involve the touching or washing of the corpse. In response to this finding, the emergency response effort intensified activities on promoting dignified, safe burial practices that involved a national campaign that engaged over 4,000 religious leaders in every region, district, chiefdom, and section in Sierra Leone. When KAP-3 was conducted in December 2014, less than 15% of the population continued to reject safe alternatives to traditional burials.

National information about core KAP indicators are urgently needed in Guinea to better understand the drivers of this persistent epidemic, even as incidence rates drop. Information of value includes use of prevention practices, sources of care sought for EVD symptoms, stigma and discrimination faced by ill persons or EVD survivors, exposure to EVD information, and or preferred sources of EVD-related health care, education, or community engagement channels as well as the reach and impact of EVD health promotion activities since the start of this outbreak. Without systematically collected information from a nation-wide assessment, Guinean health leaders will be constrained in developing evidence-based education, prevention, and care programs, to understand reasons for community resistance to EVD prevention, control, and care activities, and to identify geographic areas and populations that warrant expedited attention in order to halt continued EVD transmission and improve care for EVD cases and survivors.

It is urgent to start this assessment by mid-May before the start of the rainy season when many roads become impassable. The World Bank estimates that only 13% of roads in Guinea are paved. During rains, household members may be hard to locate, tablets used for information collection may become disabled, and Internet or satellite-based service needed for daily information transfer from the field may become unreliable.

During the same time period as the Guinea KAP in all its regions and districts, Sierra Leone, with existing CDC Foundation funding, is planning to conduct a fourth round of national KAP assessment; including Kambia district that has had the highest incidence rates of EVD in Sierra Leone in April 2015. This concurrent effort in two countries is significant because Kambia shares a long border with Forecariah, the prefecture of Guinea that has the highest rates of EVD in April 2015. This international border is highly porous; is crossed regularly for daily activities, commerce, and family affairs; and is served by common radio broadcasts. Epidemiologists from WHO and CDC report that some suspect cases or contacts of EVD cases from Kambia traveled to Forecariah in order to avoid EVD control efforts in Kambia. For this reason, KAP information in Kambia that is collected at roughly the same time as KAP information in Forecariah can generate a set of time-bound, core indicators that can elucidate and help overcome persistent

barriers to EVD prevention and control in both nations and their common borders where transmission is now most intense.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241) (Attachment 1). CDC will fund this collection through a cooperative agreement with PCI Media Impact who is subcontracting with a non-governmental organization (NGO) FOCUS 1000, which fielded the Sierra Leone KAPs, as the project lead, and the top NGO in Guinea for public health, Sante Plus, for implementation in Guinea. FOCUS 1000, CDC and Sante Plus will co-own the data, with access to data granted to other entities including Guinea MOH, UNICEF, and other actors in the national response. All requests to publish summaries of the information will be reviewed and cleared by FOCUS 1000, PCI Media Impact, and CDC.

2. Purpose and Use of Information Collection

This project is intended to advance the prevention and control of EVD in Guinea that has experienced a nation-wide epidemic for more than 12 months and contributed to major epidemics in neighboring countries of Liberia and Sierra Leone. The project has two overarching goals:

- 1) To gain an empirical understanding of the public's KAPs regarding EVD that are important indicators of the prevalence of risk factors for persistent transmission within the country and across international borders that continue despite EVD prevention and control efforts. This information will be used to identify barriers that hinder the containment of the EVD epidemic, such as rumors, misinformation, and issues that have emerged in the last three months (such as cross-border transmission and the potential for future EVD vaccines). The information will be vital in guiding the development of evidence-based prevention and care interventions based on the latest KAP assessment, while also identifying the geographic areas and vulnerable groups that now warrant the most urgent attention in EVD prevention and control. Such targeted behavior change communication and community engagement are required in order to reach the highest risk populations and geographic locations with tailored interventions that will transition Guinea to the status of zero new cases of EVD.
- 2) To assess exposure to community engagement, education, and social mobilization about EVD launched in response to this epidemic and determine if these strategies have had their expected reach and impact and how they should be refined or replaced with more effective, evidence-based methods. In essence, the assessment will serve as an outcome/impact evaluation of the national EVD response in Guinea; thereby providing time-sensitive evidence that will inform the refinement of social mobilization strategies and interventions. Also, the proposed KAP assessment will serve as an evaluation for the service delivery components of the national response - including the public's perceptions of the ambulance teams, burial teams, national call center, holding centers,

and treatment centers. Such triangulated understanding of both the demand and supply side factors will ultimately feed into the overall improvement of the national response.

3. Use of Improved Information Technology and Burden Reduction

Information collectors will read aloud questions and response options (where applicable) from instruments installed on mobile tablet devices. A mirror of the information collection instruments will be designed using Open Data Kit (ODK) and subsequently installed on the mobile tablet devices (Android-based Samsung Tab 4). This information collection method will reduce the burden on respondents, many of whom are illiterate, have low literacy, use non-written languages, or have poor vision. The information collection instruments are designed to collect the minimum information necessary for the purposes of this project.

The overall project lead NGO partner, FOCUS 1000, will use Android-based Samsung Tab 4 tablet devices for the information collection to reduce the need for double-entry and ensure rapid information collection using Open Data Kit (ODK). Information collectors will directly enter participants' responses onto the tablet during the interview process. FOCUS 1000 will program and configure the tablets with the final information collection instruments prior to the training of information collection teams. Teams of supervisors will be responsible for synchronizing the devices with the password-protected hosting server at the end of each day. During uploading process, information will be encrypted and secure electronic information collection methods will be applied to protect the privacy of participants' responses. Overall project lead FOCUS 1000 and the Guinea in-country lead Sante Plus will establish guidelines and protocols that will be signed by each information collector regarding the use of the mobile tablet devices. Once supervisors confirm that information is successfully uploaded to the server, the information will be deleted from tablets to protect the privacy of persons who participated that day. These data security and privacy protection methods were successfully used in two prior KAP assessments in Sierra Leone involving greater than 3,500 respondents from rural and urban areas.

4. Efforts to Identify Duplication and Use of Similar Information

The only other KAP assessment during the current epidemic in Guinea was funded and conducted by UNICEF. The UNICEF-funded KAP assessment did not address perceptions of health education activities; reasons for resistance to prevention and control efforts; or stigma and discrimination faced by EVD cases, survivors, or contacts.

The prior Guinea KAP assessment involved collection of data from focus groups and/or through interviews of residents and community leaders who were not randomly selected, and from only 14 prefectures. This KAP assessment did not collect data from some prefectures that have reported cases during the current outbreak. Moreover, it did not collect information on KAP related to key EVD prevention and control activities, including stigma and discrimination

experienced by Ebola survivors that may underlie resistance, or attitudes about case finding, use of Ebola treatment units, services for Ebola survivors, and potential EVD treatments vaccines now being evaluated in Guinea. For this reason, the CDC Director, Dr. Thomas Frieden, stressed after his March 2015 Guinea visit that a well-designed, nationally-representative KAP assessment was critical to CDC efforts to help Guinea end this devastating epidemic. The leader of the EVD emergency response effort at the Guinean Ministry of Health and Sanitation (MoHS), Dr. Keita Sakoba, strongly endorses the conduct of this assessment and, for reasons of health equity, recommends a nation-wide assessment to yield a national picture of KAP across a large, highly diverse nation that will be immediately used to guide prevention and control efforts.

5. Impact on Small Businesses or Other Small Entities

There is no impact on small businesses.

6. Consequences of Collecting the Information Less Frequently

This request is for a one-time information collection. There are no legal obstacles to reduce the burden. If no information is collected, the CDC, Guinea's MoHS, WHO, UNICEF, Sante Plus, and other partners involved in the EVD epidemic response will be unable to:

- Develop national-level strategies to reduce community resistance to EVD prevention, control, and care activities that reflect the diversity of a large, heterogenous nation
- Revise current education, prevention, and care programs based on recent, nationally representative evidence that reflects the current KAP
- Assess the reach and impact of community-based EVD prevention and control activities in the last 6 months
- Identify geographic areas and populations that warrant expedited attention to prevent stem continued EVD transmission, to care for EVD cases, particularly prefectures that continue to report new cases and resistance to EVD prevention and control efforts and ongoing stigma and discrimination of EVD survivors.

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

There are no special circumstances relating to the guidelines. The request fully complies with the regulation.

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

A. The requirement for the publication of a 60-day Federal Register Notice for this emergency request was waived by OMB.

B. The CDC has worked with the Guinea MoHS, UNICEF, Sante Plus, FOCUS 1000, and other partners involved in the EVD epidemic response to develop the plans for this KAP assessment. Seeing that CDC had provided technical support in undertaking series of similar KAP assessments in Sierra Leone, it has worked to strengthen the capacity of FOCUS 1000 and other local partners in best practices relating to empirical information collection in crisis situations. For the proposed assessment, CDC will continue to provide technical support to the evaluation team in ensuring that an implementation place is instituted and executed in a timely and responsive manner to the present epidemic in the country.

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9. Explanation of Any Payment or Gift to Respondents

Information collection teams will not provide any monetary payment to household members they approach about participation in the assessment. Information collection teams will provide each household that is approached, regardless of the household members' decision to participate, a bar of soap and a leaflet about EVD prevention that includes information on how to obtain more information about EVD from Guinean health authorities. For participants, these items will be provided prior to the interview. Since the start of this epidemic, soap, a precious commodity in many regions of Guinea, and EVD information leaflets have been routinely distributed by community workers involved in infection prevention and control activities.

10. Assurance of Confidentiality Provided to Respondents

The OMB PRA Advisor to the 2014 Ebola Virus Response in the CDC Emergency Operation Center (EOC) has determined that the Privacy Act does not apply to this information collection.

The Human Subjects Advisor to the 2014 Ebola Virus Response in the CDC EOC has determined that this activity is non-research and that CDC Institutional Review Board approval is not required. In addition, the government of Guinea has provided a letter of support for this effort (Attachment 2).

10.1 Privacy Impact Assessment

No formal assurance of confidentiality will be provided to the respondents. No individually identifiable information (IIF) will be collected. Any records delivered by the Guinea MoHS to the CDC will not be retained in a federal system of records.

Seeking consent for participation involves a two-part process that respects traditional lines of authority and communication in Guinea.

Interaction with community leaders

In each sampled cluster, a community leader or official will be identified. After introducing themselves and explaining the purpose of the visit to the community, information collectors will seek participation of the leader in a short interview by reading aloud a standard participation agreement and noting acceptance or refusal on the tablet. This interview also enables the information collectors to ask the leader for permission to conduct the assessment among households in the cluster. If he or she agrees, he or she will be interviewed regarding public health activities (social mobilization), health care access, and experiences with Ebola experiences in or in the vicinity of the cluster to help validate program activities within the cluster reported by health promotion organizations.

Because most leaders will have low literacy levels, information collectors will seek oral agreement for participation (Attachment 3). A signature, X mark, or thumbprint to note consent on the tablet device will not be collected because they would require touching the tablet which is not advisable during an ongoing epidemic of a highly infectious agent that can be transmitted through minimal contact. Leaders will be told that providing the information is voluntary and that the information they share will be kept private, meaning that it will not be linked to their name or names of villages or neighborhoods in the cluster in any reports or other materials to ensure that the leader would not be identified as a participant. Leaders will be told that they may choose to stop the interview at any point or refuse to answer questions you do not feel comfortable responding to. The introduction, interview, and closing statement will be conducted in a private area within or outside the leader's home or place of work, (e.g., veranda). If the leader does not give permission to conduct the assessment in the cluster, the information collection team will, after consultation with the team and regional supervisors, randomly select from a list of substitute clusters that had already been randomly selected. Information collection from community leaders will include 29 questions on these topics (Attachment 4):

- Socio-demographic characteristics

- Awareness of EVD and sources of, exposure to, and preferences for EVD information
- Perception of risk for acquiring EVD
- Knowledge and attitudes about EVD transmission, prevention, symptoms, care sources, and consequences
- Actual or anticipated practices regarding seeking care for EVD symptoms and burial of persons who have died of EVD
- Reticence regarding health workers trying to prevent or control EVD
- Recommendations about strategies to prevent or control EVD
- Participant's questions about EVD

Interaction with household members

Information collectors will only approach members of randomly sampled households of clusters in which leaders have granted permission for the assessment. After introducing themselves and explaining the purpose of the assessment, information collectors will seek participation by reading aloud a standard participation agreement and noting acceptance or refusal on the tablet. Because most participants will have low literacy levels, information collectors will seek oral agreement for participation (Attachment 5). A signature, X mark, or thumbprint to note consent on the tablet device will not be collected because they would require touching the tablet which is not advisable during an ongoing epidemic of a highly infectious agent that can be transmitted through minimal contact. Participants will be told that providing the information is voluntary and that the information they share will be kept private to the extent allowed by law, meaning that it will not be linked to respondent's name, household, village, or neighborhood within a cluster in any reports or other materials to ensure that the participant would not be identified as a participant. Participants will be told that they may choose to stop the interview at any point or refuse to answer questions you do not feel comfortable responding to. The Introduction, interview, and closing statement will be conducted in a private area of the home or outside the home (e.g., veranda).

Information collection from household members will include 88 questions on these topics (Attachment 6):

- Socio-demographic characteristics
- Awareness of EVD and sources of, exposure to, and preferences for EVD information
- Perception of risk for acquiring EVD
- Knowledge and attitudes about EVD transmission, prevention, symptoms, care sources, and consequences
- Actual or anticipated practices regarding seeking care for EVD symptoms and burial of persons who have died of EVD
- EVD-related stigma and discrimination for persons with EVD and survivors of EVD
- Reticence regarding health workers trying to prevent or control EVD
- Interest in EVD vaccination for self and children, if EVD vaccination became available
- Recommendations about strategies to prevent or control EVD
- Participant's questions about EVD

Once the interview is over, the interviewer will conclude with closing remarks (Attachment 6).

Teams of supervisors will be responsible for synchronizing the tablet devices with the password-protected hosting server at the end of each day. During uploading process, information will be encrypted and secure electronic information collection methods will be applied to protect the privacy of participants' responses. FOCUS 1000 and the NGO partners will establish guidelines and protocols that will be signed by each information collector regarding the use of the mobile tablet devices. Once supervisors confirm that information is successfully uploaded to the server, the information will be deleted from tablets to protect the privacy of persons who participated that day. These data security and privacy protection methods were successfully used in prior KAP assessments that were funded in full by CDC Foundation in Sierra Leone involving greater than 3,500 respondents from rural and urban areas.

To protect privacy, all collected information will be encrypted before uploading to aggregated files and secured using password-protected analysis files. Additionally, reports will present information using table cell sizes that are large enough to prevent identification of specific participants, villages, neighborhoods, and households within clusters. All collected information will be co-owned by FOCUS 1000, CDC and Sante Plus with access granted to other entities including Guinea MOH, UNICEF, and other actors in the national response. All requests to publish summaries of the information will be reviewed and cleared by FOCUS 1000, PCI Media Impact, and CDC.

11. Justification for Sensitive Questions

Open-ended responses to the survey may involve sensitive matters such as sexual practices, burial practices, or religious beliefs. In addition, beliefs about condom use and religious affiliation are asked as part of the assessment.

Because intimate contact is very much a part of the risk of EVD infection, all of these questions are necessary to understand where community attitudes or perceptions may present barriers for the effective detection of EVD cases and ways to break the chain of transmission in the shortest possible timeframe. Respondents will be informed that they do not have to answer questions they do not feel comfortable answering, and the information collector is obliged to mark as "no response/decline to answer" then proceeds to the next question.

12. Estimates of Burden Hours and Costs

Estimates of the hour- and wage-burden of the collection of information are provided below.

A. The assessment proposes 6,150 respondents, of which 6,000 are household members and 150 are community leaders. The hour-burden estimate for leaders is 30 minutes including the time for introduction, obtaining verbal consent, short interview and closing comments (Attachments 3 and 4). The hour-burden estimate for household members is one hour including the time for introduction, identification of the role in household, assistance with random selection of second household member, obtaining verbal consent, and the interview (Attachments 5 and 6). The hour-burden estimates were obtained by CDC project staff in Guinea who piloted and refined the assessment among less than ten locally employed Guinean staff of various education levels. Additionally, questions were further refined for comprehension in a pilot among nine Guinean community members of varied educational levels.

Estimated Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs.)	Total Burden (in hrs.)
Community Leaders	Information Collection Instrument - Leader	150	1	30/60	75
Household Members	Information Collection Instrument - Household	6,000	1	1	6,000
Total					6,075

B. For purposes of estimating average wages, minimum wages were obtained from internet pages where minimum wages are published.¹ To convert from monthly to hourly wages, the following relationships were assumed: 8 hours/day; 40 hours/week; 4 weeks/month; 160 hours/month. The following equation was used:

$$\text{Hourly minimum wage rate} = \text{USD per hour} = \frac{\text{USD} * 1 \text{ month}}{160 \text{ hours}} \text{ or } \frac{\text{USD} * 1 \text{ day}}{8 \text{ hours}}$$

West	Official	2014	Minimum Wage Estimates	Source
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¹ Accessed May 5, 2015 at <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper>

Africa	Language	Census Estimate	Country Wage	US Dollar ²		2013 Internet
				Monthly	Hourly	
Guinea	French	10.6m	440,000 G francs/month	\$60.17	\$0.38	

Due to lack of documented information from existing sources, it was assumed that 90 percent of either respondent type will be unskilled workers to which the minimum wage applies, that skilled workers have wages that are 10 times the minimum wage, and that highly skilled workers and executives have wages that are 20 times the minimum wage.

It was also assumed that:

- 8 percent from either respondent type will be skilled workers (e.g., mine workers, mechanics, community health workers, teachers); and
- 2 percent from either respondent type will be highly skilled workers and executives (e.g., business owners, clinicians) and have wages that 20 times minimum wage.

For community leaders, the cost burden estimate is \$60.04 with a weighted hourly wage rate of \$0.80 for 150 respondents; for household members, \$4,788.00 with a weighted hourly wage rate also of \$0.80 for 6,000 respondents. The total cost burden estimate is \$4,848.04.

Cost to Respondents

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Total Burden Hours	Hourly Wage Rate	Respondent Cost
Community Leaders - unskilled	135	1	68	\$0.38	\$25.84
Community Leaders - skilled	12	1	5	\$3.80	\$19.00
Community Leaders - highly skilled	3	1	2	\$7.60	\$15.20
Household Members - unskilled	5,400	1	5,400	\$0.38	\$2,052.00

² USD conversion performed 05/01/2015 at eXchangeRate.com at http://www.exchangerate.com/currency-converter/XOF/USD/60,000%20/?XR-200Plus_Converter=convert&calc_short_from_iso=59&calc_short_to_iso=239

Household Members - skilled	480	1	480	\$3.80	\$1,824.00
Household Members - highly skilled	120	1	120	\$7.60	\$912.00
Total					\$4,848.04

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

There are no costs to respondents other than their time to participate in the information collection.

14. Cost to the Government

The CDC Foundation funded the initial planning and training phases of the study. Staff of CDC Foundation, a nongovernmental organization, provided technical support regarding scope and budget of the planning and training phases of the assessment that the Foundation funded.

In total, the cost to the federal government is \$219,986 based on the estimates below:

CDC will fund the later phases of the assessment in the amount of \$158,416 to cover costs of all information collection, data management and analysis, report preparation and dissemination, through a cooperative agreement with PCI Media Impact, who will subcontract to organizations conducting the assessment (FOCUS 1000 and Sante Plus). In addition, CDC will fund the following CDC and FDA health communication, population survey specialists, and statisticians as noted in the below table for a total of 880 hours (\$61,570) to provide technical assistance to FOCUS 1000 and Sante Plus over these later project phases.

Level	Hours
GS-15 CDC	380
Title 32 CDC	180
PHS FDA	110
GS-13 CDC	110
GS-14 CDC	80
TOTAL	860

15. Explanation for Program Changes or Adjustments

This is a new information collection request.

16. Plans for Tabulation and Publication and Project Time Schedule

Activities/Tasks/Deliverables	Timeline (2015)	Responsible Partner
<p>Convene follow-up meetings with FOCUS 1000 and Sante Plus, Guinea Platform of NGO/CSO for Health and Vaccination, and UNICEF Guinea, to finalize</p> <ul style="list-style-type: none"> assessment design and methodology information collection tool based on similar KAP instruments used in Sierra Leone and additional Guinea-specific items plans to recruit information collectors and supervisors from existing staff of partner organizations training program for information collection teams and supervisors <p>Install and pilot test software on tablets</p>	April 16 – May 8	<p>Lead: FOCUS 1000 Funder: CDC Foundation</p>
<p>Finalize assessment design and methodology</p> <p>Develop draft information collection tool – using KAP instruments from SL and adding additional Guinea-specific items</p>		<p>Lead: FOCUS 1000 With input from: CDC, Sante Plus, and UNICEF Guinea</p>
Recruitment of information collectors and supervisors (Guinea Partner)	April 20 – May 8	<p>Leads: Sante Plus and Guinea Platform of Civil Society Organizations (CSO's) for Health and Immunization Funder: CDC Foundation</p>
Pre-test sections of information collection instruments with < 10	April 24 – May 9	<p>Leads: FOCUS 1000 and Sante Plus With input from UNICEF Guinea</p>

community residents and refine accordingly Training of information collection teams and supervisors		Funder: CDC Foundation
Administer KAP household assessment	May 10 - 21	Lead: Sante Plus Funder: CDC
Information cleaning, tabulation, and analysis	May 22 - 31	Lead: FOCUS 1000 Funder: CDC
Produce KAP preliminary findings – share with key partners	June 5	Lead: FOCUS 1000 With input from: Guinea CDC, UNICEF Guinea, and Sante Plus Funder: CDC
Produce and disseminate KAP final report to key partners	June 15	Lead: FOCUS 1000 Funder: CDC

FOCUS 1000 will lead the statistical analysis of the collected information using an established information analysis plan (Attachment 7). The information collected through ODK will be exported into a CSV file, which will then be imported into SPSS for analysis as per the agreed Information Analysis Plan with Guinea CDC and UNICEF.

Data Analyses Summary

Planned analyses are described in Attachment 7. The analyses will include descriptive analyses of respondents' age, sex, type of employment, marital status, number of children, religion, at the country, natural region, prefecture, and sub-prefecture levels. Frequency tables will be produced for all categorical and dichotomous survey questions categorizing the data by region, prefecture and sub-prefecture. To appropriately account for the clustering design and inter-cluster correlation, the main analyses will use mixed-effect modeling including terms accounting for household and cluster groupings.

Responses to the household member and leader interviews that are written in, i.e., “other” will be analysed using In Vivo software for qualitative software that allow for coding of main themes and issues.

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

The expiration date is displayed on the information collection instruments (Attachments 4 and 6). However, the majority of respondents are not literate and respondents will not be allowed to touch the mobile tablet due to infection control purposes, so to read the OMB information on the mobile tablet or the consent form would be impracticable.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.