SUPPORTING STATEMENT PART A

OMB No. 0920-XXXX

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MONITORING AND REPORTING SYSTEM FOR RAPE PREVENTION AND EDUCATION (RPE) PROGRAM AWARDEES

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Attachments

- **Goal**: The goal of this ICR is to collect information from Rape Prevention and Education (RPE) Program awardees related to implementation and performance monitoring of the cooperative agreement.

- **Intended use of the resulting data**: Information to be collected will provide crucial data for performance monitoring, implementation of prevention strategies, and budget tracking; and provide CDC with the capacity to respond in a timely manner to requests for information about the program from the Department of Health and Human Services (HHS), the White House, Congress, and other sources.

- **Methods to be used to collect**: Awardees will monitor and report progress on their goals, objectives, and activities as well as relevant information on the implementation of their prevention strategies annually using Excel-based fillable electronic tools. No research design or human subjects are involved.

- **The subpopulation to be studied**: No sampling. Awardees of the RPE program or designated personnel will submit completed tools annually with their non-competing continuation application.

- **How data will be analyzed**: The data will be analyzed using descriptive and summary statistics as well as qualitative summaries.

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

Sexual violence (SV) is a major public health problem, but it is preventable. According to CDC's National Intimate Partner and Sexual Violence Survey (NISVS), 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 experienced severe SV victimization other than rape at some point in their lives.[1,2] The majority of victimization starts early in life with approximately 80% of female victims experiencing their first rape before the age of 25, and almost half experiencing their first rape before the age of 18.[1,2]

CDC's Rape Prevention and Education (RPE) Program is a national initiative that addresses SV through cooperative agreement funding and technical assistance to health departments in all 50 states, the District of Columbia, and four territories (e.g., Guam, Puerto Rico, U.S. Virgin Islands, and the Commonwealth of Northern Mariana Islands) to conduct state-, district-, and territorial-wide SV prevention activities. The Violence against Women Act of 1994 (VAWA) and as amended in the Violence Against Women Reauthorization Act of 2013 authorize the RPE program and legislatively states that awardees will allot RPE funds for prevention activities conducted by local organizations (i.e., RPE sub-awardees), which include rape crisis centers; State, territorial, or tribal sexual assault coalitions; and other public and private nonprofit entities

(e.g., community-based organizations, nongovernmental organizations, and academic institutions) for the following seven permitted use of funds:

1. Educational seminars,
2. Operation of hotlines,
3. Training programs for professionals,
4. Preparation of informational materials,
5. Education and training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities,
6. Education to increase the awareness about drugs and alcohol used to facilitate rapes or sexual assault, and
7. Other efforts to increase awareness of the facts about, or to help prevent, sexual assault including efforts to increase awareness in underserved communities and awareness among individuals with disabilities as defined in Section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. Section 12102).

The current RPE cooperative agreement (CDC-RFA-CE14-1401) builds on a decade of investments (2002–2012) in the infrastructure and capacity to implement and advance SV prevention activities through three components:

1. Implementation and program evaluation of SV prevention strategies using a public health approach and effective prevention principles
2. Provision of training and technical assistance (TA) to RPE-funded organizations on the implementation of SV prevention strategies
3. Participation in RPE Program support activities

Awardees are required to adhere to general principles of effective prevention, which include addressing modifiable risk and protective factors for perpetration and victimization, addressing multiple levels of the social ecological model, emphasizing primary prevention, having sufficient dosage or intensity, being culturally relevant, and being developed and implemented in collaboration with stakeholders and based on best available evidence. Individual-level strategies alone will have limited reach and sustainability; community-level strategies will more likely lead to population-level changes in SV outcomes and related risk and protective factors. Therefore, awardees are highly encouraged to implement community change strategies (e.g., community mobilization, coalition building, policy activities and social norms change) that complement and support the legislatively approved prevention strategies.

RPE programmatic efforts are situated in different organizational areas (e.g., maternal and child health, injury prevention, emergency management, trauma, women's health) of health departments. Moreover, the programs in the health departments and the local organizations (sub-awardees) they fund have variable levels of capacity and infrastructure to implement primary prevention efforts, engage in program improvement, and systematically collect data about implementation and outcomes of their efforts. Using a public health approach and primary prevention principles are newer concepts for these organizations as efforts in SV were primarily focused on victim services. Through the current cooperative agreement, CDC is evaluating the extent awardees use a public health approach and principles of effective prevention to implement

and evaluate their prevention strategies through the Monitoring and Reporting System (MRS), which consists of two reporting tools, ***Work Plan Tool*** (Attachment 3a–3b) and ***Program Report Tool*** (Attachment 4a–4b). As required by the current RPE cooperative agreement, awardees monitor and report progress on their goals, objectives, and activities using the Work Plan Tool. Using the Program Report Tool, awardees will report relevant information on the implementation of their prevention strategies. These data will be submitted at the time of their annual non-competing continuation application electronically. Due to the diversity of awardees' infrastructure, capacity, and funding strategy for sub-awardees, the tools have been designed with great considerations for those variabilities.

This information collection is necessary to assure that programs are moving toward achievement of their stated goals and objectives and that they are consistently demonstrating efficient and appropriate use of federal funds to implement evidence-based/-informed strategies. This is the first time CDC will systematically collect information about the RPE cooperative agreement, and information to be collected will be used to inform technical assistance (TA), program improvement, and capacity building to assess RPE Program's impact on SV outcomes over time. Information to be collected will provide crucial data for program performance monitoring and provide CDC with the capacity to respond in a timely manner to requests for information about the program from the U.S. Department of Health and Human Services (HHS), the White House, Congress, and other sources. The MRS will improve real-time communications between CDC and RPE awardees, and strengthen CDC's ability to monitor and evaluate awardees' progress and performance.

The statutory authorities of the Public Health Service Act 42 U.S.C. Section 247b (Attachment 1a) and U.S.C Section 280b (Attachment 1b), and as amended H.R. 4970 (P.L. 113-4), the Violence Against Women Reauthorization Act of 2013 (Attachment 1c) authorize the CDC's RPE Program and efforts to collect, prepare, analyze, and disseminate information and statistics relating to the incidence and prevention of sexual assault.

A.2. Purpose and Use of Information Collection

The purpose of the MRS is to collect data related to implementation of prevention strategies (e.g., use of data, target population, level of evidence, reach) using the Program Report Tool and progress towards goals and objectives using the Work Plan Tool from RPE Program awardees or designees. This systematic information collection will enable the accurate, reliable, uniform, and timely submission to CDC of each awardee's work plan and progress reports, including strategies and performance measures. The information collection and reporting requirements have been carefully designed to align with and support the specific goals and outcomes outlined in the RPE cooperative agreement.. Awardees will be able to generate reports that summarize their activities and progress towards meeting work plan strategies and performance measure targets. The tools provide a way for awardees to track their own activities and funding to local organizations as required by legislation. Some awardees may delegate a designee such as their sub-awardee to complete aspects of the tools to provide the awardees with a complete picture of their efforts.

There are significant advantages to collecting information with these reporting tools:

- The data structure will help awardees formulate performance measures that are specific, measurable, achievable, relevant, and time-framed (SMART). This formulation is intended to facilitate successful achievement of performance measures and is integral to CDC's program evaluation strategy for the program.
- The information being collected provides crucial information about each awardee's work plan, activities, partnerships, and progress over the project period.
- The tools are dynamic in the sense that additional items can be added so that awardees can report crucial information in a format that matches their structure.
- Capturing the required information uniformly will allow CDC to formulate ad hoc analyses and reports.

CDC will use the information collected to monitor each awardee's progress and to identify facilitators and barriers to program implementation and achievement of outcomes. Monitoring allows CDC to determine whether an awardee is meeting performance and budget goals and to make adjustments in the type and level of TA provided to them, as needed, to support attainment of their performance measures. Program monitoring and evaluation activities also allow CDC to identify and disseminate information about successful prevention strategies implemented by awardees. These functions are central to the NCIPC's broad mission of protecting Americans from violence and injury threats. The information collection will allow CDC to monitor the increased emphasis on strategies that affect health outcomes and impact, and is expected to reduce duplication of effort, enhance program impact and maximize the use of federal funds. Moreover, it provides CDC with the capacity to respond in a timely manner to inquiries and requests for information about the program.

Working with CDC staff, awardees will use the information collected to manage and coordinate their activities and to improve their efforts to prevent SV perpetration and victimization. The tools will allow awardees to fulfill their annual reporting obligations under the funding opportunity announcement in an efficient manner by employing user-friendly instruments to collect necessary information for both progress reports and continuation applications. This approach, which enables awardees to save pertinent information from one reporting period to the next, will reduce the administrative burden on the yearly continuation application and the progress review process. Awardee program staff will be able to review the completeness of data needed to generate required reports, enter basic summary data for reports at least annually, and finalize and save required reports for upload into other reporting systems as required.

Although program evaluation is an essential public health function and important for performance monitoring, limitations of this type of data collection are the generalizability of results and the certainty of causation. The conclusions drawn from these data may not generalize to the entire country due to differences in the demographics of targeted populations, policies, and implementing agencies. In addition, because this is not a research cooperative agreement, states are not required to implement rigorous research designs that have strong internal validity and produce generalizable knowledge. As such, the information CDC collects may make a strong inference of correlation, but causation cannot be inferred.

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

The CDC contractor, has developed the Program Report Tool and the Work Plan Tool using the Microsoft Excel platform. Since the use of Excel is relatively common, this user-friendly interface will require very little training and will be easier and more intuitive for awardees to use than special-purposed tools or software. Awardees will use the tools provided to record and update cooperative agreement information and will upload completed tools with their non-competing continuation applications to Grant Solutions website to satisfy funding annual performance reporting (APR) requirements. Awardees may also send a courtesy copy to their assigned Project Officer for technical review and feedback. Upon completion, the Project Officer will send the completed tools to be integrated into the MRS database for analysis and reporting.

These tools improve information quality by minimizing errors and redundancy. Having awardees report information in the same tools in the same manner will reduce the level of burden attributable to redundancy and reduce the workload to enter and maintain the data. Programs will have data transferred from one year to another and only modify information instead of reentry, which minimizes data re-entry, burden, and potential errors. Moreover, the tools have been designed in such a way that is flexible for awardees' program context and structure; they are able to use and print the tools for their use in a manner that fit their use.

With the MRS, the use of a standard set of data elements, definitions and specifications at all levels will help to improve the quality and comparability of performance information that is received by CDC for multiple awardees. Further, standardization will enhance the consistency of plans and reports, enable examination of cross-program performance and strategies, and will facilitate a higher degree of reliability by ensuring that the same information is collected on all strategies and performance measures with slightly different areas of emphasis, depending on strategies chosen by the awardee. Finally, the report generation capabilities of the system will reduce the respondent burden associated with paper-based reports by enabling collection and reporting of the information in an efficient, standardized, and user-friendly manner that will generate a variety of routine and customizable reports. Without the reporting tools and the integrated approach to information collection and reporting, both awardees and CDC would need to continue to use time consuming, labor intensive procedures for information collection and reporting.

A.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, the information collected from RPE awardees is not available from other sources. This information is specific to the RPE Program. The collection of this information is part of a federal reporting requirement for funds received by awardees. The tools will consolidate information necessary for both continuation applications and progress reports so that information entered once can be used to generate multiple types of reports without having to duplicate efforts. As CDC's primary SV prevention initiative, RPE occupies a unique niche within the larger scope of HHS violence prevention initiatives. The U.S. Department of Justice, Office of

Violence against Women (OVW) makes funding available to territorial domestic and SV coalitions to focus on victim service provision for individuals. The CDC RPE cooperative agreement, however, can only be used for prevention and cannot be used to fund victim services; therefore, information collected from RPE awardees will not duplicate information collected from OVW awardees.

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

No small businesses will be involved in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

Reports will be collected annually. The annual progress report is due 120 days before the end of the budget period and serves as a non-competing continuation application. Less frequent reporting would undermine accountability efforts at all levels and negatively impact monitoring awardee progress. The annual reporting schedule ensures that CDC responses to inquiries from HHS, the White House, Congress and other stakeholders are based on timely and up-to-date information.

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

The 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.8.a) Federal Register Notice

A 60-day Federal Register Notice (FRN) was published in the Federal Register on November, 27, 2015, vol. 80 No. 228, and pp.74108–74109 (Attachment 2). There were no comments to the 60-day FRN.

A.8.b) Efforts to Consult Outside the Agency

CDC and contracting agency, Deloitte, who have been designing these data systems throughout CDC, have been collaboratively designing the MRS since 2014. Consultation with Deloitte will continue throughout the implementation of the MRS.

Pilot testing of the Work Plan and Program Report Tools with nine awardees from select states and CDC program staff was completed. The tools were sent with instructions to provide feedback about content, design, relevance, and usability of the tools. Comments were extracted and information inputted were reviewed. Follow up interviews were

conducted with eight of the nine awardees to clarify feedback and obtain suggestions to improve the tools. A thematic analysis was conducted across all feedback and the findings were used to modify order of question items, reword questions, modify instructions to be clearer, and modify design to allow flexibility for respondents to add additional items. The tools were revised to accommodate the wide variety in which awardees structure and track RPE funding and activities. Awardees also documented the amount of time it took them to complete the tools. The revised tools allow for adding additional objectives to accommodate awardees in larger state and those with larger range. The revisions also reduce duplication of information for the same prevention strategies implemented in different settings.

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

Respondents will not receive payments or gifts for providing information.

A.10. Protection of the privacy and confidentiality of information provided to respondents

The CDC Office of the Chief Information Officer has determined that the Privacy Act does not apply to this information collection request. Respondents are RPE cooperative agreement awardees (i.e., state and territorial health departments) or their designated personnel. No sensitive information or personal contact information will be collected. Only names of the organizations for whom the RPE awardees provide sub-awards will be collected.

Data will be kept through the end of the RPE funding period January 2019 plus two additional years for analysis purposes. All data will be discarded in January 2021. Data will be maintained in a secure, password protected system, and information will be reported in aggregate form. All data will be reported in aggregate form, with no identifying information included. Awardees or their designee will provide programmatic information. The information collection does not require consent from individuals. All procedures have been developed, in accordance with federal, state, and local guidelines, to ensure that the rights and privacy of key awardees' program staff (e.g. program director) will be protected and maintained. While consent is not required to report aggregate data, awardee approval will be obtained if specific data are used for publications, reports, or other publicly disseminated information.

No system of records will be created under the Privacy Act. Submission and access to data will be controlled by a password-protected login to the secure site. Access to data will be controlled by a password-protected Microsoft Access database. Access levels vary from read-only to read-write, based on the user's role and needs. Each awardee will have access to viewing its own information in pre-determined reports, which they can share with designated program staff and designees. The extent to which local partners may access an awardee's information will be decided by that awardee. CDC will have varying levels of access to the system with role-appropriate security training, based on the requirements of their position(s). Aggregated

information will be stored on an internal CDC Access server subject to CDC's information security guidelines.

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

IRB Approval

The CDC National Center for Injury Prevention and Control's OMB and human subject research officer has determined that IRB approval is not needed (Attachment 5).

Sensitive Questions

The proposed tools do not collect sensitive information.

A.12. Estimates of Annualized Burden Hours and Costs

Respondents will be the 55 awardees (State, District of Columbia, and Territorial Health department) or their designees of the RPE Program cooperative agreement. Respondents will report information to CDC about their progress, implementation, and performance using the MRS tools once per year (or annually). Due to varying structures of their programs, some awardees may delegate a designee to complete information on their behalf. Two Excel-based information collection tools will be used: ***Work Plan Tool*** (Attachment 3a–3b) and ***Program Report Tool*** (Attachment 4a–4b). The same instruments will be used for all annual information collection and reporting. Because awardees do not need to reenter information for subsequent year and only need to modify or update their information, the burden estimates for each information collection tool vary for initial and subsequent years. The time commitments for data collection, entry, and training will be greatest during the initial reporting. In subsequent reporting years, burden is limited to entering changes, providing progress information, and adding new activities as they would not have to reenter information.

The initial population of the tools occur only during the first year of information collection for all 55 awardees. Estimated burden for the one-time initial population of the Work Plan Tool is ten hours, and will be annualized over the 3-year clearance period. Estimated burden for the one-time initial population of the Program Report Tool is eight hours, and will be annualized over the 3-year clearance period. These estimate is based on the pilot test and includes the time it took to becoming familiar with, interfacing with and entering information into the system.

For the annual reporting after initial population, the burden estimates are lower and are the three hours for each response for each tool. The total estimated annualized burden hours is 654 hours per year, as summarized in Table A.12-A.

Table A.12-A. Estimated Annualized Burden Hours

Type of respondents	Form Name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
RPE Program Awardees (State, District of Columbia, and Territorial Health Departments) or Designees	Work Plan Tool (Attachment 3) Initial Population	18	1	10	180
	Program Report Tool (Attachment 4) Initial Population	18	1	8	144
	Work Plan Tool (Attachment 3) Annual Reporting	55	1	3	165
	Program Report Tool (Attachment 4) Annual Reporting	55	1	3	165
				Total	654

A.12.b) Annual burden cost

For each of the 55 RPE Program awardee, a program manager or designee will complete the tools. 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 used. The estimated annualized burden costs is $33,347.50, as summarized in Table A.12-B.

Table A.12-B. Estimated Annualized Burden Costs

Type of respondents	Form Name	Total burden (in hours)	Hourly wage Rate	Total Respondent cost
RPE Program Awardees (State, District and Territorial Health Departments) or Designees	Work Plan Tool (Attachment 3) Initial Population	180	$50.99	$9,178.20
	Program Report Tool (Attachment 4) Initial Population	144	$50.99	$7,342.60
	Work Plan Tool (Attachment 3) Annual Reporting	165	$50.99	$8413.40
	Program Report Tool (Attachment 4) Annual Reporting50.99	165	$50.99	$8413.40
	Total			$33,347.50

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

No capital or maintenance costs are expected. Additionally, there are no start-up, hardware, or software costs.

A.14. Annualized Cost to the Government

The average annualized cost to the federal government is $84,200, as summarized in Table A.14. Major cost factors for the electronic information collection system include design and development costs as well as data analysis and reporting costs.

Table A.14. Estimated Annualized Cost to the Government

Type of Cost	**Description of Services**	**Annual Cost**
CDC Personnel	40% salary (assuming GS-13 at $85,500/year) = $34,200 Subtotal, CDC Personnel	$34,200
Contractor	Data System Contractor	$50,000
	Total Annual Estimated Costs	**$84,200**

A.15. Explanation for Program Changes or Adjustments

This is a new collection.

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

A. Time schedule for the entire project
The cooperative agreement cycle is five years. OMB approval is being requested for three years. Reports will be generated by the awardees per the FOA requirements once a year due 120 days before the end of the budget period.

B. Publication plan
Information collected by the awardees will be reported to CDC leadership and shared back with awardees. CDC will also generate reports that describe activities across multiple awardees and able to provide this information back to awardees or to respond to inquiries from HHS, the White House, Congress and other stakeholders about the national RPE Program activities and their impact. CDC will also report data to other external audiences, as needed, to describe the state of sexual violence prevention activities across the nation. Information will be analyzed and synthesized for specific reporting purpose and response to inquiries. Such reports will be used inform RPE Program impact as well as TA and planning of programmatic efforts.

C. Analysis plan

CDC will not use complex statistical methods for analyzing information. Most statistical analyses will be descriptive (i.e., frequencies and crosstabs) and content analysis. For example, the percent of objectives met versus proposed will also be documented and analyzed. Furthermore, the information in the work plan will allow for CDC staff to monitor program activities and implementation and provide TA to awardees after a review has been completed.

Table 4. Project Time Schedule

Activities	**Timeline**
Notification of Tool Availability	Immediately upon OMB approval
User Training	Immediately upon OMB approval and ongoing through expiration date
Data Collection for ending funding year and upcoming funding year	1–6 months after OMB approval
Data Publication	Annually
Data Analysis	1–36 months after OMB approval

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

The display of the OMB expiration date is not inappropriate.

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

There are no exceptions to the certification.

REFERENCES

1. National Center for Injury Prevention and Control (NCIPC). National Intimate Partner and Sexual Violence (NISVS) Survey: Fact Sheet. Retrieved July 2015 from: http://www.cdc.gov/ViolencePrevention/pdf/NISVS_FactSheet-a.pdf
2. Breiding MJ, Smith SG, Basile KC, Walters ML, Chen J, Merrick MT. Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—national intimate partner and sexual violence survey, United States, 2011. MMWR Surveill Summ. 2014; 63(8):1-18.