

- Documented experience recruiting qualified medical personnel for projects of similar complexity and scope of activities.

- Documented capability and past history of funds management meeting the highest acceptable standards of accounting.

(4) *Facilities and Resources (15 points)*:

Documented availability and adequacy of facilities, equipment and resources necessary to carry out the activities specified under Program Requirements, including logistical support facilities and resources.

#### VI.1 Award Administration Information

HHS does not release information about individual applications during the review process until final funding decisions have been made. When these decisions have been made, applicants will be notified by letter regarding the outcome of their applications. The official document notifying an applicant that an application has been approved and funded is the Notice of Grant Award, which specifies to the award recipient the amount of money awarded, the purpose of the cooperative agreement, the terms and conditions of the cooperative agreement award, and the amount of funding, if any, to be contributed by the award recipient to the project costs.

#### VI.2. Administration and National Policy Requirements

In accepting this award, the grantee stipulates that the award and any activities hereunder are subject to all provisions of 45 CFR parts 74 and 92, currently in effect or implemented during the period of the grant. Within 60 days of receiving the Notice of Grant Award, a finalized work plan for year one of the project will be negotiated with the OFP Project Officer. In the succeeding years, the training plan and other training events will be a part of the continuation application. The OFP will identify training priorities for the coming year to the male training program within 60 days of the due date for the continuation application.

The Buy American Act of 1933, as amended (41 U.S.C. 10a–10d), requires that Government agencies give priority to domestic products when making purchasing decisions. Therefore, to the greatest extent practicable, all equipment and products purchased with grant funds should be American-made.

A Notice providing information and guidance regarding the “Government-wide Implementation of the President’s

Welfare-to-Work Initiative for Federal Grant Programs” was published in the **Federal Register** on May 16, 1997. This initiative was designated to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the Notice is available electronically on the OMB home page at <http://www.whitehouse.gov/omb>.

The HHS Appropriations Act requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, grantees shall clearly state the percentage and dollar amount of the total costs of the program or project which will be financed with Federal money and the percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

#### VI.3 Reporting

A successful applicant under this notice will submit: (a) Annual progress reports; (b) annual Financial Status Reports; and (c) a final progress report and Financial Status Report. Reporting formats are established in accordance with provisions of the general regulations which apply under 45 CFR parts 74 and 92. Applicants must submit all required reports in a timely manner, in recommended formats (to be provided) and submit a final report on the project, including any information on evaluation results, at the completion of the project period. Agencies receiving \$500,000 or more in total Federal funds are required to undergo an annual audit as described in OMB Circular A–133, “Audits of States, Local Governments, and Non-Profit Organizations.”

#### VII. Agency Contacts

For assistance on administrative and budgetary requirements, Eric West, HHS Office of Public Health and Science (OPHS) Grants Management Office, (301) 594–0758.

For assistance with questions regarding program requirements, Dr. Amar Bhat, HHS Office of Global Health Affairs, (301) 443–1410.

Dated: August 20, 2004.

**Arthur J. Lawrence,**

*Assistant Surgeon General, Acting Principal Deputy Assistant Secretary for Health, Office of Public Health and Science.*

[FR Doc. 04–19462 Filed 8–24–04; 8:45 am]

**BILLING CODE 4150–28–U**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

[30 Day–04–OC]

#### 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

Survey Development: Child Stress and Toxics (Pediatric Environmental Perception Scale)—New—The Agency for Toxic Substances and Disease Registry (ATSDR). ATSDR is mandated pursuant to the 1980 Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) and its 1986 amendments, the Superfund Amendments and Reauthorization Act (SARA), to serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease related to toxic substances.

For the past 6 years, ATSDR has worked with the U.S. Environmental Protection Agency (EPA), the Substance Abuse and Mental Health Services Administration (SAMSHA), state health departments, and local communities on the issue of psychosocial stress due to the presence of toxic hazards. A significant amount of research has focused on adult psychosocial stress in communities affected by hazardous substances. Comparatively little is known about levels of psychosocial stress among children or other susceptible populations in these settings. There is a critical need to develop a research instrument to screen children who live in communities at or near hazardous waste sites for elevated stress levels. The instrument will facilitate the establishment of group norms for levels of stress in children and is not intended to provide clinical

or diagnostic information on individual children.

The purpose of this project is to: (1) Develop and pilot-test a scale to assess levels and sources of psychosocial stress in children who live in communities at or near hazardous waste sites; (2) modify the scale based on pilot-test results; (3) validate the scale on children living in communities near hazardous

waste sites; and (4) provide an evidence base for planning and conducting interventions in affected communities.

CDC will pilot test the scale on at least 50 children in two age groups (6th and 8th grade levels) at one or more test sites. Semi-structured interviews or focus groups will be conducted to determine whether additional variables need to be included in the scale. During

the second and third phases of the project, a scale will be used to screen up to 4,950 children in communities at or near hazardous waste sites. CDC plans to then use this data to create effective interventions methods to predict and explain levels of stress in children living around hazardous waste sites. The estimated annualized burden is 825 hours; there are no costs to respondents.

Respondents	Number of respondents	Number of responses/respondent	Average burden/response (in hours)
Children 10–17 years old—Phase I .....	50	1	40/60
Children 10–17 years old—Phase II .....	200	1	20/60
Children 10–17 years old—Phase III .....	4,750	1	30/60

Dated: August 13, 2004.

**Alvin Hall,**

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

[FR Doc. 04–19424 Filed 8–24–04; 8:45 am]

**BILLING CODE 4163–18–M**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Disease Control and Prevention**

**Fetal Alcohol Syndrome Prevention and Surveillance in South Africa: Developing Community-Level Strategies That Work**

*Announcement Type:* New.

*Funding Opportunity Number:* RFA DD05–011.

*Catalog of Federal Domestic Assistance Number:* 93.283.

*Key Dates:*

*Letter of Intent Deadline:* September 24, 2004.

*Application Deadline:* November 23, 2004.

**I. Funding Opportunity Description**

*Authority:* This program is authorized under Sections 307,317(C), and 317(k)(2) of the Public Health Service Act 42 U.S.C., Sections 241, 242 (I), 247b-4 and 247b (k) (2) as amended].

*Purpose:* The purpose of this program is to develop a model prevention program, successful in reducing hazardous alcohol use, reducing unintended pregnancies and/or promote pregnancy delay among childbearing age women at risk for an alcohol-exposed pregnancy in high risk communities (urban and rural) for Fetal Alcohol Syndrome (FAS) in South Africa. This program should be conducted in three stages.

*Stage 1:* The formative research state is composed of qualitative and quantitative research of knowledge, attitudes and practices in high risk women (women of child-bearing age at high risk of an alcohol-exposed pregnancy; women with children with FAS, spouses/partners, health care providers, obstetricians and nurses, specialty providers including alcohol treatment and substance abuse services, community leaders, etc.) regarding use of alcohol in pregnancy, use of contraception, knowledge of FAS, as well as issues such as identification of services and barriers to services. The formative research will describe the socio-demographic characteristics and attributes of the targeted community at risk, identify constraints and opportunities for behavior change, and allow the initiation and conduct of community and person-level interventions under stage 2.

*Stage 2:* The protocol and intervention development stage will use the information gathered in Stage 1 in combination with previous evidence-based research in FAS and HIV prevention in the U.S. and South Africa to develop a model intervention.

*Stage 3:* This stage will test the feasibility of the major components of the program in the high risk FAS communities targeted in this announcement.

The targeted communities should include geographic areas and/or selected subpopulations of childbearing-age women at high risk for an alcohol-exposed pregnancy in urban and rural areas of South Africa.

This program addresses the “Healthy People 2010” focus area of *Substance Abuse and Maternal, Infant, and Child Health*.

Measurable outcomes of the program will be in alignment with one (or more)

of the following performance goal(s) for the National Center on Birth Defects and Developmental Disabilities (NCBDDD): Prevent birth defects and developmental disabilities.

*Research Objectives and Background:* FAS is caused by maternal alcohol use during pregnancy and is one of the leading causes of preventable birth defects and disabilities. Recently, the highest prevalence of FAS worldwide was reported among children living in the winery area of the Western and Northern Cape region of South Africa with FAS prevalence rates ranging from 40.5 to 46.4 per 1,000 children. In the Gauteng region of South Africa(outside the wine-growing region) FAS prevalence rates range from 11.8 to 41.0 per 1,000 children. In addition, CDC has implemented a monitoring system in the area of De AAR, where the FAS prevalence rate was 80 per 1,000 live births. These rates show that FAS is a serious public health problem in some areas or subgroups of the South African population.

Important risk factors associated with heavy alcohol use among childbearing-age women include use of tobacco and other drugs, co-existing psychiatric conditions, history of sexual or physical abuse during childhood and/or adulthood, and a previous alcohol-exposed pregnancy. Studies have found that the strongest predictor of alcohol use during pregnancy is the level of alcohol use prior to pregnancy. Most of the same risk factors in women at risk of an alcohol-exposed pregnancy are also found in women at high risk for HIV infection.

Essential strategies for preventing alcohol-exposed pregnancies among high-risk women who are heavy alcohol users can include individual, group and community level interventions. Examples of individual level