Information Collection Request
Supporting Statement
Part A

National HIV Behavioral Surveillance System

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A. Justification

1. Circumstances Making the Collection of Information Necessary

Historically, surveillance to describe the HIV/AIDS epidemic in the United States has primarily involved case surveillance for HIV infection and AIDS, although some supplemental surveillance systems and surveys have been used to provide additional information about behaviors related to HIV infection. Because many years may pass between the time when a person is infected with HIV and the time that HIV infection is diagnosed, case surveillance for HIV infection and AIDS does not reflect recent trends in the behaviors that fuel the epidemic. Therefore, surveillance of HIV-related behaviors is an important component of an integrated surveillance system.

The need for development of a national behavioral surveillance system for persons at risk for HIV infection was articulated in CDC's HIV Prevention Strategic Plan. A surveillance system to provide ongoing, systematic collection of data on behaviors related to HIV acquisition addresses the goal of strengthening the capacity nationwide to monitor the epidemic to better direct and evaluate prevention efforts.

The limitations of previous, locally-driven studies and the need to meet the goals of the HIV Prevention Strategic Plan influenced the proposal to develop the National HIV Behavioral Surveillance System (NHBS). Through NHBS, CDC will work with state and local health departments to obtain HIV-related behavioral data from three groups at highest risk for infection: men who have sex with men, injecting drug users, and heterosexuals in high-prevalence areas.

CDC'S HIV/AIDS surveillance system is the nation's source for timely information used to track the epidemic. CDC funds and assists state and local health departments to collect the information. Health departments report their data to CDC so that information from around the country can be analyzed to determine who is being affected and why. The ultimate surveillance goal is a nationwide system that combines information on AIDS cases, new HIV infections, and behaviors and characteristics of people at high risk. By meeting this goal, CDC can track the epidemic and direct HIV prevention funding to where it is needed the most. Developing a specific behavioral surveillance component, targeting populations at highest risk for infection, is consistent with the goals of HIV/AIDS surveillance.

Collection of HIV and AIDS case surveillance data is regulated by Title III – General Powers and Duties of Public Health Service, Section 301 (241.)a. Research and investigations generally (Attachment 1).

2. Purpose and Use of Information Collection

The primary objective of NHBS is to conduct behavioral surveillance among persons at high risk for HIV infection in the United States in order to assess prevalence of and trends in: 1) risk behaviors for HIV infection, 2) HIV testing behaviors, 3) HIV seroprevalence and incidence, and 4) exposure to, use of, and impact of HIV prevention services. The focus of NHBS is on behaviors directly related to transmission and those that are amenable to intervention through prevention programs. The explicit ability to identify gaps in HIV prevention services is a unique aspect of NHBS.

At the national level, NHBS data will be useful for tracking national trends in risk behaviors, HIV testing, and prevention service access and utilization for focusing and prioritizing national initiatives to improve the provision of prevention services, and for evaluating progress towards national prevention initiatives. A large and geographically diverse sample that will be obtained through NHBS provides an important data source for evaluating progress towards national public health goals, such as the following Healthy

People 2010 goals: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men (13.2); Reduce the number of new AIDS cases among females and males who inject drugs (13.3); Increase the proportion of sexually active persons who use condoms (13.6); and Increase the number of seropositive persons who know their serostatus (13.7). Data will also be used at the national level to assess progress in performance goals of CDC's National Center for HIV, STD, and TB Prevention (NCHSTP) to: Increase the proportion of people who consistently engage in behaviors that reduce risk of HIV transmission or acquisition (which specifically includes MSM, IDU, and at-risk, sexually active women and heterosexual men); Develop an integrated monitoring system to measure incidence of new infections, track the prevalence of disease, monitor behaviors that increase the risk of HIV infection (for those who are HIV-uninfected); Provide locally relevant data for community planning. NHBS also addresses Goal 5 of the Government Performance and Results Act (GPRA): Strengthen the capacity nationwide to monitor the HIV/AIDS epidemic; develop and implement effective HIV prevention interventions; and evaluate prevention programs.

National data from NHBS will be useful for documenting the need for prevention resources and the reach of prevention programs targeting persons at highest risk. Data on changing patterns of utilization of prevention resources will be critical to determining resource requirements for future funding cycles for prevention programs. Data from NHBS will be used to answer national questions about prevention service reach, gaps, and impact of allocated resources.

National data will also be relevant to evaluate prevention initiatives for persons at risk for HIV, as envisioned in CDC's HIV Prevention Strategic Plan goals for reducing the number of people at risk for transmitting HIV infection. Data on key indicators of behavioral risks for acquiring HIV infection as well as seroprevalence will be available from multiple areas with high AIDS prevalence, and can be used to determine progress towards national goals for HIV prevention and identify populations in need of additional research, improved interventions, or additional funds to support prevention programs.

At the local level, the NHBS data will be useful for local HIV prevention program planning purposes, including the development of local epidemiologic profiles and responding to data requests. NHBS will provide information on the characteristics of persons receiving HIV prevention services and the types of services they are accessing, and will identify needs for prevention services. Information about access to and use of these services can be used in the evaluation of local prevention services for people at risk for HIV. CDC provides training in data analysis and shares programs to promote local analysis and dissemination of NHBS data.

Without NHBS data, the best sources of behavioral data would come from case surveillance, which only collects a limited amount of information, or from small-scale, periodic or ad hoc behavioral surveys. These studies are not likely to have the large sample size, geographic diversity, or simultaneous collection of specimens for HIV testing. Not having NHBS data would adversely affect the ability to monitor the HIV/AIDS epidemic both locally and nationally.

The overall strategy for NHBS involves conducting rotating annual cycles of surveillance in three different populations at high risk for HIV: men who have sex with men (MSM), injection drug users (IDU) and heterosexuals in high prevalence areas (HET). Surveillance activities for NHBS include eligibility screening, the survey, and HIV testing. Each cycle will use a different sampling method to recruit participants for the survey and HIV testing, based on what is known about reaching the specific population. The MSM cycle uses time space sampling, which is venue-based. Respondent driven sampling (RDS) is used for the IDU cycle and the HET cycle; this is a type of chain referral sampling. These methods and the definition of heterosexuals in high prevalence areas are explained in more detail in Section B.

NHBS will collect data through face-to-face interviews. A short screening survey to assess various eligibility criteria and limited demographics will be administered to those intercepted by field staff or recruited by peers for participation in NHBS (Attachment 2). The data collected from the interview will include self-reported demographics, sex and substance use behaviors, HIV testing patterns, and exposure to and use of HIV prevention services (Attachment 2). NHBS grantees may choose the HIV testing method most suitable for their local situation (standard or rapid tests); depending on laboratory needs, oral fluid specimens or blood specimens from fingerstick or venipuncture are collected for the purpose of HIV testing.

3. Use of Improved Information Technology and Burden Reduction

Interview data will be collected electronically to minimize burden to respondents and interviewers. The eligibility screener and the standardized interview instrument (Attachment 2) will be provided by CDC in a Handheld-Assisted Personal Interview computer format, i.e., an electronic handheld device. The interview instrument will be developed using Questionnaire Development System (QDS) software (NOVA Research Company, Bethesda, Maryland). All interviews will be conducted by trained state/local NHBS staff.

Data linking recruiters and recruits for the IDU and HET cycles using RDS will be entered directly into a computer program, called "Coupon Manager." By entering data directly into the computer, the efficiency of data collection is improved as compared to using paper and then entering the data. The Coupon Manager program also reduces the time and effort to validate coupons and tracks payments of incentives. During a participant's visits to the field site, data can be called up efficiently through use of search terms, such as by coupon number. With logic checks and range values programmed in, the quality of the data is improved. Data from Coupon Manager linking recruiters and recruits is also used in analysis and weighting to produce adjusted estimates.

For the MSM cycle, a computer program will be used for 2-stage random sampling of venues and day-time periods within venues (described more fully in Section B); this program is called the VDT program, for "venue-day-time." The computer program will ensure that selections are made randomly. This program also records the selections that were made, and can generate a monthly calendar of recruitment events. The information generated from this program is then used to weight the data for probability of selection.

An evaluation of supplemental surveillance data using handheld interview devices such as the ones being used for NHBS has shown the following: a reduction in the duration of the interview by up to 20%; a decrease in the average number of interviewer errors per interview such as skip patterns, out of range answers and missing data from an average of 2.5 per interview to 0.3 per interview; and the elimination of the need for data cleaning associated with data entry and the errors listed above, resulting in a reduction in the time between the last interview and the production of a final analysis dataset from approximately 6 months to only 1 month. Also, the cost of data collection using handheld devices instead of paper data collection forms is also reduced despite the increased startup costs associated with purchasing the handheld devices and interview software. The incremental cost of each collected survey decreases with each subsequent interview conducted, so that when collecting more than 195 interviews, it is less expensive to use the handheld devices than paper.

CDC/DHAP has implemented the use of handheld devices for other national surveillance systems. Many of the state and local health departments are licensed to use the software and have extensive experience with implementing interview projects using electronic data collection in the field.

CDC will conduct training and site visits to provide instructions and technical assistance on how to use the CDC-provided software, conduct the interviews, archive the collected data, and transfer the data. CDC will also provide training with detailed instructions on methods for conducting the interviews to participating state and local health departments. CDC will regularly train the interviewers and convene lessons learned meetings to understand the problems that can occur with the software and hardware that is used for conducting the interviews. Automated edit checks will be built into the computer software programs as a further quality control measure. Provision of electronic data collection software, training and technical assistance will help to reduce the burden on grantees conducting NHBS.

Computer-assisted personal interviewing reduces burden for the respondent because it collects the data using a computer and a skilled interviewer. The computer customizes the question wording for each respondent. The interviewer's role can focus on explaining complex terms or definitions, to give instructions, to ensure that answers are relevant and entered accurately, and to maintain the respondent's privacy.

CDC is investigating several software products which will enhance the security of data stored on electronic devices. It is anticipated that licenses for this software will be provided to project areas by CDC prior to the start of data collection for the 2008 NHBS cycle. The NHBS data files must be transferred, or uploaded, from the electronic devices to the project area's secure storage drive on a frequent basis. All NHBS data files must be transmitted to CDC using the Secure Data Network (SDN).

4. Efforts to Identify Duplication and Use of Similar Information

There are currently no rigorously and systematically collected locally or nationally representative data on behaviors of these 3 groups of people at risk for HIV infection (MSM, IDU, HET).

Within CDC, data elements from two HIV supplemental surveillance projects and other studies were reviewed and incorporated into NHBS:

- Supplement to HIV/AIDS Surveillance Project (SHAS) (OMB 0920-0262) exp. 06/30/2004
- Medical Monitoring Project (MMP) (under OMB review)

CDC discontinued the SHAS project in anticipation of MMP and to avoid duplication of data collection efforts. MMP will collect data on a population-based sample of HIV-infected patients in care, not specific populations at increased risk for HIV.

CDC has already established relationships with other federal stakeholders and consultants during the conception and development of NHBS. Beginning in December 2001, consultations have been held with state and local health department, the National Institutes of Health (NIH), and other agencies. To promote collection of data that can be used by multiple agencies, ongoing communications with these federal and non-governmental partners will continue for the duration of this project. Meetings with these federal stakeholders and consultants who are aware of data collection on persons at risk for HIV infection ensured that duplicate or similar data collection efforts do not exist. Other surveys may have obtained data related to topics covered in NHBS, but most were more limited in the questions they ask, the populations they represent, the geographic areas covered, or all of these factors.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this study.

6. Consequences of Collecting the Information Less Frequently

NHBS data collection activities will occur during each calendar year from 2008-2010; as a surveillance system, it is expected that NHBS will continue beyond this initial funding period. The overall strategy for NHBS involves conducting rotating 12-month cycles of data collection among the three populations in the selected MSAs. In order to follow trends over time, the same 3 populations will be surveyed repeatedly in the same MSAs. Thus, surveillance data will be collected in the same population every three years. Survey operations will run for approximately 8-9 months during each calendar year, with an additional 3-4 months to plan for and wrap up each cycle (Attachment 3). Data collected for fewer than 8 months may result in grantee agencies not meeting their sample size goals.

Participants interviewed during an NHBS cycle are only eligible to participate once during that cycle. Each person approached will be asked if they have been interviewed for the project during the surveillance cycle; those who indicate that they have been interviewed already will not be interviewed again. It is possible that a person could be recruited for participation in NHBS in more than one cycle, as some may engage in multiple risk behaviors.

Data for prevention and resource planning need to be conducted on an annual basis to meet reporting requirements of CDC and local planning groups. Data from each of the three population groups are not needed annually; data collection for each group every 3 years is sufficient to be able to track trends over time. Collecting data less than every 3 years per population group would not be advantageous, nor would it meet the needs of the grantees collecting the data and planning groups that rely on the data for resource allocation. The Healthy People 2010 Objectives require that the data be available at least 3 times per decade; data collection every 3 years per group meets this requirement.

There are no legal obstacles to reduce the burden.

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

This request fully complies with the guidelines of 5 CFR 1320.5.

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

8A. A 60-day notice to solicit public comments was published in the *Federal Register* on January 19, 2007 (Volume 72, Number 12, pages 2529-2530). See Attachment 4 for a copy of the *Federal Register* notice. Two comments were received; a response was sent for one (Attachment 5).

8B. Several consultations were conducted with various scientists and public health practitioners outside the agency. All names, affiliations, and contact information is included in Attachment 6.

A consultation on issues related to sampling hidden populations at high risk for acquiring HIV infection was held in December 2001. Key participants included Dr. Cornelis Rietmeijer, Dr. Mary Ann Chiasson, Ms. Miguelina Leon, Dr. Harry Haverkos, Dr. Michael Ross, Dr. John Peterson.

A technical consultation on sampling methods to reach injecting drug users was held in December 2002. Key participants included: Drs. Douglas Heckathorn, Ricky Bluthenthal, Alex Kral, Sam Friedman, Don Des Jarlais, Merrill Singer, and Tobi Saidel. A follow up consultation was held in October 2004, which

included Dr. Heckathorn and numerous representatives from city and state health departments and community based organizations.

From February through April 2004 a series of consultation meetings were held via internet to solicit input on the definition of "heterosexuals at risk" and methods for sampling this group. Key participants included: Drs. Ada Adimora, Pamina Gorbach, Elisa Sobo, Judith Porter, Sharon Weir, Sheana Bull, Yasmina Katsulis; Ms. Lisa Bond, and Ms. Eve Mokotoff. These internet-based consultations were followed by an in-person meeting in October 2005 to further discuss sampling methods for heterosexuals at risk. Key participants in this consultation included Dr. Stephen Thompson (provided consultation prior to the meeting but could not attend), Dr. Brian Burke, and numerous representatives from city and state health departments and community based organizations.

9. Explanation of any Payment or Gift to Respondents

Incentives will be used in NHBS as the project seeks to conduct surveys with hard-to-reach and highly selective populations and ask them highly sensitive questions about issues such as sexual behavior and substance use (Kulka, 1995). Because the interview will take approximately 30-45 minutes to complete, to increase response rates patients will be offered an incentive to participate. With increased response rates, the reliability of the data will be improved as the samples will be more representative of the underlying populations of interest.

Participants will be given approximately $25 in cash for participation in the interview. If local regulations prohibit cash incentives, equivalent incentives may be offered in the form of gift certificates, cash cards, or bus or subway tokens. Participants who agree to HIV testing will be offered an additional incentive. Participants who give a specimen for HIV testing will be given approximately $25 in cash for participation. As with the survey incentives, if local regulations prohibit cash incentives, equivalent incentives may be offered in the form of gift certificates or cash cards.

A dual-incentive system is a standard part of the RDS methodology in which participants receive an incentive for completing the surveillance activities and for recruiting their peers. To increase peer recruitment, for cycles in which RDS is used (IDU and HET) additional incentives will be provided to those who recruit an eligible participant who completes the survey (the "recruiter reward"). Recruiter rewards will be approximately $10 for up to three peer referrals, which is standard for RDS studies (Heckathorn, Semaan, et al., 2002; Ramirez-Valles, 2005; Wang, 2004). As with the survey and testing incentives, if local regulations prohibit cash incentives, equivalent incentives may be offered in the form of gift certificates or cash cards.

The need for and amount of incentives is based, in part, on the fact that other, similar research projects that ask HIV risk behavior questions of the 3 NHBS populations in the participating areas offer similar incentives. Thus, NHBS would be competing with local researchers who do offer incentives; without incentives, it is likely that participation in NHBS would be low (McKnight, 2006; Stueve, 2001; Valleroy, 2000). Incentives were used in the SHAS project (OMB 0920-0262, exp. 06/30/2004, described in #4 above), which asks questions similar to those in NHBS and has a similar length of time for completing the survey. These incentives were used to help increase participation rates; participants were offered approximately $25 as compensation for their time.

10. Assurance of Confidentiality Provided to Respondents

This submission has been reviewed for Privacy Act applicability and it has been determined that the

Privacy Act does not apply. Data collected will become part of grantees' pre-existing records systems. NHBS is anonymous, in that name or social security number are not collected. Full date of birth is collected for the purpose of identifying potential duplicate records or participants who have done the survey more than once per cycle. Records that have the exact same date of birth will be compared on date of survey and other demographic information such as race, education, and zip code; determinations of whether a record is a duplicate or a participant has taken the survey more than once per cycle will be made based on how closely this information matches. Data collected through NHBS, both locally and at CDC, are stored and accessed by a survey identification number. Other data collected through NHBS, while sensitive, are not personally identifying; these survey questions are described in Section 11.

In addition to limiting the amount of personally identifying information collected, NHBS is covered by an Assurance of Confidentiality for HIV/AIDS surveillance data (Attachment 7). The Assurance provides the highest level of legal confidentiality protections to the individual persons who are the subject of this data collection, and to the individuals and organizations responsible for data collection. The terms of the Assurance of Confidentiality reflect the collective experience of CDC, health departments, and the Council of State and Territorial Epidemiologists with respect to the collection, electronic transmission, and dissemination of HIV/AIDS surveillance data. The Assurance includes established policies and procedures governing all aspects of data collection and de-identification, physical security for paper forms and records, electronic data storage and transmission, and the release of aggregate data in forms that cannot be linked back to individual respondents. The protections afforded by the Assurance of Confidentiality last forever, and endure even after the respondent's death.

The Assurance of Confidentiality is enforced with appropriate training and contractual agreements which clarify the responsibilities of all participants in HIV/AIDS surveillance activities who have access to directly identifiable data or to data that are potentially identifiable through indirect means. State and local health department personnel who conduct HIV/AIDS surveillance are subject to the confidentiality obligations described in the CDC guidelines for the security and confidentiality of HIV/AIDS Reporting System (HARS) data (http://www.cdc.gov/hiv/topics/surveillance/index.htm) and are required to undergo security and confidentiality training. NHBS interviewers and data managers will undergo the same security and confidentiality training as required for health department staff. CDC's Procurement and Grants Office will require the inclusion of 308(d) clauses in any HIV/AIDS support services work done by contractors (e.g., data analysis, computer programming, LAN support). All CDC permanent employees and their contractors will be required to attend annual confidentiality training, to sign a Nondisclosure Agreement and to update their confidentiality agreements on an annual basis. Contractors must sign a "Contractor's Pledge of Confidentiality." Access to HIV/AIDS surveillance data maintained at CDC is restricted to authorized personnel who have signed the "Agreement to Abide by Restrictions on Release of Data." CDC-funded cooperative agreements to state and local health departments reference the Assurance of Confidentiality as a condition of award. Any NHBS data maintained at CDC that is released to persons other than study staff would not include full date of birth.

NHBS data will be transmitted to CDC using the internet-based system that is used to transmit HIV/AIDS surveillance data to CDC. This system is referred to as the Secure Data Network (SDN). Databases submitted through the SDN must be encrypted before being sent to CDC. Encryption security for all NHBS data must meet the current National Institute of Standards and Technology (NIST) Federal Information Processing Standards (FIPS), which meet or exceed Advanced Encryption Standards (AES). See the document "Technical Guidance for HIV/AIDS surveillance Programs, Volume III: Security and Confidentiality Guidelines" for further information (www.cdc.gov/hiv/surveillance.htm).

A number of required protections ensure the security of the data on the handheld computers. The handheld computers are solely used for NHBS data collection activities. NHBS data are encrypted when stored on a handheld device. Handheld computers are protected by using a coded password only known

by authorized NHBS project staff. NHBS data are deleted from the handheld computers after the last interview of the day by uploading the collected interviews to the main database. The handheld computers must be kept with the staff at all times when in the field; the computers are collected and secured by the field supervisor after the last interview each day. When not in use in the field, the handheld computers are to be locked in a drawer or office.

This project was submitted to the CDC IRB for expedited review and approval. The informed consent process for respondents may be fulfilled by obtaining oral consent from the respondent. All sites must obtain consent from respondents and document it in the data collection form on the handheld computer. An example consent document is included as Attachment 8. Consent must be obtained for the survey and HIV testing separately. Participants may elect to do the survey and not be tested; however, they may not be tested without completing the survey (those persons who only want an HIV test may be given information on where to seek an HIV test elsewhere). In conducting the proposed NHBS surveillance activities, respondents will be informed that their data will be kept private and secure and that the data will be reported in aggregate format. All interviews will be conducted by trained NHBS staff in a private location where the questions and responses cannot be overheard by others.

11. Justification for Sensitive Questions

HIV can be transmitted from person to person through sexual contact and the sharing of HIV-contaminated needles and syringes. These modes of transmission necessitate the collection of sensitive data regarding sexual practices and drug use. Other sensitive data are collected because the specific behaviors, experiences or conditions have been shown to be associated with HIV infection. For NHBS, this includes the collection of information about medical information related to HIV status, STD diagnosis and testing, Hepatitis diagnosis and vaccinations; history of incarceration in the past 12 months; alcohol use, and income. Geographic information such as zip code and, for the HET cycle only, census tract, is collected for the purposes of spatial analysis of the data to understand the geographic distribution of disease and risk, and to assess the definition of HET.

Although the information requested from participants is highly sensitive, the purposes of NHBS cannot be accomplished without their collection. Collection of these data will be used to understand barriers to engaging in protective behaviors and to using HIV prevention services. These data will also be used to enhance HIV prevention programs designed to reduce high risk behaviors in persons most likely to acquire or transmit HIV. Justifications for NHBS questions and their sources are in Attachment 9.

The context in which questions are asked help to overcome their potential sensitivity. There are several steps taken in NHBS to minimize sensitivity and reiterate to the respondent the legitimate need for the information:

- Nearly all questions allow for responses of “don’t know” or “refuse to answer.”
- Consent scripts make it clear that the survey is sponsored by CDC and the local health department and that the information will be put to important uses.
- Toll-free phone numbers are provided if the respondent has questions about the survey.
- The questionnaire is carefully organized to lead smoothly from one topic to another. Transitions are made clear to respondents and the need for the information explained. Assurances about the privacy and confidentiality of the data are reiterated.
- The use of handheld computers for data collection addresses concerns about privacy the respondent might have (that others can see their answers).
- The payment of an incentive indicates clearly to the respondent that the information is important to the survey sponsors.

12. Estimates of Annualized Burden Hours and Costs

The goal is to interview 12,500 persons per year. In order to achieve this goal, an additional 1250 – 5000 persons must be screened for eligibility, depending on the cycle. The screener takes 5 minutes to complete. Each interview will take approximately 30-55 minutes. The IDU and HET cycles have a slightly longer survey length due to the need to collect information about the peer recruitment. The IDU cycle is estimated to take longer, on average, as all respondents are expected to respond to questions on sexual behavior and drug use, whereas in the MSM and HET cycles fewer respondents are expected to answer as many questions regarding drug use. HIV testing, as a clinical procedure, is not included in the burden estimates.

Table A-12-1: Estimate of Annualized Burden Hours

Respondents	Number of Respondents	Number of Responses per Respondent	Average burden per Response (in hours)	Total burden (in hours)
NHBS-MSM				
Screener	17,500	1	5/60	1,458
Survey	12,500	1	30/60	6,250
NHBS-IDU				
Screener	13,750	1	5/60	1,146
Survey	12,500	1	55/60	11,458
NHBS-HET				
Screener	13,750	1	5/60	1,146
Survey	12,500	1	40/60	8,333
TOTAL				29,791
TOTAL ANNUALIZED BURDEN				**9,930**

Table A-12-2: Annualized Cost to Respondents

Note: The hourly rate was determined by using information obtained from the US Department of Labor, Bureau of Labor Statistics.

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Total Burden Hours	Hourly wage rate	Total Respondent Cost
Screened, MSM	17,500	1	1458	$16.34	$23,824
Interviewed, MSM	12,500	1	6250	$16.34	$102,125
Screened, IDU	13,750	1	1146	$16.34	$18,726
Interviewed, IDU	12,500	1	11,458	$16.34	$187,224
Screened, HET	13,750	1	1146	$16.34	$18,726

Interviewed, HET	12,500	1	8333	$16.34	$136,161
Total					$486,786
Total Annualized Cost					$162,262

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

There are no other costs to respondents associated with this proposed collection of information.

14. Annualized Cost to the Government

Government Related Expenses	**Year 1 (NHBS-MSM)**	**Year 2 (NHBS-IDU)**	**Year 3 (NHBS-HET)**	**Average Annual Cost**
Personnel	$141,176	$141,176	$141,176	$141,176
Incentives to participants	$625,000	$812,500	$812,500	$750,000
Travel	$30,000	$30,000	$30,000	$30,000
Meetings	$2,000	$30,000	$30,000	$30,000
Printing	$2,000	$2,000	$2,000	$2,000
Cooperative agreements	$9,875,000	$9,875,000	$9,875,000	$9,875,000

The personnel related to this data collection include project officers at the GS 14, 13, and 12 levels, a GS 12 level public health analyst, 2 project coordinators, and 2 data managers. Approximately 15% of related personnel's time will be allocated to activities related to data collection. Incentives of $25 will be offered to each respondent for the survey and for HIV testing ($50 per participant); across the 25 participating cities, this is a total cost of $625,000. The cost for recruiter rewards for the IDU and HET cycles is an additional $30; however, not all participants recruit their peers so the costs for incentives were calculated based on half the participants receiving recruiter rewards which totals to $812,500. Travel is related to providing technical assistance and conducting site visits. Examples of meetings that will be held include interviewer training and the local principal investigators' meeting. NHBS will be funded through cooperative agreements with 25 cities; the average amount per cooperative agreement is $395,000. The cooperative agreement amount includes salaries, travel, equipment, and supplies; it does not include incentives, which were calculated separately.

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Attachment 3 provides an overview of NHBS activities for each cycle across the 3-year funding period. The following is a brief overview of the NHBS Timeline for the first year (MSM Cycle); other cycles are expected to follow a similar time schedule in the subsequent years. If OMB approval is not secured by February 2008 this timeline will be adjusted accordingly; however, if OMB approval is secured prior to February 2008, the timeline will still be as described below (i.e., will not be moved up).

Activities	Time Schedule
Interviewer Training	February 2008
Begin interviewing MSM participants	April 2008
End interviewing MSM participants	November 2008 – February 2009
Evaluate the MSM cycle	February 2009
Analysis of MSM data	March 2009 – December 2009

Data from NHBS are expected to inform prevention programs services and increase existing knowledge in the behaviors that lead to acquisition of HIV infection. Results are also expected to guide national behavioral surveillance efforts by increasing our understanding of conditions that were difficult to asses using only interview. As NHBS is a surveillance system that represents persons at risk for HIV infection in the US, it will be imperative to notify the project areas and stakeholders of the findings of this project as soon as they are available.

Most of the results are expected to be useful at the local level, while other results will be more meaningful aggregated across sites. Each participating health department will be responsible for the release of local data. CDC will have primary responsibility for the release of cycle-specific data aggregated from all geographic areas. These data will be distributed to the participating agencies, researchers, policy makers and other interested parties through presentations at local, national and international conferences, publications in peer reviewed journals, and presentations at different forums such as continuing medical education courses and seminars. Furthermore, CDC will regularly publish surveillance reports using data collected annually; depending on publication schedules, these reports should be published within 12 months of the end of each cycle of data collection.

Community members will be able to be informed of NHBS findings through multiple conduits of information. National data results will be released through national publications and presentations at conferences. Local data results will be reported back to the community through means such as local publications, Epidemiologic Profile reports, presentations to local AIDS Service Organizations and community planning bodies and at local conferences and workshops.

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

The OMB expiration date will be displayed on the handheld device in the questionnaire program.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement identified in Item 13, Paperwork Reduction Act Submission Worksheet, Part I: Information Collection Request.