WORKPLAN TEMPLATE—Continued

Goal					
Objectives	Activities	Measures of effectiveness	Data	Timeframe for assessing progress	Team members responsible

Workplan—Definition of Terms

Goals

Goals are general, ''big picture'' statements of outcomes a program intends to accomplish to fulfill its mission.

Objectives

Objectives are the ''big steps'' a program will take to attain its goals. Objectives should be S.M.A.R.T. (specific, measurable, achievable, realistic, and time-phased).

Activities

Activities are the ''smaller steps'' a program takes to meet its objectives. Examples include reviewing data and research, identifying resources and staff for program implementation and evaluation, creating Public Service Announcements about screening recommendations, and health provider training about screening technology.

Measures of Effectiveness

Measures of effectiveness, or indicators, translate program concepts and expected impacts into specific measures that can be analyzed and interpreted. There should be at least one measure of effectiveness for each objective. The change measured by an indicator should represent progress a program has made toward achieving goals and objectives.

Examples of indicators include: participation rates, individual behavior, health status, and attitude. Success in achieving the goal of maintaining coalition partnerships could be measured by analyzing participation rates or the number of members at the beginning, throughout and near the end of plan implementation. An increase (or decrease/no change) in participation rate indicates level of progress toward meeting the goal.

Data

Data is a list of sources that will be used to gather information on measures of effectiveness. Data sources may include: People, observations and documents. Examples of data sources include: Behavioral Risk Factor Surveillance System (BRFSS), Surveillance, Epidemiology, and End Results (SEER), needs and satisfaction assessments, program records and reports, cancer registries, interviews, focus groups, and medical claims data.

Attachment D—References for Centers for Disease Control and Prevention RFA AA030, Colorectal Cancer Screening Demonstration Program

1. American Cancer Society. Cancer Facts and Figures, 2005. Atlanta, Georgia: American Cancer Society, 2005 (publication no. 5008.05).

2. Mandel JS, Bond JH, Church TR, Snover DC, Bradley GM, Schuman LM, Ederer F. Reducing mortality from colorectal cancer by screening for fecal occult blood. Minnesota Colon Cancer Control Study. N Engl J Med 1993;328:1365–71.

3. Mandel JS, Church TR, Bond JH, *et al.* The effect of fecal occult-blood screening on the incidence of colorectal cancer. N Engl J Med 2000;343:1603–7.

4. Selby JV, Friedman GD, Quesenberry CP Jr, Weiss NS. A case-control study of screening sigmoidoscopy and mortality from colorectal cancer. N Engl J Med 1992; 326:653–657.

5. Hardcastle JD, Chamberlain JO, Robinson MH, et al. Randomised controlled trial of faecal-occult-blood screening for colorectal cancer. Lancet 1996; 348:1472–1477.

6. Kronborg O, Fenger C, Olsen J, Jorgensen OD, Sondergaard. Randomised study of screening for colorectal cancer with faecal-occult-blood test. Lancet 1996; 348:1467–1471.

7. Seeff LC, Nadel MR, Klabunde C, Thompson T, Shapiro JA, Vernon SW, Coates RJ. Patterns and Predictors of Colorectal Cancer Test Use in the Adult U.S. Population. Cancer 2004;100:2093–103.

[FR Doc. 05–10296 Filed 5–23–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Request for Applications (RFA) 05075]

Expansion and Support of HIV/AIDS/STI/TB Information, Education, and Communication and Behavioral Change Communication Activities in Ethiopia—Amendment

A notice announcing the availability of fiscal year (FY) 2005 funds for Expansion and Support of HIV/AIDS/STI/TB Information, Education, and Communication and Behavioral Change Communication Activities in Ethiopia was published in the **Federal Register** on Tuesday, May 3, 2005, Volume 70, Number 84, pages 22875–22881. The notice is amended as follows:

Replace the current language, starting in the second column on page 22879 through the first column of page 22880, regarding Prostitution and Related Activities with the following:

• Prostitution and Related Activities.

The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons.

Any entity that receives, directly or indirectly, U.S. Government funds in connection with this document (''recipient'') cannot use such U.S. Government funds to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides. A recipient that is otherwise eligible to receive funds in connection with this document to prevent, treat, or monitor HIV/AIDS shall not be required to endorse or utilize a multisectoral approach to combating HIV/AIDS, or to endorse, utilize, or participate in a prevention method or treatment program to which the recipient has a religious or moral objection. Any information provided by recipients about the use of condoms as part of projects or activities that are funded in connection with this document shall be medically accurate and shall include the public health benefits and failure rates of such use.

In addition, any recipient must have a policy explicitly opposing prostitution and sex trafficking. The preceding sentence shall not apply to any ''exempt organizations'' (defined as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, the International AIDS Vaccine Initiative or to any United Nations agency).

The following definition applies for purposes of this clause:

• Sex trafficking means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. 22 U.S.C. 7102(9).

All recipients must insert provisions implementing the applicable parts of

this section, ''Prostitution and Related Activities,'' in all sub-agreements under this award. These provisions must be express terms and conditions of the sub-agreement, must acknowledge that compliance with this section, ''Prostitution and Related Activities,'' is a prerequisite to receipt and expenditure of U.S. government funds in connection with this document, and must acknowledge that any violation of the provisions shall be grounds for unilateral termination of the agreement prior to the end of its term. Recipients must agree that HHS may, at any reasonable time, inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that relate to the organization's compliance with this section, ''Prostitution and Related Activities.''

All prime recipients receiving U.S. Government funds (''prime recipients'') in connection with this document must certify compliance prior to actual receipt of such funds in a written statement referencing this document (*e.g.*, ''[Prime recipient's name] certifies compliance with the section, 'Prostitution and Related Activities.' '') addressed to the agency's grants officer. Such certifications by prime recipients are prerequisites to the payment of any U.S. Government funds in connection with this document.

Recipients' compliance with this section, ''Prostitution and Related Activities,'' is an express term and condition of receiving U.S. government funds in connection with this document, and any violation of it shall be grounds for unilateral termination by HHS of the agreement with HHS in connection with this document prior to the end of its term. The recipient shall refund to HHS the entire amount furnished in connection with this document in the event it is determined by HHS that the recipient has not complied with this section, ''Prostitution and Related Activities.''

Dated: May 18, 2005.

William P. Nichols,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Health Promotion and Diabetes Prevention Projects for American Indian/Alaska Native (AI/AN) Communities: Adaptations of Practical Community Environmental Indicators

Announcement Type: New.

Funding Opportunity Number: RFA AA029.

Catalog of Federal Domestic Assistance Number: 93.945.

Key Dates: Letter of Intent Deadline (LOI): June 23, 2005.

Application Deadline: July 8, 2005.

I. Funding Opportunity Description

Authority: Public Health Service (PHS) Act, as amended, sections 317(k)(2), 42 U.S.C. 247b(k)(2).

Background

Type 2 diabetes was rare among American Indians until the 1950s, so uncommon that some scientists believed that indigenous people might have some type of immunity to it. In the past 50 years, diabetes has become one of the most common and serious illnesses among American Indians and Alaska Natives (AI/AN). In 2002, the age-adjusted prevalence of diabetes was 15.3 percent among AI/AN adults, in contrast to seven point three percent for the overall U.S. population (August 1, 2003, MMWR). If not controlled over time, diabetes can damage every organ in the body, diminishing the quality and the length of life. The explanations for high rates of diabetes among indigenous North American peoples, however, are not limited to recent societal trends, environmental changes and deliberate lifestyle choices. They are rooted in historical legacies of forced dispossession of their lands, culture, and language. Understanding and acknowledging the complex array of factors involved in diabetes causation and care are important steps in addressing this disease. Culturally-sensitive, community-based prevention interventions, coupled with committed tribal leadership and aggressive clinical programs for risk reduction, are most likely to succeed in stabilizing and eventually reducing the rates of chronic disease in Native communities. Many communities are developing, implementing and evaluating such ecological prevention approaches, which recognize the history, cultural and environmental contributions to high rates of diabetes. These approaches include multiple individual, family, community, and policy interventions that are expected to have positive impact for current and future generations. Multi-level, broad-spectrum approaches to the prevention of diabetes take time to yield results, and can be challenging to sustain the engagement of communities over time.

However, limited practical environmental prevention interventions for diabetes on a community level may have some unique benefits. These benefits may include supplementing multi-level programs by creating an environment supportive of the broader, long-term approaches. Limited practical environmental interventions may also help garner the community's interest in identifying opportunities for environmental adaptations and tracking the progress of community indicators. Incremental progress in improving environmental indicators identified by the community as contributing risk factors for diabetes can have several positive results. For example, they may help to increase community knowledge, confidence in health practices and dispel hopelessness about the devastating impacts of diabetes. Such approaches maintain momentum toward steady progress in identified community health goals and/or health promotion activities.

This program will provide support for community-based and culturally appropriate practical environmental interventions for health promotion and diabetes prevention. These interventions will target practical environmental indicators identified by the community as contributing to risk factors for diabetes. The projects will collaborate with existing local diabetes programs and other community organizations (*e.g.,* schools, supermarkets, restaurants). The interventions will focus on environmental factors that can be adapted and measured by community-level indicators. These indicators can reflect behavioral, policy, or practice adaptations by the community and/or its members. The indicators do not involve evaluation of individual behavior or outcomes and do not require human subject approvals.

The prevention interventions proposed (environmental adaptations) to be implemented by the communities can be measured in various ways. For example, by economic means (*e.g.,* purchase rates of foods), environmental (*e.g.,* increased number of walking paths, increased use of fitness facilities, use of pedometers at pow-wows/community dances) or process measures (*e.g.,* school menus meeting nutritional