

**AMENDMENT II (03/23/2011):**

*1. Pages 71-75 - Questions and Answers from the Pre-Application Workshop*

**AMENDMENT I (03/01/2011):**

*1. Page 65 - Added language:*

*Pre-Application Workshops*

*CDC South Africa will host three pre-application workshops, as follows:*

- *Johannesburg: March 9, 2011*
- *Durban: March 10, 2011*
- *Cape Town: March 11, 2011*

*Applicants should contact Carlos Toledo ([ToledoC@sa.cdc.gov](mailto:ToledoC@sa.cdc.gov)) regarding time, venue, and registration details.*

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)**

Centers for Disease Control and Prevention (CDC)

**Planning, Implementation and Evaluation of Comprehensive HIV Prevention  
Programs in the Republic of South Africa under the President's Emergency Plan for  
AIDS Relief (PEPFAR)**

**I. AUTHORIZATION AND INTENT**

**Announcement Type:** New

**Funding Opportunity Number:** CDC-RFA-GH11-1152

**Catalog of Federal Domestic Assistance Number:** 93.067

**Key Dates:**

**Application Deadline Date:** April 18, 2011, 5:00pm U.S. Eastern Standard Time

**Authority:**

This program is authorized under Public Law 108-25 (the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003) [22 U.S.C. 7601, et seq.] and Public Law 110-293 (the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008).

**Background:**

The President's Emergency Plan for AIDS Relief (PEPFAR) has called for immediate, comprehensive and evidence based action to turn the tide of global HIV/AIDS. As called for by the PEPFAR Reauthorization Act of 2008, initiative goals over the period of 2009 through 2013 are to treat at least three million HIV infected people with effective combination anti-retroviral therapy (ART); care for twelve million HIV infected and affected persons, including five million orphans and vulnerable children; and prevent twelve million infections worldwide (3,12,12). To meet these goals and build sustainable local capacity, PEPFAR will support training of at least 140,000 new health care workers in HIV/AIDS prevention, treatment and care. The Emergency Plan *Five-Year Strategy* for the five year period, 2009 - 2014 is available at the following Internet address:

<http://www.pepfar.gov>.

**Purpose:**

Under the leadership of the U.S. Global AIDS Coordinator, as part of the President's Emergency Plan, the U.S. Department of Health and Human Services' Centers for

Disease Control and Prevention (HHS/CDC) works with host countries and other key partners to assess the needs of each country and design a customized program of assistance that fits within the host nation's strategic plan and partnership framework.

HHS/CDC focuses primarily on two or three major program areas in each country. Goals and priorities include the following:

- Achieving primary prevention of HIV infection through activities such as expanding confidential counseling and testing programs linked with evidence based behavioral change and building programs to reduce mother-to-child transmission;
- Improving the care and treatment of HIV/AIDS, sexually transmitted infections (STIs) and related opportunistic infections by improving STI management; enhancing laboratory diagnostic capacity and the care and treatment of opportunistic infections; interventions for intercurrent diseases impacting HIV infected patients including tuberculosis (TB); and initiating programs to provide anti-retroviral therapy (ART);
- Strengthening the capacity of countries to collect and use surveillance data and manage national HIV/AIDS programs by expanding HIV/STI/TB surveillance programs and strengthening laboratory support for surveillance, diagnosis, treatment, disease monitoring and HIV screening for blood safety.
- Developing, validating and/or evaluating public health programs to inform, improve and target appropriate interventions, as related to the prevention, care and treatment of HIV/AIDS, TB and opportunistic infections.

In an effort to ensure maximum cost efficiencies and program effectiveness, HHS/CDC also supports coordination with and among partners and integration of activities that promote Global Health Initiative principles. As such, grantees may be requested to participate in programmatic activities that include the following activities:

- Implement a woman- and girl-centered approach;
- Increase impact through strategic coordination and integration;
- Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement;
- Encourage country ownership and invest in country-led plans;
- Build sustainability through investments in health systems;
- Improve metrics, monitoring and evaluation; and
- Promote research, development and innovation.

The purpose of this program is to develop, implement, and evaluate comprehensive HIV prevention programs in South Africa. The successful applicant(s) of this award will work with the South African Government HIV/AIDS structures at district, provincial, and national levels as well as other partners, and will provide programmatic and technical assistance accordingly. In some cases financial support through sub-grants to partners, including government, may be provided to achieve program goals.

The overall goal of this program is to reduce the number of new HIV infections in target geographic areas within South Africa by:

- Promoting knowledge of one's sero-status and actively and safely facilitating mutual disclosure to sexual partners and appropriate household members;
- Promoting safer sexual behaviors and sexual norms;
- Working with communities to determine the best strategies to reduce the number of multiple concurrent sexual partners;
- Promoting consistent and correct condom use with any sexual partner who is living with HIV/AIDS or whose sero-status is not known;
- Promoting prevention with positives (PwP) programs;
- Counseling and providing referrals to safe medical male circumcision (MMC) services;
- Working with health facilities to improve diagnosis and treatment of sexually transmitted infections;
- Integrating new effective technologies and innovative HIV-prevention interventions if found to be efficacious during project period; and
- Depending on funding availability and programmatic needs, adding other HIV prevention services in subsequent years.

Measurable outcomes of the program will be in alignment with the following performance goal(s):

1. Within six months of the beginning of the award period, complete an assessment to determine the local situation, including program gaps and needs for linkages between programs. This assessment may include enumeration exercises to determine an accurate size of the population targeted.

2. Within six months of the beginning of the award period, the grantee should develop an implementation plan to reach the target population with HIV prevention interventions. The plan should set annual targets to eventually meet the overall goal of reaching 80% of the targeted population with HIV prevention interventions. The plan should also include a logic framework with associated program activities, targets, and outcomes to reach the 80% goal..
3. Within six months of the beginning of the award period, the grantee should ensure appropriate and up-to-date training of program staff. This may include development of a training program and provision of training to members from the targeted community to provide HIV prevention interventions, or linkage to existing training mechanisms in the community. Training of staff and community members will be an ongoing activity, as needed.
4. Within six months of the beginning of the award period, the grantee should develop an ongoing monitoring system to assure quality of program and service delivery. The monitoring system should include reporting requirements, tools, and systems to ensure quality assurance
5. Conduct ongoing program evaluation that measures HIV prevention indicators (measures may be amended as reporting requirements change; grantees may collect additional information for programmatic purposes), including:
  - Proportion of people receiving HIV testing and counseling to learn their serostatus, as well as that of their partner(s);
  - Proportion of people reached with comprehensive behavioral HIV prevention information and education to:

- Increase knowledge of HIV risks and transmission;
  - Delay initiation of sex;
  - Increase condom use;
  - Decrease number of sexual partners;
  - Decrease number of sexual partners of sero-discordant status;
  - Disclose serostatus;
  - Decrease alcohol-associated sexual risk behaviors; and
  - Decrease cross-generational sex.
- Number of men referred and linked to MMC services;
- Proportion of people living with HIV/AIDS receiving a minimum package of Prevention with Positive services, including services for serodiscordant couples;
- Proportion of eligible persons referred and linked to sexually transmitted infection (STI) prevention and treatment;
- Proportion of eligible persons referred and linked to substance abuse treatment;
- Proportion of eligible persons referred and linked to other medical and social services;
- Proportion of eligible persons referred and linked to prevention of mother to child transmission (PMTCT);
- Number of people reached with an individual, small group or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS;

- Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS.

This announcement is only for non-research activities supported by the Centers for Disease Control and Prevention within HHS (HHS/CDC). If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address:

<http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>.

## **II. PROGRAM IMPLEMENTATION**

### **Recipient Activities:**

Partners receiving HHS/CDC funding must place a clear emphasis on developing local indigenous capacity to deliver HIV/AIDS related services to the South African population and must also coordinate with activities supported by South African, international or USG agencies to avoid duplication. Partners receiving HHS/CDC funding must collaborate across program areas whenever appropriate or necessary to improve service delivery.

The selected applicant(s) of these funds is responsible for activities in multiple program areas.

The grantee will implement activities both directly and, where applicable, through sub-grantees; the grantee will, however, retain overall financial and programmatic management under the oversight of HHS/CDC and the strategic direction of the Office of the U.S. Global AIDS Coordinator. The grantee must show measurable progressive reinforcement of the capacity of health facilities to respond to the national HIV epidemic as well as progress towards the sustainability of activities.

Applicants should describe activities in detail that reflect the policies and goals outlined in the *Five-Year Strategy* for the President's Emergency Plan and the Partnership Framework for South Africa. The grantee will produce an annual operational plan, which the U.S. Government Emergency Plan team on the ground in South Africa will review as part of the annual Emergency Plan review-and-approval process managed by the Office of the U.S. Global AIDS Coordinator.

The grantee may work on some of the activities listed below in the first year and in subsequent years, and then progressively add others from the list to achieve all of the Emergency Plan performance goals as cited in the previous section. HHS/CDC, under the guidance of the U.S. Global AIDS Coordinator, will approve funds for activities on an annual basis, based on availability of funding and USG priorities, and based on documented performance toward achieving Emergency Plan goals, as part of the annual Emergency Plan for AIDS Relief Country Operational Plan review-and-approval process.

Grantee activities for this program are as follows:

The program will collaborate and integrate activities with orphans and vulnerable children (OVC), Most-At-Risk-Populations (MARPs), Prevention of Mother to Child HIV Transmission (PMTCT), care and treatment, and blood safety programs being implemented in the geographic area(s).

Applicants are expected to propose activities in targeted geographic areas within one or more of South Africa's nine provinces (when appropriate, target geographic areas should include the South African Government's 18 priority health districts). **Applicants must submit a separate application for the province they intend to implement or work in and can receive funding to work in no more than 3 provinces.**

Applicants are expected to respond to one or more of the following provinces:

- Eastern Cape
- Free State
- Gauteng
- Kwa Zulu-Natal
- Limpopo
- Mpumalanga
- North West
- Northern Cape
- Western Cape

In addition to the program narrative the applicant must include a separate budget for each proposed province and in form SF 424 item number 14, the applicant should state the province they are applying to work in. Failure to indicate the area of work will make the application non-responsive. Applicants should consider linkages between the various program areas within their application, either by proposing to provide linked services or by proposing to ensure linkages to existing services not specifically provided by the applicant.

It is expected that extreme care will be taken to have a strong evidence-based and theoretical foundation upon which to base project activities. Each recipient is expected to maintain adequate staff capacity to provide excellent services and technical assistance to partners. This capacity should include prevention or behavior professionals with a strong academic and theoretical grounding in developing, implementing and evaluating HIV prevention strategies.

The following principles will guide the implementation of this program:

- Multi-sectoral and multi-level approaches to increase involvement and participation of all potential stakeholders and actors;
- Mainstreaming and integration of activities to facilitate comprehensive and multi-pronged approaches to assure a continuum of social, health, and HIV/AIDS services;

- Establishing partnerships and common approaches to eliminate fragmentation and duplication of efforts while emphasizing delivery of common messages and utilization of all existing systems for wider coverage;
- Evidence-based approaches that take into account dynamics of the epidemic and contexts of sub-population groups;
- Quality assurance informed by central policy guidelines and standards;
- Accelerating HIV/AIDS prevention in the context of universal access to prevention, treatment, care and services; and
- Promoting human rights, equity and gender equality.

Approaches to HIV prevention include a combination of behavioral, biomedical, and structural components.

- *Biomedical interventions*, such as male circumcision, use medical approaches to block infection, decrease infectiousness, or reduce infection risk. The treatment or intervention often acts as the platform for a larger prevention message. For example, PEPFAR's male circumcision package not only provides the actual circumcision procedure, but includes a package of prevention interventions, including risk reduction counseling and outreach to the sexual partner of the man being circumcised.
- *Behavioral interventions* include a range of approaches that address key behavioral outcomes, including delay of sexual debut, partner reduction, mutual monogamy, and correct and consistent use of condoms. Approaches are geared to motivate positive behavioral change in individuals, couples, families, peer groups

or networks, institutions, and communities. These science-based, culturally- and age-appropriate interventions promote sustained behavior change through different, mutually-reinforcing program components. For example, mass media, community mobilization and interpersonal communication efforts are used in concert to encourage individuals, families, and communities to adopt and maintain healthy behaviors and norms.

- *Structural interventions* acknowledge that an individual's risk of HIV infection is in part governed by social, cultural, political, and economic norms. These interventions aim to change the larger societal, political, and economic contexts which can contribute to vulnerability and risk. For example, gender-based violence (GBV) has been linked to increased risk for HIV. Structural interventions targeting this risk include legal and policy changes that criminalize gender-based violence and result in increased awareness, reporting, and enforcement of penalties for those who engage in gender-based violence.

To respond to all of these issues in the context of a generalized epidemic, it is essential to apply a combination of activities that reach targeted geographic areas with tailored HIV prevention interventions and access to services. Activities for this program are as follows:

### **Situational Assessment and Prioritization**

1. Characterize the local epidemic and determine appropriate populations to target for interventions. Use available HIV incidence, prevalence, behavioral and epidemiological data to help determine the appropriate balance between prevention

- activities among different age groups and target populations as well as to tailor the response to meet the needs of the community. This assessment should include an accurate enumeration of the size of the target population.
2. Identify the social and structural factors that may increase HIV risk or vulnerability, such as population mobility, cross-generational and/or transactional sex.
  3. Identify opportunities to empower women and engage men to address harmful gender norms that increase risk.
  4. Address alcohol and other substance use/abuse, how they influence sexual behavior and the settings in which they are prevalent.
  5. Address HIV-positive individuals and couples in sero-discordant relationships.
  6. Establish close collaborative relationships with CDC, local, Provincial and National Departments of Health, as well as PEPFAR and non-PEPFAR funded partners to:
    - Identify program's target geographic area(s) based on epidemiological priorities of South Africa;
    - Determine what services are available in target geographic area(s) (e.g., HIV counseling and testing, medical male circumcision, HIV treatment),
    - Identify service gaps; and
    - Assess linkages between services.
  7. Establish linkages with the private sector to leverage private sector successes.

### **Intervention Planning**

The grantee(s) should develop a plan to ensure coverage of the target geographic area with comprehensive HIV prevention services that include biomedical, behavioral and structural strategies (activities should be informed by current epidemiologic data from target area[s]):

1. Develop theory- and evidence-based models, or programs adapted from these models. Programs should address relevant risk and protective factors and be able to link specific activities to the achievement of specific behavioral objectives; maximize the application of promising practices to support program impact in instances where evidence-based models do not exist.
2. Develop a program logic model that clearly identifies theoretical framework, intervention goals, activities, and anticipated outcomes. Link activities to clear behavior change objectives. Activities should provide individuals with the relevant motivation and skills needed to adopt safer behaviors rather than solely focusing on improving knowledge or awareness of HIV. Proposed activities should seek to extend beyond single contacts with key target groups and beneficiaries, to support an ongoing structured implementation approach that delivers an effective intervention.
3. Programs should also address social norms and other elements of the social and policy environment which facilitate the spread of HIV. Activities should recognize that the direct beneficiaries of intervention efforts often should not be the sole targets of those efforts and that efforts to engage leaders, peers, family members, local organizations, and the media may be essential to facilitate the widespread adoption and maintenance of safer behaviors.

4. Combination prevention should not only focus on individual susceptibility and risk but also on societal factors that affect individual risk and vulnerability.  
  
Structural interventions may include efforts to reduce harmful gender norms, make school environments safer for girls, improve educational opportunities for girls, and increase property and other legal rights for women.  
  
Define approaches to ensure linkages to care and treatment, and HIV prevention services not included in program, such as medical male circumcision.  
  
Establish standard operating procedure for training, which may be led in-house or outsourced to existing local programs, that includes materials, tools and protocols to assist in implementation of the prevention interventions and linkages to other services.
5. Design systematic monitoring and evaluation of services, linkages and referrals.
6. If applicable, develop protocol to assess cost-effectiveness of program activities.

#### **Ongoing Implementation Support**

1. Participate in inter-agency and governmental technical consultations and ensure close coordination with other USG- and non-USG supported initiatives to ensure there is no duplication.
2. Support and participate in the development, implementation, and review of provincial/district plans to foster ownership and sustainability of HIV prevention activities.

3. Advise on appropriate logistical support to ensure uninterrupted availability of supplies required for the combination prevention services for supported sites.
4. Provide quarterly report from monitoring and evaluation systems, including plans for strengthening program and overall effectiveness of program implementation.
5. Build capacity of local organizations and government to monitor, evaluate and use results for continuous program improvement.
6. Document and share lessons learned from HIV prevention program implementation in regional and national forums and workshops.

### **Intervention Implementation**

Grantees will implement a clearly defined program model that provides a strong, coordinated effort to maximize coverage and linkages to other services. Proposed programs may include a variety of community and work-place settings, and may include correctional settings. The following priority biomedical, behavioral and structural interventions may be included in the comprehensive approach (applicants should specify the target populations (i.e., youth, general population) for each proposed intervention):

1. ***HIV counseling and testing (HCT)***: HCT is the gateway to HIV prevention, care, and treatment services because some of the most effective prevention interventions rely on knowledge of HIV serostatus. HCT services may be proposed for individuals, couples, and families, with particular emphasis on identifying HIV infected individuals and HIV serodiscordant couples. All HCT services must utilize voluntary informed consent, and should provide individuals with tailored risk assessment and risk reduction plans. Because it serves as an entry point for other HIV services, HCT

programs must be especially diligent and innovative in terms of integration and/or linkages to other services based on test results, especially in settings where HCT is not integrated into a health facility. Applicants should incorporate a strategic mix of HCT service delivery models, which are outlined below.

- Provider-initiated HIV counseling and testing (PICT): PICT occurs when healthcare providers recommend HIV testing as a standard component of medical care. PICT typically occurs in a health facility setting.
- Client-initiated HIV counseling testing (CICT): CICT occurs when individuals, couples, or families actively seek HCT in any setting where these services are available.
- Stand-alone HCT sites: Free-standing HCT sites are typically associated with a CICT approach and are venues traditionally known for offering HCT. As HCT has been scaled-up, alternative settings such as health facilities, mobile clinics, outreach sites, and homes (described below) have been identified to increase access to HCT services. While free-standing sites can be important settings for persons to access HCT services, their impact and coverage should be weighed against alternative approaches and settings to ensure cost-effectiveness.
- Outreach or mobile HCT: Outreach or mobile HCT services may target entire communities or specific high-risk populations. Typically, advance community mobilization including networking with local leaders is necessary to ensure successful uptake of any outreach or mobile HCT services. Outreach HCT may occur through the use of mobile vans, tents, or other means in rural

communities, busy urban centers including train or bus stations, workplaces, educational facilities, correctional institutions including prisons, and in an array of other sites. HCT providers deployed to outreach or mobile services should have knowledge and skills to respond to the unique characteristics of the populations targeted. Linkage to follow-up services from outreach or mobile HCT can be quite challenging, therefore ensuring linkages from the testing site to surrounding health facilities or prevention services should be a primary focus of any mobile or outreach HCT program.

- Home-based HCT (HBCT): HBCT brings HCT services directly to individual households and may be effective for identifying HIV-infected individuals, serodiscordant couples, and large numbers of persons who have not been tested before. Households are most commonly identified through:
  - (1) “index patients” who already receive HIV or TB care and treatment and are willing to introduce HBCT to their homes; or
  - (2) door-to-door HCT in which services are proactively offered throughout a specified geographic area with high HIV prevalence, high population density and/or low rates of HIV testing.
- Couples and partners HCT: In couples HCT, couples learn their HIV test results together in the same session. Couples HCT has been shown to reduce HIV transmission, increase condom use, and reduce the frequency of sex acts with outside partners within serodiscordant couples. Couples counseling in antenatal clinics (ANC) reduces the burden of disclosure that so often falls on women tested alone, and couples HCT has also been shown to increase uptake

of ART among pregnant women tested with their partners as part of PMTCT programs. The CDC training curriculum for couples HCT is available for download at: <http://www.cdc.gov/nchstp/od/gap/CHTCintervention/>

- Adolescents: In provinces with a consistently high or increasing HIV prevalence among individuals aged 15-24, grantees should assess government laws and policies for adolescent HCT services and plan activities accordingly. Additional training may be needed for HCT service providers to adequately address the specific needs of HCT for adolescents. Some material on HCT for young people is available in *HIV Counseling and Testing for Youth: A Manual for Providers (FHI, 2007)*:

<http://www.fhi.org/en/Youth/YouthNet/rhtrainmat/vctmanual.htm>

- Rapid HIV Testing: Simple, rapid, HIV test kits that utilize whole blood samples and do not require cold chain are essential to the expansion of HTC services. Their advantages include ease of use, feasibility, and ability to provide same-hour results. Selection of appropriate rapid test kits must follow the USAID waiver list as well as the National Department of Health, South Africa rapid HIV testing quality assurance guidelines. All testers must be trained according to the National standards and guidance.

Applicants must align their proposed HCT interventions with the following NDOH documents:

- National HCT policy guidelines;
- National rapid testing quality assurance guidelines;
- National home based counseling and testing guidelines;

- National Mentorship guidelines;
  - National PICT guidelines; and
  - Couples Counseling Guidelines.
2. ***Referrals to medical male circumcision (MMC)***:MMC is an effective intervention to reduce the risk of male heterosexually acquired HIV infection. Ensuring and monitoring linkage and referrals to MMC should be included as grantee activities under this announcement; **provision of MMC services should not be included.** A separate funding opportunity announcement is available for scale-up of MMC.
  3. ***Condom and lubricant promotion and distribution***: Programs should ensure a consistent supply and availability of quality male and female condoms, as well as lubricants.
  4. ***Referral and linkages to sexually transmitted infection (STI) prevention and treatment***: Grantee activities should include referral and linkages to STI prevention and treatment, especially for HIV-positive persons and those at high risk for HIV infection.
  5. ***Behavioral Interventions***: Grantee activities should include a range of approaches that address key behavioral outcomes, including delay of sexual debut, partner reduction, mutual monogamy, and correct and consistent use of condoms. Approaches are geared to motivate positive behavioral change in individuals, couples, families, peer groups or networks, institutions, and communities. These science-based, culturally- and age-appropriate interventions promote sustained behavior change through different, mutually-reinforcing program components. Adaptations of evidence-based behavioral interventions (e.g., interventions from the Diffusion of

Behavioral Interventions project or Replicating Effective Programs project

[\[www.effectiveinterventions.org](http://www.effectiveinterventions.org)

and [www.cdc.gov/hiv/topics/prev\\_prog/rep/index.htm](http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm)]) are encouraged.

- a. *Adult/general population interventions*—Behavioral interventions for adults should focus on increasing correct and consistent condom use, reducing number of sexual partners and concurrent partnerships, and decreasing cross-generational sex. These interventions should also include, but are not limited to, providing accurate male circumcision messaging and providing referrals where appropriate, promoting HIV testing and counseling (including partner testing and disclosure), and linkage and cross referrals to injection and blood safety, Post-exposure prophylaxis (PEP) and PMTCT services, where appropriate.
- b. *Age-appropriate youth interventions*— Behavioral interventions for youth should address the needs of those sexually active and those not sexually active, as well as youth at high-risk.

For youth not sexually active, the following approaches should be considered:

- Address the delay of sexual initiation, incorporating other prevention messages when necessary.
- Support skills-based sex and AIDS education programs in schools. Efforts should be made to ensure basic standards for curricula and materials, and to improve teacher training to ensure high-quality implementation and completion of curricula.

- Work with parents and guardians to help improve connectedness and communication to youth about their values and expectations regarding adolescent behavior, as well as stressing the importance of monitoring and supervision of adolescents.
- Expand access to community-level prevention programs, including peer outreach, and curriculum-based programs for out-of-school youth.
- Support youth-oriented, mass-media and educational entertainment programs that can encourage youth to think about HIV prevention, and influence knowledge, attitudes, behaviors and norms. These efforts should be balanced with, and linked to, more targeted interpersonal communication, such that the two can provide mutually reinforcing support for behavior change.
- Provide necessary information and skills building to help youth prepare to make their eventual transition to sexual activity safer and healthier. This area of intervention needs increased attention.

Among sexually active older youth and high-risk youth, the following approaches should be considered:

- Tailor programming for older and sexually active and most-at-risk youth based on patterns of behavior and their needs.
- Develop skills and norms to promote delay of sexual initiation, secondary abstinence, mutual monogamy, and partner reduction.

Those who are sexually active should be provided with risk reduction

information and skills building, such as correct and consistent condom use.

- Support programming to engage influential adults within the community to create an enabling environment conducive to the adoption of safer sex behaviors among youth.
- Sexually-active youth should also be encouraged to learn their HIV status, and programs should provide or refer to confidential youth counseling and testing, and linkages to care for HIV-positive youth.

For all programs targeting youth, activities may include: the use of innovative strategies that resonate with youth; empowering adults in close contact with youth (parents, teachers, religious leaders) to provide a supportive environment that fosters health and safer sexual behaviors; and interventions to address social and cultural conditions that increase risk of HIV and STIs among youth and especially among young girls.

- c. *Family-based interventions*—These interventions work with the family as a unit to address sexual risk behaviors. Applicants may propose to implement the Families Matter Program (FMP), an evidence-based intervention targeting families. The goal of the FMP is to reduce sexual risk behaviors among adolescents, including early sexual debut, by giving parents and caregivers tools to deliver primary prevention messages to their children.

**6. *Prevention Interventions for people living with HIV/AIDS (PLWHA) and***

***serodiscordant couples***: HIV prevention messages and services for PLWHA should

be delivered as part of the routine services for HIV-positive persons in HIV care and treatment settings. In addition, community programs that serve individuals, couples, and families living with HIV also offer opportunities for providing and reiterating prevention messages and are important venues for provision of services. Support groups and prevention programs directly implemented by people living with HIV are well positioned to address the special needs and issues of fellow PLWHA and their partners through sharing of experiences and identification of best practices. All clinic- and community-based programs serving people living with HIV/AIDS should offer a comprehensive package of HIV prevention services on an ongoing basis, including delivery of or referral to the following:

- *HIV Testing of Sex Partners and Family Members*-- Sex partners and children of HIV-infected persons are at high risk for HIV infection. HIV testing identifies infected partners and family members in need of HIV care and treatment. As mentioned above, where possible, PLWHA should be encouraged to receive couples' HIV testing and counseling as it allows couples to learn their HIV status together and to make joint decisions on how to protect their health as individuals, as a couple, and as a family.
- *Counseling and Support of HIV Discordant Couples*. Early identification of HIV discordant couples and partnerships through routine HIV testing programs, and linkage of the HIV-infected individual into prevention, care and treatment services, represents an opportunity to prevent new infections to the negative spouse or partner(s).

- *Support of Disclosure to Sex Partners and Family Members.* Disclosure allows partners and family members to access HIV testing and counseling programs as well as care and treatment programs, if needed.
- *Safer Sex Counseling.* HIV-positive individuals should be given information about protecting their own health and the health of their partners and family members through safer sex practices including sexual abstinence, fidelity to one sex partner, reduction in multiple concurrent partnerships, and correct and consistent use of male and female condoms.
- *Alcohol Use Assessment and Counseling.* Alcohol use is associated with both increased risky sexual behavior and reduced adherence to ARVs. Health care providers and counselors should assess alcohol use in HIV-positive persons and encourage abstinence from alcohol or reduction in use. Moreover, patients with drug and alcohol problems should be linked to substance abuse treatment programs, where available.
- *Assessment and Treatment of Other Sexually Transmitted Infections.* Assessment and treatment of STIs in PLWHA is important for both care and prevention.
- *Family Planning and Safer Pregnancy Counseling.* Prevention of unintended pregnancy in HIV-positive women is an important intervention for prevention of mother-to-child transmission of HIV (PMTCT). Sexual activity tends to increase as health improves among HIV-positive persons on ART. However, women often report low rates of condom use in stable relationships.

- *Condom Distribution and Promotion.* All clinic and community-based programs should distribute condoms for all PLWHA at every encounter with a health care provider or counselor.
- *Adherence Counseling and Support.* Adherence counseling and support should be offered to both HIV-positive individuals and serodiscordant couples as anti-retroviral treatment (ART), when taken as prescribed, can significantly inhibit HIV viral load and replication, reduce the morbidity and mortality experienced by PLWHA, and reduce the risk of HIV transmission to sex partners.
- *Development and Support of Client-Driven Prevention Goals.* Encouraging PLWHA to set prevention goals, particularly in clinic and community counseling sessions, provides a concrete mechanism for PLWHA to consider their HIV prevention needs and to aim and accomplish improved prevention behaviors and care. Ongoing review of prevention goals allows for continuous preventative care tailored to the HIV-infected person's particular circumstances.

In some settings, lay counselors have been successfully placed in HIV clinics to provide ARV medication adherence as well as prevention and positive living counseling. Incorporating lay counselors, most of whom are HIV-positive, into clinic settings offers a cost-effective and supportive model for delivering prevention counseling and partner testing to HIV-positive patients in care and treatment settings. These lay counselors can reinforce prevention messages delivered by health care providers and assist patients in overcoming barriers to engaging in safer behaviors.

Where feasible, lay counselors should be sourced and trained from amongst capable and willing PLWHA and become part of the health care team.

7. ***Structural Interventions:*** Grantee activities may include interventions that aim to change the larger societal, political, and economic contexts which can contribute to vulnerability and risk. For example, gender-based violence (GBV) has been linked to increased risk for HIV. Structural interventions targeting this risk include legal and policy changes that criminalize GBV and result in increased awareness, reporting, and enforcement of penalties for those who engage in GBV. Other structural interventions that address social, cultural, political, and economic norms in a community that are linked to HIV risk may also be proposed. Grantees are encouraged to propose activities that address the following cross-cutting gender strategic areas:

- Increasing gender equity in HIV/AIDS activities and services;
- Reducing violence and coercion;
- Addressing male norms and behaviors;
- Increasing women's legal rights and protection, and
- Increasing women's access to income and productive resources.

8. ***Linkages and Referrals to substance abuse treatment:*** Substance abuse treatment reduces the frequency of drug use which in turn reduces HIV risk behaviors. It also improves adherence to disease treatment regimens. Treatment modalities include non-

pharmacological and pharmacological approaches; often, a combination of the two is used.

9. ***Linkages and referrals to other medical and social services:*** Linkages and referrals to other health, social, and legal services should be provided including family planning, primary health care as well as psycho-social and legal support. Special consideration should be given for post-exposure prophylaxis (PEP) due to increased risk of condom breakage and/or sexual violence. Service delivery models (i.e., mobile versus stationary sites, hours of operation, type of health service provider, etc.) for these core prevention interventions may need to be adapted to reach and engage targeted populations.
  
10. ***Innovative approaches to HIV prevention:*** HIV prevention research may demonstrate the efficacy of additional prevention interventions such as microbicides, pre-exposure prophylaxis, and vaccines. As research findings become available and program implementation policies are developed, grantees may propose activities that include these additional interventions.
  
11. ***Linkages and referrals to prevention of mother to child transmission (PMTCT):*** PMTCT is an effective intervention to reduce the risk of HIV transmission. Ensuring and monitoring linkages and referrals to PMTCT should be included as grantee activities under this announcement; **provision of PMTCT services should not be included.**

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

**CDC Activities:**

The selected applicant of this funding competition must comply with all HHS/CDC management requirements for meeting participation and progress and financial reporting for this cooperative agreement (See HHS/CDC Activities and Reporting sections below for details), and comply with all policy directives established by the Office of the U.S. Global AIDS Coordinator.

CDC activities for this program are as follows:

1. Organize an orientation meeting with the grantee to brief it on applicable U.S. Government, HHS, and Emergency Plan expectations, regulations and key management requirements, as well as report formats and contents. The orientation could include meetings with staff from HHS agencies and the Office of the U.S. Global AIDS Coordinator.
2. Review and make recommendations as necessary to the process used by the grantee to select key personnel and/or post-award subcontractors and/or subgrantees to be involved in the activities performed under this agreement, as part of the Emergency Plan for AIDS Relief Country Operational Plan review and approval process, managed by the Office of the U.S. Global AIDS Coordinator.
3. Review and make recommendations to the grantee's annual work plan and detailed budget, as part of the Emergency Plan for AIDS Relief Country

Operational Plan review-and-approval process, managed by the Office of the U.S. Global AIDS Coordinator.

4. Review and make recommendations to the grantee's monitoring-and-evaluation plan, including for compliance with the strategic-information guidance established by the Office of the U.S. Global AIDS Coordinator.
5. Meet with grantee on a quarterly basis, and more frequently if needed, to assess expenditures, as well as technical and financial progress reports in relation to approved work plan and modify plans, as necessary.
6. Meet on an annual basis with the grantee to review annual progress report for each U.S. Government Fiscal Year, and to review annual work plans and budgets for subsequent year, as part of the Emergency Plan for AIDS Relief review and approval process for Country Operational Plans, managed by the Office of the U.S. Global AIDS Coordinator.
7. Provide technical assistance, as mutually agreed upon, and revise annually during validation of the first and subsequent annual work plans. This could include expert technical assistance and targeted training activities in specialized areas, such as strategic information, project management, confidential counseling and testing, palliative care, treatment literacy, and adult-learning techniques.
8. Provide in-country administrative support to help grantee meet U.S. Government financial and reporting requirements approved by the Office of Management and Budget (OMB) under 0920-0428 (Public Health Service Form 5161).
9. Collaborate with the grantee on designing and implementing the activities listed above, including, but not limited to the provision of technical assistance to

develop program activities, data management and analysis, quality assurance, the presentation and possibly publication of program results and findings, and the management and tracking of finances.

10. Provide consultation and scientific and technical assistance based on appropriate, HHS/CDC and Office of the U.S. Global AIDS Coordinator documents to promote the use of best practices known at the time.
11. Assist the grantee in developing and implementing quality-assurance criteria and procedures.
12. Facilitate in-country planning and review meetings for technical assistance activities.
13. Provide technical oversight for all activities under this award.
14. Provide ethical reviews, as necessary, for evaluation activities, including from HHS/CDC headquarters.
15. Supply the grantee with protocols for related evaluations.
16. Advise on design of service delivery models and review and approve new implementation strategies when need arises.
17. Approve research/evaluation protocols including methodologies proposed.
18. Serve as Principal Investigator (PI) or co-PI along with the grantee, as appropriate, on evaluation projects.
19. Work with the awardee to facilitate the coordination of services with other CDC-funded implementers, PEPFAR and development partners, and National, Provincial, and District government entities operating in the geographic and service-delivery areas identified in this award as necessary to ensure maximum programmatic

efficiencies. This will include—but will not be limited to: assisting the awardee in selecting facility- and community-based sites; directing the awardee’s focus, support, and activities to specific geographic areas and/or facilities with identified programmatic and/or strategic need; facilitating the re-organization and/or rationalization of service-provision activities on a programmatic and/or geographic basis to better facilitate the South African Government coordination and ownership of PEPFAR-funded activities.

20. Provide relevant, appropriate guidance and technical assistance to the awardee when they develop scopes of work, subcontracts, and Terms of Reference for all technical and financial audits and assessments for monitoring and capacity building purposes.

21. Provide relevant, appropriate guidance and technical assistance to the awardee in developing scopes of work, subcontracts, and Terms of Reference for any trainings or interventions planned in response to audit or assessment findings.

22. Assist the awardee in accessing pooled procurement mechanisms for specific commodities and coordinate with the awardee to structure procurements in a way that supports linkages with national and central procurement systems.

23. Provide technical assistance to the awardee in preparing strategies related to the future expansion of service delivery activities (within the scope of this award) prior to their approval to ensure adequate collaboration with existing service-delivery organizations and avoid duplication of services.

24. Provide technical assistance to the awardee in preparing and submitting routine reporting requirements to CDC HQ by reviewing, critiquing, and providing concurrence with all reports and other required documents prior to submission.
25. Provide a designated, in-country CDC point-of-contact (Activity Manager) responsible for liaising with the awardee on a regular basis on matters related to programmatic, financial, and administrative performance. The Activity Manager will regularly review the awardee's financial performance, provide oversight and approval for programmatic activities, and make recommendations to the in-country CDC office on the continuation of the award, its supported activities, and associated funding.
26. Assist the awardee in the development of long-term capacity-development plans for the awardee and supported facilities.

Please note: Either HHS staff or staff from organizations that have successfully competed for funding under a separate HHS contract, cooperative agreement or grant will provide technical assistance and training.

### **III. AWARD INFORMATION AND REQUIREMENTS**

**Type of Award:** Cooperative Agreement.

**Award Mechanism:** U2G – Global HIV/AIDS Non-Research Cooperative Agreements

**Fiscal Year Funds:** 2011

**Approximate Current Fiscal Year Funding:** \$17,000,000

**Approximate Total Project Period Funding:** \$85,000,000 (This amount is an estimate, and is subject to availability of funds and includes direct costs for international organizations or direct and indirect costs for domestic grantees for all years.)

**Approximate Number of Awards:** 8-12

**Approximate Average Award:** \$800,000 (This amount is for the first 12 month budget period, and includes direct costs for international organizations or direct and indirect costs for domestic grantees.)

**Floor of Individual Award Range:** \$500,000

**Ceiling of Individual Award Range:** \$3,000,000 (This ceiling is for the first 12 month budget period and includes direct costs for international organizations or direct and indirect costs for domestic grantees.)

**Anticipated Award Date:** September 2011

**Budget Period Length:** 12 months

**Project Period Length:** Five years

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

#### **IV. ELIGIBILITY**

Eligible applicants that can apply for this funding opportunity are listed below:

- Nonprofit with 501C3 IRS status (other than institution of higher education)
- Nonprofit without 501C3 IRS status (other than institution of higher education)
- For-profit organizations (other than small business)

- Small, minority, and women-owned businesses
- Universities
- Colleges
- Research institutions
- Hospitals
- Community-based organizations
- Faith-based organizations
- Federally recognized or state-recognized American Indian/Alaska Native tribal governments
- State and local governments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau)
- Non-domestic (non-U.S.) entity
- Other (specify)

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a letter from the state or local government as documentation of the status is required. Attach with “Other Attachment Forms” when submitting via [www.grants.gov](http://www.grants.gov).

**SPECIAL ELIGIBILITY CRITERIA: Licensing/Credential/Permits**

Cost Sharing or Matching

Cost sharing or matching funds are not required for this program. If applicants receive funding from other sources to underwrite the same or similar activities, or anticipate receiving such funding in the next 12 months, they must detail how the disparate streams of financing complement each other.

## Maintenance of Effort

Maintenance of Effort is not required for this program.

## Other

If a funding amount greater than the ceiling of the award range is requested, the application will be considered non-responsive and will not be entered into the review process. The applicant will be notified that the application did not meet the eligibility requirements.

## **Special Requirements:**

### 1. PEPFAR Local Partner definition:

A “local partner” may be an individual or sole proprietorship, an entity, or a joint venture or other arrangement. However, to be considered a local partner in a given country served by PEPFAR, the partner must meet the criteria under paragraph (1), (2), or (3) below within that country:

(1) an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or

(2) an entity (e.g., a corporation or partnership): (a) must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved; (b) must be at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for

FY 2013 beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph or paragraph (3); (c) at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), and at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and (d) where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country; or

(3) a joint venture, unincorporated association, consortium, or other arrangement in which at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the funding under the PEPFAR award is or will be provided to members who are local partners under the criteria in paragraphs (1) or (2) above, and a local partner is designated as the managing member of the organization.

Host government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country served by the PEPFAR program are considered local partners. A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, similar to private corporations. However, ultimate control over the board may rest with the government.

2. If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified that the application did not meet submission requirements.

- Late submissions will be considered non-responsive. See section “V.3. Submission Dates and Times” for more information on deadlines.
- If the total amount of appendices includes more than 80 pages, the application will not be considered for review. For this purpose, all appendices must have page numbers and must be clearly identified in the Table of Contents.
- An HIV/AIDS related funding matrix must be submitted in order for the application to be considered for review. All applicants must indicate whether they are receiving other HIV/AIDS related funding. If the applicant is receiving or has applied for other HIV/AIDS related funding, the following information must be submitted:
  - ✓ Funding mechanism (i.e. contract, CoAg, grant)
  - ✓ Amount of award
  - ✓ Period performance
  - ✓ Funding agency
  - ✓ Contact details for funding agency
  - ✓ Brief description of program activities
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive U.S. Government funds constituting a grant, loan, or an award.

### **Intergovernmental Review of Applications**

Executive Order 12372 does not apply to this program.

## **V. APPLICATION CONTENT**

Unless specifically indicated, this announcement requires submission of the following information:

**A Project Abstract** must be completed in the Grants.gov application forms. The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information.

The abstract must be submitted in the following format:

- Maximum of 2-3 paragraphs;
- Font size: 12 point unreduced, Times New Roman;
- Single spaced;
- Paper size: 8.5 by 11 inches (preferred), or generally accepted paper size; and
- Page margin size: One inch.

**A Project Narrative** must be submitted with the application forms. The project narrative must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: 25 (If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.);
- Font size: 12 point, unreduced, Times New Roman;
- Double spaced;
- Paper size: 8.5 by 11 inches (preferred), or generally accepted paper size;
- Page margin size: One inch;
- Number all pages of the application sequentially from page one (Application Face Page) to the end of the application, including charts, figures, tables, and appendices; and
- *Project Context and Background (Understanding and Need)*: Describe the background and justify the need for the proposed project. Describe the current infrastructure system; targeted geographical area(s), if applicable; and identified gaps or shortcomings of the current health systems and AIDS control projects;
- *Project Strategy - Description and Methodologies*: Present a detailed operational plan for initiating and conducting the project. Clearly describe the applicant's technical approach/methods for implementing the proposed project. Describe the existence of, or plans to establish partnerships necessary to implement the project. Describe linkages, if appropriate, with programs funded by the U.S. Agency for International Development;
- *Project Goals and Objectives*: Describe the overall goals of the project, and specific objectives that are measurable and time phased, consistent with the objectives and numerical targets of the Emergency Plan and for this Cooperative

Agreement program as provided in the “Purpose” Section at the beginning of this Announcement;

- *Project Outputs:* Be sure to address each of the program objectives listed in the “Purpose” Section of this Announcement. Measures must be specific, objective and quantitative so as to provide meaningful outcome evaluation;
- *Project Contribution to the Goals and Objectives of the Emergency Plan:* Provide specific measures of effectiveness to demonstrate accomplishment of the objectives of this program;
- *Work Plan and Description of Project Components and Activities:* Be sure to address each of the specific tasks listed in the activities section of this announcement. Clearly identify specific assigned responsibilities for all key professional personnel;
- *Performance Measures:* Measures must be specific, objective and quantitative;
- *Timeline* (e.g., GANTT Chart); and
- *Management of Project Funds and Reporting.*

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit. **The total amount of appendices must not exceed 80 pages and can only contain information related to the following:**

- *Project Budget Justification:*  
With staffing breakdown and justification, provide a line item budget and a narrative with justification for all requested costs. Be sure to include, if any, in-kind support or other contributions provided by the national government and its

donors as part of the total project, but for which the applicant is not requesting funding.

Budgets must be consistent with the purpose, objectives of the Emergency Plan and the program activities listed in this announcement and must include the following: line item breakdown and justification for all personnel, i.e., name, position title, annual salary, percentage of time and effort, and amount requested.

The recommended guidance for completing a detailed budget justification can be found on the HHS/CDC Web site, at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

For each contract, list the following: (1) name of proposed contractor; (2) breakdown and justification for estimated costs; (3) description and scope of activities the contractor will perform; (4) period of performance; (5) method of contractor selection (e.g., competitive solicitation); and (6) methods of accountability. Applicants should, to the greatest extent possible, employ transparent and open competitive processes to choose contractors;

- *Curricula vitae* of current key staff who will work on the activity;
- *Job descriptions* of proposed key positions to be created for the activity;
- *Applicant's Corporate Capability Statement*;

- ***Letters of Support*** (5 letters maximum) *Letters of support from Department of Health from province(s) in which activities are proposed are strongly encouraged;*
- ***Evidence of Legal Organizational Structure; and***
- ***If applying as a Local Indigenous Partner***, provide documentation to self-certify the applicant meets the PEPFAR local partner definition listed in “Special Requirements,” Part IV. ELIGIBILITY section of the FOA.

Additional requirements for additional documentation with the application are listed in Section VII. Award Administration Information, subsection entitled “Administrative and National Policy Requirements.”

## **APPLICATION SUBMISSION**

Registering your organization through [www.Grants.gov](http://www.Grants.gov), the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the “Get Registered” screen of [www.Grants.gov](http://www.Grants.gov). Please visit [www.Grants.gov](http://www.Grants.gov) at least 30 days prior to submitting your application to familiarize yourself with the registration and submission processes. The “one-time” registration process will take three to five days to complete. However, the Grants.gov registration process also requires that you register your organization with the Central Contractor Registry (CCR) annually. The CCR registration can require an additional one to two days to complete.

International organizations also require a NATO CAGE Code (NCAGE). The NCAGE request may take from two business days to two weeks to complete. NCAGE is needed before registering with the Central Contractor Registry (CCR). After registering with CCR, the applicant can proceed to register with Grants.gov (See “Other Submission Requirements” session below for more information).

Submit the application electronically by using the forms and instructions posted for this funding opportunity on [www.Grants.gov](http://www.Grants.gov). If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO-TIMS) staff at (770) 488-2700 for further instruction.

***Note: Application submission is not concluded until successful completion of the validation process.***

***After submission of your application package, applicants will receive a “submission receipt” email generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, applicants are also strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.***

***In the event that you do not receive a “validation” email within two (2) business days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0 page 57.***

## **Other Submission Requirements**

A letter of intent is not applicable to this funding opportunity announcement.

**Dun and Bradstreet Universal Number (DUNS)**

The applicant is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) identifier to apply for grants or cooperative agreements from the Federal government. The DUNS is a nine-digit number which uniquely identifies business entities. There is no charge associated with obtaining a DUNS number. Applicants may obtain a DUNS number by accessing the Dun and Bradstreet website or by calling 1-866-705-5711. This is a requirement for domestic and international organizations.

**Central Contractor Registration (CCR)**

The applicant is required to have a CCR registration to apply for grants or cooperative agreements from the Federal government. For more information on CCR and how to register go to [www.ccr.gov](http://www.ccr.gov).

**Other Submission Requirement for International Organizations:**

**NATO CAGE Code (NCAGE)**

After obtaining DUNS, the applicant is required to have a NATO CAGE Code in order to apply for grants or cooperative agreements from the Federal government. Applicants can complete the request online at [www.dlis.dla.mil/forms/Form\\_AC135.asp](http://www.dlis.dla.mil/forms/Form_AC135.asp). If the organization cannot submit this form by Internet, the organization can obtain an NCAGE by contacting the National Codification Bureau of the country where the organization is located. For a list of addresses, go to [www.dlis.dla.mil/nato\\_poc.asp](http://www.dlis.dla.mil/nato_poc.asp). Please note that

NCAGE code is required for international organizations in order to register with the Central Contractor Registration (CCR) and Grants.gov.

**Electronic Submission of Application:**

Applications must be submitted electronically at [www.Grants.gov](http://www.Grants.gov). Electronic applications will be considered as having met the deadline if the application has been successfully made available to CDC for processing from Grants.gov on the deadline date.

The application package can be downloaded from [www.Grants.gov](http://www.Grants.gov). Applicants can complete the application package off-line, and then upload and submit the application via the Grants.gov Web site. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (<http://www.grants.gov>), are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when HHS/CDC receives the application. The tracking number serves to document submission and initiate the electronic validation process before the application is made available to CDC for processing.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week. The Contact Center provides customer service to the

applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by email at [support@grants.gov](mailto:support@grants.gov). Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

***Organizations that encounter technical difficulties in using [www.Grants.gov](http://www.Grants.gov) to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, [support@grants.gov](mailto:support@grants.gov)). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to PGO TIMS for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevent electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to PGO TIMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.***

***If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.***

### **Submission Dates and Times**

This announcement is the definitive guide on application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

**Application Deadline Date:** April 18, 2011, 5:00pm U.S. Eastern Standard Time

### **VI. APPLICATION REVIEW INFORMATION**

Eligible applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goals stated in the “Purpose” section of this announcement. Measures of effectiveness must be objective, quantitative and measure the intended outcome of the proposed program. The measures of effectiveness must be included in the application and will be an element of the evaluation of the submitted application.

### **Evaluation Criteria**

Applicants are expected to propose activities in targeted geographic areas within one or more of South Africa’s nine provinces (when appropriate, target geographic areas should include the South African Government’s 18 priority health districts). Applicants must submit a separate application for the province they intend to implement or work in and

can receive funding to work in no more than 3 provinces. In addition to the program narrative the applicant must include a separate budget for each proposed province and in form SF 424 item number 14, the applicant should state the province they are applying to work in. Failure to indicate the area of work will make the application non-responsive. Applicants should consider linkages between the various program areas within their application, either by proposing to provide linked services or by proposing to ensure linkages to existing services not specifically provided by the applicant.

Applicants are expected to respond to one or more of the following provinces:

- Eastern Cape
- Free State
- Gauteng
- Kwa Zulu-Natal
- Limpopo
- Mpumalanga
- North West
- Northern Cape
- Western Cape

**Eligible applications will be evaluated against the following criteria:**

**Ability to Carry Out the Proposal (20 points):**

Does the applicant demonstrate the local experience in South Africa and institutional capacity (both management and technical) to achieve the goals of the project with

documented good governance practices? (5 points) Does the applicant have the ability to coordinate and collaborate with existing Emergency Plan partners and other donors, including the Global Fund and other U.S. Government Departments and agencies involved in implementing the President's Emergency Plan, including the U.S. Agency for International Development? (10 points) Is there evidence of leadership support and evidence of current or past efforts to enhance HIV prevention? Does the applicant have the capacity to reach rural and other underserved populations in South Africa? Does the organization have the ability to target audiences that frequently fall outside the reach of the traditional media, and in local languages? (5 points) To what extent does the applicant provide letters of support?

**Technical and Programmatic Approach (20 points):**

Does the application include an overall design strategy, including measurable time lines, clear monitoring and evaluation procedures, and specific activities for meeting the proposed objectives? (5 points) Does the applicant display knowledge of the strategy, principles and goals of the President's Emergency Plan, and are the proposed activities consistent with and pertinent to that strategy and those principles and goals? (5 points) Does the applicant describe activities that are evidence based, realistic, achievable, measurable and culturally appropriate to achieve the goals of the President's Emergency Plan? (5 points) Does the application propose to build on and complement the current national response in with evidence-based strategies designed to reach underserved populations and meet the goals of the President's Emergency Plan? (5 points) Does the application include reasonable estimates of outcome targets? (For example, the numbers

of sites to be supported, number of clients the program will reach.) To what extent does the applicant propose to work with other organizations? The reviewers will assess the feasibility of the applicant's plan to meet the target goals, whether the proposed use of funds is efficient, and the extent to which the specific methods described are sensitive to the local culture.

**Capacity Building (15 points):**

Does the applicant have a proven track record of building the capacity of indigenous organizations and individuals? Does the applicant have relevant experience in using participatory methods, and approaches, in project planning and implementation? Does the applicant describe an adequate and measurable plan to progressively build the capacity of local organizations and of target beneficiaries to respond to the epidemic? (10 points) If not a local indigenous organization, does the applicant articulate a clear exit strategy which will maximize the legacy of this project in the intervention communities? Does the capacity building plan clearly describe how it will contribute to a) improved quality and geographic coverage of service delivery to achieve the "3,12,12<sup>1</sup>" targets of the President's Emergency Plan, and b) (if not a local indigenous organization) an evolving role of the prime beneficiary with transfer of critical technical and management competence to local organizations/sites in support of a decentralized response? (5 points)

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<sup>1</sup> The President's Emergency Plan for AIDS Relief (PEPFAR) has called for immediate, comprehensive and evidence based action to turn the tide of global HIV/AIDS. As called for by the PEPFAR Reauthorization Act of 2008, initiative goals over the period of 2009 through 2013 are to treat at least three million HIV infected people with effective combination anti-retroviral therapy (ART); care for twelve million HIV infected and affected persons, including five million orphans and vulnerable children; and prevent twelve million infections worldwide.

### **Monitoring and Evaluation (15 points):**

Does the applicant demonstrate the local experience and capability to implement rigorous monitoring and evaluation of the project? (5 points) Does the applicant describe a system for reviewing and adjusting program activities based on monitoring information obtained by using innovative, participatory methods and standard approaches? Does the plan include indicators developed for each program milestone, and incorporated into the financial and programmatic reports? Are the indicators consistent with the President's Emergency Plan Indicator Guide? Is the system able to generate financial and program reports to show disbursement of funds, and progress towards achieving the numerical objectives of the President's Emergency Plan? (10 points) Is the plan to measure outcomes of the intervention, and the manner in which they will be provided, adequate? Is the monitoring and evaluation plan consistent with the principles of the "Three Ones"? "Applicants must define specific output and outcome indicators must be defined in the proposal, and must have realistic targets in line with the targets addressed in the Activities section of this announcement.

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<sup>2</sup> The Emergency Plan supports the multi-sectoral national responses in host nations, adapting U.S. support to the individual needs and challenges of each nation where the Emergency Plan is at work. Countries and communities are at different stages of HIV/AIDS response and have unique drivers of HIV, distinctive social and cultural patterns (particularly with regard to the status of women), and different political and economic conditions. Effective interventions must be informed by local circumstances and coordinated with local efforts. In April 2004, OGAC, working with UNAIDS, the World Bank, and the U.K. Department for International Development (DfID), organized and co-chaired a major international conference in Washington for major donors and national partners to consider and adopt key principles for supporting coordinated country-driven action against HIV/AIDS. These principles became known as the "**Three Ones**": - **one national plan, one national coordinating authority, and one national monitoring and evaluation system** in each of the host countries in which organizations work. Rather than mandating that all contributors do the same things in the same ways, the Three Ones facilitate complementary and efficient action in support of host nations.

**Understanding of the Problem (10 points):**

Does the applicant demonstrate a clear and concise understanding of the current national HIV/AIDS response and the cultural and political context relevant to the programmatic areas targeted? (5 points) Does the applicant display an understanding of the Five-Year Strategy and goals of the President's Emergency Plan? (5 points) To what extent does the applicant justify the need for this program within the target community?

**Personnel (10 points):**

Does the organization employ staff fluent in local languages who will work on this project? Are the staff roles clearly defined? As described, will the staff be sufficient to meet the goals of the proposed project? If not an indigenous organization, does the staff plan adequately involve local individuals and organizations? Are staff involved in this project qualified to perform the tasks described? Curricula vitae provided should include information that they are qualified in the following: management of HIV/AIDS prevention activities, especially confidential, voluntary counseling and testing; and the development of capacity building among and collaboration between Governmental and non-governmental partners.

**Administration and Management (10 points):**

Does the applicant provide a clear plan for the administration and management of the proposed activities, and to manage the resources of the program, prepare reports, monitor and evaluate activities, audit expenditures and produce collect and analyze performance

data? Is the management structure for the project sufficient to ensure speedy implementation of the project? If appropriate, does the applicant have a proven track record in managing large laboratory budgets; running transparent and competitive procurement processes; supervising consultants and contractors; using subgrants or other systems of sharing resources with community based organizations, faith based organizations or smaller non-governmental organizations; and providing technical assistance in laboratory or pharmacy management? The grantee must demonstrate an ability to submit quarterly reports in a timely manner to the HHS/CDC office.

**Budget (Reviewed, but not scored):**

Is the itemized budget for conducting the project, along with justification, reasonable and consistent with stated objectives and planned program activities? Is the budget itemized, well justified and consistent with the goals of the President's Emergency Plan for AIDS Relief? If applicable, are there reasonable costs per client reached for both year one and later years of the project?

**Funding Preferences (18 points):**

In addition to direct consideration of findings from the Objective Review Panel, funding under this award will be subject to several preferences based on programmatic needs and in-country strategic priorities. **Applicants meeting the criteria set forth in these funding preferences will receive additional points beyond the possible total of 100 as follows:**

1. Local indigenous organizations with the institutional capacity to undertake the project activities, including experience in the delivery of HIV prevention services, will receive an additional **8 points**.
2. Organizations with the ability to provide human capacity-development and training in local languages for the implementation and management of HIV prevention, care, and treatment programs in resource-constrained settings will receive an additional **2 points**.
3. Organizations that demonstrate the experience or ability to collaborate with the Government of the Republic of South Africa through letters of support, MOU's, etc., will receive an additional **3 points**.
4. Organizations that have the ability to utilize relationships with local indigenous organizations and local communities to carry out advocacy and social mobilization activities, as demonstrated through letters of support, MOU's etc., will receive an additional **5 points**.

#### Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services. Recipients may purchase equipment and complete minor renovations if deemed necessary to accomplish program objectives in accordance with applicable federal law and HHS/CDC policy;

however, recipients must request prior approval by HHS/CDC officials in writing and conduct procurements in a transparent and competitive manner.

- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.
- The costs that are generally allowable in grants to domestic organizations are allowable to foreign institutions and international organizations, with the following exception: With the exception of the American University, Beirut and the World Health Organization, Indirect Costs will not be paid (either directly or through sub-award) to organizations located outside the territorial limits of the United States or to international organizations regardless of their location.
- The applicant may contract with other organizations under this program; however the applicant must perform a substantial portion of the activities (including program management and operations, and delivery of prevention services for which funds are required.)
- All requests for funds contained in the budget, shall be stated in U.S. dollars. Once an award is made, CDC will not compensate foreign grantees for currency exchange fluctuations through the issuance of supplemental awards.
- Foreign grantees are subject to audit requirements specified in 45 CFR 74.26(d). A non-Federal audit is required, if during the grantees fiscal year, the grantee expended a total of \$500,000.00 or more under one or more HHS awards (as a direct grantee and/or as a sub-grantee). The grantee either may have (1) A

financial related audit (as defined in the Government Auditing Standards, GPO stock #020-000-00-265-4) of a particular award in accordance with Government Auditing Standards, in those case where the grantee receives awards under only one HHS program; or, if awards are received under multiple HHS programs, a financial related audit of all HHS awards in accordance with Government Auditing Standards; or (2) An audit that meets the requirements contained in OMB Circular A-133.

- A fiscal Grantee Capability Assessment may be required, prior to or post award, in order to review the applicant's business management and fiscal capabilities regarding the handling of U.S. Federal funds.

The applicant can obtain guidance for completing a detailed justified budget on the CDC website, at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

### **The 8% Rule**

The President's Emergency Plan for AIDS Relief (PEPFAR) seeks to promote sustainability for programs through the development, use, and strengthening of local partnerships. The diversification of partners also ensures additional robust capacity at the local and national levels.

To achieve this goal, the Office of the Global AIDS Coordinator (OGAC) establishes an annual funding guideline for grants and cooperative agreement planning. Within each

annual PEPFAR country budget, OGAC establishes a limit for the total amount of U.S. Government funding for HIV/AIDS activities provided to a single partner organization under all grant and cooperative agreements for that country. **For U.S. Government fiscal year (FY) 2011, the limit is no more than 8 percent of the country's FY 2011 PEPFAR program funding (excluding U.S. Government management and staffing costs), or \$2 million, whichever is greater.** The total amount of funding to a partner organization includes any PEPFAR funding provided to the partner, whether directly as prime partner or indirectly as sub-grantee. In addition, subject to the exclusion for umbrella awards and drug/commodity costs discussed below, all funds provided to a prime partner, even if passed through to sub-partners, are applicable to the limit. PEPFAR funds provided to an organization under contracts are not applied to the 8 percent/\$2 million single partner ceiling. Single-partner funding limits will be determined by PEPFAR after the submission of the COP(s). Exclusions from the 8 percent/\$2 million single-partner ceiling are made for (a) umbrella awards, (b) commodity/drug costs, and (c) Government Ministries and parastatal organizations. A parastatal organization is defined as a fully or partially state-owned corporation or government agency. For umbrella awards, grants officers will determine whether an award is an umbrella for purposes of exception from the cap on an award-by-award basis. Grants or cooperative agreements in which the primary objective is for the organization to make sub-awards and at least 75 percent of the grant is used for sub-awards, with the remainder of the grant used for administrative expenses and technical assistance to sub-grantees, will be considered umbrella awards and, therefore, exempted from the cap. Agreements that merely include sub-grants as an activity in implementation of the award but do not meet

these criteria will not be considered umbrella awards, and the full amount of the award will count against the cap. All commodity/drug costs will be excluded from partners' funding for the purpose of the cap. The remaining portion of awards, including all overhead/management costs, will be counted against the cap.

Applicants should be aware that evaluation of proposals will include an assessment of grant/cooperative agreement award amounts applicable to the applicant by U.S.

Government fiscal year in the relevant country. An applicant whose grants or cooperative agreements have already met or exceeded the maximum, annual single-partner limit may submit an application in response to this RFA/APS/FOA. However, applicants whose total PEPFAR funding for this country in a U.S. Government fiscal year exceeds the 8 percent/\$2 million single partner ceiling at the time of award decision will be ineligible to receive an award under this RFA/APS/FOA unless the U.S. Global AIDS Coordinator approves an exception to the cap. **Applicants must provide in their proposals the dollar value by U.S. Government fiscal year of current grants and cooperative agreements (including sub-grants and sub-agreements) financed by the Emergency Plan, which are for programs in the country(ies) covered by this RFA/APS/FOA.**

For example, the proposal should state that the applicant has \$\_\_\_\_\_ in FY2011 grants and cooperative agreements (for as many fiscal years as applicable) in South Africa. For additional information concerning this RFA/APS/FOA, please contact the Grants Officer for this RFA/APS/FOA.

### **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 and its six Regional Offices, 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 subagreements under this award. These provisions must be express terms and conditions of the subagreement, 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 that receive 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 that makes reference to 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 HHS determines the recipient has not complied with this section, “Prostitution and Related Activities.”

*Any enforcement of this clause is subject to Alliance for Open Society International v. USAID, 05 Civ. 8209 (S.D.N.Y., orders filed on June 29, 2006 and August 8, 2008)(orders gaining preliminary injunction) for the term of the Orders.*

*The List of the members of GHC and InterAction is found at:*

*[http://www.usaid.gov/business/business\\_opportunities/cib/pdf/GlobalHealthMemberlist.pdf](http://www.usaid.gov/business/business_opportunities/cib/pdf/GlobalHealthMemberlist.pdf).*

### **Application Review Process**

All eligible applications will be initially reviewed for completeness by the Procurement and Grants Office (PGO) staff. In addition, eligible applications will be jointly reviewed for responsiveness by HHS/CDC Global AIDS Program staff and PGO. Incomplete

applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified the application did not meet eligibility and/or published submission requirements.

An objective review panel will evaluate complete and responsive applications according to the criteria listed in Section VI. Application Review Information, subsection entitled “Evaluation Criteria”. The panel may include both U.S. Federal Government and non-U.S. Federal Government participants.

### **Applications Selection Process**

Applications will be funded in order by score and rank determined by the review panel unless funding preferences or other considerations stated in the FOA apply.

The following “*Funding Preferences*” may affect the funding decision:

1. Preference will be given to local indigenous organizations with the institutional capacity to undertake the project activities, including experience in the delivery of HIV prevention services.
2. Preference will be given to organizations with the ability to provide human capacity-development and training in local languages for the implementation and management of HIV prevention, care, and treatment programs in resource-constrained settings.
3. Preference will be given to organizations that demonstrate the experience or ability to collaborate with the Government of the Republic of South Africa through letters of support, MOU’s, etc.

4. Preference will be given to organizations that have the ability to utilize relationships with local indigenous organizations and local communities to carry out advocacy and social mobilization activities, as demonstrated through letters of support, MOU's etc.

CDC will provide justification for any decision to fund out of rank order.

### **Pre-Application Workshops**

CDC South Africa will host three pre-application workshops, as follows:

- Johannesburg: March 9, 2011
- Durban: March 10, 2011
- Cape Town: March 11, 2011

Applicants should contact Carlos Toledo ([ToledoC@sa.cdc.gov](mailto:ToledoC@sa.cdc.gov)) regarding time, venue, and registration details.

## **VII. AWARD ADMINISTRATION INFORMATION**

### **Award Notices**

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the program director. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

### **Administrative and National Policy Requirements**

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. The following additional requirements apply to this project:

- AR-4 HIV/AIDS Confidentiality Provisions
- AR-6 Patient Care
- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-15 Proof of Non-Profit Status
- AR-21 Small, Minority, and Women-Owned Business
- AR-23 States and Faith-Based Organizations
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with EO13513, “Federal Leadership on Reducing Text Messaging while Driving”, October 1, 2009
- AR-30 Section 508 Compliance

Additional information on the requirements can be found on the CDC Web site at the following Internet address: [http://www.cdc.gov/od/pgo/funding/Addtl\\_Reqmnts.htm](http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm).

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address:  
<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>.

CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>.

## **TERMS AND CONDITIONS**

### Reporting Requirements

Each funded applicant must provide CDC with an annual Interim Progress Report submitted via [www.grants.gov](http://www.grants.gov):

1. The interim progress report is due no less than 90 days before the end of the budget period. The Interim Progress Report will serve as the non-competing continuation application, and must contain the following elements:
  - a. Standard Form (“SF”) 424S Form.
  - b. SF-424A Budget Information-Non-Construction Programs.
  - c. Budget Narrative.
  - d. Indirect Cost Rate Agreement.
  - e. Project Narrative.
  - f. Activities and Objectives for the Current Budget Period;

- g. Financial Progress for the Current Budget Period;
- h. Proposed Activity and Objectives for the New Budget Period Program;
- i. Budget;
- j. Measures of Effectiveness, including progress against the numerical goals of the President's Emergency Plan for AIDS Relief for South Africa; and
- k. Additional Requested Information;

Additionally, funded applicants must provide CDC with an original, plus two hard copies of the following reports:

- 2. Annual progress report, due 90 days after the end of the budget period. Reports should include progress against the numerical goals of the President's Emergency Plan for AIDS Relief for South Africa.
- 3. Financial Status Report (SF 269) due no more than 90 days after the end of the budget period.
- 4. Final performance and Financial Status Reports, no more than 90 days after the end of the project period.

These reports must be submitted to the attention of the Grants Management Specialist listed in the Section VIII below entitled “Agency Contacts”.

### **VIII. AGENCY CONTACTS**

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

Carlos Toledo, Project Officer  
Department of Health and Human Services  
Centers for Disease Control and Prevention  
Global AIDS Program—South Africa  
PO Box 9536  
Pretoria 0001  
Telephone: +27 12-424-9000 x9073  
E-mail: [ToledoC@sa.cdc.gov](mailto:ToledoC@sa.cdc.gov)

For **financial, grants management, or budget assistance**, contact:

Dionne Bounds, Grants Management Specialist  
Department of Health and Human Services  
CDC Procurement and Grants Office  
2920 Brandywine Road, MS: K-75  
Atlanta, GA 30341  
Telephone: 770-488-2082  
E-mail: [yhv5@cdc.gov](mailto:yhv5@cdc.gov)

For **assistance with submission difficulties**, contact Grants.gov (see page 47):

Phone: 1-800-518-4726  
Email: [support@grants.gov](mailto:support@grants.gov)

Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays.

For **application submission** questions, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

Email: [pgotim@cdc.gov](mailto:pgotim@cdc.gov)

CDC Telecommunications for the hearing impaired or disabled is available at:

TTY 1-888-232-6348

### **Other Information**

Other CDC funding opportunity announcements can be found on Grants.gov Web site,

Internet address: <http://www.grants.gov>.

### **QUESTIONS AND ANSWERS FROM THE PRE-APPLICATION WORKSHOP:**

#### **QUESTIONS ABOUT FOA APPLICATION PROCESS**

1. The guidance on the project abstract says that it should be 2-3 paragraphs, single-spaced. Can those paragraphs take up more than one page?  
**ANSWER:** No
2. The narrative is limited to 25 pages and the appendices are limited to 80 pages. Does that mean that the entire submission can be no longer than 105 pages, or are there other items not included in that tally? For example, the project abstract?

**ANSWER:** The total pages including all appendices cannot be more than 105 pages.

3. Can an organization already receiving funds from USG still apply to this FOA?

**ANSWER:** Yes, organizations that already receive USG funding can still apply for this FOA; however, the new award must be for a distinct scope of work from their existing funding.

4. Can an organization receiving funds from USAID apply to this FOA?

**ANSWER:** Yes, organizations that already receive USG funding can still apply for this FOA; however, the new award must be for a distinct scope of work from their existing funding.

5. Is there a limit on the number of FOAs to which one organization can apply?

**ANSWER:** There is no limit on the number of FOAs to which an organization can apply.

6. Can one organization, with offices in multiple geographic areas, apply to one FOA multiple times, each time on behalf of a different office?

**ANSWER:** If an organization meets the eligibility requirements, as stated in the FOA, they are encouraged to apply.

7. What are the definitions of research activities and non-research activities?

**ANSWER:** The CDC definition of research versus non-research can be found at the following link: <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>

The PEPFAR definition of evaluation and non-evaluation activities can be found at the following link: <http://www.pepfar.gov/strategy/ghi/134856.htm>

8. Is there a deadline by which applicants must ask questions about FOAs?

**ANSWER:** PGO can accept questions up to the last day before the submission deadline, but it will take 1-2 weeks before questions are posted online.

9. Do USG agencies coordinate their portfolios when they are funding organizations to perform similar activities?

**ANSWER:** USG agencies strive to coordinate their programs and projects to maximize impact and minimize duplication. There are several mechanisms and staff in place to encourage this coordination.

10. If an applicant has previously registered for DUNS, but address information and contacts have changed, do we need to reregister and get a new number?

**ANSWER:** For assistance with DUNS Numbers please go to: [www.grants.gov](http://www.grants.gov) or <http://fedgov.dnb.com/webform/displayHomePage.do>

11. Can we apply for an extension on the submission date?

**ANSWER:** CDC does not recommend applying for an extension.

12. Is preference given to any specific types of organizations?

**ANSWER:** Each FOA lists its specific eligibility criteria and funding preferences.

13. Can we use a South African SIC code instead of the American SIC code?

**ANSWER:** Please use only the code you find on the American OSHA Web site:  
<http://www.osha.gov/oshstats/sicscr.html>

14. Who can we contact for technical assistance with the CCR?

**ANSWER:** See [www.grants.gov](http://www.grants.gov), click the link “Register with CCR”

15. Should the line spacing on appendices be single or double?

**ANSWER:** There are no specifications for line spacing for the appendices as long as the total number of pages does not exceed 80.

16. Are funds confirmed available for the first year of the awards, or are they conditional upon USG budgets?

**ANSWER:** All awards are subject to the availability of funds.

17. There are two types of DUNS numbers – regular DUNS, and DUNS+4. Which one will applicants be assigned? Do they get to choose?

**ANSWER:** For assistance with DUNS Numbers please go to: [www.grants.gov](http://www.grants.gov) or <http://fedgov.dnb.com/webform/displayHomePage.do>

#### **QUESTIONS SPECIFIC TO CDC-RFA-GH11-1152:**

1. Do individual program referrals require Institutional Review Board (IRB) review?

**ANSWER:** Individual program referral activities should not fall under IRB review; if your organization is awarded funding you can work with your project officer/activity manager to clarify these issues.

2. Why are awardees being limited to working in a maximum of three provinces each?

**ANSWER:** This FOA aims to support comprehensive services, and by limiting the number of provinces in which an individual awardee can operate, we hope to preserve organizational capacity to provide quality services.

3. The FOA requires separate applications for each province in which activities are proposed. Does this mean that the first year award ceiling (3 million USD) applies to each individual application?

**ANSWER:** Yes. This ceiling is for the first 12 month budget period and includes direct costs for international organizations or direct and indirect costs for domestic grantees.

4. How will the PEPFAR-SA alignment process impact awardees activities?  
**ANSWER:** Many of the activities in the FOA do not fall under the current alignment process.
5. Has CDC prioritized any specific geographic areas?  
**ANSWER:** All nine provinces are open for activities; however, the FOA does specify focus on the 18 priority health districts in South Africa.
6. Does the award ceiling specified in the FOA only apply to the first year's funding?  
**ANSWER:** Yes, only the first year.
7. Does CDC have working relationships with SAG, and are awardees expected to also establish relationships with SAG?  
**ANSWER:** Yes, CDC has relationships with SAG, and yes, partners will also be responsible for establishing relationships with South African relevant government entities as detailed in the FOA.
8. Can you please elaborate on CDC's assistance to awardees in terms of accessing pooled procurement mechanisms?  
**ANSWER:** When possible, CDC/PEPFAR will work to assist awardees in accessing pooled/bulk procurement mechanisms; however, commodities cannot be guaranteed, therefore all applicants should include procurement of any commodities necessary for the project in their own budgets and work plans.
9. The title of this FOA refers to "evaluation" of prevention programs – can you elaborate on that?  
**ANSWER:** In this case, "evaluation" refers to ongoing monitoring of your program activities.
10. Do you have a requirement for training of individuals or is this strictly planning and implementation?  
**ANSWER:** The FOA specifies requirements for staff training; applicants should put together the most reasonable and accurate model for full service provision.
11. If an applicant is focused on behaviour change communications that have national coverage, are their activities still limited to only three provinces?  
**ANSWER:** Awardees may propose programs that happen to have a national reach, but they will only be funded for the portion of that activity covering the specific province in their application(s).
12. Should the application/budget only be for first year or all five?  
**ANSWER:** First year only.
13. When will we be notified if we have been awarded?  
**ANSWER:** Awardees should be notified in September 2011.

14. Can an organization submit separate applications for more than three provinces?  
**ANSWER:** Yes, organizations can submit more than three applications, but they will only be funded to perform activities in a maximum of three provinces.
15. Does this FOA support orphans and vulnerable children (OVC) activities?  
**ANSWER:** No, this FOA does not support OVC activities; however, collaboration and linkages with OVC can be proposed.
16. Timeline for implementation of program?  
**ANSWER:** Five year project period, but application(s) should only address activities in year 1.
17. There was also a CDC FOA issued to do an impact evaluation of combination HIV prevention programs – how are they linked, can one apply to both?  
**ANSWER:** The FOA reference is GH-RFA-CDC 11-1106, specifically for evaluation activities/impact evaluation, not service delivery. An organization can apply to both.
18. Can you explain about submission of separate applications for each province? We are running programs in multiple cities/provinces.  
**ANSWER:** You must separate applications if you are proposing to do activities in different provinces. Describe how your comprehensive prevention project proposed will apply for each area.
19. We already receive funding from USAID – does that make us eligible?  
**ANSWER:** Yes, you are eligible as long as the activities proposed in your application have a distinct scope of work from your existing funding.
20. We currently receive USAID funding in some provinces and in reading this FOA, it appears you are looking for a new rather than an established program. Could we propose activities in a province where we already work but in a different area?  
**ANSWER:** Yes.
21. Can we apply to other US government agencies for funding?  
**ANSWER:** Yes.
22. Is there stronger preference for some provinces or locations over others? You don't specify. Will you award more than one grantee per province?  
**ANSWER:** You can apply to do work in any of the 9 provinces, as well as the 18 priority health districts. We will award approximately 8-12 awards in total.
23. You don't seem to have any preference for types of interventions – are you looking for proposals that cover all of them, which doesn't seem feasible, or are you going to see what you get and pick the best from that?

**ANSWER:** You should submit applications for comprehensive, evidence-based prevention programs that meet the needs of the target geographic area you propose.

24. Is it possible to apply to implement a Test and Treat program?

**ANSWER:** Currently this FOA does not allow for care and treatment services. But proven, innovative approaches may be possible in future years.

25. We're an organization operating in 6 provinces, could we submit 6 applications?

**ANSWER:** Yes, but you only have the opportunity to be awarded on a maximum of three applications.

26. Is the limitation of three provinces applicable to prime partners as well as subgrantees? Can a subgrantee be awarded by multiple primes, thus covering more than 3 provinces?

**ANSWER:** The three province limit only refers to the prime partner.