others were available in July 2010. The Office of the Assistant Secretary of Preparedness and Response (ASPR) within the Department of Health and Human Services (HHS) is submitting this document for public consideration as the lead agency in a broad interagency process to draft the implementation plan.

DATES: The public is encouraged to submit written comments on this proposed document. Comments may be submitted to HHS/ASPR in electronic form at the HHS/ASPR e-mail address and URL shown below. All comments should be submitted by April 18, 2011. All written comments received in response to this notice will be available for review by request. This document is available in hard-copy for all those that request it from the federal point of contact.

FOR FURTHER INFORMATION CONTACT: Lisa Kaplowitz, Deputy Assistant Secretary, Office of Policy and Planning, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC 20201; phone: 202–205–2882; *http://www.phe.gov/nhss;* e-mail address: *nhss@hhs.gov.*

SUPPLEMENTARY INFORMATION:

The *National Health Security Strategy (2009)* can be found at: *http://www.phe.gov/Preparedness/planning/authority/nhss/Pages/default.aspx.*

Dated: March 28, 2011.

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

[30 Day–11–11BP]

Agency Forms Undergoing Paperwork Reduction Act Review

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) 639–5960 or send an e-mail to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Community-based Organization (CBO) Monitoring and Evaluation Project (CMEP) of Women Involved in Life Learning from Other Women (WILLOW)—New—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

Background and Brief Description

CDC began formally partnering with CBOs in the late 1980s to expand the reach of HIV prevention efforts. CBOs were, and continue to be, recognized as important partners in HIV prevention because of their history and credibility with target populations and their access to groups that may not be easily reached. Over time, CDC's program for HIV prevention by CBOs has grown in size, scope, and complexity to respond to changes in the epidemic, including the diffusion and implementation of Effective Behavioral Interventions (EBIs) for HIV prevention. Women Involved in Life Learning from Other Women (WILLOW) is an EBI that focuses on health education and social skills building among women living with HIV.

CDC's EBIs have been shown to be effective under controlled research environments, but there is limited data on intervention implementation and client outcomes in real-world settings (as implemented by CDC-funded CBOs). The purpose of CMEP is to improve the performance of CDC-funded CBOs delivering particular individual- or group-level behavioral interventions. This is done by monitoring changes in clients' self-reported HIV transmission risk behaviors after participating in the intervention. CMEP also assesses the fidelity of the implementation of the selected intervention at the CBO. The project also plans to conduct process monitoring of the delivery of the intervention in terms of recruitment, retention, and data collection, entry, and management. Four CBOs will receive supplemental funding under PS 10–1003 over a five-year period to participate in CMEP–WILLOW.

From July 1, 2011 to June 30, 2015, CBOs will conduct outcome and process monitoring for this project. Each agency will recruit 400 women living with HIV who are 18 years of age and older, have known their positive HIV status for at least 6 months, and are enrolled in the WILLOW intervention to participate in CMEP–WILLOW. Each participant will complete a 20 minute, self administered, computer based interview prior to their participation in the WILLOW intervention and an 18 minute, self administered, computer based interview at two follow-up time points (90- and 180-days following the WILLOW intervention) to assess their HIV-related attitudes and behavioral risks. CBOs will be expected to retain 80% of these participants at both follow-up interviews.

Throughout the project, funded CBOs will be responsible for managing the daily procedures of CMEP–WILLOW to ensure that all required activities are performed, all deadlines are met, and quality assurance plans, policies and procedures are upheld. CBOs will be responsible for participating in all CDC-sponsored grantee meetings related to CMEP–WILLOW. The total estimated annual burden hours are 338.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondent	Form	Number of respondents	Number of responses per respondent	Average burden response (in hours)
General population	Screener	400	1	2/60
General population	Baseline Interview	400	1	20/60
General population	90-Day Follow-Up Interview	320	1	18/60
General population	180-Day Follow-Up Interview	320	1	18/60

Daniel Holcomb,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2011–7888 Filed 4–1–11; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-11–11DT]

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 or 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

Monitoring Outcomes of the Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project-New-National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The scope of the HIV epidemic in the United States is significant, particularly in large urban areas where HIV/AIDS cases are concentrated. In 2006, approximately 56,000 new HIV infections occurred in the U.S., demonstrating the need to expand targeted HIV prevention efforts. In 2010, twelve U.S. metropolitan statistical areas (MSAs) received funding, through their city and state health departments, to conduct the Enhanced Comprehensive HIV Prevention Planning (ECHPP) project. These twelve MSAs (Atlanta, GA; Baltimore, MD; Chicago, IL; Dallas, TX; District of Columbia; Houston, TX; Los Angeles, CA; Miami, FL; New York City, NY; Philadelphia, PA; San Francisco, CA; and San Juan, PR) had the highest AIDS prevalence rates in the U.S. at the end of 2007, representing 44% of all U.S. AIDS cases. The purpose of ECHPP is to enhance existing HIV prevention services in these high prevalence areas and provide an optimal mix of evidence-based behavioral, biomedical, and structural interventions to have maximum impact on the HIV/AIDS epidemic at the community level. ECHPP goals are consistent with CDC's Division of HIV/AIDS Prevention Strategic Plan for HIV Prevention and with the National HIV/AIDS Strategy: (1) Prevent new HIV infections, (2) increase linkage to, and impact of, prevention and care services for HIV-positive individuals, and (3) reduce HIV-related health disparities.

To evaluate ECHPP, data will be collected through both existing CDC data sources and through new data collection activities. Existing CDC data sources will include HIV surveillance systems (*e.g.,* National HIV Behavioral Surveillance System, Medical Monitoring Project) that routinely collect information about behavioral and clinical outcomes from at-risk target populations in the 12 MSAs. A new data collection activity is proposed through this project to collect information about behavioral and clinical outcomes from injection drug users, high-risk heterosexuals, and HIV-positive individuals who access medical care in six of the 12 ECHPP-funded MSAs. These MSAs are: District of Columbia; Houston, TX; Los Angeles, CA; Miami, FL; New York City, NY; and San Francisco, CA. The purpose of this new data collection activity is to monitor community-level outcomes of ECHPP and supplement HIV surveillance data routinely collected in these areas. Outcome data will be collected in these MSAs at two time points from 2011 to 2014.

Two surveys will be used in this project: (1) A community-based survey to be administered to injection drug users and high-risk heterosexuals, and (2) a clinic-based survey to be administered to HIV-positive individuals seeking care at clinics that provide HIV-related services. Both surveys will collect data on demographics, sexual behavior, alcohol and drug use history, HIV testing experiences, exposure to HIV prevention messages, and participation in HIV prevention activities. The clinic survey will also include questions about HIV treatment, treatment adherence, sources of care, and medical outcomes. For the community survey, we intend to recruit and screen 1500 injection drug users and 1500 high-risk heterosexuals using venue-based, convenience sampling methods. For the clinic survey, we intend to recruit and screen 2400 HIV-positive individuals seeking HIV care at medical clinics. A total of 1200 eligible injection drug users (age ≥ 18 yrs), 1200 eligible high-risk heterosexuals (age 18 to 60 yrs), and 2400 eligible HIV-positive individuals (age ≥ 18 yrs) will be surveyed. CDC will collaborate with local health department staff and outreach workers in each MSA to identify venues and clinics appropriate for data collection. Surveys will be administered by trained, local interviewers. There is no cost to respondents other than their time.

ESTIMATE OF ANNUALIZED BURDEN TABLE

Target population	Data collection form	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Injection drug users	Community Screener	500	1	5/60	42
Eligible injection drug users	Community Survey	400	1	25/60	167
High-risk heterosexual individuals	Community Screener	500	1	5/60	42
Eligible high-risk heterosexual individuals	Community Survey	400	1	25/60	167
HIV-positive individuals	Clinic Screener	933	1	5/60	78