

**Background**

CDC is requesting approval for the continued use of three currently approved forms (under OMB Control No. 0920-0497) for collecting HIV partner counseling and referral services (PCRS) program data. The current forms expire October 31, 2004. This request is for clearance for use of these forms through April, 2006. The extension of the current forms will allow grantees to continue to collect PCRS data as they transition to the new Program Evaluation and Monitoring System (PEMS) over the next year. This clearance will also allow CDC to collect information on how federal funds are allocated by grantees for HIV prevention.

CDC funds HIV prevention projects in 65 public health agencies (50 states, 6 cities, 7 territories, Washington, DC, and

Puerto Rico) through cooperative agreements. PCRS is one of a number of public health strategies supported by CDC that is designed to control and prevent the spread of HIV.

A fundamental feature of PCRS is informing current and past partners of an HIV-infected person that they have been identified as a sex or injection-drug-paraphernalia-sharing partner, and advising them to be tested for HIV. Informing partners of their exposure to HIV is confidential, and partners are not told who reported their name, or when the reported exposure occurred. Notified partners who may not have suspected their risk can choose whether to have HIV counseling and testing. Those who choose to be tested and are found to be HIV positive can receive a medical evaluation, treatment, and prevention services designed to modify

their high risk behavior, thereby possibly reducing the number of new HIV infections.

HIV prevention programs that conduct PCRS interventions can reach significant numbers of persons at very high risk of contracting HIV. The CDC requires aggregate PCRS program data to determine if interventions are being delivered as intended, gauge the degree to which program performance indicator targets are being achieved, and help agencies improve their programs to better deliver effective PCRS. Until grantees transition to PEMS, it is essential that they be allowed to continue to collect aggregate PCRS data using the existing forms.

Each health department funded to conduct PCRS will prepare and submit aggregate PCRS data to the CDC annually.

**ANNUALIZED BURDEN TABLE**

Form	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)
PCRS Process Monitoring Form .....	65	1	2
Budget by Major Funding Activities Form .....	65	1	30/60
Budget by Major Providers Form .....	65	1	30/60

Dated: October 25, 2004.

**Alvin Hall,**

*Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.*

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Centers for Disease Control and Prevention**

[30Day-05-0214]

**Proposed Data Collections Submitted for Public Comment and Recommendations**

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 498-1210 or send an e-

mail to [omb@cdc.gov](mailto:omb@cdc.gov). Send written comments to CDC Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395-6974. Written comments should be received within 30 days of this notice.

**Proposed Project**

2005 National Health Interview Survey, OMB No. 0920-0214—Revision—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

The annual National Health Interview Survey (NHIS) is a basic source of general statistics on the health of the U.S. population. Respondents to the NHIS also serve as the sampling frame for the Medical Expenditure Panel Survey which is conducted by the Agency for Healthcare Research and Quality. The NHIS has long been used by government, university, and private researchers to evaluate both general health and specific issues, such as cancer, AIDS, and access to health care. Journalists use its data to inform the general public. It will continue to be a

leading source of data for the Congressional-mandated "Health US" and related publications. NHIS is the single most important source of statistics to track progress toward the National Health Promotion and Disease Prevention Objectives, "Healthy People 2010."

The NHIS has been in the field continuously since 1957. Due to survey integration and changes in the health and health care of the U.S. population, demands on the NHIS have changed and increased, leading to a major redesign of the annual core questionnaire or Basic Module, and a shift from paper questionnaires to computer assisted personal interviews (CAPI). These redesigned elements were fully implemented in 1997. This clearance is for the ninth full year of data collection using the core questionnaire on CAPI, and for the implementation of a supplement sponsored by the National Cancer Institute. There is no cost to the respondents other than their time. The estimated annualized burden is 39,837 hours.

## ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of responses/respondent	Average burden/response (in hrs)
Family Core (adult family member) .....	39,000	1	24/60
Adult Core (sample adult) .....	32,000	1	18/60
Adult Topical Module (sample adult) .....	32,000	1	18/60
Child Core (adult family member) .....	13,000	1	16/60
Child Topical Module (adult family member) .....	13,000	1	6/60
Re-interview Survey .....	3,250	1	5/60

Dated: October 25, 2004.

**B. Kathy Skipper,**

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Disease Control and Prevention**

**Grants for Dissertation Awards for Doctoral Candidates for Violence-Related and Unintentional Injury Prevention Research in Minority Communities**

*Announcement Type:* New.

*Funding Opportunity Number:* CE05-025.

*Catalog of Federal Domestic Assistance Number:* 93.136.

*Key Dates:*

Letter of Intent Deadline: December 1, 2004.

Application Deadline: January 31, 2005.

**I. Funding Opportunity Description**

**Authority:** This program is authorized under section 301 (a) [42 U.S.C. 241(a)] of the Public Health Service Act, and section 391 (a)[42 U.S.C. 280 b (a)] of the Public Service Health Act, as amended.

**Purpose:** The purposes of the program are to:

- Solicit research applications that address the priorities reflected under the heading, "Research Objectives".
- Build the scientific base for the prevention and control of injuries, disabilities, and deaths disproportionately experienced in minority communities.
- Encourage doctoral candidates from a wide spectrum of disciplines, including epidemiology, medicine, biostatistics, public health, law and criminal justice, behavioral, and social sciences to perform research in order to prevent and control injuries more effectively.

- Assist students in the completion of their dissertation research on a violence-related or unintentional injury topic.

- Encourage investigators to build research careers related to the prevention of violence-related or unintentional injuries, disabilities, and deaths in minority communities.

This program addresses the "Healthy People 2010" focus area of Injury and Violence Prevention.

A dissertation represents the most extensive research experience formulated and carried out by a doctoral candidate, with the advice and guidance of a mentor (the chair or another member of the dissertation committee). Dissertation research involves a major investment of the doctoral student's time, energy, and interest and its substance is often the basis for launching a research career. This research initiative is aimed at providing students with assistance to complete their dissertation research on a violence-related or unintentional injury topic and, thereby, increasing representation of junior investigators in violence-related or unintentional injury research.

Injuries are the number-one killer of children and young adults in the United States. They are the leading cause of years of potential life lost before age 65. More than five million people in the U.S. report suffering from chronic, injury-related disabilities, and the lives of millions of others have been dramatically affected by injuries to themselves or someone they love. Funding for research to prevent these injuries falls into two categories: violence prevention, and the prevention of unintentional injury.

**Violence**

Deaths and injuries associated with interpersonal violence and suicidal behavior are a major public health problem in the United States and around the world. In 1999, more than 46,000 people died from homicide and suicide in the United States. Among 15 to 24 year olds, homicide and suicide rank as the second and the third leading causes of death. Violent deaths are the

most visible consequence of violent behavior in our society. Morbidity associated with physical and emotional injuries and disabilities resulting from violence, however, also constitutes an enormous public health problem. For every homicide that occurs each year there are more than 100 non-fatal injuries resulting from interpersonal violence. For every completed suicide it is estimated that there are 20 to 25 suicide attempts. The mortality and morbidity associated with violence are associated with a variety of types of violence including child mistreatment, youth violence, intimate partner violence, sexual violence, elder abuse, and self-directed violence or suicidal behavior.

Violence has a disproportionate impact on racial and ethnic minorities. In 1999, homicide was the leading cause of death for African Americans and the second leading cause of death for Hispanics between the ages of 15 and 34. Suicide was the second leading cause of death for American Indians and Alaskan Natives and Asian and Pacific Islanders 15 to 34 years of age. It is important to note that existing research indicates that race or ethnicity, per se, is not a risk factor for violent victimization or a cause of violent behavior. Rather, racial or ethnic status is associated with many other factors that do influence the risk of becoming a victim or behaving violently. As a result, racial and ethnic minorities in the United States experience high rates of both violent victimization and perpetration. A better understanding of the factors that contribute to this vulnerability or protection from such risk is important to furthering effective violence prevention programs that address racial and ethnic minorities.

**Unintentional Injury**

Unintentional injuries are a leading cause of death for Americans of all ages, regardless of gender, race, or economic status. Unintentional injuries are the leading cause of death for persons ages 1-34 years, and the fifth leading cause of death overall. Nearly 100,000 people