**Focus Group Testing to Effectively Plan and Tailor Cancer Prevention and Control Communication Campaigns**

Generic Information Collection

OMB No. 0920-0800

Expiration Date 10/31/2025

Supporting Statement Part B

April 28, 2023

Technical Monitor:

Ally Moehring

Health Communication Specialist

Office of Policy, Partnerships, and Communication (OPPC)

Division of Cancer Prevention and Control (DCPC)

Centers for Disease Control and Prevention

404.498.1576

nhx1@cdc.gov

Supported by:

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division of Cancer Prevention and Control

TABLE OF CONTENTS

[B. DATA COLLECTION & STATISTICAL METHODS 2](#_Toc529832690)

[B1. Respondent Universe 2](#_Toc529832691)

[B2. Procedures for Information Collection 3](#_Toc529832695)

[B3. Methods to Maximize Response Rates 4](#_Toc529832696)

[B4. Tests of Procedures or Methods to be Undertaken 4](#_Toc529832697)

[B5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data 5](#_Toc529832698)

**List of Tables**

[Table B1. Young Women Respondents 3](#_Toc529832692)

**B. DATA COLLECTION & STATISTICAL METHODS**

Data collection will consist of a virtual focus group methodology. Focus groups are widely used in stages 1 and 2 of the Health Communication Process (National Cancer Institute, 2002). In a focus group, a small group of people engage in a discussion of selected topics of interest typically directed by a moderator who guides the discussion in order to obtain the group’s opinions (Edmunds, 1999; Krueger & Casey, 2000). Focus groups capture the collective insight of a group while preserving individual preferences. In this setting, participants can describe their experiences and preferences without the limitations of preset response categories. Furthermore, focus groups produce rich data complete with nuances that often may be obscured in quantitative data collection techniques.

Statistical methods will not be employed to analyze focus group data, as it is not appropriate to report the percentage of focus group participants who expressed a particular view (Carey, 1995; Morgan, 1995; National Cancer Institute, 2002; Webb & Kevern, 2001). Typically, not every participant 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 participants who expressed a particular view.

***B1. Respondent Universe***

Study participants will include cisgender women 18–44 years old who are i) unaware of their risk for breast cancer, or may know, but have not yet taken steps to lower or mitigate their risk and ii) previvors, those aware of their increased risk for breast cancer and actively taking steps to mitigate and/or manage their risk.

Focus groups will be further segmented into five priority groups identified by Team Edelman through formative studies as key audiences of the Bring You Brave campaign. These groups represent underserved populations, including cisgender women generally, women of specific racial and ethnic groups (i.e., Hispanic women whose preferred language is Spanish, Black and African American women, and American Indian/Alaskan Native women), and women of minoritized sexual identity groups (e.g., Lesbian, Bisexual, Queer, and Asexual or LBQA).

The study design includes eight focus groups for English-speaking women, two focus groups for Spanish-speaking women. Additional inclusion and exclusion criteria will vary depending on the campaign target audience. Questions drawn from the recruitment screening forms (Attachments 2A and 2B) will allow us to identify respondents with the relevant characteristics.

The information collection will be conducted with 10 focus groups. A breakdown of the number of participants per group is included in Table B1:

**Table B1. Young Women Respondents**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Young Women Respondents (ages 18-44)** | | | | | |
|  | **Black/ African American** | **Hispanic** | **General Population** | **American Indian/ Alaskan Native** | **Sexual Identity Groups (LBQA)** |
| **Unaware** | 1 group  English | 1 group  Spanish | 1 group  English | 1 group  English | 1 group  English |
| **Previvor** | 1 group  English | 1 group  Spanish | 1 group  English | 1 group  English | 1 group  English |
| **Total Groups** | 5 groups with women unaware of personal risk, age 18–44, 1 group in Spanish  5 groups with previvors, age 18–44, 1 group in Spanish | | | | |
| **Inclusion Criteria** | Include mix of   * sexual identities * geographic location (i.e., urban, suburban, rural) * income levels * education levels * have/have not undergone genetic counseling and testing to better understand their risk of breast cancer. | | | | |
| **Exclusion Criteria** | Exclude women who   * are transgender * are breast cancer survivors * are employed in communication, marketing, advertising, digital media, or health fields * do not have a desktop, laptop, or smartphone for participation | | | | |

***B2. Procedures for Information Collection***

In order to elicit focus group responses to effectively plan and/or tailor existing DCPC communication campaigns, the following steps will occur:

1. Participants will be identified and recruited from a variety of geographic regions (e.g. Northeast, South, Midwest, and West Coast) and in both large and small cities in order to collect data from a diverse group of individuals. Participants will be recruited using proprietary databases of commercial focus group companies, and other sources. Eligibility criteria will be established for all focus group participants, and potential participants will be screened using a telephone or self-administered screening form (Attachments 2A and 2B). Prior to conducting the individual focus groups, participants will provide verbal consent to participate and will be provided a participant information sheet (Attachments 4A and 4B).
2. Focus group discussion, not to exceed 90 minutes, will occur under the direction of a professionally trained moderator. A focus group discussion guide will be utilized throughout the duration of the session (Attachments 5A and 5B). The verbal discussion that ensues will be partly directed by the moderator and partly by the comments of other participants.

As all DCPC communication campaigns utilize the Health Communication Process, similar categories of questions will be used in focus groups regardless of the specific campaign being evaluated. In stage 2, concepts, messages, and materials will be developed and pretested.

All focus groups for this information collection will be audio-recorded, and a verbatim transcript will be compiled for each group.Research team members will analyze transcripts and code them for key patterns and themes.

***B3. Methods to Maximize Response Rates***

Participants will be recruited from the database of the commercial research facilities where the groups are held.

To minimize the possibility of having too few appropriate focus group participants (thereby forcing group cancellation), two additional participants will be recruited to each group than is needed. In the event that too many participants report, excess participants will receive the honorarium and will be dismissed.

***B4. Tests of Procedures or Methods to be Undertaken***

All DCPC communication campaigns are guided by the Health Communication Process (National Cancer Institute, 2002) which involves four stages: (stage 1) planning and strategy development; (stage 2) developing and pretesting concepts, messages, and materials; (stage 3) implementing the program; and (stage 4) assessing effectiveness and making refinements. The Health Communication Process is not linear, but rather is a circular model in which stages are revisited in a continuous loop of planning, development, implementation, and refinement. DCPC campaign staff carefully record all aspects of campaign development, operation, and evaluation. Innovations and improvements are incorporated into subsequent campaign cycles and periodically published in the peer-review literature (Cooper, et al., 2005; Cooper et al., 2011). In fact, the use of focus group methodology to inform the development and refinement of communication campaigns has been well documented throughout the literature (Bull, et al., 2002; Edmunds, 1999; Jorgensen, et al., 2001; Krueger, 1994; Krueger & Casey, 2000; Wong, et al, 2004; Cooper et al., 2011). Thus, the formative and materials-testing methods currently used by DCPC campaigns have been refined in over twelve years of campaign operations.

***B5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data***

The proposed protocol and discussion guide were developed and reviewed extensively by DCPC staff and Team Edelman staff identified below. DCPC and Team Edelman staff will participate in the analysis of the data and campaign planning and/or material refinement.

Temeika L. Fairley, PhD

Health Scientist

Office of the Director

Division of Cancer Prevention and Control

National Center for Chronic Disease Prevention and Health Promotion

Centers for Disease Control and Prevention

Chamblee, GA 30341

Phone: 770-488-4518

Email: tff9@cdc.gov

Ally Moehring

Health Communication Specialist

Office of Policy, Partnerships, and Communication (OPPC)

Division of Cancer Prevention and Control (DCPC)

Centers for Disease Control and Prevention

Phone: 404.498.1576

Email: nhx1@cdc.gov

Sam Evans

Managing Researcher, Health Communication Research

Fors Marsh

4250 North Fairfax Drive, Suite 520

Arlington, VA 22203

Phone: 571-858-3805

Email: sevans1@forsmarsh.com