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National STD Surveillance Data Dissemination—Who Wants To Know What?

Final Report

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NATIONAL STD DATA DISSEMINATION – WHO WANTS TO KNOW WHAT? FINAL REPORT

1. Introduction

1.1 Purpose of the Report

The following report presents the results of an evaluation of the Centers for Disease Control and Prevention's (CDC's) sexually transmitted disease (STD) data dissemination methods. RTI International conducted the evaluation, *National STD Surveillance Data Dissemination—Who wants to know what?*, under contract to CDC. This report summarizes information contained in topline reports prepared for this contract.

The following chapter provides background information about the project and describes the organization of the remainder of the report. Chapter 2 describes the methods used for each of these phases of the evaluation. Chapter 3 presents the results of each part of the evaluation, including a description of key stakeholder audiences. Chapter 4 synthesizes the results of each component, including a presentation of the uses of the report. Chapter 5 presents a summary of the desired changes the participants reported. Chapter 6 offers our conclusions for the evaluation, and Chapter 7 presents RTI's recommendations to CDC.

1.2 Background and Rationale for the Project

CDC's Division of STD Prevention (DSTDP), in partnership with local and state health departments, public and private hospitals, laboratories, and private physicians, has established several systems for monitoring sexually transmitted diseases across the nation. STDs are an important public health problem in the United States. These infections may result in infertility, ectopic pregnancy, chronic pelvic pain, low birth weight, stillbirth, spontaneous abortions, cancer, and sometimes death. STDs have been found to increase the risk of HIV infection, cause anxiety and other emotional problems, and result in lifelong adverse consequences. An estimated 18.9 million new cases of STDs occurred in 2000 (Weinstock, Berman, and Cates, 2004), resulting in direct and indirect costs, not including HIV/AIDS-related costs, totaling billions of dollars (Institute of Medicine [IOM], 1997). The United States has the highest rate of curable STDs in the developed world, higher than rates found in some developing countries (IOM, 1997).

Various state, local, and private stakeholders implement prevention, treatment, and control programs to preserve and promote sexual health. Fundamental program components include surveillance activities such as screening, counseling, and reporting; contacting and

treating sex partners of infected individuals to decrease further transmission; and conducting community outreach. The mix and intensity of these activities vary depending on disease incidence, program funding, community receptiveness, and the risk population. STD prevention and control is by nature a dynamic enterprise, and public health programs must be able to adapt to an ever-changing environment and respond quickly to rapid increases in incidence. The planning and implementation of effective activities are improved by accurate and timely information on STD incidence and prevalence.

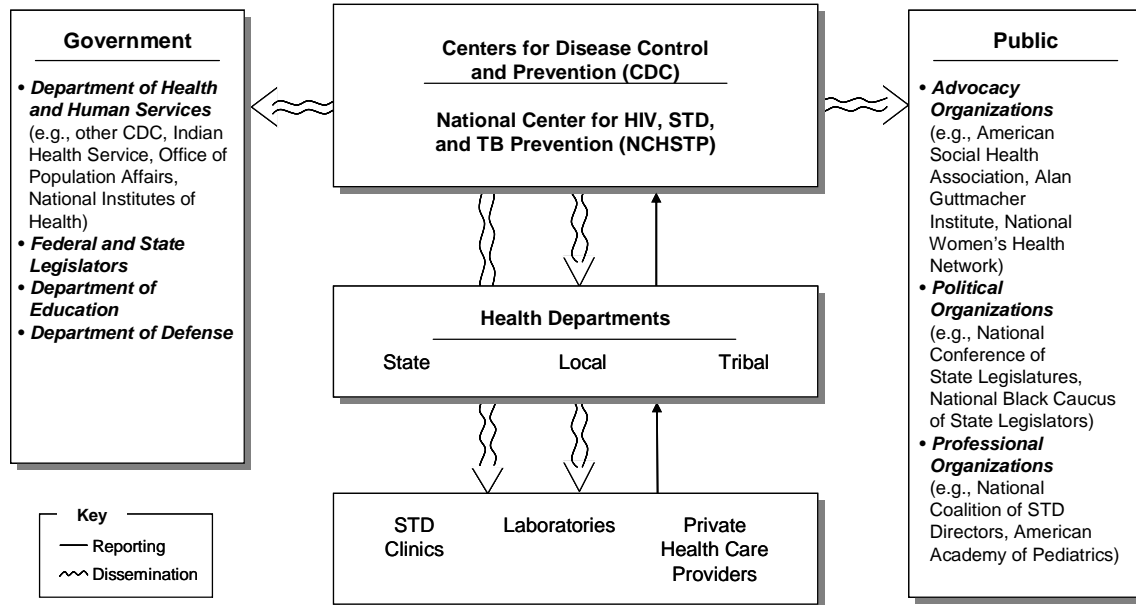
DSTDP disseminates STD information through a variety of channels, including the Center's website, downloadable reports, mailed reports, CDC Wonder, and articles in the Morbidity and Mortality Weekly Report (MMWR) and scientific journals. The STD surveillance reports, and the efforts those reports represent, are a key component in the nation's struggle against STDs. Although many state and local programs provide some form of feedback to those who provide STD data, in some instances CDC's surveillance reports are the only feedback providers receive. As such, the reports serve many purposes, including the following:

- Informing key stakeholders and the U.S. public about STDs
- Assisting public health professionals and advocates with intervention planning
- Providing feedback on the effectiveness of interventions and other control efforts
- Raising awareness of CDC's role in controlling STDs
- Providing support for policies related to STD control efforts
- Facilitating stakeholder compliance or buy-in with STD control measures

Exhibit 1 illustrates the reporting of STD data to CDC and dissemination of aggregated STD information back to various stakeholder groups. Note that **Exhibit 1** is an idealized version of how reporting and dissemination occurs. Information on who actually subscribes to the annual STD surveillance report and disease-specific supplements is provided in Chapter 3.

CDC recognized that changes in technology and norms regarding information dissemination necessitated a reevaluation of the current methods used to disseminate STD surveillance data. Increased use of the Internet and the widespread availability of computing systems in public health have changed the demand for and use of all types of surveillance data. CDC contracted with RTI International to provide information about the needs and desires of key

Exhibit 1 Model of STD Information Reporting and Dissemination



stakeholder groups related to data dissemination and the format of the annual STD surveillance report. CDC wanted to know more about who is using STD surveillance data and the best ways of getting the information out to current or prospective data users.

2. Methods – Conducting the Research

In order to provide a comprehensive qualitative evaluation of CDC's STD data dissemination methods, a multifaceted approach was used to collect information about the data needs, preferred methods of data display, and preferred methods of data access of a wide range of users of STD surveillance information. The different components of this approach included:

- Interviews with CDC DSTDP staff members;
- Analysis of STD surveillance report subscriber data;
- Web-based group discussions with STD program staff and academicians working in STD control; and
- In-depth interviews with four types of key stakeholder groups: local health department staff members, policymakers/advocates, STD partner organizations, and users of the disease-specific STD supplemental reports.

Note, the evaluation as originally planned included soliciting comments on the STD surveillance report via the Federal Register and an examination of the CDC DSTDP website usage. After discussion of whether a Register notice would be appropriate, CDC elected to not use the Register and instead collect information via additional semi-structured in-depth interviews. Initial analyses of CDC's website data revealed the popularity of the STD fact sheets and the STD statistics and surveillance homepage; however, because it was not possible to determine which audience group accessed which webpages or to distinguish between novel and repeat browsers, the website analysis did not contribute greatly to understanding the needs and desires of various STD data audiences and was discontinued.

Given the nature of the evaluation research (i.e., secondary data analysis, online group discussions, and telephone interviews), only oral consent was obtained for participation. All participation was voluntary and no monetary compensation was provided. RTI emailed all participants thank you notes after completion of their group discussion or interview. All participants were provided with an email address to contact the study director with any questions or comments. Only two participants used the address. One participant sent an email thanking the researchers, and another participant emailed a link with an example of online data analyses and shared concerns about the need for CDC to clarify and explain why CDC believes certain trends exist (e.g., disparities between age groups and between data sources such as clinics, corrections, etc.).

2.1 *DSTDP Interviews*

In fall 2004, RTI International staff interviewed various Division of STD Prevention personnel to ask them who they believed were the audiences for the annual STD surveillance report and who, in general, used STD surveillance data. Other topics addressed in the interviews included elements of the surveillance report they wanted RTI to investigate, specific target groups that should be included in the evaluation, and their own use of the STD surveillance report and supplements. These interviews, with the exception of one telephone interview, took place in person in DSTDP's Atlanta offices.

2.2 *Subscriber Databases*

RTI analyzed eight mailing lists or keys sent by CDC for the annual STD surveillance report and disease-specific surveillance supplements. RTI combined these lists on the basis of information provided by CDC (see Appendix A) and removed duplicate addresses within each new file created from its constituent parts. RTI identified duplicate addresses by visual

inspection of names and addresses and various computer SAS searches. When possible, Internet searches were used to determine which of two or more addresses for the same name was correct.

After unduplicating the databases, we examined the organizational affiliation (e.g., health department, CDC, academic) and organizational function (e.g., administrator, epidemiologist, library) for each of the hardcopy subscribers to the STD surveillance report and its supplements. As the same data fields were not available for online requests for the reports, a more limited analysis was conducted for the database of online requests. We also conducted Internet searches for 140 of these addresses or company names on the STD surveillance report mailing list to clarify the nature of the work environment mentioned. After we coded manually, we printed the results in SAS by category to check for errors.

2.3 *Group Discussions*

In early 2005, RTI conducted four Web-based group discussions using a commercial Internet conferencing service. An online format was chosen so the moderator could show various figures to the participants, and obtain feedback, at appropriate times during the discussion. The first of these groups served to test the discussion protocol and gather information from CDC staff members. The three other discussions included persons suggested by CDC for inclusion in the research. A total of 18 people participated in the four discussion groups (ranging from 2 to 7 participants each). The majority of the participants were from STD program areas (i.e., they work with federal, state, or local STD programs), three participants were from academia, and one participant was from both areas. Participants were geographically dispersed, located in seven states (California, Georgia, Illinois, Maryland, New York, Texas, and Washington). RTI questioned participants on their general uses of the STD data in the report; the usefulness of the text, figures, and tables; preference for hardcopy or online versions of the reports; and if there were any groups that should be paying attention to STD surveillance data that are not currently doing so. In addition, RTI asked participants if they desired any changes within these reports and if so, what kinds of changes.

2.4 *Stakeholder Interviews*

Following the completion of the focus group research, a series of semi-structured interview protocols was created for use with each of the key stakeholder groups in order to expand the quantity and depth of the information collected. The loose structure of the protocol allowed the interviewers to gather highly similar information, in a more conversational format than typically employed with in-depth interviews, without asking the same questions to more than 9 people. In preparation for the interviewing, each of the interviewers reviewed their

applicable protocols, listened in on a mock interview with a staff person from the Washington, D.C., Department of Health, and conducted a mock interview with another interviewer. The study director also spoke with each interviewer and reviewed their notes after the completion of their first or second interview in order to ensure that topics were sufficiently probed.

Each of the individuals interviewed were suggested either by CDC, by other interviewees, or by RTI because they were quoted or referenced in popular press STD articles and thus were likely users of STD surveillance data. The interviewees were selected to fit into one or more of the following categories: local public health department staff, STD partner organization, disease-specific supplement user (i.e., syphilis, GISP, or chlamydia), or policymaker. Note, the policymakers interviewed were policy advocates or those who help establish policies, not elected officials. Each of the potential interviewees was first solicited for participation in the evaluation research by email; subsequent requests for participation were by either phone and/or email. All participants were sent, when possible, an email thanking them for their participation.

3. Results – Users of Surveillance Data

3.1 Interviews and Discussions

The evaluation research revealed widespread agreement that the Division targets health departments, meaning state or local health directors, STD program managers, and epidemiologists. Participants also agreed that students in various disciplines use the report. Very few people, however, said that they thought the STD surveillance report is meant for non-public health audiences. The participants suggested a wide range of potential users of STD surveillance data that may be classified into eight broad categories:

- Maternal-child health/family planning organizations
- HIV organizations (community-level)
- Corrections agencies
- Policymakers
- Substance abuse organizations
- Educational organizations
- Managed care organizations
- Funding agencies

The participants thought that these groups are not paying enough attention to STDs and that CDC should work to facilitate their interest in, and use of, STD surveillance data.

3.2 *Mailing Key Analysis*

Analysis of the eight mailing lists and online requests for the STD surveillance report and supplements revealed that the report is widely disseminated, but at levels lower than what might be expected. Although the STD surveillance report is sent to every state and territory in the nation and 47 foreign countries, examination of the mailing lists revealed that less than 20 percent of local health departments subscribe to the surveillance report and fewer than 18 percent ($n = 10$) of the Division of STD's 57¹ partner organizations subscribe (see Appendix B). Only two partner organizations, the Indian Health Service and the National Network of STD/HIV Prevention Centers, subscribed to both the main STD data surveillance report and all of the supplements. The disease-specific supplements to the surveillance report are also sent to every U.S. state and territory, but fewer supplements are sent to international locales. In general, states with high rates of STDs have more STD surveillance reports, syphilis supplements, and GISP supplements sent to them. Interestingly, this trend did not appear to be true for the chlamydia supplement.

As more than half of the subscribers to the surveillance report did not provide a job title, and because there are many different titles in public health, the mailing lists were examined for the organizational affiliation (e.g., CDC, state health department, local health department) and subscribers' organizational function (e.g., they work in an epidemiology or statistics unit). As can be seen in **Exhibit 2**, the largest group of subscribers to the STD Surveillance Report consisted of employees in state and local government health, or public health, agencies (37.2 percent), followed by CDC staff members (17.4 percent). A large numbers of subscribers were in clinical settings, and some were in academic settings.

¹ Includes non-DSTDP CDC.

Exhibit 2 Organizational Affiliation of Hardcopy STD Surveillance Report and Surveillance Supplement Subscribers

Characteristics of Subscribers^a	STD Surveillance Report Total n = 2,101 n (% of total)	GISP Supplement Total n = 314 n (% of total)	Chlamydia/Syphilis Supplements Total n = 434 n (% of total)
State or territorial health department	360 (17.1)	272 (86.6)	217 (50.0)
Local health department (regional, city, county, district)	435 (20.7)	36 (11.5)	15 (3.5)
Centers for Disease Control and Prevention	366 (17.4)	0	198 (45.6)
Health care setting (including county/city health clinics)	293 (13.9)	2 (0.6)	2 (0.5)
Academic	218 (10.4)	3 (1.0)	2 (0.5)
Partner organizations, foundations, professional organizations, and nonprofit institutes	76 (3.6)	0	0
Foreign (not CDC)	100 (4.8)	0	0
Other	62 (3.0)	1 (0.3)	0
Missing or not a business address	191 (9.1)	0	0

^a Mailing lists only; not online requests.

Many of the CDC employees who subscribed to the reports work in state or local health departments (see **Exhibit 3**). In fact, when examined by a more narrow set of organizational functions, CDC public health advisors placed in state or local health departments were the most common subscribers to the STD surveillance report (8.8 percent) and the most common subscribers to the syphilis supplement and chlamydia supplement (42.2 percent). No CDC public health advisors subscribed to the GISP supplement. The most common subscribers to the GISP supplement are managerial personnel in STD or other communicable disease control programs in state and local health programs (38.9 percent).

Exhibit 3 Organizational Function of Hardcopy STD Surveillance Report and Surveillance Supplement Subscribers

Characteristics of Subscribers^a	STD Surveillance Report Total n = 2,101 n (% of total)	GISP Supplement Total n = 314 n (% of total)	Chlamydia/Syphilis Supplements Total n = 434 n (% of total)
State and Local Health Agencies (except library)	781 (37.2)	308 (98.1)	232 (53.5)
Agency-wide administrators	91 (4.3)	57 (18.0)	55 (12.7)
Laboratory director	43 (2.0)	37 (11.9)	37 (8.5)
Epidemiologists and surveillance or statistical unit personnel	65 (3.1)	54 (16.9)	50 (11.5)
Communicable disease control/STD program–health department manager or director	77 (3.7)	122 (38.9)	69 (15.9)
Communicable disease control/STD program–health department nonmanagerial	170 (8.1)	20 (6.4)	3 (0.7)
Other state/local government	87 (4.1)	12 (3.8)	12 (2.8)
Not specified	248 (11.8)	6 (1.9)	6 (1.4)
CDC (except library)	365 (17.4)	0	198 (45.6)
Public health advisor (state/local assignee) (CDC center assignment)	185 (8.8) 29 (1.4)	0 0	183 (42.2) 2 (0.5)
Epidemiologist/health scientist (center)	24 (1 .1)	0	0
Other, center assignment	107 (5.1)	0	1 (0.2)
Other, field assignment	20 (1.0)	0	11 (2.5)
Not specified	0	0	1 (0.2)
Health Care Setting	304 (14.4)	2 (0.6)	2 (0.5)
Infectious disease treatment/control	69 (3.3)	0	0
Not specified	63 (3.0)	0	0
Other (not library)	172 (8.2)	2 (0.6)	2 (0.5)

(continued)

Exhibit 3 Organizational Function of Hardcopy STD Surveillance Report and Surveillance Supplement Subscribers (continued)

Characteristics of Subscribers^a	STD Surveillance Report Total n = 2,101 n (% of total)	GISP Supplement Total n = 314 n (% of total)	Chlamydia/Syphilis Supplements Total n = 434 n (% of total)
Academic	142 (6.8)	3 (1.0)	2 (0.5)
Medical school	62 (3.0)	2 (0.6)	1 (0.2)
Other (not library)	45 (2.1)	1 (0.3)	1 (0.2)
Not specified	35 (1.7)	0	0
Libraries (all settings)	159 (7.6)	0	0
Academic	76 (3.6)	0	0
Health care	47 (2.2)	0	0
Other	36 (1.7)	0	0
Other	338 (16.1)	1 (0.3)	0
Missing	191 (9.1)	0	0

^a Mailing lists only; not online requests.

According to the National Association of County and City Health Officials (2005), there are some 2,753 local health departments in the United States. We identified 435 unduplicated mailing addresses that we classified as belonging to a local (i.e., regional, city, county, or district) health department; only 15.8 percent of local health departments subscribe to the STD surveillance report. Far fewer (n = 36, 1.31 percent, for GISP and n = 15, 0.5 percent, for both the chlamydia and syphilis supplements) subscribe to the disease-specific supplements. These estimates, especially for the main surveillance report, are somewhat larger than the actual subscription rate in that several of the unduplicated addresses are to different people at the same address. For example, five copies of the STD surveillance report are sent to the same address (different names) at the Knox County health department in Tennessee. While these estimates of subscription are slightly larger than actual, they are conservative as estimates of exposure and use of STD surveillance data. It is not clear from the available data if local health departments

view the surveillance supplement online, look at STD data presented in the *Morbidity and Mortality Weekly Report (MMWR)* or other publications, or received any copies of the reports at any of the conferences for which CDC made online requests.

According to the Institute for International Medical Education (2005), there are 144 medical and osteopathic schools in the United States, but only 62 STD surveillance reports were sent to medical schools (43.1 percent). This estimate is confounded by some schools' receiving more than one copy and the possibility that some subscribers are actually medical school faculty who did not include the name of the school in their mailing address. Not all of the nonmedical academic subscribers were public health related, and it was not possible to determine the academic discipline of some subscribers based on the information available. However, because only 218 academic-related subscriptions were included in the mailing keys, there is sufficient information to conclude that there is not universal subscription to the STD surveillance data report and disease-specific supplements by U.S. medical and public health institutions.² Libraries in general were a large category of subscribers for the STD surveillance data reports but not for the supplements. None of the subscribers to the supplements identified themselves as a library.

The vast majority of subscribers did not have their degree listed in the mailing keys. Of those that did, more than half had a doctoral-level professional medical degree (e.g., MD, DO, DDS, DVM) (51.2 percent to 57.7 percent). While this finding may at least partially reflect greater reporting of degrees on the part of medically trained practitioners, it is clear that a substantial portion of the audience has a medical professional educational background. The educational background of a great many other subscribers is simply unknown. A small number of subscribers listed a qualification but not a degree, such as Certified Health Education Specialist (CHES).

A large proportion of online orders, 950 of the 2,263 surveillance reports requested online (42 percent) and 350 of 472 syphilis supplements (74 percent), are for CDC exhibits at professional conferences. However, according to the data provided, none of the online requests for the chlamydia supplement were for CDC conference exhibits. The information provided does not clarify who attended the events, whether all of the reports ordered were disseminated, or if any of the reports were later returned to inventory. Online requests for the STD surveillance report or supplements are not added to the subscription database (i.e., the mailing keys).

² According to the Council on Education for Public Health (2005), there are 37 accredited schools of public health and 101 accredited graduate public health programs.

4. Results – Uses of Surveillance Data

The evaluation research participants reported a variety of uses for the main STD surveillance report. The most often reported use of STD data was to compare how their state/area compared to the nation and other nearby states or areas. The second most reported use was to examine trends in STD transmission. Although the majority of participants did not specify which trends were of most interest to them, a small number of people said that they typically examine only those trends relevant to their work (e.g., syphilis elimination or programs related to adolescents). A few participants did not know about the Other Sexually Transmitted Disease section of the surveillance report, and a few seemed unfamiliar with much of the content of the Special Focus Profiles sections. At least one person, however, stated that he used the special profiles and tables far more than the national profile sections. Reasons cited for infrequent use of the STD surveillance report included “we meet most of our needs with our local data” and that they only look to see how the data are presented so “use it sporadically.”

Several participants stated that they used the surveillance report to monitor STDs in their area and nationally; in fact, one participant stated that CDC’s annual surveillance report was the only STD information he has to work with (i.e., he does not have access to state or local data). Participants said they use the surveillance report to do their own annual STD surveillance reports, to examine STDs in other parts of the country, as a referral source for people who call them with questions, to write grant applications, for developing teaching materials, for slides to be used in trainings and presentations, and as a reference guide. When discussing the syphilis supplement, one participant emphasized the importance of using CDC’s data by saying that they are “the official presentation of numbers” used when providing information to others.

Uses for the STD surveillance report

- to monitor STD trends in their area and nationally
- to develop state STD surveillance reports
- as a referral source for people who call in with questions
- to conduct research
- to write grants and articles
- for teaching purposes
- for slides in trainings and presentations
- to calculate the cost of STDs
- to inform policy
- to advocate for public health policy
- to provide comments to the media
- as a reference guide

The majority of participants did not use the supplements as often as the main report, but when they did use them, they used the information for similar purposes as the main report. Several participants were not familiar with the supplements. In addition, a few participants stated that they use the supplements to provide state-specific information. Of the participants who said they used the supplements, most stated that they used them mainly as a reference guide. One participant stated that he used the GISP supplement for comparisons between national and state data. Another used the GISP supplement to send providers information about alternate treatment and the men who have sex with men (MSM) population.

Within the main STD surveillance report, the majority of participants stated that they use the tables most often. Participants also described using the graphs from specific sections. Other sections mentioned as being particularly useful included the special focus profiles and the graphs. Interestingly, however, the special profile sections were also mentioned as one of the least useful sections of the report. In fact, the text and the special profile sections were both mentioned by various participants as being the least useful sections of the main surveillance report. A number of other participants said that they found the supplements to be the least useful part of the report (i.e., they considered the main surveillance report and the supplements to be one report). Participants provided a variety of reasons for their choices including that they have local data available, that graphs with national data are not useful because no tables are attached, and that they get all the information they need from the tables. Although most respondents³ stated that they did not use the Other Sexually Transmitted Diseases section, the respondents felt that the surveillance information on other STDs was useful to include because the data were not available on a local level.

An important issue for several of the participants was the timeliness of the reported data. Although the majority of the participants understood CDC's limitations in acquiring and disseminating the report in a more timely manner, many participants commented that the usefulness of the data would increase if they were to receive the report earlier in the year.

5. Participants' Desired Changes

The evaluation research participants stated various needs and desires related to the STD surveillance report and CDC's information dissemination methods. Most of the key issues raised by the participants centered on facilitating how the stakeholders use the report and supplements to find information on STD trends and compare data from various locations. Examples of such issues include (but are not limited to) the need for more of the following:

³ Questions about this section of the report were only asked during the online group discussions.

- Trend data and explanations of trend data
- CDC recommendations for STD control
- Formatting changes
- Cross linking/cross referencing within and between reports
- Discussions of data limitations
- Discernment between county and city data
- Manipulation and downloading of data online

In examining the suggested changes, we have classified the suggestions into the following five domains: (1) audience; (2) data analysis; (3) data interpretation; (4) data presentation, including both what data to include and how to illustrate and discuss that data; and (5) data dissemination.

5.1 Audience-Related Changes

Audience-related recommendations for change primarily focused on increasing awareness and use of STD data. The participants suggested eight categories of groups that should be using STD data (see Section 3 of this report). Note that in some cases the participants did not provide broad groups so much as specific targets for the data (e.g., policymakers includes specific participants' suggestions related to members of Congress and the White House). Other audience-related changes recommended by various STD data users included working with local program areas to promote the use of STD data and providing an executive summary and/or a nontechnical summary for a broad-based audience.

5.2 Data Analysis Changes

Participants in the evaluation research suggested that CDC provide additional information to help make comparisons and aid understanding of differences in STD rates between states, ethnic groups, and so on (e.g., rate ratios, incremental probability, or other information in addition to providing base rates and state rankings). The participants related stories of how they had to enter data displayed in the report into database programs and stated a desire to more easily make comparisons between specific groups, locations, and time periods. Some participants suggested facilitating comparisons by providing downloadable databases or online data analysis engines so that STD data users could conduct their own analyses. Other participants, however, simply advocated that CDC present the comparisons they desired. Suggestions for what years of data to present or make available in the reports and online varied from 3–5 years, to 8–10 years, to some saying all years should be made available (i.e., all data would be available online and the print report would contain recent years).

Providing more detailed data about specific diseases, strains, or populations was another issue that the evaluation research participants emphasized. Examples of such issues include (but are not limited to) the need for more of the following:

- Specific breakdowns by age, gender, or race
- Analysis to show disproportionate disease burdens or outbreaks
- Success or failures related to CDC prevention efforts
- Information on behaviors and sexual orientation
- Information on lymphogranuloma venereum (LGV)

5.3 *Data Interpretation Changes*

Several participants and several types of STD data users expressed the desire for text that clearly states what trends CDC perceives to be a problem that needs to be addressed. These participants also felt that the report needed more text explaining why CDC believes the trends exist. The participants suggested that the text bullets in the report be grouped under subheadings and/or prioritized. Policymakers especially indicated that the presentation of the text should be more “user-friendly” for those not as familiar with the report and its terminology.

There was a general consensus across evaluation research participants that the report should include both text and figures for ease of usability. With only one exception, all of the participants asked thought that the text should be more closely linked to the corresponding figures. This linkage was often discussed as placing the text on the same page or adjacent pages. In other words, the participants felt that the written description of STD data should accompany the graphics associated with that data to increase the likelihood that both the text and figures are understood correctly. As indicated by their other concerns, it is likely that the participants thought the text should not only state the basic facts of a figure, but also interpret the information by providing information about why a trend might exist. It was not clear from the research whether the participants thought that prioritization or grouping of various text elements under subheadings would be needed if the text was predominantly grouped near related graphic elements.

5.4 *Data Presentation Changes*

Layout and Graphics: The evaluation research participants advocated for a variety of format changes, including more closely linking the text with associated figures, including more maps, and using design methods (e.g., call-out boxes or boldface type) to highlight important issues such as health disparities, CDC recommendations, data calculations and limitations, and the success or failure of CDC prevention efforts. Policymakers in particular advocated the use of maps as a quick way to convey information. One participant suggested that CDC examine recent maps related to obesity that show, via several sequential maps, how the problem of obesity has increased and spread over time.

Several participants recommended that CDC change the tables on selected large cities. The participants felt that the data presented are misleading, because many of the numbers in the table reflect cases from outside the boundaries of those cities. In fact, concern over the list of cities presented in tables was one of the biggest issues for a few participants. They thought that the data needed to be reported as belonging to a metropolitan area, meaning their county or several counties, not the specific cities.

Only the participants in the discussion groups were shown any color graphics (a “micromap” graphic showing small maps of the United States, line graphs showing trends over time, and a hierarchical listing of the states from highest to lowest rate of syphilis). Although color was generally liked by the discussion participants, it was not something mentioned by other participants in the evaluation research. Note that although the use of color was liked, the micromap format was not. Participants liked the idea of presenting trend data, using maps, and presenting a hierarchical list of states, but the combination of these three types of information into one graphic was found to be too confusing.

Data Inclusion: The participants in the evaluation research provided comments that were often more concerned with the type of data in the report than how existing data were presented. It was not always clear, however, whether participants knew that some of the information requested existed. In other words, it was not always possible to tell whether someone thought the information did not exist and wanted CDC to provide it, wanted more comprehensive versions of the current data available, or desired a figure for data currently included only in tables. For example, some users stated a desire for more inclusion of racial/ethnic data and data broken down by age groups. While it was clear that participants wanted both analyses, it was not clear if they knew that versions of both breakdowns, and a breakdown by both race/ethnicity and age group, are available in tables at the end of the report. One participant, however, was specific

in saying the current racial/ethnic information should be changed to include data on Native Americans. Similarly, another participant was specific in saying that data on pelvic inflammatory disease need better age categories than 15 to 44 years of age.

Participants suggested that the report and supplements incorporate cross-referencing to help readers find state-specific data, racial or ethnic data, and so forth. Participants also recommended duplicating key rate and trend information included in the Special Focus Profiles of the report in the disease-specific sections. They desired clearer links between the sections of the main report and between the main report and the supplements (e.g., the 2004 National Profile for syphilis does not indicate that there will be a syphilis-specific supplement or what information readers might expect to find there).

Several participants desired to see STD data combined with information from the HIV/AIDS report. Some participants also suggested that the report either include or refer readers to behavioral data such as the Behavioral Risk Factor Surveillance System (BRFSS). They felt that these data would better help them explain STD trends and plan public health control efforts.

5.5 *Data Dissemination Recommendations*

The evaluation research participants provided multiple suggestions for types of people who they felt should receive the STD surveillance report, but there was no discernable consensus as to who might be the most important new or expanded target audience. The participants advocated CDC working more closely with local program areas to promote the use of STD data and recommended either including a user-friendly executive summary with the STD surveillance report or sending the summary to nontechnical audiences in place of the main STD surveillance report.

Some participants said it was difficult to find the information they wanted on CDC's website. For example, comments from the group discussions included, "the search engine is not great," "I wish it was cleaner and less cluttered looking," and it is "a problem for people that don't know their way around it." A few participants mentioned having to email links to people that they refer to the CDC website because people have a problem finding it by themselves. Participants suggested a range of changes related to the STD surveillance data available online, including the following:

- Enabling STD users to download summary files (i.e., not case-specific files)
- Presenting more geographic information system (GIS) data maps
- Allowing online data analysis
- Making the website more interactive so that custom tables can be created
- Modifying the STD surveillance webpage to improve ease of navigation.

6. Conclusions

The *National STD Surveillance Data Dissemination - Who wants to know what?* evaluation included a wealth of qualitative research with STD data users and quantitative analysis of CDC's STD surveillance report mailing databases. The interviews with DSTDP staff and mailing list analyses indicated CDC's main audiences for STD data, and the group discussions and interviews explored what those audiences value in the reports and what changes they would like CDC to implement. The information collected will help CDC to improve the information and services it provides and reach out to potential STD surveillance data users.

CDC provides important STD surveillance data valued by a wide range of public health professionals and professionals in associated fields. These STD data users like to both check their own STD rates and compare their jurisdiction's STD incidence rates with other jurisdictions' rates. They view the information on STD trends as the most useful aspect of the report. These users would like to see various changes in the types of data presented, the way data are presented, and the way data are disseminated. One desired change suggested by participants related to a desire for CDC to clarify what it thinks is important or requires action.⁴ This need may relate to other issues such as who should be paying attention to STD data and improving the way data are presented. Other desired changes that were frequently mentioned were the need to make STD information clearer and the need to make accessing the information more user-friendly. Including more maps and changing the positioning of text and figures should help address issues of clarity, and making the STD website more interactive should help address issues of user friendliness and data access.

There appears to be a large untapped audience for STD surveillance data. Although it is not completely clear why many potential users do not subscribe to the report, there are at least four plausible explanations other than lack of awareness: (1) People get the information they need online or from colleagues who have access to the report; (2) There is no active STD problem or program in an area and thus STDs are not an actively monitored public health issue;

⁴ Note that the participants seem to be calling for CDC to state its priorities and to issue calls to action, not for CDC to tell them what to do.

(3) The STD control program operating in an area is controlled or administered by a different level of public health (e.g., at the state level); and/or (4) Potential users do not have the skills to make use of the data available. While most of the suggested changes do not directly address these issues, it seems unlikely that implementing any of the changes would make them worse. RTI's recommendations related to dissemination and increasing the number of subscribers to the surveillance report are provided in the next section.

7. Recommendations to CDC

In developing our recommendations, RTI considered CDC's goals related to increased awareness and use of STD surveillance data for resource allocation and program planning, the need to create press releases at the local and national levels, the use of surveillance data for presentations by students and public health professionals, and the use of STD surveillance data to recruit prevention partners. We also considered the diverse nature of STD data consumers and the idea that surveillance data should spark ideas for public health action at every level of government and in both the nonprofit and for-profit sectors. For more detailed recommendations with examples of suggested changes, readers are referred to the STD Data Dissemination Recommendations report prepared for this contract.

7.1 Audience-related Recommendations

A shared vision as to who are the audiences for STD surveillance data will facilitate better communication with those audiences. As such, CDC should consider working with both field and Center-based staff to develop a consensus. CDC should also consider increasing the number of STD data users by reaching out to current user groups (i.e., local health departments, medical schools, etc. that do not currently subscribe). A temporary expansion of dissemination efforts will facilitate outreach efforts and allow CDC to build a better subscription database.

Including directions or recommendations as to where behavioral surveillance data may be obtained (e.g., NHANES, Add Health, BRFSS, or YRBSS) in the STD surveillance report, the supplements, and on CDC's main STD webpage may increase the usefulness of the report and thus expand the types of audiences interested in it. Additionally, pointing to where STD data users can get information that is useful for public health programming will likely facilitate a more comprehensive approach to control efforts where both immediate outcomes (changes in attitudes and beliefs) and longer term outcomes (changes in behavior and rates of infection) are assessed.

Because many potential users of STD data may not understand the impact of STDs, we suggest that CDC highlight their importance in terms of other diseases to ensure that readers

unfamiliar with STDs appreciate the scope of the issues involved. Common ways to highlight the importance of a disease include using morbidity and mortality data, discussion of the cost of disease, pointing out a disproportionate disease burden, and comparisons with similar others (e.g., comparing the United States with Canada).

We recommend that CDC include an executive summary in the STD surveillance report. Including an executive summary sufficient to provide key information to a wide range of audiences will facilitate both a general understanding of the importance of STDs and a more specific understanding of how well the United States is addressing the issue of STDs. None of the participants who were asked about an executive summary thought it was a bad idea. Although few report users will need to use all of the information contained in the report, almost all users will want to obtain some information. The executive summary should be presented using grade-appropriate language and meaningful comparisons that allow users to relate what they know or are familiar with to what they do not know. An executive summary that is useful for a wide range of audiences will draw attention to the importance of STDs by including the following:

- National trends in overall rates of infection and rates for racial and ethnic groups (e.g., stating current rates and whether an increase or decrease has occurred in the recent past)
- Information highlighting population groups that are currently a substantively higher than normal risk (i.e., not merely including the same special population group or age groupings every year but highlighting those that require additional STD control efforts)
- A comparison of STD rates in the United States to those of other developed countries
- States and major metropolitan areas with the highest rates and changes in rates for those areas
- CDC recommendations related to surveillance and control
- Progress and threats to progress related to any CDC STD control initiatives

7.2 *Data Analysis Recommendations*

As discussed elsewhere in this report, it was not always clear whether some participants knew the extent of the data available when making their recommendations. Several participants stressed the need to provide or highlight racial/ethnic rates and age groups at high risk. These data are presented in the report, but elements that may be desired by STD data users are missing, for example, data specific to Native Americans and specific age groups for pelvic inflammatory disease. We suggest that CDC make several analyses standard for each disease that will be reported and clearly list where these analyses might be found in the Table of Contents or in an

index. Note that the list of figures and list of tables provided in the report are not very user-friendly. In order to find figures or tables of interest, readers must search through long titles with the actual descriptions of tables' content buried 1 to 1.5 inches from the start of the text.

We suggest CDC provide additional statistics that aid understanding of differences in STD rates between states, ethnic groups, and so on (e.g., rate ratios, incremental probability, or other information in addition to providing base rates and state rankings). These comparisons should be between a special population group or state and the national average or between a given state or group and the state or group with the lowest rate, not a systematic comparison between states or between two special focus populations. These additional statistics will allow STD data users to attach more meaning to the data presented. For example, reporting that in 2004 Georgia's gonorrhea rate was 35.7 percent greater than the national average and 89.5 percent more than the Healthy People 2010 target, or knowing that in 2004 Georgia had a rate just over 24 times greater than that of Idaho, the state with the lowest gonorrhea rate, facilitates greater understanding and additional meaning to knowing that Georgia was fifth in the nation for gonorrhea with a rate of 181.7 per 100,000 persons. If it is not possible to profile every state, then the additional statistics should be provided only for states exceeding the national average.

The evaluation research participants voiced needs specific to Native Americans and data from correctional institutions. As such, we recommend that CDC include STD data on Indian Health Service populations and facilities if not included. This information should be highlighted if these data indicate differential disparities or successes. Similarly, we recommend that CDC include available STD surveillance data from corrections facilities and highlight any issues that require special attention.

7.3 *Data Interpretation Recommendations*

As advocated by the evaluation research participants, we recommend that CDC clearly identify which STD trends it perceives should be a top priority requiring STD control efforts. In a limited funding situation, CDC's voice helps to play a role in coordinating STD control efforts. While all STDs are problematic, a one-size-fits-all approach tends to be a less effective way of targeting a problem, and CDC's opinion will help coordinate efforts across the nation. Although the case and rate information is different, the current format of the STD surveillance report places equal weight on the three reportable STDs and leaves unexplored many issues underpinning those numbers, such as new trends in sexual behavior and issues of data quality. We encourage CDC to consider disease-specific trends and underlying factors and, over time, systematically address them in the various surveillance reports.

Consistent with our recommendation to clearly state what issues CDC considers to be a problem, we encourage CDC to highlight these areas through the use of graphics. For example, if CDC wishes to draw attention to persistent disparities between states, we suggest that a line graph documenting high rates of persons diagnosed with STDs be used to illustrate that certain states have chronic problems that must be addressed. A line graph will better illustrate the issue than the current list of rates and tables detailing historical rates. A second example of how CDC might use graphics to draw attention to an issue (e.g., differences in data quality or reporting requirements between states) is to include the data in a map.

We recommend that CDC provide explanatory text for each figure in the reports (e.g., Figure 5, Chlamydia Rates by Sex, is not mentioned in text in the 2004 National Profile). Clear labeling and explanation of graphics is a hallmark of quality design, and most figures in the report are indeed referenced in the text. Important events should also be labeled in many of the figures. For example, if national trends of disease incidence increased because of a new reporting requirement, that information should be labeled or noted in the figure, not hidden in text elsewhere in the report (alternatively, the data prior to the reporting requirement change would be corrected to reflect the current standard—this is consistent with the idea of using “real” or inflation-adjusted dollar to examine changes in money over time).

Where known or highly suspected, we recommend that CDC include explanatory text related to why a given trend may exist (e.g., an increase in syphilis rates largely due to an increase in MSM groups or changes in data collection due to the institution of opt-out testing for STDs in pregnant women). In the 2004 report, both the syphilis and gonorrhea sections of the National Profile contain more explanatory information than the chlamydia section. There are still many areas, however, with little or no text explaining why CDC believes a trend exists. For example, the 2004 STD surveillance report does not provide information about why rates of gonorrhea are higher for African-Americans or why overall chlamydia rates are highest in the Midwest. Explanatory text will help more novice STD data users understand why certain rates and disparities exist and provide ideas for developing control programs.

In order to facilitate better understanding of the data presented, we recommend CDC try using simpler or more commonly understood terms whenever possible, especially if an executive summary is to be added to the report (e.g., “caught,” “were infected with,” or “tested positive” rather than “contracted”; “tested positive for” or “were found to have” rather than “positivity”). If not feasible, consider including a glossary of some form in the main STD surveillance report.

7.4 Data Presentation Recommendations

In examining the data presentations, RTI noticed that several elements of good graphic design are used in the STD surveillance report. Examples of good design used by CDC include showing data variation rather than design variation (i.e., substance over style) and limiting the number of information-carrying dimensions in graphics to the number of variables in the data (i.e., avoiding three-dimensional figures to represent one or two data sets)—in other words, not using graphics such as those commonly seen in popular press newspapers and magazines that tend to emphasize issues unrelated to the data (e.g., using three-dimensional trees in a figure about the cost of lumber), which is often misleading. Another good practice often employed by CDC is minimizing the use of ink not devoted to presenting data. Elements of this design aspect can be seen in the absence of excess lines (e.g., grids) and shading (e.g., shading the area below lines or making lines into three-dimensional images) on line graphs used in the reports

We recommend that CDC duplicate key rate and trend information included in the Special Focus Profiles of the report in the disease-specific sections. By duplicating key information, CDC will reduce the number of STD users who think that CDC does not conduct certain analyses (e.g., age and racial breakdowns) and, perhaps more important, reduce the number of STD data users who feel they have to hunt for the information they need. Where it is not possible to duplicate all information, we suggest that CDC clearly indicate in the main report sections where additional information might be found (e.g., “Data on syphilis in men who have sex with men (MSM) is available on page 71 of the Special Focus Profiles section of this report”).

Several participants stated that the list of selected cites presented in the report was, in their opinion, misleading. We encourage CDC to present data only on large metropolitan areas, not selected cities, and to clearly label the geographical area that encompasses the data. Ideally the data presented will match up properly with official MSAs, zip codes, and other standard means of dividing a geographical area.

We recommend that CDC include more maps that show current rates and recent trends. National maps should allow for easy comparison between states, and any state maps should help readers compare regions within the state. Policymakers in particular felt that maps were useful ways to quickly understand the issues presented.

In order to facilitate better understanding of current rates of STDs and make figures presented in the report more useful, we recommend that CDC label any line graphs presented with the current rates or include bar charts showing rate data for the current year in a subsequent

figure. An example of a bar chart following a line graph can be seen in the 2004 National Profile. Gonorrhea—Figure 16 is a bar chart that expands upon the 2004 data presented in Figure 14 (page 24). In the current format of the report, labeling the current year will keep readers from having to refer back to text on other pages or to a table at the end of the report to understand the information presented.

The participants were asked how they felt about enlarging graphs to better separate lines in the figures. The vast majority of participants said either (a) to not exclude any groups if using an enlarged or embedded graph or (b) to not have embedded graphs. In relation to the example provided, the participants felt CDC should include all races when looking at data by race/ethnicity, even if one looks inflated. Including all groups, perhaps with an explanation for trends that look more extreme than if presented at a different scale, will eliminate the confusion that participants thought would occur if groups were suddenly excluded from specific figures.

We recommend CDC include information about Healthy People goals in figures and tables whenever possible. Including Healthy People goals, when applicable, provides STD data users with both an understanding of what their goal should be and additional support in advocating for resources or specific policies.

In order to facilitate better online use of the STD surveillance data, we suggest that CDC explore ways that STD data users can rapidly get specific data they might want. For example, the 2002 chlamydia supplement page (<http://www.cdc.gov/std/chlamydia2002/default.htm>) allows browsers to access state-specific information through the use of pull-down menus. Similar mechanisms can be used to facilitate other information retrieval. An online index or search engine specific to the report could be incorporated to facilitate data retrieval from the main STD surveillance report.

One possible way of increasing the ease of obtaining relevant data via the website is through the use of interactive maps. Online STD data users could select what STD surveillance data they would like through interactive online maps or pull-down menus. The use of interactive maps addresses both participants' calls for more interactive ways to display STD data and calls for more maps. A second example of how these suggested changes may be addressed together is through the use of static online maps that show current rates and provide a hyperlink to a table containing both national and state-specific information about cases and rates.

Several of the evaluation research participants stated a desire to have dynamic ways of manipulating data on the website so that they can more easily make comparisons and/or create

custom tables. Although it is not clear what specific analyses STD data users may wish to conduct, providing a means to conduct simple comparisons will allow users to gather desired information in a faster manner than copying data out of a table.

The participants also said they wanted to be able to download STD data (i.e., summary files, not case-specific files) from the CDC website. We echo this suggested change and recommend that CDC provide a means to download summary data files. If the data can be masked in some fashion, we suggest CDC allow county-specific data to be downloaded.

7.5 *Data Dissemination Recommendations*

There was almost unanimous consensus that CDC should provide both a paper report and an online report. Only one person advocated elimination of the paper report. We suggest that CDC maintain both versions of the report but also implement measures to ensure that hardcopy versions of the report are not wasted. Although there is no comprehensive way to ensure that reports are used, cleaning and standardizing the mailing list databases will help ensure that the reports are only given to those who want them. CDC may wish to eliminate the current databases in favor of one created from subscription cards after the mailings proposed in other recommendations. Even with a new database, however, there will be a need to periodically review the information contained within it. We recommend that CDC implement a review or resubscription process to reduce errors in the subscription database(s) on a regular basis, possibly every 2 or 4 years. We also recommend that CDC allow people to subscribe to the report online rather than maintaining the current practice of limiting online requests to a one-time dissemination of the document.

To reach out to other potential users, we suggest that CDC conduct a one-time, expanded dissemination effort for the 2005 or 2006 STD surveillance report as a form of outreach and a means of revising the subscription database:

- Every health department in the United States and its territories
- All STD partner organizations
- All medical school libraries and all libraries at institutions with a public health program
- All members of the Senate and House of Representatives
- All governors and the mayors of the selected cities represented in the surveillance report
- The directors of all Department of Health and Human Services (HHS) centers, agencies, and institutes

- Non-HHS federal agencies that have health-care-related concerns such as the Federal Bureau of Prisons, Department of Veterans Affairs, and Department of Education
- All current subscribers to the report

With all expanded dissemination mailings, we recommend that CDC include a letter referring interested parties to the CDC website to download the supplements and access other information. The letter should also clearly describe the supplements so those who might not be aware of them (e.g., there were no CDC subscribers to GISP) will understand the general purpose and content of each supplement.

Several evaluation research participants said that the CDC website could be improved. We suggest that CDC simplify the main STD surveillance and statistics webpage (http://www.cdc.gov/nchstp/dstd/Stats_Trends/Stats_and_Trends.htm). The following suggestions are likely to assist STD website users:

- Simplify the page so that users do not need to scroll down to see the entire content of the main STD surveillance and statistics webpage. Web pages that require users to scroll down to obtain complete information are typically more difficult to use/understand than those that do not.
- Remove links that can be accessed from subsequent pages (i.e., the subheadings/links, especially the “Trends” links, beneath the main link to each of the annual reports). While having a lot of information available all at once might seem desirable, it may lead to confusion when the link is encountered elsewhere. The extra links may also tend to clutter the webpage, thus requiring users to scroll or making it more difficult for them to find desired information.
- Investigate whether moving the navigation menu to the left would improve website perceptions. Although several prominent browsers locate their menus on the left (e.g., <http://www.msn.com/>), there are no set rules for locating a navigation menu. CDC’s main website (<http://www.cdc.gov/>), however, has a left-side navigation menu.
- Format the main page for each of the annual reports such that all texts/links can be viewed without having to scroll down the page (e.g., the format for the 2002 report’s main page is preferable to the format for 2003).
- Make the format of each of the main pages for the annual reports identical (at least four different formats are currently used). Making the format consistent will enable STD data users to more easily access desired information in the reports.

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Appendices

APPENDIX A MAILING KEYS

Several mailing keys (i.e., lists of subscribers to the hardcopy reports) were provided by CDC. As can be seen in Exhibit A1, the chlamydia supplement and syphilis supplement are being sent to the same people. The GISP mailing keys listed in the table include various project personnel at each of the 30 STD clinics and regional laboratories that participate in GISP. These personnel may include the clinic contact (often a data entry staff member), the medical director for the clinic, the clinic manager, a laboratory contact, the laboratory director, the principal investigator (located at one of the five regional laboratories), and/or a state contact (located at the state health department).

Exhibit A1 CDC Mailing Keys Used for the Audience Analysis, 2004

Mailing Key	Description	Number of Addresses ^a	Report(s) Sent ^b
STDDIR	State, territorial, and selected metro STD prevention program project directors	66	GISP
STDMGR	State, territorial, and selected metro STD prevention program managers	67	All 3 supplements
T6	State, territorial, and selected metro STD public health advisors	202	STD surveillance report
V3	Mixed list of individuals who receive STD surveillance report	1,958	STD surveillance report
WW	DSTDP-funded STD/HIV prevention training center coordinators	18	GISP
Z2	State and territorial health department directors	58	All 3 supplements
ZW	State and territorial epidemiologists	58	All 3 supplements
ZX	State, territorial, and selected metro public health laboratory directors	56	STD surveillance report and all supplements

^a Duplicates and wrong addresses not removed.

^b All 3 supplements indicates that the syphilis, chlamydia, and GISP supplements are sent using this mailing key, but not the main surveillance report.

**APPENDIX B
PARTNER ORGANIZATIONS SUBSCRIBING TO THE
STD SURVEILLANCE REPORT**

In preparing Appendix B, Partner Organizations Subscribing to the STD Surveillance Report, we compared the mailing addresses of the STD partners listed on the CDC website (<http://www.cdc.gov/nchstp/dstd/aboutdiv.htm#partnership> and <http://www.cdc.gov/nchstp/dstd/PartnersList.htm>) to the supplement and report mailing lists. If addresses matched, we considered the addressee a partner. Ten partner organizations subscribe to the main STD surveillance report (17.2 percent), four subscribe to both the chlamydia and syphilis supplements (6.9 percent), and two subscribe to the GISP supplement (3.4 percent).

As address information and names were not included in the lists containing online or conference report requests, Table B1 does not include information about partner organizations who may have requested information online. Partners may also have viewed the reports on the CDC website, so Table B1 is a conservative estimate of partner organization exposure to the STD surveillance report and its supplements.

Exhibit B1 Partner Organizations Subscribing to the STD Surveillance Report and Surveillance Supplements

STD Partner Organizations	STD Surveillance Report	GISP Supplement	Chlamydia Supplement	Syphilis Supplement
Academy for Educational Development				
Advocates for Youth				
Alan Guttmacher Institute				
Alliance for Microbicide Development				
American Academy of Family Physicians				
American Academy of Pediatrics				
American Association of Health Plans				
American College of Obstetricians and Gynecologists	X			
American Medical Association	X			
American Medical Women’s Association				
American Pharmacists Association				
American Public Health Association				
American Social Health Association	X			
Association of Reproductive Health Professionals	X			
Association of State and Territorial Health Officials				
Association of Women’s Health, Obstetric, & Neonatal Nurses				
Centers for Disease Control and Prevention (nonDSTDP)	X		X	X
Chauncey H. Robinson Youth Foundation, Inc.				
Congress of National Black Churches, Inc. (CNBC)				

(continued)

Exhibit B1 Partner Organizations Subscribing to the STD Surveillance Report and Surveillance Supplements (continued)

STD Partner Organizations	STD Surveillance Report	GISP Supplement	Chlamydia Supplement	Syphilis Supplement
Department of Defense				
Girls Incorporated				
Global Campaign for Microbicides and Prevention Options for Women				
Health Resources and Services Administration				
U.S. Department of Health and Human Services				
Indian Health Service	X	X	X	X
National Advocacy Coalition on Youth and Sexual Orientation				
National Alliance of State & Territorial AIDS Directors				
National Alliance for Hispanic Health	X			
National Asian Women's Health Organization				
National Association for the Advancement of Colored People				
National Association of Community Health Centers				
National Association of County and City Health Officials				
National Association of Nurse Practitioners in Women's Health (NPWH)				
National Association of People with AIDS				
National Black Caucus of State Legislators				
National Coalition of STD Directors				
National Conference of State Legislatures			X	X
National Council of Churches				
National Council of La Raza				
National Education Association-Health Information Network				
National Family Planning and Reproductive Health Association				
National Lesbian & Gay Health Association				
National Medical Association				
National Network for Youth				
National Network of STD/HIV Prevention Training Centers	X	X	X	X
National Urban League, Inc.				
National Women's Health Network				
North American Society for Pediatric and Adolescent Gynecology				
Office of Population Affairs	X			
Planned Parenthood Federation of America				
Sexuality Information and Education Council of the U.S.				
Society for Adolescent Medicine				
Society for the Advancement of Women's Health Research				
Substance Abuse and Mental Health Services Administration	X			
United States Conference of Mayors				
YMCA of the U.S.A.				
YWCA of the U.S.A.				