development of an interconnected electronic laboratory platform designed at GMI with technical support from the CDC Central American Regional Office, to provide real time laboratory results to health authorities.

As a result of the collaboration between ASPR and GMI, over 5,000 public health and medical professionals from more than 10 countries in the region were trained between 2006 and 2013. Training topics included laboratory biosafety, pathogen biosecurity, rapid testing methods, qualitative detection of ricin toxin, and safe shipping of infectious material. Using advanced technologies, laboratory professionals in the region can accomplish viral subtyping and molecular characterization of different influenza viruses which contribute to global situational awareness for pandemic threats. In 2011, ASPR supported GMI to enhance their BSL–3 virology suite for detecting and diagnosing emerging influenza and other infectious disease threats, including biological threat agents and novel influenza viruses. These efforts were achieved in collaboration with CDC's Laboratory Response Network. As part of this effort, ASPR and GMI hosted the first-ever Latin-American Regional Planning Meeting of Experts aimed at establishing a regional bio-safety association for biological risk management with participants from 11 countries. Lastly, ASPR and GMI collaborated to advance IHR (2005) implementation and establishment of the IHR National Focal Point, known as the National Operations Center (*Centro Nacional de Enlace* [CNE]), in May 2013. CNE monitors all possible events that may require immediate intervention, response, or the need for international notification on a 24 hour/7 days a week basis.

Supporting IHR (2005) implementation and strengthening regional and global health security, including pandemic influenza preparedness efforts, to protect the health of the American population is a priority for the United States, as evidenced by the recent launch of the Global Health Security Agenda. After careful and thorough consideration, ASPR determined GMI is the only partner with proven capabilities to support the proposed program and meet HHS' needs of advancing IHR (2005) implementation and strengthening pandemic influenza and infectious disease preparedness in Panama. Collaboration efforts will also support infectious disease preparedness in neighboring countries, which facilitate early detection of diseases and potentially prevent regional and global spread. For the aforementioned reasons, GMI is uniquely qualified and the only appropriate partner to facilitate and support successful completion of the proposed project.

**FOR FURTHER INFORMATION CONTACT:** Please submit an inquiry via the ASPR–OPP Division of International Health Security—IHR Program Contact Form located at *http://www.phe.gov/Preparedness/international/ihr/Pages/IHRInquiry.aspx.*

Dated: July 18, 2014.

**Nicole Lurie,**

*Assistant Secretary for Preparedness and Response.*

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**BILLING CODE 4150–37–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[60Day–14–14APM]**

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

The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995. To request more information on the below proposed project or to obtain a copy of the information collection plan 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 submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget (OMB) approval. 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; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information. Written comments should be received within 60 days of this notice.

**Proposed Project**

Surveillance of Health-Related Workplace Absenteeism—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

There is currently a high global human health risk from emerging novel influenza, coronavirus and similar evolving pathogens, which is prompting the Centers for Disease Control and Prevention (CDC) to enhance situational awareness capacity for emergency preparedness and response.

During the 2009 influenza A (H1N1) virus pandemic, NIOSH/CDC conducted a pilot study to test the feasibility of using national surveillance of workplace absenteeism to assess the pandemic's impact on the workplace to plan for preparedness and continuity of operations and to contribute to health awareness during the emergency response. As part of this emergency effort, CDC contracted with the American College of Occupational and Environmental Medicine (ACOEM), which has access to a large network of affiliated medical directors and corporate health units that routinely compile absenteeism data, to conduct enhanced passive surveillance of absenteeism using weekly data from a convenience sample of sentinel worksites.

Due to the emergency situation at that time, OMB approval was not requested, erroneously, for the data collection activities associated with the pilot study. The pilot was conducted without approval under the Paperwork Reduction Act. The current request seeks to build off of the data collected

from the pilot and accounts for the burden involving all of the participants.

From September 28, 2009, through March 31, 2010, 79 sentinel worksites representing 16 different employers participated in the pilot study. Each week, ACOEM collected reports of aggregated absenteeism data from the medical directors of the participating companies using an emailed, standardized form. ACOEM replaced company names with coded unique identifiers, and sent the aggregated data to CDC/NIOSH for analysis.

The major strengths of the sentinel worksite approach to absenteeism surveillance were the use of existing, routinely collected data and timeliness. The use of existing, routinely collected data made the burden on participating companies negligible. Data were routinely compiled and thus could be collected and analyzed in near real time, making this approach useful, in principle, for providing current situational awareness and actionable intelligence that could be used to inform, prioritize, and evaluate intervention efforts during the pandemic. On the other hand, there were several limitations to the sentinel worksite surveillance done in 2009–2010, and the activity was not maintained after the H1N1 pandemic ended.

At present, two new emerging infectious diseases, novel H7N9 influenza virus and a coronavirus circulating in the Middle East, have demonstrated the need to build additional capacity for national surveillance for health-related workplace absenteeism so that it can be used to monitor the impact of these or any other disease that might reach pandemic potential and spread to the U.S.

NIOSH/CDC requests permission to collect company absenteeism data, to be able to assess the impact of disease on a company and to identify trends in the spread of influenza or other novel disease states. This will provide an additional monitoring system to CDC. The proposed project builds on the 2009/10 initiative and modifies the reporting format to collect information on a daily versus weekly basis.

The companies in the program will be those that routinely collect absenteeism data thus the burden will be minimal. We will be asking companies to record their daily absenteeism numbers into an Excel file which can be emailed to ACOEM on a weekly or monthly basis. The Excel file will be pre-populated with company name, site and dates to ease the reporting burden on companies.

ACOEM will transmit de-identified information on a weekly or monthly basis to NIOSH/CDC who will in turn conduct analysis on an aggregate basis. Data will be compiled by state and Department of Health and Human Services (HHS) region, as well as nationally to allow for trend analysis.

The initial 16 respondents in the 2009/10 study will be asked to participate and an additional 12 companies have indicated an interest in participating in the data collection activity. The employee population among these 28 companies is approximately 293,000.

The annualized estimated burden of time is 607 hours for the 28 respondents in the study. Respondents will complete the form daily; no more than 5 minutes per day/per respondent. This results in an annualized burden of 607 hours per year.

There are no costs to participants other than the time.

ESTIMATED ANNUALIZED BURDEN HOURS

| Type of respondent | Form name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) | Total burden hours |
|---|---|---|---|---|---|
| Private companies | EXCEL data template | 28 | 260 | 5/60 | 607 |
| Total | | | | | 607 |

**Leroy 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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**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Administration for Children and Families

### Submission for OMB Review; Comment Request

*Title:* Rescue & Restore Regional Program Project Data.

*OMB No.:* 0970—NEW.

Description: The Trafficking Victims Protection Act of 2000 (TVPA), as amended, authorizes the Secretary of Health and Human Services (Secretary) to expand benefits and services to victims of severe forms of trafficking in persons in the United States, without regard to the immigration status of such victims. Such benefits and services may include services to assist potential victims of trafficking in achieving certification (Section 107(b)(1)(B) of the TVPA, 22 U.S.C. 7105(b)(1)(B)). It also authorizes the President, acting through the Secretary and the heads of other Federal departments, to establish and carry out programs to increase public awareness, particularly among potential victims of trafficking, of the dangers of trafficking and the protections that are available for victims of trafficking (Section 106(b) of the TVPA, 22 U.S.C. 7104(b)).

The Secretary delegated authority to carry out these responsibilities to the Assistant Secretary for Children and Families who further delegated the authority to the Director of the Office of Refugee Resettlement (ORR).

The intent of the *Rescue & Restore Victims of Human Trafficking* campaign, launched in 2004, is to increase the identification of trafficking victims in the United States and to help those victims receive the benefits and services they need to restore their lives. The purpose of the Rescue & Restore Victims of Trafficking Regional Program (Rescue & Restore Program) is to increase the identification and protection of foreign victims of human trafficking in the United States and to promote local capacity to prevent human trafficking and protect human trafficking victims. The Rescue & Restore Program also seeks to remove barriers to prevention and protection specific to foreign human trafficking victims who live in the United States.

The Rescue & Restore Program has the following objectives: