

**Generic**

**Information Collection Through Web-based Surveys for  
Evaluating Act Against AIDS (AAA) Social Marketing  
Campaign Phases Targeting Consumers**

**Supporting Statement A**

**OMB No. 0920-0920**

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## **A. JUSTIFICATION**

The Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) requests approval for a new generic information collection package that supports generic Information Collection for Web-based surveys to evaluate phases of the CDC's *Act Against AIDS (AAA)* social marketing campaign aimed at increasing HIV/AIDS awareness, increasing prevention behaviors, and improving HIV testing rates among consumers.

### **A.1. Circumstances Making the Collection of Information Necessary**

#### **A.1.1 Background**

More than 1 million people are estimated to be living with HIV in the United States. Estimates of HIV incidence released by the Centers for Disease Control and Prevention (CDC) indicate that 56,300 people became infected with HIV in 2006 (Hall et al., 2008), and this number is higher than CDC's previous estimates of annual incidence. Almost three-quarters of the people diagnosed with HIV in 2006 were male. Although the number of HIV diagnoses for men who have sex with men (MSM) decreased during the 1980s and 1990s, recent surveillance data show an increase in HIV diagnoses among MSM (CDC, 2008a). MSM of all races accounted for 53% of all new infections in 2006 (Hall et al., 2008). The overall increase in HIV diagnoses among MSM is also coupled with racial and age disparities. From 2001 to 2006, the number of HIV/AIDS diagnoses increased by 12.4% among all African American MSM and by 93.1% among young African American MSM aged 13 to 24. Furthermore, statistically significant increases in HIV/AIDS diagnoses among MSM aged 13 to 24 were observed in nearly all racial/ethnic groups.

The HIV epidemic has severely affected African Americans in this country. Although African Americans make up approximately 12% of the U.S. population, they account for nearly half of all HIV diagnoses each year (CDC, 2008b). The primary transmission category of all African American men living with HIV in the United States is men having sex with other men, whereas the primary transmission category for African American women living with HIV is heterosexual sex. The rate of AIDS diagnoses for African Americans was almost 10 times the rate for whites and almost 3 times the rate for Latinos. Examining AIDS diagnosis rates by race and gender is even more disturbing. The rate of AIDS diagnoses for African American women is almost 23 times the rate for white women, whereas the rate of AIDS diagnoses for African American men is 8 times the rate for white men. A number of risk factors and barriers to prevention have been identified as contributing to the high rates of HIV infection among African Americans, including sexual risk factors, sexually transmitted disease, substance use, unknown serostatus, complacency about risk, social discrimination, and cultural issues, as well as a combination of these factors and barriers (CDC, 2008b). All of these issues have implications for how social marketing campaigns targeting the general public, specific racial and ethnic subgroups, and MSM are crafted and delivered.

The HIV epidemic is also a serious threat to the Hispanic/Latino community. Hispanics/Latinos comprise 15% of the U.S. population but accounted for 17% of all new HIV infections in the United States in 2006 (CDC, 2009a). During the same year, the rate of new HIV infections among Hispanics/Latinos was 2.5 times that of whites. In 2006, HIV/AIDS was the fourth leading cause of death among Hispanic/Latino men and women aged 35 to 44 (CDC, 2009a).

In response to the continued HIV epidemic in our country, CDC has launched *Act Against AIDS (AAA)*, a 5-year, multifaceted communication campaign to reduce HIV incidence in the United States (CDC, 2009b). CDC plans to release the campaign in phases, with some of the phases running concurrently. Each phase of the campaign will use mass media and direct-to-consumer channels to deliver HIV prevention and testing messages. Some components of the campaign will be designed to provide basic education and increase awareness of HIV/AIDS among the general public, and others will be targeted to specific subgroups or communities at greatest risk of infection, including MSM, African Americans, and other minority populations. The current study will assess the effectiveness of these social marketing messages aimed at increasing HIV awareness and delivering HIV prevention and testing messages among at-risk populations.

The study will consist of conducting online surveys of AAA target audiences to measure exposure to each phase of the campaign and interventions implemented under AAA. Each survey will consist of a module of questions relating to specific AAA activities and communication initiatives, see Attachments 3a and 3b for the sample survey items. Each survey sample will consist of 1,000 respondents selected from a combination of sources, including (1) online survey vendors that maintain panel lists (e.g., e-Rewards, Knowledge Networks, Harris Interactive), (2) respondent lists generated by partnership organizations (e.g., the National Urban League, the National Medical Association), (3) in advertisements placed on the internet (e.g., banner ads, electronic bulletin boards), and (4) individuals who respond to advertisements placed by external partners (e.g., community-based organizations, health departments). Participants will self-administer the questionnaire at home on personal computers. The

Web survey will be hosted by the selected online survey vendor and/or the evaluation contractor (RTI) for each phase. The research will include the respondents for this project being sampled from a population of 20,000 individuals. Over the 3 year period, a total of 12 data collections will be conducted; 1,000 respondents will be surveyed each quarter, resulting in 4,000 annual respondents and 12,000 total study respondents over a 3-year period. The actual data collection instruments will be submitted with each mini ICR under this generic ICR.

The following section of the U.S. Federal Code is relevant to this data collection: 42 USC 241, Section 301 of the Public Health Service Act and Public Health Service Act 308(**Attachment 1a and 1b**).

#### **A.1.2 Privacy Impact Assessment**

*Overview of the Data Collection System* - CDC's contractor, RTI International, will implement all rounds of this study. The respondents for this project will be sampled from a population of 20,000 individuals at risk for HIV infection or transmission over a 3-year period. Data will be collected nationally and/or in cities with high HIV and AIDS prevalence and incidence, such as Baton Rouge, Louisiana; Birmingham, Alabama; Charlotte, North Carolina; Chicago, Illinois; Cleveland, Ohio; Detroit, Michigan; Houston, Texas; Jacksonville or Miami, Florida; Los Angeles, California; Memphis, Tennessee; Newark, New Jersey; Oakland, California; Philadelphia, Pennsylvania; Richmond, Virginia; and Washington, DC.

The surveys will collect information on the following: sociodemographics; sexual identity, sexual attraction, gender identity, and masculine identity; current HIV testing behaviors; current risk behaviors; current personal prevention strategies;

substance use; knowledge, attitudes, beliefs, and perceived social norms related to HIV/AIDS; perceived risk of HIV infection; prior exposure to HIV prevention and testing messages; HIV/AIDS information seeking behaviors; self-reported exposure to specific AAA campaigns; and reactions and receptivity to AAA messages.

*Items of Information to be Collected* - Data to be collected includes information on HIV-related beliefs, attitudes, and behaviors as well as exposure to AAA campaign messages. See Section A.2 for a more detailed description of item domains. Information in identifiable form (IIF) will be collected by the online survey vendor and/or RTI as part of survey data collection procedures, and includes the following: name, mailing address, phone number, and email address (see Attachment 6). CDC will not have access to this information. For individuals recruited from sources other than the online survey vendor and/or RTI as described in Section A.10, all IIF will be collected by the online survey vendor and/or RTI in order to complete the data collection and to mail incentive payments and will be destroyed at the conclusion of the data collection. The vendors and/or RTI have explicit permission to keep IIF for their panel samples, but neither the evaluation contractor nor CDC will have access to IIF. Data collection records will not be maintained with individually identifying information and procedures will be followed to limit the linkage of this information to response data as described in Section A.2.1 and Section A.10. No identifiable information describing individual respondents will be included in the analyzed data and aggregate reports provided to CDC. While sensitive information will be collected, the complete separation of IIF and survey data as described will safeguard and secure respondents' privacy and minimize the



chances of a breach of privacy. See Section A.11 for additional details related to the collection of sensitive information for data collection activities.

Identification of Web Site(s) and Web Site Content Directed at Children Under 13 Years of Age - The survey delivered via the Internet will be specifically created for each assessment and will be accessible only to participants in the survey. Web site content will not be directed to children younger than age 13. All participants will be 18 years of age or older.

## **A.2 Purpose and Use of the Information Collection**

There are 2 purposes of the study: 1) to evaluate the potential effectiveness of the AAA campaign messages during the campaign development phase; and 2) to examine the associations between those groups who report exposure to the various AAA messages and those reporting no exposure to the various AAA messages. Any differences in outcomes cannot be directly attributed to the campaign. Some of the variables that will be examined include attitudes, beliefs, and knowledge about HIV; receptivity to AAA campaign messages; perceived credibility; perceived risks of HIV and importance of HIV prevention and testing; intentions related to HIV prevention and testing; and HIV testing related behaviors. Key research questions for the evaluation are presented in Exhibit 1. A copy of sample survey items to address the first purpose of the study, examine potential effectiveness of AAA campaign messages can be found in Attachment 3a. Attachment 3b provides sample items for the second purpose of the study, examining the associations between those groups who report exposure to the various AAA messages and those reporting no exposure to the various AAA messages. All survey items for each individual campaign will be submitted with each mini ICR under this generic ICR.

### Exhibit A.2.1. Key Evaluation Research Questions

1. What is the reach of the AAA campaign messages, and how often are target audiences exposed to AAA messages?
2. Do study participants have positive receptivity to AAA messages, including positive reactions to specific advertising executions?
3. Is exposure to AAA messages among study participants related to greater knowledge of their HIV status relative to participants not exposed?
4. Is exposure to AAA messages among participants related to an increase in knowledge of the importance of testing relative to participants not exposed?
5. Is exposure to AAA messages among participants related to an increase in beliefs that they should get tested for HIV?
6. Is exposure to AAA messages among participants related to an increase in of the participant's beliefs that community resources and HIV treatment are available to them?
7. Is exposure to AAA messages among study participants related to an increase in self reported HIV testing behaviors over time relative to participants not exposed?
8. Is exposure to AAA messages among participants related to an increase intentions to get tested for HIV relative to participants not exposed?

The information obtained from the proposed data collection activities will be used to inform CDC, policy makers, prevention practitioners, and researchers about the potential effects of campaign messages as they are developed on improving HIV-related outcomes among the targeted sample. This information will also be used to assess the fidelity of campaign implementation, providing feedback to CDC on audience reach and receptivity to AAA messages over time. The small prevalence of the targeted populations of interest for much of the AAA campaign (e.g., MSM, minority populations) combined with limited resources available to assess the multiple campaign phases necessitate the use of a multipronged sample selection approach to efficiently reach the targeted populations of interest. Although the sample is not meant to be generalized to the entire population of interest, this valuable information will enable CDC to address HIV testing

and prevention more effectively. Without this data CDC cannot make evidence-based program and funding decisions regarding the continuation of campaign phases. The data from the proposed evaluation may be used to assess the appropriateness of continued or expanded funding and dissemination of the campaign.

CDC and RTI will disseminate results through an executive summary and a full report for each survey. The executive summary will be written in clear language to be understandable to a wide range of audiences (e.g., the campaign target audience, practitioners, policy makers, researchers). The full report will include an overview of background literature to provide contextual information about the purpose of the campaign and evaluation approach, theoretical underpinnings of the analysis, and specific data and methodologies used. The report will also include a synthesis of findings across all evaluation questions and an overall assessment of the effectiveness of the AAA campaign messages, strengths and limitations of the evaluation, and recommendations for further evaluations. The report will be scientifically rigorous to capture the complexity of the analyses but also will be sensitive to nontechnical audiences and relevant to other stakeholders.

Domains of instrument items in the survey include the following:

- Sociodemographics (age, race/ethnicity, city, education, health insurance, income)
- Sexual identity, sexual attraction, gender identity, and masculine identity (for appropriate targeted populations)
- Current HIV testing behaviors
- Current risk behaviors
- Current personal prevention strategies
- Substance use
- Knowledge, attitudes, beliefs, and perceived social norms related to HIV/AIDS
- Perceived risk of HIV infection

- Prior exposure to HIV prevention and testing messages
- HIV/AIDS information seeking behaviors
- Self-reported exposure to specific AAA campaigns as they unfold
- Reactions and receptivity to specific AAA messages as they are developed

#### **A.2.1 Privacy Impact Assessment**

This information is being collected to inform CDC, policy makers, prevention practitioners, and researchers about the effects of campaign messages on HIV-related outcomes among the targeted sample. This information will also be used to assess the fidelity of campaign implementation and to provide feedback to CDC on audience reach and receptivity to AAA messages over time. These data will be used to assess the appropriateness of continued or expanded funding and dissemination of the campaign.

This study entails the measurement of sensitive HIV-related questions necessary to adequately assess the topic area (see Section A.11 for more detail). All respondents will be assured that the information will be used only for the purpose of this research and will be kept secure to the extent allowable by law, as detailed in a study consent form (see Section A.10 for more information). Respondents will be assured via the computer script that their responses will not be shared with anyone outside the research team and that their names will not be reported with responses provided. Respondents will be told that the information obtained from all of the surveys will be combined into a summary report so that details of individual questionnaires cannot be linked to a specific participant.

To maintain privacy, respondents will complete the survey on a personal computer. In addition, each respondent will have a personal password to open the survey.

RTI maintains restricted access to all data preparation areas (i.e., receipt and coding). All data files on multi-user systems will be under the control of a database manager, with access limited to project staff on a "need-to-know" basis only. The online survey vendors and/or RTI will take multiple security measures to ensure separation between respondents' identity and their survey data (see Section A.10 for more information). Data coming directly from the survey engine are stored in a proprietary database. Although these data are not encrypted, once inside the firewall, they are stored in a relational database protected by several layers of intrusion detection and access control. If an online survey vendor is used, data files delivered to the evaluation contractor (RTI) by the online survey vendors will be sent via encrypted files.

CDC will receive data for analysis in aggregate form, and the randomly generated numbers assigned as participant ID numbers will not link data to individuals. The participant ID itself will only be used to track the survey completion pattern (i.e., how many people complete a survey). Although the online survey vendors and/or RTI will retain contact information on participants for honoraria purposes, information in identifiable form (IIF) is not shared with anyone, including CDC. It is stored separately from the survey data file and is not linked in any way to participant responses.

### **A.3 Use of Improved Information Technology and Burden Reduction**

The AAA campaign evaluation will rely on Web-based surveys to be self-administered on personal computers. Use of the World Wide Web has the advantage of being able to expose respondents to television, audio, and print advertising used by each campaign phase. It also allows respondents to complete as much of the

survey as desired in one sitting and to continue the survey at another time, minimizing the possibility of respondent error by electronically skipping questions that are not applicable to a particular respondent, thus minimizing respondent burden.

#### **A.4 Efforts to Identify Duplication and Use of Similar Information**

In designing the proposed data collection activities, we have taken several steps to ensure that this effort does not duplicate ongoing efforts and that no existing data sets would address the proposed study questions. We have reviewed existing data sets to determine whether any of them are sufficiently similar or could be modified to address CDC's need for information on the effectiveness of the AAA campaign on HIV-related outcomes. Efforts to avoid duplication include a review of CDC's administrative agency reporting requirement and of existing studies of CDC's programs. We investigated the possibility of using existing data to examine our research questions, such as data collected by the Behavioral Risk Factor Surveillance System (CDC, 2005), the National Health Interview Survey (Lethbridge-Çejku, Rose, & Vickerie, 2006), the National Survey on Family Growth (Abma, Martinez, Mosher, & Dawson, 2004), and the National HIV Behavioral Surveillance Survey (Gallagher et al., 2007). However, none of these existing data include measures of exposure to the AAA campaign combined with the relevant outcome measures specific to the AAA campaign.

The AAA campaign is a new CDC social marketing campaign for which no evaluation data exist. Although some existing surveys may contain measures of the campaign's targeted outcomes (e.g., HIV prevention and testing behaviors), no existing data sources contain measures of awareness of or exposure to specific AAA campaign messages. Measures of exposure, obtained through surveys

with the target audience, are required to assess the campaign's association with HIV-related outcomes. Therefore, our evaluation requires the collection of new primary data. To date, no duplication of effort has been identified as there would be no reason for another Federal Agency to evaluate CDC's AAA campaign or its phases.

#### **A.5 Impact on Small Businesses or Other Small Entities**

No small businesses will be involved in this data collection.

#### **A.6 Consequences of Collecting the Information Less Frequently**

The present study will provide the primary data needed for federal policy makers to assess the effectiveness of the AAA campaign and its messages. If this evaluation were not conducted, it would not be possible to determine the value or impact of AAA campaign messages on the lives of the people they are intended to serve. Failure to collect these data could preclude effective use of program resources to benefit individuals at risk for HIV infection or transmission.

The evaluation includes data collection over 3 years to track and document changes in outcomes over time. We will submit a mini ICR for approval. The frequency and timing of the online surveys will vary, but will not exceed 6,000 burden hours per year (as reported in Exhibit A.12.1 Annualized Burden Hours). Each mini ICR will contain the actual data collection instruments. A measure of potential changes in attitudes, beliefs, or behaviors among participants who report exposure to the campaign messages and those reporting no exposure is necessary immediately after exposure or implementation of the initial campaign messages. This will allow us to measure short-term changes by exposure. Later

surveys for each phase will provide data about subsequent changes in or maintenance of attitudes, beliefs, or behaviors. These changes will also focus on those reporting exposure to the AAA messages and those reporting no exposure. Less frequent data collection would not allow for measurement of potential short-term immediate reactions to the campaign messages

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

This request fully complies with regulation 5 CFR 1320.5.

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

A 60-day *Federal Register* notice published on August 6, 2010 (Volume 75, Number 151, pages 47598-47599) solicited comments on Evaluating Act Against AIDS Social Marketing Campaign Phases Targeting Consumers; a non substantive comment was received from the public and did not require any changes to the package, See Attachment 2a. A 30-day *Federal Register* notice published on April 28, 2011 (Volume 76, Number 82, pages 23818-23819) solicited comments on Evaluating Act Against AIDS Social Marketing Campaign Phases Targeting Consumers; no substantive comments were received from the public and no changes were made to the package, See Attachment 2b. A list of key evaluation consultants for this project is provided in Exhibit 2. RTI staff consulted with public health scientists on the study design and evaluation instrument and with several survey specialists to estimate the interview burden for each respondent.



### Exhibit A.8.1. AAA Campaign Evaluation Consultants

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### A.9 Explanation of Any Payment or Gift to Respondents

Participants will be offered a token of appreciation of up to \$40 for completion of a survey. The token of appreciation is intended to encourage their cooperation, and convey appreciation for contributing to this important study. Numerous empirical studies have shown that honoraria can significantly increase response rates (e.g., Abreu & Winters, 1999; Shettle & Mooney, 1999).

The use of a token of appreciation is expected to enhance survey response rates without biasing responses or coercing respondents to participate. A smaller token of appreciation would not be sufficiently attractive to adults. We also believe that the token of appreciation will result in higher data validity as

adults become more engaged in the survey process. The amount of the token of appreciation was determined through discussions with RTI staff with expertise in conducting adult surveys about HIV. Because all selected individuals may not be eligible for the study, we want to assure sufficient project spending and only provide a token of appreciation to respondents after they are determined to be eligible.

#### **A.10 Assurance of Confidentiality Provided to Respondents**

##### **A.10.1 *Privacy Impact Assessment Information***

CDC will receive data for analysis in aggregate form, and the randomly generated numbers assigned as participant ID numbers will not link data to individuals. The participant ID itself will only be used to track the survey completion pattern (i.e., how many people complete a survey). Although the online survey vendors and/or RTI will retain contact information on participants for token of appreciation purposes, information in identifiable form (IIF) is not shared with anyone, including CDC. It is stored separately from the survey data file and is not linked in any way to participant responses.

This project has been reviewed and approved by the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention through a Project Determination. The online survey vendors and/or RTI will maintain a list of participant ID numbers, names, addresses, telephone numbers, and e-mail addresses only for the purpose of token of appreciation mailings and reminders about the study. CDC will only have access to the generic, randomly generated ID numbers for the purpose of tracking survey completion patterns. Although CDC will own the data, they will neither have IIF nor see names or contact information for any participant responses.

All respondents will be assured that the information will be used only for the purpose of this research and will be kept secure to the extent allowable by law, as detailed in the sample study consent form (see **Attachment 4**). Respondents will be assured that their answers to screener and survey questions will not be shared with anyone outside the research team and that their names will not be reported with responses provided. Respondents will be told that the information obtained from all of the surveys will be combined into a summary report so that details of individual questionnaires cannot be linked to a specific participant.

The introduction to the survey, which participants will receive via email or view online (see sample in **Attachment 5**), will provide a very brief description of the survey. The introduction will also provide instructions for accessing the screener. Potential participants will access the screener by clicking on the screener URL that will be imbedded in the survey introduction. At this time, the potential participant will be asked if they are willing to answer a few questions to determine if they are eligible. Each person must check either a box labeled "YES, I agree to be screened" or "NO, I do not wish to be screened." Only respondents who consent will receive a personal password which they will use to enter the screener.

Participants who are eligible to participate in the survey will be provided with a description of the study and administered informed consent. During this process, potential participants will be informed of the private and voluntary nature of the survey. After reading the informed consent, each participant must check either a box labeled "YES, I agree to participate" or "NO, I do not wish to participate." Only respondents who consent will enter the survey.

Individuals who consent to participate in the survey will be able to access the survey by clicking on the link to the survey URL and then entering his/her personal password. A respondent's personal password will not change. The personal password is required each time to access the survey and will keep the respondents' spot in the survey so they can pick up where they left off; or, if they have already completed the survey, they will not be able to complete it again.

It is possible that someone else (e.g., a family member) could view the survey on the participant's computer with or without his/her knowledge, which could create family problems or cause discomfort. The survey instructions will suggest to respondents that they complete the survey in a private location to mitigate this risk.

RTI maintains restricted access to all data preparation areas (i.e., receipt and coding). All data files on multi-user systems will be under the control of a database manager, with access limited to project staff on a "need-to-know" basis only. The online vendor panels and/or RTI will take the following security measures to ensure separation between respondents' identity and their survey data. First, the survey instrument has no personally identifying information (PII) on it. No respondent name, address, e-mail address, telephone number, or any other kind of PII appears on the survey. The only way a survey is identified is with a digital identification number. Second, although the invitation method (i.e., e-mail, mail, or direct mail) will inherently have PII information included, this will not be combined with survey responses so the responses from the survey are not linked to the PII. Third, screener data will be considered part of the survey data. The vendors and/or RTI will retain the results of the screener questions for all panelists,

regardless of whether they qualify for the study. However, they will not retain responses to screening questions for those who are deemed ineligible for any other purpose outside the scope of this project. Fourth, the vendors and/or RTI will retain study records for the duration of the study. Upon completion of the project, the vendors and/or RTI will destroy all study records, including data files, upon request. The vendors and/or RTI will not be able to supply or access this information for any reason, once destroyed. Finally, data coming directly from the survey engine are stored in a proprietary database. Although these data are not encrypted, once inside the firewall, they are stored in a relational database protected by several layers of intrusion detection and access control. If a survey vendor is used, data files delivered to RTI by the vendors will be sent via encrypted files.

#### **A.11 Justification for Sensitive Questions**

The AAA campaign is a direct initiative in response to the need to decrease the number of HIV-positive individuals who are unaware that they are infected. As such, our study entails the measurement of sensitive HIV-related questions.

Depending on the target audience for the campaign phase, the study screener will vary, but some sensitive questions must be asked to identify the intended audience. The sample study screener (see **Attachment 6**) will include questions that assess whether individuals have ever tested positive for HIV. Furthermore, because our campaign materials are targeted to various populations, screening questions may address one or more of the following items: race/ethnicity, sexual behavior, and sexual orientation.

The sample survey items e (see **Attachments 3a and 3b**) will also include questions about HIV testing behaviors and HIV status. In addition, because HIV is transmitted through sexual contact and intravenous drug use, the surveys will also include questions about these behaviors to enable us to understand the transmission behaviors of our survey respondents and examine responses by those individuals reporting exposure to various AAA campaign messages and those reporting no exposure. Furthermore, the surveys will contain a set of questions about respondents' HIV knowledge, attitudes, beliefs, and intentions to get tested for HIV. All of these questions will also enable us to determine whether change occurs among those exposed to campaign messages. The actual survey items for each campaign will be submitted in a mini-ICR.

**A.12 Estimates of Annualized Burden Hours and Costs**

Exhibits 3 and 4 provide details about how this estimate was calculated. The overall burden per respondent was calculated by multiplying the screening interview time by the maximum amount of times to complete the survey for each data collection over a three year period. The study screener is expected to take about 2 minutes to complete. Each survey is expected to take 30 minutes. We will complete 4,000 questionnaires annually. The total annual response burden is estimated at 2,667 hours. For this three year generic ICR, the total burden hours is 8,001.

**Exhibit A.12.1 Annualized Burden Hours**

<b>Respondents</b>	<b>No. of Respondents</b>	<b>No. of Responses per Respondent</b>	<b>Average Burden per Response (in Hours)</b>	<b>Total Burden Hours</b>
Study screener	60,000	1	2/60	2001
Survey Module	12,000	1	30/60	6,000

<b>Total</b>					<b>8,001</b>
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**Exhibit A.12.2 Annualized Cost to Respondents**

<b>Respondents</b>	<b>No. of Respondents</b>	<b>No. of Responses per Respondent</b>	<b>Average Burden per Response (in Hours)</b>	<b>Hourly Wage Rate</b>	<b>Total Burden Hours</b>	<b>Total Respondent Costs</b>
Study screener	60,000	1	2/60	\$6.00*	2001**	\$12,006.00
Survey Module	12,000	1	30/60	\$6.00*	6,000	\$36,000.00
<b>Total</b>						<b>\$48,006.00</b>

\* Estimate of average hourly wage for participants.

\*\* Total burden hours are rounded to the nearest whole number.

Because we do not know what the wage rate category will be for these selected participants (or even whether they will be employed at all), we used \$6.00 per hour as an estimate of average minimum wage across the country (Bureau of Labor Statistics, 2006). The estimated annual cost to participants for the hour burden for collections of information will be \$16,002. For this three year generic ICR, the total estimated cost to participants is \$48,006.

**A.13 Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers**

There are no other costs to respondents or record keepers.

**A.14 Annualized Cost to the Federal Government**

The contractor's costs are based on estimates provided by the contractor who will carry out the data collection activities. With the expected period of performance, the annual cost to the federal government is estimated to be \$247,586 (Exhibit 5). This is the cost estimated by the contractor, RTI, and includes the

estimated cost of coordination with CDC, data collection, analysis, and reporting. For this three year generic ICR, the total estimated cost to the government is \$742,758.

**Exhibit A.14.1. Total Government Costs**

<b>Item/Activity</b>	<b>Details</b>	<b>\$ Total Amount</b>
CDC oversight of contractor and project	20% of FTE: GS-13 Health Communication Specialist	\$58,140
Recruitment and data collection (contractor)	320 labor hours, data collection subcontract, and ODCs	\$438,204
Analysis and reporting (contractor)	640 labor hours and ODCs	\$246,414
<b>Total</b>		<b>\$742,758</b>

CDC = Centers for Disease Control and Prevention; FTE = full-time equivalent; ODC = other direct cost

**A.15 Explanation for Program Changes or Adjustments**

This is new generic information collection request (ICR).

**A.16 Plans for Tabulation and Publication and Project Time Schedule**

Our analyses will vary depending on survey items administered for the target audience. The first phase of data analysis will always include basic summary statistics for the purposes of describing the sample and examining the distribution of the primary outcome variables. We will also compute means for continuous, normally distributed variables of interest and frequencies for categorical variables of interest. Statistical tests, such as chi-square tests, may be conducted to evaluate preliminary differences by exposure to the AAA campaign. In addition, the distributions of primary outcome variables will be examined to determine whether the distributional assumptions of



planned analytic procedures are met. The outcome variables include but are not limited to perceived credibility, perceived risks of HIV and importance of HIV prevention and testing, intentions related to HIV prevention and testing, and HIV-related behaviors.

Once preliminary analyses are complete, we will begin to develop preliminary models that assess the association between exposure to the AAA campaign and outcomes of interest. For example, our research question as to whether exposure to the AAA campaign are associated with participant HIV testing behavior (see Exhibit 1) will be tested in a regression model, where a measure of HIV testing behavior is specified as the dependent variable and self-reported exposure is specified as the primary independent variable. These models will also include covariates for a number of background characteristics and other important confounding variables. The overall goal of these models is to determine the extent to which changes in HIV-related outcomes differ by exposure to the AAA campaign.

For this study, we expect the findings to be disseminated to a number of audiences. Therefore, the evaluation reports will be written in a way that emphasizes scientific rigor for more technical audiences but are also intuitive, easily understood, and relevant to less technical audiences. The reporting and dissemination mechanism will consist of three primary components: (1) final evaluation reports for each campaign phase, (2) peer-reviewed journal articles, and (3) conference presentations.

The final evaluation reports will be the central focus of dissemination efforts and will be written in clear language that is understandable by a wide range of audiences (the target audience, practitioners, policy makers, and researchers). The evaluation reports will include an executive summary, a report of

less than 100 pages (including an overview of background literature to provide contextual information about the purpose of the campaign and evaluation approach; a detailed summary of evaluation methods and activities; the evaluation results; a discussion of findings in comparison with those of other relevant program evaluations; strengths and limitations of the evaluation; and recommendations for future evaluations of this scope for practitioners, evaluators, and policy makers), and appendices. The results of our study also will be used to develop at least one peer-reviewed journal article (e.g., *American Journal of Public Health, Journal of Health Communication*) that summarizes findings on the overall effectiveness of the AAA campaign.

The key events and reports to be prepared are listed in Exhibit 6.

**Exhibit A.16.1 Project Time Schedule**

Project Activity	Time Schedule
Data collection	2 months after OMB approval
Data analysis	3 months after OMB approval
Submit final report	2 months after completion of each data collection
Submit at least one manuscript	1 year after completion of data collection for a campaign phase

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

We do not seek approval to eliminate the expiration date.

**A.18 Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification.

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