Amendment I (9/16/2014)

1. Page 1 and Page 33: Changed Application Deadline Date from October 6 to October 16, 2014

2. Page 35. Collaborations: Modified language around letters of support. Changed “and” to “or”. Added “A maximum of five letters of support may be provided.”

3. Page 48: Phase II Review: Added “Assessment should include reviews of letters of endorsement from the MOH and annual reports” to first criteria under Ability to Carry out the Proposal

4. Page 49. Phase II Review: Added “Assessment should include reviews of letters of endorsement from the MOH and annual reports.” To first criteria under Capacity Building

Funding Opportunity Announcement (FOA)

Strengthening Local Capacity to Deliver Sustainable Quality Assured Universal Coverage of Clinical HIV/TB Services in Manzini Region, and Provide Central Level Technical Assistance to the National Tuberculosis Control Program (NTCP) in the Kingdom of Swaziland under the President’s Emergency Plan for AIDS Relief (PEPFAR)

CDC-RFA-GH15-1583

Division of Global HIV/AIDS
Center for Global Health
Centers for Disease Control and Prevention

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Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-GH15-1583. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name

Centers for Disease Control and Prevention

B. Funding Opportunity Title

Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Manzini Region, and Provide Central Level Technical Assistance to the National Tuberculosis Control Program (NTCP) in the Kingdom of Swaziland under the President's Emergency Plan for AIDS Relief (PEPFAR)

C. Announcement Type:

New-Type 1

This announcement is only for non-research international activities supported by CDC. If research is proposed, the application will not be considered. Research for this purpose is defined at: http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

D. Agency Funding Opportunity Number

CDC-RFA-GH15-1583

E. Catalog of Federal Domestic Assistance Number

93.067 Global AIDS program

F. Dates

1. **Letter of Intent Deadline Date:** N/A

Application Deadline Date: October 16, 2014 at 11:59 p.m. U.S. Eastern Standard Time, on www.grants.gov

G. Executive Summary

1. **Summary Paragraph**

The purpose of this five year FOA is to optimize PEPFAR partners in Swaziland by implementing a system in which only one clinical partner will work in a given region. The partner for the Manzini Region will (1) work as PEPFAR Swaziland's lead agency for technical assistance to the National Tuberculosis Control Program (NTCP), providing support to all tuberculosis (TB) and multi-drug resistant TB (MDR-TB) treatment related activities at the national level as required; (2) collaborate with the Ministry of Health (MOH) in the Manzini region to rapidly expand access to the combination of Provider Initiated HIV Testing and Counseling (PIHTC), Prevention of Mother to Child Transmission of HIV (PMTCT), TB, Pediatric and Adult HIV Care and Treatment services to ensure universal coverage of comprehensive and integrated clinical HIV and TB services in the region; (3) be responsible for building Manzini Regional Health Management Team (RHMT) capacity to ensure long term sustainability of facility level delivery of services that meet national quality performance standards; and (4) collaborate with relevant stakeholders to expand access to TB and HIV services at the community level (including industrial sites, mines, and correctional facilities) within the Manzini region.

It is expected that the partner will work closely with key stakeholders (MOH, PEPFAR clinical, community, social and behavior change communication, and other development partners) to achieve the following long term outcomes at the end of the 5-year period:

- Improved quality of TB and MDR-TB services in Swaziland, resulting in reduced TB related morbidity and mortality;
- Improved quality management and performance standards of HIV and TB clinical services in the region;
- Increased number of individuals who are aware of their HIV status and successfully linked to appropriate services in the region;
- Decreased HIV incidence and HIV population viral load in the region;
- Decreased TB related mortality among HIV patients in care in the region;
- Increased TB and multidrug-resistant TB (MDR-TB) treatment success rates in the region;
- Decreased mother to child HIV transmission rate in the region;
- Reduced unmet need for family planning (FP) among HIV+ women in the region;
- Reduced HIV related maternal mortality and morbidity in the region; and
- Reduced HIV related child mortality and morbidity in the region.

a. **Eligible Applicants:** Fully Competitive

b. **FOA Type:** Cooperative Agreement

c. **Approximate Number of Awards:** 1

d. **Total Project Period Funding:** None

e. **Average One Year Award Amount:** $4,200,000.00

f. **Number of Years of Award:** 5 Years

g. **Approximate Date When Awards will be Announced:** February 2015

h. **Cost Sharing and /or Matching Requirement:** N/A

Part II. Full Text

A. Funding Opportunity Description

1. Background:

Swaziland is among the countries with the most severe HIV and TB dual epidemic in the general population. The current annual adult HIV incidence is estimated as high as 2.4%. HIV prevalence among adults aged 18-49 years is 31% and TB incidence rate is 1380/100,000 persons. About 6,000 TB cases are expected to be diagnosed by 2015. Approximately 75-80% of TB cases are co-infected with HIV. HIV prevalence among pregnant women in Swaziland is among the highest globally at 41%. While Swaziland has made significant strides in addressing the HIV and TB dual epidemic, more effort is needed to reach universal coverage at new WHO 2013 recommended guidelines; improve delivery of quality clinical services across the entire continuum of HIV testing, care, treatment and retention such that it is seamless, comprehensive and integrated within existing structures; and increase capacity for sustainable MOH stewardship at the national, regional, and facility level. Although Swaziland has made great progress in scaling up HIV and TB clinical services, including TB/HIV collaborative activities (Intensified TB case finding (ICF), Isoniazid Preventive Therapy (IPT) and TB Infection Prevention and Control (IPC)), critical gaps and missed opportunities exist in reaching children, adolescents, and key populations (KP) with HIV services, reaching pregnant women and TB clients with ART, efficient utilization of limited resources, and strengthening structures for long term sustainability of quality-assured programs.

Alignment with PEPFAR/Host Country National Government Priorities:
According to the 2014-2018 extended National Strategic Framework of Swaziland (eNSF, available at

http://www.nercha.org.sz/document/extended-national-multisectoral-hiv-and-aids-framework-ensf-2014-2018), the country is committed to the following priorities:

I. A reduction of new HIV infections among adults/adolescents and children by 50% and 90% respectively by 2015.
II. A reduction in mortality and morbidity amongst PLHIV and in particular those with TB/HIV co-infection.
III. Alleviating socio-economic impacts of HIV and AIDS among vulnerable groups such as orphans and the elderly caregivers.
IV. Improvements in efficiency and effectiveness of the national response planning, coordination and service delivery.

This FOA aligns with priorities I, II, and IV while building appropriate linkages and collaborations in support of priority III. It also aligns with PEPFAR Swaziland's Partnership Framework with the Government of Swaziland.

This FOA is aligned to the following goals and objectives of the different programs as referenced in the extended National Strategic Framework (eNSF):

- To have all children, adolescents, women, and men undertake an HIV test and know their status;
- To improve availability, access, and utilization of HIV prevention and treatment services by key populations;
- To eliminate new infections among children and keep mothers alive;
- To promote a comprehensive package of care that defines pre-ART services necessary to delay progression to AIDS, prevent and manage common opportunistic infections, and ensure early initiation of ART;
- To improve the quality of life of people living with HIV (PLHIV) through treatment and strengthen treatment as a prevention strategy;
- To achieve 50% reduction in TB incidence by 2022 relative to the 2012 level; and
- To reduce death rate among TB/HIV co-infected patients from 10% to <5% by 2019.

a. Statutory Authorities

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), and Public Law 113-56 (PEPFAR Stewardship and Oversight Act of 2013).

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. The overarching purpose of this FOA is to fund activities to prevent or control disease or injury and improve health, or to improve a public health program or service. Recipients may not use funds for research. Certain activities that may require human subjects review due to institutional requirements but that are generally considered not to constitute research (e.g., formative assessments, surveys, disease surveillance, program monitoring and evaluation, field evaluation of diagnostic tests, etc.) may be funded through this mechanism.

b. Healthy People 2020:

Healthy People 2020 provides national health objectives for improving the health of all persons by encouraging collaborations across sectors, guiding individuals toward making informed health decisions, and measuring the impact of prevention activities. Additional information on Healthy People 2020 is available at http://www.healthypeople.gov.

c. PEPFAR Priorities and Strategies

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; and
- 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 (research is not supported by this FOA).

This announcement is only for non-research activities supported by 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

d. Other National Public Health Priorities and Strategies:

N/A

e. Relevant Work:

PEPFAR Swaziland has provided assistance to the continuum of HIV prevention, care and treatment since 2006, using a vertical approach where multiple partners support different pieces of the

continuum at the same regions and facilities. CDC funded activities historically supported HIV Care and Treatment and PIHTC, while USAID supported TB and PMTCT in the same facilities. With these contributions, Swaziland has managed to reach universal antiretroviral therapy (ART) coverage of 93% at CD4<350. TB treatment success rate is currently at 74% and PMTCT coverage is over 90%. However, with the adoption of the WHO 2013 guidelines, the need for ART will almost double, bringing down the coverage to around 50% at an ART initiation threshold of CD4<500.

This FOA builds on the achievements of the vertical model that PEPFAR has used to support clinical HIV and TB services since 2006 as it transitions to an improved model of efficient use of resources and integrated technical assistance (TA) to the MOH at the regional and facility levels.

2. CDC Project Description
a. Approach:

Activities	Outcomes		
	Short-Term Outcomes (1-2 years)	Intermediate Outcomes (3-4 years)	Long-Term Outcomes (5th year)**
Objective 1: Provide Technical Assistance (TA) to MOH and the National TB Control Program (NTCP) to develop performance standards, up-to-date guidelines, standard operating procedures (SOPs) and data tools to enhance quality service delivery.			
1.1 Conduct workshops and provide expert advice to enable NTCP to develop and/or update policies, guidelines, in- service curricula, SOPs, and job aides in line with current evidence, WHO guidelines, and national priorities related to TB and MDR-TB (including TB/HIV collaborative activities in TB settings) and provide trainings of health care workers (HCW) as required	**Increased number of health workers knowledgeable about the updated policies, guidelines, SOPs and job aides on TB and MDR-TB (including TB/HIV collaborative activities in TB settings)**	**Increased health worker use of updated policies, guidelines, SOPs, and job aides on TB and MDR-TB (including TB/HIV collaborative activities in TB settings)**	**Improved quality of TB and MDR-TB services in Swaziland resulting in reduced TB related morbidity and mortality**
1.2 Provide TA including conducting workshops, meetings, and expert advice to the nursing training institutions, NTCP, and other PEPFAR partners to integrate TB services (including TB/HIV collaborative activities in TB settings), into pre-service training curriculum	**Increased knowledge among nursing students and graduates in regards to the updated policies, guidelines, SOPs, and job aides on TB services (including TB/HIV collaborative activities in TB settings)**	**Improved skills among nursing students and graduates in regards to the updated policies, guidelines, SOPs, and job aides on TB services (including TB/HIV collaborative activities in TB settings)**	
1.3 Provide TA including conducting workshops, meetings, and expert advice to NTCP and the Quality Management (QM) program to establish national performance monitoring and quality improvement system for TB services (including TB/HIV collaborative activities in TB settings)	**Increased number of health facilities that have set performance targets on TB services (including TB/HIV collaborative activities in TB settings)**	**Increased number of health facilities that have met performance targets on TB services (including TB/HIV collaborative activities in TB settings)**	
1.4 Conduct quality improvement work/piloting of new approaches to improve TB and MDR-TB services, in collaboration with PEPFAR's Epidemiology/Research partner/and the MOH Research Unit, to inform	**Increased information produced by quality improvement work/pilots of new approaches with regards to TB and MDR-TB**	**Increased uptake and utilization of TB and MDR-TB -related findings from pilots and quality**	

Activities	Outcomes		
	Short-Term Outcomes (1-2 years)	Intermediate Outcomes (3-4 years)	Long-Term Outcomes (5th year)**
evidence-based programming of TB services (including TB/HIV collaborative activities in TB settings)	**services**	**improvement projects to inform policy and programming**	
Objective 2: Build the Manzini Regional Health Management Team's (RHMT) capacity to employ strong stewardship and ownership role in quality management of HIV and TB clinical services and collaborate with the QM program and Manzini RHMT to improve and sustain high quality performance in HIV/TB service delivery at the facility level.			
2.1. Collaborate with MOH and CDC MOH cooperative agreement (CoAg) to develop and implement Manzini RHMT capacity building plan to improve organizational structure, leadership, and accountability	**Improved knowledge of RHMT on implementing organizational change, leadership and governance techniques (e.g., updated terms of reference, supervision tools, etc.) to improve HIV and TB services**	**Improved performance of RHMT in providing supportive supervision including mentoring to all health facilities in the region**	**Improved quality management and performance standards of HIV and TB clinical services in the region**
2.2. Provide TA including mentoring, expert consultations, and trainings to the Manzini RHMT to establish and strengthen regional training, mentoring and supervision systems that are government-led and sustainable	**Improved regional management system for provision of mentoring and supervision**		
2.3 Collaborate with Manzini RHMT, national MOH programs (QM program, Swaziland National AIDS Program (SNAP) and NTCP), and CDC MOH CoAg to develop and implement quality management plan in the region to meet performance targets	**Increased number of facilities who have quality management plans** **Increased representation of facilities presenting their performance data at Regional Semi Annual Review Meetings (RESAR)**	**Increased number of health facilities that meet their regionally set TB and HIV performance targets (which will be set in collaboration between MOH QM team, RHMT, regional partner, etc.)**	
Objective 3: Support comprehensive and integrated universal scale up of adult and pediatric HIV and TB clinical services at all facilities (including PIHTC, PMTCT, TB, TB/HIV, Care and treatment) and selected communities (including mines and correctional facilities) in the Manzini region.			
Provider-initiated HIV testing and counseling (PIHTC)			
3.1 Provide technical assistance, including trainings and mentoring, at all health facilities (public, mission, private) and support placement of lay counselors in high volume facilities, to ensure provision of quality	**Increased number of knowledgeable health personnel (including partner-supported lay counselors) regarding effective**	**Increased number of competent health personnel that are providing HTC services,**	**Increased number of individuals who are aware of their HIV status and successfully**

Activities	Outcomes		
	Short-Term Outcomes (1-2 years)	Intermediate Outcomes (3-4 years)	Long-Term Outcomes (5th year)**
assured HTC in Manzini in line with current guidelines	**strategies for HTC, linkage to care and prevention, and elimination of stigma and discrimination for PLHIV and key populations**	**linkage to care and prevention, and implementing stigma and discrimination free strategies for PLHIV and key populations**	**linked to appropriate services for each demographic group of adults, adolescents, and children, respectively**
3.2 Provide technical assistance, including trainings, mentoring of health care workers (HCW), and development of PITC standard operating procedures (SOPs), to improve linkage to appropriate services in Manzini region			
3.3 Collaborate with community HTC partner, PEPFAR key populations partner, and key populations technical working group (TWG) to provide TA including training and mentoring of health personnel to reduce stigma and discrimination in health facilities for HIV testing, care and treatment services for general and key populations living with HIV in Manzini Region			
HIV CARE AND TREATMENT			
3.4 Provide training and mentoring of health care workers and as necessary direct service delivery (DSD) to ensure provision of comprehensive quality HIV care (including TB screening, CTX, WHO staging, CD4 and viral load monitoring, opportunistic infection, palliative and psychosocial care, nutritional assessment, counseling and referral for food support, Ready-to-Use Therapeutic Food (RUTF) (e.g., Plumpy'nut), and non-communicable diseases) services at all health facilities in Manzini region in line with current guidelines	**Increased number of health facilities in the region providing access to comprehensive HIV care services to adults, adolescents, and children**	**Increased proportion of PLHIV in the region receiving comprehensive HIV care (integrated with non-communicable disease care) for each demographic group of adults, adolescents, and children, respectively**	**Decreased HIV incidence and HIV population viral load**
3.5 Provide TA including training and mentoring of health care workers and as necessary DSD to Manzini region to improve quality of ART services for children, adolescents, adults, and key populations (from health facilities through community delivery points in Manzini)	**Increased ART coverage for adults, adolescents, and children in line with WHO and/or national eligibility guidelines**	**Increased retention in care and treatment at 12, 24, and 36 months for each demographic group of adults, adolescents, and children, respectively**	
TB/HIV			
3.6 Provide TA including training and mentoring of health care workers and as necessary DSD to implement	**Increased proportion of HIV providers competent in**	**Increased identification of TB cases amongst HIV**	**Decreased TB related mortality among HIV**

Activities	Outcomes		
	Short-Term Outcomes (1-2 years)	Intermediate Outcomes (3-4 years)	Long-Term Outcomes (5th year)**
TB/HIV collaborative activities as per national TB/HIV policy guidelines with a focus on the 3 I's for TB infection prevention and control for PLHIV and early ART initiation for TB patients	**implementing HIV/TB services (e.g., TB screening, IPT, infection control plans, and early initiation of ART)**	**patients already in care** **Increased percent of eligible PLHIV in care who have received IPT** **Increased proportion of TB patients with HIV who received ART within 8 weeks of diagnosis**	**patients in care**
3.7 Provide TA including training and mentoring of health care workers and as necessary DSD to health facilities of the primary region to ensure provision of high quality TB and MDR TB diagnosis and treatment services for adults, adolescents, and children in line with essential healthcare package and National TB Manual at all health facilities and communities in primary region	**Improved access to quality assured TB and MDR TB diagnosis and treatment services**	**Increased number of HIV patients that received quality-assured TB and MDR TB diagnosis and treatment services in line with the TB/HIV decentralization plan**	**Increased TB and MDR TB treatment success rates in the region**
PMTCT/MNCH			
3.8 Provide TA including training and mentoring of health care workers and as necessary DSD to health facilities of Manzini region to ensure provision of high quality clinical PMTCT services in line with essential healthcare package and national PMTCT and MNCH guidelines	**Increased number of pregnant and lactating women with HIV infection who are on ART** **Increased proportion of HIV infected children 0-5 years old that receive ART**	**Increased proportion of mother-baby pair retained in care at 24 months post-partum**	**Decreased mother to child HIV transmission rate in the region** **Reduced HIV related maternal mortality and morbidity in the region**
3.9 Provide TA including training and mentoring of health care workers working at MNCH units in the primary region to ensure provision of quality MNCH services for HIV positive mothers and children	**Increased proportion of MNCH health workers that are competent in provision of MNCH/PMTCT services**	**Increased proportion of PLHIV that are receiving integrated SRH (FP, Cervical Cancer screening etc.) and HIV services**	**Reduced HIV related under 5 mortality and morbidity in the region** **Reduced unmet need for FP among HIV+**

Activities	Outcomes		
	Short-Term Outcomes (1-2 years)	Intermediate Outcomes (3-4 years)	Long-Term Outcomes (5th year)**
			women in the region

i. Problem Statement:

Swaziland has made tremendous achievements in HIV/TB service delivery over the years, much of it augmented through PEPFAR assistance. To achieve these early successes, PEPFAR partners were vertically aligned in specific program areas of PIHTC, Care and Treatment, TB, and PMTCT. This situation, however, has resulted in lack of integration of comprehensive services, incomplete coordination of partner activities such as mentoring and trainings at the regional and facility levels, and inefficiencies in resource utilization that this FOA is trying to address.

While significant strides have been made in improving access to and quality of HIV and TB care, there remains a 30% gap in ART coverage for TB patients, children, and pregnant women; 20% gap in enrollment of cases after laboratory confirmation; decentralization of HIV and TB prevention, care and treatment services to the communities remains slow; gaps in TB case detection among vulnerable populations, including children and miners; gaps in HIV drug resistance (HIVDR) monitoring at the facility level; gaps in non-communicable disease (NCD) and family planning (FP) integration; weakness in support for facility level supply chain management and lab quality monitoring. These gaps will be widened when Swaziland starts to implement recommendations from the WHO 2013 guidelines. Vertical alignment of partners at the facility level has resulted in poor integration of comprehensive services culminating in observed gaps. There are weak efforts to leverage resources across programs. As program needs increase significantly with the new guidelines, the importance of adopting efficient and comprehensive measures becomes more obvious and urgent in order to sustain and improve the gains so far made.

Also, regional level MOH stewardship and leadership required to ensure sustainable quality service delivery have remained marginal. Regional health management teams have many different partners providing overlapping services to deal with, which makes coordination a severe challenge. Similarly, CDC had challenges coordinating and dealing with partner responsibilities for activities that overlap within the continuum of clinical HIV and TB services, such as ART for infants and children under 5 and TB services for pregnant women, among others.

At the national level, the Swaziland government has committed to purchasing all ARV and TB commodity needs for the country, but inadequate resources at the program management level have warranted significant PEPFAR assistance to ensure timely updates and development of program policies, guidelines and monitoring and evaluation (M&E) tools, as well as to sustain appropriate national oversight/stewardship.

This FOA is designed to support the Ministry of Health with improving the quality of HIV and TB clinical services in line with PEPFAR priorities in Swaziland.

ii. Purpose

The purpose of this FOA is to assist the MOH to reduce HIV and TB incidence and improve TB and HIV program outcomes in Swaziland. It aims at optimizing PEPFAR partners support by implementing a system in which only one clinical partner will work in a given region.
The primary goals are to contribute to 50% reductions in new HIV and TB infections for adults and 90% for pediatrics, and to avert 20% deaths among children, adults, and pregnant women living with HIV (especially those with TB co-infection) in line with the eNSF.

The program objectives relevant to this FOA in Swaziland are to

1. Provide Technical Assistance to MOH and the National TB Control Program to develop performance standards, up-to-date guidelines, standard operating procedures (SOPs) and data tools to enhance quality service delivery.
2. Build the Manzini Regional Health Management Team's (RHMT) capacity to employ strong stewardship and ownership role in HIV/TB quality management and collaborate with the QM program and Manzini RHMT to improve and sustain high quality performance in HIV/TB service delivery at the facility level.
3. Support comprehensive and integrated universal scale up of adult and pediatric HIV and TB clinical services at all facilities and selected communities (including mines, industrial sites, uniformed services, and correctional services) in the Manzini region.

iii. Outcomes

The partner is expected to report on all level 1, 2, and 3 outcomes as outlined in the logic frame and as listed below.

Main/Long Term Outcomes:

- Improved quality of TB and MDR-TB services in Swaziland resulting in reduced TB related morbidity and mortality
- Improved quality management and performance standards of HIV and TB clinical services in the region
- Increased number of individuals who are aware of their HIV status and successfully linked to appropriate services for each demographic group of adults, adolescents, and children, respectively in the region
- Decreased HIV incidence and HIV population viral load in the region
- Decreased TB related mortality among HIV patients in care in the region
- Increased TB and MDR TB treatment success rates in the region
- Decreased mother to child HIV transmission rate in the region
- Reduced unmet need for FP among HIV+ women in the region
- Reduced HIV related maternal mortality and morbidity in the region
- Reduced HIV related child mortality and morbidity in the region

Intermediate Outcomes

- Increased health worker use of updated policies, guidelines, SOPs, and job aides on TB and MDR-TB (including TB/HIV collaborative activities in TB settings)
- Improved skills among nursing students and graduates in regards to the updated policies, guidelines, SOPs, and job aides on TB and MDR-TB services (including TB/HIV collaborative activities in TB settings)
- Increased number of health facilities that have met performance targets on TB services (including TB/HIV collaborative activities in TB settings)
- Increased uptake and utilization of TB and MDR-TB -related findings from pilots and quality improvement projects to inform policy and programming
- Improved performance of Manzini RHMT in providing supportive supervision including mentoring to all health facilities in the region
- Increased number of health facilities that meet their regionally set TB and HIV performance targets
- Increased number of competent health personnel that are providing HTC services, linkage to care and prevention, and implementing stigma and discrimination free strategies for PLHIV and key populations
- Increased proportion of PLHIV in the region receiving comprehensive HIV care (integrated

with non-communicable disease care) for each demographic group of adults, adolescents, and children, respectively

- Increased retention in care and treatment at 12, 24, and 36 months for each demographic group of adults, adolescents, and children, respectively
- Increased identification of TB cases amongst HIV patients already in care
- Increased percent of eligible PLHIV in care in the region who have received IPT
- Increased proportion of TB patients with HIV who received ART within 8 weeks of diagnosis
- Increased number of HIV patients that received quality-assured TB and MDR TB diagnosis and treatment services in line with the TB/HIV decentralization plan
- Increased proportion of mother-baby pair retained in care at 24 months post-partum
- Increased proportion of PLHIV that are receiving integrated SRH (FP, Cervical Cancer screening, etc.) and HIV services

Short Term Outcomes

- Increased number of health workers knowledgeable about updated policies, guidelines, SOPs, and job aides on TB and MDR-TB services (including TB/HIV collaborative activities in TB settings)
- Increased knowledge among nursing students and graduates in regards to the updated policies, guidelines, SOPs, and job aides on TB and MDR-TB services (including TB/HIV collaborative activities in TB settings)
- Increased number of health facilities that have set performance targets on TB and MDR-TB services (including TB/HIV collaborative activities in TB settings)
- Increased information produced by quality improvement work/pilots of new approaches with regards to TB and MDR-TB services
- Improved knowledge of RHMT on implementing organizational change, leadership and governance techniques (e.g., updated terms of reference, supervision tools, etc.) to improve HIV and TB services
- Improved regional management system for provision of mentoring and supervision
- Increased number of facilities who have quality management plans
- Increased representation of facilities presenting their performance data at Regional Semi Annual Review Meetings (RESAR)
- Increased number of knowledgeable health personnel (including partner-supported lay counselors) regarding effective strategies for HTC, linkage to care and prevention, and elimination of stigma and discrimination for general and key populations
- Increased number of health facilities in the region providing access to comprehensive HIV care services to adults, adolescents, and children
- Increased ART coverage for both adults, adolescents, and children in line with WHO and/or national eligibility guidelines
- Increased proportion of HIV providers competent in implementing HIV/TB services in (e.g., TB Screening, IPT, infection control plans, and early initiation of ART)
- Improved access to quality assured TB and MDR-TB diagnosis and treatment services
- Increased number of pregnant and lactating women with HIV infection who are on ART
- Increased proportion of HIV infected children 0-5 years old that receive ART
- Increased proportion of MNCH health workers that are competent in provision of MNCH/PMTCT services

iv. Funding Strategy

N/A

v. Strategies and Activities

NATIONALLY, the partner will be expected to:

- Support MOH and NTCP to update policies, guidelines, SOPs, job aides, and other key documents in line with current evidence, WHO guidelines, and national priorities, as well as support training of health care workers (HCW) on the documents. This support can include organizing workshops and meetings, providing expert reviews, participation in technical working group (TWG) discussions, printing of revised guidelines, policies, SOPs, job aides, etc. The partner will also assist in national level trainings in care and treatment and in defining and implementing MDR-TB services. Expected outputs are;
  - Updated policies, guidelines, in-service curricula, SOPs, and job aides on TB and MDR-TB services (including TB/HIV collaborative activities in TB settings)
  - 80% of all practicing nurses in Swaziland are competent in delivery of TB and MDR-TB services (including TB/HIV collaborative activities in TB settings)
- Conduct workshops, meetings and expert reviews to support the nursing training institutions in collaboration with Swaziland National AIDS Program (SNAP), NTCP and other PEPFAR partners, such as the human resources for health (HRH) partner, to integrate TB and MDR-TB services into pre-service training curriculum. Expected outputs will include:
  - All nursing training institutions have a revised pre-service training curriculum that includes modules TB and MDR-TB
- As the national lead for TB, provide TA to the MOH for the development of a national performance monitoring system for TB and MDR-TB in collaboration with the national QM program. This will include development of performance targets, milestones and monitoring processes, establishing a system to feedback to facilities and an award system to recognize high performing facilities. As the National Lead for TB, the partner will also be expected to provide expert consultations and strategic technical input to partners in underperforming regions at the request of MOH and/or PEPFAR based on results from facility performance monitoring as such as CDC-led site monitoring visits and/or national/regional performance review meetings/visits. Rules of engagement for such assistance will be provided jointly by PEPFAR and MOH in consultation with PEPFAR partners. Expected outputs include:
  - National performance standards for TB and MDR-TB, as well as TB/HIV management in TB settings defined and performance review system established
  - At least 80% of facilities in all regions supported by PEPFAR have met HIV care and treatment performance standards established in partnership with NTCP and the QM program
- Conduct strategic quality improvement work/piloting of new approaches, in collaboration with PEPFAR's Epidemiology/Research partner/MOH Research unit, to inform evidence-based programming on TB and MDR-TB. The partner will be expected to provide TA, including trainings, meetings and workshops among others, to the MOH in identifying key gaps in program knowledge and to collaborate with the MOH research program to design and conduct appropriate QI work/pilots to ensure that TB related policies and programs are evidence-based, including alternate strategies to deliver decentralized TB and MDR-TB services at the community level. Expected output includes:
  - At least 3 reports are finalized and widely made available among stakeholders

REGIONALLY:

The primary objective for the partner at the regional level is to scale up HTC, PMTCT, HIV Care

and Treatment and TB clinical services to achieve universal coverage in the region. The main strategy should be to ensure that HIV and TB care and treatment services are comprehensive and holistic through integration with NCDs and other essential primary healthcare platforms; and that service delivery, training, mentoring and supervision activities are sustainable. Regionally, the partner will be expected to:

- In collaboration with other MOH, CDC-MOH CoAg and donor partners, provide expert assessments to identify organizational development needs of the RHMT and assist in implementing institutional capacity building work plans to strengthen the institution's ability to effectively function as stewards of health services in the region. Expected outputs include:
    - Capacity building plans for the RHMT and its members developed, approved by the Senior Health Administrator, and being implemented
    - Increased RHMT effectiveness in its stewardship and leadership functions by 70% from baseline based on the metric developed with Senior Health Administrator
- At the regional level, provide technical assistance to the RHMT to establish and strengthen regional trainings, mentoring and supervision that is government-led and sustainable, in line with national guidance on supportive supervision and mentorship. The TA will include high level meetings, workshops, and sensitizations of key stakeholders to design, implement, and monitor a training plan and a mentoring approach that is in line with government priorities and policies. Expected outputs include:
    - Regional training, mentoring and supervision structures well defined and implementation/ capacitation plan and monitoring and evaluation (M&E) system in place
    - Independently functioning, RHMT-led training, mentoring, and supervision processes
- Work with the RHMT in implementing a quality assured health delivery system in the region in line with the MOH Quality Management Program. This will include setting and strengthening regional QM structures, routine performance reviews and QI improvement systems. It will also include identifying, and as possible, filling (or working with the GKOS and other development partners to fill) gaps in infrastructure, equipment, and human resources that are hindering the region's ability to provide quality services. Expected outputs include:
    - Number of facilities conducting routine TB/HIV performance review and have active QI projects increased to 100%
    - Number of facilities participating in RESAR increased to 100%
    - TB and HIV performance targets met by 80% of facilities in the Manzini region

For Provider-initiated HIV Counseling and Testing (PITC), the partner will be expected to:

- Expand access to PITC at all health facilities (public, mission, private) in primary region in line with current guidelines. The assistance will include support for human resource allocation such as lay counselors for high volume facilities, establishment of an enabling environment with appropriate policies and regional plans among others, as well as mentoring and training of HCW. Ongoing efforts for couple testing and family-centered HTC are to be strengthened and scaled up. Expected outputs include:
    - 100% of PEPFAR supported facilities provide quality assured testing and associated counseling to at least 80% of clients eligible for HTC
- Address PITC health system issues such as client flow, infrastructure, trainings, and SOPs, as well as barriers to linkage to appropriate services by strengthening utilization of

the national referral system. Expected outputs include:
    - Proportion of PEPFAR supported facilities with PITC SOP and patient referral and linkage system in place increased to 100%
    - Proportion of patients diagnosed with HIV successfully linked to care increased to 90%
    - Proportion of male patients testing negative for HIV successfully linked to voluntary medical male circumcision (VMMC) increased to 75%
- Provide stigma reduction trainings, mentoring and sensitization of HCWs to reduce stigma and discrimination against key populations to increase access to HIV related clinical services for key populations. This will be in partnership with the CIHTC partner and PEPFAR key populations partner. Expected outputs include:
    - Efforts to normalize/decrease stigma surrounding HIV in the general population are visible in every health facility
    - Key populations related stigma and discrimination training module integrated into Nurse-led ART Initiation NARTIS training
    - ALL NARTIS nurses refreshed/trained on stigma and discrimination against key populations

For HIV Care and Treatment, the partner will be expected to:

- Select and conduct training workshops, on-site trainings and mentoring and support supervision with the RHMT, as well as direct service deliver (DSD) at facilities, as needed, to assist expansion of and retention in quality HIV care (including palliative, psychosocial care, TB Screening, CTX, Clinical staging) services at all health facilities (public, mission, private) in primary region in line with current guidelines. The partner will be expected to support rapid roll out of the national package of pre-ART services that is integrated with NCD management to all health facilities. The partner will also support cervical screening services for women in partnership with relevant stakeholders. The partner will also be expected to strengthen Positive, Health, Dignity and Prevention activities in all HIV service delivery points. The DSD support could include hiring of Expert Clients in line with MOH priorities and policy direction. Expected outputs include:
    - 80% of HCW trained in Integrated Management of Adult and Adolescent Illness (IMAI), and other care related topics
    - 95% of health facilities with fully established pre-ART services that include retention of at least 80% of pre-ART patients in care at 12 months
- The partner will be expected to provide facility level trainings, mentoring and performance reviews and support for basic logistics and infrastructure that is in line with PEPFAR guidance as well as DSD (to selected facilities in the form of Expert Clients) in the region as needed, to increase uptake to ART, and other HIV related services. Activities will include strengthening the HIV treatment cascade across the entire continuum in all health facilities as well as employ new strategies such as community ART delivery approaches to get services closer to those who need them in order to reach universal coverage. The partner will also provide onsite trainings and mentoring to support the implementation of HIVDR and viral load monitoring at the clinical level. Expected outputs include:
    - Proportion of PEPFAR supported facilities initiating at least 90% adults (and adolescents) and 90% children who are eligible for ART has increased to 95%
    - Proportion of PEPFAR supported facilities with 90% retention in care and treatment at 36 months for each demographic group of adults, adolescents, and

children has increased to 95%
    - 90% of people on ART have viral suppression at 36 months of treatment

For TB/HIV, the partner will be expected to:

- Establish and strengthen platforms and efforts at facilities and in the region to rapidly implement collaborative TB/HIV activities including TB/HIV coordinating bodies, TB Infection Prevention and Control, Intensified Case Detection, IPT, and early ART initiation for TB/HIV patients. The implementing partner will be expected to establish strong referrals and linkages between intensified case detection and IPT or TB diagnosis and treatment services as required. Expected outputs include:
    - 90% of PEPFAR supported health facilities have facility-specific TB Infection Control Plans, implement TB screening of all HIV patients on each visit, and prescribe IPT for 60% of eligible patients
    - Proportion of facilities supported by PEPFAR in the region that screen 100% of HIV patients for TB on their last visit have increased to 95%
    - Proportion of patients screened positive for TB who have received TB diagnostic testing increased to 90%
    - Percent of PEPFAR supported facilities where 100% of TB patients with HIV received ART within 8 weeks of diagnosis increased to 90%
- Expand regional roll out of TB diagnostic sites and multidrug resistant (MDR TB) diagnosis and treatment services in line with essential healthcare package towards universal coverage. This will include rapidly turning all NARTIS sites into TB diagnostic sites and TB diagnostic sites into NARTIS sites and implementing quality assured TB services in mines and prisons. Expected outputs include:
    - 90% of PEPFAR supported health facilities in the region providing quality-assured TB and MDR TB diagnosis and treatment services in line with the TB/HIV decentralization plan

For PMTCT, the partner will be expected to:

- Increase access to high quality clinical PMTCT services, including expansion of quality PIHTC for pregnant and lactating women, early infant diagnosis (EID), and region wide expansion of Option B+ in line with the national PMTCT/MNCH program, the essential healthcare package and National PMTCT Guidelines (2014) at all health facilities (public, mission, private) in primary region to prevent mother to child transmission of HIV and keep mothers alive. The partner will be expected to collaborate with the Sexual Reproductive Health Unit (SRHU) and SNAP to develop an innovative strategy for following up exposed infants and mother-baby pairs. Expected outputs include;
    - Proportion of PEPFAR supported health facilities that achieve 95% ART coverage for pregnant and lactating women increased to 90%
    - HIV transmission rate from maternal to child decreased to less than 5% at 18 months at PEPFAR supported health facilities
- Identify (using available program reviews, evaluations and other sources) and implement strategic interventions to strengthen the MNCH platform in the region using PMTCT as an entry point to improve maternal and child health outcomes. The partner's efforts will include broadening PMTCT mentoring to cover MNCH activities such as better ANC care to identify high risk pregnancies for early referrals and expert management, active and efficient management of labor and delivery, strengthening emergency obstetric management and integration of voluntary FP. All work should be done in alignment with the national PMTCT/MNCH program and guidelines. Expected

outputs include;

- Proportion of labor and delivery sites that received at least monthly on-site mentoring visits increased to 100% in PEPFAR supported health facilities
- Proportion of supported facilities providing integrated SRH (FP, Cervical Cancer screening etc.) and HIV services increased to 100%

1. **Collaborations:** Left blank intentionally

a. With CDC funded programs:

The Partner is expected to collaborate with:

- The CDC leads and programs in HIV Testing, Care and Treatment; tuberculosis, laboratory; health systems strengthening/quality management; research/epidemiology; and infrastructure/renovation to ensure efficient use of CDC resources.
- The lead CDC partner for HIV Care and Treatment + Lubombo region (TBD) to strengthen and implement national TB and TB/HIV strategies and policies.
- The lead CDC Community Initiated HIV Testing and Counseling (CIHTC) partner (currently PSI) to ensure CIHTC complements PIHTC and that together, the two activities scale up HTC to benefit all categories of individuals in the region, and that people tested at the community level are successfully linked to care.
- The lead CDC lab partner (TBD) to improve access to and quality of lab services and lab information systems, including quality assurance (QA) of both HIV testing and associated counseling at the facility level, the introduction of new technologies, and improved turn-around time for lab results.
- The MOH-CDC Cooperative Agreement (which will be focused on health systems strengthening and quality management) to define TB performance standards, quality management strategies and implement them at the regional and facility levels.
- The lead CDC epidemiology/research partner (TBD) to coordinate major activities to ensure strengthening of local counterparts in epidemiology and use of evidence to shape programs and policy.
- The lead CDC infrastructure/renovations mechanism (TBD) to coordinate minor and major improvements to facilities.

b. With organizations external to CDC:

The Partner is expected to collaborate with:

- The Ministry of Health and other government bodies, including, among others the National TB Control Program, National AIDS Program, Sexual and Reproductive Health Unit, Health Laboratory System, Central Medical Stores, Strategic Information Department, Rural Health Motivator Program, the senior health administrator/regional health management teams, Planning Unit, the Medical and Dental Council, the Nursing Council, the Training Unit, etc. The Partner will be required to participate in all necessary TWGs where it will collaborate with other MOH partners and stakeholders to provide relevant TA to the national TB and HIV care and treatment programs.
- Other PEPFAR (USAID, Peace Corps, Department of Defense) team leads and funded partners including PMTCT/MNCH; health management information systems; supply chain; impact mitigation; human and institutional capacity development; prevention; and uniformed services.
- The USAID funded lead PMTCT/MNCH partner to strengthen and implement national PMTCT/MNCH strategies and policies in Manzini region.
- The USAID funded community prevention initiative (currently Johns Hopkins

University Health Communication Capacity Collaborative) to develop appropriate communication strategies to reduce stigma for TB, HIV, link and retain individuals to appropriate care and prevention services, and promote TB IPC activities in facilities and communities.

- The USAID funded impact mitigation partners (currently FHI360 and Pact) to ensure linkages between OVC programs and clinical services.
- The USAID funded human and institutional capacity development partners (currently Human Resources Alliance for Africa (HRAA), Abt HFG, and URC ASSIST) to ensure that pre-service and in-service trainings and continuing professional development programs are aligned with a broader HRH strategy, and that there is an absorption plan for all donor-funded positions.
- The USAID funded prevention partners (including PSI and a male circumcision partner TBD) to ensure coordination and linkages between prevention and clinical services.
- The USAID funded health management information systems partner (currently Institute for Health Measurement) to ensure coordination regarding implementation and ongoing improvement of the HMIS system (including introduction of M-health technologies) in health care facilities.
- The USAID funded supply chain systems partner (currently MSH) to ensure coordination regarding implementation and ongoing improvement of the supply chain system for health care commodities in health care facilities.
- UN Agencies (WHO, UNICEF, etc.) to ensure consistency with implementation of clinical guidelines and with the World Food Program to strengthen referrals for nutritional support for those in need.
- All nursing institutions (Southern African Nazarene University, University of Swaziland, Good Shepherd Nursing College) PEPFAR HRH partner and MOH programs and partners to ensure that pre-service programs are aligned with a broader HRH strategy.
- NERCHA to coordinate implementation of Global Fund activities.
- Other key development partners such as MSF and CHAI on the implementation and coordination of national, regional and facility-level activities.

2. Target Populations:

This FOA targets the national population with regards to TB and MDR-TB policies and guidelines, the regional health management team of Manzini with regards to capacity building on quality management, and the entire population of the Manzini Region of Swaziland for HIV and TB clinical services (including HTC, PMTCT, TB/HIV collaborative activities, TB, HIV Care and treatment). Applicants are expected to demonstrate a special focus on critical demographic groups such as men, children and adolescents, men who have sex with men (MSM) and female sex workers (FSW), discordant couples and family members of people living with HIV and infected with TB.

Inclusion:

N/A

b. Evaluation and Performance Measurement:

i. CDC Evaluation and Performance Measurement Strategy:

Throughout the 5-year FOA period, CDC Swaziland will work with awardee to demonstrate program impact through process and outcome evaluation of funded activities. CDC Swaziland will use process evaluation to assess the extent to which planned program activities have been implemented and lead to feasible and sustainable programmatic outcomes. CDC Swaziland will use outcome evaluation to assess whether funded activities are leading to intended outcomes including public health impact for an AIDS Free Generation.

Key process evaluation questions include:

- To what extent have the planned program activities been implemented?
- To what extent have number of health facilities providing comprehensive HIV care services increased in the region?
- To what extent have health workers received quality trainings and mentoring support?
- To what extent has the number of individuals who are aware of their HIV status and receive appropriate services increased in the region?
- To what extent has the partner supported institutional development needs of the RHMT to reposition them in their stewardship role for quality health service delivery in the region?

Key outcome evaluation questions include:

- To what extent have quality management and performance standards of HIV and TB clinical services improved in the region?
- To what extent has the performance of the RHMT improved in providing supportive supervision including mentoring to all health facilities in the region?
- To what extent has the linkage to care for individuals who test HIV positive increased in the region?
- To what extent has ART coverage increased in the region for adults and children in Swaziland?
- To what extent has retention in care and treatment at 12, 24, and 36 months for both adults and children increased in the region?
- To what extent proportion of mother-baby pair retained in care at 24 months post-partum in the region increased?
- To what extent has unmet need for FP among HIV+ women decreased in the region?
- To what extent has the number of HIV patients that received quality-assured TB and MDR TB diagnosis and treatment services in line with the TB/HIV decentralization plan increased in the region?
- To what extent have TB and MDR treatment success rates in the region increased?
- To what extent have the implemented program activities by the awardee lead to feasible and sustainable programmatic outcomes?

Routine Expenditure Analyses:
Annual Expenditure Analyses shall be carried out to compare financial expenditures to program outputs, outcomes and impacts. The following types of analyses shall be carried out:

- Intended focus of USG spending and investment (Performance Comparisons)
- Allocative Efficiency of USG spending (Simple Inductive Analysis; Simple Congruence Analysis and Estimating Marginal Returns)
- Technical Efficiency of USG spending (Public Expenditure Tracking and Cost Effectiveness Analysis)
- Accountability of USG spending (Incidence Analysis and Impact Evaluation)

CDC Swaziland will use performance measures for process and outcome evaluation. Awardee will manage and analyze performance measure data and will report to CDC Swaziland periodically (See performance measures table). CDC Swaziland will review data submitted by partners and will submit data to HQ-DFPM semiannually. Additional indicators in line with the HIV continuum of care will be added as necessary.

In addition, CDC Swaziland, in partnership with awardee, will conduct site monitoring visits to be used for program monitoring and quality improvement and will highlight at the end of the FOA period key process and outcome data results.

Evaluations included in this plan will be reviewed by the Project Officer, in consultation with technical Activity Managers, and will adhere to PEPFAR evaluation standards for which a “non-research” determination” will be submitted to CDC-ADS. CDC Swaziland will also report evaluation findings to relevant stakeholders and will make these publically available as per PEPFAR Evaluation Standards of Practice.

CDC Swaziland will use overall evaluation findings during the 5-year FOA period to establish key recommendations for partners on program implementation and effectiveness, sustainability, and continued program improvement upon completion of the award.

Awardee is required to allocate up to 5% of their award to support evaluation activities, and are encouraged to work with M&E staff and professional evaluators to collect and use quality process and outcome evaluation data.

Awardee is required to submit to CDC Swaziland a detailed evaluation and performance management plan within 90 days of the first budget period, and work with project officer to ensure that the evaluation plan is feasible and consistent with proposed program activities, the intent of this FOA, and CDC’s evaluation approach.

The specific evaluation and performance management plan should be based on the logic model provided and should be consistent with the CDC evaluation and performance management requirements.

Indicator	Indicator Type	Collection Frequency	Data Collection Method
HTC indicators			
Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results.	Output	Quarterly	Routine Program
Ratio of number of new patients receiving care/pre-ART or ART services to number of new individuals who test positive for HIV.	Outcome	Quarterly	Routine program
Percent of newly diagnosed individuals linked to HIV care within 90 days of HIV diagnosis.	Outcome	Quarterly	Routine program
Percentage of HTC sites that meet national service quality standards.	Output	Semi-Annual	Service quality assessment
Percentage of HTC sites with a linkage strategy in place to ensure newly diagnosed HIV-positive individuals are enrolled in HIV care services.	Outcome	Semi-Annual	Routine program
Percentage of HTC partners that experienced rapid testing kits stock-outs.	Outcome	Quarterly	Routine program
Care and support indicators			
Number of HIV positive adults and children receiving a minimum of one clinical service	Output	Semi-Annual	Routine Program
Number of HIV infected adults and children receiving who receive care and support services outside facilities	Output	Semi-Annual	Routine Program
Number of HIV infected adults and children newly enrolled in care	Output	Quarterly	Routine Program
Number of HIV positive persons (eligible for) and receiving cotrimoxazole prophylaxis	Output	Quarterly	Routine program
Number of eligible women who are screened for cervical cancer using visual inspection with acetic acid (VIA)	Output	Semi-Annual	
Percent of HIV-positive adults and children known to be alive and in care 12 months after enrollment into care- Retention in care.	Outcome	Semi-Annual	Routine program
Percent of sites with documented routine supportive supervision visits that address clinical HIV programs (New CB)	Process	Semi-Annual	Routine program
Percent of sites with documented routine QM/QI initiatives that address clinical HIV programs	Process	Semi-Annual	Routine program
Clinical Food and Nutrition Indicators			
Number of PLHIV who were nutritionally assessed via anthropometric measurement	Output	Quarterly	Routine Program

Indicator	Indicator Type	Collection Frequency	Data Collection Method
Number of PLHIV who were found to be undernourished	Outcome	Quarterly	Routine Program
Provision of therapeutic and supplementary feeding to undernourished PLHIV	Output	Quarterly	Routine Program
Referral to food security services	Output	Quarterly	Routine Program
TB/HIV indicators			
Proportion of PLHIV in HIV care or treatment who were screened for TB symptoms in HIV care or treatment settings at the last visit	Output	Quarterly	Routine program
Proportion of PLHIV in care or treatment (pre-ART or ART) who screen positive for TB symptoms and are evaluated for active TB disease	Output	Quarterly	Routine program
Proportion of PLHIV in HIV care or treatment diagnosed with active TB disease who start treatment for TB	Output	Quarterly	Routine program
Proportion of registered TB cases with known HIV status	Output	Quarterly	Routine program
Proportion of registered TB cases who are HIV positive	Output	Quarterly	Routine program
Proportion of registered TB cases who are HIV-positive who are on ART	Output	Quarterly	Routine program
Proportion of PLHIV newly enrolled in HIV care or treatment who start isoniazid preventative therapy (IPT)	Output	Quarterly	Routine program
Proportion of registered TB cases who are HIV-positive who receive cotrimoxazole preventative therapy (CPT)	Output	Quarterly	Routine program
Proportion of HIV care or treatment facilities implementing demonstrable TB infection control measures	Capacity building	Annually	Supervisory visits, program review
Number of TB basic management units and HIV care or treatment facilities completing a continuous quality improvement assessment round in the last year	Capacity building	Annually	Supervisory visits, program review
Number of TB basic management units and HIV care or treatment facilities with a documented continuous quality improvement plan for site-specific improvement	Capacity building	Annually	Supervisory visits, program review
Number of TB basic management units and HIV care or treatment facilities with a continuous quality improvement team, committee or existing meeting	Capacity building	Annually	Supervisory visits, program review
National guidelines on intensified case finding and diagnosis of TB in PLHIV are updated and consistent with international guidance, including near point of care TB diagnostics	Capacity building	Biennial	National program review

Indicator	Indicator Type	Collection Frequency	Data Collection Method
Number of TB basic management units and HIV care or treatment facilities receiving training on implementation of updated national guidelines on intensive case finding and diagnosis of TB in PLHIV, including near point of care TB diagnostics	Capacity building	Annually	Supervisory visits, program review
Number of facilities providing near point of care TB diagnostic testing participating in an external quality assurance/proficiency testing program	Capacity building	Annually	Supervisory visits, program review
Number of TB basic management units and HIV care or treatment facilities with SOPs and data tools for referring and tracking patients, and communicating core clinical information, to and from other facilities	Capacity building	Annually	Supervisory visits, program review
Number of TB basic management units with staff trained to provide HIV clinical services, including initiation and management of ART	Capacity building	Annually	Supervisory visits, program review
Number of HIV care and treatment facilities with staff trained to provide TB symptom screening, TB diagnosis, IPT and TB treatment for PLHIV	Capacity building	Annually	Supervisory visits, program review
Adult and pediatric treatment indicators			
Number of HIV infected adults and children newly enrolled on ART	Output	Quarterly	Routine Program
Number of HIV infected adults and children receiving ART [CURRENT]	Output	Quarterly	Routine Program
Number of HIV infected adults and children who ever started on ART	Output	Quarterly	Routine Program
Number of health facilities that offer ART	Output	Quarterly	Routine program
Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy. (Recommended: 6, 24, 36 months.)	Outcome	Semi Annually	Routine Program
Percent of adults and children infection receiving antiretroviral therapy (calculate at HQ)	Outcome	Annually	Combination (Numerator: Routine Program; Denominator: modeled (UNAIDS))
Percentage of adults and children who initiated ART with an undetectable viral load at 12 months (<1000 copies/ml)	Outcome	Semi Annually	Routine Program
Percentage of health facilities providing ART that have experienced any ARV drug stock outs in past 12 months (H5.3)	Outcome	Quarterly	Routine program
Percentage of ART patients picking up all prescribed ARV drugs on time (Baseline + 1 pick-up per patient)	Output	Quarterly	Routine program

Indicator	Indicator Type	Collection Frequency	Data Collection Method
Percent of sites with documented routine supportive supervision visits that address clinical HIV programs	Process	Semi Annually	Routine program
Percent of sites with documented routine QM/QI initiatives that address clinical HIV programs	Process	Semi Annually	Routine program
PMTCT indicators			
Number of pregnant women with known status (includes women who were tested for HIV and received their results)	Output	Quarterly	Routine program
Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	Output	Quarterly	Routine program
Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth	Output	Quarterly	Routine program
Percentage of infants born to HIV-positive pregnant women who were started on CTX prophylaxis within two months of birth	Outcome	Quarterly	Routine program
Percentage of HIV+ infants who are initiated on treatment	Outcome	Quarterly	Routine program (comprised of data elements from other indicators)
Percentage of HIV-positive pregnant or breastfeeding women known to be alive and on treatment 12 months after initiating antiretroviral therapy	Outcome	Annually	Routine program

ii. Applicant Evaluation and Performance Measurement Plan:

Applicants must provide an overall jurisdiction- or community-specific evaluation and performance measurement plan that is consistent with the CDC strategy. At a minimum, the plan must:

- Describe how key program partners will participate in the evaluation and performance measurement planning processes.
- Describe the type of evaluations (i.e., process, outcome, or both) to be conducted.
- Describe key evaluation questions. Describe other information (e.g., performance measures to be developed by the applicant), as determined by the CDC program, that must be included.
- Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data.
- Describe how evaluation findings will be used for continuous program quality improvement.
- Describe how evaluation and performance measurement will contribute to developing an evidence base for programs that employ strategies lacking a strong effectiveness evidence base.

c. Organizational Capacity of Awardees to Execute the Approach:

Applicant must be able to manage program performance, evaluation, performance monitoring, financial reporting, and must have capacity to manage the required funds in accordance with the HHS Grants Policy Statement, which can be found at: http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf

d. Work Plan:

Applicant must include a work plan that demonstrates how the outcomes, strategies, activities, timelines, and staffing will take place over the course of the award. Applicants must submit a detailed work plan for the first year of the project and a high level plan for the subsequent years.

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee reporting (including work plans, performance, and financial reporting). HHS grants policy specifies the following HHS expectations for post-award monitoring for grants and cooperative agreements:

- Tracking awardees progress in achieving the desired outcomes.
- Insuring the adequacy of awardee systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve objectives within stated timelines.
- Working with awardees on adjusting the work plan based on achievement of objectives and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.
- Other activities deemed necessary to monitor the award, if applicable.

These may include monitoring and reporting activities as outlined in HHS grants policy that assists grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk grantees.

f. CDC Program Support to Awardees

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 for a briefing on applicable U.S. Government, HHS/CDC, and President's Emergency Plan for AIDS Relief (PEPFAR) 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 (OGAC).

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 President's Emergency Plan for Relief (PEPFAR) Country Operational Plan (COP) review and approval process, managed by the OGAC.

3. Review and approve 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 approve the grantee's monitoring and evaluation plan, including for compliance with the strategic information guidance established by the OGAC.

5. Meet on a regular basis with the grantee to assess 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 the subsequent year, as part of the PEPFAR review and approval process for COPs, managed by OGAC.

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, and confidential counseling and testing.

9. Provide in-country administrative support to help the grantee meet U.S. Government financial and reporting requirements approved by the Office of Management and Budget (OMB) under 0920-0428.

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 technical assistance or advice on any data collections on 10 or more people that are planned or conducted by the awardee. All such data collections-- where CDC staff will be or are approving, directing, conducting, managing, or owning data-- must undergo OMB project determinations by CDC and may require OMB PRA clearance prior to the start of the project.

12. Provide consultation and scientific and technical assistance based on appropriate HHS/CDC and OGAC documents to promote the use of best practices known at the time.

13. Assist the grantee in developing and implementing quality-assurance criteria and procedures.

14. Facilitate in-country planning and review meetings for technical assistance activities.

15. Provide technical oversight for all activities under this award.

16. Conduct service delivery site visits through the Site Monitoring System (SMS) to monitor and evaluate site capacity to provide high-quality HIV/AIDS services in all program areas by assessing and scoring key program area elements of site performance and work with the grantee on identified gaps and continuous quality improvement.

17. Provide ethical reviews, as necessary, for evaluation activities, including from HHS/CDC headquarters. Evaluations can be process, outcome or impact.
    A. Process Evaluation: measures how the intervention was delivered, what worked/did not, differences between the intended population and the population served, and access to the intervention.
    B. Outcome Evaluation: determines effects of intervention in target population(s) (e.g., change in knowledge, attitudes, behavior, capacity, etc.).
    C. Impact Evaluation: measures net effects of program and prove of causality

18. Supply the awardee with protocols for related evaluations.

B. Award Information

1.	**Type of Award:**
	Cooperative Agreement: CDC's substantial involvement in this program is indicated in the "CDC program Support to Awardees" section of this document.
2.	**Award Mechanism:**
	U2G-Global HIV/AIDS Non-Research Cooperative Agreements
3.	**Fiscal Year:**
	2015
4.	**Approximate Total Fiscal Year Funding:**
	$4,200,000.00
5.	**Approximate Total Project Period Funding:**
	None

6.	**Total Project Period Length:**
	5 Years
7.	**Approximate Number of Awards:**
	1
8.	**Approximate Average Award:**
	$4,200,000.00
9.	**Floor of Individual Award Range:**
	None
10.	**Ceiling of Individual Award Range:**
	$4,200,000.00 (This amount is subject to the availability of funds)
11.	**Anticipated Award Date:**
	April 1, 2015
12.	**Budget Period Length:**
	12 months Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the awardee (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total project period comprises the initial competitive segment and any subsequent non-competitive continuation award(s). ***Note: Applicants must only apply for the first budget period funding, taking into consideration the floor of the individual award range and the ceiling of the individual award range. The proposed budget for the first budget period must not exceed the ceiling of the individual award range. If a funding amount greater than the ceiling of the individual award range is requested, the application will be considered non-responsive and will not be entered into the review process.***
13.	**Funds Tracking:**
	Applicant is required to track fund by P-accounts/sub accounts for each project/cooperative agreement awarded.
14.	**Direct Assistance:**
	Direct assistance is not available through this FOA
15.	**Indirect Costs:**
	Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). The CDC will not reimburse indirect costs unless the recipient has an indirect cost rate covering the applicable activities and period.

C. Eligibility Information

1.	**Eligible Applicants:**
	Eligible applicants that can apply for this FOA are listed below: Government Organizations:

- National Ministries of Health
- 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 Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau)[1] .
- American Indian/Alaska Native tribal governments (federally recognized or state-recognized)
- Political subdivisions of States (in consultation with States)

Non-government Organizations:

- American Indian/Alaska native tribally designated organizations
- Alaska Native health corporations
- Tribal epidemiology centers
- Urban Indian health organizations
- Nonprofit with 501C3 IRS status (other than institution of higher education)
- Nonprofit without 501C3 IRS status (other than institution of higher education)
- Research institutions (that will perform activities deemed as non-research)

Colleges and Universities

Community-based organizations

Faith-based organizations

For-profit organizations (other than small business)

Hospitals

Small, minority, and women-owned businesses

All Other eligible organizations

PEPFAR Local Partner definition:
To be considered eligible as a local partner under this Funding Opportunity Announcement, the applicant must submit supporting documentation demonstrating how their organization meets one of the three criteria listed below under the "PEPFAR Local Partner definition." The supporting documentation must be included in the Appendices of the application and must be labeled as "Eligibility Documentation for PEPFAR Local Partner Definition." Applicants that do not provide and/or label the supporting documentation required to meet the PEPFAR Local Partner definition above will not be considered eligible for review.

Under PEPFAR, 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:

(1) an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal

[1] 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.

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 75% for FY 2015 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 75% for FY 2015 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 75% for FY 2015 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 75% for FY 2015 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. Partner 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 organization rests with the government.

Note: To be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets at least one of the three criteria listed above.

2. Special Eligibility Requirements:

All applications will be initially reviewed for completeness by the Procurement and Grants Office (PGO) staff. Applications that do not include a budget narrative and project narrative will be determined non-responsive. Complete applications will be jointly reviewed for responsiveness by HHS/CDC Division of Global HIV/AIDS and PGO. Non-responsive applications will not advance through the review process. Applicants will be notified the application did not meet eligibility and/or published submission requirements.

Non-Responsive Criteria

The list below contains criteria for determining responsiveness to this FOA:

- Late submissions will be determined non-responsive. Please see section D, "Application and Submission Information," Part 4, "Submission Dates and Times" for the application deadline date. Please also see Section 16, "Other Submission Requirements" for information on technical difficulties and paper submission. All requests to submit a paper application must be received at least three calendar days prior to the application deadline.
- The applicant's proposed budget for year one must not exceed the ceiling of the individual award range listed in Section B, "Award Information." If a funding amount greater than the ceiling of the individual award range is requested for year one, the application will be considered non-responsive and will not be entered into the review process.

Page Limitations

- Applicants must abide by the page number limitation listed in Section D, #10 Project Narrative. Any pages submitted beyond the number of pages listed for the project narrative will not be reviewed.
- If the total amount of appendices includes more than 90 pages, any pages after page 90 of the appendix 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 as appendices.

3. Justification for Less than Maximum Competition:

N/A

4. Other:

N/A

5. Cost Sharing or Matching:

Cost sharing or matching funds are not required for this program. Although there is no statutory match requirement for this FOA, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

6. Maintenance of Effort:

Maintenance of Effort is not required for this program.

D. Application and Submission Information

Additional materials that may be helpful to applicants:
http://www.cdc.gov/od/pgo/funding/docs/FinancialReferenceGuide.pdf.

1. Required Registrations:

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. **Data Universal Numbering System:** All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http://fedgov.dnb.com/webform/displayHomePage.do. The DUNS number will be provided at no charge.

If funds are awarded to an applicant organization that includes sub-awardees, those sub-awardees must provide their DUNS numbers before accepting any funds.

b. **System for Award Management (SAM):** The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

c. **Grants.gov:** The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Get Registered" option at www.grants.gov.

All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants should start the registration process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http://fedgov.dnb.com/webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instruction to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http://fedgov.dnb.com/webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to www.sam.gov and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact www.fsd.gov/US Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM account before applying on grants.gov)	Register early! Log into grants.gov and check AOR status until it shows you have been approved

2. Request Application Package:

Download the application package from www.grants.gov

3. Application Package

Applicants must download the SF-424 application package associated with this funding opportunity from www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC PGO staff at 770-488-2700 or e-mail PGO PGOTIM@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-32-6348.

4. Submission Dates and Times:

If the application is not submitted by the deadline published in the FOA, it will not be processed. PGO personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by PGO.

If Grants.gov cannot receive applications due to an emergency or other unanticipated event (and circumstances preclude advance notification of an extension), then applications must be submitted by the first business day on which government operations resume.

a. **Letter of Intent (LOI) Deadline Date**: (must be postmarked by): N/A

b. **Application Deadline Date:** October 16, 2014 at 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. Late submissions will be considered non-responsive.

If Grants.gov cannot receive applications due to an emergency or other unanticipated event (and circumstances preclude advance notification of an extension), then applications must be submitted by the first business day on which government operations resume.

5. CDC Assurances and Certifications:

All applicants are required to sign and submit CDC Assurances and Certifications documents that can be found on the CDC Web site: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm

Applicants may follow either of the following processes:

- Applicants must name this file "Assurances and Certifications" and upload as a PDF on www.grants.gov.
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm

Assurances and certifications submitted directly to CDC will be kept on file for 1 year and will apply to all applications submitted to CDC within one year of the submission date.

6. Content and Form of Application Submission:

Applicants are required to submit all of the documents outlined below as their application package on www.grants.gov.

7. Letter of Intent (LOI):

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

8. Table of Contents:

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov. There is no page limit. The table of contents is not included in the project narrative page limit

9. Project Abstract Summary:

(Maximum of 1 page)
A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative:

(Maximum of 18 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages, content beyond 18 pages will not be reviewed).

The Project Narrative must include all of the bolded headings shown in this section. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire project period as identified in the CDC Project Description section.

Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov.

a. **Background:** Applicants should provide a description of relevant background information that includes the context of the problem (see CDC Background).

b. **Approach**

Problem Statement: Applicants must describe the core information relative to the problem for the jurisdictions or populations they serve. The core information should help reviewers understand how the applicant's response to the FOA will address the public health problem and support public health priorities. (See CDC Project Description).

Purpose: Applicants must describe specifically how their application will address the problem as described in the CDC Project Description.

Outcomes: Applicants must clearly identify the outcomes they expect to achieve by the end of the project period. Outcomes are the results that the program intends to achieve. All outcomes should indicate the intended direction of change (i.e., increase, decrease, maintain). See the program logic model in the Approach section of the CDC Project Description. In addition to the project period outcomes required by CDC, applicants should include any additional outcomes they anticipate.

Strategy and Activities: The applicant must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes. Whenever possible, applicants should use evidence-based program strategies as identified by the Community Guide[2] (or similar reviews) and reference it explicitly as a source. Applicants may propose additional strategies and activities to achieve the outcomes. Applicants should select existing evidence-based strategies that meet their needs, or describe the rationale for developing and evaluating new strategies or practice-based innovations. (See CDC Project description: Strategies and Activities section).

1. **Collaborations:** Applicants must describe how they will collaborate with CDC funded programs as well as with organizations external of CDC.

   Applicants must file letters of support from Ministry of Health- Swaziland or from the Ministries of Health of up to two other countries where applicant has relevant experience. Applicants must name the files "Letters of Support," and upload as PDF files at www.grants.gov. A maximum of five letters of support may be provided.

2. **Target Populations:** Applicants must describe the specific target population(s) to be addressed in their jurisdiction to allocate limited resources, target those at greatest health risk, and achieve the greatest health impact. Applicants should use data, including social determinants data, to identify communities within their jurisdictions or community served that are disproportionately affected by the public health problem, and plan activities to reduce or eliminate these disparities. Disparities by race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions (e.g., tribal communities) should be considered.

   Inclusion: N/A

c. **Applicant Evaluation and Performance Measurement Plan:** Applicants must provide an overall jurisdiction or community-specific evaluation and performance measurement plan that is

[2] http://www.thecommunityguide.org/index.html

consistent with the CDC Evaluation and Performance Measurement Strategy section of the CDC Project Description of this FOA. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement.

The plan must:

- Describe how key program partners will be engaged in the evaluation and performance measurement planning processes.
- Describe the type of evaluations to be conducted (i.e. process and/or outcome).
- Describe key evaluation questions to be answered.
- Describe other information, as determined by the CDC program (e.g., performance measures to be developed by the applicant) that must be included.
- Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data.
- Describe how evaluation findings will be used for continuous program and quality improvement.
- Describe how evaluation and performance measurement will contribute to development of that evidence base, where program strategies are being employed that lack a strong evidence base of effectiveness.

Awardees will be required to submit a more detailed evaluation and performance measurement plan within the first six months of the project, as outlined in the reporting section of the FOA.

d. **Organizational Capacity of Awardees to Execute the Approach:**
Applicant must address the organizational capacity requirements as described in the CDC Project Description. Applicants must submit CVs/Resumes of Principal Investigator, Country Director, Deputy Country Director, Technical Director, and Business Officer, as well as detailed job descriptions of these key positions. Applicants must also submit Organizational Charts. These items must be submitted as part of the appendix, clearly named "CVs/Resumes," "Job Descriptions," and "Organizational Charts," and uploaded as PDF files at www.grants.gov.

11. Work Plan:

(Included in the Project Narrative- 18 page limit)
Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the awardee plans to carry out achieving the project period outcomes, strategies, and activities, evaluation and performance measurement, including key milestones.

12. Budget Narrative:

Applicants must submit an itemized, line-item budget and narrative with staffing breakdown (i.e., name, position title, annual salary, percentage of time and effort, and amount requested) and justification for all requested costs for the first budget period. Budgets must be consistent with the purpose, objectives of the Emergency Plan, and the program activities listed in this announcement. When developing the budget narrative, applicants should consider whether the proposed budget is reasonable and consistent with the purpose, outcomes and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies

- Travel
- Alterations and Renovations
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

The detailed budget should identify costs associated with potential data collection activities from persons, personal records, or for laboratory specimen collection and testing that may result in a public report. For each of the potential data collection activities, also state the costs for any preparatory activities (e.g., protocol development, training, equipment, reagents, and site preparation).

When developing the budget narrative, applicants should consider whether the proposed budget is reasonable and consistent with the purpose, outcomes and program strategy outlined in the project narrative. All budget justification pages must be numbered.

For guidance on completing a detailed budget, see Budget Preparation Guidelines at: http://www.cdc.gov/od/pgo/funding/budgetguide.htm.

Applicants should name this "Budget Narrative" and upload as a PDF file to www.grants.gov.

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement must have been made less than 12 months earlier. Applicants should name this file "Indirect Cost Rate" and upload to www.grants.gov.

If a funding amount greater than the ceiling of the individual 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.

13. Tobacco and Nutrition Policies:

Awardees are encouraged to implement tobacco and nutrition policies.

Unless otherwise explicitly permitted under the terms of a specific CDC award, no funds associated with this FOA can be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to participate in implementing these optional policies.

The CDC supports implementing evidence-based programs and policies to reduce tobacco use and secondhand smoke exposure, and to promote healthy nutrition. CDC encourages all awardees to implement the following optional recommended evidence-based tobacco and nutrition policies within their own organizations. This builds upon the current federal commitment to reduce exposure to secondhand smoke, which includes The Pro-Children Act, 20 U.S.C. 7181-7184, that prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

Tobacco Policies:

1. Tobacco-free indoors – no use of any tobacco products (including smokeless tobacco) or electronic cigarettes in any indoor facilities under the control of the awardee
2. Tobacco-free indoors and in adjacent outdoor areas – no use of any tobacco products or electronic cigarettes in any indoor facilities, within 50 feet of doorways and air intake ducts, and in courtyards under the control of the awardee

3. Tobacco-free campus – no use of any tobacco products or electronic cigarettes in any indoor facilities and anywhere on grounds or in outdoor space under the control of the awardee

Nutrition Policies:

1. Healthy food service guidelines should at a minimum, align with Health and Human Services and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations for cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services (http://www.gsa.gov/graphics/pbs/Guidelines_for_Federal_Concessions_and_Vending_Operations.pdf)
2. The following are resources for healthy eating and tobacco free workplaces:
   http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm
   http://www.thecommunityguide.org/tobacco/index.html
   http://www.cdc.gov/chronicdisease/resources/guidelines/food-service-guidelines.htm

14. Intergovernmental Review:

Executive Order 12372 does not apply to this program.

15. Funding Restrictions:

Restrictions that must be considered while planning the programs and writing the budget are:

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care except as allowed by law.
- Awardees may only use funds for reasonable program purposes, including personnel, travel, supplies, and services (such as contractual).
- Generally, awardees may not use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be clearly identified in the budget in accordance with CDC's budget guidelines.
- Pre-award costs may be allowable for successful applicants under this FOA prior to award.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
  - Publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
  - The salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
  - See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC awardees.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.
- 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 plans for data collection from persons or personal records and for laboratory specimen collection and testing that are expected to result in public reports will require protocols for technical review and review of institutional human subjects protection considerations by CDC. Funds for implementing these activities will be restricted until all necessary institutional protocol approvals have been obtained. Funds for preparatory activities (e.g., protocol development, training, equipment, reagents, and site preparation) may be provided prior to protocol approval.

To facilitate the early availability of funding, the budget and narrative should clarify which activities are preparatory.

- Human subjects data collection funding restrictions which require submission of protocols will be submitted within six months of notification of such requirement, but no later than the end of the first budget year. Requests for exceptions to these deadlines will need to be submitted in writing to the Grants Management Officer. All protocol approvals should be obtained no later than the end of the second budget period after the award or Continuation has been made, provided that the Grantee submits their protocol no later than the deadline.
- Needle Exchange – No funds made available under this award may be used for needle exchange programs.
- The recipient must use funds provided under the agreement for costs incurred in carrying out the purposes of the award which are reasonable, allocable, and allowable in accordance with applicable cost principles. Unallowable costs will be determined in accordance with the applicable cost principles.
    - "Reasonable" means the costs do not exceed those that would ordinarily be incurred by a prudent person in the conduct of normal business.
    - "Allocable" means the costs are necessary to the award.
    - "Allowable" means the costs are reasonable and allocable, and conform to any limitations set forth in the award.
- The recipient is encouraged to obtain the Grants Management Officer's written determination in advance whenever the recipient is uncertain as to whether a cost will be allowable.
- 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.
- 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.
- Public Financial Management Assessment Clause: The Parties acknowledge that HHS/CDC has assessed the recipient's systems required to manage the activities supported with US Government funds under this Agreement and that this Agreement is expressly conditioned upon that assessment, as well as any measures, mitigation or means by which the recipient has or will address the vulnerabilities or weaknesses, if any, found in that assessment. The recipient agrees to take the necessary action(s) to address the recommendations or requirements of the assessment as agreed separately in writing with HHS/CDC in accordance with an action plan to be jointly developed to address such recommendations or as otherwise contained in this agreement.
- It is the policy of HHS/CDC to seek to ensure that none of its funds are used, directly or indirectly, to provide support to individuals or entities designated for United Nations Security Council sanctions. In accordance with this policy, the applicant agrees to use reasonable efforts to ensure that none of the funds provided under this grant are used to provide support of individuals or entities designated for UN Security Council sanctions (compendium of Security Council Targeted Sanctions Lists at: http://www.un.org/sc/committees/list_compend.shtml). This provision must be included in all sub-agreements, including contracts and sub-awards, issued under this award.
- **Prohibition on Assistance to Drug Traffickers**
    - HHS/CDC reserves the right to terminate assistance to, or take other appropriate measures with respect to, any participant approved by HHS/CDC who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

- The Applicant agrees not to disburse, or sign documents committing the Applicant to disburse funds to a sub-recipient designated by HHS/CDC ("Designated Sub-recipient") until advised by HHS/CDC that: (1) any United States Government review of the Designated Sub-recipient and its key individuals has been completed; (2) any related certifications have been obtained; and (3) the assistance to the Designated Sub-recipient has been approved.
- The Applicant shall insert the following clause, or its substance, in its agreement with the Designated Sub-recipient:
  - The Applicant reserves the right to terminate this Agreement or take other appropriate measures if the [Sub-recipient] or a key individual of the [Sub-recipient] is found to have been convicted of a narcotic offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

- **Conference Costs and Fees**
  U.S. Government funds under this award must not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a multilateral organization, as defined below, unless approved by the CDC in writing.
  - Definitions:
    - A foreign government delegation is appointed by the national government (including ministries and agencies but excluding local, state and provincial entities) to act on behalf of the appointing authority at the international conference. A conference participant is a delegate for the purposes of this provision, only when there is an appointment or designation that the individual is authorized to officially represent the government or agency. A delegate may be a private citizen.
    - An international conference is a meeting where there is an agenda, an organizational structure, and delegations from countries other than the conference location, in which country delegations participate through discussion, votes, etc.
    - A multilateral organization is an organization established by international agreement and whose governing body is composed principally of foreign governments or other multilateral organizations.
- **Using PEPFAR funds for Implementing Partners (IPs) and Partner Government Officials**
  IPs are required to notify their Project Officer immediately upon abstract acceptance. Once accepted, IPs are required to submit a written justification to their Project Officer stating the rationale for seeking support to attend the conference. IPs with accepted oral posters or oral abstracts for presentations that give clear attribution to PEPFAR may be authorized to use PEPFAR funds for travel providing that funds are available for travel. Funds for travel must be drawn from an existing agreement with the IP and not from PEPFAR country program management and operations budget. IPs must obtain prior approval from their respective Project Officer for participation and on availability and use of funds.

  PEPFAR partner government officials who wish to attend any large conference using PEPFAR funds must submit requests to the Project Officer, who will work with this PEPFAR Coordination office in-country, or to the designated PEPFAR Point of Contact in countries without Coordinators. Final decisions will be made in collaboration with the PEPFAR Deputy Principals and responses will be circulated to Post.
- **Attribution to PEPFAR**
  - All PEPFAR-related accepted abstracts presented by implementing partners during any conference (regardless of conference/meeting size) must be attributed to PEPFAR. All posters must include the PEPFAR logo as well as the following language: "This research

has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through HHS/CDC under the terms of CDC-RFA-GH15-1583."

- **Abortion and Involuntary Sterilization Restrictions**
  - Funds made available under this award must not be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.
  - Prohibition on Abortion-Related Activities:
    - No funds made available under this award will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to any person to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and (v) lobbying for or against abortion. The term "motivate", as it relates to family planning assistance, must not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.
    - No funds made available under this award will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded
- **Prostitution and Sex Trafficking**
  - A standard term and condition of award will be included in the final notice of award; all applicants will be subject to a term and condition that none of the funds made available under this award may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. In addition, non-U.S. nongovernmental organizations will also be subject to an additional term and condition requiring the organization's opposition to the practices of prostitution and sex trafficking.
- **Trafficking in Persons Provision**
  - No contractor or subrecipient under this Agreement that is a private entity may, during the period of time that the award is in effect:
    - engage in trafficking in persons, as defined in the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children, supplementing the UN Convention against Transnational Organized Crime;
    - procure any sex act on account of which anything of value is given to or received by any person; or
    - use forced labor in the performance of this award.
  - If HHS/CDC determines that there is a reasonable basis to believe that any private party contractor or subrecipient has violated paragraph 1 of this section or that an employee of the contractor or subrecipient has violated such a prohibition where that the employee's conduct is associated with the performance of this award or may be imputed to the contractor or subrecipient, HHS/CDC may, without penalty, (i) require the Grantee to terminate immediately the contract or subaward in question or (ii) unilaterally terminate this Agreement in accordance with the termination provision.
  - For purposes of this provision, "employee" means an individual who is engaged in the performance in any part of the Project as a direct employee, consultant, or volunteer of any private party contractor or subrecipient.
  - The Applicant must include in all subagreements, including subawards and contracts, a

provision prohibiting the conduct described in subsection a by private party subrecipients, contractors, or any of their employees

- **Requirements for Voluntary Family Planning Projects**
    - A family planning project must comply with the requirements of this paragraph.
    - A project is a discrete activity through which a governmental or nongovernmental organization or Public International Organization (PIO) provides family planning services to people and for which funds obligated under this award, or goods or services financed with such funds, are provided under this award, except funds solely for the participation of personnel in short-term, widely attended training conferences or programs.
    - (3) Service providers and referral agents in the project must not implement or be subject to quotas or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning. Quantitative estimates or indicators of the number of births, acceptors, and acceptors of a particular method that are used for the purpose of budgeting, planning, or reporting with respect to the project are not quotas or targets under this paragraph, unless service providers or referral agents in the project are required to achieve the estimates or indicators.
    - (4) The project must not include the payment of incentives, bribes, gratuities or financial rewards to (i) any individual in exchange for becoming a family planning acceptor, or (ii) any personnel performing functions under the project for achieving a numerical quota or target of total number of births, number of family planning acceptors, or acceptors of a particular method of contraception. This restriction applies to salaries or payments paid or made to personnel performing functions under the project if the amount of the salary or payment increases or decreases based on a predetermined number of births, number of family planning acceptors, or number of acceptors of a particular method of contraception that the personnel affect or achieve.
    - (5) A person must not be denied any right or benefit, including the right of access to participate in any program of general welfare or health care, based on the person's decision not to accept family planning services offered by the project.
    - The project must provide family planning acceptors comprehensible information about the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method. This requirement may be satisfied by providing information in accordance with the medical practices and standards and health conditions in the country where the project is conducted through counseling, brochures, posters, or package inserts.
        - The recipient must notify CDC when it learns about an alleged violation in the requirements for voluntary family planning projects described in paragraphs (3), (4), or (5), above.
        - The recipient must investigate and take appropriate corrective action, if necessary, when it learns about an alleged violation and must notify CDC about violations in a project affecting a number of people over a period of time that indicate there is a systemic problem in the project.
        - The recipient must provide CDC such additional information about violations as CDC may request.
- **Investment Promotion**
    - No funds or other support provided hereunder may be used to provide a financial incentive to a business enterprise currently located in the United States for the purpose of inducing such an enterprise to relocate outside the United States if such incentive or inducement is likely to reduce the number of employees of such business enterprise in the

United States because United States production is being replaced by such enterprise outside the United States.

- In the event the Applicant requires clarification from HHS/CDC as to whether the activity would be consistent with the limitation set forth above, the Applicant must notify HHS/CDC and provide a detailed description of the proposed activity. The Applicant must not proceed with the activity until advised by HHS/CDC that it may do so.
- The Applicant must ensure that its employees and subcontractors and sub-recipients providing investment promotion services hereunder are made aware of the restrictions set forth in this clause and must include this clause in all subcontracts and other sub-agreements entered into hereunder.

- **Worker's Rights**
  - No funds or other support provided hereunder may be used for any activity that contributes to the violation of internationally recognized workers' rights of workers in the recipient country.
  - In the event the Applicant is requested or wishes to provide assistance in areas that involve workers' rights or the Applicant requires clarification from HHS/CDC as to whether the activity would be consistent with the limitation set forth above, the Applicant must notify HHS/CDC and provide a detailed description of the proposed activity. The Applicant must not proceed with the activity until advised by HHS/CDC that it may do so.
  - The Applicant must ensure that all employees and subcontractors and sub-recipients providing employment-related services hereunder are made aware of the restrictions set forth in this clause and must include this clause in all subcontracts and other sub-agreements entered into hereunder.
  - The term "internationally recognized worker rights" includes-- the right of association; the right to organize and bargain collectively; a prohibition on the use of any form of forced or compulsory labor; a minimum age for the employment of children, and a prohibition on the worst forms of child labor; and acceptable conditions of work with respect to minimum wages, hours of work, and occupational safety and health.
  - The term "worst forms of child labor" means-- all forms of slavery or practices similar to slavery, such as the sale or trafficking of children, debt bondage and serfdom, or forced or compulsory labor, including forced or compulsory recruitment of children for use in armed conflict; the use, procuring, or offering of a child for prostitution, for the production of pornography or for pornographic purposes; the use, procuring, or offering of a child for illicit activities in particular for the production and trafficking of drugs; and work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety, or morals of children, as determined by the laws, regulations, or competent authority of the country.
- **Contract Insurance Requirement**
  To the extent that a host government partner enters into contracts expressly approved by the U.S. government, the host country government partner shall ensure that its contractors or subcontractors (a) provide, before commencing performance under any contracts or subcontracts funded under this agreement, such workers' compensation insurance or security as required by HHS/CDC and (b) continue to maintain such insurance until performance is completed. The host country government partner shall insert, in all contracts and subcontracts under this agreement, a clause similar to this clause (including this sentence) imposing upon those contractors and subcontractors the obligation to obtain workers' compensation insurance or security as required by HHS/CDC.
- No funds or other support provided under the award may be used for support to any military or paramilitary force or activity, or for support to any police, prison authority, or other security or

law enforcement forces without the prior written consent of HHS/CDC.

- **Conscience Clause**
  An organization, including a faith-based organization, that is otherwise eligible to receive funds under this agreement for HIV/AIDS prevention, treatment, or care—
  - Shall not be required, as a condition of receiving such assistance—
  - To endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or
  - To endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and
  - Shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements for refusing to meet any requirement described above.
- **Medically Accurate Information About Condoms**
  Information provided about the use of condoms as part of projects or activities funded under the award must be medically accurate and must include the public health benefits and failure rates of such use.
- **Financing of Terrorism**
  Consistent with numerous United Nations Security Council resolutions, including UNSCR 1267 (1999) (http://www.undemocracy.com/S-RES-1269(1999).pdf), UNSCR 1368 (2001) (http://www.undemocracy.com/S-RES-1368(2001).pdf), UNSCR 1373 (2001) (http://www.undemocracy.com/S-RES-1373(2001).pdf), and UNSCR 1989 (2011), both HHS/CDC and the Applicant are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. It is the policy of HHS/CDC to seek to ensure that none of its funds are used, directly or indirectly, to provide support to individuals or entities associated with terrorism. In accordance with this policy, the Applicant agrees to use reasonable efforts to ensure that none of the HHS/CDC funds provided under this Agreement are used to provide support to individuals or entities associated with terrorism, including those identified on the U.S. Department of Treasury Office of Foreign Assets Control Specially Designated Nationals List. This provision must be included in all subagreements, including contracts and subawards, issued under this award.
- **Source and Nationality and Other Procurement Restrictions**
  - Disbursements will be used exclusively to finance the costs of goods and services required for this Agreement [in accordance with 22 CFR 228, and] having their source and nationality in countries [included in Geographic Code [937 or 935]] OR [identified in subsection 6 below], except as HHS/CDC may otherwise agree in writing and as follows:
    - Ocean transportation costs must be financed under the Agreement only on vessels under flag registry of [countries included in Code 935] OR [the following countries: LIST. Also see subsection 7 below on use of U.S.-flag vessels.
    - Any motor vehicles financed under the Agreement will be of United States manufacture, except as HHS/CDC may otherwise agree in writing.
  - The nationality of the contractor providing ocean and air shipping services will be deemed to be the ocean vessel's or aircraft's country of registry at the time of shipment.
  - Provisions concerning restricted and ineligible goods and services may be provided in subsequent written communications between the parties. Special procurement rules apply to agricultural commodities, pharmaceuticals, pesticides, and fertilizer, none of which may be procured without advance written consent of HHS/CDC.
  - Transportation by air of property or persons financed under this agreement will be on carriers holding United States certification, to the extent service by such carriers is available under the Fly America Act. This requirement may be further described by HHS/CDC in subsequent written communications between the parties.

- Eligibility Date. No goods or services may be financed under the Agreement which are procured pursuant to orders or contracts firmly placed or entered into prior to the date of this Agreement, except as the Parties may otherwise agree in writing.
- Eligible countries for procurement: HHS/CDC to identify for specific agreement.
- Transportation
  - In addition to the requirements in subsection 1 above, costs of ocean or air transportation and related delivery services may not be financed under this Agreement, if the costs are for transportation under an ocean vessel or air charter which has not received prior HHS/CDC approval.
  - Unless HHS/CDC determines that privately owned U.S. -flag commercial ocean vessels are not available at fair and reasonable rates for such vessels, or otherwise agrees in writing:
    - At least fifty percent (50%) of the gross tonnage of all goods (computed separately for dry bulk carriers, dry cargo liners and tankers) financed by HHS/CDC which may be transported on ocean vessels will be transported on privately owned U.S.-flag commercial vessels; and
    - At least fifty percent (50%) of the gross freight revenue generated by all shipments financed by HHS/CDC and transported to the territory of the Grantee on dry cargo liners shall be paid to or for the benefit of privately owned U.S.-flag commercial vessels. Compliance with the requirements of (1) and (2) of this subsection must be achieved with respect to both any cargo transported from U.S. ports and any cargo transported from non-U.S. ports, computed separately.

- **Environmental Impact Statement**
  HHS/CDC and the Applicant agree to implement the Project in conformance with the regulatory and legal requirements of the Partner Country's environmental legislation and HHS/CDC's environmental policies.
  - The Applicant is required to create and follow an environmental mitigation plan and report (EMPR) for each thematic area covered by this agreement. The EMPR shall include the following:
    - Coversheet;
    - Narrative with project specific information, including level of effort;
    - Annexes:
      - Environmental Screening Form (Table 1);
      - Identification of Mitigation Plan (Table 2);
      - Environmental Monitoring and Tracking Table (Table 3);
    - Photos and Maps, as appropriate.
  - The EMPR will capture potential environmental impacts and also inform whether a supplemental Initial Environmental Examination (IEE) is required and should be completed and submitted to HHS/CDC.
- **Branding**
  All PEPFAR-funded programs or activities must adhere to PEPFAR branding guidance, which includes guidance on the use of the PEPFAR logo and/or written attribution to PEPFAR. PEPFAR branding guidance can be found at http://www.pepfar.gov/reports/guidance/branding/index.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) 2015, the limit is no more than 8 percent of the country's FY 2015 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 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 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 FOA. For example, the proposal should state that the applicant has $_____ in FY 2015 grants and cooperative agreements (for as many fiscal years as applicable) in Swaziland. For additional information concerning this FOA, please contact the Grants Management Officer for this FOA.

16. Other Submission Requirements:

a. **Electronic Submission:** Applications must be submitted electronically at www.grants.gov. The application package can be downloaded from www.grants.gov. Applicants can complete the application package off-line, and then submit the application by uploading it at www.grants.gov website. All application attachments must be submitted using a PDF file format. Directions for creating PDF files can be found at www.grants.gov. File formats other than PDF may not be readable by PGO TIMS staff.

Applications must be submitted electronically by using the forms and instructions posted for this funding opportunity on www.grants.gov.

If Internet access is not available or if the forms cannot be accessed on-line, applicants may contact the PGO TIMS staff at 770-488-2700 or by e-mail at pgotim@cdc.gov, Monday through Friday, 7:30 am–4:30 pm Eastern Standard Time (EST), except federal government holidays. Electronic applications will be considered successful if they are available to PGO TIMS staff for processing from www.grants.gov on the deadline date.

Do not use "special characters (i.e. %, &, * etc.) on the cover page of your application (form SF 424 – Application for Federal Assistance) as special characters are not recognized by the electronic system. Use of special characters may result in your application being rejected. When copy/paste is used on application documents, the grantee should ensure that text only is pasted. When extra, blank spaces at the end of the original are pasted into the new document it causes the system to reject the document.

b. Tracking Number: Applications submitted through www.grants.gov, are time/date stamped electronically and assigned a tracking number. The Authorized Organization Representative (AOR) will receive an email notice of receipt when www.grants.gov receives the application. The tracking number serves to document that the application has been submitted and initiates the electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until successful completion of the validation process. After submission of the application package, applicants will receive a "submission receipt" email generated by www.grants.gov. A second email message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure submission of their package is complete and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Application User Guide, Version 3.0, page 57.

d. Technical Difficulties: If the applicant encounters technical difficulties with www.grants.gov, the applicant should contact www.grants.gov Customer Service. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of Federal Holidays. You can reach the www.grants.gov Contact Center at 1-800-518-4726 or by email at support@www.grants.gov. Submissions sent by email, fax, CD's or thumb drives of applications will not be accepted. Please note that www.grants.gov is managed by HHS.

If Grants.gov is inoperable and cannot receive applications due to an emergency or other unanticipated event that results in the suspension of government operations (and circumstances preclude advance notification of an extension), then applications must be submitted by the first business day on which government operations resume.

e. **Paper Submission:** If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@www.grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail or call CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must include the following three items:

1. Include the www.grants.gov case number assigned to the inquiry;
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, PGO will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Application Review Information

1. Review and Selection Process:
Applications will be reviewed in three phases

a. Phase I Review:

All applications will be reviewed initially for completeness by the CDC's Procurement and Grants Office (PGO) staff and will be reviewed jointly for eligibility by the CDC Division of Global HIV/AIDS and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance to Phase II review. Applicants will be notified that the application did not meet eligibility and/or published submission requirements.

b. Phase II Review:

An objective review panel will evaluate complete, eligible applications in accordance with the "Criteria" section of the FOA.

Ability to Carry Out the Proposal (20 points):
Does the applicant demonstrate the local experience in Swaziland or the sub-region and institutional capacity (both management and technical) to achieve the goals of the FOA with documented good governance practices? Assessment should include reviews of letters of endorsement from the MOH and annual reports. (10 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? (5 points)
Is there evidence of current or past efforts to enhance HIV prevention, TB, care and treatment in Swaziland? Does the applicant have the capacity to reach rural and other underserved populations in Swaziland? To what extent does the applicant provide letters of support demonstrating past success in similar settings or potential for success in Swaziland? (5 points)

Technical and Programmatic Approach (20 points):

Does the application include an overall strategy, including measurable time lines, clear monitoring and evaluation procedures, and specific activities for meeting the proposed outcomes? (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 with evidence-based strategies designed to meet the goals of the President's Emergency Plan? Does the application include reasonable estimates of output 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? (5 points)
The reviewers will assess the feasibility of the applicant's plan to meet the outcomes, congruency of application with the logic model, whether the proposed use of funds is efficient, and the extent to which the specific methods described are appropriate for the local culture.

Understanding of the Problem (10 points):
Does the applicant demonstrate a clear and concise understanding of the current national HIV/AIDS and TB 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 in Swaziland? To what extent does the applicant justify the need for this FOA at the national, regional, and facility levels? (5 points)

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? Assessment should include reviews of letters of endorsement from the MOH and annual reports. (5 points)
Does the applicant describe an adequate and measurable plan to progressively strengthen the capacity of local organizations (especially government structures such as regional health management teams) and target beneficiaries to respond to the epidemic? If not a local indigenous organization, does the applicant articulate a clear exit strategy which will maximize the sustainability of project results in the intervention communities? (5 points)
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[3]" 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 in Swaziland and capability to implement performance monitoring and rigorous evaluation of the project? Does the evaluation and performance measurement plan appropriately address the components specified in this

[3] 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.

announcement (i.e. key evaluation questions, types of evaluations to be conducted, performance measures (i.e., indicators), how often performance measures must be reported, how evaluation and performance measurement will track how target populations are affected by FOA strategies, how evaluation findings and performance measures will be used and yield findings to demonstrate the value of the FOA, and how results will be disseminated)? (5 points)
Does the applicant describe a performance monitoring system used to routinely review data and adjust program activities accordingly? Is the evaluation and performance plan consistent with the principles of the "Three Ones[4]"? Are performance measures (i.e., 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 and other HHS/CDC requirements? (5 points)
Does the applicant demonstrate a 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 and HHS/CDC priorities? (5 points)

Personnel (10 points):
Does the organization employ staff with appropriate international and local experience 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? (5 points)
If not an indigenous organization, does the staff plan adequately involve local individuals and organizations? Is 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 and TB prevention, care and treatment activities; and the development of capacity building among and collaboration between Governmental and non-governmental partners. (5 points)

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? (5 points)
Is the management structure for the project sufficient to ensure speedy implementation of the project? (5 points).
The grantee must demonstrate an ability to submit quarterly reports in a timely manner to the HHS/CDC office.

Budget (Reviewed 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?

[4] 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.

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

c. Phase III Review:

Applications will be funded in order by score and rank determined by the review panel unless funding preferences or other considerations stated in this FOA apply. Final selection and approval of activities will be prioritized in collaboration with CDC.

In addition, the following factors may affect the funding decision:

Funding Preferences (10 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:

Funding Preference 1: Preference for organizations with demonstrated experience in providing TA to facilities in Swaziland, including capacity building to health care workers to provide sustainable services. (5 points)
Deliverable 1A: At least one annual report describing similar work and outcomes in Swaziland.
Deliverable 1B: A letter of endorsement from MOH Swaziland.
Label for Deliverable 1: Funding Preference for Capacity Building Experience

Funding Preference 2: Preference for organization with demonstrated successful experience providing TA to MOH at the national level on HIV care and treatment in Swaziland. (5 points)
Deliverable 2A: At least 1 annual report describing similar work and outcomes in Swaziland.
Deliverable 2B: A letter of endorsement from MOH Swaziland.
Label for Deliverable 2: Funding Preference for demonstrated HIV care and treatment experience

Applicants must submit both documents (annual report and letter of support) to be eligible to receive funding preference points for Funding Preference 2. Please note that for Funding Preference 2, funding preference points will not be awarded to applicants who do not provide both of the required deliverables (2A and 2B) listed above.

Each funding preference deliverable must be submitted as part of the appendix, clearly named using the label for the deliverable above, and uploaded as a PDF file at www.grants.gov. Funding preference points will not be awarded to applicants who do not provide the required deliverable for the applicable funding preference. Funding preference points will not be awarded to applicants who fail to label the supporting documentation as required to certify the deliverable for the funding preference.

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

2. Anticipated Announcement and Award Dates:

The anticipated announcement date is February 2015. The award date will be April 1, 2015.

F. Award Administration Information

1. Award Notices:

Awardees will receive an electronic copy of the Notice of Award (NoA) from the CDC PGO. The NoA shall

be the only binding, authorizing document between the awardee and CDC. The NoA will be signed by an authorized GMO and emailed to the awardee program director.

Any application awarded in response to this FOA will be subject to the DUNS, SAM Registration and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of the results of the application review by email with delivery receipt or by mail.

2. Administrative and National Policy Requirements:

Awardees must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. To view brief descriptions of relevant provisions visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm

The following administrative requirements apply to this project:

Generally applicable administrative requirements (ARs):

- AR-9: Paperwork Reduction Act
- AR-10: Smoke-Free Workplace
- AR-11: Healthy People 2020
- AR-12: Lobbying Restrictions
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR-24: Health Insurance Portability and Accountability Act
- AR-25: Release and Sharing of Data
- AR-26: National Historic Preservation Act of 1966
- AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving," October 1, 2009
- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR- 32: Executive Order 131410: Promoting Quality and Efficient Health Care in Federal Government (If applicable applicants should be aware of the program's current business needs and how they align with nationally adopted Public Health Information Network (PHIN) standards, services, practices, and policies when implementing, acquiring, and updating public health information systems.)
- AR-33: Plain Writing Act of 2010
- AR-34: Patient Protection and Affordable Care Act (e.g. a tobacco-free campus policy and a lactation policy consistent with S4207)

ARs applicable to HIV/AIDS Awards:

- AR-4: HIV/AIDS Confidentiality Provisions
- AR-5: HIV Program Review Panel
- AR-6: Patient Care

Organization Specific ARs:

- AR-8: Public Health System Reporting (Community-based non-governmental organizations)
- AR-15: Proof of Non-profit Status (Non-profit organizations)
- AR 23: Compliance with 45 C.F.R. Part 87 (Faith-based organizations)

Potentially Applicable Public Policy Requirements

- False or Misleading Information
- Taxes: Certification of Filing and Payment of Taxes
- Fly America Act/ U.S. Flag Air Carriers
- National Environmental Policy Act

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will have a condition of award that applies to 48 CFR section 3.908 requiring grantees to inform their employees in writing of employee whistleblower rights and protections under 41. U.S.C 4712 in the predominant native language of the workforce.

If applicable, award recipients will be required to submit an electronic version of the final, peer-reviewed manuscript of any work developed under this award upon acceptance for publication. Additional information will be provided in the award terms.

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

3. Reporting:

a. CDC Reporting Requirements:

Reporting allows for continuous program monitoring and identifies successes and challenges that awardees encounter throughout the project period. Also, reporting is a requirement for awardees who want to apply for yearly continuation of funding. Reporting helps CDC and awardees because it:

- Helps target support to applicants, particularly for cooperative agreements;
- Provides CDC with periodic data to monitor awardee progress towards meeting the FOA outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables the assessment of the overall effectiveness and impact of the FOA.

As described in the following text, awardees must submit an annual performance report, ongoing performance measures data, administrative reports, and a final performance and financial report. A detailed explanation of any additional reporting requirements will be provided in the Notice of Award to successful applicants.

b. Specific Reporting Requirements:

i. Awardee Evaluation and Performance Measurement Plan:

Awardees must provide a more detailed evaluation and performance measurement plan within the first six months of the project. This more detailed plan should be developed by awardees as part of first-year project activities, with support from CDC. This more detailed plan should build on the elements stated in the initial plan, and should be no more than 25 pages. At a minimum, and in addition to the elements of the initial plan, this plan must:

- Indicate the frequency that evaluation and performance data are to be collected.
- Describe how data will be reported.
- Describe how evaluation findings will be used to ensure continuous quality and program improvement.
- Describe how evaluation and performance measurement will yield findings that will demonstrate the value of the FOA (e.g., effect on improving public health outcomes, effectiveness of FOA as it pertains to performance measurement, cost-effectiveness, or cost-benefit).
- Describe dissemination channels and audiences (including public dissemination).
- Describe other information requested and as determined by the CDC program.

When developing evaluation and performance measurement plans, applicants are encouraged to use the Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide, available at: http://www.cdc.gov/eval/guide/index.htm

ii. Annual Performance Report:

(due no later than 120 days before the end of the budget period and serves as a continuation application).

This report must not exceed 35 pages excluding work plan and administrative reporting. Attachments are not permitted, but web links are allowed. The awardee must submit the Annual Performance Report via www.grants.gov no later than 120 days before the end of the

budget period. In addition, the awardee must submit an annual Federal Financial Report within 90 days after the end of the calendar quarter in which the budget year ends.

This report must include the following:

- **Performance Measures (including outcomes)** – Awardees must report on performance measures for each budget period and update measures, if needed
- **Evaluation Results** –Awardees must report evaluation results for the work completed to date (including any impact data)
- **Work Plan (maximum of 25 pages**) – Awardees should update work plan each budget period
- **Successes**
  - ✓ Awardees must report progress on completing activities outlined in the work plan
  - ✓ Awardees must describe any additional successes (e.g., identified through evaluation results or lessons learned) achieved in the past year
  - ✓ Awardees must describe success stories
- **Challenges**
  - ✓ Awardees should describe any challenges that hinder achievement of both annual and project period outcomes, performance measures, or their ability to complete the activities in the work plan
  - ✓ Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year
- **CDC Program Support to Awardees**
  - ✓ Awardees should describe how CDC could assist them in overcoming any challenges to achieve both annual and project period outcomes and performance measures, and complete activities outlined in the work plan
- **Administrative Reporting (not subject to page limits)**
  - ✓ SF-424A Budget Information-Non-Construction Programs
  - ✓ Budget Narrative – Must use the format outlined in Section IV. Content and Form of Application Submission, Budget Narrative Section
  - ✓ Indirect Cost Rate Agreement
  - ✓ Pipeline Analysis – Expenditures versus budget as identified in work plan, description of challenges, and explanation of unexpected pipeline (high or low).
- **Measures of Effectiveness**
  - ✓ Include progress against the numerical goals of the President's Emergency Plan for AIDS Relief for Swaziland and HHS/CDC guidance

iii. Performance Measure Reporting:

CDC programs must require awardees to submit performance measures annually at a minimum, and may require reporting more frequently. Performance measure reporting should be limited to the collection of data. When funding is awarded initially, CDC programs should specify reporting frequency, required data fields, and format.

iv. Monitoring Reporting and Evaluation:

CDC programs must ensure that grantee's Evaluation and Performance Measurement Plan is aligned with the strategic information guidance established by OGAC and other HHS/CDC requirements, including PEPFAR's Monitoring Reporting and Evaluation (MER) strategy and CDC's Data for Partner Monitoring Program (DFPM).

v. Federal Financial Reporting:

The annual FFR form (SF-425) is required and must be submitted through eRA Commons[5] within 90 days after the end of the calendar quarter in which the budget year ends. The report should include only those funds authorized and disbursed during the timeframe covered by the report. The final report must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. The final FFR expenditure data and the Payment Management System's (PMS) cash transaction data must correspond; no discrepancies between the data sets are permitted. Failure to submit the required information by the due date may affect adversely the future funding of the project. If the information cannot be provided by the due date, awardees are required to submit a letter of explanation and include the date by which the information will be provided.

vi. Final Performance and Financial Report:

At the end of the project period, awardees must submit a final report to include a final financial and performance report. This report is due 90 days after the end of the project period. The page limit for this report is not to exceed 40 pages.

At a minimum, this report must include the following:

- Performance Measures (including outcomes) – Applicants must report final performance data for all performance measures for the project period.
- Evaluation results – Applicants must report final evaluation results for the project period
- Impact of Results – Applicants must describe the effects or results of the work completed over the project period, including success stories.
- Additional forms as described in the Notice of Award, including Equipment Inventory Report and Final Invention Statement.
- FFR (SF-425)

Awardees should e-mail the report to the CDC PO and the GMS listed in the "Agency Contacts" section of the FOA.

4. Federal Funding Accountability and Transparency Act of 2006:

Federal Funding Accountability And Transparency Act Of 2006 (FFATA), Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, www.USASpending.gov.

[5] https://commons.era.nih.gov/commons/

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf,
- https://www.fsrs.gov/documents/ffata_legislation_110_252.pdf
- http://www.hhs.gov/asfr/ogapa/aboutog/Grants%20Management%20Information/ffata_guidelines.html.

5. Programmatic Impact Reporting and Monitoring:

A. The recipient is responsible for managing and monitoring each project, program, subaward, function or activity supported through this Agreement. Recipients must monitor subawards to ensure that subrecipients have met the programmatic impact requirements as set forth in the subrecipient's agreement.

B. The recipient must submit the original and two copies of annual and quarterly performance reports and quarterly pipeline analysis reports. Annual reports must be due 90 calendar days after the award year and quarterly reports must be due 30 days after the reporting period. The final performance reports are due 90 calendar days after the expiration or termination of this Agreement.

C. Performance reports must generally contain, for each award, brief information on each of the following:

- A comparison of actual accomplishments with the goals and objectives previously established for the period, including metrics outlined in the monitoring and evaluation plan (section on M&E), any findings of an external entity, or both. Whenever appropriate and the output of programs or projects can be readily quantified, such quantitative data must be included in the reports and be related to cost data for computation of unit costs. Also included should be a brief description of the methods used to assure and assess the quality of the quantitative data, including any remediation taken to improve findings of poor data quality.
- Reasons why established goals for the performance period were not met, if appropriate.
- Other pertinent information including, when appropriate, statutory or Congressional reporting requirements, analysis and explanation of cost overruns or high unit costs reported in financial reports.
- The recipient must immediately notify the awarding agency of developments that have a significant impact on the award-supported activities. Also, recipients must give notification immediately in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the award. This notification must include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.
- The Pipeline Analysis report must contain expenditures versus budget as identified in work plan, description of challenges, and explanation of unexpected pipeline (high or low).

The recipient is required to submit in a timely manner both quarterly and annual program results for all relevant programmatic indicators in accordance with U.S. government guidance.

6. Monitoring and Evaluation:

A. The recipient must submit a monitoring and evaluation plan for approval, and carry out monitoring and evaluation activities in accordance with the approved monitoring and evaluation plan. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC or other guidance otherwise applicable to this Agreement.

B. HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the Activities and use of HHS/CDC funding under this Agreement, must require a provision to this effect in all sub-awards or contracts financed by funds under this Agreement. Where applicable, this includes support for, and response to, activities associated with the Site Monitoring System and implementation of Data and Service Quality Assessments.

7. Expenditure Analysis

Recipients of PEPFAR funds are required to report annually on program expenditures. Specifically, annual completion of PEPFAR Program Expenditures (Form DS-4213, approved by OMB 1405-0208, or the relevant OMB-approved format) will be required in conjunction with the PEPFAR Annual Progress Report at the completion of the USG fiscal year.

8. Audit, Books, and Records Clause:

A. Reports and Information. The recipient must furnish HHS/CDC accounting records and such other information and reports relating to the Agreement as HHS/CDC may reasonably request.

B. The Recipient Agreement Books and Records. The recipient must maintain accounting books, records, documents and other evidence relating to the Agreement, adequate to show, without limitation, all costs incurred by the recipient, the receipt and use of goods and services acquired by the recipient, agreed-upon cost sharing requirements, the nature and extent of solicitations of prospective suppliers of goods and services acquired by the recipient, the basis of award of recipient contracts and orders, and the overall progress of the Agreement toward completion ("Agreement books and records"). The recipient must maintain Agreement books and records in accordance with generally accepted accounting principles prevailing in the United States, or at the recipient's option, with approval by HHS/CDC, other accounting principles, such as those (1) prescribed by the International Accounting Standards Committee (an affiliate of the International Federation of Accountants), or (2) prevailing in the country of the recipient. Agreement books and records must be maintained for at least three years after the date of last disbursement by HHS/CDC or for such longer period, if any, required to resolve any litigation, claims or audit findings.

C. Partner Government Audit. If $300,000 or more of US Government funds are expended by the recipient in its fiscal year under the Agreement, the recipient must have financial audits made of the expenditures in accordance with the following terms, except as the Parties may otherwise agree in writing:

i. The recipient must use its Supreme Audit Institution (SAI), if the SAI is approved by HHS/CDC, or select an independent auditor to perform the audit in accordance with the guidelines issued by HHS/CDC.

ii. The audit must determine whether the receipt and expenditure of the funds provided under the Agreement are presented in accordance with generally accepted accounting principles agreed to in Section 2 above and whether the recipient has complied with the terms of the

Agreement. Each audit must be submitted to HHS/CDC no later than nine months after the close of the recipient's year under audit.

D. Sub-recipient Audits. The recipient, except as the Parties may otherwise agree in writing, must ensure that "covered" sub-recipients, as defined below, are audited, and submit to HHS/CDC, no later than the end of the recipient's year under audit, in form and substance satisfactory to HHS/CDC, a plan for the audit of the expenditures of "covered" sub-recipients, as defined below, that receive funds under this Agreement pursuant to a direct contract or agreement with the recipient.

i. "Covered" sub-recipient is one who expends $300,000 or more in its fiscal year in "US Government awards" (i.e. as recipients of US Government cost reimbursable contracts, grants or cooperative agreements).

ii. The plan must describe the methodology to be used by the recipient to satisfy its audit responsibilities for covered sub-recipients. The recipient may satisfy such audit responsibilities by relying on independent audits of the sub-recipients; expanding the scope of the independent financial audit of the recipient to encompass testing of sub-recipients' accounts; or a combination of these procedures.

iii. The plan must identify the funds made available to sub-recipients that will be covered by audits conducted in accordance with audit provisions that satisfy the recipient's audit responsibilities.

iv. The recipient must ensure that covered sub-recipients under direct contracts or agreements with the recipient take appropriate and timely corrective actions; consider whether sub-recipients' audits necessitate adjustment of its own records; and require each such sub-recipient to permit independent auditors to have access to records and financial statements as necessary.

E. Audit Reports. The recipient must furnish or cause to be furnished to HHS/CDC an audit report for each audit arranged for by the recipient in accordance with this Section within 30 days after completion of the audit and no later than nine months after the end of the period under audit.

F. Cost of Audits. Subject to HHS/CDC approval in writing, costs of audits performed in accordance with the terms of this Section may be budgeted for, and charged to, the Agreement so long as such costs are allowable, allocable, and reasonable as defined in the Cost Allowability section of this Agreement.

G. Audit by HHS/CDC. HHS/CDC retains the right to perform the audits required under this Agreement on behalf of the recipient conduct a financial review, or otherwise ensure accountability of organizations expending US Government funds regardless of the audit requirement.

H. Opportunity to Audit or Inspect. The recipient must afford authorized representatives of HHS/CDC the opportunity at all reasonable times to audit or inspect activities financed under the Agreement, the utilization of goods and services financed by HHS/CDC, and books, records and other documents relating to the Agreement.

I. Sub-recipient Books and Records. The recipient will incorporate paragraphs (1), (2), (4), (5), (6), (7) and (8) of this provision into all sub-agreements with non-U.S. organizations which meet the $300,000 threshold of paragraph (3) of this provision. Sub-agreements with non-U.S. organizations, which do not meet the $300,000 threshold, must, at a minimum, incorporate paragraphs (7) and (8) of this provision. Sub-agreements with U.S. organizations must state that the U.S. organization is subject to the audit requirements contained in OMB Circular A-133.

9. Reporting of Foreign Taxes

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) ("United States foreign assistance funds"). Outlined below are the specifics of this requirement:

1) Annual Report: The grantee must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the grantee did not pay any taxes during the reporting period.]

2) Quarterly Report: The grantee must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:
   a. grantee name;
   b. contact name with phone, fax, and e-mail;
   c. agreement number(s) if reporting by agreement(s);
   d. reporting period;
   e. amount of foreign taxes assessed by each foreign government;
   f. amount of any foreign taxes reimbursed by each foreign government;
   g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The grantee must include this reporting requirement in all applicable

subgrants and other subagreements.

10. Human Subjects Restrictions:

Data collection protocols required for release of human subjects funding restrictions must be submitted to the DGHA Science Office within 6 months of notification of such restrictions, but no later than the end of the first budget year. Requests for exceptions to these deadlines will need to be submitted in writing to the Grants Management Officer.

All protocol approvals should be obtained no later than the end of the subsequent budget period after the award or continuation has been made, provided that the Grantee has not been granted an exception to the deadlines specified above.

G. Agency Contacts

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

Mary Mulholland, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
US Embassy Mbabane
Kent Rock
Corner of Jubela St and Sir Robert Croydon
P.O. Box 199 Mbabane Swaziland
Telephone: +268 2404 3264 (office) +268 7802 9691 (mobile)
Email: MulhollandMA@state.gov

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

Randolph Williams, Grants Management Officer
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS K75
Atlanta, GA 30341
Telephone: 770-488-8382
Email: gur2@cdc.gov

For assistance with submission difficulties related to www.grants.gov, contact:

www.grants.gov Contact Center: 1-800-518-4726.
Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays.

For all other 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 individuals with hearing loss is available at: TTY 1.888.232.6348

H. Other Information

Following is a list of acceptable attachments that applicants must upload as PDF files part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, that document will not be reviewed.

- Project Abstract (required form)
- CDC Assurances and Certifications (required form)
- Table of Contents for Entire Submission (no page limit)
- Project Narrative/Work Plan (maximum 18 pages)
- Budget Narrative (no page limit)
- SF424 (required form)
- SF424A (required form)

Applicants may submit additional information in an Appendix. The appendices will not be counted toward the project narrative page limit. **The total amount of appendices must not exceed 90 pages**. Any pages after page 90 of the appendix will not be considered for review. The following documents must be included in the application appendices:

- **Resumes/CVs of current key staff** who will work on the activity, including, but not limited to: Principal Investigator, Business Official, Project Manager
  - **Please refer to Section D, #10, part d, "Organizational Capacity of Awardees to Execute the Approach" for specific job descriptions required in this FOA, as applicable**
- **Job Descriptions of proposed key positions** to be created for the activity, including, but not limited to: Principal Investigator, Business Official, Project Manager
  - **Please refer to Section D, #10, part d, "Organizational Capacity of Awardees to Execute the Approach" for specific job descriptions required in this FOA, as applicable**
- **Letters of support:** See Collaborations section and Funding Preference section, as applicable
- **Memorandums of Understanding/Agreements (MOU/MOA):** See Collaborations section and Funding Preference section, as applicable
- **Organizational Chart**
- **Negotiated Indirect Cost Rate Agreement,** if applicable
- **Non-profit organization IRS status forms,** if applicable
- ***Funding Preference deliverables:*** See Funding Preference section in Section E, as applicable
  - ***If applying for the funding preference for local partner,*** the applicant must submit documentation to self-certify how the applicant meets the PEPFAR local partner definition listed in Section C, Eligibility Information in this FOA. The applicant must label the supporting documentation as "Eligibility Documentation for PEPFAR Local Partner Definition" and must clearly identify which criteria under paragraph 1, 2, or 3 their organization meets, and provide sufficient documentation to certify how their organization meets that criterion. Funding preference points will not be awarded to applicants who do not provide and/or label the supporting documentation required to meet the PEPFAR Local Partner definition.

Any additional information submitted via www.grants.gov must be uploaded in a PDF file format, and should be clearly labeled (i.e.: Letters of support should be named "letters of support").

Amendments, Questions and Answers (Q&As)

Applicants must submit their Q&As, if any, to the Project Officer listed under the Agency Contacts Section of this announcement no later than 15 days after the publication date in www.grants.gov. All Q&As will be published on the DGHA Website http://www.cdc.gov/globalaids/global-hiv-aids-at-cdc/FOA.html.

All changes, updates, and amendments to the FOA will be posted to www.grants.gov following the approval of CDC.

For additional information on reporting requirements, visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Other CDC funding opportunity announcements can be found on Grants.gov website, at the following internet address: http://www.grants.gov.

I. Glossary

Administrative and National Policy Requirements, Additional Requirements (ARs): outline the Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements as mandated by statute or CDC policy. CDC programs must indicate which ARs are relevant to the FOA. All ARs are listed in the template for CDC programs. Awardees must then comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Authority: Legal authorizations that outline the legal basis for the components of each individual FOA. An Office of Global Council (OGC) representative may assist in choosing the authorities appropriate to any given program.

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the Federal Government to an eligible recipient.

Budget Period/Year: the duration of each individual funding period within the project period. Traditionally, budget period length is 12 months or 1 year.

Carryover: Unobligated Federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried forward to another budget period to cover allowable costs of that budget period (whether as an offset or additional authorization). Obligated, but unliquidated, funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A catalog published twice a year which describes domestic assistance programs administered by the federal government. This government-wide compendium of Federal programs lists projects, services, and activities which provide assistance or benefits to the American public. https://www.cfda.gov/index?s=agency&mode=form&id=0bebbc3b3261e255dc82002b83094717&tab=programs&tabmode=list&subtab=list&subtabmode=list

CDC Assurances and Certifications: Standard government-wide grant application forms.

CFDA Number: The CFDA number is a unique number assigned to each program/FOA throughout its lifecycle that enables data and funding tracking and transparency.

Competing Continuation Award: An award of financial assistance which adds funds to a grant and extends one or more budget periods beyond the currently established project period.

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument establishing a binding legal procurement relationship between CDC and a recipient obligating the latter to furnish a product.

Cooperative Agreement: An award of financial assistance that is used to enter into the same kind of relationship as a grant; and is distinguished from a grant in that it provides for substantial involvement between the Federal agency and the awardee in carrying out the activity contemplated by the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal government but required of awardees. It may include the value of allowable third-party in-kind contributions, as well as expenditures by the awardee.

Direct Assistance: assistance given to an applicant such as federal personnel or supplies. See http://www.cdc.gov/stltpublichealth/GrantsFunding/direct_assistance.html.

Federal Funding Accountability And Transparency Act Of 2006 (FFATA): Requires information on Federal awards, including awards, contracts, loans, and other assistance and payments, be made available to the public on a single website, www.USAspending.gov.

Fiscal Year: The year that budget dollars are allocated to fund program activities. The fiscal year starts October 1st and goes through September 30th.

Grant: A legal instrument used by the Federal government to enter into a relationship, the principal purpose of which is to transfer anything of value to a recipient to carry out a public purpose of support or stimulation authorized by statute. The financial assistance may be in the form of money, or property in lieu of money. The term does not include: a Federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to individuals. The main difference between a grant and a cooperative agreement is that there is no anticipated substantial programmatic involvement by the Federal Government under an award.

Grants.gov: A "storefront" web portal for use in electronic collection of data (forms and reports) for Federal grant-making agencies through the www.grants.gov site, www.grants.gov.

Health Disparities: are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.

Healthy People 2020: Provides national health objectives for improving the health of all Americans by encouraging collaborations across sectors, guiding individuals toward making informed health decisions, and measuring the impact of prevention activities.

Inclusion: Inclusion refers to both the meaningful involvement of community members in all stages of the program process, and maximum involvement of the target population in the benefits of the intervention. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included.

Indirect Costs: Those costs that are incurred for common or joint objectives and therefore cannot be identified readily and specifically with a particular sponsored project, program, or activity but are nevertheless necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries are generally treated as indirect costs.

International public health work: For purposes of this template, is defined as work conducted internationally for the benefit of a foreign entity or jurisdiction.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions or Executive Orders ("legislation or other orders"), or other similar deliberations at all levels of government through communications that directly express a view on proposed or pending legislation or other orders and which are directed to members of staff, or other employees of a legislative body or to government officials or employees who participate in the formulation of legislation or other orders. Grass Roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the Federal, State or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Maintenance of Effort: A requirement contained in authorizing legislation, regulation stating that to receive Federal grant funds a recipient must agree to contribute and maintain a specified level of financial effort for the award from its own resources or other non-Federal sources. This requirement is typically given in terms of meeting a previous base-year dollar amount.

Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA): is a document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.

New FOA: Any FOA that is not a continuation or supplemental award.

Non-Governmental Organization: A non-governmental organization (NGO) is any non-profit, voluntary citizens' group which is organized on a local, national or international level.

Notice of Award: The only binding, authorizing document between the recipient and CDC confirming issue of award funding. The NoA will be signed by an authorized Grants Management Officer, and provided to the recipient fiscal officer identified in the application.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the individuals responsible for making award decisions.

OGC: Office of the General Counsel (OGC) is the legal team for the Department of Health and Human Services (HHS), providing representation and legal advice on a wide range of national issues. OGC supports the development and implementation of HHS's programs by providing legal services to the Secretary of HHS and the organization's various agencies and divisions.

Outcome: The observable benefits or changes for populations and/or public health capabilities that will result from a particular program strategy.

Performance Measures: Performance measurement is the ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals. It is typically conducted by program or agency management. Performance measures may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable

purpose or set of objectives.

Plain Writing Act of 2010: The Plain Writing Act requires federal agencies to communicate with the public in plain language to make information and communication more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. www.plainlanguage.gov

Procurement and Grants Office (PGO): PGO is the only entity within CDC which can obligate federal funds. PGO provides non-programmatic management for all CDC financial assistance activities (grants and cooperative agreements) and manages and awards all CDC contracts.

Program Strategies: Public health interventions or public health capabilities.

Program Official: The person responsible for developing the FOA – whether a project officer, program manager, branch chief, division leadership, policy official, center leadership, or similar staff member.

Project Period Outcome: An outcome that will result by the end of the FOA period of funding.

SAM: The System for Award Management (SAM) is the primary vendor database for the U.S. Federal Government. SAM validates applicant information and electronically shares the secure and encrypted data with the Federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). The SAM stores organizational information, allowing www.grants.gov to verify your identity and to pre-fill organizational information on grant applications.

Statute: An act of a legislature that declares, proscribes, or commands something; a specific law, expressed in writing. A statute is a written law passed by a legislature on the state or federal level. Statutes set forth general propositions of law that courts apply to specific situations.

Statutory Authority: A legal statute that provides the authority to establish a Federal financial assistance program or award.

Technical Assistance: The providing of advice, assistance, and training pertaining to the development, implementation, maintenance, and/or evaluation of programs.

Work Plan: The summary of annual strategies and activities, personnel and/or partners who will complete them, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.