

“Student and Teacher Perspectives on Sexual Health Education in Fort Worth Independent School District”

Submitted under GenIC OMB #0920-0840
(exp. 01/31/2019)

Supporting Statement Part A

January 28, 2016

Supported by:

Division of Adolescent and School Health
Centers for Disease Control and Prevention

Catherine Rasberry, PhD
CDC/OID/NCHHSTP, Health Scientist
(404) 718-8170
fhh6@cdc.gov

Paula Jayne, PhD
CDC/OID/NCHHSTP, Health Scientist
(404) 718-8191
pj1@cdc.gov

Table of Contents

A. 1 Circumstances Making the Collection of Information Necessary.....4

A. 2 Purpose and Use of Information Collection.....9

A. 3 Use of Improved Information Technology and Burden Reduction.....11

A. 4 Efforts to Identify and Use of Similar Information.....11

A. 5 Impact of Small Businesses or Other Small Entities.....12

A. 6 Consequences of Collecting the Information Less Frequently.....12

A. 7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....12

**A. 8 Comments in Response to the Federal Register Notice and Efforts to Consult
Outside the Agency.....12**

A. 9 Explanation of Any Payment or Gift to Respondents.....12

A. 10 Assurance of Confidentiality Provided to Respondents.....14

A. 11 Institutional Review Board (IRB) and Justification for Sensitive Questions.....16

A. 12 Estimates of Annualized Burden Hours and Costs.....16

A. 13 Estimates of Other Annual Cost Burden to Respondents or Record Keepers.....18

A. 14 Annualized Cost to Federal Government.....18

A. 15 Explanation for Program Changes or Adjustments.....19

A. 16 Plans for Tabulation and Publication and Project Time Schedule.....19

A. 17 Reason(s) Display of OMB Expiration Date is Inappropriate.....21

A. 18 Exceptions to Certification for Paperwork Reduction Act Submissions.....21

B.1 Respondent Universe and Sampling Methods.....

B.2 Procedures for the Collection of Information.....

B.3 Methods to Maximize Response Rates and Deal with No Response.....

B.4 Tests of Procedures or Methods to be Undertaken.....

**B.5 Individuals Consulted on Statistical Aspects and Individuals Collecting and/or
Analyzing Data.....**

List of Attachments

Attachment Number	Document Description
1	Public Health Service Act Legislation
2	Teacher Interview Guide
3	Supplemental Handout for Teacher Interview Guide
4	Middle School Student Focus Group Guide
5	High School Student Focus Group Guide
6	Consultants on the Information Collection
7	Documentation of IRB Approval
8	Teacher Interview Consent Form
9	Middle School Parental Consent Form
10	High School Parental Consent Form
11	Middle School Student Verbal Assent Language
12	High School Student Verbal Assent Language

Section A: Justification for Information Collection

Goal: The goal of this study is to conduct formative research to develop scientifically-valid interventions (such as professional development events and other forms of support for sexual health education teachers) in order to strengthen sexual health education that is conducted in middle and high schools in Fort Worth Independent School District (FWISD), a local education agency (LEA) funded by CDC's Division of Adolescent and School Health (DASH) under PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance*.

Intended use of resulting data: The data will be used to provide information and summary reports for FWISD, and will allow FWISD district staff to better support and prepare their teachers to provide effective sexual health education to students. These findings may also help CDC/DASH identify important lessons learned that can be shared with other CDC/DASH-funded education agency partners.

Methods: The information collection uses 2 separate, but complementary, information collections to conduct assessment student and teacher perspectives on sexual health education in Fort Worth Independent School District. Teacher interviews will be conducted with up to 30 health education teachers from FWISD and student focus groups (n=8 groups) will be conducted with up to 96 middle and high school students (n=12 students per group) to assess their experiences with and perceptions of sexual health education being implemented in FWISD.

Subpopulation to be studied: Interviews will be conducted with up to 30 middle and high school health education (which includes sexual health education) teachers in FWISD. In addition up to 96 middle and high school students (24 middle school males, 24 middle school females, 24 high school males, and 24 high school females) will be invited to participate in one of 8 focus groups with students.

Data analysis: Analysis of data from interview and focus groups will involve iterative code development, establishment of intercoder reliability, use of qualitative data analysis software (such as ATLAS.ti), and identification of major themes within the data.

A. 1 Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention (CDC) requests a 1-year OMB approval to conduct a new information collection entitled, "Student and Teacher Perspectives on Sexual Health Education in Fort Worth Independent School District" under GenIC 0920-0840 exp. 02/29/2016). The purpose of this project is to conduct formative research to develop scientifically-valid interventions (such as professional development events and other forms of

support for sexual health education teachers) in order to strengthen sexual health education that is conducted in middle and high schools in Fort Worth Independent School District (FWISD), a local education agency (LEA) funded by CDC's Division of Adolescent and School Health (DASH) under PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance*. The information collection uses 2 separate, but complementary, information collections to conduct assessment student and teacher perspectives on sexual health education in Fort Worth Independent School District. This data collection will provide data and reports for FWISD, and will allow FWISD district staff to better support and prepare their teachers to provide effective sexual health education to students. These findings may also help CDC/DASH identify important lessons learned that can be shared with other CDC/DASH-funded education agency partners.

Approximately 18% of all new HIV diagnoses are among young people aged 13-24 years, and teens and young adults have the highest rates of sexually transmitted diseases (STDs) of any age group.¹ In addition, 3 in 10 young women become pregnant before they reach the age of 20.¹ Related to that, sexual risk behaviors associated with HIV, other sexually transmitted diseases (STD), and pregnancy often emerge in adolescence. For example, 2011 Youth Risk Behavior Surveillance System (YRBSS) data revealed 47.4% of U.S. high school students reported having had sex, and among those who had sex in the previous three months, 39.8% reported having not used a condom during last sexual intercourse.²

Establishing healthy behaviors during childhood and adolescence is easier and more effective than trying to change unhealthy behaviors during adulthood. Schools are a critical setting for HIV/STD prevention and a cost-effective location for conducting the YRBS because the vast majority of youth attend school. In the United States, schools have direct contact with more than 50 million students for at least 6 hours a day during 13 key years of their social, physical, and intellectual development.³ After the family, schools are one of the primary entities responsible for the development of young people, and they can influence students' risk for HIV infection and other STD in a variety of ways, including through the provision of sexual health education.

CDC's Division of Adolescent and School Health (DASH) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) awarded funds to implement PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance* in order to build the capacity of state and local education agencies and support the efforts of national, non-governmental organizations (NGOs) to help priority school districts (districts) and schools develop and implement sustainable adolescent-focused program activities. Within that cooperative agreement, education agencies are funded under strategy 2 for implementing multiple approaches to HIV and sexually transmitted disease (STD) prevention, including exemplary sexual health education. Exemplary sexual health education includes establishment of a written middle/high school standard course of study or curriculum framework, development and use of a systematic process for identifying, selecting or adapting, and implementing sexual health education curricula, and establishing and maintaining a technical assistance and professional development system to assist schools in implementing sexual health education.

From within the group of 17 local education agencies (LEAs) funded under PS13-1308, one LEA—Fort Worth Independent School District (FWISD) in Fort Worth, Texas—was

selected to receive enhanced support from CDC/DASH to better understand their program, and more specifically the experiences and perspectives of teachers implementing sexual health education and students receiving sexual health education. The assessments included in this information collection request are designed to provide formative research to develop scientifically-valid interventions (specifically, strategies for supporting sexual health education teachers) in order to strengthen sexual health education conducted in the FWISD middle and high schools. This project will be used to provide critical information on the way sexual health education is being taught from both the perspectives of the students (the consumers) and the teachers (the first-line implementers). For FWISD district staff, the insight into what is being taught, how it is being taught, how students perceive their sexual health lessons, and the areas for which teachers feel they need additional support, will directly inform both the recommended content for their sexual health education and the strategies they use to support teachers for successful implementation of sexual health education.

The proposed qualitative research will involve two data collection activities: (1) in-person individual interviews with up to 30 teachers of health education (which includes sexual health education), and (2) qualitative focus groups (n=8 focus groups) with up to 96 middle and high school students enrolled in health education classes at FWISD (up to 12 students per focus group).

Teacher interviews. In-person individual interviews will be conducted with up to 30 health education teachers in FWISD. Interviews will last no more than 60 minutes and will ask teachers about the way they teach sexual health education, how they feel the district helped prepare them to teach sexual health, and in which areas, if any, they would like to receive additional support.

Student focus groups. In-person, 90-minute focus groups will be conducted with up to 96 students in 2 middle and 2 high schools (up to 12 students in each of 8 focus groups; 2 groups of middle school females, 2 groups of middle school males, 2 groups of high school females, and 2 groups of high school males). In focus groups, students will be asked to reflect on the way their teachers taught about sexual health topics (abstinence, puberty, and romantic relationships for middle school students; and HIV, STD, and pregnancy prevention more broadly for high school students) and on what they felt they learned, and what they wish they had learned, in class.

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

- *Healthy People 2020*, which provides national health objectives and outlines a comprehensive plan for health promotion and disease prevention in the United States. Of the Healthy People 2020 objectives, 31 objectives align specifically with PS-13-1308 activities related to reducing HIV infection, other STD, and pregnancy among adolescents.⁴
- The *National Prevention Strategy (NPS)* calls for “medically accurate, developmentally appropriate, and evidence-based sexual health education.” The NPS encourages the involvement of parents in educating their children about sexual health, the provision of sexual and reproductive health services, and the reduction of intimate partner violence.⁵

- The U.S. Department of Health and Human Services' (DHHS) *Teen Pregnancy Prevention Initiative* supports the replication of teen pregnancy prevention (TPP) programs that have been shown to be effective through rigorous research as well as the testing of new, innovative program activities to combat teen pregnancy.⁶
- The NCHHSTP program imperative calls for *Program Collaboration and Service Integration* (PCSI) to provide improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services at the user level.⁷
- *CDC Winnable Battles*, including prevention of HIV infection and TPP, have been chosen by CDC based on the magnitude of the health problems and the ability to make significant progress in improving outcomes. These are public health priorities with large-scale impact on health with known, effective strategies to address them.⁸

The privacy act does not apply as no individually identifiable information will be collected.

Any PII that is provided by FWISD for the purposes of participant recruitment will remain completely separate from the information gathered through the teacher interviews and student focus groups, and will be kept private by the project team. Upon completion of the focus groups and interviews, data will be stripped of any names and recruitment contact information will be destroyed.

Overview of the Information Collection System

The information collection system consists of (1) a teacher interview guide (see **Attachment 2**) and accompanying supplemental handout (see **Attachment 3**), and (2) student focus groups guides (see **Attachment 4 for the middle school student focus group guide** and **Attachment 5 for the high school student focus group guide**). Both explained in detail below.

Teacher Interview Guide

The information collection system consists of in-person interviews with health education teachers (see **Attachment 2**) designed to help the study team develop a better understanding of how the professional development (including trainings, teacher observation, and feedback) offered by FWISD has impacted teaching in the classroom, and to learn about teachers' experiences teaching sexual health education using the current FWISD curriculum. The information collection instrument is divided into distinct segments and will be administered as a series of in-person interviews with 20-30 different health education teachers (10-15 middle school teachers and 10-15 high school teachers). The information collection instrument (interview guide) was reviewed for content, clarity, and appropriateness by two FWISD district employees and the full study team (CDC and its contractor) which includes several former teachers; revisions were made to refine the guide based on the collective input. CDC's contractor then pilot tested the guide with 3 individuals with evaluation and/or school experience. Feedback from this group was used to refine questions as needed and establish the estimated time required to complete the interview segments.

Student Focus Group Guides

The information collection system consists of focus groups with middle and high school students enrolled in health education classes at FWISD (see **Attachment 4 for the middle school student focus group guide** and **Attachment 5 for the high school student focus group guide**) and it is designed to gather students' thoughts and perceptions about their teachers' implementation of the sexual health lessons from the sexual health education curriculum as well as gain a better understanding of students' attitudes and self-efficacy related to the content covered (e.g., abstinence, puberty, romantic relationships, and HIV, STI, and pregnancy prevention). Each focus group guide is tailored for age and curriculum content of the students (one guide for middle school and one guide for high school). The information collection instrument is divided into distinct segments and will be administered as a series of 8 focus groups (2 for middle school males, 2 for middle school females, 2 for high school males, and 2 for high school females) with up to 12 students in each focus group (96 students total). The information collection instrument (interview guide) was reviewed for content, clarity, and appropriateness by two FWISD district employees and the full research team (CDC and its contractor) which include several former teachers; revisions were made to refine the guide based on the collective input. ICF then pilot tested the guide with 4 youth between the ages of 13-17 to ensure questions were clear and easily understood by the intended ages for the focus groups. Feedback from this group was used to refine questions as needed and establish the estimated time required to complete the interview segments.

Items of Information to be collected

Teacher Interview Guide

The complete interview guide is divided into 6 domains of interest—(1) teacher background and experience, (2) teacher attitudes, comfort, and confidence related to sexual health education, teacher implementation of the current sexual health curriculum, and future professional development and final thoughts (see **Attachment 2**). Questions are open-ended.

The interview guide will collect information on the following:

- a. Teacher background and experience. There are 4 items with a total of 6 possible questions, including the subquestions/probes
- b. Teacher attitudes, comfort, and confidence related to sexual health education. There are 9 items with a total of 28 possible questions, including subquestions/probes
- c. Teacher implementation of the current sexual health curriculum. There are 5 items with a total of 8 possible questions, including subquestions/probes
- d. Future professional development and final thoughts. There is 1 item with a total of 4 possible questions, including subquestions/probes

In addition, there is a supplemental handout (see **Attachment 3**) that is used to help interview participants think about the questions in the section on teacher attitudes, comfort, and confidence related to sexual health education. This handout is used to help the participant think

about possible topics of consideration when they provide an answer. It does not include any questions for the participant.

Student Focus Group Guides

There are two student focus group guides for use in this information collection—one for middle school students (see **Attachment 4**) and one for high school students (see **Attachment 5**). The middle school guide includes questions geared toward the content of the middle school curriculum (focusing on abstinence, puberty, and romantic relationships), and the high school focus group guide asks about the way teachers taught their specific content (focusing more broadly on HIV, STD, and pregnancy prevention, which including talking about both abstinence and contraception). As a note, the guides do not ever ask students to reflect on their own behavior, but rather on how their teachers taught about these topics and how their health class may have influenced their general attitudes and perceptions related to these topics. Each guide is divided into 3 key domains of interest—(1) learning about sexual health, (2) quality of delivery of the sexual health lessons, and (3) student attitudes/perceptions related to the health education curriculum content (abstinence, puberty, and relationships for middle school students, and HIV, STD, and pregnancy prevention for high school students). Questions are open-ended.

The interview guide will collect information on the following:

- a. Learning about sexual health. The middle and high school guides each have 1 general introductory item (no additional subquestions/probes) that asks about general perceptions of learning about sexual health.
- b. Quality of delivery of the sexual health lessons. The middle and high school guides each have 10 items with a total of 15 possible questions (including subquestions/probes) that address student perceptions of the way their teachers taught sexual health education.
- c. Student attitudes/perceptions related to health education curriculum content. The middle school guide has 13 items (with no additional subquestions/probes) and the high school guide has 6 items (with no additional subquestions/probes) that ask students about their attitudes and perceptions related to the health education curriculum content focused specifically on the sexual health focused content.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age –

No websites are used in this information collection. Therefore, there is no website content directed at children.

A. 2 Purpose and Use of Information Collection

Data gathered from the teacher interviews and student focus groups will allow the FWISD, a CDC-funded local education agency, to gather formative research to inform and improve their program activities conducted under PS13-1308. Formative data collected through the teacher interviews and student focus groups will be analyzed by the study team to help FWISD better understand the way sexual health education is being taught from both the perspectives of the students (the consumers) and the teachers (the first-line implementers). It will allow them to ensure their activities are designed to best meet the needs of their health education teachers and students and to determine what types of approaches or strategies are necessary to have a positive impact on the delivery of sexual health education, and in turn, key sexual health

outcomes among their students. More specifically, FWISD district-level staff, will use this insight into what is being taught, how it is being taught, how students perceive their sexual health lessons, and the areas for which teachers feel they need additional support, to directly inform both the recommended content for their sexual health education and the strategies they use to support teachers for successful implementation of sexual health education. This supports a major public health goal reducing HIV, STD, and unintended pregnancy among youth, and CDC anticipates that these findings also will likely reveal important lessons learned for other CDC/DASH-funded education agency partners.

Analysis of data from interview and focus groups will involve iterative code development, use of qualitative data analysis software (such as ATLAS.ti), and identification of major themes within the data. The findings from this information collection also have practical utility to the government because they can impact both the activities used by FWISD and the strategies and approaches CDC recommends for use in schools more broadly.

Without this data collection, FWISD would be unable to tailor their strategies and approaches to the needs and experiences of their teachers and students. In addition, without collecting this data, CDC would have reduced understanding of emerging needs of teachers and staff in the delivery of sexual health education in schools.

A.2.1 Privacy Impact Assessment

How information will be shared and for what purpose

For the in-person interviews and focus groups, no sensitive information is being collected. Although FWISD will provide a list of teacher and student names and contact information for inviting people to participate in the interviews and/or focus groups, this information will be used only for recruitment and scheduling; all interview/focus group notes and/or recordings will be kept separate from the names of participants. Responses will only be reported in aggregate due to the small sample size. Reports will focus on experiences and perceptions of teachers and students rather than individual responses. The participants' names will not be associated with specific quotes or comments. In addition, all reports will be written in a way in which no comments will be attributed to any one person. All team members will be asked to sign privacy agreements and trained on security requirements. During data collection in the field, interviewers and focus group moderators will maintain data collection materials in their possession or in secured storage at all times. All documents associated with the study will be collected and stored in a password-protected electronic file on a secure network accessible only by the study team through restricted access settings.

Impact of the proposed collection on respondents' privacy

We anticipate no adverse impact of the proposed data collection on respondents' privacy

because no individually identifiable information will be collected as part of this information collection. Any PII that was provided for the purposes of participant recruitment will remain separate from the information gathered through the interviews and focus groups, and will be kept private by the project team. Upon completion of the focus groups and interviews, data will be stripped of any names and recruitment contact information will be destroyed.

A. 3 Use of Improved Information Technology and Burden Reduction

Interviews and focus groups will be conducted in-person by trained interviewers and focus group moderators. Interviews and focus groups will be audio-taped with permission of the respondents. This may help reduce the amount of time required of participants because the interviewer/moderator will not have to pause for note-taking.

A. 4 Efforts to Identify and Use of Similar Information

Teacher Interviews

In preparation for collection of data from teachers, the study team reviewed the literature for any existing instrument or data collection activities that provide in-depth information about the domains that related to teachers' experiences and perspectives teaching sexual health education. Although specific items for use in qualitative formative research were not identified, the general themes in the literature (such as knowledge levels, comfort, confidence/self-efficacy, were incorporated into the interview guide developed by the study team. The team did not find any other source of information that can provide the relevant in-depth information on the experiences of teachers participating in this project and teaching this specific adapted curriculum.

Student Focus Groups

In preparation for collection of data from students, the study team reviewed the literature for any existing instrument or data collection activities that provide in-depth information about the domains that related to students' experiences participating in sexual health education courses. Although specific items for use in qualitative formative research were not identified, the general themes in the literature (such as teacher delivery, having a "safe" classroom environment) were incorporated into the focus group guide developed by the study team. The team did not find any other source of information that can provide the relevant in-depth information on the experiences of students participating in this project and specific to exposure to the adapted curriculum.

A. 5 Impact of Small Businesses or Other Small Entities

This data collection will not involve small businesses.

A. 6 Consequences of Collecting the Information Less Frequently

This information collection is scheduled to occur one time in Spring 2016. Collecting the data less frequently would mean not collecting the data at all, and there would be a number of negative consequences to this. First, FWISD would not have formative information on which to tailor future enhancement to their program or by which additional strategies or approaches to better supporting their health education teachers could be informed. Without this critical information from program implementers (teachers) and consumers (students), the program might not be able to achieve its full potential. In addition, CDC would miss a valuable opportunity to develop a more in-depth understanding of the experiences, perceptions, and needs of teachers and students that can inform professional development and sexual health education approaches recommended for schools across the country.

A. 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.

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

A. The Federal Register notice was published for this collection on Thursday, June 25, 2015, Vol. 80, No. 122, pp. 36540. (**See Attachment 2**)

No other public contacts and opportunities for public comments were received.

B. The local education agency (FWISD) involved in this information collection was consulted to discuss all aspects of the data collection. They provided extensive feedback on the availability (or in this case, non-availability) of similar existing data, other data collections in their LEA and the data collection procedures for this project. In addition, CDC contractors provided extensive input into the clarity of instructions, content of questions, reporting formats, and the data elements that will be reported.

These consultations took place in 2015. A list of organizations and individuals consulted is provided in **Attachment 6: Organizations and Individuals Providing Consultation on the Information Collection**. There were no major problems that arose during the consultation, and all issues raised were resolved.

A. 9 Explanation of Any Payment or Gift to Respondents

Tokens of appreciation for data collection participation are an important tool used in studies and are particularly important for the populations in this information collection.

Educators work within extremely regimented schedules that offer little room for flexibility or variation in the way they spend the time during their work days. In the study

team's extensive experience working with schools and school staff, we have consistently heard that time is extremely hard to come by for school staff. In our experience, the lack of time for school personnel is such a substantial concern for school administrators, that local education agencies often restrict the commitments they allow school personnel to make for tasks such as data collection. A study funded by the U.S. Department of Education helped document some of the time constraints faced by school staff. In that study of middle school teachers, researchers identified a number of time-related challenges, two of which included "feeling overwhelmed" and "lack of discretionary time".⁹ Discretionary time, in that study, was defined as "the time when teachers are free from scheduled responsibilities and can decide what to do," and the study found that true discretionary time for teachers was rare. Administrators typically set teachers' schedules, and the majority of their time was spent with students. Even "free time" was often spent with set responsibilities such as team meetings, parent conferences, student meetings, supervising lunch rooms, and moving students from one place to another.⁹ It is precisely this lack of discretionary time that can make achieving high response rates among educators a challenge. In this particular data collection, it is expected that many teachers will need to participate in the data collection outside of their regular work hours, which produces an additional burden for them that threatens to impact response rates. Other researchers have found that providing incentives for school staff such as school counselors¹⁰ and school principals¹¹ have increased their likelihood of participation.

For teachers, interviews are not part of the participants' job duties and are completely voluntary in nature. Furthermore, interviews are estimated to be 1 hour, and this represents an extremely large block of time for personnel working in schools. Scheduling time for these interviews will require a great commitment from teachers, and not only will it be an activity in addition to their regular duties, it is likely many interviews will take place outside of regular working hours. In addition, in spite of attempts to minimize burden on respondents, the participants may have to leave their regular work buildings to get to the location for interviews, representing an additional expenditure of effort on behalf of the participants.

For students, participating in the focus group represents a large portion of the "free time" after school, and will require a substantial commitment by the students and their guardians. Participation in the focus group will take scarce discretionary time from both the students and their parents/guardians, some of whom may have to make alternate plans for transportation home from school on the day of the data collection. In our experience conducting focus groups with students, gifts to participants can be a key tool aiding in recruitment. Since participation will require active parental/guardian consent and follow-up action in the form of attending the group on the day of data collection, these gifts are required.

Given the considerations outlined above and the estimated burden of the in-person interviews and focus groups, gifts to respondents in the form of \$20 gift cards are proposed for teacher interview participants and \$30 gift cards are proposed for the students participating in the slightly longer (90-minute) focus groups.

A unique aspect of this proposed interview/focus group data collection is that it is not only the overall sample size that is critical to the quality of the formative research, but the participation of the specific individuals who have been invited to participate. Interviews will be requested from specific teachers based on a variety of characteristics (such as length of time teaching, whether or not they have a dedicated classroom, etc.); therefore, in order to accurately

understand the experiences of a wide variety of teachers, it will be essential to gain participation from the particular individuals invited. One of the challenges for the study team is that research shows “there is likely to be a strong association with nonresponse and the survey topics of interest”.¹¹ Students and teachers who have interest in the topic of the formative research may be more likely to participate in interviews or focus groups, introducing a bias and limiting our ability to get a true picture of the experiences and perceptions of a variety of teachers and students—including those who may find it less appealing to talk about topics such as sexual health. Given that the topic of the proposed information collection includes questions on teaching a challenging topic (sexual health education), which is likely to have widely varying levels of appeal to both students and teachers, the study team believes that the potential for bias from interest in the topic is a particular concern for the data collection. The use of gifts can help minimize bias resulting from variations in interest in the topic by helping the motivate potential participants recruited for interviews/focus groups to actually make the commitment of their time necessary for participating in the interviews/focus groups. Krueger and Casey (2009) note that the gift helps emphasize to participants that the assessment is important, which in turn will make them more inclined to make time to participate. More specifically, the gift basically “serves to protect the promised time slot from being preempted.”¹² In this data collection, the use of gifts to participants is expected to reduce bias related to interest in the topic, and therefore, increase the quality of data collected.

It is for these reasons that the study team is proposing to offer \$20 gifts to teacher interview participants and \$30 for student focus group participants. Both Goldenkoff (2004)¹³ and Quinn Patton (2002) support the use of gifts/incentives.¹⁴ We expect \$20 for teachers and \$30 for students to be sufficient to improve participation rates and those amounts are consistent with what has been cited in the literature on response rates; for example, in a 2008 article, Cantor, O’Hare, & O’Connor state that “a number of studies have found that promised incentives of \$15-\$35 increase response rates.”¹⁵ Although this amount is slightly under the standard incentive of \$40 for focus groups, we believe this is an appropriate amount given that most interviews/focus groups will be conducted on the campuses where participants work or attend school. IRB approval of the study included the review and approval of the \$20 gift for teachers and the \$30 gift for students. In addition, FWISD’s research office will have approved the data collection with these gifts included as part of the protocol and district staff involved in planning the formative data collection highly recommend the use of such gifts.

A. 10 Assurance of Confidentiality Provided to Respondents

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

Participants will be informed that providing the information for this data collection is voluntary. Participating teachers will receive a consent form (see **Attachment 8**) that provides information about the teacher interviews and informs them that participation is completely voluntary and they may choose not to participate at any time.

Students will be required to secure active parental consent and then provide passive

student assent prior to participating in the focus groups. Active parental consent forms (see **Attachment 9** for middle school and **Attachment 10** for high school) will be distributed to students in their health classes. From the pool of students who return parental consent forms, 96 students (24 middle school males, 24 middle school females, 24 high school males, and 24 high school females) will be invited to participate in one of 8 focus groups. In the introduction to the focus groups, students will be read language for which they will be able to provide their verbal assent for participation (see **Attachment 11** for assent language for middle school students and **Attachment 12** for the assent language for high school students). Both the parent consent and student assent language will inform parents and students that their participation is completely voluntary and they may choose not to participate at any time.

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

IRB Approval

The proposed teacher interview and student focus group data collection protocols have been reviewed and approved by the existing contractor's IRB (see **Attachment 7**) to conduct 20-30 in-person one-on-one teacher interviews and student focus groups. In spring 2016, the study team will conduct the interviews with teachers who are using the current sexual health education curriculum. Interviews will be conducted with 10-15 middle school and 10-15 high school teachers. Each interview will be conducted by a trained CDC contractor who is a member of the study team. The student focus groups, (n=8) will be held in late spring 2016. Each focus group will include up to 12 students and will be stratified by gender and school level (2 focus groups will include female students in high school, 2 focus groups will include male students in high school, 2 focus groups will include female students in middle school, and 2 focus groups will include male students in middle school). Focus groups will last no more than 90 minutes. All focus groups will be audio-recorded (with participant permission) to ensure an accurate account of what was discussed. Since the focus groups will take place after school hours, student transportation must be pre-arranged by the student's parent/guardian. Focus groups will be scheduled in advance to allow parents time to plan accordingly.

Sensitive Questions

No sensitive or individually identifiable information is being collected in the teacher interviews or student focus groups. All notes and/or recordings will be kept separate from the names of participants. Responses will only be reported in aggregate due to the small sample size. Reports will focus on overall experiences and perceptions of students and teachers rather than individual responses. The participants' names will not be associated with specific quotes or comments. In addition, all reports will be written in a way in which no comments will be attributed to any one person. All transcribers will be asked to sign privacy agreements and team members will be trained on security requirements. During data collection in the field, interviewers and focus group moderators will maintain data collection materials in their possession or in secured storage at all times. All documents associated with the study will be collected and stored in a password-protected electronic file on a secure network accessible only by the Contractor's study team.

A. 12 Estimates of Annualized Burden Hours and Costs

Teacher Interviews

The estimate for burden hours is based on a pilot test of the teacher interview guide by 3 individuals working in public health and/or education. In the pilot test, the average time to complete the interviews, including time for reviewing consent materials and completing the interview ranged from 45 to 60 minutes. Based on these results and the practical limitations of the school day schedule, the estimated time range for actual respondents to complete the instrument is 45-60 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 1 hour) is used.

Student Focus Groups

The estimate for burden hours is based on a pilot test of the segments of both the middle and high school focus group guides by 4 young people age 13-17. In the pilot test, the average time to complete the focus groups including time for reviewing consent materials, introducing the process and topics, and completing the focus group, ranged from 60 to 90 minutes. Based on these results, the estimated time range for actual respondents to complete the focus groups is 75-90 minutes. For the purposes of estimating burden hours, the upper limit of this range (e.g., 1.5 hours) is used.

Table A.12-1 Estimated Annualize Burden to Respondents

Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Health education teachers	Teacher Interview Guide (Att 2)	30	1	1	30
Middle school students	Middle School Student Focus Group Guide (Att 4)	48	1	1.5	72
High school students	High School Student Focus Group Guide (Att 5)	48	1	1.5	72
Total					174

Annualizing this collection over one year results in an estimated annualized burden of 174 hours.

Annualized cost.

Table A.12-2 provides estimates of the annualized cost to respondents for the collection of data.

Teacher Interviews: Estimates for the average hourly wage for respondents are based on Department of Labor (DOL) data from May 2014 providing national industry-specific occupational employment and wage estimates (http://www.bls.gov/oes/current/naics4_999200.htm#25-0000). Based on DOL data, an average salary of secondary school teachers is \$53,770. To compute an hourly rate, we estimated average teachers work approximately 9 months annually (1560 hours), which equals approximately \$34.47 an hour for teachers. (If anything, this may slightly over-estimate the cost burden for teachers, as many may work more than 40 hour weeks or slightly more than 9 months a year.) This rate is estimated for the 30 respondents. Total cost as been rounded up to the nearest whole dollar. Table A-12 shows estimated burden and cost information.

Student Focus Groups: Because student respondents will be most likely work in minimum wage jobs, if they work at all, cost estimates for the value of time students spend in responding to the questionnaire are based on a Department of Labor fact sheet describing the minimum wage for nonexempt employees as \$7.25 an hour (it should be noted that youth aged less than 20 can be paid less in some circumstances, but not less than \$4.25 an hour) (<http://www.dol.gov/general/topic/youthlabor/wages>). Table A-12 shows estimated burden and cost information.

Table A.12-2 Annualized Costs to Respondents

Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage Rate	Total Cost
Health education teachers	Teacher Interview Guide (Att 2)	30	1	1	\$34.47	\$1035
Middle school students	Middle School Student Focus Group Guide (Att 4)	48	1	1.5	\$7.25	\$522
High school students	High School Student Focus Group Guide (Att 5)	48	1	1.5	\$7.25	\$522
Total						\$2079

A. 13 Estimates of Other 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.

A. 14 Annualized Cost to Federal Government

Cost will be incurred by the government in personnel time for overseeing the project. CDC time and effort for overseeing the contractor’s assistance with data collection and answering questions posed by the contractor and funded agencies are estimated at 6% for a GS-13 (step 5) level Atlanta-based CDC employees and 6% for a GS-14 (step 6) level Atlanta-based CDC employee a year for the one year of the project. The grade and step levels were determined based on the experience levels of the staff currently proposed to work on the project. The average annual cost to the federal government for oversight and project management is \$13,310 (Table A-14-1).

The contractor’s costs are based on estimates provided by the contractor who helped plan the data collection activities. With the expected period of performance, the annual cost to the federal government from contractor and other expenses is estimated to be approximately \$192,365 (Table A-14-1). This is the cost estimated based on the current funding level of the contractor at approximately \$769,460 this year and the percentage of the contractor’s effort that is anticipated for this specific data collection. It is estimated this data collection will take approximately 25% of the contractor’s effort. This includes the estimated cost of coordination with DASH, providing assistance to the LEA for data collection and processing, and support for analysis and reporting.

The total annualized cost to the government, including direct costs to the federal government and contractor expenses is \$205,675.

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

Expense Type	Expense Explanation	Annual Costs (dollars)
<i>Direct Cost to the Federal Government</i>		
CDC oversight of the project	1 CDC Health Scientist at 6% time (GS-13)	\$6,005
CDC oversight of contractor and project	1 CDC Senior Health Scientist at 6% time (GS-14)	\$7,305
Subtotal, Direct Costs to the Government per year		\$13,310
<i>Contractor and Other Expenses</i>		

Assistance with data collection, processing, and preliminary analysis	Labor and other direct costs for supporting data collection, processing, and analysis	\$192,365
Subtotal, Contract and Other Expenses per year		\$192,365
<i>Total of all annualized expenses</i>		<i>\$205,675</i>

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

Current plans for tabulation and publication of data from this information collection include development of summary reports for FWISD that describe findings from the teacher interviews and student focus groups. Analysis will involve transcription of audio tapes, iterative code development, and thematic analysis. In addition to publication of findings in written reports for FWISD, some findings may be shared through peer-reviewed journals or presentations.

Analysis Plan

Upon completion of the interviews and focus groups, all recorded interviews/focus groups will be transcribed and the transcripts will be provided to the project team. The qualitative interview data analysis will include iterative code development, establishment of intercoder reliability, single coding of full transcripts using ATLAS.ti 7 software (or a similar software), and qualitative analysis of coded data. A team of multiple coders will be used to code the qualitative data. To establish intercoder reliability, team members will select numerous segments of text from two randomly selected interview transcripts and team members will apply the most relevant primary code to each section of text. The consistent use of these codes will be analyzed for intercoder reliability. The coding team will meet to review any discrepancies and will continue the process until an acceptable level of intercoder reliability is reached. Then, each transcript will be coded by one coding team member for analysis. The team will later systematically analyze the coded transcripts to identify common themes that emerge. Teacher and student data will initially be analyzed separately, but findings may later be triangulated for additional insight.

Findings from the data will be summarized into written reports for FWISD and may be shared with other stakeholders through mechanisms such as presentations, executive summaries, or peer-reviewed articles. Findings will be used to improve sexual health education at FWISD program and to help CDC better understand strategies that can strengthen the delivery of sexual health education in LEAs.

Project Time Schedule

Data collection is scheduled to begin in Spring 2016. It is critical for this data collection to begin no later than April 2016 in order to avoid conflicts the schools have with other non-CDC commitments (e.g., standardized testing, commencement schedules) late in the Spring semester that would make data collection challenging. As such, we are hoping to receive OMB approval for this information collection by March 2016. The data are likely to be analyzed, summarized, and reported (through unpublished or published reports) in 2016 and early 2017.

A one year clearance is being requested.

Figure A.16-1: Project Time Schedule

Activity	Time Schedule
Design information collection instruments	Complete
Develop data collection protocol, instructions, and analysis plans	Complete
Pilot test information collection instruments	Complete
Prepare OMB package	Complete
Receive OMB approval	TBD
Recruit participants and schedule interviews and focus groups.	0-1 months after OMB approval
Conduct interviews and focus groups	1-2 months after OMB approval
Transcribe interviews	2-3 months after OMB approval
Determine intercoder reliability for qualitative data analysis of interviews	4 months after OMB approval
Code and analyze interview data	5-7 months after OMB approval
Writing (and revising) of baseline data summaries, reports, and/or manuscripts	7-12 months after OMB approval

The CDC contractor, with the review and approval of the CDC staff will develop summary reports for FWISD to use for program improvement and communication with stakeholders. CDC will use the formative research findings revise or establish key recommendations for funded partners (such as school districts) on continued program improvement.

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

The display of the OMB expiration date is not inappropriate. All data collection instruments will display the expiration date for OMB approval of the information collection. We are requesting no exemption.

A. 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.

References

- [1] Centers for Disease Control and Prevention. (2015). HIV/STD prevention at a glance. Retrieved January 7, 2016, from http://www.cdc.gov/healthyouth/about/hivstd_prevention.htm
- [2] Centers for Disease Control and Prevention. (2012b). Youth Risk Behavior Surveillance--United States, 2011. *MMWR Surveillance Summaries*, 61(4), 1-168.
- [3] National Center for Education Statistics. (2011). Table 97. Enrollment for the 100 largest school districts, by enrollment size in 2009: Fall 2009, 2008-09, and federal fiscal year 2011. Retrieved October 11, 2012, from: http://nces.ed.gov/programs/digest/d11/tables/dt11_097.asp
- [4] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2016). Adolescent Health. Retrieved January 7, 2016, from: <http://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health/objectives>
- [5] National Prevention Council. (2011). *National Prevention Strategy*, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. Retrieved January 7, 2016, from: <http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf>
- [6] Office of Adolescent Health. (2016). National Evidence-based Teen Pregnancy Program. Retrieved January 7, 2016, from: http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/
- [7] Centers for Disease Control and Prevention. (2009). Program collaboration and service integration: Enhancing the prevention and control of HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis in the United States. Retrieved January 7, 2016, from: http://www.cdc.gov/nchhstp/ProgramIntegration/docs/207181-C_NCHHSTP_PCISI%20WhitePaper-508c.pdf
- [8] Centers for Disease Control and Prevention. (2015). Winnable Battles. Retrieved January 7, 2016, from: <http://www.cdc.gov/winnablebattles>
- [9] Collinson V, Cook TF. "I don't have enough time" Teachers' interpretations of time as a key to learning and school change. *J Educ Admin*. 2001;39(3):226-281.
- [10] Bauman S. Improving survey response rates of school counselors: Comparing the use of incentives. *J Sch Couns*. 2007;5(3). Retrieved January 23, 2015, from <http://www.jsc.montana.edu/articles/v5n3.pdf>
- [11] Jacob RT, Jacob B. Prenotification, incentives, and survey modality: An experimental test of methods to increase survey response rates of school principals. *J Res Educ Eff*. 2012;5:401-418. doi: 10.1080/19345747.2012.698375

- [12] Krueger RA, Casey MA. *Focus groups. A practical guide for applied research*. Thousand Oaks, CA: Sage; 2009.
- [13] Goldenkoff R. Using focus groups. In: Wholey JS, Hatry HP, Newcomer KE, eds. *Handbook of practical program evaluation* 2nd ed. San Francisco, CA: Jossey-Bass; 2004; 340-362.
- [14] Quinn Patton M. *Qualitative Research and Evaluation Methods* 3rd ed. Thousand Oaks, CA: Sage; 2002.
- [15] Cantor D, O'Hare B, O'Connor K. The use of monetary incentives to reduce non-response in random digit dial telephone surveys. In: Lepkowski JM, Tucker C, Brick JM, Leeuw ED, Japac L, Lavrakas PJ, Link MW, Sangster RL, ed. *Advances in telephone survey methodology*. New York, NY: Wiley; 2008:471-89.