The vote encompassed approval of the paragraph below for inclusion in the statement to be released shortly after the meeting:

Although the moderation in the growth of aggregate demand should help to limit inflation pressures over time, the Committee judges that some inflation risks remain. The extent and timing of any additional firming that may be needed to address these risks will depend on the evolution of the outlook for both inflation and economic growth, as implied by incoming information. In any event, the Committee will respond to changes in economic prospects as needed to support the attainment of its objectives.

By order of the Federal Open Market Committee, July 21, 2006.

Vincent R. Reinhart,

Secretary, Federal Open Market Committee.

[FR Doc. E6–12040 Filed 7–26–06; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the National Coordinator of Health Information Technology; American Health Information Community Confidentiality and Security Workgroup Meeting

ACTION: Announcement of meeting.

SUMMARY: This notice announces the first meeting of the American Health Information Community Confidentiality and Security Workgroup in accordance with the Federal Advisory Committee Act (Pub. L. 92–463, 5 U.S.C., App.).

DATES: August 4, 2006 from 2 p.m. to 4 p.m.

ADDRESSES: Mary C. Switzer Building (330 C Street, SW., Washington, DC 20201), Conference Room 4090.

FOR FURTHER INFORMATION CONTACT: *http://www.hhs.gov/healthit/ahic.html.*

SUPPLEMENTARY INFORMATION: The Confidentiality and Security Workgroup must convene in early August 2006 to begin discussion of cross-cutting issues relating to the principles of confidentiality and security in health information technology in order to meet upcoming deadlines.

The meeting will be available via internet access. Go to *http://www.hhs.gov/healthit/ahic.html* for additional information on the meeting.

Dated: July 20, 2006.

Judith Sparrow,

Director, American Health Information Community, Office of Programs and Coordination, Office of the National Coordinator for Health Information Technology.

[FR Doc. 06–6498 Filed 7–26–06; 8:45 am]

BILLING CODE 4150–24–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–06–05CP]

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 Seleda Perryman, CDC Assistant 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

Micro-Finance Project for HIV Prevention—New—National Center for HIV, STD and TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC is requesting a 3-year approval from the Office of Management and Budget to conduct focus groups and administer a one-on-one qualitative interview to women who are at risk for HIV infection and community leaders in four communities in the southeastern United States.

The purpose of this project is to conduct formative research to determine the most realistic and efficacious approach for developing a micro-finance project to reduce HIV/STD-related risk behavior among unemployed or underemployed high-risk African-American women in the southeastern United States, who are among those most at risk for HIV infection in the country. The project addresses goals of the ''CDC HIV Prevention Strategic Plan,'' specifically the goal of decreasing the number of persons at high risk of acquiring or transmitting HIV infection. Information from this project will inform the development of economic empowerment interventions to reduce risk for HIV infection.

A focus group will be conducted with eight women (who are screened for eligibility) in each of the four communities (a total of 32 women) in the southeast United States with high prevalence of HIV and other sexually transmitted diseases. A subset of these women will participate in individual interviews. Another focus group will include community leaders in each of the four communities (a total of 32 individuals). The focus groups will capture demographic information, attitudes, and knowledge regarding income-generating activities that are feasible (can be done with small capitalization and by these women with some training and other preparation), attractive (women will do this work), and useful (likely to produce income to address a reasonable proportion of economic need; the community will use the service or purchase the product of the activity).

The subset of focus group participants who also participate in individual interviews (five women in each of the four communities, with a maximum of 20 individual interviews) will respond to more personal questions. The semi-structured individual interviews will explore behavioral, social, and economic conditions that might contribute to risk for HIV infection.

The focus groups and interviews will take about two hours each to complete. A screening interview for women participants will take about 10 minutes to complete. There are no costs to respondents other than their time.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Women-Screening interview	55	1	10/60	10
Women-Focus groups	32	1	2	64
Women-individual interviews	20	1	2	40
Community leaders-Focus groups	32	1	2	64
Total				178

Dated: July 21, 2006.

Joan F. Karr,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E6–12023 Filed 7–26–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–06–06BM]

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

Randomized Controlled Trial of Routine Screening for Intimate Partner Violence—New—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Intimate partner violence (IPV) is a prevalent problem with serious health consequences that include death, physical injury, increased rates of physical illness, posttraumatic stress, increased psychological distress, depression, substance abuse, and suicide. Some studies suggest that abuse perpetrated by intimate partners tends to be repetitive and escalates in severity over time. This research has been the basis for promoting early diagnosis and intervention.

Health care providers appear to be well situated to identify IPV. Women come into contact with health care services routinely for a number of reasons such as prenatal care, family planning, cancer screening, and well baby care. Women experiencing IPV make more visits to emergency departments, primary care facilities, and mental health agencies than non-abused women. Considering the magnitude and severity of IPV, and the potential role health care providers could play in reducing its serious consequences, numerous professional and health care organizations have recommended routine screening of women for IPV in primary care settings. However, various systematic reviews of the literature have not found evidence for the effectiveness of screening to improve outcomes for women exposed to IPV.

A recent expert panel recommended that a randomized controlled trial (RCT) be conducted to establish the effectiveness of screening on women's health. In order to appropriately design a RCT, estimates of health change are required to calculate the sample size for the RCT, and consequently, establish its cost. In addition, the feasibility, acceptability, and impact of different approaches to screening and the concordance of different data collection methods need to be assessed to adequately design the RCT.

CDC has a contract to pilot test measures and procedures that are being proposed for a RCT of routine screening of IPV. This pilot test will recruit 175 women from OBGYN and family planning services in Cook County Hospital in Chicago. Women who agree to participate will be asked to complete a baseline computer-assisted and one week follow-up telephone questionnaire that will include overall health, physical and mental health, disability, health care utilization, and quality of life (QOL). Based on this pilot test, the measure will be revised and used in a RCT with 3000 women to test the impact of screening on health and QOL. There are no costs to respondents other than their time to participate in the survey.

ESTIMATED ANNUALIZED BURDEN HOURS

Form	Number of respondents	Number of responses per respondents	Avg. burden/ response (in hours)	Total burden (hours)
Screener for Pilot	210	1	1/60	4
Pilot Health and QOL questionnaire	175	2	20/60	117
Screener for Final Pilot	3750	1	1/60	63