on the Commission's privacy policy, including routine uses permitted by the Privacy Act, see *https://www.ftc.gov/site-information/privacy-policy.* For supporting documentation and other information underlying the PRA discussion in this Notice, see *http://www.reginfo.gov/public/jsp/PRA/praDashboard.jsp.*

Comments on the information collection requirements subject to review under the PRA also should be submitted to OMB. If sent by U.S. mail, they should be addressed to: Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for the Federal Trade Commission, New Executive Office Building, Docket Library, Room 10102, 725 17th Street NW, Washington, DC 20503. Comments sent to OMB by U.S. postal mail are subject to delays due to heightened security precautions and also can be sent by email to *wliberante@omb.eop.gov.*

Heather Hippsley,

Deputy General Counsel.

[FR Doc. 2019–03020 Filed 2–21–19; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–19–18UC]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled Costs of Implementing Community-based Sodium Reduction Strategies to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on June 1, 2018 to obtain comments from the public and affected agencies. The 60-day FRN was published under the title ''Evaluation of the Sodium Reduction in Communities Program.'' Since then, the project title has been modified for better alignment with study aims. CDC received two non-substantive comments related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

Costs of Implementing Community-based Sodium Reduction Strategies—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) is the primary Federal agency for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability. CDC is committed to programs that reduce the health and economic consequences of the leading causes of death and disability, thereby ensuring a long, productive, healthy life for all people.

Sodium reduction is a public health imperative. Although the *2015–2020 Dietary Guidelines for Americans* recommends no more than 2,300 mg/day of sodium for adults, U.S. adults consume an average of more than 3,500 mg/day. The significant gap between recommended intake and average intake poses a serious public health risk; high sodium intake leads to hypertension, a common and costly health risk in the United States. The increasing prevalence of hypertension is especially troubling because high blood pressure leads to serious health issues, including cardiovascular disease (CVD), stroke, and kidney disease. One study projected that the real direct medical costs of CVD will triple between 2010 and 2030, from $273 billion to $818 billion. Recent studies have shown that even modest population-level sodium reductions can lead to significant decreases in blood pressure and to potentially enormous savings—in lives and in dollars.

Reducing sodium levels presents a special set of challenges for public health programs because high sodium intake is largely the result of sodium found in processed foods and foods prepared in restaurants. As such, multiple reports by the Institute of Medicine (IOM) and the Food and Drug Administration (FDA) have asserted the need for large-scale, population-based efforts to decrease sodium consumption.

Recognizing the importance of population-based approaches, CDC launched the first round of the Sodium Reduction in Communities Program (SRCP) in 2010 to reduce sodium intake by helping to create healthier food environments and a second round in 2013 to reduce sodium intake in food environments through population-based sodium reduction strategies. SRCP's project goals include increasing access to and availability of lower-sodium food options. The long-term goal of the initiative is to reduce sodium intake to within the recommended levels in the *2010 Dietary Guidelines for Americans.* CDC funded eight SRCP grantees in 2016 to continue improving community and environmental supports for sodium reduction and to build practice-based evidence around effective population-based strategies to reduce sodium consumption. Grantees included state and local health departments and one university medical center. These communities are partnering with organizations to implement sodium reduction strategies in their food service venues. By creating a healthier environment, CDC seeks to decrease the population-wide burden of sodium intake.

CDC and RTI International propose to collect information from all partners of SRCP recipients that are willing to participate in order to estimate the costs to SRCP partners of implementing sodium reduction strategies. Partner organizations are those that work to implement the sodium reduction strategies in their food services and can

include worksites, schools, universities, hospitals, senior meal programs, food banks, and restaurants. The information collection will occur via the SRCP Partner Cost Survey, in which respondents will be asked about a key set of sodium reduction activities that were developed based on a pilot study with eight partners as part of the evaluation of SRCP Round 2. Activities include: Establishing nutrition guidelines, developing lower sodium products or recipes, preparing lower-sodium food, promoting lower-sodium foods, and attending additional meetings. We will request participation from all SRCP partners via email and offer a $50 gift card as an incentive. Complete surveys will be returned to CDC's data collection contractor by email. The estimated burden per response is one hour.

The insights to be gained from this data collection will be critical to understanding the full costs of implementing community-based sodium reduction strategies. Estimates will be considered preliminary and not externally generalizable but can provide a basis for future planning and evaluation. Understanding the costs to partners is important for program planning to support program longevity and sustainability. For example, CDC can use findings to provide guidance or technical assistance to entities that are interested in population-based strategies for reducing sodium consumption. Results will also be disseminated to other state and local organizations to inform planning and sustainability of other community-based public health initiatives.

OMB approval is requested for one year. CDC estimates that information will be collected from 44 of the SRCP's community partners (50% response rate). Participation is voluntary and there are no costs to respondents other than their time. The estimated annualized burden hours are 44.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Partner Program Manager	SRCP Partner Cost Survey	44	1	1

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

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BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2014–0012]

Information for Providers To Share With Male Patients and Parents Regarding Male Circumcision and the Prevention of HIV Infection, Sexually Transmitted Infections, and Other Health Outcomes

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Disease Control and Prevention (CDC), within the Department of Health and Human Services (HHS), announces the availability of ''Information for Providers to Share with Male Patients and Parents Regarding Male Circumcision and the Prevention of HIV infection, Sexually Transmitted Infections, and other Health Outcomes.''

FOR FURTHER INFORMATION CONTACT: Division of HIV/AIDS, National Centers for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS D–21, Atlanta, Georgia 30329; phone: 404–639–5200; email: *circumcision@cdc.gov.*

SUPPLEMENTARY INFORMATION: On December 2, 2014, CDC published a notice in the **Federal Register** (79 FR 71433) requesting public comment on a draft document titled *Recommendations for Providers Counseling Male Patients and Parents Regarding Male Circumcision and the Prevention of HIV Infection, STIs, and Other Health Outcomes* (referred to as The Initial Draft Document). On August 30, 2018, the title was changed to *Information for Providers to Share with Male Patients and Parents Regarding Male Circumcision and the Prevention of HIV infection, Sexually Transmitted Infections, and other Health Outcomes* to better align with the content in the final version of the document.

The intent of this document is to assist health care providers in the United States who share information with men and parents of male infants, children and adolescents for their use in decision making about male circumcision as it relates to the prevention of human immunodeficiency virus (HIV) infection, sexually transmitted infections (STIs), and other health outcomes. Such decision making is made in the context of not only health considerations, but also other social, cultural, ethical, and religious factors. Although observational and ecologic data have been accumulating about infant male circumcision for many years, clinical trials conducted between 2005–2010 have demonstrated safety and significant efficacy of voluntary adult male circumcision performed by clinicians for reducing the risk of acquisition of human immunodeficiency virus (HIV) by a male during penile-vaginal sex (''heterosexual sex''). Three randomized clinical trials conducted in Kenya, Uganda, and South Africa [1] [2] [3] showed that adult male circumcision reduced HIV infection risk by 50–60%. These trials also found that adult circumcision reduced the risk of men acquiring two common sexually transmitted infections (STIs), herpes simplex virus type-2 (HSV–2) and types of human papilloma virus (HPV) that can cause penile and other anogenital cancers. Since the release of these trial data, various medical professional organizations have updated their information about adult male and infant male circumcision.

Initial comment period. The initial comment period was open for public and peer review during December 2, 2014—January 16, 2015.

Public comments (initial comment period). CDC received 3,234 comments on the *Initial Draft Document* from the public, including but not limited to

[1] Bailey RC, Moses S, Parker CB, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. Lancet. 2007; 369 (9562):643–656.

[2] Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med. 2005;2(11):e298.

[3] Gray RH, Kigozi G, Serwadda D, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. Lancet. 2007; 369 (9562): 657–666.