

AMENDMENT I (03/28/2011):

1. Page 9: The following language has been removed from the Recipient Activities Section:

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 Uganda. The grantee will produce an annual operational plan, which the U.S. Government Emergency Plan team on the ground in Uganda will review as part of the annual Emergency Plan review-and-approval process managed by the Office of the U.S. Global AIDS Coordinator.

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

Centers for Disease Control and Prevention (CDC)

**Enhanced HIV Prevention in the Republic of Uganda under the President's
Emergency Plan for AIDS Relief (PEPFAR)**

I. AUTHORIZATION AND INTENT

Announcement Type: New

Funding Opportunity Number: CDC-RFA-GH11-1164

Catalog of Federal Domestic Assistance Number: 93.067

Key Dates:

Application Deadline Date: April 27, 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 improve the effectiveness of HIV prevention programming in Uganda by improving risk-group targeting, incorporating evidence-based prevention intervention design, delivering combination prevention packages at multiple levels, and by strengthening prevention intervention program monitoring and evaluation.

Measurable outcomes of the program will be in alignment with one (or more) of the following performance goals will be met by the end of project period:

- 1) Enhanced Prevention Plan (EPP) developed and implemented utilizing data from censuses, HIV/AIDS indicator surveys, demographic and health surveys or other

data sources to improve risk-group targeting by maximizing the use of socio-demographic and epidemiologic data related to HIV prevalence/incidence.

- a. Is an Enhanced Prevention Plan included (yes/no)
- b. Are data used from census, HIV/AIDS indicator surveys, demographic and health surveys, or other appropriate data sources to justify targeting selected population? (Yes/No)
- c. Does the selected target population have an HIV prevalence equal to or above national HIV prevalence estimates? (Yes/No)
- d. Are HIV incidence data used to justify target population (Yes/No)
 - i. Are HIV incidence data from repeat HIV testing conducted among individuals participating in longitudinal studies? (Yes/No)
 - ii. Are HIV incidence data derived from incidence assays such as BED or avidity assays? (Yes/No).

2) Develop, incorporate and strengthen theoretically grounded, evidence-based prevention interventions and increase the likelihood that evidence-based interventions will be delivered with sufficient fidelity to influence mediators, outcomes and impacts.

- a. Is the prevention intervention based upon empirical evidence supporting its effectiveness? (Supporting evidence must be provided) (Yes/No)
- b. Is there empirical evidence that the prevention intervention has been effective in reducing HIV risk in Uganda? (Supporting evidence must be provided) (Yes/No)

- c. Is the prevention intervention based upon theoretical paradigm(s) related to health behavior, social and behavioral science, biomedical/epidemiological science, or other theory related to individual-, dyadic-, organizational-, community-, structural-, or policy-level change? (Yes/No)
 - d. Are quality control measures incorporated to insure that prevention interventions are delivered with fidelity to original intervention with demonstrated effectiveness? (Yes/No)
- 3) EPP delivered to optimize risk reduction by integrating behavioral, biomedical and structural interventions that include combination prevention strategies at multiple levels.
- a. Does the prevention intervention integrate social, behavioral, biomedical, and structural activities to optimize program impact (Yes/No)
 - b. Does the prevention intervention include the delivery of appropriate combination “prevention packages” to optimize prevention effectiveness within the target populations? (Yes/No)
 - c. Does the prevention intervention deliver program components at multiple levels such as individual, dyadic, group, community, organizational, structural, and policy levels? (Yes/No)
- 4) EPP developed to include monitoring and evaluation framework which includes specific indicators, data sources and data analysis plan; implementation planning

that delineates the activities, roles and responsibilities for EPP activities and a timeline; and an integration and dissemination plan.

- a. Does the EPP include a monitoring and evaluation framework that is based upon the theoretical foundation of the prevention intervention?
(Yes/No)
- b. Do the indicators of prevention intervention effects include quantitative measures of theoretical constructs hypothesized to be related to behavioral change, reduced risk of HIV exposure, or other constructs hypothesized to be related to HIV risk reduction (e.g., mediators)?
- c. Are data systematically collected using standardized, reliable, appropriately periodic, and valid methods? (Yes/No)
- d. Do data collection methods include technology that decreases data collection burden and facilitates cost-effectiveness of data collection (e.g., computer-assisted data collection using PDAs, etc.)? (Yes/No)
- e. Is the data management plan sufficient to insure that data are secure, that confidentiality is protected, that data are of good quality, and that collection of data does not interfere with service delivery goals of the program? (Yes/No)
- f. Is the prevention program monitoring and evaluation plan sufficient to demonstrate that program delivery, changes in mediating variables, and program outcomes are consistent with expectations of effective prevention programs? (Yes/No)

- g. Does the EPP sufficiently delineate roles and responsibilities of appropriate staff for tasks related to the enhanced prevention program?
(Yes/No).
- h. Is the proposed timeline adequate for accomplishing goals proposed goals in the EPP? (Yes/No)

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/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>

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 Uganda population and must also coordinate with activities supported by Uganda, 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.

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:

An Enhanced Prevention Plan (EPP) will be developed and implemented based upon the Know Your Epidemic, Evidence Base, Know Your Response model. The EPP should be developed to enhance and improve existing HIV prevention intervention and should include specific strategies to:

1. **Improve Targeting of Populations**

Goal: To improve prevention targeting by maximizing the use of HIV prevalence and incidence data.

- a. **Socio-demographic Information** – A specific understanding of the general characteristics of the target population is important for program design, delivery, and effectiveness, and facilitates the identification of risk factors related to HIV infection. Data from censuses, HIV/AIDS indicator surveys, demographic and health surveys, program data, and other data sources that include demographic information related to a program’s catchment area should be incorporated into the EPP. These data should include age, sex, education, geographic distribution within the program catchment area, mobility, economic information, and other data that are important for the effective development and delivery of HIV prevention and treatment services.

- b. **Epidemiologic and Clinical Data** - This data should demonstrate the scope of HIV/AIDS in the target population and catchment area, should include HIV prevalence, and if possible, HIV incidence. Other biologic indicators of HIV risk should also be included in the EPP, such as, prevalence and incidence of sexually transmitted infections. Data related to AIDS cases within the catchment area can also inform and justify program activities and should be included in the EPP. Where possible, data should be presented by time to identify important temporal trends that would guide the direction of prevention programming activities. Where sufficient epidemiologic and HIV case data are not available, the EPP

should include a plan for developing and sustaining access to such data. These plans should include developing data collection activities within the context of program delivery and M&E, working with organizations supported by PEPFAR and other donors to collect and report health-related data, public health evaluations, published literature, and identifying and incorporating data from secondary sources that could inform EPP targeting.

Further considerations regarding risk group targeting and available data:

- i. Where possible, secure HCT program data from multiple sources, recent data are preferable. Existing HCT program data may provide a baseline prevalence to consider for enhanced interventions related to this FOA.
- ii. Assess and document causes for non-existent/less recent data.
- iii. Determine groups targeted for enhanced interventions. Under this FOA, the targeted groups should have a documented HIV prevalence exceeding 6%.
- iv. HIV incidence data are highly desirable for targeting prevention interventions, however, availability of these data may be lacking. HCT data for repeat testers, incidence or avidity assays conducted on existing samples, cohort derived incidence estimates, or other means of estimating incidence should be considered for optimal prevention intervention targeting and included in the Enhanced Prevention Plan.

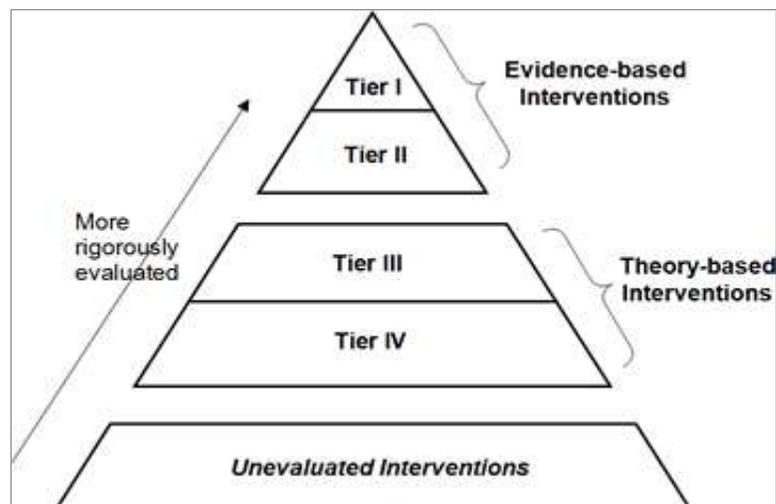
2. Strengthen Evidence-Based Intervention Design, Delivery, and Evaluation

The intent of this goal is to support programs to develop, incorporate, and strengthen theoretically grounded, evidence-based prevention interventions and to increase the likelihood that evidence-based interventions will be delivered with sufficient fidelity to influence mediators, outcomes, and impacts.

Proposals should identify where their existing prevention intervention to be enhanced by this Enhanced Prevention FOA currently falls on the Tiers of Evidence Framework (Figure 1.) More details on the Tiers of Evidence Framework can be found at:

<http://www.cdc.gov/hiv/topics/research/prs/tiers-of-evidence.htm>.

Figure 1. Tiers of Evidence Framework



If program interventions are not based upon theory or evidence-based interventions, then the EPP should include a plan for incorporating and measuring theory-based constructs at individual-, dyadic-, group-, community-, structural-, or policy-levels as appropriate for specific interventions. If prevention interventions are based upon theory and evidence, then the EPP should describe the evidence-base and include a plan for moving towards stronger evidence-based practice (moving from unevaluated interventions to Tier-I interventions) and for measuring evidence-based indicators related to outputs, mediators, moderators, outcomes,

and impacts. Where possible, evidence-based plans should strive to go beyond individual-level strategies and deliver prevention interventions at higher levels such as dyadic, group, community, structural, or policy-level interventions. Example measures for outputs, mediating variables, outcomes, and impacts related to theory-driven prevention interventions are provided in Table 1.

Table 1. Examples of potential Enhanced Prevention Program measures of outputs, mediators, outcomes, and impacts.	
Outputs	<ol style="list-style-type: none"> 1. Number/types of trainings conducted specific to evidence-based programming and delivery, number/percentage of persons trained by cadre 2. Number/type of combination intervention packages delivered. Percentage and type of combination interventions delivered by target group, geographic location, time, and other coverage variables 3. Integration of theory-based constructs/indicator measures into program delivery <ol style="list-style-type: none"> A. specific indicator(s) B. number of indicators C. frequency of collection D. method and frequency of analysis and reporting
Mediating variables	<ol style="list-style-type: none"> 1. Individual-level <ol style="list-style-type: none"> A. Behavioral intentions B. Perception of risk C. Normative perceptions D. Attitudes toward safer sex, condom use, etc. E. Perceptions of barriers F. Perception of HIV as a chronic manageable disease G. Drug/alcohol use H. Self-efficacy I. Other theoretical variables on which intervention is based 2. Dyadic-level <ol style="list-style-type: none"> A. Adherence to combination prevention components B. Disclosure of HIV status C. Communication skills D. Attitudes toward safer sex, condom use, etc. E. Partner norms F. Financial dependence G. Gender based violence, power issues H. Other theoretical variables 3. Community-level <ol style="list-style-type: none"> A. Aggregate of individual-level theoretical variables B. Aggregate of other theoretical variables on which intervention is based

	<ul style="list-style-type: none"> C. Community normative perceptions, stigmatization, etc. D. Number/percentage of target population on ART E. Community viral load <p>4. Structural-level</p> <ul style="list-style-type: none"> A. Exposure to interventions (e.g., if condoms available for free at sex trade locations) B. Increased household income <p>5. Policy-level</p> <ul style="list-style-type: none"> A. Exposure to interventions (e.g., if policy made MSM/CSW legal)
Outcomes	<ul style="list-style-type: none"> 1. Individual-level <ul style="list-style-type: none"> A. Sexual risk behavior B. Drug/alcohol use C. Adherence D. Receive PEP, ART, circumcision, STI, other biomedical interventions 2. Dyadic-level <ul style="list-style-type: none"> A. ART for HIV infected person in HIV serodiscordant partnership B. Sexual risk behavior C. STI treatment, circumcision, other biomedical interventions 3. Community-level <ul style="list-style-type: none"> A. Community-level risk behavior B. Community-level adherence C. Percentage of target population on ART D. Community viral load 4. Structural-level <ul style="list-style-type: none"> A. Risk environment change B. Treatment environment change 5. Policy-level <ul style="list-style-type: none"> A. Implementation of policy to reduce HIV risk B. Implementation of policy to improve access to care
Impacts	Reduced HIV Incidence

3. **Deliver Integrated Combination Prevention Intervention Packages at Multiple Levels**

Single or limited-focus individual-level interventions are helpful in reducing HIV risk, however, are not sufficiently effective to be used alone in reducing HIV transmission. To optimize risk reduction, the EPP should propose integrated behavioral, biomedical, and structural interventions that include combination prevention strategies. The Enhanced Prevention Interventions supported by this FOA should be delivered as integrated combination packages at multiple levels.

EPPs should describe target population specific combination prevention packages and their delivery at multiple levels (e.g., individual, dyadic, group, community, structural, and policy) as appropriate for the specific prevention intervention. For example, a combination prevention package targeting commercial sex workers (CSWs) could include the following components: HIV counseling and testing; treatment for HIV and sexually transmitted infections; condom skills training; sexual negotiation skills training; gender-based violence interventions; normative perception, attitude and behavior change interventions; reproductive health services; post-exposure prophylaxis; financial and legal empowerment services, among others.

Each of these components could be delivered at the individual level. Many of these same components could also be delivered at the dyadic-level to CSWs and their primary sex partners. Community-level interventions addressing HIV transmission in the context of commercial sex work could include interventions with clients of CSWs, such as, police and military personnel, truckers, teachers, etc. Structural interventions could include establishing services in major sex trade areas such as

trucking routes, brothels, strolls, and could be as simple as providing free HIV counseling and testing, mobile STI screening/treatment, increasing the availability of free condoms, and decreasing alcohol use in these areas. Interventions supported by this FOA and described in the EPP should be delivered as a combination package. Ideally, multi-level, combination interventions should be developed and implemented for a specific target population and proposed in the EPP. Programs should enhance existing interventions by delivering integrated combination prevention packages at multiple levels. Thus, if an existing intervention is delivered at the individual level, the EPP should propose an additional intervention level innovation not previously implemented. Similarly, if the existing prevention program does not deliver a “combination package” of interventions, then the EPP should propose additional intervention components in the existing prevention intervention program package.

At a minimum, the EPP should propose interventions that are implemented and measured across two levels (e.g., individual-level, dyadic, family, peer group/network, structural, institutional, community, etc.) and output indicators should be proposed to measure this multi-level delivery. Also, output indicators should reflect the extent to which combination prevention packages are delivered, from what levels they are delivered, and to whom they are delivered. The EPP should clearly state how an existing prevention intervention will be enhanced using a combination prevention, multi-level approach.

4. **Strengthen Program Specific Monitoring and Evaluation**

The EPP should include a monitoring and evaluation (M&E) framework to guide the assessment of progress toward intervention goals and objectives. This M&E framework should specify the goals and objectives of the intervention and the conceptual approach that integrates the inputs, activities, outputs, outcomes, and impact. The M&E framework should specify the indicators, the data sources, and the data analysis plan. The M&E framework should also include implementation planning that delineates the activities, roles and responsibilities for the Enhance Prevention Program activities, and a timeline for completing all activities. Finally, an integration and dissemination plan should be included in that addresses how the data will inform program design and delivery, and how the results will be disseminated to stakeholders.

The EPP M&E framework should include the following:

1. Program logic model that includes goals, objectives, activities, assumptions and measurable indicators for each. The intervention logic model should present the hypothesized linkages between interventions, mediating variables, outcomes, and impact.
2. A description of prevention intervention enhancements should include combination package development and design, and should indicate at what levels the intervention is delivered.
3. Definition of indicators specific to inputs, activities, outputs, mediators, outcomes, and impacts.
 - a. Indicators should be specific, measureable, and directly relevant to the program/intervention and should approximate examples in Table 1.

- b. Outcome and impact measures should be specific to program intent, such as increased condom use, decreased numbers of partners, knowledge of HIV serostatus, decreased concurrence of sexual partnerships, increased adherence to treatment regimens, decrease in STI's, decreased HIV infection, etc.
 - c. Develop or incorporate existing intermediate-level, mediating, theoretically based indicators that can inform programs as to the need for intervention program modifications and enhancements prior to longer-term measurement and evaluation of outcome or impact indicators. For example, such indicators could include perceptions of risk, normative perceptions of behavior, outcome expectancies, perceived barriers to protective action, self-efficacy, knowledge, gender power dynamics, agency linkages and fragmentation, service integration,
4. Data collection plan.
- a. From whom will data be collected (sample).
 - i. If sampling strategies are required, specify.
 - ii. Indicate how intermediate-level indicators and program specific outcome/impact measures will be incorporated in standard program data collection operating procedures and systems.
 - b. Frequency of data collection.
 - c. Propose enhanced tools and systems for collecting intervention data. Such tools could include PDAs, GPS mapping, computer-assisted interview technology, etc. Incorporate both intermediate-level indicators and

program specific outcome/impact measures in standard program data collection operating procedures and systems and develop new tools and systems for collecting prevention intervention program data. For example, PDA's could be used to collect standard face-to-face interview data related to program delivery and outcomes and could also be used to map interview location, and transmit data in real time.

- d. Data management, analysis, and reporting.
 - i. Indicate how data will be managed, validated, secured, and backed up.
 - ii. Include an analysis plan that includes basic frequencies, means, trends, mapping.
 - iii. Desirable to map intermediate-level indicators and program specific outcome/impact measures to identify successes and to specify the need for intervention modifications and improvement by geographic area.
 - iv. Data should be gathered, analyzed, and reported in a timely manner to inform program delivery, indicator development, and to mobilize communities. These data would include process indicators as well as baseline and follow-up measurements of moderators, mediators, outcomes, and impacts.
- e. Regulatory requirements for monitoring and evaluation activities.

- i. Present regulatory requirements for your organization's prevention M&E activities.
5. Plan for incorporating M&E findings into prevention intervention program delivery.

For agencies delivering locally-developed interventions that want to build their evidence for their local intervention, the Tiers of Evidence Framework and the enhanced monitoring and evaluation plan can be used to guide understanding as to where agency interventions currently fit and what sort of evaluation evidence is needed to move up to the next tier. Agencies should strive to increase their evaluation capacity and for increased levels of evidence for their interventions. This means that agencies should move forward in increasing their ability to detect behavior change effects for their locally-developed interventions by moving from process evaluation (Tier IV) to outcome monitoring (Tier III) on the Tiers of Evidence Framework.

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.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring. 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 sub-grantees 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 on a monthly basis with the grantee to assess monthly expenditures in relation to approved work plan and modify plans, as necessary.

6. Meet on a quarterly basis with the grantee to assess quarterly technical and financial progress reports and modify plans as necessary.
7. 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.
8. 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.
9. 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).
10. 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.
11. 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.

12. Assist the grantee in developing and implementing quality-assurance criteria and procedures.
13. Facilitate in-country planning and review meetings for technical assistance activities.
14. Provide technical oversight for all activities under this award.
15. Provide ethical reviews, as necessary, for evaluation activities, including from HHS/CDC headquarters.
16. Supply the grantee with protocols for related evaluations.
17. CDC will work with grantee to develop and implement theory-based HIV prevention programming indicators, to establish and implement an M&E plan, to develop a data system, and to conduct analyses related to the Enhanced Prevention Program.
18. Monitor the cooperative agreement.
19. Collaborate with recipient to establish priorities for the development and implementation of recipient activities.
20. Participate in the analysis and dissemination of information, data and findings from the project, facilitating disseminations of results.

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: FY2011

Approximate Current Fiscal Year Funding: \$350,000

Approximate Total Project Period Funding: \$1,750,000 (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: 1

Approximate Average Award: \$350,000 (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: \$300,000

Ceiling of Individual Award Range: \$350,000 (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
- American Indian/Alaska native tribally designated organizations
- Alaska Native health corporations
- Urban Indian health organizations
- Tribal epidemiology centers
- 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)
- Political subdivisions of States (in consultation with States)
- 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 legal binding agreement, from the state

or local government as documentation of the status is required. Attach with “Other Attachment Forms” when submitting via 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 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:

If projects that involve the collection of information from 10 or more individuals are owned by USG and used to benefit USG funded programs in this or other countries, the project will be subject to review and approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

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

Other Submission Requirements

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

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
- The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed.
- *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;
- *Applicant's Corporate Capability Statement*;
- *Letters of Support* (5 letters maximum);
- *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, 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. Please visit 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. 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 check the status 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.

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.

International registrants can confirm by sending an e-mail to ccrhelp@dnb.com, including Company Name, D-U-N-S Number, and Physical Address, and Country.

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.

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. 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. 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. 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. 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 Grants.gov 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, with the exception of all Federal Holidays. 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. 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 to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, 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 27, 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 Funding Opportunity Announcement CDC-RFA-GH11-1164. 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

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 Uganda and institutional capacity (both management and technical) to achieve the goals of the project with documented good governance practices? (5 points) Does the applicant demonstrate 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 Uganda? 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"¹ 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)

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 incorporate them 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?

¹ 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.

Is the monitoring and evaluation plan consistent with the principles of the "Three Ones"²?

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.

Understanding of the Problem (10 points):

Does the applicant demonstrate a clear and concise understanding of the current Ugandan 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 as it relates to Uganda? (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

² 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.

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, including managing the resources of the program, preparing reports, monitoring and evaluating activities, auditing expenditures, collecting and analyzing 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 (10 points):

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

- **Local Indigenous Organization**

Applicants registered in the country as a local indigenous organization and in compliance with the definition given in the FOA for “Local partner” will receive **10 points** in addition to the points established under the Evaluation Criteria.

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, such as contractual.

- Awardees may not generally use HHS/CDC funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- 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. PEPFAR publishes the single-partner funding limits annually as part of guidance for preparing the Country Operational Plan (COP). U.S. Government Departments and agencies must use the limits in the planning process to develop Requests for Applications (RFAs), Annual Program Statements (APSs), or Funding Opportunity Announcements (FOAs). However, as PEPFAR country budgets are not final at the COP planning stage, the single partner limits remain subject to adjustment. The limit is no more than 8 percent of the country's FY 2011 PEPFAR program budget or \$2 million, whichever is greater). (Grants officers should insert the following sentence if the Department or agency issues the RFA prior to Congressional appropriation and final COP approval: "Please note that the current limit is based on an estimated country budget developed for planning purposes; thus, the limit is also an estimate and subject to change based on actual appropriations and the final approved

country budget.”) 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 FY 2011 grants and cooperative agreements (for as many fiscal years as applicable) in Uganda. 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 sub-agreements under this award. These provisions must be express terms and conditions of the sub-agreement, must acknowledge that compliance with this section, “Prostitution and Related Activities,” is a prerequisite to receipt and expenditure of U.S. government funds in connection with this

document, and must acknowledge that any violation of the provisions shall be grounds for unilateral termination of the agreement prior to the end of its term. Recipients must agree that HHS may, at any reasonable time, inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that relate to the organization's compliance with this section, "Prostitution and Related Activities."

All prime recipients 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 Inter-Action is found at:

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. However, the following “*Funding Preference*” may affect the funding decision:

- **Local Indigenous Organization**

Applicants registered in the country as a local indigenous organization and in compliance with the definition given in the FOA for “Local Partner.”

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

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-7 Executive Order 12372
- AR-8 Public Health System Reporting Requirements

- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-12 Lobbying Restrictions
- AR-13 Prohibition on Use of CDC Funds for Certain Gun Control Activities
- 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.

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:

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 Uganda; 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.
3. Financial Status Report (SF 269) 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:

Bradford N. Bartholow, Ph.D., Project Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

2190 Kampala Place

Dulles, VA. 20189-2190

Telephone: +256 752 751 036

E-mail: bnbl@ug.cdc.gov

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

Kathy Raible, Grants Management Specialist

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS: K-75

Atlanta, GA 30341

Telephone: 770-488-2045

E-mail: kcr8@cdc.gov

For assistance with submission difficulties, contact:

Grants.gov Contract Center Phone: 1-800-518-4726

Email: support@grants.gov

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

For 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

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 at www.grants.gov