

“Assessing School-Centered HIV/STD Prevention Efforts in a Local Education Agency”

OMB #0920-14YI

Supporting Statement Part A

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Division of Adolescent and School Health
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Section A: Justification for Information Collection

A. 1 Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention (CDC) requests a 3-year OMB approval to conduct a new information collection entitled, “Assessing School-Centered HIV/STD Prevention Efforts in a Local Education Agency”. The information collection uses a self-administered paper-pencil questionnaire, the Youth Health and School Climate Questionnaire, to conduct in-depth assessment of HIV and STD prevention efforts that are taking place in one local education agency (LEA) funded by the Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH) under strategy 4 (School-Centered HIV/STD Prevention for Young Men Who Have Sex with Men) of PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance*. Under this cooperative agreement, the participating school district identified 7 high schools in which it would conduct programmatic work. As part of the agreement to receive program activities from the school district, each of the 7 participating schools also agreed to participate in the evaluation activities requested by the district (which includes this proposed information collection) (see **Attachment 9** for the letter of agreement the district used to recruit schools for participation in the program as well as the related evaluation components). CDC’s role in this information collection is that it is helping provide technical assistance and support for the local education agency (school district) to conduct this evaluation of its CDC-funded programmatic work.

Data will be collected from an estimated 16,500 high school students from all 7 of the participating schools in both 2014 and in 2016. The goal of the data collection is to provide data and reports for the funded LEA and allow the LEA to identify areas of the program that are working well and other areas that will need additional improvement. In addition, the findings will allow CDC to determine if changes in key outcomes took place following the implementation of currently recommended strategies and make changes to those recommendations if necessary. Data will be collected by LEA staff with support from a CDC-funded evaluation contractor. The questionnaire will include questions on the following topics: demographic information; HIV and STD risk behaviors; use of HIV and STD health services; experiences at school, including school connectedness, harassment and bullying, homophobia, support of LGBTQ students; receipt of referral for HIV and STD prevention health services; and health education.

CDC’s DASH awarded funds to implement PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance* in order to build the capacity of state and local education agencies and support the efforts of national, non-governmental organizations (NGOs) to help priority school districts (districts) and schools develop and implement sustainable adolescent-focused program activities. Within that

cooperative agreement, three local education agencies and one national, non-governmental organization were funded under strategy 4 for to prevent HIV and STDs among 13-19 year old black and Latino young men who have sex with men (YMSM). In this project, YMSM are defined to include young men who report sexual activity with other males, attraction to other males, or who identify as gay or bisexual. Program activities funded by the cooperative agreement will focus on impacting short-term and intermediate outcomes believed to lead to the prevention of HIV and STDs. Of specific interest, are increasing access of students (particularly YMSM) to key sexual health services and making the school environment safer and more supportive for YMSM. The safer and more supportive environment for YMSM is seen as a foundational requirement for school staff to be able to increase access to sexual health services. The primary programmatic activities include implementation of a referral system for connecting youth to key services, programs and professional development to improve school climate, social marketing campaigns that address key outcomes, and educating staff on existing policies that are related to access to care or the school environment. These program activities are expected to impact key short-term and intermediate outcomes (preventive and risk behaviors, and perceptions) assessed by the student questionnaire in this ICR, including HIV and STD risk behaviors; use of HIV and STD health services; experiences at school, including school connectedness, harassment and bullying, homophobia, support of LGBTQ students; receipt of referral for HIV and STD prevention health services; and health education. The purpose of this ICR is to collect data to directly assess changes in these key outcomes, all of which are tied to specific aspects of the programmatic work. These key short-term and intermediate outcomes are believed critical for movement in the longer-term goal of preventing HIV and other STDs.

In addition, it is important to note that although the focus of the work is to prevent HIV and STDs among YMSM, the specific nature of school settings often requires that programs to reach YMSM be broader in scope such that they reach and serve all students (or larger subgroups of students, such as all males) within the schools. This broader frame is essential so that YMSM can receive critical services even in instances where they are not comfortable disclosing sexual identities to others in the schools. Given this, the activities of this program are currently designed to reach all youth in the schools (for example, a referral system will be implemented to link any student in the school to necessary services), and will have aspects or components that are designed to specifically meet the unique needs of YMSM. Because of this, data will also be analyzed to look for changes in key outcomes among all students as well as among the priority group of YMSM students.

HIV infections remain high among young men who have sex with men.¹ The estimated number of new HIV infections increased between 2008 and 2010 both overall and among MSM ages 13 to 24.² Furthermore, sexual risk behaviors associated with HIV, other sexually transmitted disease (STD), and pregnancy often emerge in adolescence. For example, 2011 Youth Risk Behavior Surveillance System (YRBSS) data revealed 47.4% of U.S. high school students reported having had sex, and among those who had sex in the previous three months, 39.8% reported having not used a condom during last sexual intercourse.³ In addition, 2001-2009 YRBSS data revealed high school students identifying as gay, lesbian, and bisexual and those reporting sexual contact with both males and females were more likely to engage in sexual risk-taking behaviors than heterosexual students.⁴

Given the disproportionate risk for HIV among YMSM ages 13-24, it is important to find

ways to reach the younger youth (i.e., ages 13-19) in this range to decrease sexual risk behaviors and increase health-promoting behaviors such as routine HIV testing. Schools provide one opportunity for this. Because schools enroll more than 22 million teens (ages 14-19)⁵ and often have existing health and social services infrastructure, schools and their staff members are well-positioned to connect youth to a wide range of needed services, including housing assistance, support groups, and sexual health services such as HIV testing. As a result, CDC's DASH has focused a number of HIV and STD prevention efforts on strategies that can be implemented in or centered around schools.

The proposed data collection applies to only strategy 4 of PS13-1308, and it is part of a multi-component assessment of the HIV and STD prevention work conducted by the three LEAs and one NGO funded for strategy 4. The proposed data collection will involve administration of paper-and-pencil questionnaires to all students in the seven high schools participating in the project in one of the funded LEAs. This component of the assessment is designed to provide in-depth assessment findings for a single LEA. All students will be invited to participate in questionnaire administration for two reasons: (1) program activities are designed in a manner that will reach all students even though certain aspects will be more tailored to YMSM, and (2) it is critical to collect data from all students in order to have a sufficient number of YMSM included in the analysis sample to support statistical analyses for that subgroup of interest. YMSM students are estimated to make up a small percent of the general student population; as a point of reference, weighted data from 10 school districts participating in the Youth Risk Behavior Surveillance System (YRBSS) between 2009 and 2011 revealed that 5.4% of males reported being gay or bisexual, and an additional 3.0% reported being not sure about their sexual identity.⁶

CDC is authorized to collect the data described in this request by Section 301 of the Public Health Service Act (42 USC 241). A copy of this enabling legislation is provided in **Attachment 1**. In addition to this legislation, there are several national initiatives and programs that this data collection would serve to support, including but not limited to:

- *Healthy People 2020*, which provides national health objectives and outlines a comprehensive plan for health promotion and disease prevention in the United States. Of the Healthy People 2020 objectives, 31 objectives align specifically with PS-13-1308 activities related to reducing HIV infection, other STD, and pregnancy among adolescents.
- The *National Prevention Strategy* (NPS) calls for “medically accurate, developmentally appropriate, and evidence-based sexual health education.” The NPS encourages the involvement of parents in educating their children about sexual health, the provision of sexual and reproductive health services, and the reduction of intimate partner violence.⁷
- The U.S. Department of Health and Human Services' (DHHS) *Teen Pregnancy Prevention Initiative* supports the replication of teen pregnancy prevention (TPP) programs that have been shown to be effective through rigorous research as well as the testing of new, innovative program activities to combat teen pregnancy.⁸
- The NCHHSTP program imperative calls for *Program Collaboration and Service Integration* (PCSI) to provide improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services at the user level.⁹
- *CDC Winnable Battles*, including prevention of HIV infection and TPP, have been

chosen by CDC based on the magnitude of the health problems and the ability to make significant progress in improving outcomes. These are public health priorities with large-scale impact on health with known, effective strategies to address them.¹⁰

A.1.1 Privacy Impact Assessment

The privacy act does not apply as no individually identifiable information will be collected. Data collection involves collecting anonymous data from students through the use of a self-administered paper-and-pencil questionnaire. CDC will receive no personal information.

Overview of Data Collection System

This data collection system involves administration of a paper-and-pencil questionnaire to seven high schools that are participating in the HIV/STD prevention project of a local education agency (Broward County Public Schools in Broward County, Florida) that is funded with support from CDC's PS13-1308. This LEA was selected as the site for enhanced efforts to assess activities of PS13-1308. Data collection partners include LEA staff and CDC contractors (with oversight from CDC staff).

The questionnaire, the Youth Health and School Climate Questionnaire, will be administered to approximately 16,500 students across the seven schools. The questionnaire format and administration have been designed to mirror those procedures designed and approved for school-based student data collection through the National Youth Risk Behavior Survey in Florida schools, and was pilot tested by fewer than 10 evaluation contractor staff to estimate the length of time necessary for survey administration. The questionnaire will be administered in 2014 and 2016. (We are also anticipating data collection in 2018, pending an extension of this approval.) These data collection points coincide with the initiation of project activities and the mid-way and end points of the PS13-1308 cooperative agreement. We anticipate that each year of data collection will yield data from up to 16,500 high school students in grades 9 through 12 at the selected school. Although some students may take the questionnaire in multiple years, this is not a longitudinal design and students' responses will not be tracked across the years. No personally identifiable information will be collected.

At least one week prior to data collection, school staff will distribute passive parental consent forms (see **Attachment 4**) that describe the study and allow the parents to return a signed form if prefer their children not complete the voluntary questionnaire. These forms will be provided in English, Spanish, and French Creole. Students whose parents opt them out of the data collection will be given an alternate activity during the time of questionnaire administration. This process for parental consent has been approved by CDC contractor's IRB and the participating LEA's research office.

The questionnaire will take one class period of 35-45 minutes to complete (estimated to be 40 minutes). The questionnaire will be administered by teacher proctors who will have been trained by the project team to proctor the questionnaire. Students who choose to participate in the self-administered Youth Health and School Climate Questionnaire will be asked to read through the questions in the booklet and fill out the Scantron answer choices for each question. Students will be informed of how long they have to complete the questionnaire through a script

read aloud by the trained teacher proctor. Students will not sign their names to student assent forms. The student assent language is provided on the first page of the questionnaire. Students will then read the assent language and instructions on the first page of the questionnaire which will include a description of the study and clear statement that completing the questionnaire is voluntary and they can choose not to participate without penalty. This language is presented clearly in the third paragraph of the student assent statement on the front of the questionnaire (see page 1 of **Attachment 3**). The instructions also clearly state that students may skip any question they are not comfortable answering. In addition, training materials used for teacher proctors (**Attachment 10**—Teacher Proctor Instructions and Script) prompt the proctors to emphasize that students can choose not to take the questionnaire and this will have no penalty or impact on their grades (see highlighted sections of **Attachment 10**). This process for student assent is consistent with what the school district uses for other student questionnaires such as the Youth Risk Behavior Survey, and it has been approved by the Contractor’s IRB and the LEA’s research office.

Upon completion of the questionnaire, students will place questionnaires into a large envelope at the front of the classroom. This envelope will be collected by members of the project team and logged by classroom to ensure all data are collected. These will be sealed and mailed to the CDC contractor’s data processing facility for processing, scanning, and creation of the analytic data file. All paper-pencil questionnaires will be shredded after creation and verification of the data file.

Items of Information to be collected

Although the questionnaire was developed for this study (included in **Attachment 3**), questionnaire items were selected from valid and reliable instruments whenever possible. The questionnaire contains questions on the following topics: demographic information; HIV and STD risk behaviors; use of HIV and STD health services; experiences at school, including school connectedness, harassment and bullying, homophobia, support of LGBTQ students; sexual orientation; receipt of referral for HIV and STD prevention health services; and health education. Questionnaires will be completed in scannable Scantron questionnaire booklets. No individually identifiable information will be collected. The required OMB number and related language will be included on the front page of the questionnaire once approval is received (see placeholder language in **Attachment 3**).

A. 2 Purpose and Use of Information Collection

Data gathered from these questionnaires will allow the funded local education agency to assess program activities conducted under PS13-1308. It will allow them to ensure their activities are helping improve HIV/STD prevention practices and services in schools, and to determine if their activities are impacting HIV/STD preventive and risk behaviors among students. In particular, the approach of collecting data from all students in the participating schools allows a sufficient sample size for the LEA to examine key outcomes for the subgroup of interest, young men who have sex with men (defined in this project to include young men who report sexual activity with other males, attraction to other males, or who identify as gay or bisexual). This supports a major public health goal of reducing disparities in HIV/STD

infections experienced by adolescent young men who have sex with men.

Data are expected to be analyzed after each data collection point by the project team, and all analyses will be provided to the LEA. The resulting analyses (which may include frequencies, tests for differences between sub-populations of students, or comparison from across data collection points) will be used by the LEA to identify areas for program improvement and to assess program impact.

Furthermore, this data collection will provide the most extensive assessment to date of a set of new and innovative school-based strategies for HIV and STD prevention efforts that are being supported under PS13-1308, a cooperative agreement that scheduled to be funded by DASH through 2018. The approach of collecting data from all students in each participating school will allow assessment of the impact of project strategies on all students (which is a logical outcome given the nature of some program strategies), but it should also allow for data collection from a large enough number of YMSM students that those data can be analyzed separately to determine the impact of tailored approaches on this critical subgroup that experiences disproportionately high risk for HIV and STD. The findings from this information collection have practical utility to the government because they will directly impact both the activities used by the CDC-funded LEA and the strategies and approaches the CDC recommends for use in schools.

Without this data collection, the LEA would be unable to determine if their program activities had the desired impact on the school climate and the students' health-enhancing and risk behaviors related to HIV and STD. In addition, without collecting this data, the CDC would have little evidence on several of the new and innovative strategies that are being used to enhance HIV and STD prevention efforts in schools. Furthermore, neither the LEA nor the CDC would be able to identify the impact of these strategies on the small group of students at particularly high risk for HIV and STDs, the subgroup of students who are young men who have sex with men.

A.2.1 Privacy Impact Assessment

How information will be shared and for what purpose

Data will be shared in aggregate with the local education agency so that they can determine program impact and identify areas for program improvement. CDC staff and contractors will work with the LEA to ensure secure the data storage systems are in place. All data collectors and project team members will be asked to sign agreements that specify how data collection and data management needs to be handled to maintain anonymity and security.

In addition, CDC contractors will assist the LEA with data analyses and provide all findings to the LEA. Summaries of findings (not the raw data) may also be shared with other stakeholders (e.g., the other LEAs and the NGO funded under strategy 4 of PS13-1308, CDC staff) and researchers in the field, once appropriate permissions and clearances have been secured from both CDC and the LEA.

Impact of the proposed collection on respondents' privacy

We anticipate no adverse impact of the proposed data collection on respondents' privacy because no individually identifiable information will be collected. Data collection involves collecting anonymous data from students. After data are collected, they will be sealed and shipped to a CDC contractor for processing. The contractor will scan data and prepare an analytic output data file that will be sent to the CDC contractor's main office via a secure, password-protected server. All paper-pencil questionnaires will be shredded after creation and verification of the data file. The data file will remain stored on a password-protected server. At the end of the assessment, data will be shared in aggregate with the participating local education agency, but because no individually identifiable information will have been collected, there is no risk to respondents' privacy.

A. 3 Use of Improved Information Technology and Burden Reduction

This proposed information collection does not involve the use of automated, electronic, mechanical, or other technological collection techniques or forms of information technology. Although information technology certainly can reduce burden of information collection in some cases, it is not always appropriate or feasible. In this information collection, we determined electronic submission of data by respondents was not feasible. We considered various means of electronic submission, but because data collection will be conducted with all students in each school during the same 35-45 minute class period, the technology resources in each school were not sufficient to provide all students with simultaneous access to electronic forms of submission. Furthermore, the expense of and logistics involved in bringing in devices to support such data collection was too restrictive to make this feasible.

The use of paper-and-pencil questionnaires in the school setting actually makes it easier for the schools to participate in data collection with minimal disruption to the school day and minimal loss of instructional time. Students can remain in their regular classrooms and can return to normal classroom activities upon completion of the questionnaire.

A. 4 Efforts to Identify and Use of Similar Information

The complete content of the questionnaire used in this information collection is not duplicated in any other single data collection system. However, a few items on this questionnaire have been pulled from other existing data collection systems. Several demographic and risk behavior questions on this questionnaire came from the Youth Risk Behavior Survey (YRBS), and the school climate and school connectedness questions came from National School Climate Survey conducted by the Gay, Lesbian, and Straight Education Network (GLSEN) and the National Longitudinal Study of Adolescent Health.

Despite the fact that questions similar to our existed in other data collection systems, only one of those questionnaires (the YRBS) is currently being used in the local education agency participating in this project. We were unable to use the YRBS for our assessment activities for two reasons. First, we needed to include questions that examined outcomes that were not captured by the YRBS, such as use of HIV and STD health services; a broad range of experiences at school, including school connectedness, homophobia, support of LGBTQ students; and receipt of referral for HIV and STD prevention health services. Second, we needed to administer our questionnaire to all students in the participating high schools in order to capture

the largest possible number of students who met our project's definition of young men who have sex with men. By collecting data from all students in the schools, we enhance our ability to conduct statistical analyses with sufficient power to make statement about this subgroup of students at disproportionate risk.

A. 5 Impact of Small Businesses or Other Small Entities

No small businesses or other small entities will be involved in or impacted by this data collection.

A. 6 Consequences of Collecting the Information Less Frequently

This information collection is scheduled to occur in 2014, 2016, and 2018. These time points align with the initiation of program activities (for baseline data collection in 2014) and then the mid-way point (2016) and end point (2018) of program activities funded under PS13-1308. The first two data collections (2014 and 2016) will be covered by this ICR. (We anticipate requesting an extension of this ICR to cover the final data collection in 2018.)

There would be a number of consequences to collecting the data less frequently. First of all, this was designed to use the fewest data collections to achieve project goals. The 1308 Strategy 4 program components are planned and about to begin in Broward County School District. Therefore the first data collection will serve as a true baseline for our evaluation outcomes and present an accurate picture of what students' experiences were like prior to initiation of program activities and strategies. Without this first data collection, it would be impossible to determine if the program had any impact. Furthermore, this initial baseline data collection provides critical information that LEA staff can use to determine the most appropriate focus of their activities. It will allow them to determine areas of greatest need that can be incorporated into program planning.

The second (mid-point) data collection (in 2016) is critical to our evaluation of the program because the Strategy 4 program components are staggered in their planned implementation and designed to have a cumulative, additive effect on the outcomes of interests to this evaluation. The midpoint data collection will capture the effects of development of referral systems for these schools and any initial changes in school climate for YMSM; these components are delivered to the initiative schools in the first years of the program. Latter years of the program may introduce programmatic efforts that further support school climate, such as Gay-Straight Alliances (GSAs) or Safe Space programs, and HIV and STD testing campaigns or activities. The staggered and multi-component nature of the program implementation make it necessary to have more than two data collection periods to adequately capture the effects of the initiative as it unfolds in the school district.

In addition, one of the key purposes of the assessment is not simply to know if activities worked, but to be able to make mid-course corrections to improve the likelihood that future activities can have even greater impact. The mid-program data collection will allow the LEA to assess impact midway through the program and to make improvements based on strengths or weaknesses revealed by the 2016 data. Evaluators anticipate looking most closely at outcomes related to school climate and referral for sexual health services with the data from the 2016 mid-

point data collection. The presence or absence of significant changes in outcomes at this mid-point of the program may help program staff determine where to best focus their limited resources. For example, if data reveal improvements in perceptions of school climate, but no significant increase in the number of students reporting receipt of referrals from school staff, program staff could refocus their efforts on activities to help support staff in referring youth for services. Another valuable aspect of the 2016 data collection at the mid-point of the program is that it increases the evaluators' options for data analysis. It allows for the analysis of 2 cohorts of students—group one (those in 9th or 10th grade in 2014, and in 11th or 12th grade in 2016) and group two (those in 9th or 10th grade in 2016, and in 11th or 12th grade in 2018).

Finally, the 2018 data collection (not covered by this ICR) is essential for determining the full impact of the funded activities and will allow time for program activities to actually result in changes at the student level. Without these three data collection points, the LEA and CDC would not be able to achieve both goals of improving program activities and assessing their impact—both for all students in general, and for the specific group of young men who have sex with men who are at disproportionately higher risk for HIV and STDs.

In addition, collecting data from all students is essential to reaching the goals of the information collection. By sampling students rather than taking a census, the project team could easily miss some of the students who meet the project's definition of young men who have sex with men. In fact, other student data collections that sample students (rather than take a census of all students) find relatively low numbers of students who fit into this group and have found it necessary to combine multiple years or jurisdictions of data in order to get sufficient numbers of responses to support statistical analyses.⁶ The census approach is essential in this information collection for the project team to be able to answer questions about program impact among YMSM.

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

There are no special circumstances. This 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. As required by 5 CFR 1320.8(d), a 60-day Notice was published in the *Federal Register* on Wednesday, May 14, 2014, Vol. 79, No. 93 (see **Attachment 2**). One non-substantive public comment was received and a response was sent (see **Attachment 8**).

B. The local education agency involved in this information collection was consulted to discuss all aspects of the data collection. They provided extensive feedback on the availability of existing data, other data collections in their LEA and the frequency of data collection for this project. In addition, CDC contractors provided extensive input into the clarity of instructions and reporting format and the data elements that will be reported. LEA staff also reviewed and approved this information.

These consultations took place in 2013 and 2014. A list of organizations and individuals consulted is provided in **Attachment 5**. There were no major problems that arose during the consultation, and all issues raised were resolved.

A. 9 Explanation of Any Payment or Gift to Respondents

This data collection does not provide any payment, gift, or incentive to the respondents for their participation.

A. 10 Assurance of Confidentiality Provided to Respondents

No individually identifiable information is being collected. CDC staff have reviewed this information collection request and determined that the Privacy Act does not apply.

IRB approval

This proposed data collection has been reviewed and approved by the existing contractor's IRB (see **Attachment 6**). In addition, the protocol has been reviewed and approved by the research office of the participating school district. If the contractor for the assessment changes during the period of this approval, the data collection protocol will also be reviewed and approved by the new contractor's IRB.

10.1 Privacy Impact Assessment Information

- A. **Voluntary collection.** Participants will be informed that providing the information for this data collection is voluntary.
- B. **Consent.** Parents will receive a passive parental consent form (see **Attachment 4**) that provides information about the questionnaire and provides them with an opportunity to opt their children out of participation. Student participants will read a student assent form (see page 1 of the questionnaire in **Attachment 3**) that explains the study is completely voluntary and they may choose not to participate, or they may choose to skip any questions with no penalty.
- C. **Safeguards and security.** No personally identifiable information is being collected; this data collection is completely anonymous. Once questionnaires are completed, they will be placed into envelopes that will be sealed and shipped by the project team to the CDC contractor's data processing center. During receipt and data processing, hard copy data will be stored on-site at the contractor's facility in locked filing drawers. Only approved project staff will be given access to the data. Hard copy data will be scanned and processed. Electronic data will be stored on a secure network location. Access to this network requires user authentication by entering a user name and password. Although CDC contractors are involved in data collection and the processing of the data, the data collected will be ultimately owned by the participating LEA.

D. **System of records.** A system of records is not being created under the Privacy Act.

A. 11 **Justification for Sensitive Questions**

A few questions on this in this information collection are of a sensitive nature. These include questions about sexual risk and protective behaviors and sexual orientation or attraction. These questions are necessary because they represent key outcomes of the program. In order to assess the impact of program strategies on behaviors that can impact HIV and STD transmission, it is essential to include questions about sexual behavior (such as whether or not the respondent has had sex, use of condoms, etc.). In addition, it is necessary to ask questions related to sexual orientation in order to identify respondents who are classified as YMSM for subgroup analysis of the program impact. Because YMSM are at such disproportionate risk for HIV and STDs, and because they are the focus of many program activities, it is essential for the project team to be able to analyse data to look for program impact among that subgroup of students. Participants will be given an overview of the content of the questionnaire in the assent form (and parents will have received an overview of the content of the questionnaire on their passive consent forms). Parents may choose for their children not to participate, and a student may choose not to participate at any time. Students are also given the option to skip any question that makes them uncomfortable or that they do not want to answer. Furthermore, even though sensitive questions are being asked, there is no individually identifiable information being collected on the questionnaire, so there is no way to link any individual response with any particular student.

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

Burden hours. **Table A.12-1** provides estimates of burden for the data collection. The amount of time required to complete the questionnaires is based on a pilot test with fewer than 10 evaluation contractor staff as well as estimates that DASH compiled relying on their experience with previous data collections on health risk and protective behaviors among high school students and their discussions with the local education agency during the process undertaken to develop measures. Administration of will be completed via the paper-and-pencil questionnaire in classrooms of seven high schools. The questionnaire is listed in the burden table below. The estimated burden time includes the time for receiving instructions, reviewing the student assent, and completing, reviewing, and handing in the questionnaire.

An estimated 16,500 high school students from 7 schools will complete the questionnaire in 2014 and in 2016. The estimated burden per response ranges from 35-45 minutes. This variation in burden is due to the slight variability in skip patterns that may occur with certain responses and variations in the reading speed of students. The burden estimates presented here are based on the assumption of an average 40-minute response time per response. Students in the 12th grade in fall 2014 will complete the questionnaire only once. It is estimated that students in the 9th, 10th, and 11th grade will complete the questionnaire in fall of 2014 and again in the spring of 2016 when they will be 10th, 11th, and 12th grade students. In addition, students who are in the 9th grade in spring of 2016 will also complete the questionnaire. The Youth Health and School Climate Questionnaire is provided in **Attachment 3**. Annualizing this collection over three years results in an estimated annualized burden of 7,333 hours.

Table A.12-1 Estimated Annualize Burden to Respondents

| Respondents | Form Name | Number of Respondents | Number of Responses per Respondent | Average Burden per Response (in hours) | Total Burden (in hours) |
|-----------------------------|---|-----------------------|------------------------------------|--|-------------------------|
| Students in the grades 9-12 | Youth Health and School Climate Questionnaire | 11,000 | 1 | 40/60 | 7,333 |
| Total | | | | | 7,333 |

Annualized cost. **Table A.12-2** provides estimates of the annualized cost to respondents for the collection of data. Because student respondents are expected to be under the age of 20, cost estimates for the value of time students spend in responding to the questionnaire are based on a Department of Labor fact sheet describing the minimum wage for students aged less than 20 years as \$4.25 an hour (<http://www.dol.gov/whd/regs/compliance/whdfs32.pdf>). Total cost has been rounded up to the nearest whole dollar.

Table A.12-2 Annualized Costs to Respondents

| Respondent | Form Name | Number of Respondents | Number of Responses per Respondent | Average Burden per Response (in hours) | Average Hourly Wage Rate | Total Cost |
|-----------------------------|---|-----------------------|------------------------------------|--|--------------------------|------------|
| Students in the grades 9-12 | Youth Health and School Climate Questionnaire | 11,000 | 1 | 40/60 | \$4.25 | \$31,166 |
| Total | | | | | | \$31,166 |

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

No capital, start-up, operation, or maintenance costs are involved.

A. 14 Annualized Cost to Federal Government

Cost will be incurred by the government in personnel time for overseeing the project. CDC time and effort for overseeing the contractor's assistance with data collection and answering questions posed by the contractor and funded agencies are estimated at 40% for two GS-13 level CDC employees and 5% for a GS-14 level senior CDC employee a year for the

three years of the project. The senior level employee supervises the two GS13-level employees. The average annual cost to the federal government for oversight and project management is \$89,130 (Table A.14-1).

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 from contractor and other expenses is estimated to be approximately \$210,000 (Table A.14-1). This is the cost estimated based on the current funding level of the contractor at approximately \$600,000 per year and the percentage of the contractor’s effort that is anticipated for this specific data collection. It is estimated this data collection will take approximately 15% of the contractor’s effort in the first year, 15% of the contractor’s effort in the second year, and 5% of the contractor’s effort in the third year. This includes the estimated cost of coordination with DASH, providing assistance to the LEA for data collection and processing, and support for analysis and reporting.

The total annualized cost to the government, including direct costs to the federal government and contractor expenses is \$299,130.

Table A.14-1. Annualized and Total Costs to the Federal Government

| Expense Type | Expense Explanation | Annual Costs (dollars) |
|--|---|-------------------------------|
| <i>Direct Cost to the Federal Government</i> | | |
| CDC employee oversight for project (1 GS-14 staff member at 5% time) | CDC Supervisor labor costs | \$6,230 |
| CDC oversight of contractor and project (2 GS-13 staff members at 40% time) | CDC Project Officers labor costs | \$82,900 |
| Subtotal, Direct Costs to the Government per year | | \$89,130 |
| <i>Contractor and Other Expenses</i> | | |
| Assistance with data collection, processing, and preliminary analysis in years 1 and 2 | Labor and other direct costs for supporting data collection, processing, and analysis | \$180,000 |
| Assistance with data analysis and reporting in year 3 | Labor and other direct costs for supporting data analysis and reporting | \$30,000 |
| Subtotal, Contract and Other Expenses per year | | \$210,000 |
| <i>Total of all annualized expenses</i> | | <i>\$299,130</i> |

A. 15 Explanation for Program Changes or Adjustments

This is a new data collection.

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

Current plans for tabulation and publication of data from this information collection include analyzing data for differences in key outcomes between baseline and follow-up data collections and publication of these findings in written reports for the LEA and possibly, peer-reviewed journals. In addition, basic analyses of baseline (2014) data will be shared in written reports for the LEA and may also be shared through published reports for other stakeholders.

Analysis Plan

Data will be analyzed using both descriptive and inferential statistics. As relevant (where multiple items were developed to measure a larger construct such as school climate), data reduction techniques/factor analyses and item correlation analyses will be used to develop scales from within the questionnaire items, as needed. In addition, because not all questions have been tested with youth (though all have been either used by youth, or tested and examined by experts on youth), close inspection of the data for aberrant or unexpected patterns in responses will be used to identify any questions that may not be performing appropriately. More detail on the study-developed questions and the validity checks for those questions is provided in **Attachment 11**.

Descriptive statistics of data will assist in data cleaning, generating additional hypotheses, and summarizing the characteristics, attitudes, intentions and behaviors of YMSM students, as well as for the full student population, for each of the seven schools, all schools pooled together, and at each data collection time point. In terms of analyses for each of the seven schools, it is important to note that the unique school identification codes will be applied to the questionnaires at the point of scanning and processing the questionnaires. These will allow for analysis of data for individual schools. For all school-specific analyses, the evaluation team will keep a close watch on the size of all sub-groups to ensure that (1) subgroups are large enough to support statistical analyses, and (2) any sub-group analyses (particularly subgroup analyses within specific schools) will be presented only if the subgroup is large enough that no individual within that subgroup could be identified. Summary reports will share summative findings from the survey aggregated across all 7 schools and selected school-specific data where cell sizes are not less than n=20 (the standard minimum for reliable estimates and a sufficient number to protect against identifying information being surmised by school/district partners). If cell size becomes problematic, the school identifier could be stripped from the data set prior to sharing the actual data set with school staff. To address our primary research question about the effect of the PS13-1308 activities focused on teen YMSM in Broward County Public Schools, we plan to pool the data from YMSM students from across all 7 schools involved in the study. (The pooling of data across all schools enabled us to power the study to assess changes in outcomes among the program's priority population of YMSM students.) We will examine changes in attitudes, experiences, and testing behavior among YMSM students across three time

points. The samples will be successive independent samples (non-linked). Logistic regression will be used to model changes in HIV and STD testing among the YMSM sample as a function of time. Multivariate linear regression will be used to assess for change over time in continuous outcomes of interest (referral receipt, perceived school climate, intention to test for HIV and STD) among the YMSM sample. Additional analyses will be explored to determine if school intervention implementation level (high v low implementation) may be used as a predictor of change in these models. In examining other predictors of testing related behaviors at single cross sections, linear and logistic regression models will be used to analyze data from this key subsample while controlling for covariates. Chi-square analyses and t-tests will also be used to examine differences between the YMSM sample and the non-YMSM sample on the list of dependent variables believed to be influenced by the activities supported by PS13-1308 (such as school climate, referral receipt and referral completion for sexual health services, testing behavior for HIV and STD). A few example table shells are provided in **Attachment 7**.

Although it is not the primary purpose of the questionnaire to develop point estimates or establish trends for the YMSM student population in Broward County Public Schools, the data will allow for some examination of these. Where this is the case, descriptive statistics (percentages and confidence intervals) will be calculated to quantify the extent of experiences, attitudes, or behaviors.

In addition to analyzing data for our subpopulation of interest, YMSM, we anticipate also conducting analyses (multivariate linear regression, logistic regression, chi-square analyses, and t-tests) to look for changes in the attitudes, experiences, and testing behaviors among all students in the schools (or designated larger subgroups of students, such as all males). This is a secondary purpose of the project, but because the program is designed in a way that all students will be exposed to many program activities, it is valuable for the district to also be able to assess the impact of the programs on the broader population of students. In addition, the full set of data (from all students—not only YMSM) will be used to provide Broward County Public Schools with information that can help them learn more about their current student population and their needs and experiences related to sexual risk and protective behaviors, school climate (including aspects like bullying and school connectedness), and access to health services.

Project Time Schedule

Baseline data are scheduled to be collected in late 2014. It is critical for this data collection to begin no later than December 2014 in order to avoid conflicts the schools have with other non-CDC commitments in the Spring semester that would make data collection challenging. As such, we are hoping to receive OMB approval for this information collection in the first half of the fall semester of 2014. The baseline data are likely to be analyzed, summarized, and reported (through unpublished or published reports) in 2015. The first round of follow-up data (data collected at the mid-point of the program) will be collected in Spring 2016. These data, and differences in baseline and follow-up data, are likely to be analyzed, summarized, and shared through unpublished or published reports in 2016 and 2017.

A three year clearance is being requested. At the end of this period, we anticipate seeking an extension of the approval for a second round of follow-up data to be collected at the end of the program's 5-year funding cycle.

Figure A.16-1: DASH Project Time Schedule

| Activity | Time Schedule |
|---|---------------------------------|
| First Period of Data Collection | |
| School staff trained to proctor the questionnaire | 0-1 months after OMB approval |
| Parental consent forms distributed | 0-1 months after OMB approval |
| Baseline data collection | 1-2 months after OMB approval |
| Data processing and cleaning | 2-4 months after OMB approval |
| Data analysis | 4-6 months after OMB approval |
| Writing (and revising) of baseline data summaries, reports, and/or manuscripts | 7-15 months after OMB approval |
| Second Period of Data Collection | |
| School staff trained to proctor the questionnaire | 16-19 months after OMB approval |
| Parental consent forms distributed | 16-19 months after OMB approval |
| First round of follow-up data collection (program mid-point) | 17-20 months after OMB approval |
| Data processing and cleaning | 21-23 months after OMB approval |
| Data analysis | 23-25 months after OMB approval |
| Writing (and revising) of follow-up data summaries, reports, and/or manuscripts | 26-36 months after OMB approval |

The CDC contractor, with the review and approval of the CDC staff and the LEA, will develop specific reports for the LEA to use for program improvement and communication with the LEA’s stakeholders. CDC will use the LEA’s assessment findings during the project period to establish key recommendations for partners on program impact, sustainability, and continued program improvement.

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

The display of the OMB expiration date is not inappropriate. All data collection instruments will display the expiration date for OMB approval of the information collection.

A. 18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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