# Systematic Identification and Assessment of Sexual Violence Prevention Strategies

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

# Supporting Statement – Section A

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- **Goal**: The goal is to solicit nominations of practice-based sexual violence (SV) prevention strategies with the purpose of identifying prevention strategies that (1) have high potential for population-level impact on SV outcomes, (2) have high potential for widespread adoption, and (3) are ready for an evaluability assessment (EA) to be reviewed and considered for a site visit EA by CDC.

- **Intended use of the resulting data**: Data will be used by a review panel to assess and rate the prevention strategies, and make recommendations to CDC, who will use the findings to invite selected practice-based SV prevention strategies to undergo a site visit EA. CDC will also use the results to develop briefs that describe the major features of each strategy, and some strategies may be considered for future CDC assessment activities. Moreover, the results and processes will be shared or published through reports, briefs, factsheets, PowerPoint presentations, manuscripts, peer-reviewed publications, or dissemination at national conferences about the process, results, and lessons learned to inform SV prevention evidence base and practice.

- **Methods to be used to collect:** A one-time web-based instrument (i.e., Sexual Violence Prevention Strategy Description) will be used to collect information about practice-based SV prevention strategies.

- **The subpopulation to be studied:** 55 SV program managers within health departments in 50 states, the District of Columbia, and four U.S. territories (i.e., Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands) and 470 of their delegates located in all 50 states, the District of Columbia, and one territory.

- **How data will be analyzed**: The information to be collected will be analyzed using descriptive statistics and qualitative content analysis.

## Section A – Justification

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

**Background**

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) — OMB No. 0920-0879. The respondent universe for this information collection aligns with that of the O2C2. Information about sexual violence (SV) prevention strategies will be voluntarily submitted by 55 SV program managers within health departments in 50 states, the District of Columbia, and four U.S. territories (i.e., Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands) and 470 of their delegates (i.e., non-profit organizations, public academic institutions, private organizations, local health departments) located in all 50 states, the District of Columbia, and one territory (**see Att. A—RPE**

**Awardees and Sub-Awardees Count**) acting on behalf of those health departments in their official capacities funded through CDC's Rape Prevention and Education (RPE) Program cooperative agreement funding to implement SV primary prevention strategies (total of 525 respondents).

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health service(s) of:

- ☐ 1. Monitoring health status to identify community health problems
- ☐ 2. Diagnosing and investigating health problems and health hazards in the community
- ☐ 3. Informing, educating, and empowering people about health issues
- ☒ 4. Mobilizing community partnerships to identify and solve health problems
- ☐ 5. Development of policies and plans that support individual and community health efforts
- ☐ 6. Enforcement of laws and regulations that protect health and ensure safety
- ☐ 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- ☐ 8. Assuring a competent public health and personal health care workforce
- ☒ 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- ☐ 10. Research for new insights and innovative solutions to health problems [1]

CDC's National Intimate Partner and Sexual Violence Survey reports that nearly 1 in 5 women and 1 in 71 men in the U.S. have been raped during their lifetime, and nearly 1 in 2 women and 1 in 5 men have experience some form of SV victimization in their lifetime.[2] Additionally, high-risk groups, such as racial and ethnic minorities and youths (<25 years old) continue to experience high rates of SV in a variety of forms.[2] SV victimization is associated with adverse health consequences, and is a risk factor for further victimization and violence perpetration. SV is a serious public health problem that affects millions of individuals, but it is preventable.

CDC's Division of Violence Prevention (DVP) within the National Center for Injury Prevention and Control (NCIPC) is leading the field in SV research to improve SV outcomes and evidence-based practice, build federal partnerships to increase influence, and advance prevention practice through the RPE Program. The RPE Program, authorized under the Violence against Women Act of 1994 (VAWA) and Violence against Women Reauthorization Act of 2013 (**see Att. B—VAWA Reauthorization Legislation**) and under the Public Health Service Act Title 42 Chapter 6A Subchapter II Part J Section USC 280b-1b (**Att. C—Public Health Service Act 42 USC 280b-1b**), is a national initiative to address the public health burden of SV through cooperative agreement funding and technical assistance to health departments in all 50 states, the District of Columbia, and four U.S. territories (i.e., Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands) (**see Att. D—Rape Prevention and Education Program Factsheet**).

There is great diversity in the organization and management of SV prevention efforts within those government jurisdictions because SV prevention is situated with different topics (e.g., maternal and child health, injury prevention, emergency management, trauma, women's health) across different

state and territorial agencies. Through the VAWA legislations, health departments are mandated to allot funding to different local organizations (i.e., sub-awardees) to implement primary prevention strategies to prevent SV. Based on administrative data (**see Att. A—RPE Awardees and Sub-Awardees Count**), a total of 470 sub-awardees located in all 50 states, the District of Columbia, and one territory is estimated for this information collection. Of that total, 396 are non-profit organizations (e.g., rape crisis centers and state sexual assault coalitions), 52 are public academic institutions (e.g., universities, middle school, high school), 16 are private organizations (e.g., assessment consultants and private academic institutions), and 6 are local health departments (e.g., city and county health departments). These sub-awardees are delegates because the SV programs in the state and territorial health departments are legislatively required by VAWA to allot RPE funding to those local organizations to provide legislatively mandated public health provisions on their behalf to raise awareness, affect community change, and ultimately prevent SV from occurring in the first place (**see Att. B—VAWA Reauthorization Legislation page 31 and Att. C—Public Health Service Act 42 USC 280b-1b).**

The CDC invests in building the infrastructure and capacity RPE awardees and sub-awardees to implement evidence-based prevention strategies with an expectation of reducing SV outcomes.[3] However, CDC found through a systematic review of the literature that the SV field currently lacks sufficient evidence-based strategies that impact population-level health outcomes.[4] DeGue, et al reviewed 140 outcome assessments of prevention strategies for SV perpetration from 1985 until 2012 and found that only three strategies have been shown to be effective on preventing SV perpetration in a rigorous assessment.[3] This review was the first comprehensive, systematic review of assessment research on primary prevention strategies for SV perpetration and concluded that the lack of effective prevention strategies is not only due to a lack of rigorous assessment of prevention strategies, but also the quality of the prevention strategies developed.[3] This indicates that the field's ability to identify effective SV prevention strategies lies in the quality of available research, and that more rigorous assessments should be conducted to determine whether a strategy is likely to achieve its desired outcomes.[3] Additionally, this points to a need to develop more quality SV prevention strategies. Quality prevention strategies are rooted in the principles of prevention and contain the following "best practices" characteristics: comprehensive, appropriately timed, utilized varied teaching methods, had sufficient dosage, were administered by well-trained staff, provided opportunities for positive relationships, were socio-culturally relevant, were theory-driven, and included outcome evaluation.[5] A large portion of the research to date have been invested in prevention strategies that are not consistent with the principles of prevention.[3] Therefore, there is a need for more prevention strategies based on (1) a coherent theory of change with plausible likelihood for impact on SV perpetration, (2) addressing a range of risk and protective factors for SV, and (3) community- and societal-level prevention approaches in the field of SV prevention.[3]

An evaluability assessment (EA) that was conducted from 2001 through 2004 of the RPE Program, found that RPE awardees echoed this need for more evidence-based SV prevention strategies.[6] An EA is a method used to determine (1) if the necessary program activities are in place for a successful outcome assessment, (2) if the program activities include plausible and well defined

program objectives, and (3) if the intended uses of information from an outcome assessment have been clearly outlined.[7] This method was developed by Joseph Wholey and colleagues at the Urban Institute and the method has been expanded to ask if a program can realistically achieve the intended goals or anticipated effects.[7,8] Through document review and interviews with stakeholders, 92% of respondents of RPE awardees indicated that training and technical assistance needs included a need for evidence-based prevention strategies, especially focused on youth.[6] As the evidence of effective SV prevention strategies is emerging, DVP is developing and providing tools, and also is providing training and technical assistance to RPE awardees for understanding the continuum of evidence and making evidence-based decisions. Meanwhile, states are assessing the capacity of state and local organizations to collect data about their prevention strategies and use that data to improve their work.

To advance the evidence base for SV prevention, it is necessary to understand what works in practice. The Center for the Study of Social Policy suggests that a useful approach to solve complex, social problems is to obtain practice-based evidence that are rooted in population- and community-level influences.[9] One method to identify practice-based prevention strategies is the Systematic Screening and Assessment (SSA) Method.[10] The SSA Method has been used by both CDC's Division of Nutrition, Physical Activity and Obesity and Division of Cancer Prevention and Control to identify promising practice-based programs and strategies in their respective fields. The SSA Method integrates a review by subject matter experts of nominated strategies developed in practice (practice-based) with EAs to identify strategies that meet criteria for effective prevention through the following steps: (1) soliciting and assessing nominations of strategies; (2) identifying strategies to undergo EAs through a review panel consisting of assessors, practitioners, subject matter experts, and allies in the field of SV prevention; (3) conducting EAs; (4) determining strategies ready to be further assessed through a second review panel. DVP is using this method to advance its work by identifying practice-based SV prevention strategies that have high potential for population-level impact on SV outcomes, have high potential for widespread adoption, and are ready for more assessment in order to lay the foundation for demonstrating the impact of these prevention strategies and building the evidence base for SV prevention practice.

The goal of this information collection request is to solicit nominations of practice-based SV prevention strategies with the purpose of identifying prevention strategies that (1) have high potential for population-level impact on SV outcomes, (2) have high potential for widespread adoption, and (3) are ready for an EA to be reviewed and considered for a site visit EA by CDC. The solicitation of nominations is the crucial first step in the SSA Method to gather a list of prevention strategies (Step 1 of SSA) for a review panel to systematically assess and rate the strategies based a set of specified criteria related to their quality, implementation, potential for impact, and readiness for a site visit EA (Step 2 of SSA). Using the review panel's recommendations, CDC will select prevention strategies to conduct a site visit EA (Step 3 of SSA).

Fifty-five state and territorial SV program managers and 470 delegates will voluntary submit information to nominate prevention strategies to be reviewed and considered for a site visit EA. DVP and its partner—National Sexual Violence Resource Center (NSVRC), who provide technical

assistance to SV programs—will advertise the call for nominations, and encourage organizations receiving RPE funding to submit nominations of SV prevention strategies that focus on any of the three following prioritized areas: creating safe and protective environments, promoting healthy social norms that protect against SV, or using gender equity approaches. These focus areas were identified after a thorough review of key DVP documents, the SSA literature, and RPE activities, in addition to input from our federal partners. In addition, focus areas are aligned with focus areas described in the Division of Violence Prevention's Sexual Violence technical package, to be released at the end of April 2016. The site visit EA provides an opportunity for technical assistance to the sites regarding strategy implementation, capacity building, assessment, and continuous improvement. Overall, the information to be collected will facilitate a better investment of RPE funds in evidence-based prevention strategies, improve technical assistance provided to RPE awardees and sub-awardees, and add value to the SV prevention field and its evidence base.

**Overview of the Information Collection System**

Information will be collected via a web-based form. Respondents will voluntarily complete and submit information electronically about a prevention strategy through a web-based information collection instrument via Survey Monkey (**see Att. E—Instrument Word Version** and **Att. F—Instrument Web Version**). Respondents will voluntarily submit information to nominate a prevention strategy that is both developed in practice and aligned with at least one of the focus areas (i.e., creating safe and protective environments, promoting healthy social norms that protect against SV, using gender equity approaches).

The information collection instrument was pilot tested by 3 public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, estimate completion time, and to ensure only the minimum number of questions are required to minimize burden while asking for necessary information for the purpose of this information collection.

**Items of Information to be Collected**

The online information collection instrument consists of 23 main questions of various types, including dichotomous (yes/no), multiple response, and open-ended questions. The instrument was designed to collect only the necessary information for the review panel to assess and rate the nominated practice-based SV prevention strategies based on the following criteria which includes, but is not limited to: transportability/generalizability, innovativeness, ethical approach, sustainability of intended outcomes, potential impact, feasibility of implementation, feasibility of adoption, readiness for more assessment, reach to target population, and strategy sustainability. The instrument addresses three main areas: (1) strategy goals and focus, (2) strategy implementation, and (3) information collection and assessment efforts. These key areas were chosen to best identify prevention strategies that (1) have high potential for population-level impact on SV outcomes, (2) have high potential for widespread adoption, and (3) are ready for more assessment. Specifically, the instrument will collect information about the following:

- Strategy Goals and Focus

    - SV prevention focus areas
    - Social Ecological Model levels
    - General strategy description and activities
    - Adaptation of promising or evidence-based strategy
    - Target population
    - Outcomes addressed by strategy
- Strategy Implementation
    - Setting of implementation of prevention strategy
    - Duration of strategy
    - Reach of prevention strategy
    - Resources necessary to implement strategy
- Information Collection and Assessment Efforts
    - Information or data on strategy implementation
    - Information or data on outcomes of strategy
    - Data to potentially be collected
- Additional Questions
    - Reason for nominating strategy
    - Any additional information to share

The review panel will rate the nominated prevention strategies on criteria related to their quality, implementation, potential for impact, and readiness to be further assessed, which includes, but is not limited to: transportability/generalizability, innovativeness, ethical approach, sustainability of intended outcomes, potential impact, feasibility of implementation, feasibility of adoption, readiness for more assessment, reach to target population, and strategy sustainability. An effort was made to limit questions requiring narrative responses from respondents whenever possible.

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

The goal of this information collection is to solicit nominations of practice-based SV prevention strategies for the purposes of identifying prevention strategies that (1) have high potential for population-level impact on SV outcomes, (2) have high potential for widespread adoption, and (3) are ready for an EA, to be reviewed and considered for a site visit EA by CDC. The solicitation of nominations is the crucial first step in the SSA Method to gather a list of prevention strategies and collect information about their goals and focus, strategy implementation, and information collection and assessment efforts.

Data will be used to conduct a review panel to assess and rate the prevention strategies and make recommendations to CDC, who will use those recommendations to invite selected practice-based SV prevention strategies to undergo a site visit EA. The CDC and its contractors will conduct an initial review and analysis of the nominated prevention strategies, and will develop and present summary reports of each prevention strategy to the review panel. Assessors, practitioners, SV subject matter experts, and allies in the field of SV prevention will comprise the review panel. As part of the SSA Method, each nominated prevention strategy will be reviewed and rated based on quality of the

prevention strategy, quality of strategy implementation, and evaluation capacity. The review panel will make recommendations to CDC on strategies that are ready for an EA. In turn, CDC will use the review panel's recommendations to inform its selection of SV prevention strategies for EAs, which will include a site visit from CDC staff to further assess readiness to be further assessed, and provide recommendations for program improvement and assessment design. The site visit EA provides an opportunity for technical assistance regarding strategy design, implementation, capacity building, assessment, and continuous improvement. CDC will also use the results to develop briefs that describe the major features of each strategy, and some strategies may be considered for future CDC assessment activities. Moreover, the results and processes will be shared or published through reports, briefs, factsheets, PowerPoint presentations, manuscripts, peer-reviewed publications, or dissemination at national conferences about the process, results, and lessons learned to inform SV prevention evidence base and practice. For example, a summary report of the panel review will be prepared and shared with CDC leadership, RPE Program leadership, and other key stakeholders. This will facilitate a better investment of RPE funds in evidence-based prevention strategies and improve technical assistance provided to RPE awardees and sub-awardees.

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

Information will be collected via a web-based questionnaire allowing respondents to complete and submit their responses electronically. This method was chosen to reduce the overall burden on respondents. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 23 questions).

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

Since CDC is the only federal agency providing funding for state and territorial health departments to conduct SV prevention work by emphasizing prevention of first-time rape perpetration (i.e., primary prevention), the information to be collected is not available from other sources. An EA of the overall RPE program was conducted in 2004 (OMB No. 0920-0567) to establish a baseline description and understanding of the program's goals, activities, performance measures, funds allocations, and technical assistance needs and to inform strategic planning. The information to be collected is not duplicative of those efforts or of current reporting efforts.

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

No small businesses will be involved in this information collection.

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

This request is for a one time information collection. There are no legal obstacles to reduce the burden. Without this information collection, CDC will be unable to:

- Assess the quality of current practice-based SV prevention strategies, their implementation, potential for impact, and readiness for an EA
- Select prevention strategies for an EA to determine readiness for more assessment, and provide recommendations for improvement and assessment design

- Improve CDC's technical assistance related to practice-based prevention strategies
- Identify current SV practice-based strategies that have high potential for population-level impact on SV outcomes, have high potential for widespread adoption, and (3) are ready to further assessed
- Lay foundations to demonstrate the impact of practice-based SV prevention strategies
- Advance the field of SV prevention, evidence base, and prevention practice
- Facilitate better CDC investment in evidence-based prevention strategies

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

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

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

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) — OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on October 31, 2013, Vol. 78, No. 211; pp. 653 25-26. No comments were received.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

**9. Explanation of Any Payment or Gift to Respondents**

CDC will not provide payments or gifts to respondents.

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

The Privacy Act does not apply to this information collection. STLT governmental staff and delegates will be speaking from their official roles. All data will be reported in aggregate form and all data will be kept secure following CDC information protection and security measures to ensure protection of information.

This information collection is not research involving human subjects.

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

No information will be collected that are of personal or sensitive nature.

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

The estimate for burden hours is based on a pilot test of the information collection instrument by 3 public health professionals. In the pilot test, the time to complete the instrument including time for

reviewing instructions, gathering needed information and completing the instrument averaged approximately 30 minutes for each submission. Based on these results, the estimated time range for actual respondents to complete each submission is 20 to 40 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 40 minutes) is used for each response. This burden is used for each response by RPE awardees and sub-awardees.

Note, RPE awardees may submit up to three responses while RPE sub-awardees may submit one. As noted, there is diversity in which SV prevention efforts are organized and managed in the health departments across 50 states, the District of Columbia, and four U.S. territories (i.e., Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands) because of their context in terms of geographic location and size, their organizational capacities and infrastructure, and their selected strategic approach to SV prevention. Some may implement multiple SV prevention strategies, for some of which they may sub-contract to sub-awardees and for some of which they may implement using health department capacities. Without an inventory or accurate report of these contextual information, an upper limit of three responses was used for RPE awardees to account of these contexts in order to meet the purpose of this information collection. RPE sub-awardees may only submit one nomination. Since RPE awardees can submit up to three responses, the burden is multiplied by three whereas one response was used for sub-awardees.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for medical and health services managers http://www.bls.gov/oes/current/oes_nat.htm. Based on DOL data, an average hourly wage of $50.99 is estimated for all 525 respondents. Table A-12 shows estimated burden and cost information.

**Table A-12:** Estimated Annualized Burden Hours and Costs to Respondents

| Information Collection Instrument: Form Name | Type of Respondent | | No. of Respondents | No. of Responses per Respondent | Average Burden per Response (in hours) | Total Burden Hours | Hourly Wage Rate | Total Respondent Costs |
|---|---|---|---|---|---|---|---|---|
| **Sexual Violence Prevention Strategy Description** | State | SV program managers in State health departments (SHD), including District of Columbia | 51 | 3 | 40/60 | 102 | $50.99 | $5,201 |
| | | SHD sub-awardees: non-profit organizations | 394 | 1 | 40/60 | 263 | $50.99 | $13,410 |
| | | SHD sub-awardees: public academic institutions | 52 | 1 | 40/60 | 35 | $50.99 | $1,785 |
| | | SHD sub-awardees: | 16 | 1 | 40/60 | 11 | $50.99 | $561 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | private organizations | | | | | | |
| | | SHD sub-awardees: local health departments | 6 | 1 | 40/60 | 4 | $50.99 | $204 |
| | U.S. Territory | SV program managers in Territorial health departments (THD) | 4 | 3 | 40/60 | 8 | $50.99 | $408 |
| | | THD sub-awardees: non-profit organizations | 2 | 1 | 40/60 | 1 | $50.99 | $51 |
| | | **TOTALS** | **525** | **635** | | **424** | | **$21,620** |

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

There will be no direct costs to the respondents other than their time to participate in each information collection.

**14. Annualized Cost to the Government**

There are no equipment or overhead costs. Contractors, however, are being used to support development of the collection tool, information collection, and information analysis described in this ICR. The only cost to the federal government would be the salary of CDC staff and contractors. The estimated cost for the contractor reflected is based on the independent government cost estimate (IGCE) for the activities related to the information collection described in this IC, which was part of the statement of work for the request for proposal for the overall SSA project. The IGCE was based on previous budget proposals and reports of contracts conducting work similar to the SSA method for other CDC divisions. A contractor will be selected no later than June 2016; the total cost of the contracting agency will not exceed the amount provided in table A-14. The total estimated annualized cost to the federal government for only those activities related to this information collection described herein is $252,236.80. Table A-14 describes how this cost estimate was calculated.

**Table A-14:** Estimated Annualized Cost to the Federal Government

| Staff (FTE) | Average Hours per Collection | Average Hourly Rate | Average Cost |
|---|---|---|---|
| **Behavioral Scientist (GS-12)** | 80 | $35.58 | $2,846 |
| **ORISE Fellow (GS-9 equivalent)** | 160 | $ 24.54 | $3,926 |
| **Contracting Agency** | | | $245,464 |
| **Estimated Total Cost of Information Collection** | | | **$252,236** |

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

This is a new information collection.

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

The information collected from the Sexual Violence Prevention Strategy Description will be downloaded, reviewed, and analyzed using descriptive statistics in Excel and SPSS. CDC staff and the contractor on this project will perform a content analysis of the strategy description forms and create summaries of each nominated SV prevention strategy. Descriptive statistics will also be performed to describe the information about the nominated practice-based prevention strategies.

Information collected from the Sexual Violence Prevention Strategy Description will be presented in a summary report for each nominated strategy and will rated by a review panel based on specified criteria. The review panel will make recommendations to CDC on strategies that are ready for an EA. In turn, CDC will use the review panel's recommendations to inform its selection of SV prevention strategies for EAs. CDC will use the results to develop briefs that describe the major features of each strategy, and some strategies may be considered for future CDC assessment activities. Moreover, the results and processes will be shared or published through reports, briefs, factsheets, PowerPoint presentations, manuscripts, peer-reviewed publications, or dissemination at national conferences about the process, results, and lessons learned to inform SV prevention evidence base and practice. For example, a summary report of the panel review will be prepared and shared with CDC leadership, RPE Program leadership, and other key stakeholders.

<u>Project Time Schedule</u>

- ✓ Design Sexual Violence Prevention Strategy Description.....(COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan .....(COMPLETE)
- ✓ Pilot test questionnaire .....(COMPLETE)
- ✓ Prepare OMB package .....(COMPLETE)
- ✓ Submit OMB package .....(COMPLETE)
- ❑ OMB approval .....(TBD)
- ❑ Solicit nominations .....(4–6 weeks)
- ❑ Code and analyze information.....(4 weeks)
- ❑ Prepare and provide reports to review panel .....(4 weeks)
- ❑ Review panel review and rate based on specified criteria.....(4 weeks)
- ❑ Select prevention strategies for site visit EA.....(4 weeks)
- ❑ Prepare and disseminate reports about the results of the review panel.....(4 weeks)

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

We are requesting no exemption.

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

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

## LIST OF ATTACHMENTS – Section A

A. RPE Awardees and Sub-Awardees Count
B. VAWA Reauthorization Legislation
C. Public Health Service Act 42 USC 280b-1b
D. Rape Prevention and Education Program Factsheet
E. Instrument Word Version
F. Instrument Web Version

## REFERENCE LIST


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