

Sexually Transmitted Infection Services at U.S. Colleges and Universities

OMB # 0920-new

Supporting Statement

Part A

March 21, 2014

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Sexually Transmitted Infection Services at U.S. Colleges and Universities

A. Justification

A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) requests a new one year OMB approval for information collection to conduct a new information collection entitled, “Sexually Transmitted Infection Services at U.S. Colleges and Universities” The project proposes to survey U.S. colleges and universities on the provision of sexual and reproductive health services to assess the availability of HIV and STI education, treatment, and prevention services at U.S. colleges and universities.

Background

Encouraging youth and young adults to be tested for sexually transmitted infections/human immunodeficiency virus (STI/HIV) is a major goal of the Division of STD Prevention, particularly because these diseases often show no symptoms, but cause long-term consequences. The Division has worked closely for the past 4 years with the American College Health Association to promote STI & HIV testing on college campuses. However, more formal research is needed to determine the extent to which HIV/STI education, treatment, and prevention services are being offered on campus, and to better understand why, if not. Moreover, a closer look is needed at the varying types of college campuses, for example community colleges, and schools with significant minority enrollment, to determine whether they are able to offer these services especially given that they may have a more at-risk population. Significant minority enrollment refers to schools that are identified as minority serving institutes in one of two ways: 1) Legislation. Title III of the Higher Education Act of 1965, designated a specific set of accredited institutions as Historically Black Colleges and Universities (HBCUs), whose primary mission was to educate African Americans. Three separate pieces of legislation also designated institutions that primarily serve American Indian populations as Tribal Colleges and Universities (TCU). 2) Enrollment based-criteria. Non-HBCU and Non-TCU with at least 25% of the student body consisting of one ethnic/race minority or if it does not meet the 25% threshold for any one minority group, but minority students as a whole comprised at least 50% of the total student body.

The objectives of this study are to 1) describe the proportion of schools providing and the percentage of students with access to HIV and sexually transmitted disease education, treatment, and prevention services at 2-year and 4-year U.S. colleges and universities and 2) determine the proportion of colleges not offering health services on campus and explore the reasons why. The information will be used to provide technical assistance to colleges and universities interested in alternative solutions for providing health care services to their students.

Availability of Services & Burden of Disease

Of the over 30 million 18 – 24 year olds in the U.S., approximately 43% are currently enrolled in college or graduate school. In the U.S., young adulthood is the peak age group for many risk behaviors including unprotected sex. College students, who are typically at the age of most risk for acquiring a sexually transmitted infection, may face challenges when seeking sexual and

reproductive health care on campus. The last national study exploring the availability of STI services in U.S. colleges and universities (2- and 4-year) was conducted in 2001 and found that only 60% (474/736) of schools had a health center (Koumans et al., 2001). Health centers tended to be more common among larger schools, those that were privately funded and 4-year universities that provided student housing. Of the health centers, 66% provided STI services, 55% provided obstetrical and gynecologic care, and 54% provided contraceptive services. Likewise, NSFG data estimates that the percentage of 18- to 22-year-olds ever tested for HIV is 34.2%; and only 18% reported being tested in the past year. Although risk factors for HIV/STI transmission (e.g., sex with multiple partners, unprotected sex, and using drugs or alcohol during sexual activity) can be particularly evident among college students in general, students enrolled at colleges with significant minority enrollment (e.g. Historically Black Universities and Colleges, Hispanic Serving Institutes) may face additional challenges such as greater risk of transmission during new sexual encounters due to sexual partner networks and limited access to quality healthcare and prevention education in addition to a lack of awareness of risk.

Justification for the survey

There are nearly 4,500 degree-granting institutions of higher education in the U.S., enrolling more than 19 million students (National Center for Education Statistics). These institutions comprise a mix of public and private institutions, technical schools, community colleges, 4-year colleges, and large research universities. The total number of schools that have a designated health center or in some way provide health care services to their students is unknown, and there is no accessible database with this information. As a result, the delivery of collegiate sexual health and reproductive services is not a standardized practice. Each college and university has its own unique set of circumstances; some colleges simply do not have the funds, personnel, resources, or the capacity to offer such services. Whereas a large university may have a fully-functioning and staffed, accredited student health center, student health may not even exist at the community college or 2-year college on the other side of town. In other scenarios, a school may have a health center that operates on limited hours or is run by a nurse practitioner; a physician may only be on site 1-2 days a week.

In this context, it is clear that not all schools are equipped to provide STI/HIV testing on campus or offer testing to the masses. Not surprisingly, college students are disproportionately affected by sexually transmitted infections (STIs) due to the unique challenges they face throughout their college careers. STDs impose a considerable health and economic burden among college-aged students. College students report engaging in a number of high-risk behaviors, including having multiple sex partners, unprotected sex, using drugs and binge drinking during sex (ACHA-NCHA-II, 2012). Likewise, it is important to remember that the delivery of health care starts with insurance; those that without it are less likely to seek it unless absolutely necessary. This statement is very true among the college population. Given that young adults are typically in good health, they feel more secure taking the risk of foregoing health insurance, especially when it competes for resources with tuition, books and living expenses.

Moreover, health disparities exist and persist among young people on college campuses, and the paucity of data on college students, across diverse collegiate settings, inhibits STI prevention and sexual health promotion efforts. Community colleges and minority serving institutes (e.g. Historically Black Universities and Colleges, Hispanic Serving Institutes) are understudied

populations and prime examples of how disparities can exist across collegiate settings, and well as how the data gaps make it difficult to focus STI prevention resources and efforts. Some evidence suggests that community college students are more likely than students at 4 year colleges to test positive for STDs (Rosenbaum, 2012), but research on this population is scarce. Likewise, STI prevalence, sexual risk and testing behaviors on minority serving institutes are not well documented and warrant further exploration regarding factors such as geographic location, how imbedded the university is into the community, social norms around sexual health on college campuses, and health services offered. Minority Serving Institutions are strategically situated to be primary promoters of HIV/STI prevention because they serve as a source of pride and accomplishment among their communities. This, in addition to the disproportionately high rates of STDs among these groups, makes it imperative to investigate innovative ways to link individuals to quality accessible and affordable sexual health services, when not available on campus.

The Centers for Disease Control and Prevention proposes to conduct a survey (see **Attachment 3**) on U.S. College and universities and their provision of health services to enrolled students. The survey will 1) describe the proportion of schools providing, and the percentage of students with access to, HIV and STI education, treatment and prevention services and 2) estimate the proportion of schools not offering health services on campus and explore reasons why. Information obtained will be used to provide technical assistance to schools interested in alternative solutions for providing health care services to their students.

Because youth and young adults bear higher burdens of STIs/HIV, it is essential to examine the institutions providing their health services. The list of eligible respondents comes from the Integrated Postsecondary Education Data System (IPEDS), using 2011 enrollment data. Applying our criteria to include only active, 2- or 4-year, degree granting, accredited public or private schools, that enrolled at least 500 undergraduates and/or graduate students located in the 50 states and the District of Columbia our total population was 2,753 schools. From these we sampled a stratified random sample of 885 universities and colleges to survey on their provision of health services as they relate to HIV & STI education, treatment and prevention.

The investigators will email an introductory letter inviting the contact person at each school to participate in the survey, noting that the questionnaire should be completed by the person with the most knowledge and access to information about health services on campus. After agreeing to terms outlined in the letter, participants will click a link to begin the self-administered electronic questionnaire (via SurveyMonkey). Schools will have 3 weeks to respond to the survey. Investigators will send a reminder at 1.5 weeks, 3 days prior to closeout, and then day of. This may need to be extended in order to achieve adequate power for analyses. Once all the surveys are returned, two researchers will review and contact schools about inconsistent or invalid responses, and make corrections as needed. Basic school characteristics will be gathered from the IPEDs database on each school (e.g. institution type, funding type, size of enrollments, region, etc.). The sampling frame of 2,753 schools was stratified by institution size and oversampled for larger schools because those schools are more likely to have a health center. Smaller schools are also oversampled because one of the purposes for this survey is determine alternative solutions for providing health care services for school not likely to have a student health center.

Survey and data collection will be administered and collected via an electronically self-administered questionnaire using SurveyMonkey. The survey will be a one-time, 45 minute

survey exploring student health insurance coverage, fees associated with health care, accessibility to health care on campus or linkage to care elsewhere, and student health center offerings, including: preventative services, partner management, STI/HIV prevention, education, screening, testing and treatment, confidentiality/privacy assurances, and the need for technical assistance from CDC. Individuals will be given a 3 week period to complete their survey. Expected length of data collection is approximately 4 months. This request is authorized by Title III – General Powers and Duties of the Public Health Service, Section 301 (241.)a. Research and investigations generally (Attachment 1).

A.1.2 Privacy Impact Assessment

The survey will ask questions about student health insurance coverage, fees associated with health care, accessibility to health care on campus or linkage to care elsewhere, and student health center offerings, including: preventative services, partner management, STI/HIV prevention, education, screening, testing and treatment, confidentiality/privacy assurances, and the need for technical assistance from CDC).

Information will be collected electronically. During the data collection period, only the name, title and contact information of the person filling out the survey will be obtained for the purpose of tracking participation and completion of the questionnaires, as well as to follow-up about inconsistent or invalid responses. However, records will be deidentified in the final analysis and only aggregated data will be reported. Neither students enrolled at the school nor the person filling out the questionnaire will have sensitive information collected about them. No personal opinions about the current state of health services offered or the student using or not using these services will be asked. Unit of analysis will be the institution (school) and the data collected is on the institution, rather than the individual, level. Name, email and phone number will be collected from the person completing the survey for tracking and follow-up purposes only. Data extracted from the survey for analysis purposes will not include this information. Only information regarding the institutions will be extracted and analyzed. Furthermore, only aggregated institutional level data will be reported. Survey data will be collected via SurveyMonkey¹, then downloaded and stored on secure CDC servers accessible to only active project staff. All electronic files will be password controlled, accessible only to fully authorized personnel, and maintained and protected to the extent allowable by law.

A.1.3 Overview of the Data Collection System

CDC will implement all phases of the survey implementation.

The list of eligible respondents comes from the Integrated Postsecondary Education Data System (IPEDS), using 2011 enrollment data. Applying our criteria to include only active, 2- or 4-year, degree granting, accredited public or not-for-profit private schools, that enrolled undergraduates and/or graduate students located in the 50 states and the District of Columbia. Our total population was 2,753 schools. From these we will select a proportional stratified random sample of 885 universities and colleges to survey on their provision of health services as they relate to HIV & STI education, treatment, and prevention.

¹ SurveyMonkey Security Statement can be found here: <https://www.surveymonkey.com/mp/policy/security/>

The survey duration of 45 minutes is necessary because of the complex material being measured.

- The information collection activity included in this request involves: Assessing proportion of schools providing, and the percentage of students with access to, HIV and sexually transmitted disease education, treatment, and prevention services at 2-year and 4-year U.S. colleges and universities via web-based surveys (N=885) completed by health services staff or others with knowledge of the information requested.

Data will be collected over a 4 month period.

A.1.4 Items of Information to be Collected

The proposed study will collect information on the following: student health insurance coverage, fees associated with health care, accessibility to health care on campus or linkage to care elsewhere, and student health center offerings, including: preventative services, partner management, STI/HIV prevention, education, screening, testing and treatment, confidentiality/privacy assurances, and the need for technical assistance from CDC. A copy of the survey instrument is in **Attachment 3**.

A.1.5 Identification of Web Site(s) and Web Site Content Directed at Children Under 13 Years of Age

This information collection does not involve Web sites or Web content directed at children. CDC will host the Web-based survey through the Division of STD Prevention's SurveyMonkey account. DSTDP has controlled access to this site. Survey participants will be selected from a public Postsecondary Educational Data System and will be the only ones with access to the survey. All of the survey participants are working professionals and all are adults.

A.2 Purpose and Use of the Information Collection

The purpose of this data collection is to assess the proportion of colleges providing, and the percentage of students with access to, HIV and sexually transmitted infection education, treatment, and prevention services at 2-year and 4-year U.S. colleges and universities. This information will be based on data collected from 885 colleges and universities. No sensitive information will be asked of the respondents. The data will be collected through a 45-minute, web-based survey. Data from the survey will then be quantitatively (and in some instances, qualitatively) evaluated to determine the proportion of colleges and universities providing students with HIV/STI health services.

This information needs to be collected in order to: describe the state of STI/HIV health services at 2-year and 4-year U.S. colleges and universities. The information will also provide an estimate of the proportion of colleges not offering health services on campus and explore the reasons as to why. The information obtained from the proposed data collection will be used by CDC to provide technical assistance to colleges and universities interested in alternative solutions for providing health care services to their students. A copy of the survey instrument is provided in **Attachment 3**.

Because college and universities serve young adults (including minority youth), and may be located in populations with higher rates of STI/HIV than the general population, it is essential to examine the breadth of STI/HIV health services being offered on college campuses. If college health services are not assessed, there will be no evidence-based criteria which can be used to guide future technical assistance to colleges and universities or funding opportunities for colleges to receive assistance for these types of services. Additionally, future efforts to communicate with campus administrators about STI/HIV issues will be hampered by the lack of evidence.

CDC will disseminate the study results to the public through reports prepared by CDC and through peer-reviewed journal articles and related presentations. All releases of information will be reviewed and approved by CDC.

A.3 Use of Improved Information Technology and Burden Reduction

This survey will rely on a Web-based survey tool to be self-administered at home or at work on personal computers. Use of the Web and electronic surveys allows participants to complete as much of the survey as desired in one sitting and to continue the survey at another time. The technology also minimizes the possibility of participant error by electronically skipping questions that are not applicable to a particular participant, thus minimizing participant burden. The use of this web-based technology for data collection will also help to reduce interviewer biases and minimize social desirability.

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

The last national study exploring the availability of STI services in U.S. colleges and universities (2- and 4-year) was conducted in 2001 by Koumans et al. Although similar to our study regarding unit of analysis (i.e., school) and methodology (i.e., oversampling of larger schools), our data sources differ in that our sampling frame comes from the Integrated Postsecondary education data system, whereas the Koumans study pulls its sample from Peterson's Publishing and Research undergraduate data. Also, the questions on our survey differ in that we do not only want to describe services provided at schools with the capacity to provide them (i.e., larger schools with health centers) but we include questions aimed to describe the reasons as to why some schools do not provide services. We hope to answer this question by oversampling smaller schools as well. Whether it is due to lack of resources or perception of need, our survey aims to describe possible structural and environmental factors that may affect provision of services. The current research on these factors is limited in that they are restricted to a small number of schools not generalizable to all schools in the nation. The ACHA's Annual Pap Test and STI Survey and National College Health Assessment reveal important health services and behavioral data on our nation's college students; however the schools are self-selected and primarily reflect four year universities and capture a very low proportion of minority serving institutes and community colleges.

A.5 Impact on Small Businesses or Other Small Entities

This collection request does not involve burden to small businesses or other small entities. This includes small universities and colleges.

A.6 Consequences of Collecting the Information Less Frequently

The activities involve a one-time collection of data over a 4 month period. Repeated surveys are not projected.

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

This data collection request fully complies with the regulation 5 CFR 1320.5.

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

A Federal Register Notice was published on December 3, 2013; Volume 78, No. 232, Pp 72677-72679. (see **Attachment 2**). One non-substantive comment received on December 9, 2013. CDC's standard response was sent.

No consultations were made from any person or entity outside the agency.

A.9 Explanation of Any Payment or Gift to Respondents

No incentives are being provided for participation in this survey.

A.10 Assurance of Confidentiality Provided to Respondents

This submission has been reviewed by the NCHHSTP who determined that the Privacy Act does not apply because CDC is not receiving any person identifiable information. During the data collection period, only the name, title and contact information of the person filling out the survey will be obtained for the purpose of tracking participation and completion of questionnaires, as well as to follow-up about inconsistent or invalid responses. Records will be deidentified in the final analysis and only aggregated data will be reported. Neither students enrolled at the school nor the person filling out the questionnaire will have sensitive information collected about them. No personal opinions about the current state of health services offered or the student using or not using these services will be asked. CDC will retain contact information on participants for future technical assistance. All participants will be assured that the IIF will be used only for the purpose of this research and will be kept private to the extent allowable by law, as detailed in the invitation/consent email (see **Attachment 4**). All electronic files will be password controlled, accessible only to fully authorized personnel, and maintained and protected to the extent allowable by law.

Participants will be assured that their answers to the survey questions (see **Attachment 3**) will not be shared with anyone outside the research team and that their names will not be reported with responses provided. Participants 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 institution.

Once a potential participant has entered the secure Web site, a brief introduction will inform the participant of the secure and voluntary nature of the survey. After reading the invitation/consent email, each participant must either agree to participate or choose not to participate in the survey. Those who agree to participate will click on the URL and will be directed to a page that where they will indicate their consent by clicking a box that will then take them to the survey. A participant's unique ID number will not change. It is possible that if a participant does not log out or close the survey a colleague, spouse, family member, or someone else could view the a participant's responses without his or her knowledge, which may expose their responses.

Upon completion of final reports, CDC will retain these data for purposes of operational research, such as studies of response rates. Five years after the end of the project period, all data will be archived appropriately.

Privacy Impact Assessment

Information will be collected electronically. During the data collection period, only the name, title and contact information of the person filling out the survey will be obtained for the purpose of tracking participation and completion of questionnaires, as well as to follow-up about inconsistent or invalid responses. Records will be deidentified in the final analysis and only aggregated data will be reported. Neither students enrolled at the school nor the person filling out the questionnaire will have sensitive information collected about them. No personal opinions about the current state of health services offered or the student using or not using these services will be asked. CDC will not receive any personally identifiable information (PII). Therefore, the Privacy Act does not apply. All electronic survey data records are stored in a secured database that does not contain personally identifying information. No evaluation materials, surveys, Web sites or Internet content will be directed at anyone who is not an adult. All personal identifiers needed to locate potential participants will be stored in separate locked offices in a secured facility. All electronic files will be password controlled, accessible only to fully authorized personnel, and maintained and protected to the extent allowable by law.

This study does not entail the measurement of any sensitive information. All participants will be assured that the information will be used only for the purpose of this research and will be kept private to the extent allowable by law. The invitation/consent email includes a statement about this risk and informs participants that they may choose not to answer a particular question if they wish and/or end the study at any time without penalty. Participants will be assured by 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. Participants will be told that the information obtained from all of the surveys will be combined into a summary report so that details of individual responses cannot be linked to a specific participant.

CDC 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 authorized personnel only, with access limited to project staff on a "need-to-know" basis only.

A.11 Justification for Sensitive Questions

Not applicable. This study does not ask questions of a sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

A. Estimated Annualized Burden Hours

Exhibits A.12.A and A.12.B provide details about how this estimate was calculated. 885 Health Services Directors or Campus Administrations will take the college web-based survey, which will take 45 minutes to complete for a total of 664 burden hours. The total annualized response burden is estimated at 664 hours.

Exhibit A.12-1. Annualized Burden Hours

Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (hrs.)	Total Burden in Hours
Health Services Directors or Campus Administrators	College Survey Att3	885	1	45/60	664
Total					664

A.12.B Estimated Annualized Costs

The figure of \$47.77 per hour as an estimate of average hourly wage rate across the country for the general public was obtained from the United States Department of Labor, Bureau of Labor Statistics; May, 2012(http://www.bls.gov/oes/current/oes_nat.htm#00-0000). The estimated annual cost to participants for the collection of information will be \$31,719.

Exhibit A.12.B Annualized Cost to Respondents

Activity	Total Burden Hours	Hourly Wage Rate	Total Respondent Cost
College Survey	664	47.77	\$31,719
Total	664		\$31,719

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

None. CDC does not anticipate providing start up or other related costs to private entities.

A.14 Annualized Costs to the Federal Government

One CDC Technical Monitor will be responsible for obtaining CDC approvals, providing project oversight, and participating in data collection, analysis and dissemination of the results.

Exhibit A.14.A Estimates of Annualized Cost to the Government

Expense Type	Expense Explanation	Annual Costs
CDC oversight of project	10% of FTE: GS-12 Health Scientist	\$8,000
Recruitment, data collection, analysis, and reporting	100% (15/hrs week - \$9) of work study student	\$2,500
	25% of ORISE Fellow	\$13,140
	Total	\$23,640

A. 15. Explanation for Program Changes or Adjustments

Not applicable – request is for a collection under a new ICR.

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

Data analysis will be conducted to describe the proportion of colleges and universities providing, and the percentage of students with access to, HIV and sexually transmitted disease education, treatment, and prevention services at 2-year and 4-year U.S. colleges and universities. Data will be analyzed overall, as well as by school characteristics (size, region, 2-year vs. 4-year, significant minority enrollment, etc.). Response rates for individual questions will be calculated. Data analysis will include basic summary statistics for the purposes of describing the sample and examining the distribution of the primary outcome variables. Analyses will focus on the primary question to be addressed: what proportion of colleges and universities are providing students with access to STI/HIV education, treatment, and prevention services, and if not, why. CDC will disseminate the study results to the public through peer-reviewed journal articles and related presentations.

The key events and reports to be prepared are listed in ***Exhibit 16.A***

Exhibit 16.A Project Time Schedule

Project Activity	Time Schedule
Data collection	1 months after OMB approval
Data analysis	3 month after completion of data collection
Submit manuscript for clearance	6 month after completion of data analysis

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

OMB Expiration Date will be displayed.

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

There are no exceptions to the certification.