SUPPORTING STATEMENT: PART A

OMB#

Pilot Implementation of the Violence Against Children and Youth Survey (VACS) in the US

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This request describes the Pilot Implementation of the Violence Against Children and Youth Survey (VACS) in the United States, which CDC has conducted in 24 countries globally and has adapted for a domestic context. More specifically, this request details the adaptations to the survey and methods for piloting the survey in one urban and one rural area of the United States.

Goals of the Pilot Test:

- Adapt the Violence Against Children Surveys (VACS) methodology for implementation in the U.S.
- Pilot the adapted VACS methodology in Baltimore using a representative sample of youth ages 13-24 that yields results that are representative of the Baltimore youth population and collect pilot data with a convenience sample in rural Garrett County in Maryland to test the VACS in-person methodology in a rural location.
- Estimate the prevalence of physical, emotional and sexual violence perpetrated against youth in Baltimore.
- Identify risk and protective factors for physical, emotional and sexual violence against children to inform stakeholders and guide prevention efforts.
- Identify the health and social consequences associated with violence against children.
- Assess the knowledge and use of medical, psychosocial, legal, and protective services available for children who have experienced sexual, emotional and physical violence.
- Identify substantive areas for further research.
- Make recommendations to relevant organizations in Baltimore (and similar cities in the US) on developing, improving and enhancing prevention and response strategies to address violence against children as part of a larger, comprehensive, multi-sectoral approach to child protection.

Intended use of the resulting data.

The findings from this pilot study will be used primarily to better understand the feasibility and effectiveness of implementing VACS in the U.S., which will ultimately inform CDC's understanding of the magnitude of violence against children, including sexual violence, and its underlying risk and protective factors in order to make recommendations to national and international agencies and non-governmental organizations on developing strategies to identify, treat and prevent violence against children. The CDC will be using the results of this survey to inform its violence prevention efforts and refine practices related to the protection of children.

Methods to be used to collect data.

Data will be collected through in-person probability-based household surveys, which will be conducted using a combination of interviewer-administration and Audio Computer-Assisted Self-Interview (ACASI) Software on tablets.

The subpopulation to be studied.

Youth ages 13-24 in urban Baltimore or rural Garrett County, Maryland who speak English.

How data will be analyzed.

Data will be analyzed using appropriate statistical software to account for the complexity of the survey design to compute weighted counts, percentages, and confidence intervals using probability-based survey data at the local level.

SUMMARY TABLE

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

The CDC seeks OMB approval for up to 3 years of data collection to conduct a pilot test of the Violence Against Children and Youth Surveys (VACS) in the United States, specifically in Baltimore and Garrett County, Maryland. In recent years, the Violence Against Children and Youth Surveys (VACS) have been implemented in 24 countries across Africa, Southeast Asia, Eastern Europe in Central and South America, yielding nationally representative and sub-national data on the burden, contexts, and consequences of violence against children and youth.[i]

Violence against children is a global human rights violation that spans every country worldwide and affects a billion children each year.[ii] In the US, a large number of youths are the victims of multiple forms of violence and abuse. An estimated 10 million children in the US have experienced child abuse and neglect (CAN), [iii] [iv] while approximately 676,000 victims of CAN were reported to child protective services in 2016.[v] Each day, about a dozen youth are victims of homicide and more than a 100 times that number (~1,400) are treated annually in emergency rooms for physical assault injuries.[vi] Youth are also involved in high levels of peer violence, which is one of the leading causes of death for people ages 10-24.[vii] Among U.S. high school students, YRBS data indicate that past-year prevalence of physical fighting (23.6%), school bullying (19.0%), electronic bullying (14.9%), physical dating violence (8.0%), sexual violence (9.7%), attempted suicide (7.4%), and lifetime prevalence of forced sexual intercourse (7.4%) demonstrate that violence is common among youth in the US.[viii]

A body of research has shown that the impact of violence against children goes far beyond the initial incident, and that those who have experienced emotional, physical, and sexual violence can experience severe short to long-term health and social consequences.[ix] CAN has serious negative physical health effects and is associated with a variety of chronic diseases as adults.[x] Victims of CAN also suffer from negative psychological sequelae[xi] and increased risk for smoking, alcoholism, and drug abuse.[xii] Neurobiological and behavioral research indicates that early childhood exposure to violence can affect brain development and thereby increase the child's susceptibility to a range of mental and physical health problems that can span into adulthood including anxiety or depressive disorders, cardiovascular health problems, and diabetes.[xiii,xiv,xv] Youth violence is associated with poorer academic performance,[xvi,xvii,xviii,xix,xx,xxi] suspension, unexcused absences,[xxii] higher dropout rates,[xxiii,xxiv] and delinquency for its victims.[xxv,xxvi,xxvii,xxviii] Similar deleterious outcomes are found for violent victimization by dating partners in adolescence,[xxix,xxx,xxxi,xxxii] with nearly one in five youth reporting sexual or physical victimization by a partner.[xxxiii]

Given the serious and lasting impact on children, it is critical to understand the magnitude and nature of violence against children in order to develop effective prevention and response strategies.

Currently, data to guide state and local violence prevention and response efforts in the US are quite limited. While some studies have provided information on the risks and impact on violence against children, they are mostly limited in scale and cannot be generalized to the scope of violence against youth across the US or for specific regions.[xxxiv,xxxv] Existing estimates of violence against youth in the United States are based on telephone studies, such at the National Survey of Children's Exposure to Violence, which includes caregiver respondents for young children. Disclosure of violence in this study therefore may be lower, as parents do not know or wish to reveal the full extent of their child's exposure to violence and youth participants may not have the privacy needed to feel comfortable disclosing.[xxxvi] In addition, the existing national studies cannot yield estimates at the state and local levels, making the data less actionable at these levels. These studies also often have lower response rates.

Another well-known data system that measures child abuse is the National Child Abuse and Neglect Data System (NCANDS), a voluntary data collection system that gathers information from all 50 states, the District of Columbia, and Puerto Rico about reports of child abuse and neglect. However, this system is limited to official reports of child abuse and neglect. While large, the NCANDS is also not nationally representative and analyses cannot be extrapolated to the entire U.S. population of children abused.

Furthermore, less focus has been given to understanding protective factors for violence against children. Consequently, this study will assess potential risk and protective factors for violence against children and include risk and protective factors that have been associated with violence in other countries. For example, this study will examine a number of factors related to degree of parental involvement and will ask respondents about whether a parent has died, how long a respondent lived with each biological parent, reasons why they may no longer be living with a parent, parent education level, relationship quality with parents, and perceived family and social support. Although some of these factors are not readily modifiable, these associations would have implications for identifying those at highest risk for violence and therefore help to determine how best to identify and allocate available prevention resources. CDC anticipates that a greater understanding of the risk and protective factors influencing violence against children could guide the development of prevention strategies designed to buffer against these risks and bolster facets of protection.

Without integrative research into the breadth and depth of the problem and investigation into why violence is so highly stigmatized and hidden, current response options may be ineffective, leaving children with limited access to services and protection. Moreover, there are gaps in what data is available at the state and local level, which make it difficult to determine how many children are exposed to violence and to characterize the circumstances and contexts in which such violence occurs. There is a need for data that are representative of the entire spectrum of violence against children and youth and are comprehensive in terms of describing multiple types of violence (physical, sexual, and emotional) as well as the contexts of violence victimization, and its risk and protective factors.

Population-based, comprehensive data are essential to effectively planning, implementing, and assessing the impact of programs addressing violence against children and youth.

Current Request

VACS measure the magnitude of physical, sexual, and emotional violence against children as well as associated risk and protective factors. VACS have contributed to research throughout the world, demonstrating the high prevalence of violence against children in a variety of countries and cultures, and have proven to be critical tools that can fill data gaps in ways that are vital to informing strategic planning and evidence-based public health efforts in many countries. However, VACS have not been implemented in the U.S., and the existing representative datasets of violence against youth in the U.S. have significant limitations that prevent the data from being actionable for prevention planning by public health departments at the local level. VACS in the U.S will help fill this gap with rigorous probability-based estimates of the problem of youth violence combined with an internationally tested approach to embed the VACS survey into the local strategic planning process of local public health partners. Since the U.S. is a much different context than the countries that have previously conducted VACS, this request is for pilot testing the adapted survey and methodology in two contexts: (1) a representative sample of 13-24 year old youth in Baltimore and (2) a convenience sample of 13-24 year old youth in rural Garrett County, Maryland to test the VACS in-person methodology in a rural location. CDC will also conduct two pre-tests prior to the fill pilot implementation: Pre-test 1 will include interviewing nine participants to detect problems with the instrument and allow time to fix those problems (not included in the burden estimate because it is below the nine case OMB threshold); Pre-test 2 will include 60 participants to test the final instrument and all study protocols in the field and is included in the burden for this collection.

The use of probability-based sampling in Baltimore is based on the need to develop scientific estimates of violence against children in a standard urban area where the VACS in-person methodology has proven to be successful in other countries. More formative/methodological research is necessary in a rural area in the U.S. to assess first the suitability of the in-person VACS methodology. There are no instances of violence against children data being collected in-person in rural areas in the U.S. to move directly to producing scientific estimates of violence against children. Once the in-person VACS methodology is shown to work with a convenience sample in a rural area, as proposed in this study, CDC will be positioned in the future to create scientific estimates of violence against children with large samples of rural locales.

Authority for CDC's National Center for Injury Prevention and Control to collect these data is granted by Section 301 of the Public Health Service Act (42 U.S.C. 241) (Attachment A). This act gives Federal health agencies, such as CDC, broad authority to collect data and carry out other public health activities, including this type of study.

A.2. Purpose and Use of Information Collection

This research initiative seeks to provide comparable, population-based estimates, which describe the magnitude and nature of the problem, as well as the epidemiologic patterns of risk and protective factors of violence experienced by children in Baltimore for the purpose of informing VACS implementation in the U.S., as well as developing and implementing effective prevention strategies. The information collection is focused around the following goals:

- Adapt the Violence Against Children Surveys (VACS) methodology for implementation in the U.S. The pilot VACS implementation will use a representative sample of youth ages 13-24 and conduct in-person data collection using in-person household survey methods.
- Pilot the adapted VACS methodology in Baltimore that yields results that are representative of the Baltimore City youth population and collect pilot data in a rural county in Maryland.
- Test minor variations in the methodology to determine which yield the best response rates.
- Estimate the prevalence of physical, emotional and sexual violence perpetrated against boys and girls, including sexual touching without permission, attempted sexual intercourse, physically forced sexual intercourse, and pressured sexual intercourse perpetrated against boys and girls.
- Identify risk and protective factors for physical, emotional and sexual violence against children to inform stakeholders and guide prevention efforts.
- Identify the health and social consequences associated with violence against children.
- Assess the knowledge and use of medical, psychosocial, legal, and protective services available for children who have experienced sexual, emotional and physical violence.
- Identify areas for further research.
- Make recommendations to relevant organizations in Baltimore (and similar cities in the U.S.) on developing, improving and enhancing prevention and response strategies to address violence against children as part of a larger, comprehensive, multi-sectoral approach to child protection.

The findings from this pilot study will be used primarily to better understand the feasibility and effectiveness of implementing VACS in the U.S., which will ultimately inform CDC's understanding of the magnitude of violence against children and underlying risk and protective factors in order to make recommendations to national and international agencies and non-governmental organizations on developing strategies to identify, treat and prevent violence against children. If successful, VACS could be scaled up and ultimately provide decision makers with state or city-level data on the magnitude and nature of violence against children in the US. The CDC will be using the results of this survey to inform its violence prevention efforts and refine practices related to the protection of children. In addition to the primary use mentioned above, the findings of the survey will also serve as a foundation for enhancing and developing strategies focused on youth violence prevention in the City of Baltimore.

Following COVID-19 guidance, at the time of the interview, social distancing and other public health safety measures will be implemented as necessary when data collection begins in October 2021. CDC awarded NORC at the University of Chicago a contract to provide scientific services to adapt the VACS

methodology for implementation in the United States. NORC's role includes managing and conducting the interviews in the field. NORC has developed a *Planning for In-Person Data Collection Task Force* to create a template for projects to reintroducing in-person data collection during the COVID-19 pandemic in such a way that is safe and accepted by interviewers and respondents, and ensures the quality of data collection. Protocols that have been developed to date include requirements for maintaining physical distance, requiring both the interviewer and respondents to wear masks (NORC staff will have extra masks with them to provide a mask to the respondent if they do not have one available to wear) and other personal protective equipment (i.e., facial shield and gloves), disinfecting wipes to be used after each interaction with materials and equipment, and interviewing outdoors when possible or siting in an indoor area with adequate ventilation. As the situation evolves, the task force will continue updating protocols to ensure the safety of participants and interview staff. All interviewers and field managers will be trained on all protocols prior to entering the field. We will adhere to the most up to date CDC guidelines on testing, quarantine, and other mitigation efforts. In addition to following guidance developed by the NORC task force, the study team will follow the example of other federal research organizations, such as the U.S. Census Bureau, and train our interviewers on adhering to public health guidelines and applicable state and local orders within Maryland.

The in-person data collection methodology is essential for this research for several reasons. First, given the sensitivity of the questionnaire, in-person data collection will help ensure the privacy and safety of the participant. Interviewers will be trained to secure a private space within the home so that other household members do not see or overhear sensitive questionnaire items (see section A.10.). Interviewers will also be trained to connect participants who have an adverse reaction to the survey with a social worker and/or other resources within the community. Additionally, in-person data collection has been shown to yield higher response rates compared to telephone or online survey methods.[xxxvii] CDC has had success with implementing VACS in 24 countries using in-person data collection methodology. CDC hired NORC as a contractor to pilot test the VACS questionnaire and methodology as an in-person household survey in the United States, with the purpose of determining the feasibility of implementing this study throughout the United States. As outlined below in section A.4., the in-person methodology is essential for filling a gap in research on violence against children in the United States. Should in-person data collection not be feasible in Fall 2021 as planned due to safety concerns related to the COVID-19 pandemic we will propose delaying data collection until it is safe to do so, based on public health protocols in Maryland. With the recent news on the upcoming availability of multiple COVID-19 vaccines as early as Dec. 2020, we are encouraged that the pandemic will gradually be brought under more control and in-person data collection will be able to proceed using the above precautionary steps.

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

The pilot implementation of VACS in the United States intends to use electronic data collection, specifically tablets for interviewer-administered and Audio Computer-Assisted Self-Interview (ACASI) Software survey items. This pilot study will be the first VACS study to use ACASI. This software capitalizes on the use of improved information technology, allowing participants to be able to read, listen, and respond to questions on the tablet themselves, instead of responding to the interviewer. ACASI with a headset for working privately will be used because it allows for the collection of sensitive information in a way that maximizes participant comfort with disclosure, increasing the likelihood of the collection of reliable and valid data on sensitive items.

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

The information to be collected from participants is not available from other sources. As described above, while VACS has been implemented in 24 countries globally, it has never been conducted in the United States, and therefore representative data collected in-person on the prevalence, context, and risk and protective factors of violence against children does not exist.

While developing the global VACS, CDC engaged international partners, including UNICEF, WHO, USAID, and Together for Girls to ensure that the information was both useful and unique. In the development of the domestic surveys, CDC met with two state public health departments and experts from CDC, CDC Foundation, academia and non-profit organization partners to gather insight on important topics for inclusion in the questionnaire to gain a comprehensive understanding of violence against children in the U.S. Furthermore, while adapting the survey instrument for use in the pilot implementation in Baltimore, Maryland, CDC collaborated with the Baltimore City Health Department (BCHD) to elicit their input on data needed to develop well-informed violence prevention programs within their community.

The CDC acknowledges that a lack of comprehensive data on violence against children has been one of the challenges to plan, implement, monitor and evaluate appropriate policies and programing on child protection. While there are some sources of information related to violence against youth, such as the Youth Risk Behavior Survey (YRBS, OMB# 0920-0493), and Behavioral Risk Factor Surveillance System (BRFSS, OMB# 0920-1061), these sources are not violence-focused, and thus do not capture local prevalence and the comprehensive context of youth violence victimization and perpetration across the U.S. Furthermore, much ACEs data are focused on adults, rather than youth populations. Alternatively, there are other data systems that cover violence such as CDC's National Intimate Partner and Sexual Violence Survey (NISVS, OMB# 0920-0822), the National Crime Victimization Survey (NCVS, OMB# 1121-0111) conducted by the Bureau of Justice Statistics, and the National Survey of Children's Exposure to Violence (NatSCEV) funded in the past by the Office of Juvenile Justice and Delinquency Prevention. The NISVS only includes adults aged 18 and older (VACS targets youth ages 13-24). The NCVS includes U.S. households with occupants age 12 or older but only

includes victimization, with no coverage of perpetration of violence. Furthermore, the NCVS survey questions are couched within a crime context (querying participants about being a 'crime' victim), but the VACS will ask behaviorally specific/neutral questions couched in a public health context which is associated with much higher levels of disclosure. Within a crime context, youth may not disclose violence because they do not equate violence by people they trust with crime. The NatSCEV is not actively collecting data (the last archived NatSCEV dataset was 2014) and involved three rounds of data collection, NatSCEV I (baseline), NatSCEV II, and NatSCEV III. The NatSCEV was designed to obtain lifetime and one-year incidence estimates of a comprehensive range of childhood victimizations (but perpetration is not covered in NatSCEV). The NatSCEV is collected via phone interviewing and does not use the more rigorous in-person data collection methods used in VACS. Data collection via phone tends to yield lower response rates than in-person[xxxviii] and cannot ensure participant privacy. Also, NatSCEV includes in its nationally representative sample of children only youth less than 18 years of age and does not use the more expansive definition of adolescents to include young people up to age 24 years old.

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

The primary consequence of collecting these data less frequently is that stakeholders would have less timely access to city, state, and national prevalence estimates and other data on violence against children. In order to generate state-level or national-level estimates, the VACS adapted for the U.S. context must be pilot tested. Because no comprehensive, ongoing and representative data on violence against children exists in the U.S., reducing the frequency of data collection would greatly impact the CDC's ability to conduct future VACS studies to gain a comprehensive understanding of violence against children to therefore use to inform prevention efforts.

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 was published in the Federal Register on July 28, 2020 Volume 85, Number 145, pp 45432 (**Attachment B**). CDC did not receive public comments.

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

CDC has consulted with several organizations outside the agency in the adaptation of the U.S. VACS. CDC staff in NCIPC recruited a panel of experts to attend a meeting in July 2017 to begin discussions on the feasibility of adapting the VACS for the U.S. Attendees included representatives from CDC, key partners of the global VACS projects, and experts in children and youth violence from academia and community organizations. The panel meeting discussed methodology modifications that would be necessary for the U.S., key ethical considerations, and survey adaptations to capture relevant and comprehensive data on violence against children in the U.S. NORC and CDC held several preparatory meetings in September through November 2019 before holding an introductory workshop in Baltimore, with representatives from the Baltimore City Health Department, Baltimore's steering committee, NORC, and the CDC VACS team.

Following the introductory/preparatory workshop on violence against children survey in December 2019, facilitated by the Baltimore City Health Department (BCHD), NORC, and CDC, agreed to pursue the implementation of the survey and established the Baltimore Steering Committee on Violence against Children Survey. Baltimore was selected for the pilot site due to high rates of violence in the city[xxxix] and the city's strong interest in designing prevention programs to combat youth violence.[xl] The BCHD will serve as the coordinating agency for the project. The BCHD is a compelling option given this agency's experience in both youth violence data collection and prevention program implementation, as well as their deep experience in leading stakeholder coalitions to address local public health challenges. The sampling will take place within urban (e.g., City of Baltimore) and rural areas (i.e., through a separate agreement with the Garrett County Public Health Department).

Since September 2019, there has been regular contact between key partners participating in the U.S. pilot implementation on VACS and CDC to discuss survey materials, human subject protection planning, community entry protocols, survey sample size requirements and logistics, and other critical topics in the preparation for the U.S. pilot implementation of violence against children survey in Baltimore and Garrett County, MD. Such ongoing dialogue has succeeded in adapting the survey tool and survey procedures for the United States.

Further, CDC has engaged several Federal partners to learn about ongoing experiments being conducted in Federal surveys to improve response rates, to assess the feasibility of partnering to conduct mutually beneficial experiments, and to learn from methods being implemented by other Federal surveys. Since July 2017, CDC has consulted with or referred to publications and work from other Federal and non-Federal partners (including BJS, CDC–BRFSS, CDC–National Survey of Family Growth (NSFG), CDC–National Health Information Survey (NHIS), National Highway Traffic Safety Administration (NHTSA), National Science Foundation (NSF), Census Bureau, National Center for Health Statistics (NCHS), American Association for Public Opinion Research (AAPOR), Office of Juvenile Justice and Delinquency Prevention's redesign of the National Survey of Children's Exposure to Violence, and

Research Triangle Institute (RTI)) to learn more about studies that are currently in the field or pending and that could have implications for VACS.

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

Incentives are one of the most effective ways to decrease non-response bias in survey research. Nonresponse bias refers to the bias that exists when respondents to a survey are different from those who did not respond (e.g., in terms of demographic or attitudinal variables). Nonresponse bias occurs when there is a connection between the likelihood of participation in the survey and the specific survey measure of interest. The degree to which sampled respondents differ from the survey population (i.e., nonresponse bias) is central to evaluating the representativeness of a survey.[xli] Nonresponse bias is a problem because it can lead to incorrect estimates that are inflated or deflated. Our team will assess whether the process by which respondents participate in the VACS survey is associated with the outcomes the survey is designed to measure.[xlii] If a nonresponse variable is correlated with the phenomenon of interest in the research, the results will be biased.[xliii]

NORC and CDC have conducted a review of the incentive literature and found that while much of the literature suggests that the use of incentives has a positive effect on participant response rates, little research has examined the impact of their use specifically on nonresponse bias reduction among youth surveyed in-person in a household survey. Among the few youth studies (either not in-person or not on violence) done the effect of incentives, results were mixed. One study on youth and nutrition found that incentives were a main reason for participating[xliv] while another on youth and health care found that the incentive did not influence the decision to participate.[xlv] Interestingly, one study with older university students (not in-person) on sexual assault found higher response rates with a $25 incentive compared to a $10 incentive, but no difference between $25 and $40.[xlvi] In this same survey, sexual victimization was higher in the $10 incentive group than the $25 incentive group, potentially suggesting that victims were more motivated to participate even when a lower incentive was offered. However, the higher prevalence of victimization among those receiving the $40 compared to the $25 incentive may suggest that victims are susceptible to higher incentive offers.[xlvii]

Overall, research across the field of survey research (not specific to youth) suggests that a $10 incentive significantly increases survey response rates and reduces non-response bias,[xlviii] and that a $20 incentive increases response rates over a $10 incentive.[xlix] Research has also shown that a $1 pre-incentive increases response rates by 6 percentage points and also reduces non-response bias.[l]

NORC and CDC's review of the literature demonstrates the need for further incentive experimentation with youth participants in household surveys. We do not have results from other experiments with youth that can be relied upon to address our pilot study questions about the best way to reduce non-response bias, especially in the context of an urban environment experiencing elevated rates of violence.

Therefore, CDC is planning to take the following approach to the use of incentives. First, participants will receive a small incentive as a token of appreciation for their time. Households will be mailed a $1 pre-incentive to their homes to encourage participation in the screener component of the project. Beyond that, because this is a pilot test, three incentive structures will be experimentally tested to determine the optimal amounts and structure for incentives for the VACS population (see Table 1): (1) a direct offer of $20 upon survey completion; (2) recruitment offering $40 early bird incentive if completed within two weeks after screening in, otherwise a $20 post-incentive upon completion; and (3) an initial offer of $20 upon survey completion, with additional communication to non-responders later in the field period with an escalation offer of $40. All post-participation incentives will be distributed to the youth participant in the form of a gift card by the field interviewer at completion of the interview. In sum, an incentive experiment is necessary to determine the total dollar values and timing of incentive offers that will yield the greatest reductions in non-response bias, which can ultimately save resources in future VACS studies in the U.S. and produce the highest quality data.

Table 1. Use of Incentives for the Domestic VACS Pilot Implementation Study

Incentive groups by sample frame	**Sample size per group***
Pre-paid Incentive with letter to households $1	7,083
Direct offer of $20 upon completion $20	340
Early bird incentive $40	340
Follow-up $40 for non-respondents $40	340

* Number of eligible sampled persons who are offered the incentive. Estimate contingent on response rates assumed in the sample design.

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

Privacy and Confidentiality

The CDC Office of the Chief Information Officer has determined that the Privacy Act does not apply. No system of records will be created under the Privacy Act. The Privacy Impact Assessment (PIA) for this evaluation is attached. (Attachment C). All persons working on the project will be required to protect confidentiality as stipulated in HHS regulations for the protection of human subjects in research (45 CFR

46), the Common Rule (45 CFR 46 Subpart A) and keep the study information private to the fullest extent allowable by law. All persons working on the project will be informed about and asked to maintain strict confidentiality about the nature of the study and will sign a confidentiality agreement prior to fieldwork, and interviewers will be trained on measures for preserving the confidentiality of participants.

Several procedures will be used to maintain the privacy of the respondent. The interviewers will be instructed to identify a private space in consultation with the participant and head of household that is safe and private within the home, unless it is determined that a private space outside the home is safer and more appropriate. The interviewer will reschedule for another time if privacy cannot be ensured. Privacy and confidentiality during interviews will be further secured using ACASI software, which will allow participants to answer sensitive questions via a tablet and headphones. With ACASI and headphones, the interviewers will not have to read violence-related questions aloud, reducing the risk of others in the household overhearing.

Upon introducing the survey to the community, heads of households, parents, and potential survey participants, the information will describe the study as being on young people's health, education, and life experiences. Only those who complete the survey will know the full extent of the topics included as a precaution to protect the privacy of those who participate in the survey. Additionally, the survey design utilizes a split sample approach, such that the survey for females will be conducted in different segments/enumeration areas than the survey for males. This approach serves to further protect the confidentiality of participants by eliminating the chance that opposite sex perpetrators will be interviewed in the same community, discover the purpose of the study, and possibly retaliate against participants. For instance, a male perpetrator of a sexual assault and the female who was the victim of his sexual assault in the same community would not both be interviewed. Similarly, the design eliminates the chance that a female perpetrator and a male victim of sexual violence from the same community would both be interviewed.

Participant personally identifiable information (PII) will be collected, including addresses and phone numbers in order to contact households for survey completion. These data will be collected separately from survey data, so any names, addresses, phone numbers, e-mail addresses, will never be associated or directly linked with the survey data. Questionnaire data and personally identifiable information (PII), including addresses, names, and maps, will always be kept separately and never transmitted to CDC.

Any PII collected will be accessible only to authorized NORC data collection staff. A household identifier is assigned by NORC during fieldwork and is only known by the survey team while in the field and is *not* connected to any person or any address and therefore cannot be linked to any individual or household. Since there is no personal identifier, participants cannot be linked to the data once they have completed the interview. NORC will take several steps to ensure all data is protected and remains confidential. Specifically, upon receipt of tablets from CDC, NORC will password protect and encrypt the devices via AirWatch, a mobile management system that allows NORC IT system administrators to control device images and assign specific users. Tablets are further secured via Knox, which registers the

device to the assigned interviewer and allows the device to be remotely locked down if lost or stolen. All data, including PII, is encrypted prior to being synced from tablets to NORC servers. Once data resides on NORC servers, highly secure internal network storage protocols are used to prevent data loss, corruption, and unauthorized breach, as well as to administer least privilege, password-protected access rights.

All NORC system environments meet or exceed FISMA, HIPAA, and NIST 800-53 Revision 4 moderate-level framework compliance standards. Further, all remote access to internal NORC computing resources requires two-factor authentication and encrypted channels. Data access restriction is accomplished using unique case identifiers that allow the database to create a partition between response data and other data that could be used to identify an individual. These security measures ensure that PII is never connected to questionnaire data and will never be delivered to CDC. Once CDC has confirmed receipt of the data and consider the data final, NORC will delete all VACS related data from all NORC systems.

Informed Consent

The interviewer will first obtain consent (Attachment D) from the head of household to participate in a short survey (approximately 15 minutes) about the household (Attachment E,). For all selected eligible participants under 18 years of age, it will be necessary to first obtain the verbal consent from the parent/primary caregiver of the youth for participation in the survey and to speak with the study participant (Attachment D). In the parental/primary caregiver "consent" form, the survey is described as an opportunity to learn more about the social welfare of young people in Maryland which includes health, educational, and life experiences and only mentions "community violence" as part of a list of broad topics, such as access to health services and education, that are included in the survey as a way to inform parents or primary caregivers about sensitive topics included in the survey but is careful not to make any reference to violence that may be occurring in the home or being perpetrated by the head of household or other household members. The interviewer will inform the parent/primary caregiver that the survey is both voluntary and confidential, and about incentive that will be given to the survey participant. The need to initially describe the study in general terms is critical for adhering to World Health Organization (WHO) ethical and safety guidelines for research on domestic violence. Although the proposed survey is not specifically on domestic violence, we believe that these guidelines are relevant since a perpetrator of sexual, physical, or emotional violence may be a household member. More specifically, WHO ethical and safety recommendations will be followed regarding how to obtain informed consent for participation in a survey that contains questions on domestic violence in such a way that safety issues are taken into consideration for both the participant and the interviewer.[*]

Once consent has been obtained from the head of household/parent, a trained interviewer will read an initial information form to the participant, which introduces the survey as an opportunity to

[*] World Health Organization, *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*, 2001, Department of Gender and Women's Health, World Health Organization: Geneva, Switzerland.

learn more about young peoples' health, educational, and life experiences (Attachment F). This initial information form indicates that participation is completely voluntary. After obtaining parental/caregiver consent, the trained interviewer will next obtain informed assent from the minor participant (13-17 years old) (Attachment F). Participants will be informed that the information they share is confidential and will not be shared with anyone. Informed verbal assent will be obtained from each participant at the end of the assent form.

In households where the selected participant is an adult (18-24 years old) or emancipated minor by Maryland law, a similar consent process will be used as described above except that the parental/caregiver "consent" will not be necessary. These participants will still be administered the initial information form described above. Once the initial information form is read, verbal consent to provide more information about the study will be obtained from each participant. Once the interviewer and participant have privacy, the trained interviewer will read the contents of a verbal consent form.

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

IRB Approval

The study protocol has been reviewed and approved by the NORC Institutional Review Board (FWA00000142). A copy of the approval letter is provided (Attachment G).

Justification for Sensitive Questions

The team will receive a Certificate of Confidentiality (COCs) as part of the project. The COC protects the privacy of research subjects by prohibiting disclosure of identifiable, sensitive research information to anyone not connected to the research except when the subject consents or in a few other specific situations. COCs are now automatically issued by HHS agencies to HHS funded projects to protect identifiable research information from forced disclosure.

In order to conduct an effective study to better understand violence against children for the purposes of prevention, it is important to collect data that will yield useful results. Very few people, including children, report sexual, emotional, or physical violence to the police or other authorities; therefore, survey data provide the best source of information regarding its prevalence. In the U.S., there have been studies in which children as young as 10 years of age have been interviewed about sexual violence, and the data from these studies have been extremely effective in mobilizing key entities into taking action to prevent violence against children.[li] As no comprehensive, representative data on violence against children exists in the U.S., this data collection is necessary.

A.12. Estimates of Annualized Burden Hours and Costs

Estimates of Annualized Burden Hours.

The total estimated respondent burden and costs for this 3 years collection is calculated below. The burden was derived by using 9,363 as the expected number of households contacted, a 90% response rate for 8,424 completed screeners, a 25% eligibility rate for 2,106 households consented, a 90% consent completion rate for 1,896 completed head of household questionnaires, and 1,131 completed core questionnaires. This number considers a response rate of 65% for females and 55% for males. CDC will also use 60 cases for Pre-test 2 to pre-test adaptations to the core survey with youth in the target age group. Therefore the annualized numbers are 3,121 households contacted with an invitation letter, 2,808 completed screeners, 702 households consented, 632 completed head of household questionnaires, and 377 completed core questionnaires including the Pre-test 2 (20/year).

Table 2. Estimated Annualized Burden Hours

Type of Respondents	Data Collection	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Head of Household	Invitation letter (Attachment H)	3,121	1	2/60	104
	Screener Questionnaire (Attachment I)	2,808	1	3/60	140
	Head of Household Consent (Attachment D)	702	1	2/60	23
	Head of Household Questionnaire (Attachment E)	632	1	15/60	158
Youth ages 13-24 in Baltimore or Garrett County, Maryland	Youth participant consent/assent (Attachment F)	632	1	3/60	32
	Core Youth Participant Questionnaire (Attachment J)	377	1	1	377
					Total: 834

Estimates of Annualized Burden Cost

The annual burden cost will be $22,627 (Table 3). The total cost for the three-year project will be $67,881. The estimated costs to respondents is based on the Bureau of Labor Statistics (BLS) data from May 2019. The mean hourly wage for all occupations in Baltimore is $28.49.

The estimates of individual annualized costs are based on the number of respondents interviewed and the amount of time required from individuals who were reached and completed the one-time screener, head of household, and core questionnaires. The screener will take up to 3 minutes to determine whether a household is eligible. For those who agree to participate, the head of household survey will take up to 15 minutes to complete, including screening and verbal informed consent. For those who agree to participate in the core survey, it will take up to 60 minutes, including verbal informed consent.

Table 3. Estimated Annualized Burden Costs

Type of Respondent	Data Collection	Number of Respondents	Number of Responses per Respondent	Total burden	Average Hourly Wage Rate (in dollars)	Total Respondent Cost
Head of Household	Invitation Letter	3,121	1	104	$28.49	$2,963
	Screener	2,808	1	140	$28.49	$3,989
	Consent	702	1	23	$28.49	$656
	Questionnaire	632	1	158	$28.49	$4,501
Youth ages 13-24 Participant	Consent/ Assent	632	1	32	$28.49	$912
	Core questionnaire	377	1	377	$28.49	$10,741
Total Annualized Burden Cost						**$23,762**

A.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 the data collection. CDC does not anticipate providing capital or start up or other related costs to private entities

A.14. Annualized Cost to the Government

The contract to conduct the study was awarded to NORC at the University of Chicago through competitive bid in September of 2019. The total cost for the data collection is $5,882,602, including $2,501,446 in contractor costs and $3,381,156 in costs incurred directly by the federal government (Table 4). These total costs are annualized in Table 4.

Costs for this study include personnel for designing the study, developing, programming, and testing the survey instrument; drawing the sample; training the recruiters/interviewers; collecting and analyzing the data; and reporting the study results. The government costs include personnel costs for federal staff involved in the oversight, study design, and analysis, as presented in detail in Table 4.

Table 4. Estimated Annualized Cost to the Government

Labor	Cost
CDC personnel for project oversight (15% GS-13 scientist)	$1,127,052
Contract labor for planning and design, development of study protocols, recruitment of respondents, data collection, data preparation, data analysis, report writing, and dissemination of findings	$833,815
Total estimated annualized government costs	$1,960,867

A.15. Explanation for Program Changes or Adjustments

This is a new information collection.

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

The schedule for data collection, analysis, and reporting is shown in Table 5 below. Data from each phase of data collection will be stored in password-protected files. Results will be developed for publication and dissemination to stakeholders and other federal agencies.

***Table 5.* Project Time Schedule**

Activities	Time Schedule
Primary sampling unit selection	Within 2 months of OMB approval
Pre - testing	Within 2 months of OMB approval
Data collection in Baltimore	Starting October 2021. Within 2 - 36 months of OMB approval
Data collection in Garrett County	Starting October 2021. Within 2 - 36 months of OMB approval
Clean, edit, and analyze dataset	Within 11 - 36 months of OMB approval
Complete report	Within 12 - 36 months of OMB

documenting results and methodology recommendations related to implementation of VACS in the U.S.	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.

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