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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-11–10FB]

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 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Developing a Sexual Consent Norms Instrument—New—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Sexual violence prevention strategies are increasingly focusing on promoting positive behavioral norms such as safety, equality and respect in relationships. However, psychometrically validated measures do not exist for programs to use in evaluating their strategies. This project provides an opportunity to significantly contribute to the literature base and fill a gap in evaluation tools by developing a measure specific to consent norms for use in three populations: College students, late adolescents (ages 15–18) and early adolescents (ages 11–14). Sound measures of sexual consent norms will improve program evaluation efforts and potentially contribute to understanding of effective prevention strategies as well as the etiology of sexual violence perpetration.

The development of these measures will occur in four phases. All phases will consist of Asian, Black or African American, Hispanic or Latino and White students. Phase one will consist of multiple two-hour focus groups of 8–10 participants: 1 with prevention educators, 8 with college students, 8 with late adolescents (ages 15–18) and 8 with early adolescents (ages 11–14). Samples of college students and adolescents will include Asian, Black or African American, Hispanic or Latino, and White students. Half of the college student focus groups will be conducted with students who grew up in the United States; the other half will be conducted with students who came to the United States within the last five years. Focus group participants will be asked to comment on the proposed instruments relevant to their group. Prevention educators will comment on all three instruments. Comments will be used to refine the measures.

In phase two, 200 college students and 100 adolescents will complete the revised instrument appropriate to age group, plus a set of existing instruments that assess related variables, using online data collection methods.

Phase three will consist of multiple two-hour focus groups of 8–10 participants: 2 with prevention educators, 1 with college students, 1 with late adolescents (ages 15–18) and 1 with early adolescents (ages 11–14). Half of the college student focus groups will be conducted with students who grew up in the United States; the other half will be conducted with students who came to the United States in the last five years. All focus group participants will be asked to comment on data collected with the revised instruments in their age group. Prevention educators will be asked to comment on data from all age groups. Comments will be used to refine the instrument again, before administering it to larger samples.

In phase four, the refined instruments plus a set of existing instruments that assess related variables will be administered to 500 adolescents (200 early and 200 late). Data collection will occur via an online survey. These data will be used to examine the psychometric properties of the new instruments.

Findings will be used to demonstrate the adequacy of new instruments for use in racially and ethnically diverse populations of college student and adolescents by sexual assault prevention programs funded through the Rape Prevention and Education Program. There is no cost to respondents other than their time. The total estimated annual burden hours are 3005.

ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Average burden per response (hours)
Phase I: Focus Group of Prevention Educators	10	1	3
Phase I: Focus Group of College Students	80	1	2.5
Phase I: Focus Group of Late Adolescents	80	1	3
Phase I: Focus Group of Early Adolescents	80	1	3
Phase II: College Student Survey	200	1	2
Phase II: Late Adolescent Survey	50	1	2
Phase II: Early Adolescent Survey	50	1	1
Phase III: Follow-up Focus Group of Prevention Educators	20	1	3
Phase III: Follow-up Focus Group of College Students	10	1	2.5
Phase III: Follow-up Focus Group of Late Adolescents	10	1	3
Phase III: Follow-up Focus Group of Early Adolescents	10	1	3
Phase IV: Confirmatory Survey of College Students	500	1	2
Phase IV: Confirmatory Survey of Late Adolescents	200	1	2
Phase IV: Confirmatory Survey of Early Adolescents	200	1	1

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Carol E. Walker,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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[30Day–11–11AC]

Agency Forms Undergoing Paperwork Reduction Act Review

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Proposed Project

Using Traditional Foods and Sustainable Ecological Approaches for Health Promotion and Diabetes Prevention in American Indian/Alaska Native Communities—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Type 2 Diabetes was rare among American Indians until the 1950s. Since that time, diabetes has become one of the most common and serious illnesses among American Indians and Alaska Natives (AI/AN). From 1994 to 2004, the age-adjusted prevalence of diagnosed diabetes doubled (from 8.5 to 17.1 per 1,000 population) among AI/ANs less than 35 years of age who used Indian Health Service healthcare services. However, dietary management and physical activity can help to prevent or control Type 2 diabetes.

In 2008, the CDC's Native Diabetes Wellness Program (NDWP), in consultation with American Indian/Alaska Native Tribal elders, issued a cooperative agreement entitled, "Using Traditional Foods and Sustainable Ecological Approaches for Health Promotion and Diabetes Prevention in American Indian/Alaska Native Communities." The Traditional Foods program seeks to build on what is known about traditional ways in order to inform culturally relevant, contemporary approaches to diabetes prevention for AI/AN communities. The program supports activities that enhance or re-introduce indigenous foods and practices drawn from each awardee's landscape, history, and culture. Example activities include the cultivation of community gardens, organization of local farmers' markets, and the dissemination of culturally appropriate health messages through storytelling, audio and video recordings, and printed materials.

CDC requests OMB approval to collect standardized information, called Traditional Foods Shared Data Elements (SDE), from awardees over a three-year period. The SDE will be organized in three domains: Traditional Local Healthy Foods, Physical Activity, and Social Support for Healthy Lifestyle Change and Maintenance. Since each awardee currently maintains activity data for local program improvement, reporting summary information to CDC in SDE format is not expected to entail significant burden to respondents.

The SDE will allow CDC to compile a systematic, quantifiable inventory of activities, products, and outcomes associated with the Traditional Foods program. The SDE will also allow CDC to analyze aggregate data for improved technical assistance and overall program evaluation, reporting, and identification of outcomes; allow CDC and awardees to create a comprehensive inventory/resource library of diabetes primary prevention ideas and approaches for AI/AN communities and identify emerging best practices; and improve dissemination of success stories. The annual Spring SDE submission will supplement the narrative progress report that awardees submit to CDC as part of the annual continuation application for funding. An additional SDE collection will be conducted annually in the Fall.

Respondents will be 17 Tribes and Tribal organizations that receive funding through the Traditional Foods program. The estimated burden per response is two hours. The SDE will be reported using a Web-based survey interface. The total estimated burden for routine, semi-annual information collection is 68 hours.

CDC also requests OMB approval to conduct one additional cycle of retrospective data collection during the first year of the three-year information collection request. The retrospective information collection will provide baseline SDE information about awardee activities that occurred in FY2010, which is needed for comparison purposes and optimal overall program evaluation. Inclusion of the retrospective data will enable CDC and awardees to have a clearer, more quantifiable view of the growth of Traditional Foods activities over the five-year funding cycle for the cooperative agreement. The estimated annualized burden for the one-time retrospective data collection is 12 hours.

There are no costs to respondents other than their time. The total estimated annualized burden hours are 80.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avg. burden per response (in hrs)
AI/AN Tribal Awardees	Traditional Foods Shared Data Elements	17	2	2
	One-Time Retrospective Data Collection	6	1	2