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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-14-14OE]

Proposed Data Collections Submitted for

Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404-639-7570 or send comments to LeRoy Richardson, 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an email to omb@cdc.gov.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d)

ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Monitoring And Reporting System for the Rape Prevention and Education Program Awardees - NEW - National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Sexual violence is a major public health problem. According CDC's National Intimate Partner and Sexual Violence Survey (NISVS, OMB# 0920-0822), in the United States, nearly 1 in 5 women and 1 in 71 men have been raped in their lifetime, while 1 in 2 women and 1 in 5 men have experienced severe sexual violence victimization other than rape at some point in their lives, with the majority of victimization starting early in life. According to NISVS, approximately 80% of female victims experienced their first rape before the age of 25 and almost half experienced the first rape before age 18. Among male victims, 28% were first raped when they were 10 year old or younger. NISVS also found that early sexual victimization

increases women's risk of adult victimization: approximately 35% of women who were raped as minors were also raped as adults compared to 14% of women without an early rape history.

State health departments and the community-based organizations funded to implement sexual violence prevention strategies have variable, often low, levels of capacity and infrastructure to engage in program improvement and systematically collect data about sexual violence as well as the prevention strategies they are implementing. Historically, some health departments and funded community-based organizations have not had adequate resources to support a full-time staff person to deliver and implement prevention strategies. Additionally, while sexual violence prevention practitioners have undergone a sea change and expanded their focus from raising awareness of the problem to implementing primary prevention strategies, improved implementation based on best-available practices in prevention is still needed.

CDC, through the Rape Prevention and Education (RPE) Program, supports sexual violence prevention by implementing primary prevention strategies using a public health approach and effective prevention principles. The current cooperative agreement will advance this goal by supporting RPE funded organizations to implement sexual violence prevention strategies that adhere to general principles of effective prevention

strategies. These principles include: Addressing modifiable risk and protective factors for perpetration and victimization, addressing multiple levels of the social ecology, emphasizing primary prevention, having sufficient dosage or intensity, being culturally relevant, being developed and implemented with stakeholders and based on best available evidence. Additionally, it aims to improve program evaluation infrastructure and capacity at the state level.

In order to accomplish these goals, the program strategy involves the focused implementation of three main components:

- Component 1 – Implementation and program evaluation of sexual violence (SV) prevention strategies using a public health approach (this includes expectations that program evaluation activities are conducted at the state level.
- Component 2 – Provision of Training and Technical Assistance to RPE funded organizations on the implementation of SV prevention strategies.
- Component 3 – Participation in program support activities.

The primary outcome of interest is the improved ability of RPE funded organizations to use the public health approach and effective prevention principles to implement and evaluate sexual violence prevention strategies.

CDC seeks a 3-year Office of Management and Budget (OMB) approval to collect information electronically from awardees funded under the RPE cooperative agreement. Information will be collected from RPE awardees through an electronic data management information system; the Rape Prevention and Education Management Information System (RPE-MIS). The RPE-MIS will be used to collect information about the staffing resources dedicated by each awardee, as well as partnerships with external organizations. The RPE-MIS requires awardees to define their program objectives in action-oriented SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed) format, identify their target population and associated strategies citing the best available evidence and data sources, establish the link between their objectives, chosen strategies and the target population, and provide quantifiable performance measures associated with the chosen strategies. Information collected through the RPE-MIS will be used to inform performance monitoring, and program evaluation.

Anticipated respondents are a maximum of 55 awardees for the RPE Program. All respondents will be state and territorial health departments or designated personnel from their partner sexual assault coalitions. The time commitments for data entry

and training are greatest during the initial population of the RPE-MIS, typically in the first six months of implementation. Estimated burden for the first-time population of the RPE-MIS is fifteen hours. Annual Reporting is estimated at three hours per respondent.

There are no costs to respondents other than their time.

Estimated Annualized Burden to Respondents

Type of respondents	Form Name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
State and Territorial Health Departments or Sexual Assault Coalition Designee	RPE-MIS: Initial population	55	1	15	825
	RPE-MIS: Annual reporting	55	1	3	165
	Total				990

Leroy A. Richardson,
Chief, Information Collection Review Office,
Office of Scientific Integrity,
Office of the Associate Director for Science,
Office of the Director,
Centers for Disease Control and Prevention.

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