

teen and adult influencers nationally and in specified cities. Marketing efforts have been implemented in selected cities, and the campaign planners will continue to evaluate which strategies are most effective in local markets.

The Media Benchmark Survey is used to assess target audience awareness and

understanding of the campaign. The data collection is a random digit dial (RDD) telephone survey of tweens. Continuous tracking of awareness of the brand and the advertising messages are standard tools in advertising and marketing. The commitment of

resources to the campaign's marketing efforts mandates that campaign planners be able to respond quickly to changes needed in message execution or delivery as is standard practice in the advertising industry. The annualized burden for this data collection is 2,301 hours.

Respondent	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Media Benchmark Survey:			
Screeners	3,585	1	1/60
Parent	325	1	2/60
Child	325	1	12/60
Continuous Tracking Survey:			
Screeners	29,076	1	1/60
Parent	7,200	1	2/60
Child	7,200	1	12/60

Dated: February 13, 2004.

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Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-04-27]

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: Weekly Morbidity and Mortality Reports and Annual Morbidity Series, OMB No. 0920-0007—Extension—Epidemiology Program Office (EPO), Centers for Disease Control and Prevention (CDC).

Background

In 1878, Congress authorized the U.S. Marine Hospital Service (later renamed the U.S. Public Health Service (PHS) to

collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was to be used for instituting quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, a specific Congressional appropriation was made for the collection and publication of reports of these notifiable diseases. Congress expanded the authority for weekly reporting and publication in 1893 to include data from state and municipal authorities throughout the United States. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General of the Public Health Service (PHS) to provide forms for the collection and compilation of data and for the publication of reports at the national level.

Reports on notifiable diseases were received from very few states and cities prior to 1900, but gradually more states submitted monthly and annual summaries. In 1912, state and territorial health authorities—in conjunction with PHS—recommended immediate telegraphic reports of five diseases and monthly reporting by letter of 10 additional diseases, but it was not until after 1925 that all states reported regularly. In 1942, the collection, compilation, and publication of morbidity statistics, under the direction of the Division of Sanitary Reports and Statistics, PHS, was transferred to the Division of Public Health Methods, PHS.

A PHS study in 1948 led to a revision of the morbidity reporting procedures, and in 1949 morbidity reporting activities were transferred to the National Office of Vital Statistics. Another committee in PHS presented a

revised plan to the Association of State and Territorial Health Officers (ASTHO) at its meeting in Washington, DC, October 1950. ASTHO authorized a Conference of State and Territorial Epidemiologists (CSTE) for the purpose of determining the diseases that should be reported by the states to PHS. Beginning in 1951, national meetings of CSTE were held every two years until 1974, then annually thereafter.

In 1961, responsibility for the collection of data on nationally notifiable diseases and deaths in 122 U.S. cities was transferred from the National Office of Vital Statistics to CDC. For 37 years the Morbidity and Mortality Weekly Report (MMWR) has consistently served as CDC premier communication channel for disease outbreaks and trends in health and health behavior. In collaboration with the Council of State and Territorial Epidemiologists (CSTE), CDC has demonstrated the efficiency and effectiveness of computer transmission of data. The data collected electronically for publication in the MMWR provides information which CDC and State epidemiologists use to detail and more effectively interrupt outbreaks. Reporting also provides the timely information needed to measure and demonstrate the impact of changed immunization laws or a new therapeutic measure. Users of data include, but are not limited to, congressional offices, state and local health agencies, health care providers, and other health related groups. The dissemination of public health information is accomplished through the MMWR series of publications. The publications consist of the MMWR, the CDC Surveillance Summaries, the Recommendations and Reports, and the Annual Summary of

Notifiable Diseases. The estimated annualized burden is 4927 hours.

Type of respondents	Number of respondents	Frequency of response	Average time per response (in hours)	Annual hour burden (in hours)
Weekly Morbidity Report Respondent Burden				
States	50	52	1	2600
Territories	5	52	1@1 4@ 30/60	156
Cities	2	52	1	104
Subtotals	57		2860
CDC 43.5 Weekly Mortality Report Respondent Burden				
City health officers or Vital statistics registrars	122	52	12/60	1269
Annual Summary Respondent Burden				
States	50	1	14	700
Territories	5	1	14	70
Cities	2	1	14	28
Subtotals		798
Totals	179		4927

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Alvin Hall,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-29-04]

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: Building Capacity to Fluoridate: Key Informant Interviews to Understand Community Water Fluoridation—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 7 to 13 key participants in fluoridation referendum campaigns at 8 sites where fluoridation has been rejected or accepted within the last three years. Key participants in the campaigns will vary slightly by site. A total of 80 interviews will be conducted. The expected participants will include:

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

The estimated annualized burden is 140 hours.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)
Respondent Screening	43	1	10/60
Political Professionals	16	1	100/60
Civic and Grassroots Leaders	16	1	100/60