ACTION: Notification of Single Source Cooperative Agreement Award for the Pasteur Foundation for Building and Strengthening Core Capacities for Influenza Preparedness and Response in Support of International Health Regulations (2005) Implementation in Selected Countries in Sub-Saharan Africa and Southeast Asia. CFDA#: 93.019

STATUTORY AUTHORITY: Sections 301, 307, 1701 and 2811 of the Public Health Service Act, 42 U.S.C. 241, 242l, 300u, 300hh–10.

AMOUNT OF SINGLE SOURCE AWARD: $1,800,000.

PROJECT PERIOD: September 30, 2011 to September 29, 2014.

SUMMARY: In FY2011, HHS/ASPR/OPP plans to provide a Single Source Cooperative Agreement Award to the Pasteur Foundation to build and strengthen core capacities for influenza preparedness and response in support of International Health Regulations (2005) implementation in Sub-Saharan Africa and Southeast Asia.

ASPR, in close coordination with the HHS Centers for Disease Control and Prevention (CDC), will collaborate with the Pasteur Institute and Pasteur Institute affiliates in Cameroon, Central African Republic, and Senegal in Africa, and Cambodia in Asia to develop and implement activities for preparedness and response for pandemic influenza with applicability to other emerging respiratory infections and public health threats in general. The project will focus on building upon existing routine health systems to further develop IHR (2005) core capacities including communication (IHR National Focal Point communication), workforce development, and surveillance and laboratory diagnostics. This work will be performed in the context of Article 44 of the IHR (2005), which directs State Parties to collaborate with each other to detect, assess, and respond to events, and to develop, strengthen, and maintain core public health capacities for surveillance and response.

Single Source Justification

In the recent past, ASPR and Pasteur Institute collaborated on developing epidemiological surveillance capacity for influenza-like illness (ILI) in five countries in Africa and three countries in Asia as the basis for developing the capacities to detect influenza viruses with epidemic or pandemic potential. As a result of this project and the collaboration with other international partners, eighty surveillance sites were established among the eight countries, the laboratories in Cameroon and Cambodia became National Reference Laboratories for avian influenza, and all eight laboratories in the host-countries became WHO National Influenza Centers.

In Southeast Asia, the International Network of Pasteur Institutes is strategically positioned to study the natural history of Highly Pathogenic Avian Influenza (HPAI H5N1). Cambodia and its affiliated Pasteur Institute are important partners in the region that can act as a hub for training and sharing of technical expertise as its National Influenza Center can identify and isolate HPAI H5N1 strains and has experience in Influenza-Like Illness (ILI) and Severe Acute Respiratory Infections (SARI) surveillance.

In Sub-Saharan Africa, Cameroon has built a surveillance system and the *Centre Pasteur of Cameroun* under the Ministry of Health has been designated by WHO as a National Influenza Center. Moreover, the *Centre Pasteur du Cameroun* is also the National IHR Focal Point, making it a key partner for IHR (2005) implementation. The Pasteur Institute of Bangui in the Central African Republic (CAR) is recognized by WHO as a National Influenza Center. This is the only organization capable of performing influenza diagnostics in the country, which was able to detect the first case of H1N1 in 2010. This recognition will be leveraged to further strengthen and interlink the current surveillance network for highly pathogenic avian influenza H5N1. A solid partnership between Cameroon and CAR is particularly important as this is a region in Sub-Saharan Africa where the virus has been detected. In Senegal, the Pasteur Institute of Dakar has set up the influenza surveillance sentinel system, is reporting to the Ministry of Health, and is hosting the National Influenza Center. Senegal has a leading role in the West African region on influenza, and with its involvement in regional CDC's Field Epidemiology Training Program, could become an important leader with regard to IHR (2005) implementation. In addition, Senegal is the one of the two countries in Africa that currently has the potential to develop influenza vaccine manufacturing technology in the short- to medium-term, if supported by international partners, including ASPR.

In making this award, ASPR will capitalize on the Pasteur Institute International Network and its access to francophone countries in Africa and with a strong French influence in Asia. Based on the lessons learned from previous collaborations, this new investment will allow HHS to contribute to build international capacity in collaboration with a prestigious international partner by sharing experiences, strategies, and best practices, and other technical resources in helping developing countries improve their capabilities for pandemic influenza and implement IHR core capacities.

In summary, the Pasteur Institute's strong collaborative relationships with foreign governments, programmatic support, and familiarity with host-country involvement in influenza preparedness will be critical for the viability of this cooperative agreement. This collaboration will support HHS efforts to continue building capacity abroad with the ultimate intent of detecting, stopping, slowing or otherwise limiting the spread of a pandemic to the United States, ultimately enhancing the health security of the American population.

ADDITIONAL INFORMATION: The agency program contact is Dr. Maria Julia Marinissen, who can be contacted at 202–205–4214 or *Maria.Marinissen@hhs.gov*.

Dated: August 5, 2011.

Nicole Lurie,

Assistant Secretary for Preparedness and Response.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-11–11JQ]

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 404–639–5960 and send comments to Daniel Holcomb, CDC Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail 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

Data Collection for Evaluation of Education, Communication, and Training Activities—New—National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Global Migration and Quarantine (DGMQ), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ) is requesting a three year approval for a generic clearance to conduct evaluation research in order to plan and implement health communication, education, and training activities to improve health and prevent the spread of disease. These activities include communicating with international travelers and other mobile populations, training healthcare providers, and educating public health departments and other federal partners.

The information collection for which approval is sought is in accordance with DGMQ's mission to reduce morbidity and mortality among immigrants, refugees, travelers, expatriates, and other globally mobile populations, and to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States. This mission is supported by delegated legal authorities.

First, section 361 of the Public Health Service (PHS) Act (42 U.S.C. 264) authorizes the Secretary of Health and Human Services (HHS) to make and enforce regulations necessary to prevent the introduction, transmission or spread of communicable diseases from foreign countries or possessions into the United States and from one state or possession into any other state or possession. These regulations are codified in 42 Code of Federal Regulations (CFR) parts 70 and 71.

In addition, the Secretary of Health and Human Services also has the legal authority to establish regulations outlining the requirements for the medical examination of aliens before they may be admitted into the United States. This authority is provided under Section 212(a)(1)(A) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)) and Section 325 of the Public Health Service Act. These regulations are codified in 42 CFR part 34, which establish requirements that determine whether aliens can be admitted into the United States.

Successful implementation of DGMQ's regulatory authority and public health mission as outlined above requires a variety of communication, training and educational activities involving staff, partners, mobile populations and the general public. DGMQ conducts these activities in order to inform, educate and empower key audiences with respect to important public health issues.

This generic OMB clearance will allow DGMQ to quickly collect information about the knowledge, attitudes, and behaviors of key audiences (such as refugees, immigrants, migrants, international travelers, travel industry partners, healthcare providers, non-profit agencies, customs brokers and forwarders, schools, state and local health departments) to help improve and inform these activities during both routine and emergency public health events. This generic OMB clearance will help DGMQ continue to refine these efforts in a timely manner, and will be especially valuable for communication activities that must occur quickly in response to public health emergencies.

DGMQ staff will use a variety of data collection methods for this proposed project: Interviews, focus groups, group discussions, surveys, and pre-post tests. Depending on the research questions and audiences involved, data may be gathered in-person, by telephone, online, or using some combination of these formats. Data may be collected in quantitative and/or qualitative forms. Numerous audience variables will be assessed under the auspices of this generic OMB clearance. These include, but are not limited to, knowledge, attitudes, beliefs, behavioral intentions, practices, behaviors, skills, self-efficacy, and information needs and sources. Insights gained from evaluation research will assist in the development, refinement, implementation, and demonstration of outcomes and impact of communication, education, and training activities.

DGMQ estimates that 22,166 hours will be involved in evaluation research activities each year. The information being collected will not impose a cost burden on the respondents beyond that associated with their time to provide the required data.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
General Public/Healthcare Professionals Focus groups.	Screening form	3,000	1	10/60	500
	Focus Groups	1,500	1	90/60	2,250
General Public/Healthcare Professionals Interviews.	Screening Form	2,000	1	10/60	333
	Interviews	1,000	1	60/60	1,000
General Public/Healthcare Professionals Large Group Discussions.	Screening Forms	2,000	1	10/60	333
	Large Group Discussion	1,000	1	90/60	1,500
General Public/Healthcare Professionals Surveys	Screening Forms	15,000	1	10/60	2,500
	Surveys	7,500	1	45/60	5,625
General Public/Healthcare Professionals Pre/post tests.	Screening Forms	15,000	1	10/60	2,500
	Pre/Post Tests	7,500	1	45/60	5,625
Total					22,166

Dated: August 4, 2011.

Daniel Holcomb,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2011–20343 Filed 8–9–11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day-11–11JD]

Proposed Data Collections Submitted for Public Comment and Recommendations

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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

Evaluation of Dating Matters: Strategies To Promote Healthy Teen Relationships™—New—National Center for Injury Prevention and Control—Centers for Disease Control and Prevention

Background and Brief Description

Dating Matters: Strategies To Promote Healthy Teen Relationships™ is the Centers for Disease Control and Prevention's new teen dating violence prevention initiative.

Recently, efforts to prevent teen dating violence have grown, particularly in schools, among policymakers, and among sexual violence and domestic violence coalitions. Now many states and communities also are working to stop teen dating violence. However, these activities vary greatly in quality and effectiveness. To address the gaps, CDC has developed *Dating Matters,* a comprehensive teen dating violence prevention program based on the current evidence about what works in prevention.

Dating Matters focuses on high-risk, urban communities where participants include: middle school students age 11 to 14 years; middle school parents; brand ambassadors; educators; school leadership; program implementers; community representatives; and local health department representatives in four high-risk urban communities. The primary goal of the current proposal is to conduct an outcome and implementation evaluation of Dating Matters in four metropolitan cities to determine its feasibility, cost, and effectiveness. Within each city 12 schools will implement the two models of teen dating violence prevention (48 schools total over 4 sites). Our burden estimates are based on each school having 600 students, with 200 students per grade (6th, 7th, and 8th grades). Therefore the sampling frame for this data collection is 48,000 for the three years of data collection covered by this OMB package (5 cohorts of 200 students each in 48 schools; 5 x 200 x 48). The 5 cohorts will be students who are in 6th, 7th and 8th grade in year 1 of data collection, students in 6th grade in years 2 and 3 of data collection. That means the sampling frame for parents, given that we would only include one parent per student, is also 48,000 for the three years of data collection covered by this package. Based on our research and consultation with middle schools, most schools with approximately 600 students have approximately 40 staff. If we assume 40 educators per school, the sampling frame for the educator sample is 1,920. The following are explanations of estimated burden by respondent.

Students: We will use random selection to identify a subsample of students from each cohort from each school to participate in the evaluation. We estimate that we will enroll 40 students per cohort per school, for a total of 1,920 students per grade and 9,600 for the entire sample of 5 cohorts covered under this OMB package.

Parents: We will recruit all parents participating in the parent curricula and select an equal number of parents from the standard of care schools to serve as a matched comparison group. We will enroll 40 parents per grade per school, with 1920 parents per grade, so 5,760 parents per year.

Educators: We expect that 85% of all educators will participate. With an estimated 40 educators per 48 schools (1920 total), 85% is 1632 educators.

School data extractors: We will recruit one data extractor per each school (48 extractors total) to extract school data to be used in conjunction with the outcome data for the students. Individual level school data will only be collected for students participating in the evaluation, so this data will reflect the same sampling frame as the student survey data.

School leadership: We will recruit one school leadership (*e.g.,* principal, vice principal) per 48 schools, the number of respondents will be 48.

Local Health Department representative: We will recruit four local health department representatives working on the initiative per community, the number of respondents will be 16.

Parent Program Manager: With a maximum of one parent program manager per community, the number of program manager respondents will be 4.

Community Representative: We will recruit 10 community representatives per site, the number of respondents will be 40.

Parent Curricula Implementers: Each school/neighborhood implementing the comprehensive approach will have one male and one female parent implementing the parent programs with six comprehensive school/neighborhood clusters per community plus one additional pair per site (will fill-in as needed), respondents will be (2x7x4) 56 implementers.

Student Curricula Implementers: We will have six student curricula implementers per school that will be completing fidelity instruments, the total number of respondents will be 288.

Safe Dates Implementers: We will have 3 Safe Dates implementers per the 48 schools, who will implement the 8th grade Safe Dates program, the number of respondents for the Safe Dates implementer survey will be 144.

Brand Ambassadors: The Brand Ambassador Implementation Survey will be provided to each brand ambassador in each community. With a maximum of 20 brand ambassadors per community, the feedback form will be collected from a total of 80 brand ambassadors.

Communications Implementers (''Brand Ambassador Coordinators''): The Communications Campaign Tracking form will be provided to each