Generic ICR

Data Collection Through Web Based Surveys for Evaluating Act Against AIDS Social Marketing Campaign Phases Targeting Consumers

Supporting Statement A

Extension without Change

OMB No. 0920-0920

November 1, 2021

Contact Person:
Euna August, PhD
Division for HIV/AIDS Prevention
Centers for Disease Control and Prevention
1600 Clifton Rd. NE
Mailstop E-49
Atlanta, GA 30329
Telephone: (404) 639-8297
Fax: (404) 639-2007
E-mail: wvj3@cdc.gov

TABLE OF CONTENTS

EXHIBITS

LIST OF ATTACHMENTS

- Goal of the study
  The goal of this generic information collection request is two-fold: (a) evaluate the clarity, comprehension, relevance, appeal, persuasiveness, believability, and potential effectiveness of Act Against AIDS (AAA) campaign messaging and (b) examine differences in HIV knowledge, awareness, beliefs, behavioral intentions, and behaviors among individuals who have and have not been exposed to AAA messaging.

- Intended use of the resulting data
  CDC will use the resulting data to inform campaign development and dissemination activities, and to refine new and refresh existing AAA messaging to improve clarity, receptivity, relevance, and effectiveness.

- Methods to be used to collect
  The study will consist of cross-sectional surveys (2-3 per year) of nonprobability-based samples of individuals representing AAA target audiences. Respondents will be recruited through online survey panel vendors, external partners (e.g., community-based, membership organizations), and the internet.

- The subpopulation to be studied
  The subpopulations to be studied include the general population; gay and bisexual men; African Americans, Hispanics, and other racial/ethnic minority groups; transgender individuals; and people who inject drugs.

- How data will be analyzed
  The planned analyses will describe the sample, assess the extent to which exposure to AAA messages accounts for changes in outcomes of interest, and identify factors that may increase or decrease the potential effectiveness of AAA messages.

A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) requests approval for a one-year Extension without Change of "Data Collection Through Web Based Surveys for Evaluating Act Against AIDS Social Marketing Campaign Phases Targeting Consumers" (Generic ICR, OMB 0920-0920, expiration 11/30/2021). This information collection package supports generic information collection for web-based surveys (hereafter referred to as '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.

HIV infection continues to be a serious public health and health care challenge in the United States. The Centers for Disease Control and Prevention (CDC) estimates that 1.1 million individuals are currently living with HIV in the United States (U.S.), and 1 in 7 of those individuals are unaware of their infection (CDC, 2017a). Although the annual number of HIV diagnoses declined by 19% from 2005 to 2014 (CDC, 2016a), certain populations continue to be disproportionately affected. One such group is gay, bisexual, and other men who have sex with men (collectively referred to as MSM). Although MSM represent about 2% of the U.S. male population, they accounted for about 70% of new HIV infections in 2014 (CDC, 2017a), and from 2005 to 2014, diagnoses among MSM increased by about 6% (CDC, 2016a). Young MSM are particularly vulnerable to infection. In 2015, more than 90% of new HIV diagnoses among men aged 13 to 24 were among MSM. Furthermore, MSM in this age group accounted for 27% of new diagnoses among all MSM (CDC, 2018a). There are recent signs of progress in combating the HIV epidemic among MSM. For example, from 2008 to 2014, there was an 18% decline in the estimated number of new HIV infections among young MSM (CDC, 2018b), indicating that prevention efforts, including those that raise awareness and knowledge of HIV testing, prevention, and treatment, are effectively reducing the burden of HIV among this group.

Despite reductions among MSM overall, racial/ethnic disparities in HIV persist among MSM. From 2011-2015, diagnoses among African American and Latino MSM increased by 4% and 14%, respectively, compared to a 10% decrease among White MSM (CDC, 2017b). Risk among young African American and Latino MSM is particularly concerning. From 2005-2014, there was an 87% increase in HIV diagnoses among African American and Hispanic MSM aged 13 to 24 compared to an 18% reduction among young White MSM in this age group (CDC, 2016a).

The racial/ethnic disparities in HIV observed among MSM are also present among African Americans and Latinos more generally. For instance, about 45% of diagnoses in 2015 were among African Americans although they represent 12% of the U.S. population (CDC, 2018c). Likewise, in 2015, Latinos accounted for approximately 25% of all new HIV although they only represent about 18% of the U.S. population (CDC, 2018d). In 2016, the HIV diagnosis

rate was highest for African Americans at 43.6 per 100,000 (CDC, 2017a), followed by Hispanics at 17.0 per 100,000. There was a 42% decrease in HIV diagnoses among African American women from 2005 to 2014, yet they accounted for 60% of all women living with HIV at the end of 2014. In comparison, at the end of 2014, White and Hispanic women each accounted for 17% of all women living with HIV (CDC, 2018e). African Americans and Latinos diagnosed with HIV also experience poorer health outcomes than Whites. At the end of 2015, the rate of infections classified as Stage 3 was nearly seven times higher among African Americans (539.2 per 100,000) and 3 times highest among Latinos (214.4 per 100,000) compared to Whites (78.8 per 100,000) (CDC, 2017b). Also, in 2015, the death rate among persons diagnosed with HIV was highest among African Americans at 17.5 per 100,000 (CDC, 2017b), followed by 14.6 per 100,000 among multiracial persons; in the same year, the death rate was 4.4 per 100,000 among Hispanics and 2.5 per 100,000 among whites.

It has been established that risky sexual behaviors and substance use, sexually transmitted infections, and unknown serostatus are associated with HIV transmission. At the same time, MSM, racial/ethnic minorities, and other groups experience overlapping social structures and economic systems that interact in complex ways to increase vulnerability to infection. Such 'social determinants of health' include the social and physical environment, health services, and structural and environmental factors. For example, a high community prevalence of HIV coupled with limited access to a full range of prevention and treatment services may further transmission risk (CDC, 2016b). Concurrently, marginalization and stigmatization due to race/ethnicity, sexual orientation, gender, and/or HIV status can deter people from getting tested or seeking treatment, both of which increase HIV risk. Examples of disparities associated with social determinants of health abound across the HIV care continuum. For instance, among males with infections attributed to injection drug use, recent data show that linkage to care was lowest among those who lived in counties with the highest poverty (68.7%), lowest education (72.2%), lowest income (72.0%), and highest unemployment (73.2%) (CDC, 2016b). Another critical endpoint on the continuum, viral suppression was lower among African American males (47.9%) and females (49.8%) than it was among all other racial/ethnic groups (CDC, 2016b).

To address the HIV epidemic in the U.S., the Act Against AIDS (AAA) initiative was launched by the Centers for Disease Control and Prevention (CDC) and the White House in 2009 in to raise awareness among all Americans and reduce the risk of infection among the hardest-hit

populations – MSM, African Americans, Latinos, and other communities at increased risk. Today, AAA encompasses multiple campaigns and activities spanning a variety of topics and audiences to combat complacency about HIV and AIDS in the United States.

CDC has and will continue 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 heightened risk, including MSM, African Americans, and other minority populations. The extension of the ongoing study will allow for continued assessment of the effectiveness of AAA messages aimed at increasing HIV awareness and delivery of HIV prevention and testing messages among at-risk populations.

This ongoing study will include conducting surveys with AAA target audiences. Each survey will consist of a module of questions relating to specific AAA activities and communication initiatives. The samples for the surveys will consist of respondents selected from a combination of sources, including (1) online survey panel vendors that maintain proprietary sample lists; (2) external partners, including respondent lists from membership organizations (e.g., the National Urban League, the National Medical Association) and community-based organizations (CBOs) that work with the identified target audiences; and (3) advertisements placed on the internet (e.g., banner ads, electronic bulletin boards) and social media outlets (e.g., Facebook). Respondents will self-administer the surveys at home on personal computers.

A total of 10,750 respondents were approved for the renewal of this generic ICR (0920–0920) in 2015, and since the approval date, 5,305 respondents were surveyed under the GenICR, “Development of Messages for the Act Against AIDS National Testing”. The information collected from these surveys was used to evaluate specific AAA campaign phases. We are requesting an additional year to continue surveying other AAA target audiences as new phases are developed. Through this extension without change, we plan to reach the remaining approved 5,445 respondents.

This data collection is authorized under 42 USC 241, Section 301 of the Public Health Service Act and Public Health Service Act 308 (**Attachment 1**).

A.2 Purpose and Use of Information Collection

The purpose of this study is to evaluate the clarity, comprehension, relevance, appeal, persuasiveness, believability, and potential effectiveness of Act Against AIDS (AAA) campaign messaging and to examine differences in HIV knowledge, awareness, beliefs, behavioral intentions, and behaviors among individuals who have and have not been exposed to AAA messaging. The information obtained from the proposed data collection activities will be used in three primary ways: (1) 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; (2) to develop evidence-based programs and support funding decisions regarding the continuation of campaign phases; and (3) to assess the appropriateness of continued or expanded funding for AAA and dissemination activities.

Because the surveys are cross-sectional, any differences in outcomes cannot be directly attributed to the campaign; however, we can examine correlations between campaign exposure and the identified outcomes. Without this information, CDC will not know whether AAA messaging is effectively reaching and educating the target audiences nor how to refine or refresh the messaging to improve clarity, receptivity, relevance, and effectiveness. Some key research questions that will be answered through this information collection include the following:

- What is the reach of AAA messaging, and what is the frequency of exposure?
- Do the target audiences react positively to AAA messages and specific advertising executions?
- Is exposure to AAA messages among study respondents related to greater knowledge of their HIV status relative to non-exposed respondents?
- Is knowledge of HIV status and awareness of and beliefs in the importance of HIV testing greater among individuals exposed to AAA messages compared to those who were not exposed?
- Is knowledge and awareness of biomedical prevention strategies (i.e., pre- and post-exposure prophylaxis [PrEP and PEP, respectively]) greater among individuals exposed to AAA messages compared to those who were not exposed?

- Is knowledge and awareness of the importance of early antiretrovial treatment (ART) greater among people with HIV (PWH) exposed to AAA messages compared to non-exposed PWH?
- Are intentions to get tested for HIV or to practice other prevention behaviors higher among individuals exposed to AAA messages compared to those who were not exposed?

A copy of the sample survey is included in **Attachment 3**. All survey items for each individual campaign will be submitted with each genIC.

A.3 Use of Improved Information Technology and Burden Reduction

This study will use self-administered surveys; 100% of responses will be electronic. This data collection mode offers several advantages. First, it will allow us to expose respondents to the television, audio, and print advertising that will be used by each campaign phase. Second, using computer-generated skip patterns will reduce respondent burden and improve the accuracy and completeness of the data. Third, this mode allows respondents to complete as much of the survey as desired in one sitting and to continue the survey at another time. Fourth, the potential for bias related to social desirability is minimized because the survey is self-administered. Fifth, respondents may feel more comfortable revealing potentially sensitive information in a location of their choosing which will improve the validity of the data.

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 CDC's administrative agency reporting requirements, existing programmatic studies, and data sets to determine whether they are sufficiently similar or could be modified to address the goals of the planned data collection. Specifically, we investigated the possibility of using existing CDC data from the Behavioral Risk Factor Surveillance System, the National Health Interview Survey, the National Survey on Family Growth, and the National HIV Behavioral Surveillance Survey. Although some of these existing surveys 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 messaging. Measures of exposure, obtained through surveys with the target

audience, are required to assess association between AAA campaigns and messages with HIV-related outcomes. Therefore, our evaluation requires the collection of primary data.

A.5 Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses.

A.6 Consequences of Collecting the Information Less Frequently

The proposed study will provide the primary data needed for CDC leadership and federal policy makers to assess the extent to which AAA campaigns/activities and messaging improve the health and well-being of the target audiences. We anticipate conducting approximately two to three surveys per year. We considered collecting the data less frequently, but we concluded that data collections are needed at this frequency given the number of existing and planned AAA campaigns/activities and the anticipated pace of implementation. Additionally, by collecting information two to three times per year, we can reduce the number of items in the individual surveys (thereby reducing respondent burden) and target them to the most recent implementation activities, which helps to mitigate the potential for recall bias. Furthermore, by repeated measurement of short-term changes in overlapping outcomes of interest (e.g., self-reported HIV testing) over the one-year period, we can better determine the long-term impact of the AAA initiative. Failure to collect data at this frequency may undermine effective use of program resources to benefit individuals at risk for HIV infection or transmission.

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

This request fully complies with the regulation 5 CRF 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 was published on 09/7/2021, Vol. 86, No. 171, and Page 50122 (**Attachment 2)**. One non-substantive comment was received and no CDC response was sent. The comment was broadly opposed to CDC HIV work, and proposed larger budget cuts to the agency. No changes were made to the supporting statements or data collection instruments (**Attachment 2a)**.

A list of key evaluation consultants for this project is provided in Exhibit A.8.1. CDC contractor staff consulted with public health scientists on the study design and evaluation instrument to estimate the interview burden for each respondent.

Exhibit A.8.1 AAA Campaign Evaluation Consultants

Jennifer Uhrig, PhD Director - Center for Communication Science RTI International 3040 Cornwallis Road Research Triangle Park, NC 27709 Phone: (919) 316-3311 Email: uhrig@rti.org	Carla Bann, PhD RTI Fellow - Statistics and Psychometrics RTI International 3040 Cornwallis Road Research Triangle Park, NC 27709 Phone: (919) 485-2773 Email: cmb@rti.org
Kevin Davis, MA Director – Health Economics Program RTI International 3040 Cornwallis Road Research Triangle Park, NC 27709 Phone: (919) 541-6683 Email: kcdavis@rti.org	

A.9 Explanation of Any Payment or Gift to Respondents

Respondents will be offered a token of appreciation of points redeemable for purchase (value of $20-$40) for taking part in a survey; higher amounts may be offered for data collections involving specific audiences known to be difficult to reach (e.g., MSM, PWH). The amount was determined in consultation with the evaluation contractor and online survey panel vendors; in their experience, smaller amounts are insufficient for recruiting the identified target populations for surveys.

Prior research supports the provision of a token of appreciation to increase survey response rates (Abreu & Winters, 1999; Göritz, 2006; Shettle & Mooney, 1999; Yu & Cooper, 1983). Existing theories help to explain why and how tokens of appreciation motivate survey response, such as social exchange theory (Dillman, 1978), the norm of reciprocity (Groves, Cialdini, & Couper, 1992), economic exchange theory (Biner & Kidd, 1994), and leverage-saliency theory (Groves, Singer, & Corning, 2000). In addition to theory, there are psychological

factors that underpin survey response, including altruism and egoism, drives that balance the desire to be helpful with the need to further one's own self-interest.

In consideration of knowledge gained from similar research and existing theories and psychological factors that underlie survey response, we have determined that a token of appreciation is warranted for data collections conducted under this generic ICR. Based on OMB's guidance on factors that may justify provision of a token of appreciation (Office of Information and Regulatory Affairs, 2006), we have determined that the following reasons apply:

1. *Improved coverage of specialized respondents, rare groups, or minority populations*: The proposed data collection includes MSM, PWH, racial/ethnic minorities, PWID, and transgender individuals, all of whom are considered members of stigmatized and marginalized groups. To ensure that the campaigns and activities meet the needs of these diverse audiences, it is imperative that sufficient numbers are included in the data collection. Yet, based on the study team's prior experience conducting data collections with these types of populations, recruitment can be challenging due to competing basic needs, health issues, and social and emotional vulnerabilities (e.g., concerns about stigma and confidentiality). Provision of a token of appreciation is necessary to ensure adequate response rates from the targeted populations.

2. *Data quality:* If we are unable to recruit sufficient numbers of respondents to participate in the data collection, we will be unable to adequately test the messages which will limit our ability to determine if they are acceptable, understandable, motivating, etc. to the target audience and examine their potential effectiveness in achieving the desired outcomes (e.g., getting tested for HIV). This is particularly applicable when we consider that the data collection will include vulnerable/hidden subgroups (see #1).

3. *Reduced survey costs*: We anticipate that without the token of appreciation as an inducement, recruitment costs will be higher because we will need to screen more people to achieve the desired cooperation rate (McGrath, 2006). The current estimated annualized burden for the screener for the intervention study is 358 hours. Without the token of appreciation, we expect the burden to be 465 hours, an increase of approximately 30%. Costs to the Federal government will increase accordingly.

A.10 Protection of the Privacy and Confidentiality of Information Provided by Respondents

The Privacy Act does not apply to this Generic information collection. Personally identifiable information (PII) will not be collected under this extension. Privacy Impact Assessments (PIA) (**Attachment 8**).

Consent will be self-administered electronically through the secure survey website. Consent for the screener and survey will be combined. When individuals consent to participate, they are consenting to screening, as well as the survey, if they meet the eligibility criteria. The first screen on the study's secure website is the consent form (**Attachment 4**). The consent form will cover the following topics:

- The study's topic and goals;
- The procedures that will be involved, including the sensitive nature of some of the questions that will be asked;
- Potential risks and discomforts associated with participation and the right to refuse or withdraw;
- Benefits to participation;
- Remuneration amount and form;
- The measures that will be taken by CDC and the evaluation contractor to protect privacy as well as the measures respondents can take to protect their information (i.e., take the screener in a private location, such as their own home and/or in a room with a door, and close their browser window when they are finished or if they choose to withdraw); and
- Contact information for the evaluation contractor's project director if they have questions about the study and the contractor's Office of Research Protection if they have questions or concerns about their rights as a study participant.

After reading this information, potential participants will be reminded of the voluntary nature of the study and that they can refuse to participate or stop participating without penalty. They will then be asked to select, "I have read this consent form and agree to participate in the survey" or "I have read this consent form and do not want to participate in the survey". If an individual chooses not to participate, they will be thanked for their time and asked to close their browser window for privacy purposes. No additional contact will be made with individuals who

select no. Individuals who do not meet the eligibility criteria for the survey will be told they are ineligible, thanked for their time, and asked to close their browser window for privacy purposes. The consent form as well as other study materials will be at an 8th grade reading level or below.

The online survey panel vendors maintain the names of and contact information (e.g., addresses, telephone numbers, and email addresses) for panel members who are invited to take part in a survey. The vendors will also track survey completion. The vendors will use this information to invite participation, remind nonresponders to complete the survey, and determine who should receive and to disburse the token of appreciation (see **Attachment 5**). Although CDC will own the data, neither CDC nor the evaluation contractor will have access to respondents' names and contact information. This information is maintained separately by the vendor and is not part of the survey system. Additionally, the vendor will not have access to the survey responses. Thus, survey responses cannot be linked to individuals' names, email addresses, or telephone numbers.

Some online survey panel vendors also collect IP addresses to reduce the likelihood of 'ballot box stuffing,' which is when the same individual attempts to take the same survey more than once for financial gain. If this feature is available through a vendor, recording IP addresses (which is considered information in identifiable form [IIF]) is a requirement of individuals' participation in the panel. IP addresses will be automatically included in the data file that is downloaded by the evaluation contractor if this is the case. The evaluation contractor will delete the IP addresses from the data file immediately upon download. CDC will only have access to the deidentified data file. When working with a survey panel vendor that records IP addresses, the consent form will inform individuals that this is the case and the reason why this is necessary. Individuals who do not agree to this condition can decline to take the survey.

It is possible that someone else (e.g., a family member, friend, etc.) could view the survey on the respondent'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 and recommend that they close their browser window when they are finished taking the survey or if they wish to withdraw from the study.

The online survey panel vendors take the following security measures to ensure separation between respondents' identity and their survey data.

- The survey instrument (which also includes the screener) will not include (or collect) IIF maintained by the survey panel vendors.
- Although the survey invitation method will inherently include IIF (e.g., email addresses), this information will not be combined with survey responses; thus, there is no link between individuals' names and contact information and survey responses.
- Although some survey panel vendors record IP addresses and include them in the data file, the evaluation contractor will delete this information when they download the data file. Therefore, the data file maintained by the contractor will not include IIF.
- The vendor will provide screener data for all panelists, regardless of whether they qualify for the study. However, they will not retain screener data for those who are deemed ineligible for any other purpose outside the scope of this project.
- The vendors will retain study records for the duration of the study. Upon final delivery of data files to the evaluation contractor and completion of the project, the vendors will destroy all study records, including data files, upon request.

The evaluation contractor will maintain restricted access to all project data. Data are kept on a network drive behind the contractor's firewall that requires multi-factor authentication to access. Within the contractor's firewall, access to the folder with data are restricted to only select users who need access to carryout project work.

Screener and survey data will be encrypted end-to-end in both transmission and at rest. Data are transmitted from the user's device by SSL the survey platform. The survey vendor will initially store the data on a hard drive, and the data will be encrypted. This means individuals who are not authorized to access the data will be unable to do so, even if they have physical access to the hard drive. For the evaluation contractor to retrieve the data, they will need to use their master key to decrypt and then download the data by SSL. Only the evaluation contractor can decrypt and download the data. No more than two contractor staff have access to the master key which reduces the risk that IIF will be exposed. The survey vendors have no logical access

to the data or a master key to decrypt the data. With the data encrypted at rest, even in the event of a physical breach at the vendors' location, the data would not be readable by any party.

A.11 Institutional Review Board (IRB) and Justification for Sensitive Questions

Institutional Review Board

CDC has determined that the planned data collections is not research involving human subjects; therefore, IRB approval is not required.

Sensitive Questions

The goal of AAA is to combat complacency about HIV and AIDS in the United States among specific target audiences. Therefore, it will be necessary to ask sensitive demographic and behavioral questions in the screener (**Attachment 6**) and survey (**Attachment 3**) to ensure inclusion of individuals representing targeted groups and to determine the extent to which exposure to AAA messages affects outcomes of interest. For example, if CDC develops a campaign phase to raise awareness of HIV testing among young MSM, they will need to ask sensitive questions about sexual orientation, HIV testing, and HIV status to identify the target audience and determine the extent to which exposure to AAA messages is associated with HIV testing behaviors and identify specific factors that may diminish their effectiveness. **Attachment 7** includes a list of sensitive questions that may be included in the screener and survey.

Potentially sensitive screening topics include the following:

- Sexual orientation
- Sexual behavior
- HIV testing
- HIV status
- HIV diagnosis date
- HIV status of sexual partners

Potentially sensitive survey topics include the following:

- Perceived risk for HIV
- Condom use
- PEP and PrEP use

The introduction to the screener clarifies the target audience and the purpose of the research and describes the sensitive questions that will be asked. Individuals will also be informed that their participation is voluntary, that they can refuse to answer any question or stop participating at any time, and that their information will be protected to the extent permissible by law. Only individuals who consent to screening will be asked screening questions. Individuals who are eligible and choose to participate in the survey are presented with more in-depth information covering these same topics before taking the survey. Individuals must indicate separate consent for the web survey to proceed with the study.

A.12 Estimates of Annualized Burden Hours and Costs

The overall annual burden per respondent was calculated by summing the burden hours for the screener and survey. Note that the calculations are based on a sample size of 5,445 over the one-year period, the number of remaining approved respondents. During this one-year project, we anticipate screening 30,880 individuals to yield 5,445 survey respondents. The total estimated burden hours are 1,029 for the screener and 2,722 for the survey. To calculate the burden hours, we multiplied the number of respondents for each data collection by the average time burden per response (approximately 2 minutes for the study screener and 30 minutes for the survey). The annual response burden is estimated at 3,751 hours; for this one-year generic ICR, this is also the total number of estimated burden hours.

Exhibit A.12.1 Annualized Burden Hours

Respondents	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in Hours)	Total Burden Hours
Study Screener (**Attachment 6**)	30,880	1	2/60	1,029
Survey Module (**Attachment 3**)	5,445	1	30/60	2,722
Total				**3,751**

Because we do not know what the wage rate category will be for these selected respondents (or even whether they will be employed at all), we used $22.69 per hour as an estimate of average hourly wage across the country (Bureau of Labor Statistics, 2017). The

estimated annual cost to respondents will be $85,110.19. This is also the total estimated cost to respondents for this one-year generic ICR.

Exhibit A.12.2 Annualized Cost to Respondents

Respondents	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in Hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Study Screener (**Attachment 6**)	30,880	1	2/60	1,029	$22.69	$23,348.01
Survey (**Attachment 3**)	5,445	1	30/60	2,722	$22.69	$61,762.18
Total						**$85,110.19**

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 annual cost to the federal government is estimated to be $253,378. This is the cost estimated by CDC's contractor, and includes the estimated cost of coordination with CDC, data collection, analysis, and reporting. For this one-year generic ICR, this is also the total estimated cost to the government.

Exhibit A.14.1 Annualized Costs to the Government

Item/Activity	Details	$ Total Amount
CDC oversight of contractor and project	20% of FTE: GS-13 Health Communication Specialist	$18,326
Recruitment and data collection (contractor)	320 labor hours, data collection subcontract with e-Rewards, and ODCs	$150,450

Analysis and reporting (contractor)	640 labor hours and ODCs	$84,602
Total		**$253,378**

FTE = full-time equivalent; ODC = other direct cost

A.15 Explanation for Program Changes or Adjustments

This is an extension without change request for generic IC 0920-0920. There are no program changes or adjustments We are requesting additional time to use the remaining burden hours.

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

Data from this study will be tabulated and published. The analyses will vary depending on which survey items are administered. 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 or messages and outcomes of interest. For example, we will use regression modeling to assess the extent to which campaign exposure is associated with HIV testing, where self-reported receipt of HIV testing is specified as the dependent variable and 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.

Publications will include evaluation reports and peer-reviewed manuscripts. The 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 (e.g., the target audiences, practitioners, policy makers, and researchers). The evaluation reports will include an executive summary, an overview of the 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; strengths and limitations of the evaluation; and recommendations for improving AAA messages and dissemination efforts; and applicable appendices. The results of our study also will be used to develop at least one manuscript that summarizes findings to be published in a peer-reviewed journal (e.g., *American Journal of Public Health*, *Journal of Health Communication*).

The project timeline for this one-year Generic ICR is shown in Exhibit A.16.1. Data collections will coincide with the development of AAA messages/campaign phase; two to three data collections will take place annually. Each round of testing, encompassing recruitment, data collection and analysis, and preparation of the final report, will take approximately five months to complete.

Exhibit A.16.1 Project Time Schedule

Project Activity	Time Schedule
ICR clearance	January 2022
Recruitment	2 months after OMB approval
Data collection	3 months after OMB approval
Data analysis	4 months after OMB approval
Complete final report	5 months after OMB approval
Publish peer-reviewed manuscript	12-18 months after OMB approval

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.

REFERENCES

Abreu, D. A., & Winters, F. (1999). Using monetary incentives to reduce attrition in the survey of income and program participation. In *Proceedings of the Survey Research Methods Section of the American Statistical Association*.

Biner, P. M., & Kidd, H. J. (1994). The interactive effects of monetary incentive justification and questionnaire length on mail survey response rates. *Psychology and Marketing, 11*(5), 483–492.

Bureau of Labor Statistics (BLS). (2017, May). *May 2017 state occupational employment and wage estimates: Georgia* [Data table]. Retrieved from https://www.bls.gov/oes/2017/may/oes_ga.htm#00-0000

Centers for Disease Control and Prevention (CDC). (2016a, February). *Trends in U.S. HIV diagnoses, 2005-2014* [Fact sheet]. Retrieved from https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/hiv-data-trends-fact-sheet-508.pdf

Centers for Disease Control and Prevention (CDC). (2016b, December). Social determinants of health and selected HIV care outcomes among adults with diagnosed HIV infection in 32 states and the District of Columbia, 2014. *HIV Surveillance Supplemental Report, 21*(7). Retrieved from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-7.pdf

Centers for Disease Control and Prevention (CDC). (2017a, November). *HIV in the United States: At a glance* [Infographic]. Retrieved from https://www.cdc.gov/hiv/pdf/statistics/overview/cdc-hiv-us-ataglance.pdf

Centers for Disease Control and Prevention (CDC). (2017b, November). Diagnoses of HIV infection in the United States and dependent areas, 2016. *HIV Surveillance Report, 28*. Retrieved from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

Centers for Disease Control and Prevention (CDC). (2018a, February). *HIV among gay and bisexual men* [Web page]. Retrieved from https://www.cdc.gov/hiv/group/msm/index.html

Centers for Disease Control and Prevention (CDC). (2018b, February). *HIV among youth* [Web page]. Retrieved from https://www.cdc.gov/hiv/group/age/youth/index.html

Centers for Disease Control and Prevention (CDC). (2018c, February). *HIV among African Americans* [Web page]. Retrieved from https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html

Centers for Disease Control and Prevention (CDC). (2018d, February). *HIV among Hispanics/Latinos* [Web page]. Retrieved from https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html

Centers for Disease Control and Prevention (CDC). (2018e, March). *HIV among women* [Web page]. Retrieved from https://www.cdc.gov/hiv/group/gender/women/index.html

Dillman, D. A. (1978). *Mail and telephone surveys: The total design method*. New York: Wiley.

Göritz, A. S. (2006). Incentives in web surveys: Methodological issues and a review. *International Journal of Internet Science, 1*, 58–70.

Groves, R. M., Cialdini, R. B., & Couper, M. P. (1992). Understanding the decision to participate in a survey. *Public Opinion Quarterly, 56*, 475–495.

Groves, R. M., Singer, E., & Corning A. D. (2000). A leverage-saliency theory of survey participation: Description and illustration. *Public Opinion Quarterly, 64*, 299–308.

McGrath, D. E. (2006, December). *An incentives experiment in the U.S. Consumer Expenditure Quarterly Survey*. Prepared for the Bureau of Labor Statistics. Retrieved from https://www.bls.gov/osmr/pdf/st060030.pdf

Office of Information and Regulatory Affairs, Office of Management and Budget (OMB). (2006, January). *Questions and answers when designing surveys for information collections*. Retrieved from http://www.cio.noaa.gov/itmanagement/pdfs/OMBSurveyGuidance_0106.pdf

Shettle, C., & Mooney, G. (1999). Monetary incentives in U.S. government surveys. *Journal of Official Statistics, 15*, 231–250.

Yu, J., & Cooper, H. (1983). A quantitative review of research design effects on response rates to questionnaires. *Journal of Marketing Research, 20*, 36–44.