

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control and Prevention**

[60Day-03-103]

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 the CDC Reports Clearance Officer on (404) 498-1210.

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. Send comments to Anne O'Connor, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project: Building Capacity to Fluoridate—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Since the first fluoridation of a public water system in Grand Rapids, Michigan in 1945, fluoridation of community water supplies has dramatically reduced the prevalence of dental caries in the United States. Scientific evidence compiled over nearly six decades demonstrates that adjusting the fluoride concentration of public water systems is a safe, cost-effective, and equitable intervention that benefits everyone in a given community regardless of financial status.

The percentage of the U.S. population living in areas with fluoridated water grew steadily from 1945 to the mid-1970s. Adoption of fluoridation is ultimately a choice made by community decision makers and often is put before the public for vote as a referendum. In spite of survey findings that roughly 70 percent of the U.S. population favors fluoridation, referenda since the 1980's have often resulted in community

decisions not to fluoridate. Thus, the rate of increase in access to fluoridated water among those on public water systems has slowed. In 2000, 65.8 percent of this population had access to fluoridated water, still far short of the 75 percent fluoridation target set in both the *Healthy People 2000* and *2010 objectives*.

The purpose of this research is to identify and describe the variables that influence community fluoridation decisions made by public vote and provide enhanced knowledge that may be useful to communities considering fluoridation.

In-person interviews will be conducted with seven (7) to 13 (thirteen) key players in fluoridation referendum campaigns at eight (8) sites where fluoridation has been rejected or accepted within the last three years. Key participants in the campaigns will vary slightly by site. We expect, however, these participants to include:

- State or local health department staff
- Campaign directors
- Local elected officials
- Outside political consultants
- Grassroots leaders
- Media representatives

A total of 80 interviews will be conducted. The interviews will consist of approximately 30 questions and last 1½ hours. There are no costs to the respondents.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)	Total burden (in hrs.)
Key participants in local fluoridation referendum campaigns	80	1	90/60	120

Dated: July 31, 2003.

Thomas A. Bartenfeld,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention.

[FR Doc. 03-19978 Filed 8-5-03; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control and Prevention**

[60Day-03-104]

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on respondents, including through the use of automated collection techniques or other forms of information technology. Send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project: Lessons Learned from Emergency Medical Responses to Chemically-Contaminated Patients—New—Agency for Toxic Substances and Disease Registry (ATSDR). Since the September 11, 2001, World Trade Center Attack, there has been increased interest in improving medical preparedness for contaminated casualties. Anecdotal evidence and observations from non-chemical disasters suggests that medical planning may be based on some assumptions that

are invalid. For example, planning is often based on the following assumptions: (1) That victims will be decontaminated by first responders on the scene; (2) that victims will be transported by ambulances that can be directed to a hospital designated for contaminated casualties; and (3) that hospitals will receive advance notice that casualties will be arriving, so that special preparations can be made to receive them (e.g., lining floors and walls with plastic tarps; donning respirators and chemical resistant clothing).

We propose assessing 10 incidents over a three-year period involving patients treated at hospitals for actual or possible contamination by chemicals

which could pose a threat of illness or injury to the hospital staff that treat them. Data will be collected not only from hospitals but from other emergency medical and public safety organizations, and even members of the public who have become involved in the response. This is because the actions of these groups can have a profound effect on how hospitals carry out their emergency tasks. The lessons-learned during these responses will be collected by a field research team using semi-structured, open-ended interviews of those involved in the responses, for example: patients and their families, hospital staff, police, firefighters, emergency medical technicians,

emergency dispatchers, and others who have knowledge of the response.

Certain standardized data will also be collected, such as: number of victims, chemical identity, distribution of casualties among area hospitals, time of incident, time of hospital notification, type of protective clothing and respiratory protection used by hospital staff. A review of the existing field disaster research literature has failed to identify other studies that have collected this type of information. The results of the project will be used to develop and update training materials for hospitals and other emergency responders. There are no costs to respondents.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Emergency Responders	100	2	1	200
Patients and/or Family	40	2	1	80
Total				280

Dated: July 31, 2003.

Thomas A. Bartenfeld,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention.

[FR Doc. 03-19979 Filed 8-5-03; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-60-03]

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. 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: Assessment of Exposure to Arsenic through Household Water, OMB No. 0920-0472—Revision—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background

Arsenic is a naturally occurring element present in food and water as both organic and inorganic complexes. Epidemiologic evidence shows a strong link between ingestion of water containing inorganic arsenic and an increase in certain cancers (e.g., bladder cancer, lung cancer). Although consumption of arsenic-contaminated food is the major source of arsenic exposure for the majority of U.S. citizens, in some areas of the United States, elevated levels of arsenic occur frequently in water. In such areas, ingestion of water can be the primary source of arsenic exposure.

Currently, point-of-use (POU) devices are the preferred method of treatment of private domestic well water containing elevated levels of arsenic. Bottled water and POU treatment systems are considered effective means of managing arsenic exposure based on the

assumption that people's other water exposures, such as bathing, brushing of teeth, cooking, and drinking occasionally from other taps, contribute relatively minor amounts to a person's total daily intake of arsenic.

We propose to conduct a study to methodically test the validity of the commonly made assumption that secondary water exposures, such as bathing, will not result in a significant increase in arsenic exposure above background dietary levels. Specifically, we are interested in assessing total urine arsenic levels and levels of organic and inorganic arsenic species among people in areas in which ingestion of arsenic-containing water is controlled by either POU treatment or use of bottled water.

Potential participants who are interested in being part of the study will be interviewed by telephone. Recruited participants will be asked to participate in a survey interview about potential exposures to arsenic. Participants in the study will use short-term diaries to record diet, water consumption, and bathing frequency. In addition, we will assess long-term arsenic exposure by analyzing toenail samples for total arsenic.

The total annualized burden hours are estimated to be 2,689.