of the project is to use existing knowledge of diabetes risk factors and complications to implement community level interventions to reduce the prevalence and severity of diabetes in communities with large African American populations. A community in Raleigh, North Carolina was selected as the demonstration site for the project. An area in Greensboro, North Carolina was identified as a suitable comparison community. CDC, Division of Diabetes Translation (DDT) is collaborating with the state of North Carolina to implement and evaluate public health strategies for reducing the burden of diabetes in this predominantly African American community.

Project DIRECT has three distinct intervention components—Health Promotion, Outreach, and Diabetes Care. The goals of all three interventions are to reduce or prevent diabetes and its complications, but each has a different but complimentary approach. In 1996–1997, Project DIRECT implemented a baseline population-based survey. Interventions have been employed since then and continue to the present. A follow-up study is now required to evaluate the impact of the multilevel approach to diabetes prevention and control. Data from this project will be critical to CDC on-going efforts to reduce the burden of diabetes, and to determine whether a similar program could be implemented successfully in other communities. A pre-post design was selected for the evaluation to determine if any changes observed from these outcomes might be attributed to the interventions used in Project DIRECT by comparing changes in the intervention and comparison communities. The baseline study for the pre-post evaluation was conducted during 1996–1997.

In Phase 2, households in the Raleigh and Greensboro communities will be selected at random using mailing lists. An interviewer will verify the address and do an initial screening for eligible participants in the household. Eligible participants will be asked to participate in the study and will have to complete a consent form. All participants will be asked to complete an interview on their health status and lifestyle and will be measured for height and weight. Participants who self-report a history of diabetes will be asked additional questions (diabetes module) about their management of diabetes and its complications and other related health conditions.

All participants who self-report a history of diabetes and a sub-sample of those without diabetes will be invited to participate in a household examination that will include blood pressure and waist circumference measurement and a blood draw for laboratory analysis including glucose and lipids concentrations. For quality control purposes, a small sample of participants will be asked to do a short telephone interview to verify information collected during the general interview. The estimated annualized burden for this data collection is 3,946 hours.

Form	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Screening Form	4,587	1	5/60
Consent Form	3,136	1	5/60
General Population Questionnaire	3,136	1	40/60
Diabetes Module	773	1	20/60
Household Exam, Consent Forms and HIPPA Authorization	1,854	1	30/60
Verification Questionnaire	314	1	5/60

Dated: January 14, 2004.

Alvin Hall,

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–21–04]

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: Work Organization Predictors of Depression in Women—New—The National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background

Depression is a costly and debilitating occupational health problem. Research has indicated that the costs to an organization of treatment for depression can rival those for heart disease, and both major depressive disorder and forms of minor depression have been found to be associated with more disability days than other types of health diagnoses. This may be of particular relevance for working women. Various national and international studies indicate that women in developed countries experience depression at up to twice the rate of men. Studies that have examined this gender difference have focused on social, personality, and genetic explanations while few have explored factors in the workplace that may contribute to the gender differential.

Examples of workplace factors that may contribute to depression among women include: Additive workplace and home responsibilities, lack of control and authority, and low paying and low status jobs. Additionally, women are much more likely to face various types of discrimination in the workplace than men, ranging from harassment to inequalities in hiring and promotional opportunities, and these types of stressors have been strongly linked with psychological distress and other negative health outcomes. On the positive side, organizations that are judged by their employees to value diversity and employee development engender lower levels of employee stress, and those that enforce policies against discrimination have more committed employees. Such organizational practices and policies may be beneficial for employee mental

health, particularly the mental health of women. This research will focus on the following questions: (1) Which work organization factors are most predictive of depression in women, and (2) are there measurable work organization factors that confer protection against depression in women employees.

The research will use repeated measures, and a prospective design with data collection at three points (baseline and 1-year and 2-year follow-ups). A 45 minute survey will be administered by telephone to 2500 newly employed women and men at different organizations. The survey will contain questions about (1) traditional job stressors (*e.g.*, changes in workload, social support, work roles); (2) stressors not traditionally examined, but may be linked with depressive symptoms among women (*e.g.*, roles and responsibilities outside of the workplace, discrimination, career issues); (3) depression symptoms; and (4) company policies, programs, and practices. One Human Resource (HR) representative at each company will also be surveyed about company policies, programs and practices. This survey will take approximately 20 minutes. Analyses will determine which work organization factors are linked with depressive symptoms and what effect the organizational practices/policies of interest have on depression. Findings from this prospective study will also help target future intervention efforts to reduce occupationally-related depression in women workers. This request is for three years. The estimated annualized burden for this data collection is 1,892 hours.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Worker Survey	2,500	3	45/60
HR Survey	50	3	20/60

Dated: January 13, 2004.

Alvin Hall,

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

Foreign Quarantine

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of embargo of civets (Family: Viverridae).

SUMMARY: According to published scientific articles, Severe Acute Respiratory Syndrome (SARS)-like virus has been isolated from civets (Family: Viverridae) captured in areas of China where the 2002–2003 SARS outbreak originated. Shipments of civets are being imported into the United States and further distributed. CDC is banning the importation of all civets immediately and until further notice. CDC is taking this action to prevent the importation and spread of SARS, a communicable disease.

DATES: This embargo is effective on January 13, 2004, and will remain in effect until further notice.

FOR FURTHER INFORMATION CONTACT: Paul Arguin, National Center for Infectious Diseases, Centers for Disease Control and Prevention, Mailstop C–14, 1600 Clifton Rd., Atlanta, GA 30030, telephone 404–498–1600.

SUPPLEMENTARY INFORMATION:

Background

Severe Acute Respiratory Syndrome (SARS) is a viral respiratory illness caused by a coronavirus, called SARS-associated coronavirus (SARS-CoV). In general, SARS begins with a high fever (temperature greater than 100.4F (>38.0°C)). Other symptoms may include headache, an overall feeling of discomfort, and body aches. Some people also have mild respiratory symptoms at the outset. About 10 percent to 20 percent of patients have diarrhea. After 2 to 7 days, SARS patients may develop a dry cough. Most patients develop pneumonia. The case-fatality rate among persons with illness is approximately 10%.

The main way that SARS seems to spread is by close person-to-person contact. The virus that causes SARS is thought to be transmitted most readily by respiratory droplets (droplet spread) produced when an infected person coughs or sneezes. Droplet spread can happen when droplets from the cough or sneeze of an infected person are propelled a short distance (generally up to 3 feet) through the air and deposited on the mucous membranes of the mouth, nose, or eyes of persons who are nearby. The virus also can spread when a person touches a surface or object contaminated with infectious droplets and then touches his or her mouth, nose, or eye(s). In addition, it is possible that the SARS virus might spread more broadly through the air (airborne spread) or by other ways that are not now known.

At this time, there is no known effective treatment for SARS.

Public Health Risks

SARS was first reported in Asia in February 2003. Over the next few months, the illness spread to more than two dozen countries in North America, South America, Europe, and Asia. According to the World Health Organization (WHO), during the SARS outbreak of 2003, a total of 8,098 people worldwide became sick with SARS; of these, 774 died. In the United States, there were a total of 192 cases of SARS among people, using the 2003 WHO case definitions of ''probable'' and ''suspect,'' all of whom recovered. Eight of these cases were subsequently laboratory confirmed as SARS-CoV.

Public health officials worldwide commonly used isolation and quarantine measures to control the outbreak. In the United States, some states exercised their legal authorities to compel isolation of suspect cases. On April 4, 2003, the President added SARS to the list of diseases for which the federal government could isolate or quarantine individuals, though use of this federal authority never became necessary.

The SARS global outbreak of 2003 was contained after extraordinary global effort that focused on reducing contact with infected individuals. Subsequently, there have been 2 laboratory acquired cases of SARS, one in Taiwan and one in Singapore; however, on January 5, 2004 the government of China and the World Health Organization confirmed the first non-laboratory-acquired case of SARS infection in a human since the initial